Heal th Financi	al Systems	ST. CATHERINE H	IOSPI TAL	In Lieu	J of Form CMS-2552-10
	s required by Law (42 USC 1395g;				
payments made	since the beginning of the cost	t reporting period being	deemed overpayments (4	2 USC 1395g).	OMB NO. 0938-0050 EXPIRES 03-31-2022
AND SETTLEMENT		ST REPORT CERTIFICATION	Provider CCN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/23/2021 10:24 am
PART I - COST					
Provi der	1. [X] Electronically prepared	•		Date: 11/23/20	D21 Time: 10:24 am
use only	 2. [] Manually prepared cost 3. [0] If this is an amended 		of times the provider r	resubmitted this co	st report
	4. [F] Medicare Utilization.				
Contractor		. Date Received:		NPR Date:	
use only	(1) As Submitted 7 (2) Settled without Audit 8	. Contractor No.	nr this Provider CCN 12	Contractor's Vendo	r Code: 4
	(2) Settled without Audit (3) Settled with Audit	[N] Final Report for	this Provider CCN		es reopened = 0-9.
	(4) Reopened				
	(5) Amended				
PART II - CERT	I FLCATION				
	ION OR FALSIFICATION OF ANY INF	FORMATION CONTAINED IN T	HIS COST REPORT MAY BE	PUNISHABLE BY CRIM	INAL, CIVIL AND
	ACTION, FINE AND/OR IMPRISONME				
	ROCURED THROUGH THE PAYMENT DIRE		KICKBACK OR WERE OTHER	WISE ILLEGAL, CRIM	INAL, CIVIL AND
	E ACTION, FINES AND/OR IMPRISON				
	FICATION BY CHIEF FINANCIAL OFF				
	EBY CERTIFY that I have read the conically filed or manually subr				
	ses prepared by ST. CATHERINE H				
	g 06/30/2021 and to the best of				
	ete and prepared from the books				
	t as noted. I further certify n care services, and that the se				
	and regulations.		is cost report were pro		
	I have read and agree with the	above certification stat	ement I certify that I	intend my electro	ni c
	signature on this certification				
		(Si gned)) DANIEL O'BRIEN		
				strator of Provid	er(s)
			CFO		
			Title		
			(Dated when report	t is electronicall [,]	v si aned.)
			Date		,

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	463, 562	-96, 148	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	110, 086	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	573, 648	-96, 148	0	0	200.00

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 and review the 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 the 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.

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi de	er CCN		Period: From 07/01/	2020	Workshe Part I	et S-2	
						To 06/30/		Date/Ti 11/23/2		
	1.00	2.00		3.00			4.00			
	Hospital and Hospital Health Care Co									
	Street: 4321 FIR STREET	PO Box:	Zin Code	. 4401	2 Count					1.
00	City: EAST CHICAGO	State: IN Component Name	Zip Code	CBSA		y: LAKE Date	Davmo	nt Syst	om (D	2.
		component Name	Number	Numbe		Certified		0, or		
							V V	XVIII		1
		1.00	2.00	3.00) 4.00	5.00	6.00	7.00	8.00	1
	Hospital and Hospital-Based Componen				1					
		ST. CATHERINE HOSPITAL	150008	2384	4 1	07/01/1966	N	P	P	3.
	Subprovider - IPF Subprovider - IRF	ST. CATHERINE HOSPITAL	15T008	2384	4 5	01/01/2002	N	Р	Р	4.
0		- REHAB	151006	2304	4 5	01/01/2002		P	P	5.
0	Subprovider - (Other)	REIAD								6.
	Swing Beds - SNF									7.
	Swing Beds - NF									8.
0	Hospital-Based SNF									9.
	Hospital-Based NF									10.
	Hospital-Based OLTC									11.
	Hospital-Based HHA									12
	Separately Certified ASC								-	13.
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC									15
	Hospital-Based Health Clinic - FQHC									16
	Hospital - Based (CMHC) I									17
	Renal Dialysis									18
00	Other									19
						From:		To		4
	Cast Demanting Danied (my (dd (my y))					1.00	000	2.0		20
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					07/01/2	020	06/30,	2021	20.
00	Type of control (see this full the finit)					2				21.
					1.00	2.00		3. (00	1
	Inpatient PPS Information									
00	Does this facility qualify and is it	currently receiving p	ayments for		Y	N				22.
	disproportionate share hospital adju									
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo		menament							
	Did this hospital receive interim un		nts for this	د	Y	Y				22
	cost reporting period? Enter in colu									22
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N									
	reporting period occurring on or after	er October 1. (see ins	tructions)							
	Is this a newly merged hospital that				N	N				22
	payments to be determined at cost re			s)						
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob or "N" for no, for the portion of th									
	October 1.	e cost reporting perio								
	Did this hospital receive a geograph	ic reclassification fr	om urban to		Ν	N		Ν		22
	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reporting			r						
	in column 2, "Y" for yes or "N" for	•								
	reporting period occurring on or after			_						
	Does this hospital contain at least counted in accordance with 42 CFR 41.									
	yes or "N" for no.	Z. 1007: LITER TH COLUM	., J, T IU	'						
	Did this hospital receive a geograph	ic reclassification fr	om urban to		Ν	N		N		22
	rural as a result of the revised OMB									
	adopted by CMS in FY 2021? Enter in									1
	for the portion of the cost reporting			r						1
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft			_						
	Does this hospital contain at least			UI I		1				1
	counted in accordance with 42 CFR 41	2.105)? Enter in colu	1111 3 , 1 10	- I						
	counted in accordance with 42 CFR 41 yes or "N" for no.					3 N				22
00	counted in accordance with 42 CFR 41. yes or "N" for no. Which method is used to determine Me	dicaid days on lines 2	4 and/or 25			3 N				23
00	counted in accordance with 42 CFR 41 yes or "N" for no.	dicaid days on lines 2 of admission, 2 if cen	4 and/or 25 sus days, o	r 3		3 N				23

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	N: 15-0008		eri od:		Worl		t S-2	2552-1
					Fr Tc	om 07/0 06/3	0/2021 Dat 11/		rt te/Time Pre /23/2021 10		pared: 24 ar
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	S Mea eli	ut-of State di cai d i gi bl e npai d	Medic HMO d	aid	Oth Medio day	ner cai d	
		1.00	2.00	3.00		4.00	5.0	0	6.0	00	
	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2, 297	249			404		, 580		99	
	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the 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.	77	17	0		0		, 077		20095	25.
						Urban/R 1.(Date	2.00		
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	rural.				1.0	1	1	2.00		26. 0 27. 0
	reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	~"2" for r cation in	ural. If ap column 2.	plicable,			(35.0
	effect in the cost reporting period.					Begi nr	ni ng:	-	Endi ng		
5.00	Enter applicable beginning and ending dates of SCH s	tatus Subs	crint line	36 for numb	per	1. (00		2.00		36.
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	es.					C	D			37.
7. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)										37.
				•							
	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.			ne 37 is							38.
	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of			ne 37 is		Y/			Y/N		38.
9. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	f periods i payment a), (ii), or the mileage	n excess of djustment f (iii)? Ent requiremer	ne 37 is one and for low volu ter in columnts in	nn	Y/ 1. (N	00		Y/N 2.00 N	1	
9. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii	f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente	djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y	ne 37 is one and for low volu er in colum hts in 2 "Y" for yes (" for yes o	nn es or	1. (00		2.00 N		38. 39. 40.
9. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente	djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y	ne 37 is one and for low volu er in colum hts in 2 "Y" for yes (" for yes o	nn es or	1. C N	00		2.00 N N	XI X 3. 00	39.
 0.00 0.00 0.00 	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment	f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst	n excess of (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions)	ne 37 is For low volu Per in colum hts in P. "Y" for yes (" for yes or res or "N" f	nn es or for	1. (N	00 V	0 2.	2.00 N N	XI X	39.
 0.00 0.00 0.00 0.00 	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst nt for disp	djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina	ne 37 is for low volu er in colum ts in ? "Y" for yes (" for yes or ves or "N" f e share in ary circums1	nn es or for accutance	1.(N N ordance es	00 V 1.0	0 2.	2.00 N N	XI X 3. 00	39. 40. 45.
2. 00 0. 00 0. 00 0. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "/" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment	f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst nt for disp eption for t. L, Pt. I capital? E	djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r"Y" for y ructions) roportionat extraordina II and Wkst	ne 37 is for low volu for low volu er in colum hts in 2 "Y" for yes wes or "N" for es share in ary circumst c. L-1, Pt.	nn es or for accu tancu I t	1.0 N N ordance es hrough	00 V 1.0 N	0 2.	2.00 N N 111 00 Y	XI X 3. 00 N	39.
. 00 . 00 . 00 . 00 . 00 . 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "\" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete WKS? Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pi year, and are you are impacted by CR 11642 (or applic	f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst ter inst capital? E t? Enter " approved G e to column cograms in cable CRs)	djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina ll and Wkst nter "Y for y" for yes ME programs 1 is "Y", the prior y	ne 37 is for low volu er in colum its in ? "Y" for yes (" for yes of res or "N" for es share in ary circums1 c. L-1, Pt. yes or "N" or "N" for s? Enter "Y" or if this rear or penu	nn es for for accc tancc tancc t to no.	1.(N N ordance es hrough r no. r yes or pital mate	DO V 1.0 N N N N N	0 2.	2.00 N N 1111 00 Y N N	XI X 3. 00 N N	39. 40. 45. 46. 47. 48.
2. 00 5. 00 5. 00 5. 00 7. 00 5. 00 7. 00 7. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412. 101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412. 101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412. 320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412. 348(f)? If yes, complete WKSP Pt. III. Is this a new hospital under 42 CFR §412. 300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pro-	f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst ter inst approved G e to column cograms in cable CRs) umn 2. period duri r yes or "N th of this	djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes 1 is "Y", the programs 1 is "Y", the proir y WA direct C ng which re " for no ir cost report	ne 37 is for low volu- ter in colum tts in ? "Y" for yes (" for yes of res or "N" for cres or "N" for cres or "N" for se share in try circumsta c. L-1, Pt. yes or "N" or "N" for se r "Y" or if this rear or penu- SME payment esidents in a column 1. ting period?	nn es pr for for account of the second secon	1.(N N ordance es hrough r no. r yes or pital mate uction? roved column 1 nter "Y"	DO V 1.0 N N N N N	0 2.	2.00 N N 1111 00 Y N N	XI X 3. 00 N N	39. 40. 45. 46. 47.
9.00 0.00 5.00 5.00 5.00 5.00 7.00 7.00 3.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "\" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete WKS? Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pi year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting pi GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "Y	f periods i payment a), (ii), or the mileage i)? Enter n adjustmen ber 1. Enter (see inst (see inst cse inst t. L, Pt. I capital? E t? Enter " approved G e to column rograms in cable CRs) I umn 2. beriod duri r yes or "N th of this (", complet j, if appli bursement f	djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y WA direct for ng which re " for no ir cost report e Worksheet cable. or physicia	ne 37 is for low volu- er in column ts in 2 "Y" for yes (" for yes or ves or "N" for es share in ary circumst :. L-1, Pt. yes or "N" or "N" for s? Enter "Y" or if this vear or penu SME payment esidents in a column 1. :ing period? : E-4. If co	nn ess pr for accc tancc l t fo no. ' fo hos ultin red app lf ? E blum	1.(N N ordance es hrough r no. r yes or pital mate uction? roved column 1 nter "Y" n 2 is	DO V 1.0 N N N N N	0 2.	2.00 N N 1111 00 Y N N	XI X 3. 00 N N	39. 40. 45. 46. 47. 48. 56.

Health Financial Systems ST. CA	ATHERI NI	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 07/01/2020 o 06/30/2021	Worksheet S-2 Part I Date/Time Pre	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	11/23/2021 10 Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in col	85? (s umn 1. CR) NAHE	see If column 1	N			60.00
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.00
 column 1. (see instructions) 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
 instructions) 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
 ACA). (see instructions) 61.03 Enter the base line 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						61.04
 current cost reporting period. (see instructions). 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 						61.05
 61.04 minus line 61.03). (see instructions) 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
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.10
 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE 				0.00		61. 20
residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
			(1)===1		1.00	
ACA Provisions Affecting the Health Resources and Ser 62.00 Enter the number of FTE residents that your hospital				od for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruct 62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc Teaching Hospitals that Claim Residents in Nonprovide	Teachi Iram. (s	<u>see instructior</u>		your hospital	0.00	62.01
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base vear	2.00 is vour cost r	3.00 reporting	
64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June y train -priman all nor l non-pr n column	30, 2010. med residents ry care provider rimary care n 3 the ratio	0.00			64.00

	EX IDENTIFICATION DA	AIA Provider	Fr	eriod: om 07/01/2020	Worksheet Part I	
			To	06/30/2021	Date/Time 11/23/2021	Prepared
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	3/
			FTES	FTEs in	(col. 3 + c	ol.
			Nonprovider Site	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	
00 Enter in column 1, if line 63	1.00	2.00	0.00	0.00		000 65.
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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)						
			Unweighted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + c 2))	. 10:
			Site	позрітаі	2))	
			1.00	2.00	3.00	_
Section 5504 of the ACA Current \	Year FTE Residents i	n Nonprovider Settir				
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima	ry care resident				
(column 1 divided by (column 1 +			Unwei ghted	Unwei ghted	Ratio (col.	
	<u>column 2)). (see in</u> Program Name	structions) Program Code	FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + c 4))	
(column 1 divided by (column 1 +	column 2)). (see in	structions)	FTĔs Nonprovi der	FTEsin	(col. 3 + c 4)) 5.00	:ol .
<pre>(column 1 divided by (column 1 +</pre>	<u>column 2)). (see in</u> Program Name	structions) Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + c 4)) 5.00	:ol .
<pre>(column 1 divided by (column 1 +</pre>	<u>column 2)). (see in</u> Program Name	structions) Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + c 4)) 5.00 0.000	000 67.
<pre>(column 1 divided by (column 1 + (column 1 divided by (column 1 + name associated with each of your primary care programs in which you trained residents. 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)</pre>	<u>column 2)). (see in</u> Program Name <u>1.00</u> <u>25</u> chiatric Facility (structions) Program Code 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00	(col. 3 + c 4)) 5.00 0.000 0.000 0.000 0.000 0.000 0.000	000 67.
<pre>(column 1 divided by (column 1 + (column 1 divided by (column 1 + name associated with each of your primary care programs in which you trained residents. 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)</pre>	column 2)). (see in Program Name 1.00 1.00 value yalue yalue	structions) Program Code 2.00 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col. 3 + c 4)) 5.00 0.000 0.000 0.000	000 67. 000 67. 000 70.
<pre>(column 1 divided by (column 1 + (column 1 divided by (column 1 +) 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. 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)</pre>	column 2)). (see in Program Name 1.00 1.00 vchiatric Facility (the facility have a >fore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii) cate which program y y PPS nabilitation Facilit	structions) Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTËs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting	FTES in Hospital 4.00 0.00 0.00 1.0 rovider? N he most o. (see ing o.	(col. 3 + c 4)) 5.00 0.000 0.000 0.000 0.000 0.000	000 67. 000 67. 000 70.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Pre 11/23/2021 10	epared:
				1.00	-
Long Term Care Hospital PPS					
 D. 00 Is this a long term care hospital (LTCH)? Enter "Y" for yes I. 00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no. 			ng period? Enter	N N	80. 0 81. 0
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 5.00 Did this facility establish a new Other subprovider (excluded		2		N	85. 0 86. 0
 §413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 7. 00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 	cl assi fi ed	under sectio	ſ	Ν	87.0
			V	XIX	_
Title V and XIX Services			1.00	2.00	-
00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? E	nter "Y" for	N	Y	90.0
1.00 Is this hospital reimbursed for title V and/or XIX through th full or in part? Enter "Y" for yes or "N" for no in the appli			N	N	91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dua instructions) Enter "Y" for yes or "N" for no in the applicab	l certificat			N	92.0
3.00 Does this facility operate an ICF/IID facility for purposes o "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93.0
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	nd "N" for n	o in the	N	N	94.0
5.00 IF line 94 is "Y", enter the reduction percentage in the appl 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95. 0 96. 0
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the appl 3.00 Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo	erns and res	idents post	0. 00 N	0. 00 N	97. C 98. C
column 1 for title V, and in column 2 for title XIX. 3.01 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit	orting of ch	arges on Wks		Y	98.0
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.			Ν	Y	98.0
3.03 Does title V or XIX follow Medicare (title XVIII) for a criti reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N	98. (
3. 04 Does title V or XIX follow Medicare (title XVIII) for a CAH r outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			d N	N	98. (
3.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co column 2 for title XIX.				Y	98. (
3.06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	N	98. (
Rural Providers D5.00 Does this hospital qualify as a CAH?			N		105.0
66.00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)	nclusive met	hod of payme			106. 0
07.00 Column 1: If line 105 is Y, is this facility eligible for cos training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IPF	1. (see ins ou train I&R and/or IRF	tructions) s in an			107. (
Enter "Y" for yes or "N" for no in column 2. (see instructio 08.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 4	2 N		108. 0
	Physi cal 1.00	Occupation 2.00	al Speech 3.00	Respiratory 4.00	-
09.00 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 no for each therapy.		N	N	N	109. 0
10.00 Did this bestital participate in the Dural Community Hassital	Domonstrati	on project (\$4104	1.00 N	110.0
10.00 Did this hospital participate in the Rural Community Hospital Demonstration)for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Work	" for yes or	"N" for no.	lf yes,		110. C

Health Financial Systems ST. CATHERINE HOSPIT			eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Prov	ider CCN: 15-0008	Period: From 07/01/2020 To 06/30/2021		epared:
		1.00		
111.00 If this facility qualifies as a CAH, did it participate in the From Health Integration Project (FCHIP) demonstration for this cost repor "Y" for yes or "N" for no in column 1. If the response to column 1 integration prong of the FCHIP demo in which this CAH is participat Enter all that apply: "A" for Ambulance services; "B" for additiona for tele-health services.	orting period? Ente is Y, enter the ing in column 2.		2.00	111.00
	1.00	2.00	3.00	-
112. 00 Did this hospital participate in the Pennsylvania Rural Health Mode demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	>			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for in column 1. If column 1 is yes, enter the method used (A, B, or E in column 2. If column 2 is "E", enter in column 3 either "93" perc for short term hospital or "98" percent for long term care (include psychiatric, rehabilitation and long term hospitals providers) base the definition in CMS Pub. 15-1, chapter 22, §2208.1.	only) cent es ed on			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes "N" for no.	sor N			116.00
117.00 is this facility legally-required to carry malpractice insurance? E "Y" for yes or "N" for no.	inter Y			117.00
118.00 Is the mal practice insurance a claims-made or occurrence policy? Er	iter 1	1		118.00
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
	1.00	2.00	3.00	_
118.01 List amounts of malpractice premiums and paid losses:		1	0	0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost center		1.00 N	2.00	118.02
Administrative and General? If yes, submit supporting schedule lis and amounts contained therein. 119.00D0 NOT USE THIS LINE 120.00Is this a SCH or EACH that qualifies for the Outpatient Hold Harmle §3121 and applicable amendments? (see instructions) Enter in column "N" for no. Is this a rural hospital with < 100 beds that qualifies	sting cost centers ess provision in AC n 1, "Y" for yes or	A N	N	119. 00 120. 00
Hold Harmless provision in ACA §3121 and applicable amendments? (se Enter in column 2, "Y" for yes or "N" for no.	e instructions)			
121.00 Did this facility incur and report costs for high cost implantable patients? Enter "Y" for yes or "N" for no.	devices charged to	Y Y		121.00
122.00 Does the cost report contain healthcare related taxes as defined in Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" the Worksheet A line number where these taxes are included.				122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for yes a	nd "N" for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the	e certification dat	e		126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the	certification date			127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the	certification date			128.00
in column 1 and termination date, if applicable, in column 2. 129.00 f this is a Medicare certified lung transplant center, enter the c				129.00
column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare certified pancreas transplant center, enter t				130.00
date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter				131.00
date in column 1 and termination date, if applicable, in column 2. 132.00 f this is a Medicare certified islet transplant center, enter the				132. 00
TA TRUE THE A MEDICALE LECTIFIED ISLET FRANSDLADE CEDIEC ENTER THE	certification date			133. 00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved	number in column 1			134 00
	number in column 1			134.00

ealth Financial Systems IOSPITAL AND HOSPITAL HEALTH CARE COMPLE)			HOSPI TAL Provi der CC	N: 15-000	B Pe	eriod:	eu of Form CMS Worksheet S-	
						rom 07/01/2020 06/30/2021	I Date/Time Pr	
1.00		2.00				3.00	11/23/2021 1	10:24 an
If this facility is part of a chai	n organization, ent		nes 141 throu	uah 143 th	ne nam		of the	
home office and enter the home off								
41.00 Name: COMM FOUNDATION OF NW IN	Contractor's Na			Contr	actor'	s Number: 080	01	141.0
42.00 Street: 10010 DONALD S POWERS DRIVE		STE	201	71		47.2	01	142.0
43.00 City: MUNSTER	State:	IN		Zip C	ode:	463	21	143.0
							1.00	-
44.00 Are provider based physicians' cos	ts included in Works	sheet A?	,				Y	144.0
						1.00	2.00	1.15 0
45.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc	for yes or "N" for ude Medicare utiliz	no in c	olumn 1. lf c	olumn 1 i		Y	N	145. 0
period? Enter "Y" for yes or "N"								
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in					١£	N		146. 0
yes, enter the approval date (mm/d	d/vvvv) in column 2	PUD. 15	-z, chapter 4	10, 94020)				
							1.00	
47.00Was there a change in the statisti							Y	147.0
48.00Was there a change in the order of 49.00Was there a change to the simplifi	allocation? Enter '	"Y" for	yes or "N" fo	or no.	for n	-	N	148.0
49.00 was there a change to the simplifier	ed cost finding metr		Part A	Part		Title V	N Title XIX	149.0
			1.00	2.00		3.00	4.00	-
Does this facility contain a provi	der that qualifies	for an e						
or charges? Enter "Y" for yes or "	N" for no for each	componen		and Part	B. (S			
55.00Hospi tal			N	N		N	N	155.0
56.00 Subprovi der – IPF 57.00 Subprovi der – IRF			N N	N N		N N	N	156. C
57. 00 Subprovider – TRF 58. 00 SUBPROVIDER			IN	IN IN		IN	IN IN	158.0
59. 00 SNF			Ν	N		Ν	N	159.0
60.00 HOME HEALTH AGENCY			Ν	N		Ν	N	160. 0
61.00 CMHC				N		Ν	N	161. 0
							1.00	_
Multicampus							1.00	_
65.00 s this hospital part of a Multica	mpus hospital that H	has one	or more campu	uses in di	ffere	nt CBSAs?	N	165.0
Enter "Y" for yes or "N" for no.								
_	Name		County	State			FTE/Campus	_
	0		1.00	2.00	3.	00 4.00	5.00	00 166. 0
66. 00 f line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	JU 108. C
							1.00	_
Health Information Technology (HIT						Act	1	
57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	5 is "Y") and is a r	meani ngf	ul user (line			enter the	Y	167. 0 168. 0
68.01 If this provider is a CAH and is n	ot a meaningful use	r, does	, this provider			hardshi p		168.0
exception under §413.70(a)(6)(ii)?								
59.00 If this provider is a meaningful u		") and i	s not a CAH (line 105	is "N	"), enter the	9.0	99169.0
transition factor. (see instructio	ns)					Begi nni ng	Endi ng	-
						1.00	2.00	-
70.00 Enter in columns 1 and 2 the EHR b	eginning date and er	ndi ng da	te for the re	eporting			2.00	170. 0
period respectively (mm/dd/yyyy)								
						1.00	2.00	
71.00 fline 167 is "Y", does this prov						N		0171.0

	Financial Systems ST. CATHERIN AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	IE HOSPI TAL	CN: 15-0008	In Lie Period:	u of Form CMS- Worksheet S-2	
JSPI I	AL AND HUSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	UN: 15-0008	From 07/01/2020 To 06/30/2021		epareo
				Y/N	Date	
	Compared Instructions Enter V for all VEC recompany. Enter N	fam all NO m		<u> </u>	2.00	_
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	I TOF ALL NU FE	esponses. Ente	er all dates in i	Ine	
	COMPLETED BY ALL HOSPITALS					_
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.
00	reporting period? If yes, enter the date of the change in c					
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare F	Program2 If	1.00 N	2.00	3.00	2.
00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	5				2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.
			Y/N	Туре	Date	
	Financial Data and Dan-st-		1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	°or Compiled,	Y	A		4.
00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements of the statement of the stateme		N			5.
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6.
00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		Ν		7.
00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	Ν		8.
00	Are costs claimed for Interns and Residents in an approved	0	cal education	Ν		9.
. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c		the current	Ν		10.
. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.
					Y/N 1.00	
	Bad Debts					10
. 00 . 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	s, see instruct oolicy change o	during this co	ost reporting	Y N	12. 13.
. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I1	fyes, see ins	structions.	Ν	14.
. 00	Bed Complement Did total beds available change from the prior cost reporti			tructions.	Y	15.
		Par Y/N	rt A Date	Par Y/N	t B Date	_
		1.00	2.00	3.00	4.00	
	PS&R Data			NI NI		
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.
. 00	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	09/28/2021	Y	09/28/2021	17.
. 00	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 this	N		Ν		18.
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

Health Financial Systems

ST. CATHERINE HOSPITAL

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REINBURSEMENT QUESTIONNAIRE Provider CCR: 15-0003 Provider CCR: 15-0013 Provider CCR: 15-0014	Health Financial Systems ST. CATHERI	NE HOSPI TAL		In Lie	eu of Form CMS-	2552-10
Description V/N V/R V/R 20 0 1.00 3.00 20.00 1.00 3.00 20.00 1.00 3.00 20.00 1.00 3.00 20.00 1.00 3.00 20.00 4.00 20.00 4.00 21.00 20.00 4.00 21.00 20.00 4.00 21.00 20.00 4.00 21.00 21.00 20.00 4.00 21.00 21.00 20.00 4.00 21.00 21.00 20.00 4.00 21.00 21.00 20.00 4.00 21.00 21.00 21.00 20.00 4.00 21.00 21.00 20.00 4.00 21.00 22.00 22.00 22.00 23.00 <td>HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE</td> <td></td> <td></td> <td>Period: From 07/01/2020</td> <td>Worksheet S-2 Part II Date/Time Pre</td> <td>2 epared:</td>	HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Period: From 07/01/2020	Worksheet S-2 Part II Date/Time Pre	2 epared:
20.00 [F] F] Ine 16 or 17 is yes, were adjustments mode to PSAR N N N 20.00 Report data for Other? Describe the other adjustments: V/N Date V/N Date 21.00 3.00 4.00 21.00 N Composition 21.00 3.00 4.00 21.00 N 22.00 20.00		Descr	iption	Y/N		
Report data for 0ther? Describe the other adjustnents: Y/N Date Y/N Date 21.00 Was the cost report prepared only using the provider'S N N 21.00 21.00 Was the cost report prepared only using the provider'S N N 21.00 21.00 Was the cost report prepared only using the provider'S N N 21.00 CourtLETED BY COST REI/MURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHLDRENS HOSPITALS) 1.00 22.00 Capit tal Related Cost CourtLetteD BY COST REI/MURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHLDRENS HOSPITALS) 22.00 Capit tal Related Cost CourtLetteD BY COST REI/MURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHLDRENS HOSPITALS) 22.00 Capit tal Related Cost Cost Cost Cost 22.00 1 we change socurred in the Medicare depreciation expense due to appraisals and during the cost Cost 23.00 1 we change on new capit alized in other during the cost reporting period? If yes, see instructions. 27.00 10 27.00 20.00 Ware more Loads, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit the set structions. 27.00 28.00 20.00			0	1.00	3.00	
Image: Sec: Property and the provider's interval in the provider interval inter	20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				N	20.00
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Home Office Costs 36.00 Were home office costs claimed on the cost report? 36.00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 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. 38.00 38.00 If line 36 is yes, onter in column 2 the fiscal year end of the home office. 38.00 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 39.00 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 instructions. 1.00 2.00 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Community 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. COMMUNITY HOSPITAL 41.00 43.00 Enter the telephone number and email address of the cost 12197031267 CATHERINE. R. WOERNER@COMHS. OR 43.00						
36.00 Were home office costs claimed on the cost report? 36.00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 1f yes, see instructions. 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. 38.00 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 39.00 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 1f line 36 is yes, did the provider render services to the home office? If yes, see 40.00 1f line 36 is yes, did the provider render services to the home office? If yes, see 40.00 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectivel y. CATHERINE WOERNER 42.00 Enter the employer/company name of the cost report preparer to columns 1, 2, and 3, respectivel y. COMMUNITY HOSPITAL 42.00 43.00 Enter the telephone number and email address of the cost 12197031267 CATHERINE. R. WOERNER@COMHS. OR 43.00	Home Office Costs			1.00	2.00	
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 1f yes, see instructions. 1f 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. 38.00 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 39.00 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 1f line 36 is yes, did the provider render services to the home office? If yes, see 40.00 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. CMMUNITY HOSPITAL 42.00 Enter the employer/company name of the cost report preparer. CMMUNITY HOSPITAL 43.00 Enter the telephone number and email address of the cost 12197031267 CATHERINE. R. WOERNER@COMHS. OR 43.00	36.00 Were home office costs claimed on the cost report?					36.00
38.00 If I ine 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. 38.00 39.00 If I ine 36 is yes, did the provider render services to other chain components? If yes, see instructions. 39.00 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 41.00 Cost Report Preparer Contact Information 41.00 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Community HOSPITAL 42.00 Enter the telephone number and email address of the cost 12197031267	37.00 If line 36 is yes, has a home office cost statement been p	repared by the	home office?			37.00
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 39.00 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 41.00 If line 36 is yes, did the provider render services to the home office? If yes, see 41.00 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. CATHERINE WOERNER 42.00 Enter the employer/company name of the cost report preparer. COMMUNITY HOSPITAL 42.00 43.00 Enter the telephone number and email address of the cost 12197031267 CATHERINE. R. WOERNER@COMHS. OR 43.00	38.00 If line 36 is yes, was the fiscal year end of the home of					38.00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 40.00 Instructions. 1.00 2.00 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. CATHERINE WOERNER 41.00 42.00 Enter the employer/company name of the cost report preparer. COMMUNITY HOSPITAL 42.00 43.00 Enter the telephone number and email address of the cost 12197031267 CATHERINE. R. WOERNER@COMHS. OR 43.00	39.00 If line 36 is yes, did the provider render services to othe					39.00
Cost Report Preparer Contact Information 1.00 2.00 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. CATHERINE WOERNER 41.00 42.00 Enter the employer/company name of the cost report preparer. COMMUNITY HOSPITAL 42.00 43.00 Enter the telephone number and email address of the cost 12197031267 CATHERINE. R. WOERNER@COMHS. OR 43.00	40.00 If line 36 is yes, did the provider render services to the	home office?	lf yes, see			40.00
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 12197031267		1	00	<u></u> ر	00	
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. CATHERINE WOERNER 41.00 42.00 Enter the employer/company name of the cost report preparer. COMMUNITY HOSPITAL 43.00 42.00 43.00 Enter the telephone number and email address of the cost 12197031267 CATHERINE. R. WOERNER@COMHS. OR 43.00	Cost Report Preparer Contact Information	1. 1.		Ζ.		
42. 00respectively. Enter the employer/company name of the cost report preparer.COMMUNITY HOSPITAL42. 0043. 00Enter the telephone number and email address of the cost12197031267CATHERINE. R. WOERNER@COMHS. OR43. 00	41.00 Enter the first name, last name and the title/position	CATHERINE		WOERNER		41.00
43.00 Enter the telephone number and email address of the cost 12197031267 CATHERINE. R. WOERNER@COMHS. OR 43.00	respecti vel y.					42 00
	preparer.				EDNED@COMUS OD	
		1217/03120/		G	LINER®UUMIDS. UK	43.00

Heal th	Financial Systems ST. CAT	THERI NE	E HOSPI TAL			In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	RE	Provider C	CN: 15-0008	Perio	d: 07/01/2020	Worksheet S-2 Part II	
							Date/Time Pre 11/23/2021 10	pared: 24 am
			3.	00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	n f	REIMBURSEMENT	SUPERVI SOR				41.00
	held by the cost report preparer in columns 1, 2, and	3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost report							42.00
	preparer.							
43.00	Enter the telephone number and email address of the co	ost						43.00
	report preparer in columns 1 and 2, respectively.							

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	ST. CATHERINE	Provider CC	N. 15_0008	Peri od:	u of Form CMS-2 Worksheet S-3	
1105111	AL AND HOST THE HEALTH OAKE COMPLEX STATISTIC			N. 15 0000	From 07/01/2020 To 06/30/2021	Part I Date/Time Pre	
					10 00/30/2021	11/23/2021 10	
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	122	44, 5	30 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)						2 00
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF		100			0	6.00
7.00	Total Adults and Peds. (exclude observation		122	44, 5	30 0.00	0	7.00
0 00	beds) (see instructions)	04.00	10	0 (
8.00	INTENSIVE CARE UNIT	31.00	10	3, 6	50 0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					_	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		132	48, 1	30 0.00	0	14.00
15.00	CAH visits	10.00				0	15.00
16.00	SUBPROVIDER - IPF	40.00	0		0	0	16.00
17.00	SUBPROVIDER - IRF	41.00	20	7, 3	00	0	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	101.00					21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC					_	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		152				27.00
28.00	Observation Bed Days					0	
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC			ri od: om 07/01/2020 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/23/2021 10	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		otal Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
. 00	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)	6, 628	2, 158	27, 32	21			1.0
. 00	HMO and other (see instructions)	5, 900	10, 789					2.0
. 00	HMO IPF Subprovider	0	0					3.0
. 00	HMO IRF Subprovider	796	1, 094					4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.0
. 00	Hospital Adults & Peds. Swing Bed NF		0		0			6.0
. 00	Total Adults and Peds. (exclude observation	6, 628	2, 158	27, 32	21			7.0
~ ~	beds) (see instructions)	750						
. 00	INTENSIVE CARE UNIT	758	22	2, 73	35			8.0
. 00	CORONARY CARE UNIT							9.0
0.00	BURN INTENSIVE CARE UNIT							10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T							11.0
2.00 3.00	OTHER SPECIAL CARE (SPECIFY) NURSERY		117	80	25			12.0 13.0
4.00	Total (see instructions)	7, 386	2, 297	30, 86		0.00	779.03	
5.00	CAH visits	7, 300	2, 277	50, 00	0	0.00	117.05	15.0
6.00	SUBPROVIDER - IPF	0	0		0	0.00	0.00	
7.00	SUBPROVIDER - IRF	2,855	77	5, 37	-	0.00	28.53	
8.00	SUBPROVIDER	2,000		0,01		01 00	20100	18.0
9.00	SKILLED NURSING FACILITY							19. (
0. 00	NURSING FACILITY							20.0
1.00	OTHER LONG TERM CARE							21.0
2.00	HOME HEALTH AGENCY	0	0		0	0.00	0.00	22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)							23.0
4.00	HOSPI CE							24. (
4. 10	HOSPICE (non-distinct part)			4	42			24.
5.00	CMHC - CMHC							25.0
6.00	RURAL HEALTH CLINIC							26. (
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	
7.00	Total (sum of lines 14-26)					0.00	807.56	
B. 00	Observation Bed Days		0	4, 23	38			28. (
9.00	Ambul ance Trips	0						29.0
0.00	Employee discount days (see instruction)				0			30.0
1.00	Employee discount days - IRF				0			31.
2.00	Labor & delivery days (see instructions)	0	99	11				32.0
2.01	Total ancillary labor & delivery room				0			32. (
2 00	outpatient days (see instructions)	0						33. (
3.00	LTCH non-covered days LTCH site neutral days and discharges	0						33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/23/2021 10	pared:
		Full Time Equivalents		Di s	charges	11/23/2021 10	. 24 am
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	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)		0			5, 634	1.00
2.00	HMO and other (see instructions)			9	30 2, 079		2.00
3.00	HMO I PF Subprovider				0		3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				86		4.00 5.00
5.00 6.00	Hospital Adults & Peds. Swing Bed NF Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1, 2	90 424	5, 634	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0		0 0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	2	35 7	423	17.OC
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00					21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00 24.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23.00 24.00
24.00	HOSPICE HOSPICE (non-distinct part)						24.00
24.10	CMHC - CMHC						24.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0, 00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days	0.00					28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days				0		33.00
33.01	LTCH site neutral days and discharges				0		33.01

PI T	AL WAGE INDEX INFORMATION			Provider CC	F	eriod: rom 07/01/2020 o 06/30/2021		pared
		Wkst. A Line Number	Amount Reported	A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
0	Total salaries (see	200. 00	54, 677, 080	0	54, 677, 080	1, 679, 726. 63	32.55	1.
0	instructions) Non-physician anesthetist Part		C	o	C	0.00	0. 00	2.
0	A Non-physician anesthetist Part		704, 799		704, 799			
	В							
0	Physician-Part A - Administrative		C	0	C	0.00	0.00	4.
)1)0	Physicians - Part A - Teaching Physician and Non		C 1, 663, 441	-	C 1, 663, 441	0. 00 10, 418. 00		
	Physician-Part B							
0	Non-physician-Part B for hospital-based RHC and FQHC		C	0	C	0.00	0.00	6.
0	services Interns & residents (in an	21.00	C	о	C	0.00	0.00	7.
)1	approved program) Contracted interns and		C	0	C	0.00	0. 00	7.
	residents (in an approved programs)		_		-			
0	Home office and/or related organization personnel		C	0	C	0.00	0. 00	8.
0	SNF	44.00	C	О	C	0.00		9.
00	Excluded area salaries (see instructions)		2,045,378	0	2, 045, 378	69, 295. 76	29. 52	10.
	OTHER WAGES & RELATED COSTS			· · · · ·		1		
00	Contract Labor: Direct Patient Care		795, 971	0	795, 971	6, 569. 27	121. 17	11
00	Contract Labor: Top Level management and other management and administrative		C	0	C	0.00	0. 00	12.
00	services Contract Labor: Physician-Part		159, 232	0	159, 232	1, 037. 13	153. 53	13.
00	A - Administrative Home office and/or related		C	0	C	0.00	0.00	14
	organization salaries and wage-related costs							
	Home office salaries		6, 993, 058	1	6, 993, 058			
02 00	Related organization salaries Home office: Physician Part A		C	0	C	0.00 0.00		
	- Administrative		-		-			
00	Home office and Contract Physicians Part A - Teaching		C	0	C	0.00	0.00	16
01	Home office Physicians Part A - Teaching		C	0	C	0.00	0.00	16
02	Home office contract Physicians Part A - Teaching		C	0	C	0.00	0.00	16
00	WAGE-RELATED COSTS Wage-related costs (core) (see		13, 371, 897	0	13, 371, 897	•		17
00	instructions) Wage-related costs (other)							18
00	(see instructions)							10
00 00	Èxcluded areas Non-physician anesthetist Part		564, 836 (0	564, 836 (19 20
00	A Non-physician anesthetist Part		101, 059		101, 059			20
00	В		101,009		101,009			
	Physician Part A - Administrative		Ĺ		Ĺ			22.
01	Physician Part A - Teaching			0	105 400			22.
00 00	Physician Part B Wage-related costs (RHC/FQHC)		195, 428 C	0	195, 428 C			23. 24.
00	Interns & residents (in an		C	0	C			24.
50	approved program) Home office wage-related		1, 717, 704	0	1, 717, 704			25.
51	(core) Related organization		C	0	C			25.
52	wage-related (core) Home office: Physician Part A		ſ	0	ſ			25.
	- Administrative - wage-related (core)							

Heal th	Financial Systems		ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part II Date/Time Pre 11/23/2021 10	pared:
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0		0		25.53
	OVERHEAD COSTS - DIRECT SALARIE							
26.00	Employee Benefits Department	4.00	400, 934		400, 93			26.00
27.00	Administrative & General	5.00	6, 579, 565		6, 579, 56			27.00
28.00	Administrative & General under contract (see inst.)		1, 014, 914	0	1, 014, 91	4 7, 237. 26	140. 23	28.00
29.00	Maintenance & Repairs	6.00	0	0		0 0.00	0.00	29.00
30.00	Operation of Plant	7.00	1, 694, 568	0	1, 694, 56			30.00
31.00	Laundry & Linen Service	8.00	89, 577		89, 57			31.00
32.00	Housekeeping	9,00	1, 821, 931	0	1, 821, 93			32.00
33.00	Housekeeping under contract (see instructions)	7.00	0	0	1, 021, 70	0 0.00		33.00
34.00	Di etary	10.00	1, 510, 713	-467,556	1, 043, 15	57, 030. 23	18 29	34.00
35.00	Dietary under contract (see instructions)	101.00	0	0	1,010,10	0 0.00		
36.00	Cafeteri a	11.00	0	467, 556	467, 55	25, 561. 00	18. 29	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00		37.00
38.00	Nursing Administration	13.00	1, 476, 584	0	1, 476, 58	64, 338. 51		38.00
39.00	Central Services and Supply	14.00	0	0		0 0.00		39.00
40.00	Pharmacy	15.00	0	0		0 0.00		40.00
41.00	Medical Records & Medical Records Library	16.00	0	0		0 0.00		41.00
42.00	Soci al Service	17.00	0	n		0 0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0 0.00		43.00

Heal th	Financial Systems		ST. CATHERIN	IE HOSPI TAL		In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 07/01/2020 To 06/30/2021			
		Worksheet A		Recl assi fi cati	,		Average Hourly		
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷		
				`	$(col.2 \pm col.$	Salaries in	col. 5)		
				Worksheet A-6)	3)	col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		53, 323, 754	0	53, 323, 75	4 1, 670, 020. 14	31.93	1.00	
	instructions)								
2.00	Excluded area salaries (see instructions)		2,045,378	0	2, 045, 37	8 69, 295. 76	29. 52	2.00	
3.00	Subtotal salaries (line 1 minus line 2)		51, 278, 376	0	51, 278, 37	6 1, 600, 724. 38	32.03	3.00	
4.00	Subtotal other wages & related costs (see inst.)		7, 948, 261	0	7, 948, 26	1 194, 413. 40	40. 88	4.00	
5.00	Subtotal wage-related costs (see inst.)		15, 089, 601	0	15, 089, 60	1 0.00	29. 43	5.00	
6.00	Total (sum of lines 3 thru 5)		74, 316, 238	0	74, 316, 23	8 1, 795, 137. 78	41.40	6.00	
7.00	Total overhead cost (see instructions)		14, 588, 786	0	14, 588, 78	6 515, 232. 90	28. 31	7.00	

	nancial Systems WAGE RELATED COSTS		OSPITAL Provider CCN	: 15-0008	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 07/01/2020		
					To 06/30/2021		
						11/23/2021 10 Amount	24
						Reported	
						1.00	
PA	RT IV - WAGE RELATED COSTS					1.00	
	irt A - Core List						
	TI REMENT COST						
	D1K Employer Contributions					0	1 1
	ax Sheltered Annuity (TSA) Employer Contributi	i on				1, 710, 230	
	onqualified Defined Benefit Plan Cost (see ins					0	
	ualified Defined Benefit Plan Cost (see instru					0	
PL	AN ADMINISTRATIVE COSTS (Paid to External Org	gani zati on)					
20 40	D1K/TSA Plan Administration fees					0	5
00 Le	egal/Accounting/Management Fees-Pension Plan					0	6
00 Em	nployee Managed Care Program Administration Fe	ees				0	7
HE.	ALTH AND INSURANCE COST						
00 He	ealth Insurance (Purchased or Self Funded)					0] ε
01 He	ealth Insurance (Self Funded without a Third F	Party Administra	itor)			0	8
)2 He	ealth Insurance (Self Funded with a Third Part	ty Administrator	·)			7, 164, 266	8
)3 He	ealth Insurance (Purchased)					0	8
00 Pr	rescription Drug Plan					0	9
	ental, Hearing and Vision Plan					431, 060	10
00 Li	fe Insurance (If employee is owner or benefic	ci ary)				38, 018	11
	ccident Insurance (If employee is owner or ber					0	
	sability Insurance (If employee is owner or b					35, 245	
	ong-Term Care Insurance (If employee is owner	or beneficiary)				0	
	Vorkers' Compensation Insurance					721, 491	
	etirement Health Care Cost (Only current year,	, not the extrac	ordi nary accru	ual require	ed by FASB 106.	0	16
	on cumulative portion)						
	XES					0.407.070	
	CA-Employers Portion Only					3, 137, 272	
	edicare Taxes - Employers Portion Only					760, 608	
	nemployment Insurance					235, 029	
	tate or Federal Unemployment Taxes					0	20
-	HER kecutive Deferred Compensation (Other Than Ret	tiromont Cost Da	ported on Lie	acc 1 three	igh 1 abovo (coo	0	21
	nstructions))	tirement cost Re	eported on TT	ies i throu	ign 4 above. (See	0	
	ay Care Cost and Allowances					0	22
	uition Reimbursement					0	
	otal Wage Related cost (Sum of lines 1 -23)					14, 233, 219	
	irt B - Other than Core Related Cost					14, 255, 219	24
	THER WAGE RELATED COSTS (SPECIFY)						25

Health Financial Systems	ST. CATHERINE HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0008	Peri od:	Worksheet S-3	
		From 07/01/2020	Part V	
		To 06/30/2021	Date/Time Pre	
Cost Center Description		Contract Labor	11/23/2021 10 Benefit Cost	24 80
cost center bescription		1.00	2.00	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identi	fication [.]			
1.00 Total facility's contract labor and benefit		795, 971	14, 233, 219	1.00
2.00 Hospital		795, 971	14, 233, 219	
3.00 Subprovider - IPF		0	0	3.00
4.00 Subprovider - IRF		0	0	4.00
5.00 Subprovider - (Other)		0	0	5.00
6.00 Swing Beds - SNF		0	0	6,00
7.00 Swing Beds - NF		0	0	7.00
8.00 Hospital-Based SNF				8.00
9.00 Hospital-Based NF				9.00
10.00 Hospital-Based OLTC				10.00
11.00 Hospital-Based HHA		0	0	11.00
12.00 Separately Certified ASC				12.00
13.00 Hospi tal -Based Hospi ce				13.00
14.00 Hospital-Based Health Clinic RHC				14.00
15.00 Hospital-Based Health Clinic FQHC				15.00
16.00 Hospital-Based-CMHC				16.00
17.00 Renal Dialysis		0	0	17.00
18.00 Other		0	0	18.00

Heal th	Financial Systems ST. CATHERINE HO	SPI TAL	In Lie	eu of Form CMS-:	2552-10		
		Provider CCN: 15-0008	Peri od:	Worksheet S-1	0		
			From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10			
				1.00			
	Uncompensated and indigent care cost computation			1.00			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line 202 col	umn 8)	0. 222358	1.00		
1.00	Medicaid (see instructions for each line)			0.222000	1.00		
2.00	Net revenue from Medicaid			36, 895, 079	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		i cai d?	Y	4.00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid		0	0.00		
6.00	Medi cai d charges			192, 271, 790			
7.00	Medicaid cost (line 1 times line 6)			42, 753, 171			
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 5,858,092 8.0 < zero then enter zero)						
9.00	Net revenue from stand-al one CHIP	reach rine)		0	9.00		
9.00 10.00	Stand-al one CHIP charges			0			
11.00	Stand-alone CHIP cost (line 1 times line 10)			0			
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9	if < zero then	0	•		
.2.00	enter zero)		,		12.00		
	Other state or local government indigent care program (see inst	ructions for each li	ne)		1		
13.00	Net revenue from state or local indigent care program (Not incl			15, 088	•		
14.00	Charges for patients covered under state or local indigent care 10)	program (Not includ	ed in lines 6 or	90, 464	14.00		
15.00	State or local indigent care program cost (line 1 times line 14			20, 115	•		
16.00	Difference between net revenue and costs for state or local ind	igent care program (line 15 minus line	5, 027	16.00		
	13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state/local in	digent care progra	ms (see			
17 00	Private grants, donations, or endowment income restricted to fu	nding charity care		0	17.00		
18.00	Government grants, appropriations or transfers for support of h			0			
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)		ams (sum of lines	5, 863, 119			
		Uni nsur	ed Insured	Total (col. 1			
		pati ent		+ col. 2)			
		1.00	2.00	3.00			
~~ ~~	Uncompensated Care (see instructions for each line)		000 044 50/	0.440.400	0.00		
20.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	ility 8, 218	, 093 244, 536	8, 462, 629	20.00		
21.00	Cost of patients approved for charity care and uninsured discoulinstructions)	nts (see 1,827	, 359 244, 536	2, 071, 895	21.00		
22.00	Payments received from patients for amounts previously written charity care	off as	0 0	0	22.00		
23.00	Cost of charity care (line 21 minus line 22)	1, 827	, 359 244, 536	2, 071, 895	23.00		
				1.00			
24.00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care	program?	5	N	24.00		
25.00	If line 24 is yes, enter the charges for patient days beyond th stay limit	e indigent care prog	ram's length of	0	25.00		
26.00	Total bad debt expense for the entire hospital complex (see ins			6, 144, 446	•		
				538, 283			
	Medicare allowable bad debts for the entire hospital complex (s	ee instructions)		828, 128			
28.00	Non-Medicare bad debt expense (see instructions)			5, 316, 318			
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instructio	ns)	1, 471, 971			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	no 20)		3, 543, 866			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		9, 406, 985	31.00		

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXTENSES		F	eriod: rom 07/01/2020	Worksheet A	
				T	0 06/30/2021	Date/Time Pre 11/23/2021 10	
	Cost Center Description	Sal ari es	Other		Reclassificati	Reclassified	
				+ col. 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
		1.00	2.00	3.00	4.00	5.00	
00	GENERAL SERVICE COST CENTERS		2, 567, 002	2, 567, 002	123, 845	2, 690, 847	1 1.
00	00200 CAP REL COSTS-BEDG & TTXT		3, 480, 073	3, 480, 073		3, 502, 970	
00	00300 OTHER CAP REL COSTS		0	0	0	0	
00	00400 EMPLOYEE BENEFITS DEPARTMENT	400, 934	7, 985, 657	8, 386, 591	-1, 205	8, 385, 386	
01 02	00560 PURCHASI NG RECEIVING AND STORES 00570 ADMITTING	272, 282 798, 571	28, 153 127, 394	300, 435 925, 965		300, 281 928, 173	
02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	52	52		52	
04	00590 OTHER ADMINI STRATI VE & GENERAL	5, 508, 712	24, 077, 345	29, 586, 057	-254, 906	29, 331, 151	5.
00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	-
00 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 694, 568 89, 577	4, 066, 141 672, 766	5, 760, 709 762, 343		5, 760, 697 762, 343	
00	00900 HOUSEKEEPING	1, 821, 931	577, 836	2, 399, 767		2, 397, 580	
. 00	01000 DI ETARY	1, 510, 713	1, 357, 262	2, 867, 975		1, 980, 045	
. 00	01100 CAFETERIA	0	0	0	887, 619	887, 619	
. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0 1, 476, 584	0 340, 862	0 1, 817, 446	0 -8, 959	0 1, 808, 487	
	01400 CENTRAL SERVICES & SUPPLY	1,470,304	040, 002	1, 017, 440	-0, 737	1, 000, 407	
. 00	01500 PHARMACY	0	0	0	0	0	15
	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	
7.00 9.00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
. 00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	1 19.
. 00	03000 ADULTS & PEDI ATRI CS	12, 705, 443	2, 692, 030	15, 397, 473	401, 735	15, 799, 208	30
. 00	03100 I NTENSI VE CARE UNI T	2, 502, 200	717, 244	3, 219, 444		3, 221, 535	
0.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.
. 00	04100 SUBPROVI DER – I RF 04300 NURSERY	1, 620, 096 0	868, 996 0	2, 489, 092 0	489, 682	2, 489, 092 489, 682	
. 00	ANCI LLARY SERVICE COST CENTERS	Q	0	0	407,002	407,002	
. 00	05000 OPERATI NG ROOM	2, 468, 250	3, 010, 083	5, 478, 333		5, 572, 682	
	05100 RECOVERY ROOM	1,004,466	257, 961	1, 262, 427		1, 259, 799	
. 00 . 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 390, 720 2, 262, 251	510, 996 450, 887	1, 901, 716 2, 713, 138		1, 026, 261 2, 713, 138	
. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 622, 771	833, 524	2, 456, 295		2, 456, 295	
. 00	05500 RADI OLOGY – THERAPEUTI C	201, 708	359, 503	561, 211	0	561, 211	
. 00	05600 RADI OI SOTOPE	356, 461	407, 277	763, 738		763, 738	
. 00 . 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	454, 582 208, 260	577, 824 172, 047	1, 032, 406 380, 307		1, 032, 406 380, 307	
. 00	05900 CARDI AC CATHETERI ZATI ON	731, 235	986, 729	1, 717, 964			
. 00	06000 LABORATORY	2, 466, 559	3, 343, 859	5, 810, 418		5, 878, 464	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	
	06300 BLOOD STORING, PROCESSING, & TRANS.	148, 690	667, 851	816, 541		816, 541	
. 00 . 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	437, 305 945, 838	130, 427 310, 392	567, 732 1, 256, 230		567, 667 1, 259, 410	
. 00	06600 PHYSI CAL THERAPY	1, 451, 815	756, 730	2, 208, 545		2, 208, 460	
. 00	06700 OCCUPATI ONAL THERAPY	707, 309	584, 790	1, 292, 099		1, 292, 099	
. 00	06800 SPEECH PATHOLOGY	241, 577	152, 134	393, 711		393, 711	
. 00 . 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	633, 995 225, 330	198, 982 91, 616	832, 977 316, 946		832, 977 316, 946	
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	223, 330	3, 771, 455	3, 771, 455		3, 887, 824	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 478, 387	3, 478, 387		3, 533, 723	
	07300 DRUGS CHARGED TO PATIENTS	1, 840, 787	8, 978, 069	10, 818, 856		10, 818, 356	
. 00 . 00	07400 RENAL DI ALYSI S 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 150, 622	697, 378 20, 900	697, 378 171, 522		697, 378 171, 522	
	07697 CARDI AC REHABI LI TATI ON	327, 494	47, 881	375, 375		375, 375	
	OUTPATIENT SERVICE COST CENTERS						1
. 00		966, 147	820, 641	1, 786, 788		1, 786, 788	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 606, 015	1, 069, 411	3, 675, 426	1, 642	3, 677, 068	91
00	OTHER REIMBURSABLE COST CENTERS						92
1.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101
_	SPECIAL PURPOSE COST CENTERS						4.
3. 00		54, 251, 798	82, 246, 547	136, 498, 345	-39, 746	136, 458, 599	1118
	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190
	19100 RESEARCH	0	0	0			191
2.00	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 200	-2, 383	817		817	192
	07950 OTHER NONREI MBURSEABLE	0	112, 088	112, 088		112, 088	
	07951 ADVERTI SI NG 07952 RETALL PHARMACY	0 422, 082	144, 254 6, 486, 866	144, 254 6, 908, 948		184, 000 6, 908, 948	
N 11.1					. ()I		

CLASSIFICATION AND ADJUSTME	ENTS OF TRIAL BALANCE OF	ST. CATHERIN EXPENSES	Provider CCN:	15-0008 Period:	n Lieu of Form CMS-2552 Worksheet A
				From 07/01/ To 06/30/	2021 Date/Time Prepare
Cost Center Desc	ription	Adjustments	Net Expenses		11/23/2021 10: 24
			For Allocation		
GENERAL SERVICE COST C	ENTERS	6.00	7.00		
0 00100 CAP REL COSTS-BL		58, 374	2, 749, 221		1
00 00200 CAP REL COSTS-MVI	BLE EQUI P	200, 980			2
00300 OTHER CAP REL CO	STS	0	0		3
00 00400 EMPLOYEE BENEFITS		954, 173	9, 339, 559		4
00560 PURCHASING RECEI	VING AND STORES	-112	300, 169		5
02 00570 ADMI TTI NG		0	928, 173		5
03 00580 CASHI ERI NG/ACCOUI 04 00590 OTHER ADMI NI STRA		1, 640, 930			5
00590 OTHER ADMINISTRA 00 00600 MAINTENANCE & REI		-10, 878, 915 0	18, 452, 236		5
00 00700 OPERATION OF PLA		-9, 884	5, 750, 813		7
00 00800 LAUNDRY & LINEN		0	762, 343		8
00 00900 HOUSEKEEPI NG		0	2, 397, 580		ç
00 01000 DI ETARY		-844	1, 979, 201		10
00 01100 CAFETERI A		-588, 512	299, 107		11
00 01200 MAI NTENANCE OF PI		0	0		12
00 01300 NURSI NG ADMI NI STI		83, 231	1, 891, 718		13
00 01400 CENTRAL SERVICES	& SUPPLY	0	0		14
00 01500 PHARMACY 00 01600 MEDICAL RECORDS 8		0 1, 392, 535	0 1, 392, 535		15
00 01700 SOCIAL SERVICE		1, 392, 535	1, 392, 535		17
00 01900 NONPHYSICIAN ANES	STHETI STS	0	0		19
INPATIENT ROUTINE SERV		-	-		
00 03000 ADULTS & PEDIATR		-16	15, 799, 192		30
00 03100 INTENSIVE CARE U		-406	3, 221, 129		31
00 04000 SUBPROVIDER - I PI		0	0		40
00 04100 SUBPROVIDER - IRI	F	0	2, 489, 092		41
00 04300 NURSERY	CENTERC	0	489, 682		43
ANCI LLARY SERVICE COST 00 05000 OPERATI NG ROOM	CENTERS	-372,000	5, 200, 682		50
00 05100 RECOVERY ROOM		-372,000	1, 259, 799		51
00 05200 DELIVERY ROOM & I	LABOR ROOM	-116, 250	910, 011		52
00 05300 ANESTHESI OLOGY		-2, 505, 909	207, 229		53
00 05400 RADI OLOGY-DI AGNO	STIC	-19, 425	2, 436, 870		54
00 05500 RADI OLOGY - THER	APEUTI C	0	561, 211		55
00 05600 RADI OI SOTOPE		0	763, 738		56
00 05700 CT SCAN		0	1,032,406		57
. 00 05800 MAGNETIC RESONANC . 00 05900 CARDIAC CATHETER		0 -14, 076	380, 307 1, 429, 229		58
00 06000 LABORATORY	ZATION	-14,078	5, 864, 695		60
00 06200 WHOLE BLOOD & PA	CKED RED BLOOD CELL	13, 707	0,004,075		62
00 06300 BLOOD STORING, PI		0	816, 541		63
00 06400 INTRAVENOUS THER		0	567, 667		64
00 06500 RESPI RATORY THER	APY	0	1, 259, 410		65
00 06600 PHYSI CAL THERAPY		0	2, 208, 460		66
00 06700 OCCUPATIONAL THEI	RAPY	0	1, 292, 099		67
00 06800 SPEECH PATHOLOGY		0	393, 711		68
00 06900 ELECTROCARDI OLOG		-136, 565	696, 412		69
00 07000 ELECTROENCEPHALO		0 -19, 413	316, 946 3, 868, 411		70 71
00 07200 IMPL. DEV. CHARG		- 17, 413 N	3, 868, 411		71
00 07300 DRUGS CHARGED TO		-2, 126, 000	8, 692, 356		73
00 07400 RENAL DI ALYSI S		_, .20, 000	697, 378		74
00 03550 PSYCHI ATRI C/PSYCI	HOLOGI CAL SERVI CES	-2, 282	169, 240		76
97 07697 CARDI AC REHABI LI	TATI ON	-1, 250	374, 125		76
OUTPATIENT SERVICE COS	T CENTERS				
00 09000 CLI NI C		-613, 970			90
00 09100 EMERGENCY	(NON DI CTUNICT CAST	-32	3, 677, 036		91
00 09200 OBSERVATI ON BEDS	·				92
OTHER REIMBURSABLE COS		0	0		101
SPECIAL PURPOSE COST C		0	U		101
	F LINES 1 through 117)	-13, 089, 407	123, 369, 192		118
0. 00 19000 GIFT, FLOWER, CO		0	0		190
1. 00 19100 RESEARCH		0	0		191
2. 00 19200 PHYSI CI ANS' PRI V	ATE OFFICES	0	817		192
4. 00 07950 OTHER NONREI MBUR		0	112, 088		194
4. 01 07951 ADVERTI SI NG		0	184, 000		194
4. 02 07952 RETAIL PHARMACY		0	6, 908, 948		194 200
	NES 118 through 199)				

Heal th	Financial Systems		ST. CATHERINE	HOSPI TAL	In Lie	u of Form CMS-2552-10
RECLAS	SIFICATIONS			Provider CCN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet A-6 Date/Time Prepared:
						11/23/2021 10:24 am
		Increases				
	Cost Center	Line #	Salary	Other		
		3.00	4.00	5.00		
1 00	A - BUILDING INSURANCE CAP REL COSTS-BLDG & FIXT	1.00	0	122.045		1.00
1.00 2.00			-	123, 845		2.00
2.00	CAP_REL_COSTS-MVBLE_EQUIP		<u>o</u>	1 <u>4, 2</u> 92 138, 137		2.00
	B - CAFETERIA EXPENSE		<u> </u>	130, 137		
1.00	CAFETERI A	11.00	467, 556	420, 063		1.00
1.00	TOTALS		467, 556	420,063		1.00
	C - NURSERY/LABOR & DELIVERY	I	407, 330	420,003		
1.00	ADULTS & PEDIATRICS	30.00	282, 003	103, 617		1.00
2.00	NURSERY	43.00	358, 103	131, 579		2.00
2.00	TOTALS		640, 106	235, 196		2.00
	D - COVID COSTS	I	010, 100	200, 170		
1.00	ADMI TTI NG	5.02	0	2, 208		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	16, 115		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	2, 091		3.00
4.00	LABORATORY	60,00	0	68, 046		4.00
5.00	RESPI RATORY THERAPY	65.00	0	3, 180		5.00
6.00	EMERGENCY	91.00	0	1, 642		6.00
	TOTALS		o	93, 282		
	E - INTEREST EXPENSE		·			
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8, 605		1.00
	TOTALS			8,605		
	F - INVENTORY ADJ EXPENSE					
1.00	OPERATING ROOM	50.00	0	102, 954		1.00
2.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	155, 469		2.00
	PATI ENT					
3.00	IMPL. DEV. CHARGED TO	72.00	0	119, 190		3.00
	PATI ENTS	+	+_			
	TOTALS		0	377, 613		
	G - ADVERTISING	101.01		22 74		
1.00	ADVERTI SI NG	194.01	0	39, 746		1.00
2.00		0.00	0	0		2.00
3.00		0.00		0		3.00
4.00		0.00	0	0		4.00
5.00 6.00		0.00 0.00	0	0		5.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
8.00 9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
12.00	TOTALS					12.00
500.00	Grand Total: Increases		1, 107, 662	1, 312, 642		500.00
		1	· · · · ·	- · · · · ·		1

LASSI	FICATIONS			Provider (CCN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet A-6 Date/Time Prepare 11/23/2021 10:24
		Decreases					11/23/2021 10:24
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref		
	6.00	7.00	8.00	9.00	10.00		
A	A - BUILDING INSURANCE						
0 0	OTHER ADMINISTRATIVE &	5.04	0	138, 137	1 1	2	1.
G	GENERAL						
0		0.00	0	0) 1	2	2
Т	FOTALS	T		138, 137	/	7	
B	3 – CAFETERIA EXPENSE						
o D	DI ETARY	10.00	467, 556	420, 063	6	0	1.
Т	TOTALS	T	467, 556	420,063	<u> </u>	-	
C	C - NURSERY/LABOR & DELIVERY		· · · · ·				
o D	DELIVERY ROOM & LABOR ROOM	52.00	640, 106	235, 196)	0	1.
0		0.00	0	0)	0	2
Т	TOTALS		640, 106	235, 196	,	1	
D	D - COVID COSTS						
	OTHER ADMINISTRATIVE &	5.04	0	93, 282	2	0	1.
G	GENERAL						
0		0.00	o	0)	0	2
0		0.00	o	0)	0	3
0		0.00	0	0)	0	4
0		0.00	0	0)	0	5.
0		0.00	0	0)	0	6
Т	TOTALS	+		93, 282	2	1	
E	E - INTEREST EXPENSE	· · · · ·	· · · · · ·			· ·	
0 0	DPERATING ROOM	50.00	<u>0</u>	8, 605	5 1	1	1.
Т	TOTALS		0	8, 605)		
	- INVENTORY ADJ EXPENSE						
	MEDICAL SUPPLIES CHARGED TO	71.00	0	39, 100)	0	1.
	PATIENT						
	MPL. DEV. CHARGED TO	72.00	0	63, 854	-	0	2
	PATIENTS						
	CARDIAC_CATHETERIZATION	<u>59.</u> 00	0	27 <u>4,6</u> 59		Q	3
-	TOTALS		0	377, 613	8		
	G - ADVERTISING					-1	
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 205		0	1.
-	PURCHASING RECEIVING AND	5.01	0	154	+	0	2.
		5.04		22 407		0	
	OTHER ADMINISTRATIVE &	5.04	0	23, 487		0	3.
	GENERAL	7 00		10			
	OPERATION OF PLANT	7.00	0	12		0	4
	HOUSEKEEPI NG	9.00	0	2, 187		-	5.
		10.00	0	311		0	6
	NURSING ADMINISTRATION	13.00	0	8, 959		0	7.
	RECOVERY ROOM	51.00	Ű,	2, 628		0	8
	DELIVERY ROOM & LABOR ROOM	52.00	0	153		0	9
	NTRAVENOUS THERAPY	64.00	0	65		0	10
	PHYSICAL THERAPY	66.00	0	85		0	11.
	DRUGS_CHARGED_TO_PATIENTS	73.00	0	500		띡	12
	TOTALS		0	39, 746		4	
1 (1) (-	Grand Total: Decreases		1, 107, 662	1, 312, 642	1		500

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0008 Period: From 07/01/2020 To 06/30/2021 Worksheet A-7 Part I Date/Time Prepared: 11/23/2021 10:24 am PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 0	Heal th	Financial Systems	ST. CATHERIN	E HOSPI TAL			In Lie	u of Form CMS-2	2552-10
Beginning Balances Purchases Donation Total Disposal s and Retirements 1.00 2.00 3.00 4.00 5.00 1.00 Land 5,316 0 0 0 0 1.00 2.00 Land Improvements 2,831,386 0				Provider CC	CN: 15-0008	Fro	om 07/01/2020	Part I Date/Time Pre	pared:
Bai ances Retirements 1.00 2.00 3.00 4.00 5.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 5.316 0 0 0 0 1.00 2.00 Land 5.3316 0 0 0 0 0 1.00 2.00 Land Improvements 2.831,386 0 0 0 0 4.029 2.00 3.00 4.00 Building improvements 45,307,924 2.808,790 0 2.808,790 -147,307 4.00 5.00 6.00 0					Acqui si ti on	IS			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Land 5,316 0 0 0 0 1.00 2.00 Land improvements 2,831,386 0 0 0 0 444,529 2.00 3.00 Buildings and Fixtures 40,775,906 0 0 0 0 3.00 4.00 5.316 0 0 0 3.00 444,529 2.00 3.00 Buildings and Fixtures 45.307,924 2.808,790 0 2.808,790 -147,307 4.00 5.00 Fixed Equipment 50,649,524 1.308,694 0 1.308,694 389,278 6.00 6.00 Movable Equipment 50,649,524 1.308,694 0 4.117,484 686,500 8.00 9.00 Reconciling Items 0 <t< td=""><td></td><td></td><td>Begi nni ng</td><td>Purchases</td><td>Donati on</td><td></td><td>Total</td><td></td><td></td></t<>			Begi nni ng	Purchases	Donati on		Total		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 0									
1.00 Land 5,316 0 0 0 0 1.00 2.00 Land Improvements 2,831,386 0 0 0 444,529 2.00 3.00 Buil dings and Fixtures 40,775,906 0				2.00	3.00		4.00	5.00	
2.00 Land Improvements 2,831,386 0 0 0 444,529 2.00 3.00 Buildings and Fixtures 40,775,906 0 0 0 0 3.00 4.00 Building Improvements 45,307,924 2,808,790 0 2,808,790 -147,307 4.00 5.00 Fixed Equipment 0 0 0 0 0 5.00 6.00 Movable Equipment 50,649,524 1,308,694 0 1,308,694 389,278 6.00 7.00 HIT designated Assets 0 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 139,570,056 4,117,484 0 4,117,484 686,500 8.00 9.00 Reconciling Items 0 139,570,056 4,117,484 0 4,117,484 686,500 10.00 10.00 Total (line 8 minus line 9) 139,570,056 4,117,484 0 4,117,484 686,500 10.00 2.00 Land System 5,316 0 2.00 2.366,857 2.00 2.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
3.00 Buildings and Fixtures 40,775,906 0 0 0 0 3.00 4.00 Building Improvements 45,307,924 2,808,790 0 2,808,790 -147,307 4.00 5.00 Fixed Equipment 0				0		0	0	-	
4.00 Building Improvements 45, 307, 924 2, 808, 790 0 2, 808, 790 -147, 307 4.00 5.00 Fixed Equipment 0	2.00		2, 831, 386	0		0	0	444, 529	2.00
5.00 Fixed Equipment 0 0 0 0 5.00 6.00 Movable Equipment 50, 649, 524 1, 308, 694 389, 278 6.00 7.00 HIT designated Assets 0 <			40, 775, 906	0		0	0	0	3.00
6.00 Movable Equipment 50, 649, 524 1, 308, 694 0 1, 308, 694 389, 278 6.00 7.00 HIT designated Assets 0 0 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 139, 570, 056 4, 117, 484 0 4, 117, 484 686, 500 8.00 9.00 Reconciling Items 0 139, 570, 056 4, 117, 484 0 4, 117, 484 686, 500 9.00 9.00 10.00 Total (line 8 minus line 9) 139, 570, 056 4, 117, 484 0 4, 117, 484 686, 500 10.00 9.00 PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 5, 316 0 1.00 2.08, 857 0 1.00 2.00 Land Improvements 2, 386, 857 0 2.00 3.00 3.00 3.00 3.00 3.00 Buildings and Fixtures 40, 775, 906 0 4.00 5.00 5.00 6.00 5.00 6.00 Movable Equipment 51, 568, 940 0 0 5.00 6.00	4.00	Building Improvements	45, 307, 924	2, 808, 790		0	2, 808, 790	-147, 307	4.00
7.00 HIT designated Assets 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 139,570,056 4,117,484 0 4,117,484 686,500 8.00 9.00 Reconciling Items 0 <t< td=""><td>5.00</td><td>Fixed Equipment</td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>5.00</td></t<>	5.00	Fixed Equipment	0	0		0	0	0	5.00
8.00 Subtotal (sum of lines 1-7) 139,570,056 4,117,484 0 4,117,484 686,500 8.00 9.00 Reconciling ltems 0	6.00	Movable Equipment	50, 649, 524	1, 308, 694		0	1, 308, 694	389, 278	6.00
9.00 Reconciling Items 0	7.00	HIT designated Assets	0	0		0	0	0	7.00
10.00 Total (line 8 minus line 9) 139,570,056 4,117,484 0 4,117,484 686,500 10.00 Image: I	8.00	Subtotal (sum of lines 1-7)	139, 570, 056	4, 117, 484		0	4, 117, 484	686, 500	8.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Fully Depreciated Assets 1.00 1.00 1.00 Land 5.316 0 1.00 2.00 Land Improvements 2.386,857 0 2.00 3.00 Buildings and Fixtures 40,775,906 0 3.00 4.00 5.00 Fixed Equipment 5.00 6.00 7.00 4.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 9.00 9.00 9.00 9.00	9.00	Reconciling Items	0	0		0	0	0	9.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Depreciated Assets 1.00 1.00 Land 5,316 0 1.00 1.00 2.00 Land Improvements 2,386,857 0 3.00 3.00 Buildings and Fixtures 40,775,906 0 3.00 3.00 4.00 5.00 Fixed Equipment 48,264,021 0 4.00 5.00 5.00 6.00 7.00 4.00 5.00 5.00 6.00 0 <td>10.00</td> <td>Total (line 8 minus line 9)</td> <td>139, 570, 056</td> <td>4, 117, 484</td> <td></td> <td>0</td> <td>4, 117, 484</td> <td>686, 500</td> <td>10.00</td>	10.00	Total (line 8 minus line 9)	139, 570, 056	4, 117, 484		0	4, 117, 484	686, 500	10.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1.00 1.00 1.00 2.00 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 3.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00			Ending Balance	Fully					
6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 5,316 0 2.00 Land Improvements 2,386,857 0 3.00 Buildings and Fixtures 40,775,906 0 3.00 4.00 Building Improvements 48,264,021 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 51,568,940 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 143,001,040 0 8.00 9.00 Reconciling Items 0 0 9.00			Ũ	Depreci ated					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 5,316 0 1.00 2.00 Land Improvements 2,386,857 0 2.00 3.00 Buildings and Fixtures 40,775,906 0 3.00 4.00 Building Improvements 48,264,021 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 51,568,940 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 143,001,040 0 8.00 9.00				Assets					
1.00 Land 5,316 0 1.00 2.00 Land Improvements 2,386,857 0 2.00 3.00 Buildings and Fixtures 40,775,906 0 3.00 4.00 Building Improvements 48,264,021 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 51,568,940 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 143,001,040 0 8.00 9.00 Reconciling Items 0 0 9.00			6.00	7.00					
2.00 Land Improvements 2,386,857 0 2.00 3.00 Buildings and Fixtures 40,775,906 0 3.00 4.00 Building Improvements 48,264,021 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 51,568,940 0 7.00 8.00 Subtotal (sum of lines 1-7) 143,001,040 0 8.00 9.00 Reconciling Items 0 0 9.00		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
3.00 Buildings and Fixtures 40,775,906 0 3.00 4.00 Building Improvements 48,264,021 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 51,568,940 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 143,001,040 0 8.00 9.00 Reconciling Items 0 0 9.00	1.00	Land	5, 316	0					1.00
4.00 Building Improvements 48,264,021 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 51,568,940 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 143,001,040 0 8.00 9.00 Reconciling Items 0 0 9.00	2.00	Land Improvements	2, 386, 857	0					2.00
5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 51,568,940 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 143,001,040 0 8.00 9.00 Reconciling Items 0 0 9.00	3.00	Buildings and Fixtures	40, 775, 906	0					3.00
6.00 Movable Equipment 51,568,940 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 143,001,040 0 8.00 9.00 Reconciling Items 0 0 9.00	4.00	Building Improvements	48, 264, 021	0					4.00
7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 143,001,040 0 8.00 8.00 9.00 Reconciling Items 0 0 0 9.00	5.00	Fixed Equipment	0	0					5.00
8.00 Subtotal (sum of lines 1-7) 143,001,040 0 8.00 8.00 9.00 9.00 0 0 9.00	6.00	Movable Equipment	51, 568, 940	0					6.00
9.00 Reconciling Items 0 0 9.00	7.00	HIT designated Assets	0	0					7.00
	8.00	Subtotal (sum of lines 1-7)	143, 001, 040	0					8.00
	9.00	Reconciling Items	0	0					9.00
10.00 10.00 10.00	10.00	Total (line 8 minus line 9)	143, 001, 040	0					10.00

Heal th	Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0008	Period: From 07/01/2020	Worksheet A-7 Part II	
					To 06/30/2021	Date/Time Pre	
						11/23/2021 10	:24 am
			SL	JMMARY OF CAP	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
	1	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR						
1.00	CAP REL COSTS-BLDG & FIXT	2, 561, 999	5, 003		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 525, 994	954, 079		0 0	0	2.00
3.00	Total (sum of lines 1-2)	5, 087, 993	959, 082		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 567, 002				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 480, 073				2.00
3.00	Total (sum of lines 1-2)	0	6, 047, 075				3.00

Heal th	n Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	1	Period: From 07/01/2020 Fo 06/30/2021		pared: 24 am
		COMI	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	PART III - RECONCILIATION OF CAPITAL COSTS C	1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	91, 432, 099 51, 568, 939 143, 001, 038	0	91, 432, 094 51, 568, 934 143, 001, 038 CAPI TAL	90. 36061931. 000000		1.00 2.00 3.00
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS		1	0 (11 100	44.447	1 00
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)				2, 641, 493 3, 140, 579 5, 782, 072	540, 474	1.00 2.00 3.00
0100			SI	JMMARY OF CAPI		0217007	0100
	Cost Center Description		Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	-	100.015			0.740.004	
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0 8, 605 8, 605	14, 292		0 0 0 0 0 0	2, 749, 221 3, 703, 950 6, 453, 171	1.00 2.00 3.00

Heal th	Fi nanci a	I Systems
AD JUST	MENTS TO	EXPENSES

leal th	Financial Systems		ST. CATHERIN	E HOSPI TAL	In Lie	u of Form CMS-2	<u>2552</u> -10
	MENTS TO EXPENSES			Provider CCN: 15-0008	Peri od:	Worksheet A-8	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:
				Expense Classification c	n Worksheet A	11/23/2021 10	:24 am
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00		1.00
	COSTS-BLDG & FIXT (chapter 2)		0		2.00		2.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other		0		0.00	0	3.00
. 00	(chapter 2) Trade, quantity, and time		0		0.00	о	4.00
. 00	di scounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of		0		0.00	0	5.00
. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)	_					
	Telephone services (pay stations excluded) (chapter	A	-	OTHER ADMINISTRATIVE & GENERAL	5.04	0	7.00
	21)						
. 00	Television and radio service	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
. 00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
	Provider-based physician	A-8-2	-46, 510			0	
1. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
	(chapter 23)		0		0.00	0	11.00
	Related organization	A-8-1	-5, 881, 282			0	12.00
	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
4.00	Cafeteria-employees and guests		0		0.00	0	14.00
	Rental of quarters to employee and others		0		0.00	0	15.00
	Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than						
7.00	patients Sale of drugs to other than		0		0.00	0	17.00
	patients					_	
	Sale of medical records and abstracts		0		0.00	0	18.00
9.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees,						
	books, etc.) Vending machines		0		0.00	0	20.00
	Income from imposition of		0		0.00	0	21.00
	interest, finance or penalty charges (chapter 21)						
	Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of						
	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of						
	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	* 114.00		25.00
	physicians' compensation		0	cost center bereted	114.00		25.00
4 00	(chapter 21)		0		1 00		24.00
6. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
	Physicians' assistant		0		0.00	0	
	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
	therapy costs in excess of limitation (chapter 14)						
0. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of	H-0-3	0	JILLUII FAITULUUT	68.00		31.00
	limitation (chapter 14)		~		0.00		22.22
	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

Heal th	Financial Systems		ST. CATHERIN	NE HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
	MENTS TO EXPENSES			Provider CCN: 15-0008	Peri od:	Worksheet A-8	
					From 07/01/2020		
					To 06/30/2021	Date/Time Pre 11/23/2021 10	pared:
				Expense Classification o	n Worksheet A	1172372021 10	24 am
				To/From Which the Amount is			
					2		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4.00	5.00	
33.00	ANESTHESIA - NON-SALARIES,	A 1.00		ANESTHESI OLOGY	53.00		33.00
55.00	NON-BENEF	n	00,707	ANESTHESTOLOGI	55.00		33.00
33. 01	COVID DRUG DONATIONS	В	-2.126.000	DRUGS CHARGED TO PATIENTS	73.00	0	33.01
33.02	PART B CONTRACTED SERVICES	А		OPERATING ROOM	50.00		•
33.03	PART B CONTRACTED SERVICES	A	-116, 250	DELIVERY ROOM & LABOR ROOM	52.00	0	33.03
33.04	PART B CONTRACTED SERVICES	A	-500, 000	CLINIC	90.00	0	33.04
33.05	PART B SALARIES	A	-2, 262, 251	ANESTHESI OLOGY	53.00	0	33.05
33.06	PART B SALARI ES	A	-105, 990	CLINIC	90.00	0	33.06
33.07	PRE-MERGER ASSETS DEPRECIATION	А	6, 723	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	PATIENT TELEPHONES	A	-65, 770	OTHER ADMINISTRATIVE &	5.04	0	33.08
				GENERAL			
33.09	TV DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2.00		
33.10	OTHER REVENUE	В		CAP REL COSTS-BLDG & FIXT	1.00		
33.11	OTHER REVENUE	В		CAP REL COSTS-MVBLE EQUIP	2.00	10	•
33.12	OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMEN			
33. 13	OTHER REVENUE	В	-112	PURCHASING RECEIVING AND STORES	5.01	0	33.13
33.14	OTHER REVENUE	В	-24, 227	OTHER ADMINISTRATIVE &	5.04	0	33. 14
				GENERAL	7.00		0.0.45
33.15	OTHER REVENUE	В		OPERATION OF PLANT	7.00		
33.16	OTHER REVENUE	В			10.00	0	
33. 17 33. 18	OTHER REVENUE OTHER REVENUE	B B		NURSING ADMINISTRATION ADULTS & PEDIATRICS	13.00 30.00	0	
33.10	OTHER REVENUE	В		INTENSIVE CARE UNIT	31.00	-	1
33. 19	OTHER REVENUE	B		ANESTHESIOLOGY	53.00		
33. 21	OTHER REVENUE	B		RADI OLOGY-DI AGNOSTI C	54.00	0	•
33. 22	OTHER REVENUE	В		LABORATORY	60, 00	-	
33. 23	OTHER REVENUE	В		ELECTROCARDI OLOGY	69.00		
33.24	OTHER REVENUE	В		MEDICAL SUPPLIES CHARGED TO		0	33.24
				PATI ENT			
33. 25	OTHER REVENUE	В	-2, 282	PSYCHI ATRI C/PSYCHOLOGI CAL	76.00	0	33.25
33. 26		В	1 250	SERVICES CARDIAC REHABILITATION	76.97	0	33.26
33.20 33.27	OTHER REVENUE OTHER REVENUE	В		CLINIC	90.00	e e e e e e e e e e e e e e e e e e e	00.20
33. 27 33. 28	OTHER REVENUE	В			90.00		
33. 20 33. 29	OTHER REVENUE	В		CAFETERIA	11.00	-	
33.30	PART B BENEFITS	A		ANESTHESI OLOGY	53.00		•
33. 31	PART B BENEFITS	A		CLINIC	90.00	0	
33. 32	PART B BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN		-	
50.00	TOTAL (sum of lines 1 thru 49)		-13, 089, 407				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

Description - all chapter references in this column pertain to CMS Pub. 15-1.
 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.

Heal th	Financial Systems	ST. CATHERI	NE HOSPI TAL	In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Period:	Worksheet A-8	8-1
OFFICE	COSTS			From 07/01/2020		
				To 06/30/2021	Date/Time Pre 11/23/2021 10	
	Line No.	Cost Center	Expense Items	Amount of	Amount	<u>, 24 am</u>
	Li në No.	cost center	Expense i tellis	Allowable Cost		
					Wks. A, column	
					5 5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF				
	HOME OFFICE COSTS:					
1.00		CAP REL COSTS-BLDG & FIXT	DEPRECIATION BLDG	72, 771	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION EQUIP	614, 864	0	2.00
3.00	5.04	OTHER ADMINISTRATIVE & GENER	A&G OTHER	4, 571, 243	0	3.00
3.02	16.00	MEDICAL RECORDS & LIBRARY	MEDI CAL RECORDS	1, 392, 535	0	3.02
3.03	5.03	CASHI ERI NG/ACCOUNTS RECEI VAB	PATIENT ACCOUNTING	1, 640, 930	0	3.03
3.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	ALLOCATED BENEFIT COSTS	1, 096, 580	0	3.04
3.05	5.04	OTHER ADMINISTRATIVE & GENER	ALLOCATED SALARY COSTS	5, 317, 752	0	3.05
4.00	13.00	NURSING ADMINISTRATION	CANCER REGISTRY	84, 331	0	4.00
4.01	5.04	OTHER ADMINISTRATIVE & GENER	CORPORATE ALLOCATION	0	16, 335, 507	4.01
4.02	5.04	OTHER ADMINISTRATIVE & GENER	PHYSICIAN ALLOCATION	0	4, 336, 781	4.02
5.00	TOTALS (sum of lines 1-4).			14, 791, 006		5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and	or Home Office		
					1	
Symbol (1)	Name	Percentage of	Name	Percentage of	1	
		Ownershi p		Ownershi p	1	
1.00	2.00	3.00	4.00	5.00		
B INTERRELATIONSHIP TO 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

1 CT IIID GT						
6.00	G	CFNI	100.00	CFNI	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	FI NANCI AL				100.00
	non-financial) specify:					

(1) Use the following symbols to indicate 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.

Health Financial Systems	ST. CATHERINE HOSPITAL	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELAT OFFICE COSTS	ED ORGANIZATIONS AND HOME Provider CCN: 15-000	B Period: Worksheet A-8-1 From 07/01/2020
		To 06/30/2021 Date/Time Prepared:

			11/23/2021 10	<u>):24 am</u>
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		1
1.00	72, 771	9		1.00
2.00	614, 864	9		2.00
3.00	4, 571, 243	0		3.00
3.02	1, 392, 535	0		3. 02
3.03	1, 640, 930	0		3.03
3.04	1, 096, 580	0		3.04
3.05	5, 317, 752	0		3.05
4.00	84, 331	0		4.00
4.01	-16, 335, 507	0		4.01
4.02	-4, 336, 781	0		4. 02
5.00	-5, 881, 282			5.00

The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

1100 1			no anothe arrenable e	in i or tino parti	
	Rel ated Organi zati on(s)				
	and/or Home Office				
	Type of Business				
	51				
	6, 00				
	B. INTERRELATIONSHIP TO RELATIONSHIP TO RELATIONSHIP TO RELATIONSHIP	ED ORGANIZATION(S) AN	ID/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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII

i ci ilibui		
6.00	HEALTHCARE HOME OFFICE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

(1) Use the following symbols to indicate 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 organizati on.

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.

Heal th	Financial Syste	ems	ST. CATHERI	NE HOSPI TAL		In Li€	eu of Form CMS-	2552-10
	R BASED PHYSIC				CCN: 15-0008	Peri od:	Worksheet A-8	
						From 07/01/2020 To 06/30/2021		
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component		Physician/Prov ider Component Hours	<u>. 24 din</u>
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5. 04	AGGREGATE-OTHER	33, 283	0	33, 28	3 211, 500	272	1.00
2.00	30.00	ADMINISTRATIVE & GEN AGGREGATE-ADULTS & PEDIATRICS	15, 000	0	15,000	211, 500	150	2.00
3.00	31.00	AGGREGATE - I NTENSI VE CARE UNI T	7, 398	0	7, 39	3 211, 500	69	3.00
4.00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	34, 272	0	34, 27	2 271, 900	144	4.00
5.00	59.00	AGGREGATE-CARDI AC CATHETERI ZATI ON	24, 753	0	24, 75	3 211, 500	105	5.00
6.00 7.00		AGGREGATE-LABORATORY AGGREGATE-ELECTROENCEPHALOGR APHY	29, 500 15, 025				148 150	6.00 7.00
8.00	0.00		0	-		0 0	0	8.00
9.00	0.00		0	0		0 0	0	9.00
10. 00 200. 00	0.00		0 159, 231	0		0	1 029	10.00 200.00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	200.00
		I denti fi er	Limit	Unadjusted RCE Limit	Memberships & Continuing Education		of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5. 04	AGGREGATE-OTHER	27, 658	1, 383	(0 0	0	1.00
2.00	30. 00	ADMI NI STRATI VE & GEN AGGREGATE-ADULTS &	15, 252	763	(o o	0	2.00
3.00	31.00	PEDI ATRI CS AGGREGATE - I NTENSI VE CARE UNI T	7, 016	351	(o o	0	3.00
4.00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	18, 824	941	(0 0	0	4.00
5.00	59.00	AGGREGATE-CARDI AC CATHETERI ZATI ON	10, 677		(0 0	0	5.00
6.00 7.00		AGGREGATE-LABORATORY AGGREGATE-ELECTROENCEPHALOGR	18, 521 15, 252			0 0 0 0	0 0	6.00 7.00
8.00	0.00	АРНҮ	0	0		0 0	0	8.00
9.00	0.00		0	0		0	0	9.00
10.00	0.00		0	0		0 0	0	10.00
200.00			113, 200				0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		AGGREGATE-OTHER ADMI NI STRATI VE & GEN	0	27, 658	5, 62			1.00
2.00		AGGREGATE-ADULTS & PEDIATRICS	0	15, 252		0 0		2.00
3.00 4.00		AGGREGATE - I NTENSI VE CARE UNI T AGGREGATE - RADI OLOGY - DI AGNOST	0	7, 016	38			3.00 4.00
4.00 5.00		I C AGGREGATE-CARDI AC		18, 824	15, 44			4.00 5.00
		CATHETERI ZATI ON						
6.00 7.00		AGGREGATE-LABORATORY AGGREGATE-ELECTROENCEPHALOGR APHY	0	18, 521 15, 252	10, 97	9 10, 979 0 0		6.00 7.00
8.00 9.00	0. 00 0. 00		0	0				8.00 9.00
10. 00 200. 00	0.00		0	0	(0 0 46, 510		10.00 200.00

Heal th Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS		ST. CATHERI N	Provi der CC	F	Period: From 07/01/2020 Fo 06/30/2021	u of Form CMS-2 Worksheet B Part I Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		11/23/2021 10	24 am
	Cost Center Description	Net Expenses for Cost Allocation	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	PURCHASI NG RECEI VI NG AND STORES	
		(from Wkst A col. 7) 0	1.00	2.00	4.00	5. 01	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.01	
1.00	00100 CAP REL COSTS-BLDG & FIXT	2, 749, 221	2, 749, 221				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	3, 703, 950	10 (50	3, 703, 950			2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00560 PURCHASING RECEIVING AND STORES	9, 339, 559 300, 169	13, 653 48, 255			397, 169	4.00
5.02	00570 ADMI TTI NG	928, 173	20, 902	78		725	
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 640, 982	4, 150			0	1
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	18, 452, 236	273, 898	222, 830	949, 333	6, 793	5.04
6.00	00600 MAINTENANCE & REPAIRS	0	0	(0 0	0	6.00
7.00	00700 OPERATION OF PLANT	5, 750, 813	619, 517	115, 908		289	
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	762, 343 2, 397, 580	9, 871 38, 167	15, 46	0 15, 437 313, 979	363 2, 492	
10.00	01000 DI ETARY	1, 979, 201	62, 536			5, 992	
11.00	01100 CAFETERI A	299, 107	27, 704	33, 479		2, 568	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	(0 0	0	12.00
13.00	01300 NURSING ADMINISTRATION	1, 891, 718	13, 719	92, 378	3 254, 464	66	
	01400 CENTRAL SERVICES & SUPPLY	0	0		0	0	
15.00 16.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0 1, 392, 535	0 15, 127		0	0	
	01700 SOCIAL SERVICE	1, 372, 333	13, 127			0	1
	01900 NONPHYSICIAN ANESTHETISTS	0	0		-	0	
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
30.00	03000 ADULTS & PEDIATRICS	15, 799, 192	434, 171	163, 96		57, 235	
31.00	03100 I NTENSI VE CARE UNI T	3, 221, 129	55, 764 0	162, 584		19, 997	
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	2, 489, 092	73, 422	60, 805		0 9, 045	40.00
43.00	04300 NURSERY	489, 682	13, 405	25, 558		2, 365	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	5, 200, 682	129, 362			74, 551	
51.00	05100 RECOVERY ROOM	1, 259, 799	42, 498			5, 139	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	910, 011 207, 229	27, 837 1, 933	53, 70 [°] 102, 457		4, 967 8, 824	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 436, 870	48, 733			7, 729	
55.00	05500 RADI OLOGY - THERAPEUTI C	561, 211	25, 348			37	55.00
56.00	05600 RADI OI SOTOPE	763, 738	9, 315			542	
57.00	05700 CT SCAN	1,032,406	7, 328			4, 776	
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	380, 307 1, 429, 229	11, 351 37, 925	2, 246 400, 331		537 10, 471	
	06000 LABORATORY	5, 864, 695	59, 703				60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	816, 541	4, 446	18, 418	3 25, 624	6, 376	63.00
64.00	06400 INTRAVENOUS THERAPY	567,667	36, 759			4, 097	
65.00	06500 RESPIRATORY THERAPY	1, 259, 410	10, 366			6, 592	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 208, 460 1, 292, 099	58, 084 16, 329			1, 512 510	
68.00	06800 SPEECH PATHOLOGY	393, 711	3, 413			164	
69.00	06900 ELECTROCARDI OLOGY	696, 412	12, 771	285, 984		3, 110	
70.00	07000 ELECTROENCEPHALOGRAPHY	316, 946	29, 244	11, 410		2, 698	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 868, 411	0	0	0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	3, 533, 723	0	104 405		0 5 500	
	07300 DRUGS CHARGED TO PATTENTS 07400 RENAL DIALYSIS	8, 692, 356 697, 378	24, 085 5, 087			5, 509 453	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	169, 240	9, 617		25,957	433	1
	07697 CARDI AC REHABI LI TATI ON	374, 125	33, 527	19, 410		149	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	1, 172, 818	12, 366			9, 168	
	09100 EMERGENCY	3, 677, 036	59, 528	92, 50	449, 102	35, 871	
72. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			I			92.00
101.00	10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	NONREI MBURSABLE COST CENTERS	123, 369, 192	2, 441, 216		9, 280, 296		
	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 748		-		190.00
	19100 RESEARCH	0	0	(-		191.00
191.00	10200 PHYSICIANS' DDIVATE OFFICES	017	104 601	· · · · · · · · · · · · · · · · · · ·			110.3 / ///
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 OTHER NONRELMBURSEABLE	817 112, 088	186, 521 99, 954	2 843) 551 3 0		192.00
192.00 194.00	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OTHER NONREI MBURSEABLE 07951 ADVERTI SI NG	817 112, 088 184, 000	186, 521 99, 954 8, 300			7	192.00 194.00 194.01

Health Fin	ancial Systems	ST. CATHERIN	E HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS			Provider CO		Period: From 07/01/2020	Worksheet B Part I		
					To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: <u>:24 am</u>	
			CAPI TAL REL	_ATED COSTS				
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	PURCHASI NG RECEI VI NG AND STORES		
		0	1.00	2.00	4.00	5. 01		
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers		0		0 0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	130, 575, 045	2, 749, 221	3, 703, 95	0 9, 353, 586	397, 169	202.00	

Heal th	Financial Systems	ST. CATHERI N	E HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CCN		eriod: rom 07/01/2020	Worksheet B Part I	
				Ť		Date/Time Pre 11/23/2021 10	pared: ·24 am
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	MAINTENANCE &	24 011
			OUNTS RECEI VABLE		ADMI NI STRATI VE & GENERAL	REPAI RS	
		5.02	5.03	5A. 03	5. 04	6.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560 PURCHASING RECEIVING AND STORES						5.01
5.02		1, 087, 498	1 (15 100				5.02
5.03 5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI NI STRATI VE & GENERAL	0	1, 645, 132 0	19, 905, 090	19, 905, 090		5.03 5.04
6.00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	
7.00	00700 OPERATION OF PLANT	0	0	6, 778, 557	1, 219, 191	0	
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	0	788, 014	141, 732	0	
9.00 10.00	01000 DI ETARY	0	0	2, 767, 679 2, 305, 616	497, 795 414, 688	0	9.00
11.00	01100 CAFETERI A	0	0	443, 433	79, 756	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0	2, 252, 345 0	405, 107 0	0	13.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	1, 407, 662	253, 182	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	U	0	0	0	19.00
30.00	03000 ADULTS & PEDI ATRI CS	183, 572	277, 633	19, 153, 944	3, 445, 020	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	16, 187	24, 489	3, 931, 362	707, 095	0	31.00
40.00 41.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	0 15, 400	0 23, 298	0 2, 950, 258	0 530, 633	0	40.00
43.00	04300 NURSERY	3, 312	5, 011	601, 046	108, 104	0	
	ANCI LLARY SERVI CE COST CENTERS						
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	90, 811 14, 507	137, 382 21, 946	6, 856, 221 1, 526, 053	1, 233, 160 274, 476	0	50.00 51.00
51.00	05200 DELIVERY ROOM & LABOR ROOM	6, 904	10, 445	1, 143, 221	274,478 205,620	0	52.00
53.00	05300 ANESTHESI OLOGY	14, 376	21, 749	746, 429	134, 253	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	37, 110	56, 142	3, 098, 052	557, 216	0	54.00
55.00 56.00	05500 RADI OLOGY - THERAPEUTI C 05600 RADI OI SOTOPE	15, 143 15, 169	22, 908 22, 948	663, 244 1, 040, 566	119, 291 187, 156	0	55.00 56.00
57.00	05700 CT SCAN	59, 820	90, 498	1, 341, 587	241, 298	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	16, 288	24, 642	471, 261	84, 761	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	42, 980 132, 998	65, 021 201, 206	2, 111, 973 6, 916, 591	379, 859 1, 244, 018	0	59.00 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	132, 770	201, 200	0, 910, 391	1, 244, 010	0	62.00
63.00	06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	6, 034	9, 128	886, 567	159, 458	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	7,094	10, 732	714, 009 1, 535, 490	128, 422 276, 173	0	64.00
66. 00	06600 PHYSI CAL THERAPY	11, 709 19, 637	17, 714 29, 707	2, 596, 905	467, 079	0	
67.00	06700 OCCUPATI ONAL THERAPY	11, 870	17, 957	1, 469, 704	264, 341	0	67.00
68.00	06800 SPEECH PATHOLOGY	3, 126	4, 729	456, 227	82, 057	0	68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	32, 947 12, 024	49, 844 18, 190	1, 190, 326 429, 344	214, 092 77, 222	0	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24, 897	37, 666	3, 930, 974	707, 025	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	14, 434	21, 837	3, 569, 994	642, 099	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	143, 550 7, 049	217, 170	9, 526, 593 720, 631	1, 713, 453 129, 613	0	73.00 74.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 363	10, 664 2, 062	208, 239	37, 454	0	74.00
76.97	07697 CARDI AC REHABI LI TATI ON	1, 603	2, 425	487, 677	87, 714	0	76.97
	OUTPATIENT SERVICE COST CENTERS		44 335				
90.00 91.00	09000 CLINIC 09100 EMERGENCY	7, 784 117, 800	11, 775 178, 214	1, 385, 210 4, 610, 058	249, 144 829, 165	0	90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	117,000	170,214	4, 010, 030	027, 103	0	92.00
	OTHER REIMBURSABLE COST CENTERS		L				
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
118.00		1,087,498	1, 645, 132	122, 918, 152	18, 527, 922	0	118.00
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	6, 748	1, 214		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0		0 187, 889	0 33, 794		191.00 192.00
	07950 OTHER NONREI MBURSEABLE	0	0	214, 892	38, 650		194.00
	07951 ADVERTI SI NG	0	0	192, 302	34, 587		194.01
194.02 200.00	07952 RETAIL PHARMACY Cross Foot Adjustments	0	0	7, 055, 062	1, 268, 923	0	194. 02 200. 00
200.00		О	О	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	1, 087, 498	1, 645, 132	130, 575, 045	19, 905, 090	0	202.00

Health Financial Systems	ST. CATHERIN				u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 07/01/2020	Worksheet B Part I	
			Т	06/30/2021	Date/Time Pre 11/23/2021 10	
Cost Center Description	OPERATION OF	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT 7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS	Т					
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00560 PURCHASING RECEIVING AND STORES						5.01
5. 02 00570 ADMI TTI NG						5.02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.03
5. 04 00590 OTHER ADMINI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS						5.04 6.00
7.00 00700 OPERATION OF PLANT	7, 997, 748					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	44, 631	974, 377				8.00
9.00 00900 HOUSEKEEPI NG	172, 570		3, 438, 044	0 404 07/		9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	282, 754		121, 918 39, 849	3, 124, 976	688, 300	10.00 11.00
12. 00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	000, 500	12.00
13.00 01300 NURSING ADMINISTRATION	62, 030	0	13, 401	0	35, 982	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	0 68, 394	0	0 21, 347	0	0	15.00 16.00
17. 00 01700 SOCIAL SERVICE	00, 394	0	21, 347	0	0	17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS	T					
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	1, 963, 081 252, 135			2, 234, 945	235, 626	
40. 00 04000 SUBPROVIDER - IPF	252, 155		163, 711	93, 105 0	35, 982 0	31.00 40.00
41. 00 04100 SUBPROVIDER - IRF	331, 974	-	176, 472	377, 778	33, 661	41.00
43. 00 04300 NURSERY	60, 610	21, 647	6, 641	0	5, 804	43.00
ANCI LLARY SERVI CE COST CENTERS	E04 001		421 020	0	20.202	50.00
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM	584, 901 192, 154	0	431, 930 16, 604	0 3, 278	38, 303 15, 089	50.00 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	125, 863		152, 279	77, 315	11, 607	52.00
53. 00 05300 ANESTHESI OLOGY	8, 740		0	0	8, 125	
54. 00 05400 RADI OLOGY – DI AGNOSTI C	220, 342		151, 211	0	30, 178	
55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	114, 609		48, 862 9, 488	0	2, 321 3, 482	55.00 56.00
57. 00 05700 CT SCAN	33, 132		0	0	5, 804	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	51, 323	0	6, 641	0	2, 321	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	171, 477		93, 692	0	8, 125	
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	269, 944		105, 551 0	0	47, 589 0	60.00 62.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	20, 103		0	0	2, 321	63.00
64.00 06400 INTRAVENOUS THERAPY	166, 205		0	0	8, 125	
65. 00 06500 RESPI RATORY THERAPY	46, 871	0		0	15, 089	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	262, 624 73, 830	0	127, 848	0	20, 893 10, 446	
68. 00 06800 SPEECH PATHOLOGY	15, 432		0	0	3, 482	
69. 00 06900 ELECTROCARDI OLOGY	57, 742		8, 302	0	10, 446	
70.00 07000 ELECTROENCEPHALOGRAPHY	132, 227		11, 860	0	4, 643	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	108, 901	0	13, 520	0	0 22, 053	72.00 73.00
74. 00 07400 RENAL DI ALYSI S	22, 998		4, 032	0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	43, 484		889	0	2, 321	
76. 97 07697 CARDI AC REHABI LI TATI ON	151, 593	0	10, 674	0	4, 643	76.97
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	55, 912	0	16, 011	0	13, 928	90.00
91. 00 09100 EMERGENCY	269, 152				44, 107	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
						101 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 605, 118	974, 377	3, 069, 349	2, 805, 790	682, 496	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	30, 510		14, 943	0		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0 843, 346	-	0 13, 283	0		191.00 192.00
192.0019200 OTHER NONREIMBURSEABLE	451, 937		331, 218	319, 186		192.00
194. 01 07951 ADVERTI SI NG	37, 529	0	3, 558	0	0	194. 01
194. 02 07952 RETAIL PHARMACY	29, 308	0	5, 693	0	5, 804	194.02
200.00Cross Foot Adjustments201.00Negative Cost Centers				0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	7, 997, 748	974, 377	3, 438, 044	3, 124, 976	688, 300	

	Financial Systems NLLOCATION - GENERAL SERVICE COSTS	ST. CATHERI	NE HOSPITAL Provider CC	N: 15-0008 Pc	In Lie	u of Form CMS-: Worksheet B	2552-10
C031 F	LEUCATION - GENERAL SERVICE COSTS		FIONIDEI CO		rom 07/01/2020	Part I Date/Time Pre	pared:
	Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	11/23/2021 10 MEDI CAL	24 am
		PERSONNEL	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
		12.00	13.00	14.00	15.00	16. 00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560 PURCHASING RECEIVING AND STORES						5.01
5.02 5.03	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5.03
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL						11.00
12.00	01300 NURSI NG ADMI NI STRATI ON		2, 768, 865				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0 0	0			14.00
15.00		0	0	0	0	1 750 505	15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE			0	0	1, 750, 585 0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0 0	0	0	0	•
	INPATIENT ROUTINE SERVICE COST CENTERS	-				005 404	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT			0	0	295, 101 26, 064	•
40.00	04000 SUBPROVI DER – I PF			0	0	20,004	
41.00	04100 SUBPROVIDER - IRF	0		0	0	24, 797	•
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS		34, 129	0	0	5, 334	43.00
50.00	05000 OPERATING ROOM	(233, 829	0	0	146, 221	50.00
51.00	05100 RECOVERY ROOM	0		0	0	23, 358	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	71, 535	0	0	11, 117	1
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C			0	0	23, 149 59, 754	•
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0	0	0	24, 382	•
56.00	05600 RADI OI SOTOPE	0	0	0	0	24, 425	1
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)			0	0	96, 321 26, 227	1
59.00	05900 CARDI AC CATHETERI ZATI ON		53, 619	0	0	69, 205	•
60.00	06000 LABORATORY	0	0 0	0	0	214, 151	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 715	
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06400 I NTRAVENOUS THERAPY			0	0	9, 715 11, 423	
	06500 RESPI RATORY THERAPY	0	0	0	0	18, 853	
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	31, 619	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY			0	0	19, 113 5, 034	
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	53, 050	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0 0	0	0	19, 361	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS			0	0	40, 089	•
72.00	07200 TMPL. DEV. CHARGED TO PATIENTS			0	o	23, 241 231, 142	
74.00	07400 RENAL DI ALYSI S	0	0 0	0	0	11, 350	74.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0	0	2, 195	•
76. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	(30, 894	0	0	2, 581	76.97
90.00	09000 CLINIC	0	89, 445	0	0	12, 533	90.00
91.00	09100 EMERGENCY	0	274, 768	0	0	189, 680	•
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	(0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	1	1		1		
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS		2, 768, 865	0	0	1, 750, 585	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(0	0	0	0	190.00
191.00	19100 RESEARCH		o o	0	Ō	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES			0	0		192.00
	07950 OTHER NONREI MBURSEABLE 07951 ADVERTI SI NG			0	0		194.00 194.01
	07951 ADVERTISING			0	0		194.01
200.00	Cross Foot Adjustments						200.00
201.00 202.00			0 2, 768, 865	0	0	0 1, 750, 585	201.00
202.00	I TOTAL (Sum TITIES TTO THE OUGH 201)	i C	1 2,700,000	U U	U	1,750,565	1202.00

Heal th Financial	Systems	ST. CATHERIN	IE HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION -	- GENERAL SERVICE COSTS		Provider C		Period: From 07/01/2020	Worksheet B Part I	
					To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: ·24 am
Cost	Center Description	SOCI AL SERVI CE		Subtotal	Intern &	Total	24 011
			ANESTHETI STS		Residents Cost & Post		
					Stepdown		
		17.00	19.00	24.00	Adjustments 25.00	26.00	
GENERAL SE	RVICE COST CENTERS	17.00	19.00	24.00	25.00	20.00	
	REL COSTS-BLDG & FIXT						1.00
	REL COSTS-MVBLE EQUIP DYEE BENEFITS DEPARTMENT						2.00 4.00
	HASING RECEIVING AND STORES						5.01
5.02 00570 ADMI							5.02
	I ERI NG/ACCOUNTS RECEI VABLE R ADMI NI STRATI VE & GENERAL						5.03 5.04
	TENANCE & REPAIRS						6.00
	ATION OF PLANT						7.00
8.00 00800 LAUNI 9.00 00900 HOUSI	DRY & LINEN SERVICE						8.00 9.00
10.00 01000 DI ET/							10.00
11.00 01100 CAFE							11.00
	TENANCE OF PERSONNEL I NG ADMI NI STRATI ON						12.00 13.00
	RAL SERVICES & SUPPLY						14.00
15.00 01500 PHAR							15.00
16.00 01600 MEDI (17.00 01700 SOCI	CAL RECORDS & LIBRARY	0					16.00 17.00
	HYSI CLAN ANESTHETI STS	0					19.00
	ROUTI NE SERVI CE COST CENTERS			00 004 47	-	00 004 475	
	TS & PEDIATRICS NSIVE CARE UNIT	0				30, 334, 175 5, 505, 002	30.00 31.00
	ROVIDER - IPF	0				0	40.00
	ROVIDER - IRF	0	-			4, 775, 248	
43.00 04300 NURSI	ERY SERVICE COST CENTERS	0	C	843, 315	5 0	843, 315	43.00
50.00 05000 OPER		0	C	9, 524, 565	5 0	9, 524, 565	50.00
51.00 05100 RECO		0				2, 143, 910	
52.00 05200 DELI 53.00 05300 ANES	VERY ROOM & LABOR ROOM	0		1, 798, 55 920, 696		1, 798, 557 920, 696	52.00 53.00
	DLOGY-DI AGNOSTI C	0		4, 116, 753		4, 116, 753	
	DLOGY - THERAPEUTIC	0	0	972, 709		972, 709	
56.00 05600 RADI (57.00 05700 CT S		0		1, 307, 235 1, 718, 142		1, 307, 235 1, 718, 142	
	ETIC RESONANCE IMAGING (MRI)	0	0			642, 534	
	I AC CATHETERI ZATI ON	0	0	2, 887, 950		2, 887, 950	
60.00 06000 LAB0 62.00 06200 WH0LI	E BLOOD & PACKED RED BLOOD CELL	0		8, 797, 844		8, 797, 844 0	60.00 62.00
	D STORING, PROCESSING, & TRANS.	0	0	1, 078, 164		1, 078, 164	63.00
	AVENOUS THERAPY	0	0	1, 028, 184		1, 028, 184	64.00
	I RATORY THERAPY I CAL THERAPY	0		1, 912, 875 3, 506, 968		1, 912, 875 3, 506, 968	
	PATIONAL THERAPY	0	0	1, 837, 434		1, 837, 434	
	CH PATHOLOGY	0	0	562, 232		562, 232	
69.00 06900 ELEC 70.00 07000 ELEC	TROCARDI OLOGY TROENCEPHALOGRAPHY	0		1, 533, 958 674, 657		1, 533, 958 674, 657	
	CAL SUPPLIES CHARGED TO PATIENT	0	0	4, 678, 088		4, 678, 088	
	DEV. CHARGED TO PATIENTS	0	0	4, 235, 334		4, 235, 334	
74.00 07400 RENA	S CHARGED TO PATIENTS			11, 615, 662 888, 624		11, 615, 662 888, 624	
	HI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	294, 582		294, 582	
		0	0	775, 776	5 0	775, 776	76.97
90. 00 09000 CLIN	SERVICE COST CENTERS	0	C	1, 822, 183	3 0	1, 822, 183	90.00
91.00 09100 EMER	GENCY	0				6, 721, 313	
	RVATION BEDS (NON-DISTINCT PART				0		92.00
101.00 10100 HOME	BURSABLE COST CENTERS	0	C		0 0	0	101.00
SPECIAL PU	RPOSE COST CENTERS	-	1				
	OTALS (SUM OF LINES 1 through 117)	0	C	119, 454, 669	9 0	119, 454, 669	118.00
	SABLE COST CENTERS FLOWER, COFFEE SHOP & CANTEEN	0	C	53, 415	5 0	53, 415	190.00
191.00 19100 RESE	ARCH	0	0		0 0	0	191.00
	ICIANS' PRIVATE OFFICES	0	0	1, 078, 312		1,078,312	
194. 00 07950 01HEI 194. 01 07951 ADVEI	R NONREI MBURSEABLE RTI SI NG			1, 355, 883 267, 976		1, 355, 883 267, 976	
194.0207952 RETA	IL PHARMACY	0	0	8, 364, 790		8, 364, 790	194. 02
	s Foot Adjustments		0				200.00
201.00 Nega	tive Cost Centers	0		(0 0	0	201.00

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 07/01/2020	Worksheet B	
				To 06/30/2021	Part I Date/Time Pre 11/23/2021 10	
Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	19.00	24.00	25.00	26.00	
202.00 TOTAL (sum lines 118 through 201)	0	0	130, 575, 04	5 0	130, 575, 045	202. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	ST. CATHERIN	Provi der C		eriod: com 07/01/2020	u of Form CMS-2 Worksheet B Part II	2002-11
				T		Date/Time Pre 11/23/2021 10	
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS	
		Capital Related Costs				DEPARTMENT	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		10 (50	074	14 007	14 007	2.00
1.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00560 PURCHASING RECEIVING AND STORES	0	13, 653 48, 255	374 1, 822	14, 027 50, 077	14, 027 70	4.00 5.01
5. 02	00570 ADMI TTI NG	0	20, 902	78	20, 980	206	•
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	4, 150		4, 150	0	
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	0	273, 898	222, 830	496, 728	1, 421	5.04
5.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	0 619, 517	0 115, 908	0 735, 425	0 437	6.00 7.00
3.00	00800 LAUNDRY & LINEN SERVICE	0	9, 871	115, 908	9, 871	23	
9.00	00900 HOUSEKEEPI NG	0	38, 167	15, 461	53, 628	470	
0.00	01000 DI ETARY	0	62, 536		140, 653	269	
1.00		0	27, 704	33, 479	61, 183	121	
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0	0 13, 719	0 92, 378	0 106, 097	0 381	12.00
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	00,077	0	14.00
5.00	01500 PHARMACY	0	0	0	0	0	15.00
	01600 MEDICAL RECORDS & LIBRARY	0	15, 127	0	15, 127	0	16.00
	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17.00
9.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	0	U	0	1 19.00
30.00	03000 ADULTS & PEDIATRICS	0	434, 171	163, 961	598, 132	3, 375	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	55, 764	162, 584	218, 348	646	
0.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	
1.00 3.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0	73, 422 13, 405	60, 805 25, 558	134, 227 38, 963	418 92	
10.00	ANCI LLARY SERVI CE COST CENTERS		10, 100	20,000	00, 700	/2	10.00
50.00	05000 OPERATING ROOM	0	129, 362	798, 072	927, 434	637	50.00
	05100 RECOVERY ROOM	0	42, 498	9,061	51, 559	259	•
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	27, 837 1, 933	53, 701 102, 457	81, 538 104, 390	194 584	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	48, 733	231, 811	280, 544	419	
5.00	05500 RADI OLOGY – THERAPEUTI C	0	25, 348	3, 836	29, 184	52	55.0
6.00	05600 RADI OI SOTOPE	0	9, 315	167, 424	176, 739	92	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	7, 328 11, 351	68, 420 2, 246	75, 748 13, 597	117 54	1
59.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0	37, 925	400, 331	438, 256	189	1
	06000 LABORATORY	0	59, 703	138, 772	198, 475	636	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	-	0	0	
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	4, 446		22, 864	38	
64.00 5.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	36, 759 10, 366	12, 298 66, 700	49, 057 77, 066	113 244	
6.00	06600 PHYSI CAL THERAPY	0	58, 084	29, 309	87, 393	375	
7.00	06700 OCCUPATI ONAL THERAPY	0	16, 329		25, 375	182	
8.00	06800 SPEECH PATHOLOGY	0	3, 413		12, 865	62	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	12, 771 29, 244	285, 984 11, 410	298, 755 40, 654	164 58	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	29, 244	0	40, 034	0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	24, 085	126, 695	150, 780	475	
	07400 RENAL DI ALYSI S	0	5, 087	0	5,087	0	•
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07697 CARDI AC REHABI LI TATI ON	0	9, 617 33, 527	0 19, 410	9, 617 52, 937	39 84	1
2. 11	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	55, 527	17,410	52, 737		1
	09000 CLI NI C	0	12, 366		17, 166	249	90.00
	09100 EMERGENCY	0	59, 528	92, 507	152, 035	672	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0		92.00
01.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
18.00		0	2, 441, 216	3, 635, 515	6, 076, 731	13, 917	118.00
90 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		6, 748	0	6, 748	0	190. 00
	19000 RESEARCH	0	0, 748 N	0	0, 748		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	186, 521	0	186, 521		192.00
94 00	07950 OTHER NONREI MBURSEABLE	0	99, 954	2, 843	102, 797		194.00
					0 200	0	194.0
94.01	07951 ADVERTI SI NG 07952 RETAI L PHARMACY	0	8, 300 6, 482	65, 592	8, 300 72, 074		194.0

Health Fina	ancial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider C	1	Period: From 07/01/2020 Fo 06/30/2021		pared: :24_am
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
201.00	Negative Cost Centers		0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	2, 749, 221	3, 703, 950	6, 453, 171	14, 027	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	ST. CATHERINE	E HOSPITAL Provider CO	CN: 15-0008 P	In Lie Period:	u of Form CMS- Worksheet B	2552-10
122001				F	rom 07/01/2020 o 06/30/2021	Part II Date/Time Pre	pared:
	Cost Center Description	PURCHASI NG RECEI VI NG AND	ADMI TTI NG	CASHI ERI NG/ACC OUNTS	ADMI NI STRATI VE	11/23/2021 10 MAI NTENANCE & REPAI RS	:24 am
		STORES 5.01	5.02	RECEI VABLE 5.03	& GENERAL 5. 04	6.00	
	GENERAL SERVICE COST CENTERS	5.01	5.02	0.00	5.04	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00560 PURCHASING RECEIVING AND STORES	50, 147					4.00 5.01
5.01	00570 ADMI TTI NG	92	21, 278				5.02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	4, 150			5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	858	0	0			5.04
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 37	0	0		0	
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	46	0			0	
9.00	00900 HOUSEKEEPING	315	0	0		0	
	01000 DI ETARY	757	0	0		0	10.00
		324	0	0		0	
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0	0		-	0	
	01400 CENTRAL SERVICES & SUPPLY	0	0	0		0	1
	01500 PHARMACY	0	0	0	-	0	1
	01600 MEDI CAL RECORDS & LI BRARY	0	0	0		0	16.00
	01700 SOCIAL SERVICE	0	0	0	-	0	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
30, 00	03000 ADULTS & PEDIATRICS	7, 227	3, 416	578	86, 361	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 525	320	64		0	1
	04000 SUBPROVI DER – I PF	0	0	0	-	0	
41.00	04100 SUBPROVIDER - IRF	1, 142	304	61	13, 303	0	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	299	65	13	2, 710	0	43.00
50.00	05000 OPERATING ROOM	9, 413	1, 795	359	30, 915	0	50.00
	05100 RECOVERY ROOM	649	287	57		0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	627	136			0	
53.00	05300 ANESTHESI OLOGY	1, 114	284	57		0	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	976 5	733 299	147		0	
56.00	05600 RADI OI SOTOPE	68	300	60		0	56.00
57.00	05700 CT SCAN	603	1, 182	236		0	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	68	322	64		0	
	05900 CARDI AC CATHETERI ZATI ON	1, 322	849	170		0	
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	11, 884	2, 628 0	526 0		0	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	805	119	24	-	0	
64.00	06400 I NTRAVENOUS THERAPY	517	140	28		0	1
65.00	06500 RESPI RATORY THERAPY	832	231	46	6, 924	0	65.00
	06600 PHYSI CAL THERAPY	191	388			0	
67.00	06700 OCCUPATI ONAL THERAPY	64	235	47		0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	21 393	62 651	12 130		0	
	07000 ELECTROENCEPHALOGRAPHY	341	238			0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	492	98		0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	285			0	
	07300 DRUGS CHARGED TO PATIENTS	696	2,837	567		0	
	07400 RENAL DI ALYSI S 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	57	139 27	28	3, 249 939	0	
	07697 CARDI AC REHABI LI TATI ON	19	32	6		0	1
	OUTPATIENT SERVICE COST CENTERS	1			_,		
	09000 CLI NI C	1, 158	154	31	6, 246	0	
	09100 EMERGENCY	4, 529	2, 328	466	20, 787	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	1 0	0				
118.00		49, 982	21, 278	4, 150	464, 483	0	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	19100 RESEARCH	0	0		-		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			192.00
	07950 OTHER NONREI MBURSEABLE 07951 ADVERTI SI NG		0	0			194.00 194.01
	07951 ADVERTISING 07952 RETAIL PHARMACY	164	0	0	31, 811		194.01
200.00			0	ĺ	5., 611		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	50, 147	21, 278	4, 150	499, 007	0	202.00

Heal th	Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lieu	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		eriod: 	Worksheet B Part II	
				To		Date/Time Pre 11/23/2021 10	pared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
		PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.01	00560 PURCHASING RECEIVING AND STORES						5.01
5.02	00570 ADMI TTI NG						5.02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.03
5.04 6.00	00590 OTHER ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.04 6.00
7.00	00700 OPERATION OF PLANT	766, 464					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	4, 277	17, 770				8.00
9.00	00900 HOUSEKEEPI NG	16, 538		83, 430			9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	27, 098 12, 004		2, 959 967	182, 132 0	76, 598	10.00
12.00	01200 MAINTENANCE OF PERSONNEL	12,004		987	0	76, 598 0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	5, 945	0	325	0	4, 004	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	C	0	0	0	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 6, 555	0	0 518	0	0 0	
17.00	01700 SOCIAL SERVICE	0, 555		0	0	0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	C	0	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	·	1	I			
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	188, 131			130, 259	26, 222 4, 004	
40.00	04000 SUBPROVIDER - IPF	24, 163	1, 341	3, 973 0	5, 426 0	4,004	
41.00	04100 SUBPROVIDER - IRF	31, 815	2, 635	4, 282	22, 018	3, 746	
43.00	04300 NURSERY	5, 809	395	161	0	646	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	56, 054	0	10, 482	0	4, 263	50.00
51.00	05100 RECOVERY ROOM	18, 415		403	191	4,203	
52.00	05200 DELIVERY ROOM & LABOR ROOM	12, 062	0	3, 695	4, 506	1, 292	52.00
53.00	05300 ANESTHESI OLOGY	838		0	0	904	1
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	21, 116 10, 984		3, 669 1, 186	0	3, 358 258	1
56.00	05600 RADI OLOGI - THERAPEOTIC	4, 036		230	0	388	1
57.00	05700 CT SCAN	3, 175		0	0	646	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	4, 919		161	0	258	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	16, 433 25, 870		2, 274 2, 561	0	904 5, 296	59.00 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	25, 870		2, 301	0	5, 290	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 927	C	0	0	258	1
64.00	06400 I NTRAVENOUS THERAPY	15, 928		0	0	904	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 492 25, 169		495 3, 102	0	1, 679 2, 325	
67.00	06700 OCCUPATI ONAL THERAPY	7,075		0	0	1, 163	
68.00	06800 SPEECH PATHOLOGY	1, 479	0	0	0	388	
69.00	06900 ELECTROCARDI OLOGY	5, 534		201	0	1, 163	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12,672		288	0	517 0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 437		328	0	2, 454	
74.00	07400 RENAL DIALYSIS	2,204		98	0	0	
76. 00 76. 97	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07697 CARDI AC REHABI LI TATI ON	4, 167 14, 528		22 259	0	258 517	1
/0. //	OUTPATIENT SERVICE COST CENTERS	14, 520		237		517	/0. //
90.00	09000 CLI NI C	5, 358		389	0	1, 550	
91.00	09100 EMERGENCY	25, 794	0	11, 770	1, 129	4, 908	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	<u> </u>					92.00
101.00	10100 HOME HEALTH AGENCY	0	C	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00		633, 001	17, 770	74, 483	163, 529	75, 952	118.00
190 00	NONREIMBURSABLE COST CENTERS	2, 924	0	363	0	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	2, 724	0	0	o		190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	80, 822		322	0	0	192.00
	07950 OTHER NONREI MBURSEABLE	43, 311		8, 038	18, 603		194.00
	07951 ADVERTI SI NG 07952 RETAI L PHARMACY	3, 597 2, 809		86 138	0		194.01 194.02
200.00		2,009		138	0	040	200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	766, 464	17, 770	83, 430	182, 132	76, 598	202.00

Health Financial Systems	ST. CATHERIN	NE HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: 	Worksheet B Part II	
			To		Date/Time Pre 11/23/2021 10	pared:
Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL	. 24 am
	PERSONNEL	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	12.00	13.00	14.00	15.00	16.00	
1.00 GENERAL SERVICE COST CENTERS						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00560 PURCHASING RECEIVING AND STORES						4.00
5. 01 00560 PURCHASING RECEIVING AND STORES 5. 02 00570 ADMITTING						5. 01 5. 02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.03
5. 04 00590 OTHER ADMINI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS						5.04 6.00
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERI A						11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON		126, 916				12.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	0			14.00
	0	0	0	0	20 547	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE			0	0	28, 547 0	16.00 17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 O3000 ADULTS & PEDI ATRI CS		66, 949	0	0	4, 874	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		0	0	4, 874	
40. 00 04000 SUBPROVI DER - I PF	C	-	0	0	0	40.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY		.,	0	0	403 87	41.00 43.00
ANCI LLARY SERVI CE COST CENTERS		1,001				10.00
50. 00 05000 OPERATING ROOM			0	0	2, 378	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM) 4, 258 3, 279	0	0	380 181	51.00 52.00
53. 00 05300 ANESTHESI OLOGY	C	0 0	0	0	376	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C	0		0	0	972 397	54.00 55.00
56. 00 05600 RADIOLOGI - THERA LUTTO	0		0	0	397	56.00
57. 00 05700 CT SCAN	C	0	0	0	1, 566	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION		0 0 2,458	0	0	427 1, 125	58.00 59.00
60. 00 06000 LABORATORY	C	0	0	Ō	3, 483	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	62.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 64. 00 06400 I NTRAVENOUS THERAPY			0 0	0	158 186	
65. 00 06500 RESPI RATORY THERAPY	C	0 0	0	0	307	65.00
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY			0	0	514 311	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0		0	0	82	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	863	
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0	0	315 652	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	0	0	378	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0	0	0	0	3, 759 185	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES			0	0	36	
76. 97 07697 CARDI AC REHABI LI TATI ON	C	1, 416	0	0	42	76. 97
0UTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	(4, 100	0	0	204	90.00
91. 00 09100 EMERGENCY	C	.,	0	0	3, 085	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	C	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 1 NONREI MBURSABLE COST CENTERS	17) 0	126, 916	0	0	28, 547	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0	0	190.00
191.00 19100 RESEARCH	C	0	0	0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 OTHER NONREIMBURSEABLE			0	0		192.00 194.00
194. 01 07951 ADVERTI SI NG	() () () () () () () () () ()		0	0	0	194.01
194. 02 07952 RETAIL PHARMACY	C	0	0	0	0	194.02
200.00Cross Foot Adjustments201.00Negative Cost Centers	C	o	0	0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	c	126, 916	0	Ō	28, 547	

ALLCATION OF CAPITAL RELATED COSTS Provider CC: 8-000 Period To the 2002/071 Period Description Period Description	Heal th	Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
To Co-02/2020 Distortion Program Date Durition BODUAL SERVICE MUNDMYSIC List Substant Television Television Common Distortion Distortion MUNDMYSIC List Substant Television Television Common Distortion To To To Television Television Television Common Distortion To To To To Television Television Television Common Distortion To To To Television Tel	ALLOCAT	ION OF CAPITAL RELATED COSTS		Provider C				
Upsit Lenter: Description SOLTAL: SERVICE: MULTINIST Subtracted Intern a prime Intern a stephen Intern 24.00 Intern 25.00 Intern 26.00 1.00 D0000 CAR REL COST CANTERS 19.00 24.00 20.00 20.00 2.00 D0000 CAR REL COST CANTERS 19.00 24.00 20.00 20.00 2.00 D0000 CAR REL COST SUBJERCE 10.00 20.00 20.00 20.00 2.00 D0000 CAR REL COST SUBJERCE 10.00 20.00 20.00 20.00 0.0000 CAR REL COST SUBJERCE FUNDER 10.00 20.00 20.00 20.00 20.00 0.0000 CARRENT RECEIVABLE 10.00 20.00 20.00 20.00 20.00 0.0000 CARRENT RECEIVABLE 10.00 20.00							Date/Time Pre	
Image: Control of the contro		Cost Center Description	SOCIAL SERVICE		Subtotal			
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OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 0 36,605 0 36,605 90.00 90.00 91.00 9240,097 0 240,097 91.00 91.00 92.00 92.00 0 240,097 0 240,097 92.00 92.00 0 92.00 0 0 0 92.00 92.00 0 0 0 92.00 92.00 0 0 0 0 92.00 92.00 92.00 0 0 0 0 92.00 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></t<>			0					
91. 00 09100 EMERGENCY 0 240,097 0 240,097 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBITOTALS (SUM OF LINES 1 through 117) 0 0 5, 880, 273 0 5, 880, 273 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 10, 065 0 10, 065 190. 00 191. 00 191.00 19100 RESEARCH 0 0 0 0 191. 00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 268, 513 0 268, 513 192. 00 194.00 07950 OTHER NONREI MBURSEABLE 0 173, 719 0 173, 719 194. 00 194.01 07952 RETAI L PHARMACY 0 107, 751			0		12,037		72,037	70.77
92.00 O9200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS O O O 0 0 101.00 101.00 10100 HOME HEALTH AGENCY O O O 0 101.00 SPECI AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) O O 5,880,273 O 5,880,273 118.00 NONREI MBURSABLE COST CENTERS Image: Cost Centers Image: Cost Centers Image: Cost Centers 118.00 10,065 0 10,065 190.00 191.00 191.00 191.00 191.00 191.00 191.00 191.00 191.00 191.00 192.00 192.00 192.00 192.00 192.01 192.00 192.00 192.00 192.00 192.00 192.01 192.01 192.02 192.01 192.02 192.01 192.02 192.01 192.02 192.01 192.02 192.01 192.02 192.01 192.02 192.01 192.02 192.01 192.02 192.01 192.02								
101.00 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 SPECI AL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 5,880,273 0 5,880,273 118.00 NONREL MBURSABLE COST CENTERS 190.00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 10,065 0 109.00 191.00 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 268, 513 0 268, 513 192.00 194.00 07950 OTHER NONREI MBURSABLE 0 173, 719 0 173, 719 174.00 173, 719 194.00 194.01 07951 ADVERTI SI NG 0 122, 850 0 12, 850 194.01 194.02 07952 RETAI L PHARMACY 0 107, 751 0 107, 751 194.02 200.00 0 <td></td> <td></td> <td>0</td> <td></td> <td>240, 097</td> <td></td> <td>240, 097</td> <td></td>			0		240, 097		240, 097	
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 5,880,273 0 5,880,273 190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 10,065 0 100,065 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 268,513 0 268,513 192.00 194.00 07950 OTHER NONREI MBURSEABLE 0 173,719 0 173,719 194.00 194.01 07951 ADVERTI SI NG 0 12,850 0 12,850 194.01 194.02 07952 RETAI L PHARMACY 0 107,751 0 107,751 194.02 200.00 Cross Foot Adj ustments 0 0 0 0 200.00								101 00
SUBTOTALS (SUM OF LINES 1 through 117) O O 5,880,273 O 5,880,273 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 10,065 0 100.00 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 10,065 0 190.00 191.00 192.00 192.00 192.00 192.00 192.00 191.00 191.00 191.00 191.00 192.00 268,513 0 268,513 192.00 191.00 194.00 173,719 0 173,719 194.00 174.00 173,719 194.00 12,850 0 12,850 194.01 194.00 12,850 194.01 194.02 107,751 0 107,751 194.02 107,751 194.02 107,751 194.02 107,751 194.02 107,751 194.02 107,751 100 107,751 194.02 200.00 100,751 194.02 100,751 194.02 100,751 194.02 100,751 194.02 100,751 194.02 100,751 194.02 <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>101.00</td>			0		0	0	0	101.00
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 10,065 0 10,065 190.00 191.00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 268,513 0 268,513 192.00 194.00 07950 OTHER NONREI MBURSEABLE 0 173,719 0 173,719 194.00 194.01 07951 ADVERTI SI NG 0 12,850 0 12,850 192.00 194.02 07952 RETAI L PHARMACY 0 107,751 0 107,751 194.02 200.00 Cross Foot Adj ustments 0 0 0 0 0 200.00	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	5, 880, 273	0	5, 880, 273	118.00
191.00 19100 RESEARCH 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 268, 513 0 268, 513 192.00 194.00 07950 OTHER NONREI MBURSEABLE 0 173, 719 0 173, 719 194.00 194.01 07951 ADVERTI SI NG 0 12, 850 0 12, 850 194.01 194.02 07952 RETAI L PHARMACY 0 107, 751 0 107, 751 194.02 200.00 Cross Foot Adj ustments 0 0 0 0 200.00			0		10, 065	ol	10, 065	190.00
194. 00 07950 OTHER NONREI MBURSEABLE 0 173, 719 0 173, 719 194. 00 194. 01 07951 ADVERTI SI NG 0 12, 850 0 12, 850 194. 01 194. 02 07952 RETAIL PHARMACY 0 107, 751 0 107, 751 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 200. 00	191.00	19100 RESEARCH	0		0	0	0	191.00
194. 01 07951 ADVERTI SI NG 0 12, 850 0 12, 850 194. 01 194. 02 07952 RETAI L PHARMACY 0 107, 751 0 107, 751 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 200. 00			0			0		
200.00 Cross Foot Adjustments 0 0 0 0 200.00	194.01	07951 ADVERTI SI NG	0		12, 850	0	12, 850	194. 01
			0	_		0		
		3	о	0	-	0		

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				From 07/01/2020 To 06/30/2021		narod
				10 00/30/2021	11/23/2021 10	:24 am
Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN	Subtotal	Intern &	Total	
		ANESTHETI STS		Residents Cost		
				& Post		
				Stepdown		
				Adjustments		
	17.00	19.00	24.00	25.00	26.00	
202.00 TOTAL (sum lines 118 through 201)	0	0	6, 453, 17	1 0	6, 453, 171	202.00

	Financial Systems LOCATION - STATISTICAL BASIS	ST. CATHERIN	Provi der CO		eriod:	u of Form CMS-2 Worksheet B-1	
				T	rom 07/01/2020 o 06/30/2021	Date/Time Pre	
		CAPI TAL RE	LATED COSTS			11/23/2021 10	:24 am
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	PURCHASING RECEIVING AND	ADMI TTI NG (GROSS REVE	
				DEPARTMENT	STORES	NUE)	
				(GROSS	(COSTED REQ)		
		1.00	2.00	SALARI ES) 4. 00	5. 01	5.02	
	GENERAL SERVICE COST CENTERS	1.00	2.00	1.00	0.01	0.02	
	00100 CAP REL COSTS-BLDG & FIXT	455, 095					1.00
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	2.260	9, 473, 046 957				2.00 4.00
	00560 PURCHASING RECEIVING AND STORES	2, 260 7, 988		54, 276, 146 272, 282			5.01
	00570 ADMI TTI NG	3, 460		798, 571	296	537, 218, 876	•
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	687	0	0	0	0	5.03
	00590 OTHER ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	45, 340	569, 898	5, 508, 712	2, 772 0	0	
	00700 OPERATION OF PLANT	102, 552	296, 440	1, 694, 568	118	0	
	00800 LAUNDRY & LINEN SERVICE	1, 634	0	89, 577	148	0	
	00900 HOUSEKEEPI NG	6, 318		1, 821, 931	1, 017	0	9.00
	01000 DI ETARY 01100 CAFETERI A	10, 352 4, 586		1, 043, 157 467, 556		0	10.00
	01200 MAINTENANCE OF PERSONNEL	4, 300	03,025	407, 330	1, 040	0	12.00
13.00	01300 NURSING ADMINISTRATION	2, 271	236, 261	1, 476, 584	27	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 504	0	0	0	0	15.00 16.00
	01700 SOCIAL SERVICE	2, 304	0	0	0	0	•
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS	74.074	440.000	10 007 444	00.05/	00 (45 4/0	1 00 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	71, 871 9, 231	419, 338 415, 818	12, 987, 446 2, 502, 200		90, 615, 169 7, 997, 678	
	04000 SUBPROVI DER – I PF	9,231	413, 010	2, 302, 200	0, 100	0	
	04100 SUBPROVI DER – I RF	12, 154		1, 620, 096		7, 608, 701	•
	04300 NURSERY	2, 219	65, 365	358, 103	965	1, 636, 588	43.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	21, 414	2,041,121	2, 468, 250	30, 422	44, 866, 892	50.00
	05100 RECOVERY ROOM	7,035		1, 004, 466		7, 167, 269	1
	05200 DELIVERY ROOM & LABOR ROOM	4, 608		750, 614		3, 411, 036	•
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	320		2, 262, 251	3,601	7, 102, 995	•
	05500 RADI OLOGY - THERAPEUTI C	8, 067 4, 196	592, 868 9, 812	1, 622, 771 201, 708	3, 154 15	18, 334, 946 7, 481, 504	•
	05600 RADI OI SOTOPE	1, 542		356, 461	221	7, 494, 510	•
	05700 CT SCAN	1, 213		454, 582		29, 555, 240	•
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	1, 879 6, 278	5, 743 1, 023, 866	208, 260 731, 235		8, 047, 602 21, 234, 976	
	06000 LABORATORY	9,883				65, 710, 520	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	
	06300 BLOOD STORING, PROCESSING, & TRANS.	736		148, 690		2, 981, 072	
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	6, 085 1, 716		437, 305 945, 838		3, 504, 954 5, 784, 995	
	06600 PHYSI CAL THERAPY	9,615		1, 451, 815		9, 701, 943	
67.00	06700 OCCUPATI ONAL THERAPY	2, 703	23, 136	707, 309	208	5, 864, 624	67.00
	06800 SPEECH PATHOLOGY	565		241, 577	67	1, 544, 571	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	2, 114 4, 841	731, 418 29, 182	633, 995 225, 330		16, 278, 152 5, 940, 723	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 041	0	0	0	12, 301, 035	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7, 131, 474	72.00
	07300 DRUGS CHARGED TO PATIENTS	3,987	324, 030	1, 840, 787	2, 248	70, 924, 116	
	07400 RENAL DI ALYSI S 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	842 1, 592		0 150, 622	185 0	3, 482, 807 673, 446	•
	07697 CARDI AC REHABI LI TATI ON	5, 550		327, 494		791, 913	
	OUTPATIENT SERVICE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
	09000 CLINIC 09100 EMERGENCY	2,047				3, 845, 671 58, 201, 754	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 854	236, 592	2, 606, 015	14, 638	58, 201, 754	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	L	·				1
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	404, 109	9, 298, 019	53, 850, 864	161, 538	537, 218, 876	110 00
+	NONREIMBURSABLE COST CENTERS	404,109	7, 270, 019	53, 630, 604	101, 538	557, 210, 070	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 117	0	0	0		190. 00
190.00		-		0	0	0	191.00
190. 00 191. 00	19100 RESEARCH	0	0	-			
190.00 191.00 192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	30, 876		3, 200 0		0	192.00
190.00 191.00 192.00 194.00		Ŭ	7, 272	-		0 0	

Heal th F	inancial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :24 am_
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASI NG RECEI VI NG AND STORES (COSTED REQ)	ADMI TTI NG (GROSS REVE NUE)	
		1.00	2.00	4.00	5. 01	5.02	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 749, 221	3, 703, 950	9, 353, 58	6 397, 169	1, 087, 498	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 040983	0. 390999	0. 17233	3 2. 450556	0.002024	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			14, 02	7 50, 147	21, 278	204. 00
205.00	Unit cost multiplier (Wkst. B, Part			0.00025	8 0. 309410	0. 000040	205. 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST A	Financial Systems LLOCATION - STATISTICAL BASIS	ST. CATHERINE	Provi der CC		eriod:	u of Form CMS-: Worksheet B-1	
					rom 07/01/2020 o 06/30/2021	Date/Time Pre 11/23/2021 10	
	Cost Center Description	CASHI ERI NG/ACC			MAINTENANCE &	OPERATION OF	
		OUNTS RECEI VABLE		ADMI NI STRATI VE & GENERAL	REPAI RS (SQUARE FEET)	PLANT (SQUARE FEET)	
		(GROSS REVE		(ACCUM. COST)	(SCOARE TEET)	(SCOARE TEET)	
		NUE)		· · ·			
		5.03	5A. 04	5.04	6.00	7.00	
1.00	GENERAL SERVICE COST CENTERS	[[1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560 PURCHASING RECEIVING AND STORES						5.0
5.02 5.03	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	537, 218, 876					5.0
5.03 5.04	00590 OTHER ADMINISTRATIVE & GENERAL	0	-19, 905, 090	110, 669, 955			5.0
6.00	00600 MAI NTENANCE & REPAI RS	0	0	0	0		6.0
7.00	00700 OPERATION OF PLANT	0	0	6, 778, 557	0	292, 808	
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	0	788, 014	0	1,634	
9.00 10.00	01000 DI ETARY	0	0	2, 767, 679 2, 305, 616	0	6, 318 10, 352	
11.00	01100 CAFETERI A	0	0	443, 433	0	4, 586	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.0
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	2, 252, 345	0	2, 271	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	0	0	0	14.0
	01600 MEDICAL RECORDS & LIBRARY	0	0	1, 407, 662	0	2, 504	
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.0
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.0
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00 (15 1(0	0	10 152 044	0	71 071	1 20 0
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	90, 615, 169 7, 997, 678	0	19, 153, 944 3, 931, 362	0	71, 871 9, 231	
40.00	04000 SUBPROVI DER – I PF	0	0	0, 701, 002	0	0	40.0
41.00	04100 SUBPROVI DER – I RF	7, 608, 701	0	2, 950, 258	0	12, 154	41.0
43.00	04300 NURSERY	1, 636, 588	0	601, 046	0	2, 219	43.0
50.00	ANCI LLARY SERVI CE COST CENTERS	44, 866, 892	0	6, 856, 221	0	21, 414	50.00
51.00	05100 RECOVERY ROOM	7, 167, 269	0	1, 526, 053	0	7,035	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 411, 036	0	1, 143, 221	0	4, 608	52.00
53.00	05300 ANESTHESI OLOGY	7, 102, 995	0	746, 429	0	320	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	18, 334, 946 7, 481, 504	0	3, 098, 052 663, 244	0	8, 067 4, 196	
56.00	05600 RADI OLOGI - THERAPEOTIC	7, 494, 510	0	1, 040, 566	0	1, 542	
57.00	05700 CT SCAN	29, 555, 240	0	1, 341, 587	0	1, 213	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	8, 047, 602	0	471, 261	0	1, 879	
59.00	05900 CARDI AC CATHETERI ZATI ON	21, 234, 976	0	2, 111, 973	0	6, 278	
50.00 52.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	65, 710, 520 0	0	6, 916, 591 0	0	9, 883 0	1
	06300 BLOOD STORING, PROCESSING, & TRANS.	2, 981, 072	0	886, 567	0	736	
	06400 I NTRAVENOUS THERAPY	3, 504, 954	0	714, 009	0	6, 085	
65.00	06500 RESPI RATORY THERAPY	5, 784, 995	0	1, 535, 490	0	1, 716	
56.00	06600 PHYSI CAL THERAPY	9, 701, 943	0	2, 596, 905	0	9, 615	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	5, 864, 624 1, 544, 571	0	1, 469, 704 456, 227	0	2, 703 565	
59.00	06900 ELECTROCARDI OLOGY	16, 278, 152	0	1, 190, 326	0	2, 114	
70.00	07000 ELECTROENCEPHALOGRAPHY	5, 940, 723	0	429, 344	0	4, 841	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	12, 301, 035	0	3, 930, 974	0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	7, 131, 474 70, 924, 116	0	3, 569, 994 9, 526, 593	0	0 3, 987	
74.00	07400 RENAL DIALYSIS	3, 482, 807	0	9, 520, 593 720, 631	0	3, 987 842	1
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	673, 446	0	208, 239	0	1, 592	
	07697 CARDI AC REHABI LI TATI ON	791, 913	0	487, 677	0	5, 550	76.9
		2 045 13-1		1 205 042	-	0.017	
70.00 71.00	09000 CLINIC 09100 EMERGENCY	3, 845, 671 58, 201, 754	0	1, 385, 210 4, 610, 058	0	2, 047 9, 854	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	50, 201, 754	0	4, 010, 030	0	7, 034	92.0
	OTHER REI MBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 0
110 00	SPECIAL PURPOSE COST CENTERS	527 210 07/	10 005 000	102 012 042	0	241 022	110 0
18.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	537, 218, 876	-19, 905, 090	103, 013, 062	0	241, 822	1118. U
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	6, 748	0	1, 117	190. 0
91.00	19100 RESEARCH	0	0	0	0	0	191. 0
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	187, 889	0	30, 876	
	07950 OTHER NONREI MBURSEABLE	0	0	214, 892	0	16, 546	
194.01	07951 ADVERTI SI NG 07952 RETAI L PHARMACY	0	0	192, 302 7, 055, 062	0		194. 0 [°] 194. 0
19/ 01			U	1,000,002	0	1,0/3	1174. U
194.02 200.00		5	-				200. 0

Heal th F	inancial Systems	ST. CATHERINE	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					rom 07/01/2020 o 06/30/2021		pared: :24 am_
	Cost Center Description	CASHI ERI NG/ACCR			MAINTENANCE &		
		OUNTS		ADMI NI STRATI VE	REPAI RS	PLANT	
		RECEI VABLE		& GENERAL	(SQUARE FEET)	(SQUARE FEET)	
		(GROSS REVE		(ACCUM. COST)			
		NUE)					
		5.03	5A. 04	5.04	6.00	7.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 645, 132		19, 905, 090	0	7, 997, 748	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 003062		0. 179860	0. 000000	27. 313967	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	4, 150		499, 007	0	766, 464	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000008		0.004509	0. 000000	2. 617633	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	ST. CATHERIN	E HOSPITAL Provider C	CN: 15-0008 P	In Lie	u of Form CMS-2 Worksheet B-1	2552-10
COST ALLOCATION - STATISTICAL DASIS		FIOVICEI C		rom 07/01/2020	Date/Time Pre	
Cost Center Description	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPI NG (HOUSEKEEP HOURS)	DI ETARY (MEALS SERVED)	(FTES)	11/23/2021 10 MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	:24 am
GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	12.00	
1.00 00100 CAP REL COST CLINERS 1.00 00100 CAP REL COST BLDG & FIXT 2.00 00200 CAP REL COSTS BLDG & FIXT 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 00570 ADMITTING STORES STORES <td< td=""><td>36, 235 0 0</td><td>289, 893 10, 280</td><td></td><td></td><td></td><td>$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\end{array}$</td></td<>	36, 235 0 0	289, 893 10, 280				$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\end{array}$
11.00 01100 CAFETERIA 12.00 01200 MAI NTENANCE OF PERSONNEL 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 19.00 01900 NOMPHYSI CI AN ANESTHETI STS INPATI ENT ROUTI NE SERVI CE COST CENTERS		3, 360 0 1, 130 0 1, 800 0 0		593 0 31 0 0 0 0 0	0 0 0 0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNIT	27, 321 2, 735	68, 400 13, 804		203 31	0 0	30. 00 31. 00
40. 00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	5, 374 805	14, 880 560		29 5	0	41.00 43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	36, 420	0	33	0	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	1, 400 12, 840 0	142	13 10 7	0	51.00 52.00 53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN	0 0 0	12, 750 4, 120 800 0	0 0 0	26 2 3 5	0 0 0 0	54.00 55.00 56.00 57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0 0 0 0	560 7, 900 8, 900 0 0 0 0	0	2 7 41 0 2 7	0 0 0 0 0	58.00 59.00 60.00 62.00 63.00 64.00
65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0 0 0	1, 720 10, 780 0 0		13 18 9 3	0 0 0 0	65.00 66.00 67.00 68.00
69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS	0	700 1, 000 0		9 4 0	0 0 0	69.00 70.00 71.00 72.00
73. 0007300DRUGSCHARGEDTOPATIENTS74. 0007400RENALDIALYSIS76. 0003550PSYCHI ATRI C/PSYCHOLOGI CALSERVI CES	0	1, 140 340 75	0	19 0 2	0 0 0	73.00 74.00 76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	900	0	4	0	76.97
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 350 40, 896		12 38	0 0	90. 00 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	36, 235	258, 805		588		118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 260	0	0		190. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 OTHER NONREI MBURSEABLE 194. 01 07951 ADVERTI SI NG	0 0 0	0 1, 120 27, 928 300	13, 826	0 0 0 0	0 0 0	191. 00 192. 00 194. 00 194. 01
194.0207952RETAIL PHARMACY200.00Cross Foot Adjustments201.00Negative Cost Centers	0	480	0	5		194. 02 200. 00 201. 00

Health Fi	nancial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider C		Period: From 07/01/2020	Worksheet B-1	
					To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :24 am
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	
		LINEN SERVICE	(HOUSEKEEP	(MEALS SERVED) (FTES)	PERSONNEL	
		(TOTAL PATIENT	HOURS)			(NUMBER	
		DAYS)				HOUSED)	
		8.00	9.00	10.00	11.00	12.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	974, 377	3, 438, 044	3, 124, 97	6 688, 300	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	26. 890493	11.859700	23. 08589	5 1, 160. 708263	0. 000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	17, 770	83, 430	182, 13	2 76, 598	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 490410	0. 287796	1. 34550	8 129. 170320	0. 000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	nancial Systems DCATION - STATISTICAL BASIS	ST. CATHERIN	E HOSPITAL Provider CO	N: 15-0008	Per	In Lie	u of Form CMS-: Worksheet B-1	2552-10
COST ALL	SATION STATISTICAL DAGIS			SN. 13 0000		om 07/01/2020 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :24 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUI S.)		MEDI CAL RECORDS & LI BRARY (GROSS REVE	SOCIAL SERVICE (TIME SPENT)	
		NURSI NG HRS) 13.00	REQUIS.) 14.00	15.00		NUE) 16. 00	17.00	
	NERAL SERVICE COST CENTERS	13.00	14.00	15.00		10.00	17.00	
$\begin{array}{cccc} 2.00 & 00 \\ 4.00 & 00 \\ 5.01 & 00 \\ 5.02 & 00 \\ 5.03 & 00 \\ 5.04 & 00 \\ 6.00 & 00 \\ 7.00 & 00 \\ 8.00 & 00 \\ 9.00 & 00 \\ 10.00 & 01 \end{array}$	1100 CAP REL COSTS-BLDG & FIXT 1200 CAP REL COSTS-MVBLE EQUIP 1400 EMPLOYEE BENEFITS DEPARTMENT 1560 PURCHASING RECEIVING AND STORES 1570 ADMITTING 1580 CASHI ERING/ACCOUNTS RECEIVABLE 1590 OTHER ADMINISTRATIVE & GENERAL 1600 MAINTENANCE & REPAIRS 1700 OPERATION OF PLANT 1800 LAUNDRY & LINEN SERVICE 1900 HOUSEKEEPING 100 CAFETERIA							$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00 \end{array}$
12.00 01 13.00 01 14.00 01 15.00 01 16.00 01 17.00 01 19.00 01	200 MAI NTENANCE OF PERSONNEL 300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVI CE 900 NONPHYSI CI AN ANESTHETI STS	800, 988 0 0 0 0 0	0 0 0 0 0		0 0 0 0	537, 218, 876 0 0	0 0	12.00 13.00 14.00 15.00 16.00 17.00 19.00
	PATI ENT_ROUTI NE_SERVI CE_COST_CENTERS 000 ADULTS & PEDI ATRI CS	422, 522	0		0	90, 615, 169	0	30.00
	100 I NTENSI VE CARE UNI T	64, 222	0		0	7, 997, 678	0	31.00
	000 SUBPROVI DER – I PF 100 SUBPROVI DER – I RF	0 59, 351	0		0 0	0 7, 608, 701	0	40.00
	300 NURSERY	9, 873	0		0	1, 636, 588	0	43.00
	CILLARY SERVICE COST CENTERS	67, 643	0		0	44, 866, 892	0	50.00
	100 RECOVERY ROOM	26, 874	0		0	7, 167, 269	0	51.00
	200 DELIVERY ROOM & LABOR ROOM	20, 694	0		0	3, 411, 036	0	52.00
	300 ANESTHESI OLOGY 400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	7, 102, 995 18, 334, 946	0	53.00 54.00
	500 RADI OLOGY - THERAPEUTI C	0	0		0	7, 481, 504	0	55.00
	600 RADI OI SOTOPE	0	0		0	7, 494, 510	0	56.00
	700 CT SCAN 800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	29, 555, 240 8, 047, 602	0	57.00 58.00
	900 CARDI AC CATHETERI ZATI ON	15, 511	0		0	21, 234, 976	0	59.00
	000 LABORATORY	0	0		0	65, 710, 520	0	60.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELL 300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	0	62.00
	400 INTRAVENOUS THERAPY	0	0		0	2, 981, 072 3, 504, 954	0	63.00 64.00
	500 RESPI RATORY THERAPY	0	0		0	5, 784, 995	0	65.00
	600 PHYSI CAL THERAPY	0	0		0	9, 701, 943	0	66.00
	700 OCCUPATIONAL THERAPY 800 SPEECH PATHOLOGY	0	0		0	5, 864, 624 1, 544, 571	0	67.00 68.00
	900 ELECTROCARDI OLOGY	0	0		0	16, 278, 152	0	69.00
1	000 ELECTROENCEPHALOGRAPHY	0	0		0	5, 940, 723	0	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT 200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	12, 301, 035 7, 131, 474	0	71.00 72.00
	300 DRUGS CHARGED TO PATIENTS	0	0		0	70, 924, 116	0	73.00
	400 RENAL DIALYSIS	0	0		0	3, 482, 807	0	74.00
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 697 CARDI AC REHABI LI TATI ON	0 8, 937	0		0	673, 446	0	76.00 76.97
	TPATIENT SERVICE COST CENTERS	0,937	0		J	791, 913	0	10.71
90.00 09	000 CLINIC	25, 875	0		0	3, 845, 671	0	90.00
	100 EMERGENCY	79, 486	0		0	58, 201, 754	0	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART HER REIMBURSABLE COST CENTERS							92.00
	100 HOME HEALTH AGENCY	0	0		0	0	0	101.00
118.00	ECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS	800, 988	0		0	537, 218, 876	0	118.00
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0		190. 00
	100 RESEARCH	0	0		0	0		191.00
	200 PHYSICIANS' PRIVATE OFFICES 950 OTHER NONREIMBURSEABLE	0	0		0	0		192.00 194.00
	951 ADVERTI SI NG	0	0		0	0		194.00
	952 RETAIL PHARMACY	0	0		0	0	0	194. 02
200.00 201.00	Cross Foot Adjustments Negative Cost Centers							200. 00 201. 00
201.00	1			1	1			

Health F	inancial Systems	ST. CATHERI N	E HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	(
			SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT	(COSTED		(GROSS REVE		
		NURSING HRS)	REQUIS.)		NUE)		
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 768, 865	0		1, 750, 585	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3. 456812	0. 000000	0.00000	0. 003259	0. 000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	126, 916	0		28, 547	0	204. 00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 158449	0. 000000	0.00000	0. 000053	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	ST. CATHERINE	E HOSPITAL Provider CCN: 15-0008	Peri od:	of Form CMS-2552-10 Worksheet B-1
			From 07/01/2020 To 06/30/2021	Date/Time Prepared:
Cost Center Description	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME) 19.00			11/23/2021 10:24 am
GENERAL SERVICE COST CENTERS	1			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 00570 ADMITTING SO300500 CASHIERING/ACCOUNTS RECEIVABLE 5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE SO4000 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT & GENERAL SO4000 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT SO000000 HOUSEKEEPING SO4000000000000000000000000000000000000				2.00 4.00 5.01 5.02 5.03 5.04 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
15.00 01500 PHARMACY				15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 19.00 01900 NONPHYSI CI AN ANESTHETI STS I NPATI ENT ROUTI NE SERVI CE COST	0			16. 00 17. 00 19. 00
30. 00 03000 ADULTS & PEDIATRICS	0			30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	0			31.00 40.00
41.00 04100 SUBPROVIDER - IRF	0			41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0			43.00
50.00 05000 OPERATI NG ROOM	0			50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0			51.00 52.00
53. 00 05300 ANESTHESI OLOGY	0			53.00
54. 00 05400 RADI OLOGY – DI AGNOSTI C 55. 00 05500 RADI OLOGY – THERAPEUTI C	0			54.00 55.00
56. 00 05600 RADI OI SOTOPE	0			56.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			59.00
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			60.00 62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0			63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0			64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0			66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0			67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			70.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATTENT	0			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			74.00 76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0			76. 97
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	0			90.00
91. 00 09100 EMERGENCY	0			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS				92.00
101.00 10100 HOME HEALTH AGENCY	0			101.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0			118.00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	0			190. 00 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0			192.00
194. 00 07950 OTHER NONREI MBURSEABLE 194. 01 07951 ADVERTI SI NG	0			194. 00 194. 01
194. 0107951 ADVERTISING 194. 02 07952 RETAIL PHARMACY	0			194.01
200.00 Cross Foot Adjustments				200. 00
201.00 Negative Cost Centers				201.00

Health F	inancial Systems	ST. CATHERINE	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALL	LOCATION - STATISTICAL BASIS		Provider CCN: 15-0008	Period: From 07/01/2020	Worksheet B-1
				To 06/30/2021	Date/Time Prepared: 11/23/2021 10:24 am
	Cost Center Description	NONPHYSI CI AN			
		ANESTHETI STS			
		(ASSI GNED			
		TIME)			
		19.00			
202.00	Cost to be allocated (per Wkst. B,	0			202.00
202.00	Part I)	0,000000			202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000			203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0			204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000			205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207. 00
1		I I			I

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	ST. CATHERIN		CNI. 1E 0000	Peri od:	u of Form CMS-: Worksheet C	2002 10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0008	From 07/01/2020 To 06/30/2021	Part I Date/Time Pre 11/23/2021 10	pared:
		Title	e XVIII	Hospi tal	PPS	. 24 am
				Costs	113	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	30, 334, 175		30, 334, 1	75 0	30, 334, 175	30.00
31.00 03100 INTENSIVE CARE UNIT	5, 505, 002		5, 505, 00	382	5, 505, 384	31.00
40. 00 04000 SUBPROVIDER - IPF	0			0 0	0	40.00
41.00 04100 SUBPROVIDER - IRF	4, 775, 248		4, 775, 24	48 0	4, 775, 248	41.00
43. 00 04300 NURSERY	843, 315		843, 3		843, 315	43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	9, 524, 565		9, 524, 5	65 0	9, 524, 565	50.00
51.00 05100 RECOVERY ROOM	2, 143, 910		2, 143, 9		2, 143, 910	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 798, 557		1, 798, 5		1, 798, 557	
53. 00 05300 ANESTHESI OLOGY	920, 696		920, 6		920, 696	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 116, 753		4, 116, 7		4, 132, 201	
55. 00 05500 RADI OLOGY - THERAPEUTI C	972, 709		972, 70		972, 709	
56. 00 05600 RADI OI SOTOPE	1, 307, 235		1, 307, 2		1, 307, 235	
57. 00 05700 CT SCAN	1, 718, 142		1, 718, 1		1, 718, 142	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	642, 534		642, 5		642, 534	
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 887, 950		2, 887, 9		2, 902, 026	
60. 00 06000 LABORATORY	8, 797, 844		8, 797, 8		8, 808, 823	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0,777,011		0, 1 1 1 0	0 0	0,000,020	1
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	1, 078, 164		1, 078, 1	-	1, 078, 164	
64. 00 06400 I NTRAVENOUS THERAPY	1, 028, 184		1, 028, 1		1, 028, 184	
65. 00 06500 RESPI RATORY THERAPY	1, 912, 875				1, 912, 875	
66. 00 06600 PHYSI CAL THERAPY	3, 506, 968				3, 506, 968	
67. 00 06700 OCCUPATI ONAL THERAPY	1, 837, 434				1, 837, 434	
68. 00 06800 SPEECH PATHOLOGY	562, 232				562, 232	
69. 00 06900 ELECTROCARDI OLOGY	1, 533, 958		1, 533, 9		1, 533, 958	
70. 00 07000 ELECTROENCEPHALOGRAPHY	674, 657		674, 6		674, 657	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 678, 088		4, 678, 0		4, 678, 088	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 235, 334		4, 078, 00		4, 235, 334	
73. 00 07300 DRUGS CHARGED TO PATIENTS	11, 615, 662		11, 615, 6		11, 615, 662	
74. 00 07400 RENAL DIALYSIS	888, 624		888, 6		888, 624	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	294, 582		294, 5		294, 582	
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	775, 776		775, 7	76 0	775, 776	76.97
	1 000 100		1 022 10	33 0	1 000 100	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	1, 822, 183		1, 822, 1		1, 822, 183	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 721, 313		6, 721, 3		6, 721, 313	
	4, 073, 523		4,073,52	23	4, 073, 523	92.00
OTHER REIMBURSABLE COST CENTERS	0			0	^	101.00
			122 520 1		0 123, 569, 077	
200.00 Subtotal (see instructions)	123, 528, 192					
201.00 Less Observation Beds	4,073,523		4,073,5		4, 073, 523	
202.00 Total (see instructions)	119, 454, 669	0	119, 454, 6	69 40, 885	119, 495, 554	202.00

	Financial Systems TION OF RATIO OF COSTS TO CHARGES		E HOSPITAL Provider C	CN: 15-0008	Peri od:	Worksheet C	2552-1
				311. 13 0000	From 07/01/2020		
					To 06/30/2021	Date/Time Pre	epared
			Title	XVIII	Hospi tal	11/23/2021 10 PPS):24 ai
			Charges	AVIII	HOSPITAI	PP5	
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
				í í		Ratio	
		6.00	7.00	8.00	9.00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	78, 783, 475		78, 783, 47			30.0
	03100 I NTENSI VE CARE UNI T	7, 997, 678		7, 997, 67			31.0
	04000 SUBPROVI DER – I PF	0			0		40. C
	04100 SUBPROVI DER – I RF	7, 608, 701		7, 608, 70			41. C
	04300 NURSERY	1, 636, 588		1, 636, 58	8		43. C
	NCI LLARY SERVI CE COST CENTERS	1					
	05000 OPERATING ROOM	15, 033, 513	29, 833, 379			0. 000000	
	05100 RECOVERY ROOM	978, 693	6, 188, 576			0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	2, 729, 721	681, 315			0.00000	
	05300 ANESTHESI OLOGY	2,000,147	5, 102, 848			0.00000	
	05400 RADI OLOGY-DI AGNOSTI C	3, 171, 988	15, 162, 958			0.00000	
	05500 RADI OLOGY - THERAPEUTI C	0	7, 481, 504	7, 481, 50		0.00000	
	05600 RADI OI SOTOPE	1, 629, 606	5, 864, 904	7, 494, 51		0.00000	
	05700 CT SCAN	8, 168, 275	21, 386, 965			0.00000	
	05800 MAGNETIC RESONANCE I MAGING (MRI)	2,075,372	5, 972, 230			0.00000	
	05900 CARDI AC CATHETERI ZATI ON	9, 793, 323	11, 441, 653			0.00000	
	06000 LABORATORY	22, 389, 039	43, 321, 481			0.00000	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0.00000	0.00000	
	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 930, 481	1,050,591	2, 981, 07		0.00000	
	06400 I NTRAVENOUS THERAPY	4,446	3, 500, 508			0. 000000	
	06500 RESPI RATORY THERAPY	4,867,104	917, 891	5, 784, 99		0. 000000	
	06600 PHYSI CAL THERAPY	4, 184, 808	5, 517, 135			0. 000000	
	06700 OCCUPATI ONAL THERAPY	4, 434, 298	1, 430, 326			0.00000	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	862, 726	681, 845 11, 370, 350			0. 000000 0. 000000	
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	4, 907, 802 306, 304	5, 634, 419			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 318, 289 3, 311, 865	5, 982, 746 3, 819, 609			0. 000000 0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	29, 793, 209	3, 819, 809			0. 000000	
	07400 RENAL DIALYSIS	29, 793, 209	41, 130, 907 312, 739			0. 000000	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 131	672, 315			0. 000000	
	07697 CARDI AC REHABI LI TATI ON	154, 782	637, 131			0. 000000	
-	DUTPATIENT SERVICE COST CENTERS	154,702	037, 131	771,7	<u> </u>	0.00000	/ /0.
	09000 CLINIC	759,072	3, 086, 599	3, 845, 67	0. 473827	0. 000000	90.
	09100 EMERGENCY	15, 425, 818	42, 775, 936			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 624, 064	9, 207, 630			0.000000	
	THER REIMBURSABLE COST CENTERS	2,024,004	7,207,030	1,051,05	0. 344209	0.00000	,
	0100 HOME HEALTH AGENCY	0	0		0		1101.
00.00	Subtotal (see instructions)	247, 052, 386	290, 166, 490		-		200.
01.00	Less Observation Beds	217,002,000	2,0,100,490	007,210,07	~		200.
		1		1	1		1-01.

Heal th	Financial Systems	ST. CATHERI NE	HOSPI TAL	In Lie	u of Form CMS-:	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/23/2021 10	pared: 24 am
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	· · ·				
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
40.00	04000 SUBPROVIDER - IPF					40.00
41.00	04100 SUBPROVI DER – I RF					41.00
	04300 NURSERY					43.00
	ANCI LLARY SERVI CE COST CENTERS	1 1				
50.00	05000 OPERATI NG ROOM	0. 212285				50.00
	05100 RECOVERY ROOM	0. 299125				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 527276				52.00
	05300 ANESTHESI OLOGY	0. 129621				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 225373				54.00
	05500 RADI OLOGY - THERAPEUTI C	0. 130015				55.00
	05600 RADI OLOGT - THERAPEOTIC	0. 174426				56.00
57.00	05700 CT SCAN	0.058133				57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0.079842				58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 136663				59.00
	06000 LABORATORY	0. 134055				60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000				62.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 361670				63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 293352				64.00
65.00	06500 RESPI RATORY THERAPY	0. 330661				65.00
	06600 PHYSI CAL THERAPY	0. 361471				66.00
	06700 OCCUPATI ONAL THERAPY	0. 313308				67.00
	06800 SPEECH PATHOLOGY	0. 364005				68.00
	06900 ELECTROCARDI OLOGY	0. 094234				69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 113565				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 380300				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 593893				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 163776				73.00
74.00	07400 RENAL DIALYSIS	0. 255146				74.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 437425				76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0. 979623				76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 473827				90.00
	09100 EMERGENCY	0. 115483				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.344289				92.00
.2.00	OTHER REIMBURSABLE COST CENTERS	0.011207				1
101 00	10100 HOME HEALTH AGENCY					101.00
200.00						200.00
200.00						201.00
201.00						201.00
202.00		I I				1-02.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0008	Period:	Worksheet C	
				From 07/01/2020 To 06/30/2021	Part I Date/Time Pre 11/23/2021 10	pared:
			e XIX	Hospi tal	PPS	. 24 um
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	30, 334, 175		30, 334, 1	75 0	30, 334, 175	30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 505, 002		5, 505, 00	382	5, 505, 384	31.00
10. 00 04000 SUBPROVIDER - IPF	0			0 0	0	40.00
1.00 04100 SUBPROVIDER - IRF	4, 775, 248		4, 775, 24	48 0	4, 775, 248	41.00
13. 00 04300 NURSERY	843, 315		843, 31	15 0	843, 315	43.00
ANCI LLARY SERVI CE COST CENTERS	- · · · ·					
50. 00 05000 OPERATING ROOM	9, 524, 565		9, 524, 50	65 0	9, 524, 565	50.00
51.00 05100 RECOVERY ROOM	2, 143, 910		2, 143, 9	10 0	2, 143, 910	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 798, 557		1, 798, 55		1, 798, 557	
53. 00 05300 ANESTHESI OLOGY	920, 696		920, 69		920, 696	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 116, 753		4, 116, 75		4, 132, 201	
55. 00 05500 RADI OLOGY - THERAPEUTI C	972, 709		972, 70		972, 709	
56. 00 05600 RADI OI SOTOPE	1, 307, 235		1, 307, 23		1, 307, 235	
57. 00 05700 CT SCAN	1, 718, 142		1, 718, 14		1, 718, 142	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	642, 534		642, 53		642, 534	
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 887, 950		2, 887, 9		2, 902, 026	
50. 00 06000 LABORATORY	8, 797, 844		8, 797, 84		8, 808, 823	
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0,777,011		0, , , , , 0	0 0	0,000,020	
53. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	1, 078, 164		1, 078, 16	-	1, 078, 164	1
54. 00 06400 I NTRAVENOUS THERAPY	1, 028, 184		1, 028, 18		1, 028, 184	
55. 00 06500 RESPI RATORY THERAPY	1, 912, 875	0			1, 912, 875	
56. 00 06600 PHYSI CAL THERAPY	3, 506, 968	0			3, 506, 968	
57. 00 06700 OCCUPATI ONAL THERAPY	1, 837, 434	0			1, 837, 434	
58. 00 06800 SPEECH PATHOLOGY	562, 232	0	.,		562, 232	
59. 00 06900 ELECTROCARDI OLOGY	1, 533, 958	0	1, 533, 9		1, 533, 958	
70. 00 07000 ELECTROEARDTOLOGT	674, 657		674, 65		674, 657	
	4, 678, 088		4, 678, 08		4, 678, 088	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	4, 235, 334		4, 235, 33		4, 235, 334	
73.00 07300 DRUGS CHARGED TO PATIENTS	11, 615, 662		11, 615, 60		11, 615, 662	
74.00 07400 RENAL DIALYSIS	888, 624		888, 62		888, 624	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	294, 582		294, 58		294, 582	
76. 97 07697 CARDI AC REHABI LI TATI ON	775, 776		775, 7	76 0	775, 776	76.97
OUTPATIENT SERVICE COST CENTERS	1 000 100		1 000 1		1 000 100	
20. 00 09000 CLINIC	1, 822, 183		1, 822, 18		1, 822, 183	
91.00 09100 EMERGENCY	6, 721, 313		6, 721, 3		6, 721, 313	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4,073,523		4, 073, 52	23	4, 073, 523	92.00
OTHER REI MBURSABLE COST CENTERS			1			
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
200.00 Subtotal (see instructions)	123, 528, 192	0			123, 569, 077	
201.00 Less Observation Beds	4, 073, 523		4, 073, 52		4, 073, 523	
202.00 Total (see instructions)	119, 454, 669	0	119, 454, 60	69 40, 885	119, 495, 554	202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0008	In Lie Period:	Worksheet C	
				From 07/01/2020	Part I	
				To 06/30/2021	Date/Time Pre	pared
		Ti tl	e XIX	Hospi tal	11/23/2021 10 PPS):24 a
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
D. 00 03000 ADULTS & PEDIATRICS	78, 783, 475		78, 783, 47	15		30.0
1. 00 03100 I NTENSI VE CARE UNI T	7,997,678		7, 997, 67			31.0
D. 00 04000 SUBPROVIDER - IPF	1, 337, 070		1, 777, 01	0		40.0
1. 00 04100 SUBPROVIDER - IRF	7,608,701		7, 608, 70	-		41.0
3. 00 04300 NURSERY	1, 636, 588		1, 636, 58			43.0
ANCI LLARY SERVICE COST CENTERS	1,000,000		1,000,00			
D. 00 05000 OPERATI NG ROOM	15, 033, 513	29, 833, 379	44, 866, 89	0. 212285	0. 000000	50.0
1.00 05100 RECOVERY ROOM	978, 693	6, 188, 576			0. 000000	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	2, 729, 721	681, 315	3, 411, 03	0. 527276	0. 000000	52.
3. 00 05300 ANESTHESI OLOGY	2,000,147	5, 102, 848	7, 102, 99	0. 129621	0. 000000	53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 171, 988	15, 162, 958	18, 334, 94	0. 224530	0.00000	54.
5. 00 05500 RADI OLOGY – THERAPEUTI C	0	7, 481, 504	7, 481, 50	0. 130015	0. 000000	55.
5. 00 05600 RADI OI SOTOPE	1, 629, 606	5, 864, 904			0. 000000	
7. 00 05700 CT SCAN	8, 168, 275	21, 386, 965			0. 000000	
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2,075,372	5, 972, 230			0. 000000	
9. 00 05900 CARDI AC CATHETERI ZATI ON	9, 793, 323	11, 441, 653			0. 000000	
D. 00 06000 LABORATORY	22, 389, 039	43, 321, 481			0.00000	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0.000000	0.00000	
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	1, 930, 481	1,050,591			0.00000	
	4,446	3, 500, 508			0.00000	
	4,867,104	917, 891			0.00000	
5. 00 06600 PHYSI CAL THERAPY 7. 00 06700 OCCUPATI ONAL THERAPY	4, 184, 808	5, 517, 135 1, 430, 326			0. 000000 0. 000000	
3. 00 06800 SPEECH PATHOLOGY	4, 434, 298 862, 726	681, 845			0. 000000	
2. 00 06900 ELECTROCARDI OLOGY	4, 907, 802	11, 370, 350			0. 000000	
D. 00 07000 ELECTROENCEPHALOGRAPHY	306, 304	5, 634, 419			0. 000000	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 318, 289	5, 982, 746			0. 000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 311, 865	3, 819, 609			0. 000000	
3. 00 07300 DRUGS CHARGED TO PATIENTS	29, 793, 209	41, 130, 907			0. 000000	
. 00 07400 RENAL DIALYSIS	3, 170, 068	312, 739			0. 000000	
5. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 131	672, 315			0. 000000	
5. 97 07697 CARDI AC REHABI LI TATI ON	154, 782	637, 131			0. 000000	
OUTPATIENT SERVICE COST CENTERS						
D. 00 09000 CLINIC	759, 072	3, 086, 599	3, 845, 67	0. 473827	0. 000000	90.
1.00 09100 EMERGENCY	15, 425, 818	42, 775, 936	58, 201, 75	0. 115483	0. 000000	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 624, 064	9, 207, 630	11, 831, 69	0. 344289	0.00000	92.
OTHER REIMBURSABLE COST CENTERS			1			
D1.00 10100 HOME HEALTH AGENCY	0	C		0		101.
00.00 Subtotal (see instructions)	247,052,386	290, 166, 490	537, 218, 87	6		200.
D1.00 Less Observation Beds						201.
D2.00 Total (see instructions)	247,052,386	290, 166, 490	537, 218, 87	6		202.

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CON. 15-0008 Period. From 07/01/2002 Worksheet C To 06/20/2021 Cost Center Description PPS Inpatient Ratio Title XIX Hospital 01/23/2021 INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 30.00 31.00 30.00 03000 ADULTS & PEDIATRICS 31.00 31.00 31.00 31.00 41.00 UNERNEY CARE UNIT 40.00 40.00 40.00 40.00 30.00 G3000 ADULTS & PEDIATRICS 31.00 31.00 31.00 40.00 41.00 D4000 SUBROVIDER - 1PF 41.00 41.00 40.00 40.00 43.00 D40200 SUBROVIDER - 1RF 65.00 55.00 55.00 55.00 55.00 55.00 51.00 D51.00 RECOVERY ROM 0.227276 55.00	Heal th	Financial Systems	ST. CATHERI NE	HOSPI TAL	In Lie	u of Form CMS-	2552-10
Cost Center Description PPS Inpatient Ratio PS Inpatient Ratio 30:00 03000 ADULTS & PEDIATRICS 30:00 31:00 03100 (DITENSI VE CABE UNIT 31:00 40:00 04000 SUBPROVIDER - IPF 41:00 41:00 43:00 05500 (DELOREY ROM 0.212285 50:00 05000 (DECOVERY ROM 0.299125 51:00 51:00 05100 (DECOVERY ROM 0.299125 51:00 50:00 05000 (DECOVERY ROM 0.299125 51:00 50:00 05000 (DECOVERY ROM 0.222533 54:00 50:00 05500 (ADULGY - HERAPEUTIC 0.13015 55:00 50:00 05500 (ADULGY - HERAPEUTIC 0.174426 55:00 50:00 05500 (ADOULGY - HERAPEUTIC 0.134055 56:00 50:00 05600 (ADOULGY - HERAPEUTIC 0.134055 58:00 50:00 05500 (HETCERSONACE HAGING (MRI) 0.134663 59:00 50:00 05600 (ADOULAGY - HERAPEUTIC 0.330661 66:00 60:00 064000 (ADOULAGY - HERAPEUTIC 0.346633 59:00	COMPUT	ATION OF RATIO OF COSTS TO CHARGES			From 07/01/2020 To 06/30/2021	Part I Date/Time Pre 11/23/2021 10	epared:):24 am
Ratio Ratio 11.00 11.00 0.01 03000 AULTS & PENTRICS COST CENTERS 30.00 0.02 03000 INTENSIVE CARE UNIT 40.00 0.01 04100 SUBPROV DER - 1 PF 40.00 13.00 04100 SUBPROV DER - 1 RF 43.00 13.00 04100 SUBPROV DER - 1 RF 43.00 13.00 05100 PECOVERY ROM 0.212285 15.00 05000 PELVERY ROM & LABOR ROM 0.227276 15.00 05100 PECOVERY ROM & LABOR ROM 0.222533 15.00 05500 PADI ORGY TESI UCGY 0.129621 15.00 05500 PADI OLGY - THERAPEUTI C 0.130015 15.00 05500 PADI OLGY - THERAPEUTI C 0.13065 16.00 05900 PADI OLGY - THERAPEUTI C 0.130015 16.00 05900 DS900 CABDI AC CATHETER LATION 0.134663				Title XIX	Hospi tal	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00		Cost Center Description	PPS Inpatient				
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 COSTO ONDUTS & PEDIATRICS 31.00 31.00 COSTO ONDUTS & PEDIATRICS 31.00 31.00 CARE UNIT 40.00 41.00 CARE UNIT 40.00 41.00 CARE UNIT 40.00 43.00 CARE UNIT 40.00 43.00 CARE UNIT 41.00 43.00 CARE UNIT 43.00 43.00 CARE UNIT 55.00 50.00 CSOO OPERATINE ROM 0.527276 51.00 CARE UNIT 0.225373 55.00 CARE UNIT 0.225373 55.00 CARE UNIT 0.225373 55.00 CARE UNIT 0.57026 55.00 CARE UNIT 0.57333 55.00 CARE UNIT 0.57646 56.00 CA			Ratio				
30:00 03000 ADULTS & PEDIATRICS 30:00 31:00 03100 NITES VECARE UNIT 40:00 40:00 04000 SUBPROVIDER - 1 FF 41:00 41:00 04000 SUBPROVIDER - 1 FF 41:00 40:00 04000 SUBPROVIDER - 1 FF 43:00 41:00 04000 SUBPROVIDER - 1 FF 50:00 50:00 05000 QFECVER YROM 0.212285 50:00 05100 RECOVERY ROM & LABOR ROM 0.527276 51:00 05300 ARESTHESI OLOGY 0.129621 53:00 05300 AREDICARY REPUTIC 0.225373 54:00 05000 RADIDICARY - THERPEUTIC 0.130015 55:00 05000 RADIDICARY - THERPEUTIC 0.130015 56:00 05000 RADIDICARY - THERPEUTIC 0.130015 56:00 05000 RADIDICARY - THERPEUTIC 0.130015 56:00 05000 RADIDICARY - THERPEUTIC 0.130015 57:00 05700 CT SCAN 0.58133 57:00 05700 CT SCAN 0.5900 RADIDICARY + THERPEUTIC 59:00 05900 CARDIAL C ATHETER LATION 0.134055 50:00 05000 CARDIA			11.00				
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65.00 06500 RESPI RATORY THERAPY 0.330661 65.00 66.00 06600 PHYSI CAL THERAPY 0.361471 66.00 67.00 0CCUPATI ONAL THERAPY 0.313308 67.00 68.00 06800 SPEECH PATHOLOGY 0.364005 68.00 69.00 06900 ELECTROCARDI OLOGY 0.094234 69.00 70.00 07000 ELECTROCREPHALOGRAPHY 0.113565 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.380300 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.593893 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.163776 73.00 74.00 07400 RENAL DI ALYSI S 0.255146 74.00 76.97 OARDI AC REHABI LI TATI ON 0.979623 76.97 76.97 00100 EMERENCY 0.115483 91.00 91.00 90.00 91.00 91.00 91.00 09100 CLINIC 0.473827 91.00 92.00 92.00 91.00 09200 DESERVATI ON BEDS (NON-D	63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 361670				63.00
66.00 06600 PHYSI CAL THERAPY 0.361471 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.313308 67.00 68.00 06800 SPEECH PATHOLOGY 0.364005 68.00 69.00 06900 ELECTROCANDIOLOGY 0.094234 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.113565 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.380300 71.00 72.00 07200 I IMPL DEV. CHARGED TO PATI ENTS 0.593893 72.00 73.00 07300 D RUGS CHARGED TO PATI ENTS 0.163776 73.00 74.00 07400 RENAL DI ALYSI S 0.255146 74.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.437425 76.00 76.97 07697 CARDI AC REHABI LI TATI ON 0.979623 90.00 90.00 OPGOOL CLINIC 0.473827 90.00 91.00 09000 CLINIC 0.115483 91.00 92.00 055ERVATI ON BEDS (NON-DI STI NCT PART 0.344289 92.00 071.00 10100 HOME HEALTH AGENCY	64.00	06400 INTRAVENOUS THERAPY	0. 293352				64.00
67.00 06700 0CCUPATIONAL THERAPY 0.313308 67.00 68.00 06800 SPECH PATHOLOGY 0.364005 68.00 69.00 06900 ELECTROCARDIOLOGY 0.094234 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.113565 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.380300 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.163776 73.00 74.00 07400 RENAL DIALYSIS 0.255146 74.00 76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0.437425 76.07 76.97 07697 CARDIAC REHABILITATION 0.979623 76.97 09100 CHINIC 0.473827 90.00 90.00 91.00 09100 EMERGENCY 0.115483 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0.344289 92.00 011.00 HOME HEALTH AGENCY 0.344289 92.00 011.00 HOME HEALTH AGENCY 0.344289 92.00 0101.00 BUStotal (see instructions)	65.00	06500 RESPI RATORY THERAPY	0. 330661				65.00
68.00 06800 SPECH PATHOLOGY 0.364005 68.00 69.00 06900 ELECTROCARDI OLOGY 0.094234 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.113665 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.380300 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.593893 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.163776 73.00 74.00 07400 RENAL DI ALYSI S 0.255146 74.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.437425 76.00 76.97 07697 CARDI AC REHABI LI TATI ON 0.979623 90.00 90.00 09000 CLI NI C 0.473827 90.00 91.00 09100 EMERGENCY 0.115483 91.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.344289 92.00 011.00 HOME HEALTH AGENCY 101.00 200.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00 Less Observation Be	66.00	06600 PHYSI CAL THERAPY	0. 361471				66.00
69.00 06900 ELECTROCARDIOLOGY 0.094234 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.113565 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.380300 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.593893 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.163776 73.00 74.00 07400 RENAL DI ALYSI S 0.255146 76.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.437425 76.00 76.70 07697 CARDI AC REHABI LI TATI ON 0.979623 76.97 000 09000 CLI NI C 0.473827 90.00 90.00 09100 EMERGENCY 0.115483 91.00 91.00 09100 EMERGENCY 0.344289 91.00 91.00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART 0.344289 92.00 01.00 IONE HEALTH AGENCY 0.344289 92.00 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 <	67.00	06700 OCCUPATI ONAL THERAPY	0. 313308				67.00
69.00 06900 ELECTROCARDIOLOGY 0.094234 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.113565 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.380300 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.593893 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.163776 73.00 74.00 07400 RENAL DI ALYSI S 0.255146 76.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.437425 76.00 76.07 07697 CARDI AC REHABI LI TATI ON 0.979623 76.97 0UTPATI ENT SERVI CE COST CENTERS 0.473827 90.00 90.00 91.00 09100 EMERGENCY 0.115483 91.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.344289 92.00 01.00 IONE HEALTH AGENCY 0.344289 92.00 0200.00 Subtotal (see instructions) 200.00 201.00 200.00 Less Observati on Beds 200.00 201.00	68.00	06800 SPEECH PATHOLOGY	0, 364005				68.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0.113565 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.380300 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.593893 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.163776 73.00 74.00 07400 RENAL DI ALYSI S 0.255146 74.00 76.00 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVICES 0.437425 76.00 76.01 07697 CARDI AC REHABILITATION 0.979623 76.97 00TPATIENT SERVICE COST CENTERS 0.415483 90.00 90.00 90.00 91.00 90.00 ILINIC 0.473827 91.00 91.00 09200 DISERVATION BEDS (NON-DI STINCT PART 0.344289 91.00 92.00 01.00 IONE HEALTH AGENCY 0.344289 92.00<							69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.380300 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.593893 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.163776 73.00 74.00 07400 RENAL DI ALYSI S 0.255146 74.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES 0.437425 76.00 76.97 040740 RENAL DI ALYSI S 0.979623 76.97 0UTPATI ENT SERVICE COST CENTERS 0.4174827 90.00 90.00 90.00 09000 CLI NI C 0.473827 91.00 91.00 09100 EMERGENCY 0.315483 91.00 92.00 OSSERVATI ON BEDS (NON-DI STI NCT PART 0.344289 92.00 0THER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 200.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00							1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.593893 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.163776 73.00 74.00 07400 RENAL DI ALYSI S 0.255146 74.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.437425 76.00 76.97 0407 CARDI AC REHABILI TATI ON 0.979623 76.97 0000 0100 EMERGENCY 0.115483 90.00 90.00 09200 OLSENKATI ON BEDS (NON-DI STI NCT PART 0.344289 91.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.344289 92.00 0THER REI MBURSABLE COST CENTERS 101.00 10000 Mome HEALTH AGENCY 101.00 101.00 Less Observati on Beds 200.00 201.00 201.00							
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74.00 07400 RENAL DI ALYSI S 0.255146 74.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.437425 76.00 76.97 07697 CARDI AC REHABILI TATI ON 0.979623 76.97 0UTPATI ENT SERVI CE COST CENTERS 0.473827 90.00 90.00 91.00 09100 EMERGENCY 0.115483 91.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.344289 91.00 01.00 10100 HOME HEALTH AGENCY 0.344289 92.00 011.00 10100 Subtotal (see instructions) 200.00 201.00 200.00 201.00 Less Observati on Beds 201.00 201.00 201.00 201.00							1
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES 0.437425 76.00 76.07 07697 CARDI AC REHABI LI TATI ON 0.979623 76.97 0UTPATI ENT SERVICE COST CENTERS 0.473827 90.00 90.00 91.00 09000 CLI NI C 0.473827 90.00 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.344289 91.00 92.00 DISERVATI ON BEDS (NON-DI STI NCT PART 0.344289 92.00 011.00 10100 HOME HEALTH AGENCY 101.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00							
76. 97 07697 CARDI AC REHABI LI TATI ON 0.979623 76. 97 0UTPATI ENT SERVICE COST CENTERS 00 99000 CLI NI C 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 91. 00 90. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0. 344289 91. 00 92. 00 92. 00 000000000000000000000000000000000000							
OUTPATI ENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0.473827 90.00 91.00 09100 EMERGENCY 0.115483 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART 0.344289 92.00 0THER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00							
90.00 09000 CLINIC 0.473827 90.00 91.00 09100 EMERGENCY 0.115483 91.00 92.00 09SERVATION BEDS (NON-DISTINCT PART 0.344289 92.00 0THER REIMBURSABLE COST CENTERS 101.00 10000 HOME HEALTH AGENCY 101.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00	70.97		0. 979023				/0. 9/
91.00 09100 EMERGENCY 0.115483 91.00 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0.344289 92.00 92.00 0THER REIMBURSABLE COST CENTERS 0.344289 101.00 10100 HOME HEALTH AGENCY 101.00 200.00 Subtotal (see instructions) 101.00 200.00 201.00 201.00	00.00		0 472027				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.344289 92.00 0THER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 101.00 200.00 200.00 201.00 Less Observation Beds 201.00							
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00							
101.00 10100 HOME HEALTH AGENCY 101.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00 201.00		· · · · · · · · · · · · · · · · · · ·	0. 344289				92.00
200.00 Subtotal (see instructions) 200.00 200.00 201.00 201.00			1				· · · · ·
201.00 Less Observation Beds 201.00							
202.00 Total (see instructions) 202.00							
	202.00	Total (see instructions)					202.00

leal th F	inancial Systems	ST. CATHERINE HOSPITAL			In Lieu of Form CMS-2552-10			
	TION OF OUTPATIENT SERVICE COST TO CHARGE R. DNS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part II Date/Time Pre 11/23/2021 10	pared 24 a	
			Titl	e XIX	Hospi tal	PPS		
	Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost		
		(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction		
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount		
				col. 2)				
		1.00	2.00	3.00	4.00	5.00		
	NCILLARY SERVICE COST CENTERS							
	5000 OPERATING ROOM	9, 524, 565	1,054,448	8, 470, 1			50.0	
51.00 0	5100 RECOVERY ROOM	2, 143, 910	85, 018	2, 058, 89	92 0	0	51. C	
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	1, 798, 557	112, 692	1, 685, 86	65 0	0	52.0	
53.00 0	5300 ANESTHESI OLOGY	920, 696	111, 913	808, 78	33 0	0	53.0	
64.00 0	5400 RADI OLOGY-DI AGNOSTI C	4, 116, 753	325, 903	3, 790, 8	50 0	0	54.0	
5.00 0	5500 RADI OLOGY - THERAPEUTI C	972, 709	45, 416	927, 29	93 0	0	55.0	
6.00 0	5600 RADI OI SOTOPE	1, 307, 235	187, 002	1, 120, 23	33 0	0	56.0	
7.00 0	5700 CT SCAN	1, 718, 142	89, 322			0		
8.00 0	5800 MAGNETIC RESONANCE I MAGING (MRI)	642, 534	21, 995			0	58.	
	5900 CARDI AC CATHETERI ZATI ON	2, 887, 950	473, 503			0		
	6000 LABORATORY	8, 797, 844	282, 546				60.	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0,777,011	0		0 0			
	6300 BLOOD STORING, PROCESSING, & TRANS.	1, 078, 164	30, 191					
	6400 I NTRAVENOUS THERAPY	1, 028, 184	70, 092					
	6500 RESPI RATORY THERAPY	1, 912, 875	92, 316					
	6600 PHYSI CAL THERAPY	3, 506, 968	131, 244					
	6700 OCCUPATI ONAL THERAPY	1, 837, 434	41, 079					
	6800 SPEECH PATHOLOGY	562, 232	17, 028				68.	
	6900 ELECTROCARDI OLOGY	1, 533, 958	313, 221					
	17000 ELECTROENCEPHALOGRAPHY		57, 067					
		674,657						
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENT	4, 678, 088	18, 967		-			
	7200 IMPL. DEV. CHARGED TO PATIENTS	4, 235, 334	16, 817					
	7300 DRUGS CHARGED TO PATIENTS	11, 615, 662	215, 288			0		
	17400 RENAL DI ALYSI S	888, 624	11, 047					
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	294, 582	15, 110					
	7697 CARDI AC REHABI LI TATI ON	775, 776	72, 039	703, 73	37 0	0	76.	
	UTPATIENT SERVICE COST CENTERS					1		
	9000 CLINIC	1, 822, 183	36, 605					
	9100 EMERGENCY	6, 721, 313	240, 097				1	
	9200 OBSERVATION BEDS (NON-DISTINCT PART	4, 073, 523	154, 244	3, 919, 2	79 0	0	92.	
	THER REIMBURSABLE COST CENTERS	1		1		1		
	0100 HOME HEALTH AGENCY	0	0		0 0		101.	
00.00	Subtotal (sum of lines 50 thru 199)	82, 070, 452	4, 322, 210				200.	
01.00	Less Observation Beds	4, 073, 523	154, 244				201.0	
202.00	Total (line 200 minus line 201)	77, 996, 929	4, 167, 966	73, 828, 96	53 0	1 0	202. 0	

Health Finar	ncial Systems	ST. CATHERINE	HOSPI TAL		In Lie	u of Form CMS	-2552-10
	OF OUTPATIENT SERVICE COST TO CHARGE R FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part II Date/Time Pr 11/23/2021 1	epared:
			Titl	e XIX	Hospi tal	PPS	0.24 am
	Cost Center Description	Cost Net of	Total Charges			1.10	
	Free Free Free Free Free Free Free Free		(Worksheet C,				
		Operating Cost					
		Reduction	8)	/ col. 7)			
		6.00	7.00	8.00			
ANCI L	LARY SERVICE COST CENTERS	· ·					
50.00 05000	OPERATING ROOM	9, 524, 565	44, 866, 892	0. 2122	85		50.00
51.00 05100	RECOVERY ROOM	2, 143, 910	7, 167, 269	0. 2991	25		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1, 798, 557	3, 411, 036		76		52.00
53.00 05300	ANESTHESI OLOGY	920, 696	7, 102, 995	0. 1296	21		53.00
	RADI OLOGY-DI AGNOSTI C	4, 116, 753	18, 334, 946				54.00
55.00 05500	RADI OLOGY - THERAPEUTI C	972, 709	7, 481, 504		15		55.00
	RADIOISOTOPE	1, 307, 235	7, 494, 510				56.00
	CT SCAN	1, 718, 142	29, 555, 240				57.00
	MAGNETIC RESONANCE IMAGING (MRI)	642, 534	8,047,602				58.00
	CARDI AC CATHETERI ZATI ON	2, 887, 950	21, 234, 976				59.00
	LABORATORY	8, 797, 844	65, 710, 520				60.00
	WHOLE BLOOD & PACKED RED BLOOD CELL	0,777,044	03, 710, 320				62.00
	BLOOD STORING, PROCESSING, & TRANS.	1,078,164	2, 981, 072				63.00
	INTRAVENOUS THERAPY	1, 028, 184	3, 504, 954				64.00
	RESPIRATORY THERAPY	1, 912, 875	5, 784, 995				65.00
	PHYSICAL THERAPY	3, 506, 968	9, 701, 943				66.00
	OCCUPATIONAL THERAPY	1, 837, 434	5, 864, 624				67.00
	SPEECH PATHOLOGY	562, 232	1, 544, 571				68.00
	ELECTROCARDI OLOGY						
		1, 533, 958	16, 278, 152				69.00 70.00
		674,657	5, 940, 723				
	MEDI CAL SUPPLI ES CHARGED TO PATI ENT	4, 678, 088	12, 301, 035				71.00
	IMPL. DEV. CHARGED TO PATIENTS	4, 235, 334	7, 131, 474				72.00
	DRUGS CHARGED TO PATIENTS	11, 615, 662	70, 924, 116				73.00
	RENAL DIALYSIS	888, 624	3, 482, 807				74.00
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	294, 582	673, 446				76.00
	CARDIAC REHABILITATION	775, 776	791, 913	0. 9796	23		76.97
	TIENT SERVICE COST CENTERS				[
	CLINIC	1, 822, 183	3, 845, 671				90.00
	EMERGENCY	6, 721, 313	58, 201, 754				91.00
	OBSERVATION BEDS (NON-DISTINCT PART	4, 073, 523	11, 831, 694	0. 3442	89		92.00
	REIMBURSABLE COST CENTERS	-T T		1			
	HOME HEALTH AGENCY	0	C		00		101.00
200.00	Subtotal (sum of lines 50 thru 199)	82, 070, 452	441, 192, 434				200.00
201.00	Less Observation Beds	4, 073, 523	C				201.00
202.00	Total (line 200 minus line 201)	77, 996, 929	441, 192, 434				202.00

Health Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provider C	<u> </u>	Period: From 07/01/2020 Fo 06/30/2021	Worksheet D Part I Date/Time Pre 11/23/2021 10	pared: :24 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capital	Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B, Part II, col. 26)		Related Cost (col. 1 - col. 2)			
	1.00	2.00	3.00	4, 00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 ADULTS & PEDIATRICS	1, 148, 608	0	1, 148, 60	3 31, 559	36, 40	30.00
31. 00 I NTENSI VE CARE UNI T	289, 137		289, 13			
40. 00 SUBPROVIDER - IPF	0	l a		0 0	0.00	•
41.00 SUBPROVIDER - IRF	223, 758	C	223, 75	5, 374	41.64	41.00
43.00 NURSERY	50, 804		50, 80	4 805	63.11	43.00
200.00 Total (lines 30 through 199)	1, 712, 307		1, 712, 30	7 40, 473		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program Capital Cost (col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 628					30.00
31.00 INTENSIVE CARE UNIT	758	80, 136				31.00
40. 00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	2,855					41.00
43.00 NURSERY 200.00 Total (lines 30 through 199)	0 10, 241	0 440, 277				43.00 200.00

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre 11/23/2021 10	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	r	1	-	-	
50.00 05000 OPERATI NG ROOM	1,054,448					
51.00 05100 RECOVERY ROOM	85, 018				2, 447	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	112, 692					
53. 00 05300 ANESTHESI OLOGY	111, 913					
54.00 05400 RADI OLOGY-DI AGNOSTI C	325, 903				16, 280	1
55. 00 05500 RADI OLOGY – THERAPEUTI C	45, 416				0	
56. 00 05600 RADI OI SOTOPE	187, 002				14, 365	
57.00 05700 CT SCAN	89, 322				6, 556	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	21, 995					
59. 00 05900 CARDI AC CATHETERI ZATI ON	473, 503					
60. 00 06000 LABORATORY	282, 546				24, 265	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				0	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	30, 191	2, 981, 072			4, 487	63.00
64.00 06400 INTRAVENOUS THERAPY	70, 092				0	64.00
65. 00 06500 RESPI RATORY THERAPY	92, 316					65.00
66. 00 06600 PHYSI CAL THERAPY	131, 244					66.00
67.00 06700 OCCUPATI ONAL THERAPY	41,079	5, 864, 624				67.00
68.00 06800 SPEECH PATHOLOGY	17, 028					
69. 00 06900 ELECTROCARDI OLOGY	313, 221	16, 278, 152			31, 230	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	57,067					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18, 967					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	16, 817	7, 131, 474			2, 039	
73.00 07300 DRUGS CHARGED TO PATIENTS	215, 288					
74. 00 07400 RENAL DIALYSIS	11, 047	3, 482, 807			3, 398	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	15, 110					76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	72, 039	791, 913	0. 09096	39, 527	3, 596	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	36, 605					
91.00 09100 EMERGENCY	240, 097					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	154, 244					
200.00 Total (lines 50 through 199)	4, 322, 210	441, 192, 434		37, 618, 057	357, 367	200.00

Health Financial Systems	ST. CATHERI NE	E HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST		 - 	Period: From 07/01/2020 Fo 06/30/2021	11/23/2021 10	pared: :24 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School N Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Cost	All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				2.00	0.00	
30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 I NTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	31.00 40.00
41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0			0 0	
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200.00
	4.00	5.00	6.00	7.00	8.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0 0 0 0 0 0 0	31, 55 2, 73 (5, 37 80 40, 47	5 0.00 0 0.00 4 0.00 5 0.00	6, 628 758 0 2, 855 0 10, 241	31.00 40.00 41.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	0 0 0 0 0 0					30. 00 31. 00 40. 00 41. 00 43. 00 200. 00

Health Financial Systems	ST. CATHERINE	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :24 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description			Nursing Scho	ol Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	e e	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	0	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74. 00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0		
91.00 09100 EMERGENCY	0	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVE	All Other Medical	Title	CN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre	
						narod
					11/23/2021 10	:24 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Modical	Total Cost	Total	Total Charges	Ratio of Cost	
	weurcar	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
E	ducation Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS		-				
50. 00 05000 OPERATI NG ROOM	0	0		0 44, 866, 892	0.00000	50.00
51.00 O5100 RECOVERY ROOM	0	0		0 7, 167, 269		51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 411, 036	0.00000	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 7, 102, 995	0.00000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 18, 334, 946	0.00000	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 7, 481, 504		55.00
56.00 05600 RADI OI SOTOPE	0	0		0 7, 494, 510	0.00000	56.00
57.00 05700 CT SCAN	0	0		0 29, 555, 240	0.00000	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 8, 047, 602	0.00000	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 21, 234, 976	0.00000	59.00
60. 00 06000 LABORATORY	0	0		0 65, 710, 520	0.00000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0.00000	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 2, 981, 072	0.00000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 3, 504, 954	0.00000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 5, 784, 995	0.00000	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 9, 701, 943		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 5, 864, 624		
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 544, 571	0.00000	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 16, 278, 152	0.00000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 940, 723		70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 12, 301, 035		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 7, 131, 474	0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 70, 924, 116		73.00
74.00 07400 RENAL DIALYSIS	0	0		0 3, 482, 807	0.00000	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 673, 446		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 791, 913	0.000000	76.97
				0 0.045 (74	0.000000	00.00
90. 00 09000 CLINIC	0	0		0 3, 845, 671	0.000000	90.00
91.00 09100 EMERGENCY	0	0		0 58, 201, 754		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)	0	0		0 11, 831, 694 0 441, 192, 434		
200.00 Total (lines 50 through 199)	U	0		0 441, 192, 434		200. 00

Health Financial Systems	ST. CATHERI NE	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	Provider C	CN: 15-0008	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre	narod
				10 00/30/2021	11/23/2021 10	:24 am
		Title	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
'	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
	(col. 6 ÷ col.	-	Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS					-	
50.00 05000 OPERATING ROOM	0. 000000	3, 833, 360		0 5, 029, 759	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	206, 316		0 880, 601	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	14, 493		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	479, 965		0 673, 323	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	915, 887		0 1, 521, 244	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0 2, 933, 650	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	575, 714		0 1, 341, 058	0	56.00
57.00 05700 CT SCAN	0. 000000	2, 169, 285		0 3, 417, 695	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	588, 593		0 1, 025, 316		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 762, 064		0 3, 498, 966	0	59.00
60. 00 06000 LABORATORY	0. 000000	5, 643, 121		0 2, 899, 618	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	443, 026		0 94, 718	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 1, 374, 084	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 223, 876		0 185, 814	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	602, 034		0 26, 359	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	591, 530		0 18, 486	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	157, 789		0 49, 904	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 623, 021		0 2, 582, 922	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	88, 166		0 678, 488	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 629, 229		0 1, 447, 873	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	864, 758		0 964, 407	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	7, 120, 123		0 12, 619, 609	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	1, 071, 360		0 161, 456		74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	579		0 118, 399	0	76.00
76. 97 07697 CARDI AC REHABILI TATI ON	0. 000000	39, 527		0 157, 163	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	129, 038		0 585, 672		
91.00 09100 EMERGENCY	0. 000000	3, 990, 327		0 4, 345, 101	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	854, 876		0 1, 541, 034		
200.00 Total (lines 50 through 199)		37, 618, 057		0 50, 172, 719	0	200.00

Health Financial Systems		ST. CATHERIN			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Peri od:	Worksheet D	
					From 07/01/2020 To 06/30/2021	Part V Date/Time Pre	nared
					10 00/ 50/ 2021	11/23/2021 10	
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
Cost Center D	escription	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	. ,	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE C							
50.00 05000 OPERATI NG R00		0. 212285			0 31, 086	1, 067, 742	50.00
51.00 05100 RECOVERY ROOM		0. 299125	880, 601		0 0	263, 410	51.00
52.00 05200 DELIVERY ROOM	& LABOR ROOM	0. 527276	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOG	Y	0. 129621	673, 323		0 0	87, 277	53.00
54.00 05400 RADI OLOGY-DI A	GNOSTI C	0. 224530	1, 521, 244		0 0	341, 565	54.00
55.00 05500 RADI OLOGY - T	HERAPEUTI C	0. 130015	2, 933, 650		0 0	381, 419	55.00
56. 00 05600 RADI 0I SOTOPE		0. 174426	1, 341, 058		0 0	233, 915	56.00
57.00 05700 CT SCAN		0. 058133	3, 417, 695		0 0	198, 681	57.00
58.00 05800 MAGNETIC RESO	NANCE IMAGING (MRI)	0. 079842	1, 025, 316		0 0	81, 863	58.00
59.00 05900 CARDI AC CATHE	TERI ZATI ON	0. 136000	3, 498, 966		0 0	475, 859	59.00
60.00 06000 LABORATORY		0. 133888	2, 899, 618		0 0	388, 224	60.00
62.00 06200 WHOLE BLOOD &	PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING	, PROCESSING, & TRANS.	0. 361670	94, 718		0 0	34, 257	63.00
64.00 06400 INTRAVENOUS T	HERAPY	0. 293352	1, 374, 084		0 0	403, 090	64.00
65. 00 06500 RESPI RATORY T	HERAPY	0. 330661	185, 814		0 0	61, 441	65.00
66.00 06600 PHYSI CAL THER	APY	0. 361471	26, 359		0 0	9, 528	66.00
67.00 06700 0CCUPATI ONAL	THERAPY	0. 313308	18, 486		0 0	5, 792	67.00
68.00 06800 SPEECH PATHOL	OGY	0. 364005	49, 904		0 0	18, 165	68.00
69.00 06900 ELECTROCARDI 0	LOGY	0. 094234	2, 582, 922		0 0	243, 399	69.00
70.00 07000 ELECTROENCEPH	ALOGRAPHY	0. 113565			0 0	77,052	70.00
71.00 07100 MEDI CAL SUPPL	IES CHARGED TO PATIENT	0. 380300	1, 447, 873		0 0	550, 626	71.00
72.00 07200 IMPL. DEV. CH	ARGED TO PATIENTS	0. 593893			0 0	572, 755	72.00
73.00 07300 DRUGS CHARGED	TO PATIENTS	0. 163776			0 17, 402	2, 066, 789	
74.00 07400 RENAL DIALYSI		0. 255146			0 0	41, 195	
	SYCHOLOGI CAL SERVI CES	0. 437425			0 0	51, 791	
76. 97 07697 CARDI AC REHAB	I LI TATI ON	0. 979623			0 0	153, 960	•
OUTPATIENT SERVICE	COST CENTERS						
90. 00 09000 CLINIC		0. 473827	585, 672		0 0	277, 507	90.00
91.00 09100 EMERGENCY		0. 115483			0 0	501, 785	
	EDS (NON-DISTINCT PART	0. 344289			0 0	530, 561	•
	instructions)		50, 172, 719		0 48, 488		
	ic Lab. Services-Program				0 0		201.00
Only Charges							
	line 200 - line 201)		50, 172, 719		0 48, 488	9, 119, 648	202.00
	,						

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/23/2021 10	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
	Servi ces Subj ect To	Services Not Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				_
ANCI LLARY SERVI CE COST CENTERS		(500				
50. 00 O5000 OPERATING ROOM	0	6, 599				50.00
51.00 O5100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0				55.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0				63.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 850				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	9, 449				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	0	9, 449				202.00

Health Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C Component	CN: 15-0008 CCN: 15-T008	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre 11/23/2021 10	
		Title	e XVIII	Subprovider - IRF	PPS	<u> </u>
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)	J		
	26)	,	· ·			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	·					
50. 00 05000 OPERATI NG ROOM	1,054,448	44, 866, 892	0. 02350	02 108, 510	2, 550	50.00
51.00 05100 RECOVERY ROOM	85, 018	7, 167, 269	0. 0118	62 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	112, 692	3, 411, 036	0. 03303	37 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	111, 913	7, 102, 995	0.0157	56 12, 384	195	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	325, 903	18, 334, 946	0. 0177	75 87, 595	1, 557	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	45, 416	7, 481, 504	0.0060	70 0	0	
56. 00 05600 RADI OI SOTOPE	187,002	7, 494, 510	0. 0249	52 9, 044	226	56.00
57.00 05700 CT SCAN	89, 322	29, 555, 240	0.0030	68, 793	208	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	21, 995	8, 047, 602	0.00273	33 21, 546	59	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	473, 503	21, 234, 976	0. 0222	98 0	0	59.00
60. 00 06000 LABORATORY	282, 546	65, 710, 520	0.00430	00 685, 332	2, 947	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.0000	0 00	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	30, 191	2, 981, 072	0. 0101:	28 13, 428	136	63.00
64.00 06400 INTRAVENOUS THERAPY	70, 092	3, 504, 954	0.0199	98 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	92, 316			58 186, 342	2, 974	65.00
66. 00 06600 PHYSI CAL THERAPY	131, 244	9, 701, 943	0. 0135	28 1, 379, 870	18, 667	66.00
67.00 06700 OCCUPATI ONAL THERAPY	41,079	5, 864, 624	0.0070	1, 405, 532	9, 846	67.00
68.00 06800 SPEECH PATHOLOGY	17,028	1, 544, 571	0. 0110	24 178, 655	1, 969	68.00
69. 00 06900 ELECTROCARDI OLOGY	313, 221	16, 278, 152	0. 01924	42 22, 993	442	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	57,067	5, 940, 723	0.00960	3, 994	38	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18, 967	12, 301, 035	0.0015	42 177, 310	273	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	16, 817	7, 131, 474	0.0023	58 13, 705	32	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	215, 288	70, 924, 116	0.0030	35 1, 234, 713	3, 747	73.00
74.00 07400 RENAL DIALYSIS	11,047	3, 482, 807	0.0031	72 310, 046	983	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	15, 110	673, 446	0. 02243	37 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	72, 039			58 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	36, 605				-	
91. 00 09100 EMERGENCY	240, 097	58, 201, 754			35	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00 Total (lines 50 through 199)	4, 167, 966	441, 192, 434	l	5, 928, 281	46, 884	200.00

Health Financial Systems	ST. CATHERI N	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	5 Provider C	CN: 15-0008	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T008	From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre	narod
		component	CCN. 15-1008	10 00/30/2021	11/23/2021 10	
		Title	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description			Nursing Scho	ol Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments	0.00	Adjustments	0.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2A	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0			0	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	o	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C)	0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	C		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			1	-		
90. 00 09000 CLINIC	0	0		0 0		90.00
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)	0	0		0 0	0	92.00 200.00
	l O	C	1	0 0	0	1200. OU

Health Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0008	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020		
		Component	CCN: 15-T008	To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: 24 am
		Title	e XVIII	Subprovider -	PPS	. 2 4 0111
				. I RF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-	-	1			
50.00 05000 OPERATING ROOM	0	0		0 44, 866, 892		•
51.00 05100 RECOVERY ROOM	0	C		0 7, 167, 269		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 3, 411, 036		
53.00 05300 ANESTHESI OLOGY	0	C		0 7, 102, 995		•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 18, 334, 946		•
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 7, 481, 504		
56. 00 05600 RADI OI SOTOPE	0	0		0 7, 494, 510		•
57. 00 05700 CT SCAN	0	0		0 29, 555, 240		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 8, 047, 602		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 21, 234, 976		
60. 00 06000 LABORATORY	0	0		0 65, 710, 520		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0.000000	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 2, 981, 072		
64.00 06400 INTRAVENOUS THERAPY	0	0		0 3, 504, 954	0.00000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 5, 784, 995		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 9, 701, 943		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 5, 864, 624		
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 544, 571	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 16, 278, 152	0.00000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 940, 723	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 12, 301, 035	0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 7, 131, 474	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 70, 924, 116	0.00000	73.00
74.00 07400 RENAL DIALYSIS	0	C		0 3, 482, 807	0.00000	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C		0 673, 446	0.00000	76.00
76. 97 07697 CARDIAC REHABILITATION	0	C		0 791, 913	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS	-					
90. 00 09000 CLINIC	0	C		0 3, 845, 671		
91. 00 09100 EMERGENCY	0	C		0 58, 201, 754	0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 11, 831, 694	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0		0 441, 192, 434		200.00

Health Financial Systems	ST. CATHERINE	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-0008	Period: From 07/01/2020	Worksheet D Part IV	
		Component (CCN: 15-T008	To 06/30/2021	Date/Time Pre 11/23/2021 10	
		Ti tl e	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	_					
50.00 05000 OPERATING ROOM	0. 000000	108, 510		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	12, 384		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	87, 595		0 0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0.000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0.000000	9,044		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	68, 793		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	21, 546		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0.000000	685, 332		0 0	0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0		0 0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	13, 428		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	10, 120		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	186, 342		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 379, 870		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0, 000000	1, 405, 532		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0.000000	178,655		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	22, 993		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000	3, 994		0 0	0	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3, 994 177, 310		0 0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	13, 705		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000	1, 234, 713		0 0	0	
74. 00 07400 RENAL DI ALYSI S	0.000000	310, 046		0 0	0	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.00000	0		0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
	0.000000		1	0	-	00.00
90. 00 09000 CLINIC	0.00000	0		0 0	0	
91. 00 09100 EMERGENCY	0.00000	8, 489		0 0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 000000	0		0 0	0	
200.00 Total (lines 50 through 199)		5, 928, 281		0 0	0	200.00

	ncial Systems	ST. CATHERIN		01 45 0000		u of Form CMS-	2552-10
APPORITONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 15-0008	Period: From 07/01/2020	Worksheet D Part V	
			Component	CCN: 15-T008	To 06/30/2021	Date/Time Pre 11/23/2021 10	
			Title	e XVIII	Subprovider - IRF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	LARY SERVICE COST CENTERS	1 1		1			-
	OPERATING ROOM	0. 212285	0		0 0	0	
	RECOVERY ROOM	0. 299125	0		0 0	0	
	DELIVERY ROOM & LABOR ROOM	0. 527276	0		0 0	0	
	ANESTHESI OLOGY	0. 129621	0		0 0	0	
	RADI OLOGY-DI AGNOSTI C	0. 224530	0		0 0	0	
	RADI OLOGY - THERAPEUTI C	0. 130015	0		0 0	0	
	RADI OI SOTOPE	0. 174426	0		0 0	0	
	CT SCAN	0.058133	0		0 0	0	
	MAGNETIC RESONANCE IMAGING (MRI)	0.079842	0		0 0	0	
	CARDI AC CATHETERI ZATI ON	0. 136000	0		0 0	0	
	LABORATORY	0. 133888	0		0 0	0	
	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0		0 0	0	
	BLOOD STORING, PROCESSING, & TRANS.	0.361670	0		0 0	0	
	INTRAVENOUS THERAPY	0. 293352	0		0	0	
		0. 330661	0		0	0	
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0. 361471 0. 313308	0		0 0	0	
	SPEECH PATHOLOGY	0. 313308	0		0 0	0	1
	ELECTROCARDI OLOGY	0. 094234	0		0 0	0	1
		0. 094234	0		0 0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 380300	0		0 0	0	
	IMPL. DEV. CHARGED TO PATIENTS	0. 593893	0		0 0	0	
	DRUGS CHARGED TO PATIENTS	0. 163776	0		0 0	0	
	RENAL DIALYSIS	0. 255146	0		0 0	0	
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 437425	0		0 0	0	
	CARDI AC REHABILI TATI ON	0. 979623	0		0 0	0	
	TI ENT SERVICE COST CENTERS	0.777020		I			10.77
		0. 473827	0		0 0	0	90.00
	EMERGENCY	0. 115483	0		0 0	0	
	OBSERVATION BEDS (NON-DISTINCT PART	0. 344289	0		0 0	0	
200.00	Subtotal (see instructions)		0		0 0		200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0	-	201.00
	Only Charges						

Health Finar	ncial Systems	ST. CATHERINE	HOSPI TAL		In Lie	u of Form CMS	-2552-1
APPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0008	Period: From 07/01/2020	Worksheet D Part V	
			Component	CCN: 15-T008	To 06/30/2021	Date/Time Pr 11/23/2021 1	
			Title	e XVIII	Subprovider - IRF	PPS	
		Cos	ts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins. (see inst.)	Ded. & Coins. (see inst.)				
		6.00	7.00	-			
ANCLL	LARY SERVICE COST CENTERS	0.00	7.00				
	OPERATING ROOM	0	0				50.00
51.00 05100	RECOVERY ROOM	0	0				51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 05300	ANESTHESI OLOGY	0	0				53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0	0				54.0
55.00 05500	RADI OLOGY - THERAPEUTI C	0	0				55.0
56.00 05600	RADI OI SOTOPE	0	0				56.0
57.00 05700	CT SCAN	0	0				57.0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.0
59.00 05900	CARDI AC CATHETERI ZATI ON	0	0				59.0
	LABORATORY	0	0				60.0
	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.0
	BLOOD STORING, PROCESSING, & TRANS.	0	0	1			63.0
	INTRAVENOUS THERAPY	0	0				64.0
	RESPIRATORY THERAPY	0	0	1			65.0
	PHYSICAL THERAPY	0	0				66.0
	OCCUPATIONAL THERAPY	0	0				67.0
	SPEECH PATHOLOGY	0	0				68.00
		0	0				69.0
	ELECTROENCEPHALOGRAPHY	0	0				70.0
	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.0
	DRUGS CHARGED TO PATIENTS	0	0				73.0
	RENAL DI ALYSI S	0	0				74.0
	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	•			76.0
	CARDIAC REHABILITATION	0	0				76.9
	ATIENT SERVICE COST CENTERS	. 0	0	1			- , ,
		0	0				90.0
	EMERGENCY	0	0	•			91.0
	OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.0
200.00	Subtotal (see instructions)	0	0				200. 0
201.00	Less PBP Clinic Lab. Services-Program	0					201.0
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part I Date/Time Pre 11/23/2021 10	pared: :24 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 148, 608	0	1, 148, 60	8 31, 559	36.40	30.00
31.00 INTENSIVE CARE UNIT	289, 137		289, 13	7 2, 735	105.72	31.00
40. 00 SUBPROVIDER - IPF	0	0		0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	223, 758	0	223, 75	8 5, 374	41.64	41.00
43.00 NURSERY	50, 804		50, 80	4 805	63.11	43.00
200.00 Total (lines 30 through 199)	1, 712, 307		1, 712, 30	7 40, 473		200.00
Cost Center Description	Inpatient	Inpatient			•	
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00]			
INPATIENT ROUTINE SERVICE COST CENTERS					-	
30. 00 ADULTS & PEDIATRICS	2, 158	78, 551				30.00
31.00 INTENSIVE CARE UNIT	22	2, 326				31.00
40.00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	77	3, 206				41.00
43.00 NURSERY	117					43.00
200.00 Total (lines 30 through 199)	2, 374					200.00

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre 11/23/2021 10	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	-		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	r					
50.00 O5000 OPERATI NG ROOM	1,054,448				16, 346	
51.00 05100 RECOVERY ROOM	85, 018				618	•
52.00 05200 DELIVERY ROOM & LABOR ROOM	112, 692				7, 424	
53. 00 05300 ANESTHESI OLOGY	111, 913					
54.00 05400 RADI OLOGY-DI AGNOSTI C	325, 903				3, 178	
55. 00 05500 RADI OLOGY – THERAPEUTI C	45, 416				0	55.00
56. 00 05600 RADI OI SOTOPE	187,002	7, 494, 510			1, 427	56.00
57.00 05700 CT SCAN	89, 322				951	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	21, 995				254	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	473, 503	21, 234, 976			1, 508	59.00
60. 00 06000 LABORATORY	282, 546	65, 710, 520			4, 753	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	30, 191	2, 981, 072	0. 01012	28 26, 811	272	63.00
64.00 06400 I NTRAVENOUS THERAPY	70, 092	3, 504, 954	0. 01999	98 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	92, 316		0. 01595	58 197, 632	3, 154	65.00
66. 00 06600 PHYSI CAL THERAPY	131, 244	9, 701, 943	0. 01352	96, 089	1, 300	66.00
67.00 06700 OCCUPATI ONAL THERAPY	41,079	5, 864, 624	0.00700	05 62, 741	440	67.00
68.00 06800 SPEECH PATHOLOGY	17,028	1, 544, 571	0.01102	43, 593	481	68.00
69. 00 06900 ELECTROCARDI OLOGY	313, 221	16, 278, 152	0. 01924	153, 001	2, 944	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	57,067				270	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18, 967				383	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	16, 817	7, 131, 474	0.0023	68, 074	161	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	215, 288				4, 406	73.00
74.00 07400 RENAL DIALYSIS	11, 047	3, 482, 807	0.0031	95, 703	304	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	15, 110	673, 446	0. 02243	37 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	72, 039	791, 913	0. 09096	58 1, 275	116	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	36, 605					
91. 00 09100 EMERGENCY	240, 097					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	154, 244				1, 985	
200.00 Total (lines 50 through 199)	4, 322, 210	441, 192, 434		6, 064, 324	56, 765	200. 00

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	epared: 0:24 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Healt	n Allied Health	All Other	
	Post-Stepdown		Post-Stepdow	n Cost	Medi cal	
	Adjustments		Adj ustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	C)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	31.00
40. 00 04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
41. 00 04100 SUBPROVIDER - IRF	0	0		0 0	0	
43. 00 04300 NURSERY	0				0	
200.00 Total (lines 30 through 199)	0	0		0 0	-	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Dation	t Per Diem (col.	Inpati ent	200.00
COST CENTER Description	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Days	J + COI. 0)		
		minus col. 4)				
	4.00	5.00	6.00	7.00	8,00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	31, 55	.9 0.00	2, 158	30.00
31. 00 03100 NTENSI VE CARE UNI T	0	0	2,73			
40. 00 04000 SUBPROVIDER - IPF	0		2,73	0.00		
	0		Г. D. Т.			
41.00 04100 SUBPROVIDER - IRF	0	0	5, 37			
43.00 04300 NURSERY		0	80			
200.00 Total (lines 30 through 199)		0	40, 47	3	2,374	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
40. 00 04000 SUBPROVIDER – IPF	0					40.00
41. 00 04100 SUBPROVI DER – I RF	0					41.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	ST. CATHERI N	E HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre 11/23/2021 10	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description		Nursing School Post-Stepdown	Nursing Scho	ol Allied Health Post-Stepdown	Allied Health	
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2	2.00	0,1		
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 0	0	
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57. 00 05700 CT SCAN	0	0		0 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0008	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre	nared
				10 00/ 30/ 2021	11/23/2021 10	:24 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum o	f Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS		1		-		
50.00 O5000 OPERATING ROOM	0	0		0 44, 866, 892		
51.00 05100 RECOVERY ROOM	0	0		0 7, 167, 269		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 411, 036		
53. 00 05300 ANESTHESI OLOGY	0	0		0 7, 102, 995		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 18, 334, 946		
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0)	0 7, 481, 504	0.000000	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 7, 494, 510	0.000000	56.00
57.00 05700 CT SCAN	0	0		0 29, 555, 240	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 8, 047, 602	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0 21, 234, 976	0. 000000	59.00
60. 00 06000 LABORATORY	0	0)	0 65, 710, 520	0. 000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0)	0 0	0. 000000	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0)	0 2, 981, 072	0. 000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0)	0 3, 504, 954	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0 5, 784, 995	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0 9, 701, 943	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0)	0 5, 864, 624	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 544, 571	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0 16, 278, 152	0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0)	0 5, 940, 723	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 12, 301, 035	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 7, 131, 474	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 70, 924, 116	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0)	0 3, 482, 807	0.000000	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0)	0 673, 446	0.000000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	c c		0 791, 913	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	C		0 3, 845, 671	0.00000	90.00
91.00 09100 EMERGENCY	0	C		0 58, 201, 754		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		0 11, 831, 694		
200.00 Total (lines 50 through 199)	0			0 441, 192, 434		200.00
				1	I	

Health Financial Systems	ST. CATHERINE	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0008	Period: From 07/01/2020 To 06/30/2021		pared: :24 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient	Inpati ent	I npati ent	Outpati ent	Outpatient	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	695, 523		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	52, 086		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	224, 711		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	121, 173		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	178, 815		0 0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	57, 185		0 0	0	56.00
57.00 05700 CT SCAN	0.000000	314, 844		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000	92, 807		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	67, 636		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	1, 105, 380		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	26, 811		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	20,011		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	197, 632		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	96, 089		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	62, 741		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	43, 593		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	153,001		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	28, 099		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	248, 410		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0.000000	68, 074			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 451, 875			0	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	95, 703			0	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.000000	95, 703		0 0	-	76.00
76. 97 07697 CARDIAC REHABILITATION	0.000000	1, 275			0	76.97
OUTPATIENT SERVICE COST CENTERS	0.000000	1,275	1	0 0	0	/0. 7/
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0.000000	528, 610		0 0		90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	152, 251		0 0		•
200.00 Total (lines 50 through 199)	0.000000	6, 064, 324		0 0		200.00
	1	0,004,324	I	9 0	1 0	200.00

Health Financial Systems	ST. CATHERIN				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C	CN: 15-0008	Peri od:	Worksheet D	
		Component	CCN: 15-T008	From 07/01/2020 To 06/30/2021	Part II Date/Time Pre	narod
		component	CCN. 15-1008	10 00/30/2021	11/23/2021 10	:24 am
		Titl	e XIX	Subprovider -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	5	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ co	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)		0.00			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1 054 440					
50. 00 O5000 OPERATI NG ROOM	1, 054, 448				0	
51.00 05100 RECOVERY ROOM	85, 018				0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	112, 692				0	52.00
53.00 05300 ANESTHESI OLOGY	111, 913				0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	325, 903				20	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	45, 416				0	55.00
56. 00 05600 RADI 0I SOTOPE	187, 002				0	56.00
57.00 05700 CT SCAN	89, 322				0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	21, 995				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	473, 503				0	59.00
60. 00 06000 LABORATORY	282, 546				63	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	-	0.0000		0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	30, 191	2, 981, 072			0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	70, 092				0	64.00
65. 00 06500 RESPI RATORY THERAPY	92, 316				130	
66.00 06600 PHYSI CAL THERAPY	131, 244				448	1
67.00 06700 OCCUPATI ONAL THERAPY	41, 079				262	67.00
68.00 06800 SPEECH PATHOLOGY	17,028				34	68.00
69. 00 06900 ELECTROCARDI OLOGY	313, 221	16, 278, 152			0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	57,067				0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	18, 967				20	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	16, 817				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	215, 288				192	73.00
74.00 07400 RENAL DIALYSIS	11,047				95	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	15, 110				0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	72, 039	791, 913	0.0909	68 0	0	76.97
OUTPATIENT SERVICE COST CENTERS				1		
90. 00 09000 CLINIC	36, 605				0	
91.00 09100 EMERGENCY	240, 097				0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0				0	92.00
200.00 Total (lines 50 through 199)	4, 167, 966	441, 192, 434	1	203, 883	1, 264	200.00

Health Financial Systems	ST. CATHERI N	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C	CN: 15-0008	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T008	From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre	narod
		component	CCN. 15-1008	10 00/30/2021	11/23/2021 10	
		Titl	e XIX	Subprovider -	PPS	
				I RF		
Cost Center Description			Nursing Scho	ol Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments	0.00	Adjustments	0.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2A	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM		0		0 0	0	50,00
51. 00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0			0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	C		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0 0	0	76.97
			1	0 0	0	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0	0		0 0	0	90.00 91.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	U		0	0	91.00
200.00 Total (lines 50 through 199)	0	C		0 0	-	200.00
	, oj	0	I	с ₁ 0	0	200.00

Health Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0008	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020		
		Component	CCN: 15-T008	To 06/30/2021	Date/Time Pre 11/23/2021 10	epared:):24 am
		Titl	e XIX	Subprovider -	PPS	
				I RF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medical	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7) (see	
			and 4)		instructions)	
	4,00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 44, 866, 892	0.00000	50.00
51. 00 05100 RECOVERY ROOM	0			0 7, 167, 269		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 3, 411, 036		
53. 00 05300 ANESTHESI OLOGY	0			0 7, 102, 995		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 18, 334, 946		
55. 00 05500 RADI OLOGY - THERAPEUTI C	0			0 7, 481, 504		
56. 00 05600 RADI OI SOTOPE	0	C C)	0 7, 494, 510		
57.00 05700 CT SCAN	0	c		0 29, 555, 240	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0 8, 047, 602	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0 21, 234, 976	0.000000	59.00
60. 00 06000 LABORATORY	0	0		0 65, 710, 520	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0)	0 0	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 2, 981, 072		
64.00 06400 INTRAVENOUS THERAPY	0	0		0 3, 504, 954		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 5, 784, 995		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 9, 701, 943		
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 5, 864, 624		
68.00 06800 SPEECH PATHOLOGY	0	C		0 1, 544, 571		
69.00 06900 ELECTROCARDI OLOGY	0	C		0 16, 278, 152		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 940, 723		
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0		0 12, 301, 035		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 7, 131, 474		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 70, 924, 116		
74.00 07400 RENAL DI ALYSI S	0	0		0 3, 482, 807		
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 673, 446		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	1 0	1	0 791, 913	0.00000	76.97
0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	0	1	0 3, 845, 671	0.00000	90.00
91. 00 09100 EMERGENCY	0	, s		0 58, 201, 754		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 11, 831, 694		
200.00 Total (lines 50 through 199)	0			0 441, 192, 434		200.00
			1		I	

Health Financial Systems	ST. CATHERI NE	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0008	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020	Part IV	
		Component (CCN: 15-T008	To 06/30/2021	Date/Time Pre 11/23/2021 10	pared:
			e XIX	Subprovider -	PPS	. 24 am
				IRF	115	
Cost Center Description	Outpatient	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 101		0 0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0 0	l o	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	l o	56.00
57. 00 05700 CT SCAN	0.000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	14, 571		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	0		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	8, 163		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	33, 085		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	37, 414		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	3,077		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3,077		0 0	0	•
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	13,035			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	13, 035		0 0	-	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000	63, 365		0 0	0	•
		63, 365 30, 072			-	
	0. 000000			-	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.00000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
	0.000000		1	0 0		00.00
90. 00 09000 CLINIC	0.00000	0		0 0	0	
91.00 09100 EMERGENCY	0.00000	0		0 0	-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0		
200.00 Total (lines 50 through 199)	I I	203, 883	I	0 0	0	200. 00

WPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0008	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre 11/23/2021 10	pare
	Cost Center Description	Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
00	Inpatient days (including private room days and swing-bed day	rs. excluding newborn)		31, 559	1 1.
00	Inpatient days (including private room days, excluding swing-	0		31, 559	
00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	rivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		27, 321	4.
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
	reporting period			_	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7.
	reporting period				
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8.
00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	6, 628	9
	newborn days) (see instructions)	0			
00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e		5 /		
00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room davs)	0	13
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lir	ne)	-	
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
00	reporting period			0.00	
00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of 1	the cost	0.00	20
00	reporting period				
	Total general inpatient routine service cost (see instruction	2		30, 334, 175	
00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1} x line 17)	er 31 of the cost report	ing period (line	0	22
00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
	x line 18)				
00	Swing-bed cost applicable to NF type services through Decembe 7×1 (ine 19)	er 31 of the cost reporti	ng period (line	0	24
00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
~~	x line 20)			0	
00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 30, 334, 175	
00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			00,001,170	'
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	
00 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)	nuc line 22) (coo instruc	stions)	0.00	
00 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0.00 0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0	36
00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	30, 334, 175	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				ł
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			1
	Adjusted general inpatient routine service cost per diem (see			961.19	
			1		
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		6, 370, 767 0	

MPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	1
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	
		Title	XVIII	Hospi tal	PPS	J. 24
Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 = col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	+
00 NURSERY (title V & XIX only)	0	0	0.00	0 0	C) 42
Intensive Care Type Inpatient Hospital		0.305			1 505 000	
00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT	5, 505, 384	2, 735	2, 012. 94	4 758	1, 525, 809	9 43 44
00 BURN INTENSIVE CARE UNIT						44
00 SURGICAL INTENSIVE CARE UNIT						46
00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	-
00 Program inpatient ancillary service co	st (Wkst D_3 col 3	Line 200)			1.00 7,175,375	5 48
00 Total Program inpatient costs (sum of			ns)		15, 071, 951	
PASS THROUGH COST ADJUSTMENTS	<u> </u>					
00 Pass through costs applicable to Progr	am inpatient routine s	services (from	Wkst. D, sum	of Parts I and	321, 395	5 50
) .00 Pass through costs applicable to Progr	am inpationt ancillary	, convicos (fr	om Wkst D si	um of Parts II	357, 367	7 51
and IV)		y services (II	Uni wkst. D, St		337, 307	' ⁵ '
00 Total Program excludable cost (sum of					678, 762	
.00 Total Program inpatient operating cost		ated, non-phy	sician anesthe	stist, and	14, 393, 189	9 53
medical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
00 Program di scharges					C	54
00 Target amount per discharge					0.00	55
00 Target amount (line 54 x line 55)					0	
00 Difference between adjusted inpatient 00 Bonus payment (see instructions)	operating cost and tar	rget amount (I	ine 56 minus i	ine 53)		
.00 Lesser of lines 53/54 or 55 from the c	ost reporting period e	endi na 1996, u	pdated and cor	npounded by the		
market basket						
.00 Lesser of lines 53/54 or 55 from prior					0.00	
.00 If line 53/54 is less than the lower of which operating costs (line 53) are le					C) 61
amount (line 56), otherwise enter zero		5 (TTTES 54 X	00), 01 1% 01	the target		
.00 Relief payment (see instructions)	. ,				C	
. 00 Allowable Inpatient cost plus incentiv		ctions)			0) 63
PROGRAM INPATIENT ROUTINE SWING BED CO 00 Medicare swing-bed SNF inpatient routi		mber 31 of the	cost reportir	na period (See	C	0 64
instructions)(title XVIII only)	ne costs through beech		cost reportin		Ĭ	
.00 Medicare swing-bed SNF inpatient routi	ne costs after Decembe	er 31 of the c	ost reporting	period (See	C	65
instructions) (title XVIII only)	routing goots (ling ((1 plug ling (E) (+; + > V/////		c	
.00 Total Medicare swing-bed SNF inpatient CAH (see instructions)	routine costs (The c	54 prus rine o	s)(litie xviii	onry). For		66
.00 Title V or XIX swing-bed NF inpatient	routine costs through	December 31 o	f the cost rep	porting period	C	67
(line 12 x line 19)						
.00 Title V or XIX swing-bed NF inpatient	routine costs after De	ecember 31 of	the cost repor	ting period	C	68 0
(line 13 x line 20) .00 Total title V or XIX swing-bed NF inpa	tient routine costs (l	ine 67 + line	68)		C	69
PART III - SKILLED NURSING FACILITY, O	•		,		_	
00 Skilled nursing facility/other nursing						70
.00 Adjusted general inpatient routine ser .00 Program routine service cost (line 9 >		ne 70 ÷ line	2)		ľ	71
.00 Program routine service cost (line 9 > .00 Medically necessary private room cost	,	(line 14 x li	ne 35)		1	72
. 00 Total Program general inpatient routir					1	74
.00 Capital-related cost allocated to inpa	tient routine service	costs (from W	orksheet B, Pa	art II, column	1	75
26, line 45)	5 · lino 2)				ł	
00 Per diem capital-related costs (line 7 00 Program capital-related costs (line 9	,				1	76
.00 Inpatient routine service cost (line 7					1	78
00 Aggregate charges to beneficiaries for	excess costs (from pr		· · · ·		1	79
00 Total Program routine service costs fo	•	ost limitation	(line 78 minu	ıs line 79)		80
00 Inpatient routine service cost per die 00 Inpatient routine service cost limitat)			1	81
00 Reasonable inpatient routine service cost minital	•				1	83
00 Program inpatient ancillary services (•				1	84
.00 Utilization review - physician compens						85
.00 Total Program inpatient operating cost		rough 85)				86
.00 PART IV - COMPUTATION OF OBSERVATION B Total observation bed days (see instru					4, 238	3 87
. 00 Adjusted general inpatient routine cos		line 2)			961.19	
Agusted general inpatrent routine cos						

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: 24 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	1, 148, 608	30, 334, 175	0. 03786	5 4, 073, 523	154, 244	90.00
91.00 Nursing School cost	0	30, 334, 175	0.00000	0 4, 073, 523	0	91.00
92.00 Allied health cost	0	30, 334, 175	0.00000	0 4, 073, 523	0	92.00
93.00 All other Medical Education	0	30, 334, 175	0.00000	0 4, 073, 523	0	93.00

	Financial Systems ST. CATHERINE ATLON OF INPATIENT OPERATING COST	Provi der CCN: 15-0008	Peri od:	u of Form CMS-2 Worksheet D-1	
01		Component CCN: 15-T008	From 07/01/2020 To 06/30/2021	Date/Time Prep 11/23/2021 10	parec
		Title XVIII	Subprovider -	PPS	.24 6
	Cost Center Description			1.00	
	PART I – ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
. 00	Inpatient days (including private room days and swing-bed day			5, 374	
00 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed of		ivata room dave	5, 374 0	2. 3.
00	do not complete this line.	days). It you have only pr	i vate i ooni uays,	0	3.
00	Semi-private room days (excluding swing-bed and observation	bed days)		5, 374	4.
00	Total swing-bed SNF type inpatient days (including private r		r 31 of the cost	0	5.
	reporting period				
. 00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6.
. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	and days) through December	21 of the cost	0	7.
. 00	reporting period	Join days) thi ough becember	ST OF THE COST	0	/.
. 00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	1 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	2, 855	9.
	newborn days) (see instructions)			0	10
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instru		oom days)	0	10.
1.00	Swing-bed SNF type inpatient days applicable to title XVIII		oom davs) after	0	11.
	December 31 of the cost reporting period (if calendar year,			-	
2. 00	Swing-bed NF type inpatient days applicable to titles V or >	KIX only (including privat	e room days)	0	12.
	through December 31 of the cost reporting period				
3. 00	Swing-bed NF type inpatient days applicable to titles V or > after December 31 of the cost reporting period (if calendar			0	13.
I. 00	Medically necessary private room days applicable to the Proc			0	14.
5.00	Total nursery days (title V or XIX only)	gram (exer adring swring bea	uuys)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 o	f the cost	0.00	17.
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	10
5. 00	reporting period			0.00	'0.
9.00	Medicaid rate for swing-bed NF services applicable to service	ces through December 31 of	the cost	0.00	19.
	reporting period				
0. 00	Medicaid rate for swing-bed NF services applicable to service	ces after December 31 of t	he cost	0.00	20.
1.00	reporting period Total general inpatient routine service cost (see instruction	anc)		4, 775, 248	21
	Swing-bed cost applicable to SNF type services through Decen		ing period (line	4, 775, 248	21.
2.00	5 x line 17)	iber 31 of the cost report	rig period (rine	0	22.
3.00	Swing-bed cost applicable to SNF type services after December	er 31 of the cost reportin	g period (line 6	0	23.
	x line 18)				
4. 00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost reporti	ng period (line	0	24.
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December	c 31 of the cost reporting	period (line 8	0	25.
5.00	x line 20)	ST OF the cost reporting	period (inne o	0	25.
6. 00	Total swing-bed cost (see instructions)			0	26.
7.00	General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		4, 775, 248	27.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		<u>`</u>		
	General inpatient routine service charges (excluding swing-b	bed and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 30.
	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	···,		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4))		0.00	
	Average per diem private room charge differential (line 32 m		tions)	0.00	
	Average per diem private room cost differential (line 34 x l			0.00	
b. 00	Private room cost differential adjustment (line 3 x line 35)		fforontial (li	4 775 249	36.
7.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	i anu private room cost di	inerentiai (IIne	4, 775, 248	31.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	DJUSTMENTS			1
				000 50	1
	Adjusted general inpatient routine service cost per diem (se			888.58	
9.00	Program general inpatient routine service cost (line 9 x lin	ne 38)		2, 536, 896	39.
9.00).00		ne 38) gram (line 14 x line 35)			39. 40.

	Financial Systems ATION OF INPATIENT OPERATING COST	ST. CATHERIN		CCN: 15-0008	Period:	eu of Form CMS- Worksheet D-1	
				CCN: 15-T008	From 07/01/2020 To 06/30/2021) Date/Time Pre	epare
				e XVIII	Subprovider -	11/23/2021 10 PPS): 24
					I RF		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Pers sDiem (col. 1 col. 2)	5	Program Cost (col. 3 x col. 4)	
	1	1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0		0 0.	00 0	0	42
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0 0.	00 0		43.
. 00	CORONARY CARE UNIT	Ŭ		0.			44.
6.00	BURN INTENSIVE CARE UNIT						45
. 00	SURGI CAL INTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	+
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1, 574, 696	48
. 00	Total Program inpatient costs (sum of lines -			ons)		4, 111, 592	49
~~	PASS THROUGH COST ADJUSTMENTS					110.000	1 - 0
. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	m of Parts I and	118, 882	2 50
. 00	Pass through costs applicable to Program inpa	atient ancillar	v services (f	rom Wkst. D.	sum of Parts II	46, 884	51
	and IV)		,				
2.00	Total Program excludable cost (sum of lines	,				165, 766	
8.00	Total Program inpatient operating cost exclu- medical education costs (line 49 minus line 5		lated, non-ph	iysi ci an anest	hetist, and	3, 945, 826	53
	TARGET AMOUNT AND LIMIT COMPUTATION	52)				1	
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00 . 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (line 56 minus	line 53)	0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endina 1996	updated and c	ompounded by the	-	
	market basket						
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of lines					0	61
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		S (TIMES 54 X	. 60), OF 1% 0	i the target		
2. 00	Relief payment (see instructions)					0	62
3. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST	to through Dooo	mbor 21 of th	a agat rapart	ing pariod (Caa	0	
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through bece	inder 31 OF th	le cost report	ring period (see	0	64
6. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65
	instructions)(title XVIII only)						
5.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	ll only). For	0	66
7 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	eporting period	0	67
. 00	(line 12 x line 19)		December 31	of the cost i	cporting period		10,
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	0	68
	(line 13 x line 20)			(0)			
0. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0) 69
0. 00	Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service co	2		•	,		71
. 00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost application	U	•				73
. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient				Part II column		74
. 00	26, line 45)	foutifie service	0313 (11011	worksheet D,			1,2
. 00	Per diem capital-related costs (line 75 ÷ li	· ·					76
. 00	Program capital -related costs (line 9 x line						77
. 00 . 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess		rovi der rocer	chs)			78
00	Total Program routine service costs for compa				nus line 79)		80
. 00	Inpatient routine service cost per diem limit			(81
. 00	Inpatient routine service cost limitation (I	ine 9 x line 81					82
. 00	Reasonable inpatient routine service costs (s)				83
. 00 . 00	Program inpatient ancillary services (see in:		ns)				84
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PASS		. sagn bby			<u> </u>	
. 00	Total observation bed days (see instructions					0	87
3. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88
	Observation bed cost (line 87 x line 88) (see						89 (

Health Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1	
		Component (To 06/30/2021		pared: :24 am
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	223, 758	4, 775, 248	0. 04685	8 0	0	90.00
91.00 Nursing School cost	0	4, 775, 248	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 775, 248	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 775, 248	0.00000	0 0	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0008	Period: From 07/01/2020	Worksheet D-1	
			To 06/30/2021	Date/Time Pre 11/23/2021 10	pare
		Title XIX	Hospi tal	PPS	. 27
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	we excluding newborn)		31, 559	1 1.
00	Inpatient days (including private room days, excluding swing-bed da			31, 559	
00	Private room days (excluding swing-bed and observation bed d		rivate room days,	0 17 007	
	do not complete this line.				
00	Semi-private room days (excluding swing-bed and observation		01 6 11	27, 321	
00	Total swing-bed SNF type inpatient days (including private r reporting period	com days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private ro	oom days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private ro	nom davs) after December 3	and the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	on days) after becember a	of the cost	0	
00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	2, 158	9
~ ~	newborn days) (see instructions)				
00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instru		room days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII		room davs) after	0	1
	December 31 of the cost reporting period (if calendar year,	enter 0 on this line)	5 /		
. 00	Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including privat	e room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including privat	e room dave)	0	1:
00	after December 31 of the cost reporting period (if calendar			0	'`
00	Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)			805	
00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			117	10
00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 d	of the cost	0.00	1 13
	reporting period	J. J			
00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	the cost	0.00	10
00	reporting period	the organization of the		0.00	1.
. 00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of t	he cost	0.00	20
. 00	reporting period			30, 334, 175	2
	Total general inpatient routine service cost (see instructio Swing-bed cost applicable to SNF type services through Decem		ing period (line	30, 334, 175	
	5 x line 17)		ing porrou (rino	Ū	
. 00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reportin	ng period (line 6	0	2
00	x line 18) Swing had cost applicable to NE type corvices through Decemb	or 21 of the cost reporti	ng pariod (line	0	24
00	Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	er si or the cost report	ng period (inne	0	2
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	2!
~~	x line 20)				
00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(lipo 21 minus lipo 26)		0 30, 334, 175	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			30, 334, 175	2
00	General inpatient routine service charges (excluding swing-b	ed and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TIne 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 2) + line 4)			0.00	
	Average per diem private room charge differential (line 32 m	ninus line 33)(see instruc	ctions)	0.00	34
00	Average per diem private room cost differential (line 34 x l			0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost		fferential (line	0 30, 334, 175	
. 00	27 minus line 36)	ana private ruum cust ar		30, 334, 175	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD				
	Adjusted general inpatient routine service cost per diem (se	•		961.19	
	Decemper general impetient mouther service sect (1) 0				
00	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog			2, 074, 248 0	

JMPUI	TATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0008	Period: From 07/01/2020	Worksheet D-1	
					To 06/30/2021	Date/Time Pre 11/23/2021 10	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	843, 315	805			122, 569	42.
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT	5, 505, 384	2, 735	2, 012. 9	22	44, 285	
00 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
00							46
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			1, 205, 558	48
. 00				ns)		3, 446, 660	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	ı Wkst. D, sum	of Parts I and	88, 261	50
. 00	Pass through costs applicable to Program inpa	atient ancillar	v services (fr	om Wkst D s	um of Parts II	56, 765	51
	and IV)		j (
. 00	Total Program excludable cost (sum of lines					145, 026	
. 00	Total Program inpatient operating cost exclu- medical education costs (line 49 minus line 4		lated, non-phy	sician anesth	etist, and	3, 301, 634	53
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00						0	54
00	5 1 5					0.00	55
00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996 u	indated and co	mpounded by the		
	market basket	oor tring por rou	onding 1770, c		inpoundou by the	0100	
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		S (TTHES 54 X	60), OF 1% OF	the target		
. 00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Doco	mbor 21 of the	cost roporti	ng pariod (Saa	0	64
. 00	instructions) (title XVIII only)	is through bece		cost reporti	ng period (see	0	04
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65
~ ~	instructions)(title XVIII only)			->			
. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVII	I ONLY). FOR	0	66
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost re	porting period	0	67
. 00	(line 12 x line 19)	a costs after D	locombor 21 of	the cost rope	rting poriod	0	60
. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs arter D	ecember 31 01	the cost repo	n tring period	0	68
. 00	Total title V or XIX swing-bed NF inpatient					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil		•				70
. 00	Adjusted general inpatient routine service of						71
00	Program routine service cost (line 9 x line			,			72
. 00	Medically necessary private room cost application	, C	•				73
. 00	Total Program general inpatient routine serv	•			art II aalumn		74
. 00	Capital-related cost allocated to inpatient 1 26. line 45)	routine service	COSTS (TFOM W	Orksneet B, P	art II, column		75
. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital-related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu:		nould				78
00 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	· ·			us line 70)		80
00	Inpatient routine service cost per diem limit				ido TTTC 77)		81
00	Inpatient routine service cost limitation (I)				82
00	Reasonable inpatient routine service costs (s)				83
. 00	Program inpatient ancillary services (see in:						84
00 .	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
. 00	Total observation bed days (see instructions))				4, 238	
00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			961.19	88
00	Observation bed cost (line 87 x line 88) (see	•	,			4, 073, 523	00

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :24 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 148, 608	30, 334, 175	0. 03786	5 4, 073, 523	154, 244	90.00
91.00 Nursing School cost	0	30, 334, 175	0.00000	0 4, 073, 523	0	91.00
92.00 Allied health cost	0	30, 334, 175	0.00000	0 4, 073, 523	0	92.00
93.00 All other Medical Education	0	30, 334, 175	0.00000	0 4, 073, 523	0	93.00

	Financial Systems ST. CATHERINE ATION OF INPATIENT OPERATING COST ST. CATHERINE	Provi der CCN: 15-0008	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T008	From 07/01/2020 To 06/30/2021	Date/Time Prep 11/23/2021 10	
		Title XIX	Subprovider -	PPS	. 2 1
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
. 00	Inpatient days (including private room days and swing-bed da			5, 374 5, 374	1. 2.
. 00 . 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d		ivate room davs	5, 374	3.
00	do not complete this line.	ays). It you have only pr	rvate room days,	0	5
00	Semi-private room days (excluding swing-bed and observation	bed days)		5, 374	4
00	Total swing-bed SNF type inpatient days (including private r	oom days) through Decembe	r 31 of the cost	0	5
~~	reporting period		04 6 11 1		
00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	om days) through December	31 of the cost	0	7
00	reporting period	om days) through becomber		0	ĺ '
00	Total swing-bed NF type inpatient days (including private ro	om days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	77	9
D. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	oply (including privato r	oom dave)	0	10
). 00	through December 31 of the cost reporting period (see instru		ooni uays)	0	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year,		•		
2.00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including privat	e room days)	0	12
3. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	IV only (including privat	o room dave)	0	13
5.00	after December 31 of the cost reporting period (if calendar			0	13
1.00	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	14
	Total nursery days (title V or XIX only)		5,	805	15
5.00	Nursery days (title V or XIX only)			117	16
7.00	SWING BED ADJUSTMENT	and through December 21 a	f the east	0.00	17
/. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through becember 31 o	T the cost	0.00	
3. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	the cost	0.00	19
D. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	as after December 21 of t	ho cost	0.00	20
J. 00	reporting period		ne cost	0.00	20
1.00	Total general inpatient routine service cost (see instructio	ins)		4, 775, 248	21
2.00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost report	ing period (line	0	22
	5 x line 17)				
3.00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	er 31 of the cost reportin	g period (line 6	0	23
4 00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	ng period (line	0	24
1.00	7 x line 19)			0	2
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)				
6.00	Total swing-bed cost (see instructions)	(line 21 minute line 24)		0	26
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		4, 775, 248	27
8.00	General inpatient routine service charges (excluding swing-b	ed and observation bed ch	arges)	0	28
9.00	Private room charges (excluding swing-bed charges)		3 /	0	29
0. 00	Semi-private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m		tions)	0. 00 0. 00	
8.00	The stage per arom private room enange differential (fille JZ III			0.00	
3.00 1.00	Average per diem private room cost differential (line 34 x l			0	36
2.00 3.00 4.00 5.00 6.00				-	
3.00 4.00 5.00	Average per diem private room cost differential (line 34 x l		fferential (line	4, 775, 248	37
3.00 4.00 5.00 5.00	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)		fferential (line	4, 775, 248	37
3.00 4.00 5.00 5.00	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	and private room cost di	fferential (line	4, 775, 248	37
3.00 4.00 5.00 5.00 7.00	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	and private room cost di	fferential (line		
3. 00 4. 00 5. 00 5. 00 7. 00 3. 00	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD Adjusted general inpatient routine service cost per diem (se	and private room cost di JUSTMENTS e instructions)	fferential (line	888. 58	38
3.00 4.00 5.00 6.00	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	and private room cost di JUSTMENTS e instructions) e 38)	fferential (line		

	Financial Systems TATION OF INPATIENT OPERATING COST	ST. CATHERIN		CN: 15-0008	Period:	eu of Form CMS- Worksheet D-1	
				CCN: 15-T008	From 07/01/2020 To 06/30/2021	Date/Time Pre	epare
			Titl	e XIX	Subprovider -	11/23/2021 10 PPS): 24
					I RF		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0	C	0.	00 C	0	42
8. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	C	0.	00 0	0	43
. 00	CORONARY CARE UNI T						44
6.00	BURN INTENSIVE CARE UNIT						45
00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						46
. 00	Cost Center Description			<u> </u>			47
						1.00	
. 00 . 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ns)		52, 709 121, 130	
. 00	PASS THROUGH COST ADJUSTMENTS	41 through 40)(see manuelle	/13)		121,130	47
. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, su	m of Parts I and	3, 206	50
. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillar	V SARVICAS (Fr	COM What D	sum of Parte II	1, 264	51
. 00	and IV)		J 301 VI COS (11	on most. D,	Sum OF FAILS II	1, 204	
2.00	Total Program excludable cost (sum of lines					4, 470	
3. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		lated, non-phy	/sician anest	netist, and	116, 660	y 53
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program discharges					0	
. 00 . 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	5	5 (,	0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	updated and c	ompounded by the	0.00	59
). 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	narket basket		0.00	60
. 00	If line 53/54 is less than the lower of line					0	
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% o	f the target		
2.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	riisti ucti olisj				0	62
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doco	mbor 21 of the	cost roport	ing pariod (Saa	0	64
. 00	instructions) (title XVIII only)	ts through bece		e cost report	ing period (see		/ 04
. 00	5 1	ts after Decemb	er 31 of the c	cost reportin	g period (See	0	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	61 plus lipe 6	5) (+i +l o XVI	LL only) For	0	66
. 00	CAH (see instructions)	ne costs (inne	04 prus rine c	5)(title xi	ri oniy). Toi		/ 00
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost r	eporting period	0	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost ren	orting period	0	68
	(line 13 x line 20)				or tring period		
9.00	Total title V or XIX swing-bed NF inpatient					0	69
). 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service c	2		•			71
. 00	Program routine service cost (line 9 x line		(line 14 v li	no 25)			72
. 00	Medically necessary private room cost applic Total Program general inpatient routine serv	U U	•	,			73
5.00	Capital -related cost allocated to inpatient	•			Part II, column		75
~~~	26, line 45)						<u>-</u> ,
. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76
. 00	Inpatient routine service cost (line 74 minu	•					78
. 00							79
. 00 . 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitatior	n (line 78 mi	nus line 79)		80
. 00	Inpatient routine service cost per drem rimi		)				82
. 00	Reasonable inpatient routine service costs (	see instruction					83
. 00	Program inpatient ancillary services (see in		nc)				84
5.00 5.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PAS					u	1
7.00	3 .					0	
3.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	rine 2)			0.00	) 88 ) 89
0 00							

Health Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1	
		Component (		To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: 24 am
		Titl	e XIX	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	223, 758	4, 775, 248	0. 04685	8 0	0	90.00
91.00 Nursing School cost	0	4, 775, 248	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 775, 248	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 775, 248	0. 00000	0 0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Drawidar C	CNI. 1E 0000	Period:		2552-10
INPATIENT ANCILLARY SERVICE CUST APPORTIONMENT	Provider C	CN: 15-0008	From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Pre 11/23/2021 10	pared:
	Title	e XVIII	Hospi tal	PPS	1. 24 dili
Cost Center Description		Ratio of Cos		Inpatient	
Cost Center Description		To Charges		Program Costs	
		10 ondriges		(col. 1 x col.	
			ondi goo	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			17, 560, 365		30.00
31. 00 03100 I NTENSI VE CARE UNI T			2, 076, 615		31.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41. 00 04100 SUBPROVI DER – I RF			0		41.00
43. 00 04300 NURSERY			-		43.00
ANCI LLARY SERVI CE COST CENTERS		1			
50. 00 05000 OPERATI NG ROOM		0. 2122	85 3, 833, 360	813, 765	50.00
51.00 05100 RECOVERY ROOM		0. 2991		61, 714	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 5272		7,642	
53. 00 05300 ANESTHESI OLOGY		0. 1296		62, 214	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2253		206, 416	
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 1300		200, 110	1
56. 00 05600 RADI OI SOTOPE		0. 1744		100, 419	
57. 00 05700 CT SCAN		0. 0581		126, 107	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0798		46, 994	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1366		377, 472	
60. 00 06000 LABORATORY		0. 1340		756, 489	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 3616		160, 229	
64. 00 06400 I NTRAVENOUS THERAPY		0. 2933		00,227	
65. 00 06500 RESPI RATORY THERAPY		0. 3306		404, 688	
66. 00 06600 PHYSI CAL THERAPY		0.3614		217, 618	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 3133		185, 331	
68. 00 06800 SPEECH PATHOLOGY		0.3640		57, 436	
69. 00 06900 ELECTROCARDI OLOGY		0. 0942		152, 944	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1135		10, 013	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3803		619, 596	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5938		513, 574	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1637		1, 166, 105	
74. 00 07400 RENAL DI ALYSI S		0. 2551		273, 353	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 4374		273, 353	
76. 97   07697   CARDI AC REHABI LI TATI ON		0. 9796		38, 722	
OUTPATIENT SERVICE COST CENTERS		0. 7790.	2.5 37, 327	30, 722	10.71
90.00 09000 CLINIC		0. 4738	27 129, 038	61, 142	90.00
90. 00 109000 CETNIC 91. 00 109100 EMERGENCY		0. 4738		460, 815	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1154		294, 324	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0. 3442	37, 618, 057	7, 175, 375	
· · · · · · · · · · · · · · · · · · ·	(1: (1)		37, 018, 037	1, 110, 370	200.00
201.00 Less PBP Clinic Laboratory Services-Program only char					

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0008	Peri od:	Worksheet D-3	<u>2552-1</u>
		CCN: 15-T008	From 07/01/2020 To 06/30/2021	Date/Time Pre	
				11/23/2021 10	
	Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS					30.0
30. 00 03000 ADDETS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT					30.0
40. 00 04000 SUBPROVIDER - IPF					40.0
41. 00  04100  SUBPROVI DER - I RF			4, 057, 299		40.0
43. 00  04300 NURSERY			4,037,299		41.0
ANCI LLARY SERVI CE COST CENTERS					43.0
50. 00 05000 OPERATI NG ROOM		0. 2122	85 108, 510	23, 035	50.0
51.00 05100 RECOVERY ROOM		0. 2991		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 5272		0	
53. 00  05300  ANESTHESI OLOGY		0. 1296		1, 605	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2253			
55. 00 05500 RADI OLOGY – THERAPEUTI C		0. 1300		0	55.0
56. 00 05600 RADI 0I SOTOPE		0. 1744	26 9, 044	1, 578	56.0
57.00 05700 CT SCAN		0. 0581	33 68, 793	3, 999	57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0798	42 21, 546	1, 720	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1366		0	
50. 00  06000  LABORATORY		0. 1340		91, 872	
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
53. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 3616			
64.00 06400 I NTRAVENOUS THERAPY		0. 2933		0	
65. 00 06500 RESPI RATORY THERAPY		0. 3306			
66.00 06600 PHYSI CAL THERAPY		0.3614			
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY		0. 31330		440, 364 65, 031	
69. 00 06900 ELECTROCARDI OLOGY		0. 3840			
70. 00 07000 ELECTROCARDIOLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 0942		454	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 38030		67, 431	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5938			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1637		202, 216	
74.00 07400 RENAL DI ALYSI S		0. 2551			
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 43742			
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 9796			
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLI NI C		0. 4738	27 0	0	90.0
91. 00 09100 EMERGENCY		0. 1154	83 8, 489	980	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3442	89 0	0	92.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			5, 928, 281	1, 574, 696	200. 0
201.00 Less PBP Clinic Laboratory Services-Program only char	rges (line 61)		0		201.0
202.00 Net charges (line 200 minus line 201)		1	5, 928, 281		202.0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN· 15-0008	Peri od:	u of Form CMS-: Worksheet D-3	
		UN. 13 0000	From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	pared:
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
0. 00 03000 ADULTS & PEDIATRICS			3, 622, 923		30.0
1.00 03100 INTENSIVE CARE UNIT			260, 520		31.0
0. 00 04000 SUBPROVIDER - IPF			0		40.0
1. 00 O4100 SUBPROVIDER - IRF			0		41.0
3. 00 04300 NURSERY			211, 948		43.0
ANCI LLARY SERVI CE COST CENTERS		1			
0.00 05000 OPERATING ROOM		0. 2122		147, 649	
1.00 05100 RECOVERY ROOM		0. 2991		15, 580	
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 5272		118, 485	
3. 00 05300 ANESTHESI OLOGY		0. 1296	21 121, 173	15, 707	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2253	73 178, 815	40, 300	54.0
5. 00 05500 RADI OLOGY – THERAPEUTI C		0. 1300	15 0	0	55.0
6. 00 05600 RADI OI SOTOPE		0. 1744	26 57, 185	9, 975	56.0
7.00 05700 CT SCAN		0. 0581	33 314, 844	18, 303	57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0798	42 92, 807	7, 410	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1366	63 67, 636	9, 243	59.0
0. 00 06000 LABORATORY		0. 1340	55 1, 105, 380	148, 182	60.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000	0 00	0	62.0
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0.3616	70 26, 811	9, 697	63.0
4. 00 06400 INTRAVENOUS THERAPY		0. 2933	52 0	0	64.0
5. 00 06500 RESPI RATORY THERAPY		0. 3306	61 197, 632	65, 349	65.0
6. 00 06600 PHYSI CAL THERAPY		0. 3614	71 96, 089	34, 733	66.0
7.00 06700 OCCUPATI ONAL THERAPY		0. 31330	08 62, 741	19, 657	67.0
8.00 06800 SPEECH PATHOLOGY		0.36400	25 43, 593	15, 868	68.0
9. 00 06900 ELECTROCARDI OLOGY		0. 09423	34 153, 001	14, 418	69.0
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1135	65 28, 099	3, 191	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 38030	248, 410	94, 470	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5938	93 68, 074	40, 429	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 1637	76 1, 451, 875	237, 782	73.0
4. 00 07400 RENAL DIALYSIS		0. 2551	46 95, 703	24, 418	
6. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 4374		0	1
6. 97 07697 CARDI AC REHABI LI TATI ON		0. 9796		1, 249	
OUTPATIENT SERVICE COST CENTERS					1
0. 00 09000 CLINIC		0. 4738	27 0	0	90.0
1. 00 09100 EMERGENCY		0. 1154		61, 045	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3442		52, 418	
00.00 Total (sum of lines 50 through 94 and 96 through 98)			6, 064, 324	1, 205, 558	
01.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0,001,021	., 200, 000	201.0
02.00 Net charges (line 200 minus line 201)	(		6, 064, 324		202.0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0008	Peri od:	Worksheet D-3	3
		CCN: 15-T008	From 07/01/2020 To 06/30/2021	Date/Time Pre	epared
		e XIX	Subprovider -	11/23/2021 10 PPS	):24 a
		C XIX	IRF	115	
Cost Center Description	· ·	Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
		1			1 20 0
0. 00 03000 ADULTS & PEDI ATRI CS 1. 00 03100 I NTENSI VE CARE UNI T					30.0
0. 00 04000 SUBPROVIDER - IPF					40.0
1. 00 04000 SUBPROVIDER - TRI			109, 010		40.0
3. 00 04300 NURSERY			107, 010		43.0
ANCI LLARY SERVI CE COST CENTERS		1			
0. 00 05000 OPERATING ROOM		0. 21228	85 0	0	50.0
1.00 05100 RECOVERY ROOM		0. 29912		0	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 5272	76 0	0	52. (
3. 00 05300 ANESTHESI OLOGY		0. 12962	21 0	0	53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2253	73 1, 101	248	54.
5. 00 05500 RADI OLOGY - THERAPEUTI C		0. 1300	15 0	0	55.
6. 00 05600 RADI OI SOTOPE		0. 17442		0	56.
7.00 05700 CT SCAN		0. 05813		0	
8.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0. 07984		0	
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 13660		0	
		0. 1340		1, 953	
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000			
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0.3616			
4. 00 06400 I NTRAVENOUS THERAPY		0. 2933		0	
5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY		0. 33060		2, 699 11, 959	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 31330		11, 722	
8. 00 06800 SPEECH PATHOLOGY		0.36400		1, 120	
9. 00 06900 ELECTROCARDI OLOGY		0. 09423			
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 11350		0	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 38030		4, 957	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 59389		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1637			
4. 00 07400 RENAL DIALYSIS		0. 25514		7,673	
6. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 43742			76.
6. 97 07697 CARDI AC REHABI LI TATI ON		0.97962	23 0	0	76. 9
0.00 09000 CLINIC		0. 47382	27 0	0	90.0
1. 00 09100 ELENTC		0. 47382			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 34428		0	
00.00 Total (sum of lines 50 through 94 and 96 through 9	8)	0. 34420	203, 883		
01.00 Less PBP Clinic Laboratory Services-Program only c			203, 883		200.0
02.00 Net charges (line 200 minus line 201)			203, 883		202.0

ALCUL	Financial Systems ST. CATHERINE ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0008	Period: From 07/01/2020 To 06/30/2021	u of Form CMS-: Worksheet E Part A Date/Time Pre	pared:
		Title XVIII	Hospi tal	11/23/2021 10 PPS	: 24 an
		•		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (	see	0 3, 297, 326	1.0 1.0
. 02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	9, 403, 774	1.0
. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	prior to October	0	1.0
. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or discharges occurring	on or after	0	1.0
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.0 2.0
. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	ions)		0	2.0
2.03	Outlier payments for discharges occurring prior to October 1			19, 923	
. 04	Outlier payments for discharges occurring on or after October	1 (see instructions)		69, 305	2.0
00	Managed Care Simulated Payments	sting pariod (and instru	unti ana)	0	3.0
. 00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	string period (see fisting		120.27	4.0
. 00	FTE coult for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	st recent cost reporting	period ending on	0.00	5.0
. 00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)	he criteria for an add-o	on to the cap for	0.00	6.0
. 00 . 01	MMA Section 422 reduction amount to the IME cap as specified ACA $\S$ 5503 reduction amount to the IME cap as specified under			0.00 0.00	7.0 7.0
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	8.0
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8.0
8. 02	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospi tal	0.00	8.0
0. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	nes (8, 8,01 and 8,02)	see	0.00	9.0
0.00	FTE count for allopathic and osteopathic programs in the curr	rent year from your recor	rds	0.00	
1.00 2.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00 0.00	
3.00	Total allowable FTE count for the prior year.			0.00	
4.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Sep	otember 30, 1997,	0.00	
5.00	Sum of lines 12 through 14 divided by 3.			0.00	15. C
6.00	Adjustment for residents in initial years of the program			0.00	
7.00	Adjustment for residents displaced by program or hospital clo	osure		0.00	
8.00 9.00	Adjusted rolling average FTE count			0.00	
	Current year resident to bed ratio (line 18 divided by line 4 Prior year resident to bed ratio (see instructions)	•).		0. 000000 0. 000000	
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
2.00	IME payment adjustment (see instructions)			0	
2. 01	IME payment adjustment - Managed Care (see instructions)			0	22. (
3. 00	Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE resid		CFR 412. 105	0.00	23. (
4.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24.0
.4. 00 .5. 00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00	
6.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.
7.00	IME payments adjustment factor. (see instructions)			0.000000	
B. 00	IME add-on adjustment amount (see instructions)			0	28.
8.01	IME add-on adjustment amount - Managed Care (see instructions	5)		0	
9. 00 9. 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	01)		0	29. ( 29. (
0. 00	<u>Disproportionate Share Adjustment</u> Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instrug	rtions)	12.12	30.
0.00 1.00	Percentage of Medicaid patient days (see instructions)	arrent udys (see Instruc		42.57	
2.00	Sum of Lines 30 and 31			42.57 54.69	
3.00	Allowable disproportionate share percentage (see instructions	5)		34.33	
	Disproportionate share adjustment (see instructions)			1,090,072	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Pre 11/23/2021 10	
		Title XVIII	Hospi tal	PPS	. 24
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment		0.250.500.00/	0.000.014.501	1 25
	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000198454	8, 290, 014, 521 0. 000210935	
	Hospital uncompensated care payment (If line 34 is zero, ent	er zero on this line) (see			
J. 02	instructions)		1,007,212	1, 710,001	00.
5. 03	Pro rata share of the hospital uncompensated care payment am	nount (see instructions)	416, 567	1, 307, 895	35.
	Total uncompensated care (sum of columns 1 and 2 on line 35.		1, 724, 462		36.
	Additional payment for high percentage of ESRD beneficiary d				1 40
0. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, instructions)	684 and 685. (See	0		40.
			Before 1/1	On/After 1/1	
			1.00	1.01	
I. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0	0	41.
1 01	instructions)		_	_	4.1
. 01	Total ESRD Medicare covered and paid discharges excluding MS an 685. (see instructions)	שאט-טגטא סיע, 683, 684	0	0	41
. 00	Divide line 41 by line 40 (if less than 10%, you do not qual	ifv for adiustment)	0.00		42
	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6		0		43
	instructions)				
. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44
. 00	days) Average weekly cost for dialysis treatments (see instruction	us)	0.00	0.00	45
	Total additional payment (line 45 times line 44 times line 4		0.00	0.00	46
	Subtotal (see instructions)		15, 604, 862		47
. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only. (see instructions)			A	
				Amount 1.00	
9.00	Total payment for inpatient operating costs (see instruction	าร)		15, 604, 862	49
	Payment for inpatient program capital (from Wkst. L, Pt. I a			1, 097, 359	50
	Exception payment for inpatient program capital (Wkst. L, Pt			0	51
1	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions).		0	52
1	Nursing and Allied Health Managed Care payment			0	53
. 00	Special add-on payments for new technologies Islet isolation add-on payment			110, 874	54 54
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55
	Cost of physicians' services in a teaching hospital (see int			0 0	56
	Routine service other pass through costs (from Wkst. D, Pt.		nrough 35).	0	57
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)	-	0	58
. 00	Total (sum of amounts on lines 49 through 58)			16, 813, 095	
	Primary payer payments			0	
. 00	Total amount payable for program beneficiaries (line 59 minu	IS II në 60)		16, 813, 095	
	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			1, 167, 952 100, 887	
	Allowable bad debts (see instructions)			410, 482	
	Adjusted reimbursable bad debts (see instructions)			266, 813	
. 00	AUJUSTEU TETIIDUI SADLE DAU UEDTS (SEE TIISTI UCTIONS)			164, 740	
. 00 . 00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		15, 811, 069	67
. 00 . 00 . 00 . 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)			15, 011, 009	
. 00 . 00 . 00 . 00 . 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (se		0	
. 00 . 00 . 00 . 00 . 00 . 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)	applicable to MS-DRGs (se		0	68 69
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	applicable to MS-DRGs (se . (For SCH see instructions	5)	0 0 0	69 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	applicable to MS-DRGs (se (For SCH see instructions stration) adjustment (see i	5)	0 0 0 0	69 70 70
<ol> <li>00</li> <li>0</li></ol>	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration	applicable to MS-DRGs (se (For SCH see instructions stration) adjustment (see i	5)	0 0 0	69 70 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	applicable to MS-DRGs (se .(For SCH see instructions stration) adjustment (see i	5)	0 0 0 0 0	69 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	applicable to MS-DRGs (se .(For SCH see instructions stration) adjustment (see i	5)	0 0 0 0 0	69 70 70 70 70 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 50 . 87 . 88 . 89 . 90	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	applicable to MS-DRGs (se .(For SCH see instructions stration) adjustment (see i	5)	0 0 0 0 0 0	69 70 70 70 70 70 70 70
. 00 . 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	applicable to MS-DRGs (se .(For SCH see instructions stration) adjustment (see i	5)		69 70 70 70 70 70 70 70 70
. 00 5. 00 5. 00 7. 00 6. 00 9. 00 9. 00 9. 00 9. 00 9. 88 9. 89 9. 90 9. 91 9. 92 9. 93	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	applicable to MS-DRGs (se .(For SCH see instructions stration) adjustment (see i	5)	0 0 0 0 0 0 0 0	69 70 70 70 70 70 70 70 70 70 70

ealth Financial Systems SALCULATION OF REIMBURSEMENT SETTLEMENT	ST. CATHERINE HOSPITAL Provide	r CCN: 15-0008	Peri od:	eu of Form CMS- Worksheet E	
			From 07/01/2020 To 06/30/202	) Part A	nar
			10 00/ 30/ 202	1 Date/Time Pre 11/23/2021 10	
	Ti	tle XVIII	Hospi tal	PPS	
		F	FY (уууу) 0	Amount 1.00	
.96 Low volume adjustment for federal fiscal year (	yyyy) (Enter in column	0	0		70
the corresponding federal year for the period p					
. 97 Low volume adjustment for federal fiscal year ( the corresponding federal year for the period e			0	0	70
. 98 Low Volume Payment-3	nuing on or after 10/1,	,		0	70
.99 HAC adjustment amount (see instructions)				0	
.00 Amount due provider (line 67 minus lines 68 plus	s/minus lines 69 & 70)			15, 803, 497	71
.01 Sequestration adjustment (see instructions)				0	
. 02 Demonstration payment adjustment amount after so	equestration			0	
.03 Sequestration adjustment-PARHM pass-throughs .00 Interim payments				15, 339, 935	71
.01 Interim payments-PARHM				10,007,700	72
.00 Tentative settlement (for contractor use only)				0	73
. 01 Tentative settlement-PARHM (for contractor use					73
.00 Balance due provider/program (line 71 minus line 73)	es 71.01, 71.02, 72, ar	nd		463, 562	74
. 01 Balance due provider/program-PARHM (see instruc	tions)				74
.00 Protested amounts (nonallowable cost report iter	,			569, 662	
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through					
00 Operating outlier amount from Wkst. E, Pt. A, I plus 2.04 (see instructions)	ine 2, or sum of 2.03			0	90
00 Capital outlier from Wkst. L, Pt. I, line 2				0	91
00 Operating outlier reconciliation adjustment amo	unt (see instructions)			0	92
00 Capital outlier reconciliation adjustment amoun				0	
.00 The rate used to calculate the time value of mo .00 Time value of money for operating expenses (see	3			0.00	
.00  Time value of money for operating expenses (see .00  Time value of money for capital related expense:				0	
				On/After 10/1	
UCD Danua Daymant Amount			1.00	2.00	-
HSP Bonus Payment Amount D. 00 HSP bonus amount (see instructions)				0 0	100
HVBP Adjustment for HSP Bonus Payment				0	
1.00 HVBP adjustment factor (see instructions)			0.00000000	0.000000000	101
2.00 HVBP adjustment amount for HSP bonus payment (se	ee instructions)		(	0 0	102
HRR Adjustment for HSP Bonus Payment			0,000	0.0000	110
3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (se	e instructions)		0.000		10.
Rural Community Hospital Demonstration Project		Adiustment		0	10.
).00 Is this the first year of the current 5-year de	• •				200
. Our sthis the first year of the current 5-year de	monstration period unde	1 110 2131			
Century Cures Act? Enter "Y" for yes or "N" for					1
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement	no.				201
<u>Century Cures Act? Enter "Y" for yes or "N" for</u> <u>Cost Reimbursement</u> 1.00 Medicare inpatient service costs (from Wkst. D-	no.				
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 0.00 Medicare inpatient service costs (from Wkst. D- 2.00 Medicare discharges (see instructions)	no.				202
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D- 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limi	no. 1, Pt. II, line 49)		rent 5-year demons	stration	202
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D- 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limi period)	no. 1, Pt. II, line 49)		rent 5-year demons	strati on	202 203
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 1.000 Medicare inpatient service costs (from Wkst. D- 2.000 Medicare discharges (see instructions) 3.000 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limip period) 4.000 Medicare target amount	no. 1, Pt. II, line 49) tation (N/A in first ye		rent 5-year demons	stration	202 203 204
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 1.000 Medicare inpatient service costs (from Wkst. D- 2.000 Medicare discharges (see instructions) 3.000 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limi- period) 4.000 Medicare target amount 5.000 Case-mix adjusted target amount (line 203 times	no. 1, Pt. II, line 49) tation (N/A in first ye line 204)		rent 5-year demons	stration	202 203 204 204
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D- 2.00 Medicare discharges (see instructions) 8.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limi- period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times 5.00 Medicare inpatient routine cost cap (line 202 t Adjustment to Medicare Part A Inpatient Reimburs	no. 1, Pt. II, line 49) tation (N/A in first ye line 204) imes line 205) sement	ear of the curr	rent 5-year demons	stration	201 202 203 204 205 206
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D- 2.00 Medicare discharges (see instructions) 8.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limi- period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times 5.00 Medicare inpatient routine cost cap (line 202 t Adjustment to Medicare Part A Inpatient Reimburs 7.00 Program reimbursement under the §410A Demonstra	no. 1, Pt. II, line 49) tation (N/A in first ye line 204) imes line 205) sement tion (see instructions)	ear of the curr	rent 5-year demons	strati on	202 203 204 205 206 206
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D- 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limi period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times 5.00 Medicare inpatient routine cost cap (line 202 t Adjustment to Medicare Part A Inpatient Reimburs 7.00 Program reimbursement under the §410A Demonstra 3.00 Medicare Part A inpatient service costs (from W	no. 1, Pt. II, line 49) tation (N/A in first yet line 204) imes line 205) sement tion (see instructions) kst. E, Pt. A, line 59	ear of the curr	rent 5-year demons	strati on	202 203 204 205 206 206
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D- 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limit period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times 5.00 Medicare inpatient routine cost cap (line 202 t Adjustment to Medicare Part A Inpatient Reimburs 7.00 Program reimbursement under the §410A Demonstra 8.00 Medicare Part A inpatient service costs (from W 9.00 Adjustment to Medicare IPPS payments (see instruc-	no. 1, Pt. II, line 49) tation (N/A in first yet line 204) imes line 205) sement tion (see instructions) kst. E, Pt. A, line 59	ear of the curr	rent 5-year demons	strati on	202 203 204 205 206 207 208 209
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 1.000 Medicare inpatient service costs (from Wkst. D- 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limit period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times 5.00 Medicare inpatient routine cost cap (line 202 t Adjustment to Medicare Part A Inpatient Reimburs 7.00 Program reimbursement under the §410A Demonstra 3.00 Medicare Part A inpatient service costs (from W 0.00 Adjustment to Medicare IPPS payments (see instru- 0.00 Reserved for future use	no. 1, Pt. II, line 49) tation (N/A in first ye line 204) imes line 205) sement tion (see instructions) kst. E, Pt. A, line 59; uctions)	ear of the curr	rent 5-year demons	strati on	202 203 204 205 206 206 206 206 206 206 206
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D- 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limi- period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times 6.00 Medicare inpatient routine cost cap (line 202 t Adjustment to Medicare Part A Inpatient Reimburs 7.00 Program reimbursement under the §410A Demonstra 8.00 Medicare Part A inpatient service costs (from W 9.00 Adjustment to Medicare IPPS payments (see instru- 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see Comparision of PPS versus Cost Reimbursement	no. 1, Pt. II, line 49) tation (N/A in first ye line 204) imes line 205) sement tion (see instructions) kst. E, Pt. A, line 59; uctions) instructions)	ear of the curr	rent 5-year demons	stration	202 203 204 205 206 207 208 209 210 211
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D- 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limi- period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times 6.00 Medicare inpatient routine cost cap (line 202 t Adjustment to Medicare Part A Inpatient Reimburs 7.00 Program reimbursement under the §410A Demonstra 8.00 Medicare Part A inpatient service costs (from W 9.00 Adjustment to Medicare IPPS payments (see instruction) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see Comparision of PPS versus Cost Reimbursement 2.00 Total adjustment to Medicare Part A IPPS payment	no. 1, Pt. II, line 49) tation (N/A in first ye line 204) imes line 205) sement tion (see instructions) kst. E, Pt. A, line 59; uctions) instructions)	ear of the curr	rent 5-year demons	stration	202 203 205 206 207 208 209 210 211 211
Century Cures Act? Enter "Y" for yes or "N" for Cost Reimbursement         1.00       Medicare inpatient service costs (from Wkst. D- 2.00         Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limit period)         4.00       Medicare target amount         5.00       Case-mix adjusted target amount (line 203 times         6.00       Medicare inpatient routine cost cap (line 202 t Adjustment to Medicare Part A Inpatient Reimburs         7.00       Program reimbursement under the §410A Demonstrata         8.00       Medicare Part A inpatient service costs (from W         9.00       Adjustment to Medicare IPPS payments (see instruction of the served for future use         1.00       Total adjustment to Medicare IPPS payments (see	no. 1, Pt. II, line 49) tation (N/A in first yet line 204) imes line 205) sement tion (see instructions) kst. E, Pt. A, line 59; uctions) instructions) ts (from line 211)	ear of the curr	rent 5-year demons	strati on	202 203 204 205 206 207

	ATION OF REIMBURSEMENT SETTLEMENT Prov	ider CCN: 15-0008	Period: From 07/01/2020	Worksheet E Part B	
			To 06/30/2021	Date/Time Pre	
		Title XVIII	Hospi tal	11/23/2021 10: PPS	:24 am
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)			9, 449	1.00
. 00	Medical and other services reimbursed under OPPS (see instructions)			9, 119, 648	
. 00	OPPS payments			7, 613, 229	
. 00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			7, 897 0	
. 00	Enter the hospital specific payment to cost ratio (see instructions	;)		0.000	
. 00	Line 2 times line 5			0	
. 00 . 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	
. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, co	ol. 13, line 200		0	
	Organ acquisitions			0	
1.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			9, 449	11.00
	Reasonabl e charges				
	Ancillary service charges			48, 488	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69 Total reasonable charges (sum of lines 12 and 13)	·)		0 48, 488	
1. 00	Customary charges			10, 100	11.00
	Aggregate amount actually collected from patients liable for paymen			0	
6.00	Amounts that would have been realized from patients liable for paym had such payment been made in accordance with 42 CFR §413.13(e)	ent for services o	on a chargebasis	0	16.00
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
	Total customary charges (see instructions)			48, 488	
9.00	Excess of customary charges over reasonable cost (complete only if instructions)	line 18 exceeds li	ne 11) (see	39, 039	19.00
0. 00	Excess of reasonable cost over customary charges (complete only if	line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			9, 449 0	
	Cost of physicians' services in a teaching hospital (see instruction	ons)		0	
4.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	•		7, 621, 126	24.00
5.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
	Deductibles and Coinsurance amounts relating to amount on line 24 (	for CAH, see instr	ructions)	1, 429, 492	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus t	he sum of lines 22	2 and 23] (see	6, 201, 083	27.00
8.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50	))		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			6, 201, 083	
	Primary payer payments Subtotal (line 30 minus line 31)			5, 705 6, 195, 378	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			0, 173, 370	02.00
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			408, 841 265, 747	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	ons)		203, 747	
	Subtotal (see instructions)			6, 461, 125	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			58 0	
	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.5
9. 97	Demonstration payment adjustment amount before sequestration			0	
9. 98 9. 99	Partial or full credits received from manufacturers for replaced de	evices (see instruc	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			6, 461, 067	
	Sequestration adjustment (see instructions)			0	1
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs Interim payments			6, 557, 215	40.0 41.0
1.01	Interim payments-PARHM				41.0
	Tentative settlement (for contractors use only)			0	
	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-96, 148	42.0 43.0
3. 01	Balance due provider/program-PARHM (see instructions)				43.0
4. 00	Protested amounts (nonallowable cost report items) in accordance wi §115.2	th CMS Pub. 15-2,	chapter 1,	0	44.00
0.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	92.0
	Time Value of Money (see instructions)			0	93.0

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0008 Component CCN: 15-T008	Peri od: From 07/01/2020 To 06/30/2021	u of Form CMS-: Worksheet E Part B Date/Time Pre	pare
		Title XVIII	Subprovi der – I RF	11/23/2021_10 PPS	: 24
				1.00	
00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0	1
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		0	
00	OPPS payments	,		0	3
00	Outlier payment (see instructions)			0	
01 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0 0. 000	
00	Line 2 times line 5			0	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV. col. 13. line 200		0	
. 00	Organ acqui si ti ons	,		0	
. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				1
. 00	Ancillary service charges			0	
. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		0	
. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	1 14
. 00	Aggregate amount actually collected from patients liable for			0	
. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13	1 5	on a chargebasis	0	16
00	Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0. 000000	17
. 00	Total customary charges (see instructions)			0	
. 00	Excess of customary charges over reasonable cost (complete or instructions)	nly if line 18 exceeds li	ne 11) (see	0	19
. 00	Excess of reasonable cost over customary charges (complete or	nly if line 11 exceeds li	ne 18) (see	0	20
~~	instructions)			0	
. 00 . 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			0	
. 00	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction	ns)		0	25
. 00	Deductibles and Coinsurance amounts relating to amount on lin		ructions)	0	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	2 and 23] (see	0	27
. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	line 50)		0	28
. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
. 00 . 00	Subtotal (sum of lines 27 through 29) Primary payer payments			0	
. 00	Subtotal (line 30 minus line 31)			0	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	I CES)			
. 00 . 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	
. 00	Adjusted reimbursable bad debts (see instructions)			0	
. 00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	
. 00 . 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instruction				39
. 97 . 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla		rtions)	0	
. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
. 00	Subtotal (see instructions)			0	
. 01 . 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	
. 02	Sequestration adjustment-PARHM pass-throughs			0	40
00	Interim payments			0	
. 01 . 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41
. 01	Tentative settlement-PARHM (for contractor use only)				42
. 00	Balance due provider/program (see instructions)			0	
. 01 . 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2.	chapter 1.	0	43
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90
. 00	Outlier reconciliation adjustment amount (see instructions)			0	
. 00	The rate used to calculate the Time Value of Money			0.00	92
. 00	Time Value of Money (see instructions)			0	93

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC	N: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part I Date/Time Prep 11/23/2021 10:	pared
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		14, 898, 7! 441, 1		6, 196, 925 360, 290	1. 2. 3.
. 00	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) Program to Provider					5.
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.
. 02 . 03				0	0	3. 3.
. 03				0	0	3.
. 05				0	0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51 52				0	0	3.
. 53				0	0	3.
. 54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15, 339, 93	35	6, 557, 215	4.
~~	TO BE COMPLETED BY CONTRACTOR	I				
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	TENTATI VE TO PROVI DER			0	0	5
02				0	0	
03				0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
50 51				0	0	
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)		44.2 5	( )		6
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		463, 50	0	0 96, 148	6
02	Total Medicare program liability (see instructions)		15, 803, 49	-	6, 461, 067	
	,			Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0008 CCN: 15-T008	Period: From 07/01/20 To 06/30/20		parec
		Title	XVIII	Subprovi der I RF		. 21 0
		Inpatien	t Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy		
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		5, 441, 3	44 0	0	
00	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) Program to Provider					3.0
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02				0	0	
03				0	0	
04 05				0	0	
55	Provider to Program			0	0	3
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	3
53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
~~	3. 50-3. 98)		E 441 0			
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5, 441, 3	44	0	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider			-		
)1	TENTATI VE TO PROVIDER			0	0	
)2				0	0	
)3	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52				0	0	5
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		110, 0	86	0	
)2	SETTLEMENT TO PROGRAM			0	0	-
00	Total Medicare program liability (see instructions)		5, 551, 4	30 Contractor	NPR Date	7
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	

Heal th	Financial Systems ST. CATHERINE	HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Date/Time Pr 11/23/2021	repared:
		Title XVIII	Hospi tal	PPS	_
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				_
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 ${\sf I}$				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168 $$	ertified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)		32.00

	Financial Systems ST. CATHERI ATION OF REIMBURSEMENT SETTLEMENT	NE HOSPITAL Provider CCN: 15-0008	Peri od:	u of Form CMS-2 Worksheet E-3	
LOOL		Component CCN: 15-T008	From 07/01/2020 To 06/30/2021	Part III Date/Time Pre	par
		Title XVIII	Subprovider -	11/23/2021 10 PPS	: 24
			I RF		
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	-
00	Net Federal PPS Payment (see instructions)			5, 137, 273	1
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0691	
00	Inpatient Rehabilitation LIP Payments (see instructions)			428, 962	
00	Outlier Payments			37, 921	
00	Unweighted intern and resident FTE count in the most recerto November 15, 2004 (see instructions)	nt cost reporting period en	ding on or prior	0.00	
01	Cap increases for the unweighted intern and resident FTE of program or hospital closure, that would not be counted with CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	
00	New Teaching program adjustment. (see instructions)			0.00	
00	Current year's unweighted FTE count of I&R excluding FTEs teaching program" (see instructions)	in the new program growth p	eriod of a "new	0.00	
00	Current year's unweighted I&R FTE count for residents with teaching program" (see instructions)		eriod of a "new	0.00	
00	Intern and resident count for IRF PPS medical education ac	djustment (see instructions)		0.00	
). 00	Average Daily Census (see instructions)			14.723288	
. 00	Teaching Adjustment Factor (see instructions)			0.000000	
. 00	Teaching Adjustment (see instructions)			0	1
. 00	Total PPS Payment (see instructions)			5, 604, 156	
. 00	Nursing and Allied Health Managed Care payments (see instr	ruction)		0	
. 00	Organ acquisition (DO NOT USE THIS LINE)			0	1
. 00	Cost of physicians' services in a teaching hospital (see i Subtotal (see instructions)	instructions)		0 5, 604, 156	
. 00 . 00	Primary payer payments			5, 604, 156	1
. 00	Subtotal (line 17 less line 18).			5, 604, 156	
. 00	Deducti bl es			28, 692	
. 00	Subtotal (line 19 minus line 20)			5, 575, 464	
. 00	Coinsurance			29, 757	
. 00	Subtotal (line 21 minus line 22)			5, 545, 707	
. 00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		8, 805	
. 00	Adjusted reimbursable bad debts (see instructions)			5, 723	
. 00	Allowable bad debts for dual eligible beneficiaries (see i	instructions)		0,720	2
. 00	Subtotal (sum of lines 23 and 25)			5, 551, 430	
. 00	Direct graduate medical education payments (from Wkst. E-4	4. line 49)		0,001,100	2
. 00	Other pass through costs (see instructions)	.,		0	2
. 00	Outlier payments reconciliation			0	3
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instruct	tions)		0	3
. 99	Demonstration payment adjustment amount before sequestrati			0	3
. 00	Total amount payable to the provider (see instructions)			5, 551, 430	3
. 01	Sequestration adjustment (see instructions)			0	3
. 02	Demonstration payment adjustment amount after sequestration	on		0	3
. 00	Interim payments			5, 441, 344	3
. 00	Tentative settlement (for contractor use only)			0	3
. 00	Balance due provider/program (line 32 minus lines 32.01, 3	32.02, 33, and 34)		110, 086	3
. 00	Protested amounts (nonallowable cost report items) in accost115.2	ordance with CMS Pub. 15-2,	chapter 1,	0	3
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount from Wkst. E-3, Pt. III, line 4			37, 921	
. 00	Outlier reconciliation adjustment amount (see instructions	5)		0	5
2. 00	The rate used to calculate the Time Value of Money			0.00	1 5

	Financial Systems ST. CATHERIN E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 07/01/2020	Worksheet G	
y)				Го 06/30/2021	Date/Time Pre 11/23/2021 10	pare 24
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	2, 100	(	0 0	0	1.
00	Temporary investments	0	(	0 0	0	2
00	Notes receivable	0		0 0	0	
00	Accounts receivable	13, 589, 365	(	0 0	0	
00	Other receivable	0	(	0	0	
00 00	Allowances for uncollectible notes and accounts receivable	4 971 E02			0	
00	Inventory Prepaid expenses	6, 871, 592			0	
00	Other current assets	4, 116, 302			0	-
00	Due from other funds	0		0	0	
	Total current assets (sum of lines 1-10)	24, 579, 359		0 0	0	
	FIXED ASSETS					
00	Land	0	(	0 0	0	] 12
00	Land improvements	0		0 0	0	
00	Accumulated depreciation	0		0 0	0	
	Buildings	34, 771, 499		0 0	0	
00	Accumulated depreciation	0			0	
	Leasehold improvements Accumulated depreciation	0			0	
	Fixed equipment				0	
	Accumulated depreciation	0		0	0	
	Automobiles and trucks	0			0	
	Accumulated depreciation	0	(	o o	0	22
00	Major movable equipment	0		0 0	0	23
	Accumulated depreciation	0		-	0	
	Minor equipment depreciable	0	(	0 0	0	
	Accumulated depreciation	0	(	0	0	
	HIT designated Assets	0		0	0	
	Accumulated depreciation Minor equipment-nondepreciable	0			0	
	Total fixed assets (sum of lines 12-29)	34, 771, 499			0	
00	OTHER ASSETS	54,771,477	``````````````````````````````````````		0	1 50
00	Investments	0	(	0 0	0	31
00	Deposits on leases	0	(	o o	0	32
00	Due from owners/officers	0	(	0 0	0	33
00	Other assets	1, 663, 799	(	0 0	0	34
	Total other assets (sum of lines 31-34)	1, 663, 799		0 0	0	
00	Total assets (sum of lines 11, 30, and 35)	61, 014, 657	(	0 0	0	36
00	CURRENT LI ABI LI TI ES	7(1.)()		0 0	0	1 27
00 00	Accounts payable Salaries, wages, and fees payable	761, 263 6, 836, 872			0	
	Payrol I taxes payable	0,030,072			0	
	Notes and Loans payable (short term)	0		0	0	
	Deferred income	0		0 0	0	
00	Accelerated payments	0				42
00	Due to other funds	0	(	0 0	0	43
	Other current liabilities	53, 618, 241		0 0	0	
00	Total current liabilities (sum of lines 37 thru 44)	61, 216, 376	(	0 0	0	45
~~	LONG TERM LIABILITIES	0			0	1
00 00	Mortgage payable Notes payable	0		0	0	
	Unsecured Loans	0			0	
	Other long term liabilities	8, 963, 017			0	
	Total long term liabilities (sum of lines 46 thru 49)	8, 963, 017		o o	0	
	Total liabilities (sum of lines 45 and 50)	70, 179, 393		0 0	0	
	CAPI TAL ACCOUNTS					1
00	General fund balance	-9, 164, 736				52
00	Specific purpose fund		(	D		53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0	^	56
00 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
00	replacement, and expansion				0	1 36
		-9, 164, 736	(		0	59
00	Total fund balances (sum of lines 52 thru 58)					

Heal th	Financial Systems	ST. CATHERINE	HOSPI TAL			In Lie	eu of Form CM	S-2!	552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0008	Peri From To	od: 07/01/2020 06/30/2021	Worksheet G Date/Time P 11/23/2021	rep	
		General	Fund	Speci al	Purpo	ose Fund	Endowment Fu	nd	
		1.00	2.00	3.00		4.00	5.00	_	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NET ASSETS RELEASED NET ASSETS TRANSFERRED CONTRIBUTIONS INVESTMENT INCOME Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) NET ASSETS TRANSFERRED NET ASSETS RELEASED ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 172,000 0 760,000 13,000 0 4,425,000 582,000 339 0 0	-6, 041, 245 938, 848 -5, 102, 397 945, 000 -4, 157, 397 5, 007, 339 -9, 164, 736			4.00 0 0 0 0 0 0 0 0 0 0		0 0 0 0	$\begin{array}{c} 1. 00\\ 2. 00\\ 3. 00\\ 4. 00\\ 5. 00\\ 6. 00\\ 7. 00\\ 8. 00\\ 9. 00\\ 10. 00\\ 11. 00\\ 12. 00\\ 13. 00\\ 14. 00\\ 15. 00\\ 16. 00\\ 17. 00\\ 18. 00\\ 19. 00\\ 19. 00\\ \end{array}$
		Endowment Fund	PI ant				1		
1 00	Fund halanasa at basinging of pariad	6.00	7.00	8.00	0				1 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NET ASSETS RELEASED NET ASSETS TRANSFERRED CONTRIBUTIONS INVESTMENT INCOME	0	0 0 0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) NET ASSETS TRANSFERRED NET ASSETS RELEASED ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0	0 0 0 0 0 0		0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
19.00	sheet (line 11 minus line 18)	0			U				19.00

Heal th	Financial Systems ST. CATHERINE	HOSPI TAL		In Lie	u of Form CMS-2	2552-1
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet G-2 Parts I & II Date/Time Pre 11/23/2021 10	pared
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		79, 421, 30	2	79, 421, 302	1. (
2.00	SUBPROVIDER - IPF			0	0	2.0
3.00	SUBPROVIDER - IRF		7, 429, 59	5	7, 429, 595	3.0
4.00	SUBPROVI DER					4. (
5.00	Swing bed - SNF			0	0	5.0
6.00	Swing bed - NF			0	0	6.0
7.00	SKILLED NURSING FACILITY					7.(
8.00	NURSING FACILITY					8. (
9.00	OTHER LONG TERM CARE					9.
10.00			86, 850, 89	7	86, 850, 897	10.
	Intensive Care Type Inpatient Hospital Services			1 1		
			8, 087, 42	2	8, 087, 422	11.
	CORONARY CARE UNI T					12.
	BURN INTENSIVE CARE UNIT					13.
	SURGI CAL I NTENSI VE CARE UNI T					14.
	OTHER SPECIAL CARE (SPECIFY)					15.
	Total intensive care type inpatient hospital services (sum o 11-15)		8, 087, 42		8, 087, 422	16.
	Total inpatient routine care services (sum of lines 10 and 10	5)	94, 938, 31		94, 938, 319	17.
	Ancillary services		152, 114, 06		152, 114, 067	18.
	Outpatient services			0 285, 191, 269	285, 191, 269	19.
	RURAL HEALTH CLINIC			0 0	0	20.
				0 0	0	21.
	HOME HEALTH AGENCY			0	0	22.
	AMBULANCE SERVICES					23.
24.00						24.
	AMBULATORY SURGICAL CENTER (D. P.)					25.
						26.
	PHYSICIAN OFFICES		2, 392, 27		7, 624, 387	27.
27.01	REGENCY			0 4, 981, 648	4, 981, 648	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 to Wkst.	249, 444, 66	4 295, 405, 026	544, 849, 690	28.
	G-3, line 1)					
20.00	PART II - OPERATING EXPENSES		1	140 ((4 450		20
	Operating expenses (per Wkst. A, column 3, line 200)			143, 664, 452		29. 30

29.00	Operating expenses (per Wkst. A, column 3, line 200)	143, 664, 452	2 29.00
30.00	ADD (SPECIFY)	0	30.00
31.00		0	31.00
32.00		0	32.00
33.00		0	33.00
34.00		0	34.00
35.00		0	35.00
36.00	Total additions (sum of lines 30-35)		36.00
37.00	DEDUCT (SPECIFY)	0	37.00
38.00		0	38.00
39.00		0	39.00
40.00		0	40.00
41.00		0	41.00
42.00	Total deductions (sum of lines 37-41)		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	143, 664, 452	43.00
	to Wkst. G-3, line 4)		

STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0008	Peri od:	Worksheet G-3	
			From 07/01/2020		
			To 06/30/2021	Date/Time Pre 11/23/2021 10	
1 00	Tatal astist and assessed (from What C. 2. Dant L. saluma 2. L	1		1.00	1 00
1.00 2.00	Total patient revenues (from Wkst. G-2, Part I, column 3, I Less contractual allowances and discounts on patients' acco			544, 849, 690 409, 508, 263	
2.00	Net patient revenues (line 1 minus line 2)	Junts		409, 508, 263 135, 341, 427	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, lir	20 42)		143, 664, 452	
4.00 5.00	Net income from service to patients (line 3 minus line 4)	le 43)		-8, 323, 025	
5.00	OTHER INCOME			-0, 323, 023	5.00
6.00	Contributions, donations, bequests, etc			2, 126, 025	6.00
7.00	Income from investments			98, 522	7.00
8.00	Revenues from telephone and other miscellaneous communicati	on services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. OC
12.00	Parking lot receipts			0	12.00
13.00				0	13.00
14.00	Revenue from meals sold to employees and guests			588, 512	
15.00	Revenue from rental of living quarters			0	
16.00	5 11	r than patients		0	
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			6, 727	
22.00	Rental of hospital space			1, 230, 456	
23.00	Governmental appropriations			0	23.00
24.00	CAPITATION REVENUE			-7, 937, 643	
24.01	GRANT I NCOME			0	
24.02				482, 957	
24.03 24.04	PHARMACY INCOME CLASSES			8, 906, 782 1, 250	
24.04	TEMP RESTRICTED			409, 412	
24.05	COVID-19 PHE Funding			3, 348, 873	
24.50	Total other income (sum of lines 6-24)			3, 348, 873 9, 261, 873	
26.00				9, 201, 873	
27.00	OTHER EXPENSES (SPECIFY)			930, 040 0	20.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	27.00
	Total other expenses (sum of time z/ and subset pts)			0	20.00

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0008	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Pre 11/23/2021 10	
		Title XVIII	Hospi tal	PPS	. 2 1 0
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
. 00	Capital DRG other than outlier			981, 319	
. 01	Model 4 BPCI Capital DRG other than outlier			0	1.
. 00	Capital DRG outlier payments			1, 128	
. 01	Model 4 BPCI Capital DRG outlier payments			0	
. 00 . 00	Total inpatient days divided by number of days in the cost Number of interns & residents (see instructions)	reporting period (see inst	ructions)	82.65 0.00	
. 00 . 00	Indirect medical education percentage (see instructions)			0.00	
.00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1 01	columns 1 and	0.00	6.
. 00	1.01) (see instructions)	the sum of fiftes fand f. of		0	0.
. 00	Percentage of SSI recipient patient days to Medicare Part A	A patient days (Worksheet F	part A line	12.12	7.
	30) (see instructions)		, pare in titlo		
. 00	Percentage of Medicaid patient days to total days (see ins	tructions)		42.57	8.
. 00	Sum of lines 7 and 8			54.69	9.
0. 00	Allowable disproportionate share percentage (see instruction	ons)		11.71	10.
1.00	Disproportionate share adjustment (see instructions)			114, 912	11.
2.00	Total prospective capital payments (see instructions)			1, 097, 359	12.
				1.00	
. 00	PART II - PAYMENT UNDER REASONABLE COST			0	1 1.
.00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)	1		0	
. 00	Total inpatient program capital cost (line 1 plus line 2)	.)		0	
. 00	Capital cost payment factor (see instructions)			0	
. 00	Total inpatient program capital cost (line 3 x line 4)			0	
. 00				0	<u> </u>
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00	Program inpatient capital costs (see instructions)			0	
00	Program inpatient capital costs for extraordinary circumst	ances (see instructions)		0	2.
00	Net program inpatient capital costs (line 1 minus line 2)			0	
00	Applicable exception percentage (see instructions)			0.00	
00	Capital cost for comparison to payments (line 3 x line 4)			0	5
00	Percentage adjustment for extraordinary circumstances (see		(line ()	0.00	
00 00	Adjustment to capital minimum payment level for extraording	ary circumstances (illne 2 >	( I I I I I I I I I I I I I I I I I I I	0	
00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap	n li cablo)		0	
	Current year comparison of capital minimum payment level to		less line 9)	0	1
. 00	Carryover of accumulated capital minimum payment level ove			0	111.
	Worksheet L, Part III, line 14)	novmente (list 10 sluv li	. 11)	0	1.0
	Net comparison of capital minimum payment level to capital			0	
	Current year exception payment (if line 12 is positive, en			0	13.
3.00	Corrector of accumulated conital minimum payment lovel aver		orrowing period	0	14.
3. 00	Carryover of accumulated capital minimum payment level ove	er capital payment for the i	orrowing porrou		
3. 00 4. 00	(if line 12 is negative, enter the amount on this line)		or on one of point ou	0	15
3. 00 4. 00 5. 00		instructions)	5	0	15