Heal th Financ		ST. CATHERINE H			u of Form CMS-2552-10
	s required by law (42 USC 1395g; 42 e since the beginning of the cost re				FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022
HOSPITAL AND AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLEX COST R IT SUMMARY	EPORT CERTIFICATION	Provider CCN: 15-0008	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepared: 11/22/2022 9:24 am
PART I - COST	REPORT STATUS			1	THE LOLL HELL AM
Provi der	1. [X] Electronically prepared co	ost report		Date: 11/22/2	022 Time: 9:24 am
use only	2. [] Manually prepared cost rep	oort .			
	3.[0]If this is an amended repo 4.[F]Medicare Utilization. Ente	ort enter the number er "F" for full or "L	of times the provider re " for low.	esubmitted this co	ost report
Contractor use only	(1) As Submitted 7. Co (2) Settled without Audit 8.	te Received: ntractor No. N]Initial Report fo N]Final Report for	11.C r this Provider CCN 12.[pr Code: 4 Iumn 1 is 4: Enter wes reopened = 0-9.
PART II - CEF	RTIFICATION BY A CHIEF FINANCIAL OFF	I CER OR ADMINISTRATO	R OR PROVIDER(S)		
ADMINISTRATIN PROVIDED OR F	TION OR FALSIFICATION OF ANY INFORM. /E ACTION, FINE AND/OR IMPRISONMENT /ROCURED THROUGH THE PAYMENT DIRECTL /E ACTION, FINES AND/OR IMPRISONMENT	UNDER FEDERAL LAW. I Y OR INDIRECTLY OF A	FURTHERMORE, IF SERVICES	IDENTIFIED IN TH	IIS REPORT WERE
CERT	FICATION BY CHIEF FINANCIAL OFFICER	OR ADMINISTRATOR OF	PROVI DER(S)		
el ec Stat begi are appl rega	REBY CERTIFY that I have read the ab tronically filed or manually submitt ment of Revenue and Expenses prepar nning 07/01/2021 and ending 06/30/20 true, correct, complete and prepared cable instructions, except as noted rding the provision of health care s ded in compliance with such laws an	ed cost report and s red by ST. CATHERINE 22 and to the best o I from the books and I. I further certify services, and that th	ubmitted cost report and HOSPITAL (15–0008) for f my knowledge and belic records of the provider that I am familiar with	the Balance Shee the cost reporti of, this report ar in accordance with the laws and regu	et and ng period nd statement th ulations
SI GNATU	RE OF CHIEF FINANCIAL OFFICER OR ADM			ELECTRONI C	
	1	2		IATURE STATEMENT	
1	Daniel R. Obrien	Y	I have read and agree statement. I certify signature on this ce	/that I intend my	/ electronic

	Dann		binding equivalent of my original signature.	
2	Signatory Printed Name	Daniel R. Obrien		2
3	Signatory Title	CFO		3
4	Date	(Dated when report is electronica		4

			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	658, 609	-33, 368	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-17, 947	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	640, 662	-33, 368	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 d	ler CCN		Period: From 07/01/ To 06/30/	2021 2022	Workshe Part I Date/Ti 11/22/2	me Pre	pare
	1.00	2.00		3.00		4	1.00			
	Hospital and Hospital Health Care Co									
00	Street: 4321 FIR STREET	PO Box:								1.
00	City: EAST CHICAGO	State: IN	Zip Code			y: LAKE	-			2.
		Component Name	CCN	CBS		Date		nt Syst		
			Number	Numb	er Type	Certified		0, or		4
							V	XVIII	-	4
		1.00	2.00	3.0	0 4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componen									
00		ST. CATHERINE HOSPITAL	150008	2384	14 1	07/01/1966	N	P	P	3.
00	Subprovider - IPF							-		4.
00	Subprovider - IRF	ST. CATHERINE HOSPITAL	15T008	2384	14 5	01/01/2002	N	P	P	5.
		- REHAB								
00	Subprovider - (Other)									6.
00	Swing Beds - SNF									7.
00	Swing Beds - NF									8.
00	Hospital-Based SNF									9.
00	Hospital-Based NF									10.
00	Hospital-Based OLTC									11.
00	Hospital-Based HHA									12.
	Separately Certified ASC									13.
00	Hospi tal -Based Hospi ce									14.
00	Hospital-Based Health Clinic - RHC									15.
00	Hospital-Based Health Clinic - FQHC									16.
00	Hospital-Based (CMHC) I									17.
00	Renal Dialysis									18.
	Other									19.
	·	-				From:		То):	
						1.00		2.0	00	
00	Cost Reporting Period (mm/dd/yyyy)					07/01/2	021	06/30/	/2022	20.
00	Type of Control (see instructions)					2				21.
				F						4
	Innationt DDC Information				1.00	2.00		3. (00	-
00	Inpatient PPS Information	ourrently, reading no	monto for		Y	N				1 22
00	Does this facility qualify and is it				Ŷ	IN				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		enument							
01		5	to for thi		Y	Y				22.
01	Did this hospital receive interim un				T	T				22.
	cost reporting period? Enter in colu									
	the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N									
		•		USI						
റാ	reporting period occurring on or after				Ν	N				22.
02	Is this a newly merged hospital that				IN	IN				22.
	payments to be determined at cost re									
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob		, Y TOP							1
		e cust reporting period	on or oft	- I		1				1
	or "N" for no, for the portion of the	o boot i opoi ting poi i oo	on or aft							1
0.2	or "N" for no, for the portion of the October 1.				NI	NI		N		1 22
03	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph	ic reclassification fro	m urban to)	Ν	Ν				22.
03	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard	ic reclassification fro ds for delineating stat	m urban to istical ar	eas	Ν	Ν				22.
03	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in c	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or	m urban to istical ar "N" for n	eas	Ν	N			ı	22.
03	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reporting	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob	m urban to istical ar "N" for n er 1. Ente	eas	Ν	N			,	22.
03	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t	m urban to istical ar "N" for n er 1. Ente he cost	eas	Ν	N			ı	22
03	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or afte	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst	m urban to istical ar "N" for n er 1. Ente he cost ructions)	eas 10 9r	Ν	N			ı	22
03	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a	eas no er	Ν	Ν				22
03	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41.	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a	eas no er	Ν	Ν			·	22
	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no.	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a 3, "Y" fo	o reas no er er as or				Ň		
	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a 3, "Y" fo m urban to	er as br	N	N		Ν		
	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a 3, "Y" fo m urban to stical are) reas lo er ls or) eas				Ν		
	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in the	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes c	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a 3, "Y" fo m urban to stical are r "N" for) reas 10 er 15 or 20 or 20 or 20 0 0				Ν		
	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in a for the portion of the cost reporting	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a 3, "Y" fo m urban to stical are r "N" for er 1. Ente) reas 10 er 15 or 20 or 20 or 20 0 0				Ν		
	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in f for the portion of the cost reporting in column 2, "Y" for yes or "N" for	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a 3, "Y" fo m urban to stical are r "N" for er 1. Ente he cost) reas 10 er 15 or 20 or 20 or 20 0 0				Ν		
	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft. Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in a for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or after	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes c g period prior to Octob no for the portion of t er October 1. (see inst	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a 3, "Y" fo m urban to stical are r "N" for er 1. Ente he cost ructions)) reas lo Pr ls pr ls as no Pr				Ν		
	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in a for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2. 105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a 3, "Y" fo m urban to stical are r "N" for er 1. Ente he cost ructions) 99 beds (a) eas lo er ls pr ls eas no er				Ν		
	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41.	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2. 105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a 3, "Y" fo m urban to stical are r "N" for er 1. Ente he cost ructions) 99 beds (a) eas lo er ls pr ls eas no er				Ν		
04	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no.	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2. 105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2. 105)? Enter in colum	m urban to istical ar "N" for n he cost ructions) 99 beds (a 3, "Y" fo m urban to stical are r "N" for er 1. Ente he cost ructions) 99 beds (a n 3, "Y" f) eeas lo er ls br) eas no er ls for		Ν		Ν		22.
04	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in the for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Which method is used to determine Me	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum dicaid days on lines 24	m urban to istical ar "N" for n he cost ructions) 99 beds (a 3, "Y" fo m urban to stical are r "N" for er 1. Ente he cost ructions) 99 beds (a n 3, "Y" f) reas 10 er 15 or 20 er 20 er				Ν		22.
04	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft. Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes c g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum dicaid days on lines 24 of admission, 2 if cens	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a 3, "Y" fo m urban to stical are r "N" for er 1. Ente he cost ructions) 99 beds (a n 3, "Y" f and/or 25 us days, o) reas lo r s s or) eas no er s s cor s or 3 s o 3 s o 3 s o 3 s or 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o s o		Ν		Ν		22.
04	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in the for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41. yes or "N" for no. Which method is used to determine Me	ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2. 105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes c g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2. 105)? Enter in colum dicaid days on lines 24 of admission, 2 if cens of identifying the days	m urban to istical ar "N" for n er 1. Ente he cost ructions) 99 beds (a 3, "Y" fo m urban to stical are r "N" for er 1. Ente he cost ructions) 99 beds (a n 3, "Y" f and/or 25 us days, o in this c) reas lo r s s or) eas no er s s cor s or 3 s o 3 s o 3 s o 3 s or 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o 3 s o s o		Ν		Ν		22

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	Provider CC	N: 15-0008		eri od:	In Lie	Wor	kshee	t S-2	
					Tc	com 07/0 0 06/3	1/2021 0/2022	Dat	e/Tim		pared: 24 am
		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	Medica HMO da		Oth Medi da	cai d	
		1.00	2.00	3.00		4.00	5.00		6.		
5. 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. 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	2, 105				244 33	9	, 359 522		86	24. C 25. C
	Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							Det		<u></u>	
						Urban/R 1.0		Date	2.00		
	Enter your standard geographic classification (not wa		at the beg	inning of t	the		1	1	2.00		26.0
7.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status ~ "2" for r cation in d	ural. If ap column 2.	plicable,			1	1			27.0
5.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number or	periods SC	H STATUS IN	ו ו		C	ן			35.0
						Begi nr		E	Endi n	0	
6.00	Enter applicable beginning and ending dates of SCH s	tatus Subs	cript line	36 for numb	per	1.0	00		2.00)	36.0
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.					C	þ			37. (
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the according to the former with a former with the second seco		sitional pa	yment in							37. (
	accordance with FY 2016 OPPS final rule? Enter "Y" fo	or yes or "	N" for no.	(see							
8. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.	s of MDH st	atus. Ifli	ne 37 is							
B. OO	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	s of MDH st	atus. Ifli	ne 37 is		Y/			Y/N)	38.0
9. 00	<pre>instructions) 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 a accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)</pre>	payment a , (ii), or the mileage	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2	ne 37 is ⁵ one and for low volu er in colum its in "Y" for ye	nn es	Y/ 1. C N	00		Y/N 2.00 N)	38. (
9.00	instructions) 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	payment a payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente	atus. If li n excess of 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 its in e. "Y" for yes	nn es or	1. 0	00		2.00)	
9. 00	<pre>instructions) 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</pre>	payment a payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente	atus. If li n excess of 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 its in e. "Y" for yes	nn es or	1. C N	00		2. 00 N N) XI X 3. 00	38. (
9.00	<pre>instructions) 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 factordance 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</pre>	s of MDH st. f periods in payment ad), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions)	ne 37 is one and for low volu er in colum its in e "Y" for yes (" for yes or res or "N" f	nn es or for	1. C N N	D0	0 2.	2.00 N N /111 .00	XI X 3. 00	38. (39. (40. (
2. 000. 005. 00	<pre>instructions) 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 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excel </pre>	s of MDH st. f periods in payment aa), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina	ne 37 is fone and for low volu er in colum its in t' 'Y'' for yes t''' for yes t'''' for yes t'''' for yes t'''''' for yes t''''''''''''''''''''''''''''''''''''	nn es or for accutance	1.0 N N ordance es	00	0 2.	2. OC N N	XI X	38.
 9. 00 0. 00 5. 00 5. 00 5. 00 	<pre>instructions) 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 factordance with 42 CFR \$412. 101(b)(2)(i), "I" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octoon 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.</pre>	payment ad payment ad), (ii), or the mileage i)? Enter n adjustmen ber 1. Ente (see inst nt for disp eption for d	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina li and Wkst	ne 37 is one and for low volu er in colum its in "Y" for yes we or "N" for e share in try circumst	nn es for acco tanco I t	1.0 N N ordance es hrough	DO V 1. O(N N	0 2.	2.00 N N 1111 .00 Y N	XI X 3. 00 N N	38 39 40 45
0. 00 0. 00 0. 00 0. 00 0. 00	<pre>instructions) 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 1 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</pre>	s of MDH st. f periods in payment ar), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst nt for disp eption for t. L, Pt. I capital? Enter "	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina li and Wkst nter "Y for Y" for yes	ne 37 is one and for low volu- er in colum ts in "Y" for yes res or "N" for e share in ry circumst . L-1, Pt. yes or "N" or "N" for	nn es for for acc tanc l t ' fo no.	1.0 N ordance es hrough r no.	DO 1.00 N N N N N	0 2.	2.00 N N 111 .00 Y	XI X 3. 00 N	38. 39. 40. 45. 46. 47. 48.
2. 00 0. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00	<pre>instructions) 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 1 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 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 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 pr year, and are you are impacted by CR 11642 (or appli) Enter "Y" for yes; otherwise, enter "N" for no in colum </pre>	s of MDH st. f periods in payment ar), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst t for disp eption for t. L, Pt. I capital? Enter approved G e to column caple CRs) I umn 2.	atus. If li n excess of 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 prior y WA direct G	ne 37 is one and for low volu- er in colum- its in "Y" for yes res or "N" for res or "N" for res or "N" for or "N" for or "N" for or "N" for sear or penu- ME payment	mn br br for for acco tancc l ti no. ' fo hos ultii red	1.0 N N ordance es hrough r no. r yes or pital mate uction?	DO 1.00 N N N N N	0 2.	2.00 N N 111 00 Y N N	XI X 3. 00 N N	 38. 39. 40. 45. 46. 47. 48. 56.
9.00 0.00 5.00 6.00 7.00 6.00 7.00	<pre>instructions) 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 a accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no in column 1, for discharges prior to Octod no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen 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 o Is this a new 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 </pre>	s of MDH st. f periods in payment ad), (ii), or the mileage i)? Enter n adjustmen ber 1. Ente (see inst t for disp eption for disp capital? Enter approved G e to column cograms in cable CRs) I umn 2. beriod durin r yes or "N th of this of (", complete	atus. If li n excess of 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 C ng which re " for no ir cost report	ne 37 is one and for low volu- er in colum its in "Y" for yes res or "N" for e share in try circumsta L-1, Pt. yes or "N" or "N" for ? Enter "Y" or if this rear or penu ME payment sidents in column 1. ing period?	nn es pr for accc tancc l ti ' fo hos ul ti red app lf ? E	1.0 N N ordance es hrough r no. r yes or pital mate uction? roved column 1 nter "Y"	DO V 1. O N N N N N N N N	0 2.	2.00 N N 111 00 Y N N	XI X 3. 00 N N	38. 1 39. 1 40. 1
9.00 0.00 5.00 6.00 7.00 8.00 8.00	<pre>instructions) 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 faccordance 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 Octod 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 qualify and receive Capital payment with 42 CFR Section §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 thospital 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 pr 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 p 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 "N" </pre>	approved G approved G approve Approve Approve Approve Approve Approve Approve Approve Approve Approve Approve Approve Approve Approv	atus. If li n excess of 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 C ng which re " for no ir cost report cable. or physiciz	ne 37 is one and for low volu- er in column its in "Y" for yes res or "N" for res or "N" for res or "N" for res or "N" for "Yes or "N" or "N" for "Yes or "N" or "N" for sidents in a column 1. ing period? E-4. If co	nn es for for accc tancc l ti ' fo no. ' fo hos ultin red app If'? ? E blum	1.0 N N ordance es hrough r no. r yes or pital mate uction? roved column 1 nter "Y" n 2 is	DO V 1. O N N N N N N N N	0 2.	2.00 N N 111 00 Y N N	XI X 3. 00 N N	 38. 39. 40. 45. 46. 47. 48. 56.

ealth Financial Systems ST. CA NOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		E HOSPITAL Provider CO		eri od:	Worksheet S-2	
				rom 07/01/2021 o 06/30/2022	Part I Date/Time Pre 11/22/2022 9:	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
40.00 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 colu	85? (s umn 1. R) NAHE	see If column 1	N			60.00
	Y/N	IME	Direct GME	IME	Direct GME	
1.00 Did your beenitel receive FTE clate under ACA	1.00 N	2.00	3.00	4.00	5.00	61.0
11.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	IN			0.00	0.00	01.0
1.01 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						61.0
instructions) 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						61.0
 ACA). (see instructions) 1.03 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. 0
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.0
current cost reporting period. (see instructions). 1.05 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. 0
61.04 minus line 61.03). (see instructions) 1.06 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. C
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.1
 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. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. 				0. 00		61. 2
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.						
					1.00	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				iod for which	0.00	62.0
your hospital received HRSA PCRE funding (see instruc 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	tions) Teachi ram. (s	ng Health Cent see instruction	ter (THC) into		0.00	62.0
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co			N	63.0
		u	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base year	2.00 is your cost r	3.00 reporting	
period that begins on or after July 1, 2009 and befor 4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non 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	y trair -primar all nor non-pr columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00	D 0. 00	0. 000000	64.0

		TA Provider C	Fr	riod: om 07/01/2021	Worksheet S-2 Part I	
			To	06/30/2022	Date/Time Pre 11/22/2022 9:	eparec 24 an
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
-	1.00	2.00	Si te 3. 00	4.00	5.00	-
.00 Enter in column 1, if line 63	1.00	2.00	0.00	4.00) 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	Unweighted	Ratio (col. 1/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te			4
Section 5504 of the ACA Current Y	Voar ETE Rosidonts iu	n Nonnrovidor Sottin	1.00	2.00	3.00	-
beginning on or after July 1, 201 .00 Enter in column 1 the number of u	10					
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column 3	3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
.00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	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)						
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				1.0	0 2 00 3 00	-
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)				1.0		-
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)	/chiatric Facility (I	PF), or does it cont	tain an IPF subp			70.
<pre>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>	ychiatric Facility (1 the facility have ar efore November 15, 20 umn 2: Did this faci & 412.424 (d)(1)(iii) cate which program ye	n approved GME teachi DO4? Enter "Y" for y lity train residents (D)? Enter "Y" for y	ing program in th yes or "N" for no s in a new teach yes or "N" for no	rovider? N he most p. (see ing p.		
<pre>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>	ychiatric Facility (1 the facility have ar efore November 15, 20 umn 2: Did this faci & 412.424 (d)(1)(iii) cate which program ye y PPS nabilitation Facility	n approved GME teachi D04? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this	ing program in th yes or "N" for n s in a new teach yes or "N" for n s cost reporting	rovider? N he most p. (see ing p.	0	70.1

ealth Financial Systems ST. CATHERINE IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0008	Period: From 07/01/2021 To 06/30/2022		2 epared:
				1.00	-
Long Term Care Hospital PPS					
 10.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 11.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no. 			ng period? Enter	N N	80.00 81.00
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 6.00 Did this facility establish a new Other subprovider (excluded				N	85. 0 86. 0
 §413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 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	n	N	87.0
			V	XI X	
Title V and VIV Camilana			1.00	2.00	-
Title V and XIX Services 0.00 Does this facility have title V and/or XIX inpatient hospital	I services? E	nter "Y" for	N	Y	90.0
yes or "N" for no in the applicable column. 1.00 Is this hospital reimbursed for title V and/or XIX through th 1.10 Is this parts Tatas "V" for use or "N" for pain the appli			Ν	N	91.0
full or in part? Enter "Y" for yes or "N" for no in the appli 2.00 Are title XIX NF patients occupying title XVIII SNF beds (du	al certificat			N	92.00
instructions) Enter "Y" for yes or "N" for no in the applicat 3.00 Does this facility operate an ICF/IID facility for purposes of "N" for no in the application of the purple of the pur		d XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a	and "N" for n	o in the	N	N	94.00
applicable column. 5.00 f line 94 is "Y", enter the reduction percentage in the appl 6.00 Decs title V or VIX reduce apprenting cost2 Enter "X" for ver-			0.00	0.00	95.00
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N	N	96.0
 7.00 If line 96 is "Y", enter the reduction percentage in the appl 8.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX. 	terns and res	idents post	0. 00 N	0.00 N	97.0 98.0
 8.01 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 title XIX. 				Y	98.0
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.			N	Y	98.0
18.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N	98.0
8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH i outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.	column 1 for	title V, an		N	98.0
8.05 Does title V or XIX follow Medicare (title XVIII) and add bad Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co column 2 for title XIX.	olumn 1 for t	itle V, and	in	Y	98.0
8.06 Does title V or XIX follow Medicare (title XVIII) when cost i Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX. Rural Providers			N	N	98.0
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)	inclusive met	hod of payme	nt N		105. 0 106. 0
07.00 Column 1: If line 105 is Y, is this facility eligible for cost 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 approved medical education program in the CAH's excluded IPP Enter "Y" for yes or "N" for no in column 2. (see instruction	1. (see ins you train I&R F and/or IRF	tructions) s in an			107.0
08.00 Is this a rural hospital qualifying for an exception to the (CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dule? 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.					109. 0
				1.00	-
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "`complete Worksheet E, Part A, lines 200 through 218, and Work				1.00 N	110. 0

Health Financial Systems ST. CATHERINE HOSPI				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	/ider CCN: 15-000		eriod: com 07/01/2021 0 06/30/2022	Worksheet S- Part I Date/Time Pr 11/22/2022 9	epared:
			1.00	2.00	_
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 additional for tele-health services.	orting period?́En is Y, enter the ing in column 2.		N	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	N N				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.	s or N				116.00
117.00 Is this facility legally-required to carry malpractice insurance? E "Y" for yes or "N" for no.	Enter Y				117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Er if the policy is claim-made. Enter 2 if the policy is occurrence.	nter 1	1			118.00
	Premiu	ums	Losses	Insurance	
	1.00)	2.00	3.00	-
118.01 List amounts of malpractice premiums and paid losses:		1	0		0118.01
			1.00	2.00	_
 118.02 Are malpractice premiums and paid losses reported in a cost center Administrative and General? If yes, submit supporting schedule list and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 JIs this a SCH or EACH that gualifies for the Outpatient Hold Harmle 	sting cost center		N	N	118. 02 119. 00 120. 00
§3121 and applicable amendments? (see instructions) Enter in column "N" for no. Is this a rural hospital with < 100 beds that qualifies Hold Harmless provision in ACA §3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no.	n 1, "Y" for yes s for the Outpati	or			120.00
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		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.			Ν		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes a	and "N" for no.	lf	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 o	date			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 da	ate			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 da	ate			128.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the c	certification da	te in			129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter 1	he certification	n			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	• the certificati	ion			131.00
date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the					132.00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter the OPO r and termination date, if applicable, in column 2.					133. 00 134. 00
All Providers 140.00Are there any related organization or home office costs as defined	in CMS Pub 15-	1.	Y	15H054	140.00

Health Financial Systems	ST. CATHERIN	E HOSPI TAL				In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CC	N: 15-000			/01/2021 5/30/2022		epared:
1.00	2.0)0				3.00	11/22/2022 9:	24 alli
If this facility is part of a chain o				he name	e and	address	of the	
home office and enter the home office 141.00 Name: COMMUNITY FOUNDATION OF NW IN, INC.				ractor'	s Nur	mber: 0800	1	141.00
142.00 Street: 10010 DONALD S POWERS DRIVE ST 201	E PO Box:							142.00
143.00 Ci ty: MUNSTER	State: IN	I	Zip (Code:		4632	1	143.00
							1.00	-
144.00 Are provider based physicians' costs	included in Worksheet	A?					Y	144.00
				_				_
145.00 f costs for renal services are claim	od on Wkst A line 74	are the costs	for			1.00 Y	2.00	145.00
inpatient services only? Enter "Y" fo no, does the dialysis facility includ period? Enter "Y" for yes or "N" for	r yes or "N" for no in e Medicare utilization	column 1. If c	column 1 i			Į		145.00
146.00 Has the cost allocation methodology c Enter "Y" for yes or "N" for no in co yes, enter the approval date (mm/dd/y	hanged from the previo Lumn 1. (See CMS Pub.					N		146.00
							1.00	-
147.00 Was there a change in the statistical							N	147.00
148.00 Was there a change in the order of al 149.00 Was there a change to the simplified				for pr	_		N N	148.00 149.00
149. 00 was there a change to the shipitited		Part A	Part			tle V	Title XIX	149.00
		1.00	2.0			3.00	4.00	
Does this facility contain a provider or charges? Enter "Y" for yes or "N"								
155.00 Hospi tal		N	N			Ν	N	155.00
156.00Subprovider - IPF 157.00Subprovider - IRF		N	N N			N N	N N	156.00 157.00
158. 00 SUBPROVI DER		IN				IN	IN IN	158.00
159. 00 SNF		Ν	N			Ν	N	159.00
160.00 HOME HEALTH AGENCY		N	N			N	N	160.00
161.00 CMHC			N			N	N	161.00
							1.00	
Multicampus 165.00[s this hospital part of a Multicampu	s hospital that has on	e or more campu	uses in di	i fferer	nt CB	SAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name	County	State	ZipC	Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.0		4.00	5.00	
166.00 If 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)							0.00	0166.00
							1.00	-
Health Information Technology (HIT) i					Act			
167.00 Is this provider a meaningful user un 168.00 If this provider is a CAH (line 105 i reasonable cost incurred for the HIT	s "Y") and is a meanin	gful user (line			enter	the	Y	167. 00 168. 00
168.01 If this provider is a CAH and is not exception under §413.70(a)(6)(ii)? En	a meaningful user, doe ter "Y" for yes or "N"	s this provider for no. (see i	nstructi	ons)		-		168.01
169.00 If this provider is a meaningful user transition factor. (see instructions)	(The for is r) and	IS NOT A CAH (TTHE TUS), е	nter the	9.9	9169.00
				-		gi nni ng 1. 00	Endi ng 2. 00	-
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)	nning date and ending	date for the re	eporting			1.00	2.00	170.00
				-		1.00	2.00	-
171.00 If line 167 is "Y", does this provide section 1876 Medicare cost plans repo "Y" for yes and "N" for no in column 1876 Medicare days in column 2. (see	rted on Wkst. S-3, Pt. 1. If column 1 is yes,	I, line 2, col	. 6? Ente			N		0 171. 00

SPI T	Financial Systems ST. CATHERINI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE		CN: 15-0008	Period: From 07/01/2021	eu of Form CMS- Worksheet S-2 Part II	
				To 06/30/2022		
				Y/N	Date	
	Company I potriviti on Enton V for all VEC recompany. Enton N	for all NO re	ononcoo Ent	<u> </u>	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	FOR ALL NU FE	esponses. Ento	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in c	olumn 2. (see				
			Y/N	Date	V/I	_
		0.1.0	1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for	N			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe			3.		
	relationships? (see instructions)					
			Y/N	Туре	Date	
			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 diffe those on the filed financial statements? If yes, submit rec		N	N/AL		5.
				Y/N 1.00	Legal Oper. 2.00	-
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for a nursing program? Column	2: If ves. is	s the provide	r N		6.
	is the legal operator of the program?	J				
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during the	e N		7. 8.
00	Are costs claimed for Interns and Residents in an approved	graduate medio	al education	N		9.
	program in the current cost report? If yes, see instruction					
. 00	Was an approved Intern and Resident GME program initiated o	r renewed in t	the current	N		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 Is the provider seeking reimbursement for bad debts? If yes	see instruct	tions.		Y	12.
. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	olicy change d	during this c		N	13.
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? If	yes, see in:	structions.	N	14.
. 00	Did total beds available change from the prior cost reporti	ng period? If	yes, see ins	tructions.	Y	15.
		Par	rt A	Par	t B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.
00	date of the PS&R Report used in columns 2 and 4 .(see instructions) 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	Y	09/27/2022	Y	09/27/2022	17
. 00	in columns 2 and 4. (see instructions) 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	Ν		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

Health Financial Systems ST. CATHERIN	NE HOSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	CN: 15-0008	Period: From 07/01/2021 To 06/30/2022		pared:
	Descri	ption	Y/N	Y/N	
	()	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		Ν		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			
Capital Related Cost					1
22.00 Have assets been relifed for Medicare purposes? If yes, see	e instructions				22.00
23.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made duri	ng the cost		23.00
24.00 Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost rep	porting period?		24.00
25.00 Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	lf yes, see		25.00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? It	f yes, see		26.00
27.00 Has the provider's capitalization policy changed during the copy.	e cost reportin	g period?lf	yes, submit		27.00
Interest Expense	atorod into dur	ing the cost	roporting		
period? If yes, see instructions.		0			28.0
29.00 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr	ructions				29.0
30.00 Has existing debt been replaced prior to its scheduled matu instructions.	5	5			30.0
31.00 Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see		31.00
Purchased Services 32.00 Have changes or new agreements occurred in patient care ser		d through cor	ntractual		32. 0
arrangements with suppliers of services? If yes, see instru 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competit	tive bidding? If		33. 0
Provi der-Based Physi ci ans					1
34.00 Are services furnished at the provider facility under an ar	rrangement with	provi der-bas	sed physicians?		34.0
If yes, see instructions.	rangemerre in en	protraci bac	bou phyor or ano:		
35.00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the p	orovi der-based		35.0
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			36. 0 37. 0
If yes, see instructions. 38.00 If line 36 is yes , was the fiscal year end of the home off					38.0
the provider? If yes, enter in column 2 the fiscal year end 39.00 If line 36 is yes, did the provider render services to othe	d of the home o	ffi ce.			39.0
see instructions. 40.00 f line 36 is yes, did the provider render services to the		5			40.0
instructions.					
	1.	00	2.	00	
Cost Report Preparer Contact Information			WOERNER		41.0
1.00 Enter the first name, last name and the title/position	CATHERI NE		WOLKNER		
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.			WOLKNER		
 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. 	CATHERINE COMMUNITY FOUN IN, INC. 12197031267	DATION OF NW) DERNER@COMHS. OR	42.0

Heal th	Financial Systems ST. CATHER	INE HOSPITAL	In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0008	Period: From 07/01/2021	Worksheet S-2 Part II	
				Date/Time Pre 11/22/2022 9:	pared: 24 am
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	REIMBURSEMENT MANAGER			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 cost				43.00
	report preparer in columns 1 and 2, respectively.				

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	ST. CATHERINE	Provi der CC	CN: 15-0008	Peri od:	u of Form CMS- Worksheet S-3	
					From 07/01/2021 To 06/30/2022	Part I Date/Time Pre 11/22/2022 9:	
						I/P Days / O/P	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	<u>Visits / Trips</u> Title V	<u>,</u>
	component	Line Number	No. of Deus	Avai I abl e	on nours		
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	112	40, 8	80 0.00	C	1.0
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.0
3.00	HMO I PF Subprovider						3.0
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					l c	4.0
5.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						
7.00	Total Adults and Peds. (exclude observation		112	40, 8	80 0.00		
7.00	beds) (see instructions)		112	40, 8	0.00		/ /.0
3.00	INTENSIVE CARE UNIT	31.00	7	2, 5	55 0.00	l a	8.0
9.00	CORONARY CARE UNIT	01100		2,3	0.00		9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY	43.00				c c	13.0
4.00	Total (see instructions)		119	43, 4	35 0.00	c	14.0
5.00	CAH visits					0	15.0
6.00	SUBPROVI DER – I PF	40.00	0		0	0	16. (
7.00	SUBPROVI DER – I RF	41.00	12	4,3	80	C	17.0
8.00	SUBPROVI DER						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	101.00				0	
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
4.00	HOSPI CE						24.
4.10	HOSPICE (non-distinct part)	30.00					24.
5.00	CMHC - CMHC						25.
6.00	RURAL HEALTH CLINIC	00.00					26.
6.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	101			C	
7.00	Total (sum of lines 14-26)		131			c c	27.
8.00 9.00	Observation Bed Days						28.
9.00	Ambulance Trips Employee discount days (see instruction)						30.
1.00	Employee discount days (see fisting for the fi						31.
2.00	Labor & delivery days (see instructions)		0		0		32.
2.00	Total ancillary labor & delivery room		0		0		32.
2.01	outpatient days (see instructions)						32.0
3. 00	LTCH non-covered days						33.0
	LTCH site neutral days and discharges						33.0

HOSPI -	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0008		riod: om 07/01/2021 06/30/2022	Worksheet S-3 Part I Date/Time Pre	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E	11/22/2022_9: Equi val ents	24 am
	Component	Title XVIII	Title XIX	Total All Patients	1	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
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)	5, 714	1, 689	26, 36	68			1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	6, 586 0	10, 782 0					2.00 3.00
4.00	HMO IRF Subprovider	884	568					4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0	0 0		0 0			5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5, 714	1, 689	26, 36	68			7.00
8.00 9.00 10.00 11.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T	600	315	2, 16	60			8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits	6, 314 0	101 2, 105 0	78 29, 31		0.00	784.03	12.00 13.00 14.00 15.00
16.00 17.00 18.00 19.00 20.00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY	0 2, 271	0 38	4, 23	0 34	0. 00 0. 00	0. 00 21. 62	16.00 17.00 18.00 19.00 20.00
21.00 22.00 23.00 24.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0	0		0	0.00	0.00	21.00 22.00 23.00 24.00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC			3	33			24. 10 25. 00 26. 00
26.25 27.00 28.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0	0	4, 49	0 91	0.00 0.00	0.00 805.65	26.25 27.00 28.00
29. 00 30. 00 31. 00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	0			0 0			29.00 30.00 31.00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	86	ç	92 0			32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges	0 0						33. 00 33. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-0008	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part I Date/Time Prep 11/22/2022 9:2	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All 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, 174	1.00
2.00	HMO and other (see instructions)			9	55 2, 068		2.00
3.00 4.00	HMO IPF Subprovider HMO IRF Subprovider				0 48		3.00 4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF				40		5.00
6.00	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 14.00	NURSERY	0, 00	0	1, 0	22 354	5, 174	13.00 14.00
14.00	Total (see instructions) CAH visits	0.00	0	1,0	22 554	5, 174	14.00
16.00	SUBPROVIDER - IPF	0, 00	0		0 0	0	16.00
17.00	SUBPROVIDER - IRF	0,00	0		38 3	343	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY			1			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00 26.25	RURAL HEALTH CLINIC	0, 00					26.00 26.25
20.25	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0.00					20.25
28.00	Observation Bed Days	0.00					27.00
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)						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

SPI T <i>i</i>	Financial Systems AL WAGE INDEX INFORMATION			Provider CCI	F	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part II Date/Time Prep 11/22/2022 9:2	pared
		Wkst. A Line Number	Amount Reported	A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARIES							1
00	Total salaries (see instructions)	200. 00	60, 760, 665	0	60, 760, 665	5 1, 675, 755. 09	36. 26	1.
00	Non-physician anesthetist Part		0	0	C	0. 00	0. 00	2.
00	A Non-physician anesthetist Part		720, 287	0	720, 287	5, 864. 00	122. 83	3.
00	B Physician-Part A -			0	. (
	Admi ni strati ve		-					
01 00	Physicians - Part A - Teaching Physician and Non		0 1, 634, 372	0	(1, 634, 372	0.00 9,709.41		
	Physician-Part B							
00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	C	0.00	0.00	6.
00	services Interns & residents (in an	21.00	O	0	C	0.00	0. 00	7.
	approved program)		_					
)1	Contracted interns and residents (in an approved programs)		C	0	C	0.00	0.00	7.
00	Home office and/or related organization personnel		0	0	C	0.00	0.00	8
00	SNF	44.00	0	0	0	0.00		
00	Excluded area salaries (see instructions)		2, 041, 665	0	2, 041, 665	56, 922. 40	35. 87	10
	OTHER WAGES & RELATED COSTS		750.074		750.07/	F 054 20	100.04	
00	Contract Labor: Direct Patient Care		750, 874	0	750, 874	5, 854. 39	128. 26	
00	Contract Labor: Top Level management and other management and administrative services		C	0	C	0.00	0.00	12
00	Contract Labor: Physician-Part A - Administrative		196, 460	0	196, 460	1, 264. 99	155. 31	13
00	Home office and/or related organization salaries and		O	0	C	0.00	0.00	14
01	wage-related costs Home office salaries		7, 295, 491	0	7, 295, 491	191, 397. 00	38. 12	11
	Related organization salaries		7, 293, 491	0	7, 293, 491			
00	Home office: Physician Part A - Administrative		0	0	C	0.00	0.00	15
00	Home office and Contract		0	0	C	0.00	0.00	16
01	Physicians Part A - Teaching Home office Physicians Part A		0	0	C	0.00	0.00	16
02	- Teaching Home office contract Physicians Part A - Teaching		O	О	C	0.00	0.00	16
	WAGE-RELATED COSTS Wage-related costs (core) (see		13, 936, 358	0	13, 936, 358	3		 17
	instructions)							
00	Wage-related costs (other) (see instructions)							18
00 00	Èxcluded areas Non-physician anesthetist Part		496, 903 0	0	496, 903 (3		19 20
	A Non-physician anesthetist Part		77, 693	0	77, 693	3		21
	B Physician Part A -		C	0	()		22
	Admi ni strati ve		-					
	Physician Part A - Teaching Physician Part B		0 151, 599	0	151, 599			22 23
00	Wage-related costs (RHC/FQHC)		0	0	(24
00	Interns & residents (in an approved program)		0	0	(25
50	Home office wage-related (core)		1, 827, 519	0	1, 827, 519			25
51	Related organization		0	о	C	þ		25
52	wage-related (core) Home office: Physician Part A - Administrative -		O	0	C)		25

	Financial Systems		ST. CATHERIN				u of Form CMS-2	
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part II Date/Time Pre 11/22/2022 9:	pared:
		Wkst. A Line		Recl assi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	$(col.2 \pm col$		col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DI RECT SALARI E							
26.00	Employee Benefits Department	4.00	401, 260		401, 26			
27.00	Administrative & General	5.00	6,093,209		6, 093, 20			27.00
28.00	Administrative & General under		1,007,336	0	1, 007, 33	8, 510. 59	118.36	28.00
	contract (see inst.)			_				
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	1, 669, 365	0	1, 669, 36			30.00
31.00	Laundry & Linen Service	8.00	74, 272	0	74, 27			
32.00	Housekeepi ng	9.00	2,098,967	0	2, 098, 96			
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	1, 825, 062	-607, 215	1, 217, 84	7 59, 046. 52	20. 63	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	607, 215	607, 21	5 29, 440. 00	20. 63	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	1, 458, 326	0	1, 458, 32	53, 729. 44	27.14	38.00
39.00	Central Services and Supply	14.00	0	0		0 0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0		0 0.00	0.00	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0		0 0.00	0.00	41.00
42.00	Soci al Servi ce	17.00	0	0		0 0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		ST. CATHERIN	IE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part III Date/Time Prep 11/22/2022 9:2	
		Worksheet A	Amount	Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		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		59, 413, 342	0	59, 413, 34	2 1, 668, 692. 27	35.60	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		2, 041, 665	0	2, 041, 66	5 56, 922. 40	35. 87	2.00
3.00	Subtotal salaries (line 1		57, 371, 677	0	57, 371, 67	7 1, 611, 769. 87	35.60	3.00
	minus line 2)							
4.00	Subtotal other wages & related costs (see inst.)		8, 242, 825	0	8, 242, 82	5 198, 516. 38	41. 52	4.00
5.00	Subtotal wage-related costs		15, 763, 877	0	15, 763, 87	7 0.00	27.48	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		81, 378, 379	0	81, 378, 37	9 1, 810, 286. 25	44.95	6.00
7.00	Total overhead cost (see		14, 627, 797	0	14, 627, 79	7 499, 565. 09	29. 28	7.00
	instructions)							

Heal th	Financial Systems S	T. CATHERINE HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Provi der (CCN: 15-0008	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part IV Date/Time Pre 11/22/2022 9:	pared:
					Amount Reported	
					1.00	
	PART IV - WAGE RELATED COSTS				1100	
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contributio				1, 850, 145	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see inst				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instruc				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organ	ni zati on)				
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan				0	6.00
7.00	Employee Managed Care Program Administration Fee	S			0	7.00
	HEALTH AND INSURANCE COST					
8.00	Heal th Insurance (Purchased or Self Funded)				0	8.00
8.01	Health Insurance (Self Funded without a Third Pa				0	8.01
8.02	Health Insurance (Self Funded with a Third Party	Admi ni strator)			7, 543, 109	
8.03	Health Insurance (Purchased)				0	8.03
9.00	Prescription Drug Plan				0	9.00
10.00	Dental, Hearing and Vision Plan				410, 328	
11.00 12.00	Life Insurance (If employee is owner or benefici Accident Insurance (If employee is owner or bene				39, 790 0	
12.00	Disability Insurance (If employee is owner or be				29, 843	
13.00	Long-Term Care Insurance (If employee is owner of be				29, 843	
14.00	Workers' Compensation Insurance	i beneficialy)			475, 169	
16.00	Retirement Health Care Cost (Only current year,	not the extraordinary ac	crual require	d by FASB 106	473, 107	16.00
10.00	Non cumulative portion)	not the extraorariary ac		a by 1735 100.	0	10.00
	TAXES					
17.00	FICA-Employers Portion Only				3, 551, 339	17.00
18.00	Medicare Taxes - Employers Portion Only				853, 026	
19.00	Unemployment Insurance				-90, 195	
20.00	State or Federal Unemployment Taxes				0	20.00
	OTHER					
21.00	Executive Deferred Compensation (Other Than Reti instructions))	rement Cost Reported on	lines 1 throu	gh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances				0	22.00
23.00	Tuition Reimbursement				0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)				14, 662, 554	24.00
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					25.00

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 07/01/2021	Part V	
		To 06/30/2022	Date/Time Pre 11/22/2022 9:	
Cost Center Description		Contract Labor		24 alli
cost center bescription		1.00	2.00	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identif	i cati on:			
1.00 Total facility's contract labor and benefit c		750, 874	14, 662, 554	1.00
2.00 Hospi tal		750, 874	14, 662, 554	2.00
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 SKILLED NURSING FACILITY				8.00
9.00 NURSING FACILITY				9.00
10.00 OTHER LONG TERM CARE I				10.00
11.00 Hospital-Based HHA		0	0	11.00
12.00 AMBULATORY SURGICAL CENTER (D.P.) I				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 I		0	0	17.00
18.00 Other		0	0	18.00
				•

Heal th	Financial Systems	ST. CATHERINE H	IOSPI TAL		In Li€	eu of Form CMS-:	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider C	CN: 15-0008	Peri od:	Worksheet S-1	0
					From 07/01/2021 To 06/30/2022		
						1.00	
1.00	Uncompensated and indigent care cost computat Cost to charge ratio (Worksheet C, Part I lin		vided by Li	no 202 colum	2 0)	0. 230451	1 1.00
1.00	Medicaid (see instructions for each line)		vided by II	ne 202 corum	18)	0.230451	1.00
2.00	Net revenue from Medicaid					35, 084, 249	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		ntal payment	s from Medica	ai d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supple	mental payments t	From Medicai	d		0	
6.00	Medi cai d charges					205, 253, 114	
7.00	Medicaid cost (line 1 times line 6)		<i></i> – .			47, 300, 785	
8.00	Difference between net revenue and costs for	Medicaid program	(line 7 min	ius sum of lir	nes 2 and 5; if	12, 216, 536	8.00
	< zero then enter zero) Children's Health Insurance Program (CHIP) (s	ee instructions 1	or each lin	<u>م)</u>			
9.00	Net revenue from stand-al one CHIP			0)		0	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 mi	nus line 9; i	f < zero then	0	12.00
	enter zero)						
	Other state or local government indigent care						
13.00	Net revenue from state or local indigent care					12, 139	
14.00	Charges for patients covered under state or I 10)	ocal indigent cal	re program (Not included	In Tines 6 or	184, 836	14.00
15.00	State or local indigent care program cost (li	ne 1 times line '	4)			42, 596	15.00
16.00	Difference between net revenue and costs for			program (lin	ne 15 minus line		
	13; if < zero then enter zero)			p g (
	Grants, donations and total unreimbursed cost	for Medicaid, CH	IIP and stat	e∕local indig	gent care progra	ms (see	
17 00	instructions for each line)		- II I	• •			1 4 7 00
17.00 18.00	Private grants, donations, or endowment incom Government grants, appropriations or transfer					0	
18.00	Total unreimbursed cost for Medicaid , CHIP a				c (sum of lines	12, 246, 993	
17.00	8, 12 and 16)		in mangeme			12, 240, 773	17.00
				Uni nsured	Insured	Total (col. 1	
				patients	patients	+ col . 2)	
	Uncompanyated Cara (see instructions for each	line		1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each Charity care charges and uninsured discounts		acility	7, 892, 2	33 147, 064	8, 039, 297	20.00
20.00	(see instructions)	. c. the ontrie fo		,,0,2,2	147,004	0,007,277	20.00
21.00	Cost of patients approved for charity care an	d uninsured disco	ounts (see	1, 818, 7	73 147, 064	1, 965, 837	21.00
	instructions)						
22.00	Payments received from patients for amounts p	reviously writte	n off as		0 0	0	22.00
22.00	charity care			1 010 7	147.0/4	1 0/5 007	22.00
23.00	Cost of charity care (line 21 minus line 22)			1, 818, 7	73 147, 064	1, 965, 837	23.00
						1.00	
24.00	Does the amount on line 20 column 2, include	charges for patio	ent days bey	ond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or ot			0	3		
25.00	If line 24 is yes, enter the charges for pati	ent days beyond [.]	he indigent	care program	n's length of	0	25.00
0/ 07	stay limit						0/ 0-
	Total bad debt expense for the entire hospita					5, 817, 615	
27.00	Medicare reimbursable bad debts for the entir Medicare allowable bad debts for the entire h					489, 037 752, 364	
27.01 28.00	Non-Medicare bad debt expense (see instructio		see instruc	u ons)		5, 065, 251	
28.00	Cost of non-Medicare and non-reimbursable Med		nense (see	instructions		1, 430, 619	
30.00	Cost of uncompensated care (line 23 column 3				,	3, 396, 456	
	Total unreimbursed and uncompensated care cos		ine 30)			15, 643, 449	

02,100	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CC	F	eriod: rom 07/01/2021	Worksheet A	
				T	0 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
	-	1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	-
	GENERAL SERVICE COST CENTERS		2100	0100		0100	
	00100 CAP REL COSTS-BLDG & FIXT		2, 559, 265	2, 559, 265		2, 672, 865	
	00200 CAP REL COSTS-MVBLE EQUIP		3, 245, 502	3, 245, 502			
	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	401, 260	0 7, 612, 000	0 8, 013, 260	-	0 8, 013, 260	-
	00560 PURCHASING RECEIVING AND STORES	328, 722	132, 886	461, 608		461, 608	
	00570 ADMI TTI NG	858, 889	135, 554	994, 443		994, 443	
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	198	198		198	
	00590 OTHER ADMINISTRATIVE & GENERAL	4, 905, 598	23, 807, 347	28, 712, 945	-123, 935	28, 589, 010	
	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 1, 669, 365	0 5, 101, 556	6, 770, 921	0	0 6, 770, 921	6
	00800 LAUNDRY & LINEN SERVICE	74, 272	562, 808	637, 080		637, 080	
	00900 HOUSEKEEPI NG	2, 098, 967	674, 234	2, 773, 201		2, 773, 201	
	01000 DI ETARY	1, 825, 062	1, 497, 943	3, 323, 005		2, 217, 410	
		0	0	0	1, 105, 595	1, 105, 595	
	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0 1, 458, 326	0 291, 851	0 1, 750, 177	0	0 1, 750, 177	
	01400 CENTRAL SERVICES & SUPPLY	1, 430, 320	291,031	1, 750, 177	0	1, 730, 177	
	01500 PHARMACY	0	0	0	0	0	
	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	
	01700 SOCIAL SERVICE	0	0	0	0	0	
	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19
	03000 ADULTS & PEDIATRICS	15, 663, 461	3, 029, 238	18, 692, 699	431, 436	19, 124, 135	30
00	03100 INTENSIVE CARE UNIT	2, 693, 621	591, 168	3, 284, 789		3, 284, 789	
	04000 SUBPROVIDER – IPF	0	0	0	0	0	40
	04100 SUBPROVIDER - IRF	1, 552, 459	701, 878	2, 254, 337		2, 254, 337	
	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	0	0	534, 950	534, 950	43
	05000 OPERATI NG ROOM	2, 563, 497	3, 092, 988	5, 656, 485	0	5, 656, 485	50
	05100 RECOVERY ROOM	952, 008	194, 213	1, 146, 221		1, 146, 221	
	05200 DELIVERY ROOM & LABOR ROOM	1, 701, 884	388, 467	2, 090, 351		1, 123, 965	
	05300 ANESTHESI OLOGY	2, 298, 282	409, 831	2, 708, 113		2, 708, 113	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	1, 832, 832 234, 214	1, 038, 018 302, 908	2, 870, 850 537, 122		2, 870, 850 537, 122	
	05600 RADI OI SOTOPE	290, 868	401, 548	692, 416		692, 416	
	05700 CT SCAN	470, 430	544, 214	1, 014, 644	0	1, 014, 644	57
	05800 MAGNETIC RESONANCE IMAGING (MRI)	287, 372	175, 171	462, 543		462, 543	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	673, 189 2, 761, 479	526, 055 3, 367, 225	1, 199, 244 6, 128, 704		1, 199, 244 6, 128, 704	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 701, 479	3, 307, 225	0, 120, 704		0, 128, 704	
	06300 BLOOD STORING, PROCESSING, & TRANS.	137, 685	601, 039			738, 724	
	06400 I NTRAVENOUS THERAPY	508, 043	186, 067	694, 110		694, 110	
	06500 RESPI RATORY THERAPY	1, 187, 031	343, 159	1, 530, 190		1, 530, 190	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 611, 311 777, 562	685, 367 511, 314	2, 296, 678 1, 288, 876		2, 296, 678 1, 288, 876	
	06800 SPEECH PATHOLOGY	280, 388	129, 216	409, 604		409, 604	
	06900 ELECTROCARDI OLOGY	590, 633	212, 760	803, 393		803, 393	
	07000 ELECTROENCEPHALOGRAPHY	398, 182	141, 092	539, 274		539, 274	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	2, 968, 218	2, 968, 218		2, 968, 218	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 2, 056, 684	2,912,899	2, 912, 899		2, 912, 899 12, 606, 295	
	07300 DRUGS CHARGED TO PATTENTS	2,056,684	10, 549, 611 665, 523	12, 606, 295 665, 523		665, 523	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	111, 294	14, 891	126, 185		126, 185	
	07697 CARDI AC REHABI LI TATI ON	377, 386	52, 334	429, 720	0	429, 720	76
	DUTPATIENT SERVICE COST CENTERS	1 004 000	000 450	4 004 447		4 004 447	
	09000 CLINIC 09100 EMERGENCY	1, 004, 989 3, 634, 214	889, 158 1, 086, 079	1, 894, 147 4, 720, 293		1, 894, 147 4, 720, 293	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	5,054,214	1,000,077	4, 720, 275	0	4, 720, 273	92
	OTHER REIMBURSABLE COST CENTERS	ł					
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101
3. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	60, 271, 459	82, 332, 793	142, 604, 252	0	142, 604, 252	1118
ĺ	VONREI MBURSABLE COST CENTERS		, 002, 770				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190
	19100 RESEARCH	25, 729	10, 719	36, 448		36, 448	
	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OTHER NONREI MBURSEABLE	6, 800 0	4, 488 121, 335	11, 288 121, 335		11, 288 121, 335	
	07950 OTHER NORREIMBORSEABLE 07951 ADVERTI SI NG	0	208, 750	208, 750		208, 750	
	07952 RETAIL PHARMACY	456, 677	6, 940, 955			7, 397, 632	
	TOTAL (SUM OF LINES 118 through 199)	60, 760, 665	89, 619, 040			150, 379, 705	

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	<u>ST.</u> CATHERI NE F EXPENSES	Provi der CCN: 15-0	From 07/01/2021 To 06/30/2022 Date/Time	
	Cost Center Description		Net Expenses for Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	20, 101	2, 692, 966		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	221, 429	3, 477, 266		2.00
3.00	00300 OTHER CAP REL COSTS	2217 127	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 128, 174	9, 141, 434		4.00
5.01	00560 PURCHASING RECEIVING AND STORES	-7	461, 601		5.01
5.02	00570 ADMI TTI NG	- /	994, 443		5.02
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 635, 383	1, 635, 581		5.02
5.03	00590 OTHER ADMINISTRATIVE & GENERAL	-9, 227, 673			5.03
6.00		-9,227,073	19, 361, 337 0		6.00
7.00	00600 MAINTENANCE & REPAIRS	°,	-		7.00
	00700 OPERATION OF PLANT	-1,400	6, 769, 521		
8.00	00800 LAUNDRY & LINEN SERVICE	-47, 920	589, 160		8.00
9.00	00900 HOUSEKEEPI NG	0	2, 773, 201		9.00
10.00	01000 DI ETARY	-2, 987	2, 214, 423		10.00
11.00	01100 CAFETERIA	-734, 749	370, 846		11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		12.00
	01300 NURSI NG ADMI NI STRATI ON	140, 252	1, 890, 429		13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0		14.00
	01500 PHARMACY	0	0		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 270, 260	1, 270, 260		16.00
17.00	01700 SOCI AL SERVI CE	0	0		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-88	19, 124, 047		30.00
31.00	03100 INTENSIVE CARE UNIT	-8	3, 284, 781		31.00
40.00	04000 SUBPROVIDER - IPF	0	0		40.00
41.00	04100 SUBPROVIDER - IRF	0	2, 254, 337		41.00
43.00	04300 NURSERY	0	534, 950		43.00
	ANCI LLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-365,007	5, 291, 478		50.00
	05100 RECOVERY ROOM	-9	1, 146, 212		51.00
	05200 DELIVERY ROOM & LABOR ROOM	-2, 135	1, 121, 830		52.00
	05300 ANESTHESI OLOGY	-2, 467, 494	240, 619		53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	-1, 958	2, 868, 892		54.00
	05500 RADI OLOGY - THERAPEUTI C	-1, 750	537, 122		55.00
56.00	05600 RADI OLOGI - THERAPEOTIC	0			56.00
		0	692, 416		
57.00	05700 CT SCAN	0	1,014,644		57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	462, 543		58.00
	05900 CARDI AC CATHETERI ZATI ON	0	1, 199, 244		59.00
60.00	06000 LABORATORY	-163, 054	5, 965, 650		60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	738, 724		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	694, 110		64.00
	06500 RESPI RATORY THERAPY	0	1, 530, 190		65.00
	06600 PHYSI CAL THERAPY	0	2, 296, 678		66.00
	06700 OCCUPATI ONAL THERAPY	0	1, 288, 876		67.00
68.00	06800 SPEECH PATHOLOGY	0	409, 604		68.00
69.00	06900 ELECTROCARDI OLOGY	0	803, 393		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	539, 274		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-16, 783	2, 951, 435		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	-136, 804	2, 776, 095		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-3, 091, 700	9, 514, 595		73.00
74.00	07400 RENAL DIALYSIS	0	665, 523		74.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	126, 185		76.00
	07697 CARDI AC REHABI LI TATI ON	0	429, 720		76.97
	OUTPATIENT SERVICE COST CENTERS		1		
90, 00	09000 CLINIC	-605, 403	1, 288, 744		90.00
	09100 EMERGENCY	-24	4, 720, 269		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	27	.,. 20, 20,		92.00
, 2. 00	OTHER REIMBURSABLE COST CENTERS				/2.00
101 00	10100 HOME HEALTH AGENCY	0	0		101.00
	SPECIAL PURPOSE COST CENTERS	0	U		
118.00		-12, 449, 604	130, 154, 648		110 00
110.00		- 12, 447, 004	130, 134, 048		118.00
100 00	NONREI MBURSABLE COST CENTERS				100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
	19100 RESEARCH	0	36, 448		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	11, 288		192.00
192.00			101 000		194.00
192.00 194.00	07950 OTHER NONREI MBURSEABLE	0	121, 335		
192.00 194.00 194.01	07951 ADVERTI SI NG	0	208, 750		194.01
192.00 194.00 194.01	07951 ADVERTI SI NG 07952 RETAI L PHARMACY	0 0 0			

ST. CATHERINE HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems

Heal th	Financial Systems		ST. CATHERIN	NE HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLAS	RECLASSI FI CATI ONS			Provider (CCN: 15-0008	Peri od:	Worksheet A-	6
						From 07/01/2021 To 06/30/2022	Date/Time Pr 11/22/2022 9	epared: :24 am
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	A - BUILDING INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	113, 600				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10, 335				2.00
	0		0	123, 935				
	B - CAFETERIA EXPENSE							
1.00	CAFETERI A	11.00	607, 215	498, 380				1.00
	0		607, 215	498, 380				
	C - NURSERY/LABOR & DELIVERY							1
1.00	ADULTS & PEDIATRICS	30.00	351, 259	80, 177				1.00
2.00	NURSERY	43.00	435, 536	99, 414				2.00
	0		786, 795	179, 591				1
500.00	Grand Total: Increases		1, 394, 010	801, 906	1			500.00

Heal th	Financial Systems		ST. CATHERINE	HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-0008	Period:	Worksheet A-	6
						From 07/01/2021 To 06/30/2022	Date/Time Pr 11/22/2022 9	epared: :24 am
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	₽.		
	6.00	7.00	8.00	9.00	10.00			
-	A - BUILDING INSURANCE							
1.00	OTHER ADMINI STRATI VE &	5.04	0	123, 935	1	12		1.00
	GENERAL							
2.00		0.00	0	0	1	12		2.00
	0 — — — — — — —		0	123, 935				
	B - CAFETERIA EXPENSE							
1.00	DI ETARY	10.00	607, 215	498, 380		0		1.00
	0 — — — — — — —		607, 215	498, 380		7		
	C - NURSERY/LABOR & DELIVERY							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	786, 795	179, 591		0		1.00
2.00		0.00	0	0		0		2.00
	0 — — — — — — —		786, 795	179, 591		7		
500.00	Grand Total: Decreases		1, 394, 010	801, 906		\neg		500.00

Heal th	Financial Systems	ST. CATHERIN	F HOSPI TAL			In Lie	u of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0008		ri od:	Worksheet A-7	
						om 07/01/2021		
					То	06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 24 am
				Acqui si ti on	S		11/22/2022 7.	
		Begi nni ng	Purchases	Donati on	_	Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	5, 316	0		0	0	0	1.00
2.00	Land Improvements	2, 386, 857	0		0	0	24, 686	2.00
3.00	Buildings and Fixtures	40, 775, 906	3, 348		0	3, 348		3.00
4.00	Building Improvements	48, 264, 021	4, 888, 244		0	4, 888, 244	-576, 588	
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	51, 568, 940	3, 623, 806		0	3, 623, 806	7, 367, 360	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	143, 001, 040	8, 515, 398		0	8, 515, 398	6, 915, 239	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	143, 001, 040			0	8, 515, 398	6, 915, 239	10.00
		Endi ng Bal ance						
			Depreci ated					
			Assets					
	T	6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		-					
1.00	Land	5, 316	0					1.00
2.00	Land Improvements	2, 362, 171	0					2.00
3.00	Buildings and Fixtures	40, 679, 473	0					3.00
4.00	Building Improvements	53, 728, 853	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	47, 825, 386	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	144, 601, 199	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	144, 601, 199	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 CO	CN: 15-0008	Perio		Worksheet A-7	
					To	07/01/2021 06/30/2022		pared:
					_		11/22/2022 9:	
	SUMMARY OF CAPITAL							
	Cost Center Description	Depreciation	Lease	Interest		urance (see	•	
			10.00	11.00	i ns		instructions)	
		9.00	10.00	11.00		12.00	13.00	
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK					a		1 00
1.00	CAP REL COSTS-BLDG & FIXT	2, 551, 760			0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 441, 484			0	0	0	2.00
3.00	Total (sum of lines 1-2)	4, 993, 244			0	0	0	3.00
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	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	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 559, 265					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 245, 502					2.00
3.00	Total (sum of lines 1-2)	0	5, 804, 767					3.00

Heal th	Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 07/01/2021 To 06/30/2022		pared: 24 am
		COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPI TAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	96, 775, 812 47, 825, 387 144, 601, 199	0	96, 775, 812 47, 825, 387 144, 601, 199 CAPI TAL	7 0. 330740 9 1. 000000	0	1.00 2.00 3.00
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	1	6.00	7.00	8.00	9.00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS			0.574.0/4	7.505	4 00
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)				2, 571, 861 3, 080, 413 5, 652, 274		1.00 2.00 3.00
			SL	JMMARY OF CAPI			
	Cost Center Description		Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	1	11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	ENTERS 0 0	113, 600 10, 335 123, 935	0		2, 692, 966 3, 477, 266 6, 170, 232	1.00 2.00 3.00
3.00	Total (Sum of Times 1-2)	1 0	123, 935	l (ט וי	0, 170, 232	3.00

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

Heal th	Financial Systems		ST. CATHERIN	E HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period: From 07/01/2021	Worksheet A-8	
					To 06/30/2022		
				Expense CLassification o	n Worksheet A	11/22/2022 9:	24 am
				To/From Which the Amount is			
	Cost Center Description	Pacic (Code (2)	Amount	Cost Contor	lino #	What A 7 Dof	
	cost center bescription	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			CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)		0				
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
5.00	expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter						
8.00	21) Television and radio service		0		0.00	0	8.00
	(chapter 21)						
9.00 10.00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -3, 475, 097		0.00	0	9.00 10.00
	adjustment						
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization	A-8-1	-4, 121, 398			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	
15.00	Rental of quarters to employee		0		0.00	0	15.00
16.00	and others Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than						
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
	patients						
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
	charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
	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)						
24.00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
	COSTS-MVBLE EQUIP					0	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSI CI AN ANESTHETI STS	19.00 0.00	0	28.00 29.00
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00	0	30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	~		40.00		31.00
31.00	pathology costs in excess of	H-0-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14)		~		0.00	0	22.00
J∠. UU	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
							•

ealth Financial Systems DJUSTMENTS TO EXPENSES		ST. CATHERIN	Provi der CCN: 15-0008		u of Form CMS-2 Worksheet A-8	
DJUSTMENTS TO EXPENSES				Period: From 07/01/2021	WORKSneet A-8	
				To 06/30/2022	Date/Time Pre	pared
			Expense Classification o	n Warkshoot A	11/22/2022 9:	<u>24 am</u>
			To/From Which the Amount is			
				· · · · · · · · · · · · · · · · · · ·		
Cost Center Descript	ion Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
3.00 ANESTHESIA - NON-SALARIES			ANESTHESI OLOGY	53.00		33.0
NON-BENEF						
3.01 COVID DRUG DONATIONS	В	-3, 091, 700	DRUGS CHARGED TO PATIENTS	73.00	0	33.0
3. 02 OTHER REVENUE	В	-21, 120	CAP REL COSTS-BLDG & FIXT	1.00	9	33.0
3. 03 OTHER REVENUE	В	-417, 500	CAP REL COSTS-MVBLE EQUIP	2.00	10	33. C
3. 04 OTHER REVENUE	В	-690	EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	33.0
3.05 OTHER REVENUE	В		PURCHASING RECEIVING AND	5.01	0	33.0
			STORES			
3.06 OTHER REVENUE	В		OTHER ADMINISTRATIVE &	5.04	0	33. (
			GENERAL			
3. 07 OTHER REVENUE	В		LAUNDRY & LINEN SERVICE	8.00		
3. 08 OTHER REVENUE	В		DI ETARY	10.00		
3.09 OTHER REVENUE	В		CAFETERI A	11.00		
3. 10 OTHER REVENUE	В		NURSING ADMINISTRATION	13.00		
3.11 OTHER REVENUE	В		ADULTS & PEDIATRICS	30.00		
3.12 OTHER REVENUE	В		INTENSIVE CARE UNIT	31.00		
3. 13 OTHER REVENUE	В		OPERATING ROOM	50.00		
3.14 OTHER REVENUE	В		RECOVERY ROOM	51.00		
3.15 OTHER REVENUE	В		DELIVERY ROOM & LABOR ROOM	52.00		
3.16 OTHER REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00		
3.17 OTHER REVENUE	В		LABORATORY	60.00		
3. 18 OTHER REVENUE	В		MEDICAL SUPPLIES CHARGED TO	71.00	0	33. 1
			PATIENT	70.00		
3. 19 OTHER REVENUE	В		IMPL. DEV. CHARGED TO	72.00	0	33.1
	P		PATIENTS	00.00	0	22.
3. 20 OTHER REVENUE	B	-4, 284		90.00		
3. 21 OTHER REVENUE			EMERGENCY	91.00		
3. 22 PRE-MERGER ASSETS DEPRECI	1		CAP REL COSTS-BLDG & FIXT	1.00		
3. 23 TAXABLE LABS	A			60.00		
3. 24 PATI ENT TELEPHONE SERVI CE	A		OTHER ADMI NI STRATI VE & GENERAL	5.04	0	33.2
3. 25 PATI ENT TELEPHONE PURCHAS	ES A		OTHER ADMINISTRATIVE &	5.04	0	33.2
S. 25 FAILENT TELEPHONE PORCHAS	LJ A		GENERAL	5.04		33.2
3. 26 PATIENT TV DEPRECIATION	А		CAP REL COSTS-MVBLE EQUIP	2.00	9	33.2
3. 27 PATIENT TV PURCHASES	A		OPERATION OF PLANT	7.00		
0.00 TOTAL (sum of lines 1 thr		-12, 449, 604		7.00		50.0
(Transfer to Worksheet A,	u +//	12, 447, 004				30.0
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	ST. CATHERI	NE HOSPI TAL	In Lie	eu of Form CMS-	2552-10
		RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0008	Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	IRANSACIIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED	
1.00		OTHER ADMINISTRATIVE & GENER		0	3, 753, 682	1.00
2.00		OTHER ADMINISTRATIVE & GENER		6 0	15, 655, 951	2.00
3.00			HOME OFFICE ALLOC-BLDG	60, 820	0	3.00
3.01		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOC-EQUIP	639, 022	0	3. 01
3.02	5. 04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-SALARIES	5, 640, 050	0	3. 02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOC-BENEFITS	1, 214, 200	0	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOC-MEDICAL RE	1, 270, 260	0	3.04
3.05	5. 03	CASHI ERI NG/ACCOUNTS RECEI VAB	HOME OFFICE ALLOC-PATIENT AC	1, 635, 383	0	3.05
3.06	5. 04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-OTHER NON	4, 757, 126	0	3.06
3.07	5. 04	OTHER ADMINISTRATIVE & GENER	CANCER CARE ALLOCATION PER (6 0	293, 556	3.07
3.08	5. 04	OTHER ADMINISTRATIVE & GENER	CANCER CARE ALLOC-ADMIN	65, 235	0	3.08
3.09	13.00	NURSING ADMINISTRATION	CANCER CARE ALLOC-REGISTRY	140, 260	0	3.09
3.10	5. 04	OTHER ADMINISTRATIVE & GENER	CANCER CARE ALLOC-NAVIGATORS	5 159, 435	0	3.10
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			15, 581, 791	19, 703, 189	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.

1103 110	has not been posted to norksheet A, cordinars i anazor z, the amount arrowable should be mareated in cordinar 4 or this part.								
				Related Organization(s) and/	or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	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

6.00 B	0. 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		1	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 organi zati 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 provi der

Health Financial Systems	ST. CATHERINE H	IOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0008	Period: From 07/01/2021 To 06/30/2022	Worksheet A-8-1 Date/Time Prepared:

						10 00/00/2022	11/22/2022 9:	
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6.00	7.00						
			IENTS REQUIRED AS	A RESULT OF TRA	NSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO							
1.00	-3, 753, 682							1.00
2.00	-15, 655, 951							2.00
3.00	60, 820							3.00
3.01	639, 022	9						3.01
3.02	5, 640, 050	0						3. 02
3.03	1, 214, 200	0						3.03
3.04	1, 270, 260	0						3.04
3.05	1, 635, 383	0						3.05
3.06	4, 757, 126	0						3.06
3.07	-293, 556	0						3.07
3.08	65, 235	0						3.08
3.09	140, 260	0						3.09
3.10	159, 435	0						3.10
4.00	0	0						4.00
5.00	-4, 121, 398							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.

Related Organization(s)		
and/or Home Office		
Type of Business		
6.00		
B. INTERRELATIONSHIP TO RELAT	FED 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.

6.00	HEALTHCARE	6.00
7.00		7.00
8.00		8.00 9.00
9.00		9.00
10.00		10.00
7.00 8.00 9.00 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 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.

Heal th	Financial Syste	ems	ST. CATHERI	NE HOSPI TAL		In Li	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider C	CN: 15-0008	Peri od:	Worksheet A-8	3-2
						From 07/01/2027		
						To 06/30/2022	11/22/2022 9:	24 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESI OLOGY	2, 298, 282	2, 298, 282		0 C	0	1.00
2.00	90.00	CLINIC	56, 377	56, 377		o c	0	2.00
3.00	53.00	ANESTHESI OLOGY	125, 360	125, 360		o c	0	3.00
4.00	90.00	CLINIC	3, 075	3, 075		ol c	0	4.00
5.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	85, 336	85, 336		ol c	0	5.00
6.00		OPERATING ROOM	365,000	365,000			0	6.00
7.00		CLINIC	541, 667	541,667			0	
8.00	0.00		0	0,007				8.00
9.00	0.00		0	0			0	
	0.00		0	0			0	
10.00	0.00		0	0			0	10.00
200.00			3, 475, 097	3, 475, 097		0	0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ANESTHESI OLOGY	0	0		0 C		
2.00		CLINIC	0	0		o c	-	
3.00		ANESTHESI OLOGY	0	0		0 C	-	
4.00		CLINIC	0	0		0 C	0	4.00
5.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0		o C	0	5.00
6.00	50.00	OPERATING ROOM	0	0		o C	0	6.00
7.00	90.00	CLINIC	0	0		o c	0	7.00
8.00	0.00		0	0		ol c	0	8.00
9.00	0.00		0	0		ol c	0	9.00
10.00	0, 00		0	0		ol c	0	10.00
200.00			0	0			0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200100
	intot. A Erno #	I denti fi er	Component	Limit	Di sal I owance	/ dj do tillorre		
		r dontri i r di	Share of col.		Di Sul i oliunee			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00	1	
1.00		ANESTHESI OLOGY	0	0		0 2, 298, 282	,	1.00
2.00		CLINIC	0	0		0 2, 2, 6, 202		2.00
3.00		ANESTHESI OLOGY	0	0		0 125, 360		3.00
4.00		CLINIC	0	0		0 3,075		4.00
4.00 5.00		EMPLOYEE BENEFITS DEPARTMENT	0	0		0 85,336		4.00 5.00
			-				•	
6.00		OPERATING ROOM	0	0		0 365,000	•	6.00
7.00		CLINIC	0	0		0 541,667		7.00
8.00	0.00		0	0		o C		8.00
9.00	0.00		0	0		0 C		9.00
10.00	0.00		0	0		0 C		10.00
200.00			0	0		0 3, 475, 097	/	200.00

COST AL	Financial Systems LOCATION - GENERAL SERVICE COSTS	ST. CATHERI N	Provider C	1	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Brow	
					10 08/ 30/ 2022	Date/Time Pre 11/22/2022 9:	
			CAPI TAL REL	LATED CUSTS			
	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	
	GENERAL SERVICE COST CENTERS						
	DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-MVBLE EQUIP	2, 692, 966 3, 477, 266	2, 692, 966	3, 477, 260	4		1.00 2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	9, 141, 434	13, 329				4.00
	20560 PURCHASING RECEIVING AND STORES	461, 601	47, 110	1, 259	9 49, 859	559, 829	5.0
		994, 443	20, 406		0 130, 271	1, 550	
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI NI STRATI VE & GENERAL	1, 635, 581 19, 361, 337	4, 052 229, 746	153, 883	3 744,052	0 3, 701	5.03 5.04
	DO600 MAINTENANCE & REPAIRS	0	0	(0 0	0,701	6.00
	DO700 OPERATION OF PLANT	6, 769, 521	613, 869	147, 874		273	7.00
	DO800 LAUNDRY & LINEN SERVICE	589, 160	9,637	(0 11, 265	361	8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 773, 201 2, 214, 423	41, 436 61, 052			3, 639 8, 609	9.00 10.00
	D1100 CAFETERI A	370, 846	27, 046			3, 689	11.00
	01200 MAINTENANCE OF PERSONNEL	0	0	(0 0	0	12.00
	D1300 NURSI NG ADMI NI STRATI ON	1, 890, 429	13, 393	58, 97	1 221, 190	67	13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0			0	14.00 15.00
	D1600 MEDICAL RECORDS & LI BRARY	1, 270, 260	14, 768		0 0	0	16.00
	D1700 SOCIAL SERVICE	0	0		0 0	0	
	01900 NONPHYSI CLAN ANESTHETI STS	0	0	(0 0	0	19.00
	NPATIENT ROUTINE SERVICE COST CENTERS	19, 124, 047	457, 150	116, 880	2, 429, 020	77, 337	30.00
	D3100 I NTENSI VE CARE UNI T	3, 284, 781	54, 440	135, 742		20, 147	31.0
	04000 SUBPROVI DER – I PF	0	0		0 0	0	40.00
	04100 SUBPROVIDER - IRF	2, 254, 337	71, 679			9, 228	
-	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	534, 950	2, 843	19, 332	2 66, 059	3, 648	43.00
	D5000 OPERATI NG ROOM	5, 291, 478	126, 291	976, 003	3 388, 816	92, 253	50.00
	D5100 RECOVERY ROOM	1, 146, 212	41, 489			5, 240	
	D5200 DELIVERY ROOM & LABOR ROOM D5300 ANESTHESI OLOGY	1, 121, 830 240, 619	47, 493 1, 887	40, 62 ⁻ 79, 668		7, 666 10, 283	
	05400 RADI OLOGY-DI AGNOSTI C	240, 819 2, 868, 892	43, 253			11, 909	
	D5500 RADI OLOGY - THERAPEUTI C	537, 122	24, 746			7	55.00
	D5600 RADI OI SOTOPE	692, 416	9, 094			559	
	D5700 CT SCAN D5800 MAGNETIC RESONANCE IMAGING (MRI)	1, 014, 644 462, 543	7, 154 11, 082			7, 066 904	
	05900 CARDI AC CATHETERI ZATI ON	1, 199, 244	36, 447			10, 177	
60.00	D6000 LABORATORY	5, 965, 650	58, 286		2 418, 845		
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0 0	0	
	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	738, 724 694, 110	4, 341 37, 273	7, 20		9, 098 6, 631	63.0 64.0
	06500 RESPI RATORY THERAPY	1, 530, 190	10, 120			8, 746	
	D6600 PHYSI CAL THERAPY	2, 296, 678	57, 873			2, 140	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 288, 876	15, 941	11, 550		1, 410	
	06900 ELECTROCARDI OLOGY	409, 604 803, 393	3, 332 12, 473			336 3, 978	
	D7000 ELECTROENCEPHALOGRAPHY	539, 274	17, 758			5, 908	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	2, 951, 435	0	(0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	2, 776, 095 9, 514, 595	0 23, 514	88, 362	0 211 045	0	72.00
	07400 RENAL DIALYSIS	9, 514, 595 665, 523	23, 514 4, 966		2 311, 945 0 0	6, 614 717	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	126, 185	13, 240		16, 880	36	
	07697 CARDI AC REHABI LI TATI ON	429, 720	32, 732	12, 98	7 57, 240	223	76.9
	DUTPATIENT SERVICE COST CENTERS	1, 288, 744	12, 072	7, 403	2 152 421	14, 845	90.00
	D9100 EMERGENCY	4, 720, 269	58, 115			51, 207	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						107 -
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	130, 154, 648	2, 392, 928	3, 429, 393	3 9, 080, 758	558, 634	118.00
1	NONREIMBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 588	(0 0		190.00
191.00	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES	36, 448 11, 288	0 182, 093		0 3, 902 0 1, 031		191. 00 192. 00
	07950 OTHER NONREI MBURSEABLE	121, 335	97, 581	2,064		12	194.00
	07951 ADVERTI SI NG	208, 750	7,460		0 0	7	194. 0
	07952 RETAIL PHARMACY	7, 397, 632	6, 316	45, 809	9 69, 266		194.0

Health Fin	ancial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOC	CATION - GENERAL SERVICE COSTS		Provider CO		Period: From 07/01/2021	Worksheet B Part I	
		_			To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 24 am
			CAPI TAL REI	LATED 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)	137, 930, 101	2, 692, 966	3, 477, 26	6 9, 154, 957	559, 829	202.00

	Financial Systems	ST. CATHERIN				u of Form CMS-2	2552-10
COST A	LOCATION - GENERAL SERVICE COSTS		Provider CCN		eriod: rom 07/01/2021	Worksheet B Part I	
				Ť		Date/Time Pre 11/22/2022 9:	epared:
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	MAINTENANCE &	24 011
			OUNTS		ADMI NI STRATI VE	REPAI RS	
		5.02	RECEI VABLE 5. 03	5A. 03	& GENERAL 5.04	6.00	
	GENERAL SERVICE COST CENTERS	5.02	5.05	5A. 05	5.04	0.00	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	1, 146, 670					5. 01 5. 02
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 140, 070	1, 639, 633				5.02
	00590 OTHER ADMINISTRATIVE & GENERAL	0	0	20, 492, 719	20, 492, 719		5.04
	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	
	00700 OPERATION OF PLANT	0	0	7, 784, 736	1, 358, 429	0	
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	0	610, 423	106, 518	0	
	01000 DI ETARY	0	0	3, 168, 171 2, 523, 831	552, 843 440, 406	0	
	01100 CAFETERI A	0	0	517, 265	90, 262	0	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
	01300 NURSI NG ADMI NI STRATI ON	0	0	2, 184, 050	381, 115	0	
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	0	0 1, 285, 028	0 224, 236	0	15.00 16.00
	01700 SOCIAL SERVICE	0	0	1, 205, 028	224, 230	0	
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	- 1					
	03000 ADULTS & PEDIATRICS	195, 433	279, 686	22, 679, 553	3, 957, 573	0	
	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	13, 915 0	19, 894	3, 937, 471	687, 085 0	0	
	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	13, 885	19, 850	2, 649, 785	462, 385	0	
	04300 NURSERY	3, 559	5, 088	635, 479	110, 890	0	
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	92, 646	132, 453	7, 099, 940	1, 238, 932	0	50.00
	05100 RECOVERY ROOM	15, 376	21, 983	1, 379, 841	240, 781	0	
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	7,470	10, 679	1, 374, 560	239, 859	0	
	05400 RADI OLOGY-DI AGNOSTI C	14, 902 42, 591	21, 305 60, 890	717, 254 3, 482, 974	125, 160 607, 775	0	
	05500 RADI OLOGY - THERAPEUTI C	15, 319	21, 901	642, 582	112, 130	0	
	05600 RADI OI SOTOPE	11, 203	16, 016	875, 262	152, 732	0	56.00
	05700 CT SCAN	67, 250	96, 145	1, 299, 839	226, 821	0	
	05800 MAGNETIC RESONANCE I MAGING (MRI)	21, 684	31,001	572, 491	99, 899	0	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	42, 064 136, 098	60, 137 194, 575	2, 023, 735 7, 061, 338	353, 140 1, 232, 196	0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	130, 070	0	0 1,001	1, 232, 170	0	
	06300 BLOOD STORING, PROCESSING, & TRANS.	5, 508	7, 875	793, 636	138, 489	0	
	06400 I NTRAVENOUS THERAPY	9, 276	13, 262	846, 355	147, 688	0	
	06500 RESPI RATORY THERAPY	12, 117	17, 323	1, 844, 066	321, 788	0	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	19, 256 11, 280	27, 529 16, 127	2, 690, 261 1, 463, 120	469, 448 255, 313	0	
	06800 SPEECH PATHOLOGY	3, 184	4, 553	469, 509	81, 929	0	1
	06900 ELECTROCARDI OLOGY	32, 188	46, 017	1, 156, 743	201, 850	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	15, 220	21, 759	681, 638	118, 945	0	70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	21, 694	31, 015	3, 004, 144	524, 220	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	13, 109	18, 741	2, 807, 945 10, 306, 938	489, 984	0	
	07300 DRUGS CHARGED TO PATTENTS 07400 RENAL DIALYSIS	148, 954 7, 318	212, 954 10, 462	688, 986	1, 798, 550 120, 227	0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	678	970	157, 989	27, 569	0	
	07697 CARDI AC REHABI LI TATI ON	1, 470	2, 102	536, 474	93, 614	0	
	OUTPATIENT SERVICE COST CENTERS	· .		·			
	09000 CLI NI C	8, 622	12, 326	1, 496, 443	261, 128	0	
	09100 EMERGENCY	143, 401	205, 015	5, 788, 769	1, 010, 134	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>		0		0	101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 146, 670	1, 639, 633	129, 731, 343	19, 062, 043	0	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	6, 588	1, 150		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	40, 350	7,041		191.00 192.00
	07950 OTHER NONREIMBURSEABLE	0	0	194, 412 220, 992	33, 925 38, 563		192.00
194 00		0	0	216, 217	37, 730		194.00
	07951 ADVERTI SI NG				, . 50		
194.01	07951 ADVERTISING 07952 RETAIL PHARMACY	0	0	7, 520, 199	1, 312, 267	0	194.02
194.01 194.02 200.00	07952 RETAIL PHARMACY Cross Foot Adjustments	0	0	7, 520, 199 0	1, 312, 267		200.00
194.01 194.02	07952 RETAIL PHARMACY Cross Foot Adjustments Negative Cost Centers	0 0 1, 146, 670	0 0 1, 639, 633	7, 520, 199 0 0 137, 930, 101	1, 312, 267 0 20, 492, 719	0	

	Financial Systems	ST. CATHERIN		CNI, 15 0000		u of Form CMS-2 Worksheet B	2552-10
CUST	ALLUCATION - GENERAL SERVICE CUSIS		Provider C		eriod: rom 07/01/2021 o 06/30/2022	Part I Date/Time Pre	pared:
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	11/22/2022 9: CAFETERI A	24 am
		PLANT	LINEN SERVICE	0.00	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	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00560 PURCHASING RECEIVING AND STORES						4.00 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 ADMINISTRATIVE & GENERAL						5.04
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	9, 143, 165					6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	49, 936	766, 877				8.00
9.00	00900 HOUSEKEEPI NG	214, 718	0	3, 935, 732			9.00
10.00	01000 DI ETARY	316, 362	0	137, 420	3, 418, 019	700 500	10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	140, 150 0	0	44, 915	0	792, 592 0	
13.00	01300 NURSI NG ADMI NI STRATI ON	69, 403	0	15, 774	0	34, 634	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00 17.00	01600 MEDI CAL RECORDS & LI BRARY	76, 523	0	24, 062	0	0	16.00
17.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17.00 19.00
171.00	INPATIENT ROUTINE SERVICE COST CENTERS	0				0	1 1 1 0 0
30.00	03000 ADULTS & PEDI ATRI CS	2, 368, 894	602, 730		2, 532, 746	277, 073	
31.00	03100 I NTENSI VE CARE UNI T	282, 103	49, 374	184, 527	74, 541	31, 970	
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0 371, 432	0 96, 783	0 202, 921	0 351, 074	0 29, 306	40.00
43.00	04300 NURSERY	14, 730	17, 990	7, 486	0	6, 660	1
	ANCILLARY SERVICE COST CENTERS			T			
50.00	05000 OPERATING ROOM	654, 421	0	486, 850	0	42, 627	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	214, 993 246, 103	0	18, 715 170, 304	2, 213 86, 504	14, 653 14, 653	
53.00	05300 ANESTHESI OLOGY	9, 779	0	0	00, 304	9, 325	
54.00	05400 RADI OLOGY-DI AGNOSTI C	224, 130	0	172, 443	0	37, 298	
55.00	05500 RADI OLOGY - THERAPEUTI C	128, 232	0	53, 738	0	2,664	
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN	47, 124 37, 070	0	10, 694 0	0	3, 996 7, 993	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	57, 423	0	7, 486	0	3, 996	
59.00	05900 CARDI AC CATHETERI ZATI ON	188, 864	0	105, 604	0	9, 325	
60.00	06000 LABORATORY	302, 029	0	118, 838	0	58, 612	
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING, & TRANS.	0 22, 492	0	0	0	0 2, 664	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	193, 142	0	0	0	10, 657	
65.00	06500 RESPI RATORY THERAPY	52, 442	0	22, 992	0	13, 321	65.00
66.00		299, 890	0	154, 129	0	26, 642	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	82, 605 17, 267	0	0	0	14, 653 3, 996	
69.00	06900 ELECTROCARDI OLOGY	64,635	0	9, 357	0	10, 657	
	07000 ELECTROENCEPHALOGRAPHY	92, 017	0	13, 368	0	7, 993	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	101 044	0	0	0	0 26, 642	72.00 73.00
74.00	07400 RENAL DIALYSIS	121, 844 25, 732	0	13, 234 4, 010	0	20, 042	74.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	68, 608	0	19, 249	0	1, 332	
76.97	07697 CARDI AC REHABI LI TATI ON	169, 610	0	12, 031	0	6, 660	76.97
00.00	OUTPATIENT SERVICE COST CENTERS	() 557	0	17 270	0	17 017	
90.00 91.00	09000 CLINIC 09100 EMERGENCY	62, 557 301, 143	0		0 73, 988	17, 317 57, 280	90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	001,110	0	010,001	10, 700	07,200	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	7, 588, 403	766, 877	3, 526, 843	3, 121, 066	784, 599	110 00
110.00	NONREIMBURSABLE COST CENTERS	7, 566, 403	700, 877	3, 520, 643	3, 121, 000	704, 099	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	34, 136	0	16, 843	0		190. 00
191.00	19100 RESEARCH	0	0	0	0		191.00
40-	0 19200 PHYSICIANS' PRIVATE OFFICES 0 07950 OTHER NONREI MBURSEABLE	943, 584	0	8, 288	0		192.00 194.00
		505,653	0	373, 332	296, 953		194.00
194.00		38 650	n				
194.00 194.0	07951 ADVERTI SI NG 207952 RETAI L PHARMACY	38, 659 32, 730	0	4, 010 6, 416	0		194.01
194.00 194.0 194.02 200.00	07951 ADVERTISING 207952 RETAIL PHARMACY Cross Foot Adjustments		0		0	7, 993	194. 02 200. 00
194.00 194.0 194.02	07951 ADVERTISING 207952 RETAIL PHARMACY Cross Foot Adjustments Negative Cost Centers		0 0 0 766, 877	6, 416	0 0 3, 418, 019	7, 993	194. 02 200. 00 201. 00

Heal th	Financial Systems	ST. CATHERIN	NE HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: com 07/01/2021	Worksheet B Part I	
				To		Date/Time Pre 11/22/2022 9:	pared: 24 am
	Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL	
		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 00100 CAP REL COSTS-BLDG & FIXT		1				1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
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 5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5.04
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	2, 684, 976				13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY			0	0	1, 609, 849	15.00
	01700 SOCI AL SERVI CE		0	0	0	1,007,047	
19.00	01900 NONPHYSICIAN ANESTHETISTS	C	0 0	0	0	0	19.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	C	1, 469, 751	0	o	274, 396	30.00
30.00	03100 I NTENSI VE CARE UNI T			0	0	19, 536	•
40.00	04000 SUBPROVI DER – I PF	C	-	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	19, 493	•
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	36, 084	0	0	4, 996	43.00
50.00	05000 OPERATI NG ROOM	0	224, 303	0	0	130, 067	50.00
51.00	05100 RECOVERY ROOM	0		0	0	21, 587	•
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		0 75, 817 0 0	0	0	10, 487 20, 922	1
54.00	05400 RADI OLOGY-DI AGNOSTI C		o o	0	0	59, 794	•
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0	0	0	21, 506	•
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN			0	0	15, 728 94, 413	•
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	30, 443	•
59.00	05900 CARDI AC CATHETERI ZATI ON	C	48, 270	0	0	59, 054	•
60.00 62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0	0	191, 070 0	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.			0	0	7, 733	1
64.00	06400 I NTRAVENOUS THERAPY	C	0 0	0	0	13, 023	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0	0	0	17, 011 27, 033	
67.00	06700 OCCUPATI ONAL THERAPY			0	0	15, 836	67.00
68.00	06800 SPEECH PATHOLOGY	c	0 0	0	0	4, 471	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		0	0	0	45, 189	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0	0	21, 367 30, 456	•
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	0	0	18, 404	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0	0	0	209, 118	•
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES			0	0	10, 274 952	•
	07697 CARDI AC REHABI LI TATI ON	0	35, 002	0	0	2, 064	
00.00	OUTPATIENT SERVICE COST CENTERS		04.070			10.104	
	09000 CLINIC 09100 EMERGENCY			0	0	12, 104 201, 322	
	09200 OBSERVATION BEDS (NON-DISTINCT PART			c	J	2017022	92.00
	OTHER REIMBURSABLE COST CENTERS	,	1				
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	C	0	0	0	0	101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	C	2, 684, 976	0	0	1, 609, 849	118.00
100.00	NONREI MBURSABLE COST CENTERS			0	0	0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH			0 0	0		190.00 191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	07950 OTHER NONREI MBURSEABLE	0	0	0	0		194.00
	07951 ADVERTI SI NG 07952 RETAI L PHARMACY			0	0		194.01 194.02
200.00				0	0	0	200.00
201.00	Negative Cost Centers	C	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	C	2, 684, 976	0	0	1, 609, 849	1202. OO

	: B Prepared: 2 9: 24 am 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 12.00 13.00 14.00 15.00 13.00 14.00 15.00 13.00 14.00 15.00 13.00 14.00 15.00 13.00 14.00 15.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 10.00 11.00 11.00 10.00 11.00
Cost Center Description SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS Subtotal Residents Cost & Post Stepdown Adjustments Intern & Residents Cost & Post Stepdown Adjustments 100 00100 CAP REL COSTS-BLDG & FIXT 2.00 17.00 19.00 24.00 25.00 26.00 2.00 00200 CAP REL COSTS-MUBLE EQUIP 4.00 00400 EMPLOYEE BNEFI TS DEPARTMENT 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 00570 ADMI TTI NG 5.03 00580 CASHI ERING/ACCOUNTS RECEI VABLE 5.04 1	22 9: 24 am 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 12. 00 13. 00 14. 00 15. 00 16. 00
Cost Center Description SOCIAL SERVICE NONPHYSICIAN Subtotal Intern & Residents Cost Total ANESTHETISTS Subtotal Intern & ANESTHETISTS Subtotal Intern & Residents Cost Residents Cost 100 00100 CAP REL COSTS CENTERS 17.00 19.00 24.00 25.00 26.00 2.00 00200 CAP REL COSTS-BLDG & FIXT Intern & Algustments Intern & Residents Cost Intern & Residents Cost 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT Intern & Algustments Intern & Residents Cost Intern & Residents Cost 5.01 00560 PURCHASING RECEIVING AND STORES Intern & Residents Cost Intern & Residents Cost Intern & Residents Cost 5.02 00570 ADMI NI STRATI VE & GENERAL Intern & Residents Cost Intern & Residents Cost Intern & Residents Cost 5.04 00590 OTHER ADMI NI STRATI VE & GENERAL Intern & Residents Cost Intern & Residents Cost Intern & Residents Cost 6.00 00600 LAUNDRY & LI NEN SERVICE Intern & Residents Cost Intern & Residents Cost Intern & Residents Cost 9.00 00900 OUSOD DETARY Intern & Residents Cost<	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 12.00 13.00 14.00 15.00 16.00
CENERAL SERVICE COST CENTERS 17.00 19.00 24.00 25.00 26.00 00100 CAP REL COST CENTERS 17.00 19.00 24.00 25.00 26.00 2.00 00200 CAP REL COSTS-BLDG & FIXT 10.00 20.00 25.00 26.00 2.00 00200 CAP REL COSTS-MUBLE EQUI P 10.00 24.00 25.00 26.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 10.00 20.0570 ADMI TTI NG 5.01 00560 PURCHASING RECEI VING AND STORES 10.00 10.00 20.00570 ADMI TTI NG 5.02 00570 ADMI TTI NG 11.00 11.00 24.00 11.00 11.00 5.02 00570 ADMI TTI NG 11.00	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
GENERAL SERVICE COST CENTERS 17.00 19.00 24.00 25.00 26.00 1.00 00100 CAP REL COSTS-BLDG & FIXT 10.00 24.00 25.00 26.00 2.00 00200 CAP REL COSTS-BLDG & FIXT 10.00 24.00 25.00 26.00 2.00 00200 CAP REL COSTS-WUBLE EQUI P 17.00 19.00 24.00 25.00 26.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 10.0560 PURCHASING RECEI VING AND STORES 10.0560 10.0560 10.0560 20.0570 ADMI TTING 10.0560 10.0560 10.0560 20.0570 ADMI TTING 10.0560 1	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
17.00 19.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MUBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00560 PURCHASI NG RECEI VI NG AND STORES 5.02 00570 ADMI TTI NG 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 00590 OTHER ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LINEN SERVI CE 9.00 00900 HOUSEKEEPI NG 11.00 01100 CAFTERI A 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 01500 CI AL SERVI CES & SUPPLY 17.00 01500 PHARMACY <	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
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 5.03 00580 CASHI ERING/ACCOUNTS RECEIVABLE 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 12.00 01200 MAINTENANCE OF PERSONNEL 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVICE 0 10.00 01900 NONPHYSICI AN ANESTHETISTS 0 0 0 10.00 01900 NONPHYSICI AN ANESTHETISTS 0 0 0 10.00 01900 NONPHYSICI AN ANESTHETISTS 0 10.00 0 10.00 0100 DI EXTRESSENTION AND AND AND AND AND AND AND AND AND AN	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 00570 ADMITTING 5.03 00580 CASHI ERING/ACCOUNTS RECEIVABLE 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 12.00 01200 MAINTENANCE OF PERSONNEL 13.00 01300 NURSING ADMINISTRATION 4.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LI BRARY 17.00 01700 SOCIAL SERVICE OF COST CENTERS 0 00 000 NONPHYSICIAN ANESTHETISTS 0 0 INPATIENT ROUTINE SERVICE COST CENTERS	$\begin{array}{c} 4.00\\ 5.01\\ 5.02\\ 5.03\\ 5.04\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ \end{array}$
5.01 00560 PURCHASI NG RECEI VI NG AND STORES 5.02 00570 ADMI TTI NG 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 00590 OTHER ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 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 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 0 01900 NONPHYSI CI AN ANESTHETI STS 0 0 INPATI ENT ROUTI NE SERVI CE COST CENTERS	$\begin{array}{c} 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
5.02 00570 ADMI TTI NG 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 00590 OTHER ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 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 17.00 01900 NONPHYSI CI AN ANESTHETI STS 0 0 0 19.00 01900 NONPHYSI CI AN ANESTHETI STS 0 0 0	$\begin{array}{c} 5.\ 03\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
5.04 00590 OTHER ADMINISTRATIVE & GENERAL 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 DI ETARY 11.00 01000 CAFETERIA 12.00 01200 MAINTENANCE OF PERSONNEL 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 17.00 01700 SOCIAL RECORDS & LI BRARY 17.00 01700 SOCIAL SERVICE 19.00 01900 NOPHYSI CI AN ANESTHETI STS 0 0 01900 NOPHYSI CI AN ANESTHETI STS 0	$\begin{array}{c} 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01 ETARY 11.00 01100 CAFETERI A 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 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 19.00 01900 NONPHYSI CI AN ANESTHETI STS 0 0 INPATI ENT ROUTI NE SERVI CE COST CENTERS	$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 CAFETERIA 12.00 01200 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 01700 NONPHYSI CI AN ANESTHETI STS 0 01900 19.00 01900 INONPHYSI CI AN ANESTHETI STS 0 0 19.00 INPATI ENT ROUTI NE SERVICE COST CENTERS	$\begin{array}{c} 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
9.00 00900 HOUSEKEEPING Image: constraint of the service of the s	9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
10.00 DI ETARY 11.00 O1100 CAFETERIA 12.00 O1200 MAI NTENANCE OF PERSONNEL 13.00 O1300 NURSI NG ADMI NI STRATI ON 14.00 O1400 CENTRAL SERVI CES & SUPPLY 15.00 O1500 PHARMACY 17.00 O1700 SOCI AL SERVI CE 17.00 O1700 SOCI AL SERVI CE 19.00 O1900 NONPHYSI CI AN ANESTHETI STS 0 O 19.00 INPATI ENT ROUTI NE SERVI CE COST CENTERS	10.00 11.00 12.00 13.00 14.00 15.00 16.00
11.00 01100 CAFETERIA 12.00 01200 MAI NTENANCE OF PERSONNEL 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01900 NONPHYSI CI AN ANESTHETI STS 0 19.00 INPATI ENT ROUTI NE SERVICE COST CENTERS 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
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 019.00 01900 NONPHYSI CI AN ANESTHETI STS 0 19.00 INPATI ENT ROUTI NE SERVI CE COST CENTERS 0	12.00 13.00 14.00 15.00 16.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVICE 019.00 01900 NONPHYSI CI AN ANESTHETI STS 0 0 INPATI ENT ROUTI NE SERVICE COST CENTERS	14.00 15.00 16.00
15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 019.00 01900 NONPHYSI CI AN ANESTHETI STS 0 0 INPATI ENT ROUTI NE SERVI CE COST CENTERS	15.00 16.00
16.00 NEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 0 19.00 01900 NONPHYSI CI AN ANESTHETI STS 0 0	16.00
19.00 01900 NONPHYSI CI AN ANESTHETI STS 0 0 I NPATI ENT ROUTI NE SERVI CE COST CENTERS	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	I
	19.00
	, 350 30. 00
	, 718 31.00
40.00 04000 SUBPROVI DER - I PF 0 0 0 0 41.00 04100 SUBPROVI DER - I RF 0 0 4.335.684 0 4.33	0 40.00
	, 684 41.00 , 315 43.00
ANCI LLARY SERVICE COST CENTERS	
	, 140 50.00
51. 00 05100 RECOVERY ROOM 0 1, 970, 150 0 1, 970 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 2, 218, 287 0 2, 215	, 150 51.00 , 287 52.00
	, 440 53.00
	, 414 54.00
	, 852 55.00 , 536 56.00
	, 136 57.00
	, 738 58.00
	, 992 59.00 , 083 60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0	0 62.00
	, 014 63. 00
	, 865 64.00
	, 620 65.00 , 403 66.00
	, 527 67.00
	, 172 68.00
	, 431 69.00 , 328 70.00
	, 820 71.00
	, 333 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 12, 476, 326 0 12, 477 74. 00 07400 RENAL DI ALYSIS 0 0 849, 229 0 849	, 326 73.00 , 229 74.00
	, 699 76.00
	, 455 76. 97
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 1, 961, 299 0 1, 96	, 299 90.00
	, 714 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0	92.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HEALTH AGENCY 0 0 0 0	0101.00
101.00 HOME HEALTH AGENCY 0	0 101.00
SUBTOTALS SUBTOTALS SUM OF LI NES 1 through 117 0 0 126, 032, 070 0 126, 032	, 070 118. 00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 58, 717 0 55	717 100 00
	, 717 190. 00 , 391 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 1, 180, 209 0 1, 18	, 209 192. 00
	, 493 194.00
	, 616 194. 01 , 605 194. 02
200.00 Cross Foot Adjustments 0 0 0 0 0 0	0 200. 00
201.00 Negative Cost Centers 0 0 0 0	0 201.00

Health Financial Systems	ST. CATHERI NE	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2021	Worksheet B Part I	
				To 06/30/2022		
Cost Center Description		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	137, 930, 10	1 0	137, 930, 101	202.00

	inancial Systems ION OF CAPITAL RELATED COSTS	ST. CATHERIN	Provider C		eriod: rom 07/01/2021	u of Form CMS-2 Worksheet B Part II	2002-1
				Te		Date/Time Pre 11/22/2022 9:	
			CAPI TAL REI	ATED COSTS			
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFI TS DEPARTMENT	
		Related Costs					
G	ENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT	0	13, 329	194	13, 523	13, 523	2.00
5.01 0	0560 PURCHASING RECEIVING AND STORES	0	47, 110	1, 259	48, 369	74	5.01
		0	20, 406		20, 406	192	
	0580 CASHI ERI NG/ACCOUNTS RECEI VABLE 0590 OTHER ADMI NI STRATI VE & GENERAL	0	4, 052 229, 746		4, 052 383, 629	0 1, 099	
6.00 0	0600 MAI NTENANCE & REPAI RS	0	0	0	0	0	
		0	613, 869	147, 874	761, 743	374	
	10800 LAUNDRY & LINEN SERVICE 10900 HOUSEKEEPING	0	9, 637 41, 436	31, 536	9, 637 72, 972	17 470	
	1000 DI ETARY	0	61, 052	55, 031	116, 083	273	
		0	27, 046		50, 631	136	
	1200 MAI NTENANCE OF PERSONNEL 1300 NURSI NG ADMI NI STRATI ON	0	0 13, 393	0 58, 971	0 72, 364	0 327	12.00
	1400 CENTRAL SERVICES & SUPPLY	0	13, 373	0	12, 304	0	14.00
	1500 PHARMACY	0	0	0	0	0	15.00
	11600 MEDICAL RECORDS & LIBRARY 11700 SOCIAL SERVICE	0	14, 768 0	0	14, 768 0	0	16.00 17.00
	1900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
	NPATIENT ROUTINE SERVICE COST CENTERS				1		
	3000 ADULTS & PEDIATRICS	0	457, 150		574,030	3, 588	
	13100 I NTENSI VE CARE UNI T 14000 SUBPROVI DER – I PF	0	54, 440 0	135, 742	190, 182 0	603 0	
	4100 SUBPROVIDER - IRF	0	71, 679	45, 338	117, 017	348	
	4300 NURSERY	0	2, 843	19, 332	22, 175	98	43.00
	NCI LLARY SERVI CE COST CENTERS	0	126, 291	976, 003	1, 102, 294	574	50.00
	15100 RECOVERY ROOM	0	41, 489		46, 635	213	
	5200 DELIVERY ROOM & LABOR ROOM	0	47, 493	40, 627	88, 120	205	
	15300 ANESTHESI OLOGY 15400 RADI OLOGY-DI AGNOSTI C	0	1, 887 43, 253	79, 668 177, 446	81, 555 220, 699	515 411	
	5500 RADI OLOGY - THERAPEUTI C	0	24, 746		32, 709	52	
	5600 RADI OI SOTOPE	0	9, 094	101, 857	110, 951	65	
	15700 CT SCAN 15800 MAGNETIC RESONANCE IMAGING (MRI)	0	7, 154 11, 082	36, 228 1, 690	43, 382 12, 772	105 64	
1	5900 CARDIAC CATHETERIZATION	0	36, 447	573, 561	610, 008	151	
60. 00 0	6000 LABORATORY	0	58, 286		177, 738	619	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	
	6300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6400 I NTRAVENOUS THERAPY	0	4, 341 37, 273	7, 207 8, 746	11, 548 46, 019	31 114	
	6500 RESPI RATORY THERAPY	0	10, 120		95, 648	266	
	6600 PHYSI CAL THERAPY	0	57, 873		100, 264	361	
	6700 OCCUPATI ONAL THERAPY 6800 SPEECH PATHOLOGY	0	15, 941 3, 332	11, 550 5, 972	27, 491 9, 304	174 63	
	6900 ELECTROCARDI OLOGY	0	12, 473		181, 583	132	
	7000 ELECTROENCEPHALOGRAPHY	0	17, 758	21, 325	39, 083	89	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT 7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	17200 TMPL. DEV. CHARGED TO PATTENTS	0	23, 514	88, 362	0 111, 876	461	
74.00 0	7400 RENAL DI ALYSI S	0	4, 966	0	4, 966	0	74.00
	13550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 17697 CARDI AC REHABI LI TATI ON	0	13, 240		13, 240	25	
-	UTPATIENT SERVICE COST CENTERS	0	32, 732	12, 987	45, 719	85	76.9
90.00 0	9000 CLI NI C	0	12, 072	7, 403	19, 475	225	90.00
	9100 EMERGENCY	0	58, 115	59, 546	117, 661	814	
	9200 OBSERVATION BEDS (NON-DISTINCT PART THER REIMBURSABLE COST CENTERS				0		92.00
	0100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	PECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) ONREIMBURSABLE COST CENTERS	0	2, 392, 928	3, 429, 393	5, 822, 321	13, 413	118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 588	0	6, 588	0	190. 00
191.001	9100 RESEARCH	0	0	0	0	6	191.00
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	182, 093		182, 093		192.00
	17950 OTHER NONREI MBURSEABLE 17951 ADVERTI SI NG	0	97, 581 7, 460	2,064	99, 645 7, 460		194. 00 194. 01
	17952 RETAIL PHARMACY	0	6, 316		52, 125		194. 02
200.00	Cross Foot Adjustments				0		200.00

Health Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS				Worksheet B Part II Date/Time Prepared: 11/22/2022 9:24 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		201.00	
202.00 TOTAL (sum lines 118 through 201)	0	2, 692, 966	3, 477, 26	6, 170, 232	13, 523	202.00	

	Financial Systems TION OF CAPITAL RELATED COSTS	ST. CATHERINE	HOSPITAL Provider CO	NI 15 0009 D	In Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider co	F	rom 07/01/2021	Part II	norod.
		11		T		Date/Time Pre 11/22/2022 9:	24 am
	Cost Center Description	PURCHASING RECEIVING AND	ADMI TTI NG	CASHI ERI NG/ACC OUNTS	OTHER ADMI NI STRATI VE	MAINTENANCE & REPAIRS	
		STORES		RECEIVABLE	& GENERAL	KEI AI KJ	
		5.01	5.02	5.03	5.04	6.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						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 00570 ADMITTING	48, 443	20 722				5.01
5.02 5.03	00570 ADMITTING 00580 CASHI ERING/ACCOUNTS RECEIVABLE	134	20, 732 0	4, 052			5.02
5.04	00590 OTHER ADMI NI STRATI VE & GENERAL	320	0	0	385, 048		5.04
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	
7.00	00700 OPERATION OF PLANT	24	0	0	25, 526	0	
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	31 315	0	0	2, 002 10, 388	0	
	01000 DI ETARY	745	0	0	8, 276	0	1
	01100 CAFETERI A	319	0	0	1, 696	0	
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0	0	0	0	0	
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	7, 161 0	0	
	01500 PHARMACY	0	0	0	0	0	
	01600 MEDICAL RECORDS & LIBRARY	0	0	0	4, 214	0	16.00
	01700 SOCIAL SERVICE	0	0	0	0	0	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
30.00	03000 ADULTS & PEDI ATRI CS	6, 692	3, 493	881	74, 337	0	30.00
	03100 I NTENSI VE CARE UNI T	1, 743	252	46		0	
	04000 SUBPROVIDER - IPF	0	0	0	-	0	
	04100 SUBPROVI DER – I RF 04300 NURSERY	799 316	252 64	46	8, 689 2, 084	0	
+5.00	ANCI LLARY SERVI CE COST CENTERS	310		12	2,004	0	40.00
50.00	05000 OPERATI NG ROOM	7, 983	1, 679	309	23, 281	0	50.00
51.00	05100 RECOVERY ROOM	453	279	51	4, 524	0	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	663 890	135 270	25 50		0	
	05400 RADI OLOGY-DI AGNOSTI C	1,030	772	142	11, 421	0	1
55.00	05500 RADI OLOGY – THERAPEUTI C	1	278	51	2, 107	0	55.00
	05600 RADI OI SOTOPE	48	203	37	2, 870	0	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	611 78	1, 219 393	224	4, 262 1, 877	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	881	762	140		0	1
60.00	06000 LABORATORY	14, 576	2, 466	454	23, 154	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	
63.00 64.00	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	787 574	100 168	18	2, 602 2, 775	0	
	06500 RESPI RATORY THERAPY	757	220	40	6, 047	0	1
	06600 PHYSI CAL THERAPY	185	349	64	8, 821	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	122	204	38		0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	29 344	58 583	11 107	1, 540 3, 793	0	
	07000 ELECTROENCEPHALOGRAPHY	511	276			0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	393	72		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	238			0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	572	2,699		33, 796	0	
	07400 RENAL DIALYSIS 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	62	133 12	24	2, 259 518	0	74.00
	07697 CARDI AC REHABI LI TATI ON	19	27	5	1, 759	0	1
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	1, 285	156			0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 431	2, 599	479	18, 981	0	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
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) NONREIMBURSABLE COST CENTERS	48, 339	20, 732	4, 052	358, 164	0	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	22	0	190.00
	19100 RESEARCH	0	0				191.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	637	0	192.00
	07950 OTHER NONREI MBURSEABLE	1	0	0	-		194.00
	07951 ADVERTI SI NG 07952 RETAI L PHARMACY	1 102	0	0	709 24, 659		194.01 194.02
10/ 00		102	0	I U	24,009	0	1174.02
194.02 200.00							200.00
	Cross Foot Adjustments	0	0	0	0		200.00 201.00 202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	ST. CATHERIN	Provi der C		eriod: om 07/01/2021	u of Form CMS-2 Worksheet B Part II	2552-10
				To		Date/Time Pre	pared:
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPING	DIETARY	11/22/2022 9: CAFETERI A	24 am
		PLANT	LINEN SERVICE		BIEIMA		
		7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						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						5.01
5.02 5.03	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 02 5. 03
5.03 5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5.03
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT	787,667					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	4, 302	15, 989				8.00
9.00 10.00	00900 HOUSEKEEPING	18, 498	0	102, 643	154 015		9.00
11.00	01000 DI ETARY 01100 CAFETERI A	27, 254 12, 074		3, 584 1, 171	156, 215 0	66, 027	1
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	00,021	
13.00	01300 NURSING ADMINISTRATION	5, 979	0	411	0	2, 885	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 6, 592	0	0 628	0	0	
17.00	01700 SOCIAL SERVICE	0, 592	0	020	0	0	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	1
	I NPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 ADULTS & PEDIATRICS	204, 077	12, 567	24, 847	115, 754	23, 079	1
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	24, 303	1,029	4, 812	3, 407	2, 663	
40.00	04000 SUBPROVIDER - TPF 04100 SUBPROVIDER - TRF	31, 998	2, 018	Ŭ	16, 045	0 2, 441	40.00
43.00	04300 NURSERY	1, 269	375	195	0	555	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	56, 377	0	12, 697	0	3, 551	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	18, 521 21, 201	0	488 4, 441	101 3, 954	1, 221 1, 221	51.00 52.00
53.00	05300 ANESTHESI OLOGY	842	0	4, 441	3, 934	777	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 308	0	4, 497	0	3, 107	1
55.00	05500 RADI OLOGY – THERAPEUTI C	11, 047	0	1, 401	0	222	55.00
56.00	05600 RADI OI SOTOPE	4,060	0	279	0	333	
57.00	05700 CT SCAN	3, 193 4, 947	0	0	0	666	1
58.00 59.00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	4, 947 16, 270	0	195 2, 754	0	333 777	
60.00	06000 LABORATORY	26, 019	0	3, 099	0	4, 883	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	1
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 938	0	0	0	222	
64.00	06400 I NTRAVENOUS THERAPY	16, 639	0	0	0	888	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 518 25, 835		600 4, 020	0	1, 110 2, 219	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	7, 116	0	4, 020	0	1, 221	
68.00	06800 SPEECH PATHOLOGY	1, 487	0	0	0	333	
69.00	06900 ELECTROCARDI OLOGY	5, 568	0	244	0	888	
	07000 ELECTROENCEPHALOGRAPHY	7, 927	0	349	0	666	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 497	0	345	0	2, 219	
74.00	07400 RENAL DI ALYSI S	2, 217	0	105	0	. 0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	5, 910		502	0	111	1
76.97	07697 CARDI AC REHABI LI TATI ON	14, 612	0	314	0	555	76.97
90.00	OUTPATIENT SERVICE COST CENTERS	5, 389	0	453	o	1, 443	90.00
	09100 EMERGENCY	25, 943	0		3, 382	4, 772	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	,	-	,	-,	.,	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
110 00	SPECIAL PURPOSE COST CENTERS	(52 727	15 000	01.000	142 (42	(5.2/1	1110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	653, 727	15, 989	91, 980	142, 643	05, 361	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 941	0	439	0	0	190.00
	19100 RESEARCH	0	0	0	Ō	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	81, 288	0	216	0		192.00
192.00			۱ N	9, 736	13, 572	0	194.00
192.00 194.00	07950 OTHER NONREI MBURSEABLE	43, 561	-		اہ `		104 04
192.00 194.00 194.01	07950 OTHER NONREIMBURSEABLE 07951 ADVERTI SI NG	3, 330	0	105	0	0	194.01
192.00 194.00 194.01 194.02	07950 OTHER NONREI MBURSEABLE 07951 ADVERTI SI NG 07952 RETAI L PHARMACY		0		0	0	194. 02
192.00 194.00 194.01	07950 OTHER NONREIMBURSEABLE 07951 ADVERTISING 07952 RETAIL PHARMACY Cross Foot Adjustments	3, 330	0	105	0	0 666 0	

Heal th	Financial Systems	ST. CATHERIN	NE HOSPITAL		In Lie	eu of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0008	Period: From 07/01/2021	Worksheet B	
					To 06/30/2022	Date/Time Pre	
	Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	11/22/2022 9: MEDI CAL	24 am
		PERSONNEL	ADMI NI STRATI ON	SERVICES &		RECORDS &	
		12.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
	GENERAL SERVICE COST CENTERS	12.00	10.00	11.00	10.00	10.00	
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 ADMINI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS						5.04 6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERIA						11.00
12.00	01200 MAINTENANCE OF PERSONNEL	C					12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	C	89, 133				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY				0 0		14.00
16.00	01600 MEDICAL RECORDS & LI BRARY		0		0 0	26, 202	
17.00	01700 SOCIAL SERVICE	C			0 0	0	17.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	C	0 0		0 0	0	19.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	C	48, 792		0 0	4, 428	30.00
31.00	03100 I NTENSI VE CARE UNI T	0			0 0		
40.00	04000 SUBPROVI DER – I PF	C			0 0		
41.00 43.00	04100 SUBPROVI DER – I RF				0 0		41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS		1, 198		0 0	01	43.00
50.00	05000 OPERATING ROOM	C	7, 446		0 0	2, 121	50.00
51.00	05100 RECOVERY ROOM	C			0 0		1
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		2, 517 0		0 0	171 341	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	975	1
55.00	05500 RADI OLOGY – THERAPEUTI C	C	0 0		0 0		
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN				0 0	256 1, 539	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)				0 0	496	1
59.00	05900 CARDI AC CATHETERI ZATI ON	C	1, 602		0 0	963	59.00
60.00	06000 LABORATORY	C	0		0 0	3, 115	
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING, & TRANS.					0 126	1
64.00	06400 I NTRAVENOUS THERAPY		0		0 0		1
65.00	06500 RESPI RATORY THERAPY	C	0		0 0	277	
66.00	06600 PHYSI CAL THERAPY	0	0		0 0		66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY					258 73	
69.00	06900 ELECTROCARDI OLOGY	C	0		0 0	737	
70.00	07000 ELECTROENCEPHALOGRAPHY	C	0		0 0	348	1
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS				0 0	497 300	1
73.00	07300 DRUGS CHARGED TO PATIENTS				0 0	3, 410	1
74.00	07400 RENAL DI ALYSI S	C	0		0 0	168	1
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0		0 0	16	
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	C	1, 162	<u> </u>	0 0	34	76.97
90.00	09000 CLINIC	C	3, 133		0 0	197	90.00
91.00	09100 EMERGENCY	C	10, 005		0 0	3, 282	
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	C	0 0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS	1				· · · · ·	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	C	89, 133		0 0	26, 202	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191.00	19100 RESEARCH	C	-		0 0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	C	0		0 0		192.00
	07950 OTHER NONREI MBURSEABLE						194.00 194.01
	207952 RETAIL PHARMACY				0 0		194.01
200.00	Cross Foot Adjustments						200.00
201.00 202.00			0 89, 133		0 0	0	201. 00 202. 00
202.00	TITLE (Sum TITES TO LITUUGH 201)		ן 07,133	I	ч U	1 20, 202	1202.00

Heal th	Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 07/01/2021	Worksheet B Part II	
					06/30/2022	Date/Time Pre 11/22/2022 9:	
	Cost Center Description	SOCI AL SERVI CE		Subtotal	Intern &	Total	
			ANESTHETI STS		Residents Cost & Post		
					Stepdown		
		17.00	19.00	24.00	Adjustments 25.00	26.00	
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 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5.01 5.02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.03
5.04 6.00	00590 OTHER ADMINI STRATI VE & GENERAL 00600 MAINTENANCE & REPAIRS						5.04 6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERIA						11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15.00 16.00
17.00	01700 SOCIAL SERVICE	0					17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0				19.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0		1, 096, 565	0	1, 096, 565	30.00
31.00	03100 I NTENSI VE CARE UNI T	0		247, 917	0	247, 917	31.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0		0 190, 326	-	0 190, 326	40.00
43.00	04300 NURSERY	0		28, 422	-	28, 422	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	0		1 210 212	0	1 010 010	50.00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0		1, 218, 312 75, 406		1, 218, 312 75, 406	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		127, 160		127, 160	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0		87, 592 262, 362		87, 592 262, 362	53.00 54.00
55.00	05500 RADI OLOGY – THERAPEUTI C	0		48, 219	0	48, 219	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0		119, 102 55, 201	0	119, 102 55, 201	56.00 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		21, 227	0	21, 227	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0		640, 944 256, 123		640, 944 256, 123	59.00 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0		250, 125	62.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0		17, 372		17, 372	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0		67, 420 109, 483		67, 420 109, 483	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	0		142, 559	0	142, 559	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0		41, 422 12, 898		41, 422 12, 898	67.00 68.00
	06900 ELECTROCARDI OLOGY	0		193, 979		193, 979	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		51, 535 10, 813		51, 535 10, 813	70.00 71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0		9, 789		9, 789	
	07300 DRUGS CHARGED TO PATIENTS	0		166, 372		166, 372	
74.00 76.00	07400 RENAL DI ALYSI S 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		9, 934 20, 339		9, 934 20, 339	74.00 76.00
	07697 CARDI AC REHABI LI TATI ON	0		64, 291		64, 291	76.97
90.00	OUTPATIENT SERVICE COST CENTERS	0		36, 692	0	36, 692	90.00
91.00	09100 EMERGENCY	0		206, 606		206, 606	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS			L	0		92.00
101.00	10100 HOME HEALTH AGENCY	0		0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS		_				
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	0	5, 636, 382	0	5, 636, 382	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		9, 990			190. 00
	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		138 264, 236		138 264, 236	191.00 192.00
194.00	07950 OTHER NONREI MBURSEABLE	0		167, 240		167, 240	
	07951 ADVERTI SI NG	0		11, 605		11,605	
194.02 200.00	07952 RETAIL PHARMACY Cross Foot Adjustments	0	0	80, 641 0			200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201.00

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 07/01/2021 To 06/30/2022		nared
				10 00/00/2022	11/22/2022 9:	
Cost Center Description	SOCI AL SERVI CE		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, 170, 23	2 0	6, 170, 232	202.00

COST A	Financial Systems LLOCATION - STATISTICAL BASIS	JI. CATHERIN	IE HOSPI TAL Provi der CC		eriod:	u of Form CMS-2 Worksheet B-1	
				T	rom 07/01/2021 o 06/30/2022	Date/Time Pre	
		CAPI TAL RE	LATED COSTS			11/22/2022 9:	24 am
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS	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	
1.00	00100 CAP REL COSTS-BLDG & FIXT	456, 623					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2.260	10, 701, 592	(0.250.405			2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00560 PURCHASING RECEIVING AND STORES	2, 260 7, 988	598 3, 874	60, 359, 405 328, 722			4.00 5.01
5.02	00570 ADMI TTI NG	3, 460	0	858, 889		546, 892, 764	
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	687	0	0	0	0	
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	38, 956	473, 589	4, 905, 598		0	
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	104, 089	455, 094	1, 669, 365	0 264	0	
8.00	00800 LAUNDRY & LINEN SERVICE	1, 634	0	74, 272		0	
9.00	00900 HOUSEKEEPI NG	7, 026	97, 056	2, 098, 967		0	9.00
10.00	01000 DI ETARY	10, 352	169, 363	1, 217, 847		0	10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	4, 586	72, 584 0	607, 215 0		0	11.00 12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 271	181, 489	1, 458, 326	-	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	-	0	14.00
	01500 PHARMACY	0	0	0	-	0	15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2, 504	0	0	-	0	16.00 17.00
	01900 NONPHYSICIAN ANESTHETISTS		0	0		0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				· · · ·		
30.00	03000 ADULTS & PEDIATRICS	77, 515	359, 708	16, 014, 720		93, 274, 878	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	9, 231	417, 757 0	2, 693, 621 0		6, 635, 753 0	
40.00	04100 SUBPROVIDER - IRF	12, 154	139, 533	1, 552, 459	-	6, 621, 150	
43.00	04300 NURSERY	482	59, 496	435, 536		1, 697, 030	
	ANCI LLARY SERVICE COST CENTERS						
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	21, 414 7, 035	3, 003, 732 15, 837	2, 563, 497 952, 008		44, 180, 397 7, 332, 460	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 053	125, 034	915, 089		3, 562, 087	
53.00	05300 ANESTHESI OLOGY	320	245, 186	2, 298, 282		7, 106, 556	
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 334	546, 104	1, 832, 832		20, 310, 332	
55.00 56.00	05500 RADI OLOGY – THERAPEUTI C 05600 RADI OI SOTOPE	4, 196 1, 542	24, 507 313, 473	234, 214 290, 868		7, 305, 103 5, 342, 360	
57.00	05700 CT SCAN	1, 213	111, 495	470, 430		32, 069, 749	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 879	5, 202	287, 372		10, 340, 637	
59.00	05900 CARDI AC CATHETERI ZATI ON	6, 180		673, 189		20, 059, 193	
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	9, 883	367, 625	2, 761, 479	163, 033	64, 901, 472 0	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	736	22, 181	137, 685	8, 806	2, 626, 612	
64.00	06400 I NTRAVENOUS THERAPY	6, 320	26, 916	508, 043	6, 418	4, 423, 458	64.00
65.00		1, 716		1, 187, 031		5, 778, 074	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	9, 813 2, 703	130, 463 35, 547	1, 611, 311 777, 562		9, 182, 494 5, 379, 111	
68.00	06800 SPEECH PATHOLOGY	565	18, 378	280, 388		1, 518, 537	
69.00	06900 ELECTROCARDI OLOGY	2, 115	520, 451	590, 633		15, 349, 384	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 011	65, 630	398, 182		7, 257, 957	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10, 345, 168 6, 251, 229	
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 987	271, 943	2, 056, 684	-	71, 031, 999	
74.00	07400 RENAL DI ALYSI S	842	0	0	694	3, 489, 699	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 245	0	111, 294		323, 413	
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	5, 550	39, 969	377, 386	216	701, 176	76.97
90.00	09000 CLINIC	2,047	22, 783	1, 004, 989	14, 369	4, 111, 479	90.00
91.00	09100 EMERGENCY	9, 854	183, 257	3, 634, 214		68, 383, 817	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	~					101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
118.00		405, 748	10, 554, 259	59, 870, 199	540, 721	546, 892, 764	118.00
	NONREI MBURSABLE COST CENTERS	T.					
	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	1, 117	0	0			190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0 30, 876	0	25, 729 6, 800			191.00 192.00
102 00	TIZE OF THE OFFICE AND THE VEHICLES						
	07950 OTHER NONREI MBURSEABLE	16, 546	6, 351	0	12	0	194.00
194.00 194.01	07950 OTHER NONREI MBURSEABLE 07951 ADVERTI SI NG 07952 RETAI L PHARMACY	16, 546 1, 265 1, 071		0 0 456, 677	7	0	194.00 194.01 194.02

Heal th F	inancial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALL	LOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	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, 692, 966	3, 477, 266	9, 154, 95	7 559, 829	1, 146, 670	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5. 897570	0. 324930	0. 15167	4 1. 033127	0.002097	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			13, 52	3 48, 443	20, 732	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0.00022	4 0. 089398	0. 000038	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 07/01/2021 o 06/30/2022	Date/Time Pre 11/22/2022 9:	pared:
	Cost Center Description	CASHI ERI NG/ACC R			MAINTENANCE &	OPERATION OF	
		OUNTS RECEI VABLE		ADMI NI STRATI VE & GENERAL	REPAI RS (SQUARE FEET)	PLANT (SQUARE FEET)	
		(GROSS REVE		(ACCUM. COST)	(SOUARE TEET)	(SUDARE TEET)	
		NUE)		· · ·			
	GENERAL SERVICE COST CENTERS	5.03	5A. 04	5.04	6.00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						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	546, 892, 764					5.0
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	0	-20, 492, 719	117, 437, 382			5.0
5.00	00600 MAI NTENANCE & REPAI RS	0	0	0	0		6.0
7.00	00700 OPERATION OF PLANT	0	0	7, 784, 736	0	299, 183	•
3.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	0	610, 423 3, 168, 171	0	1, 634 7, 026	
10.00	01000 DI ETARY	0	0	2, 523, 831	0	10, 352	
11.00	01100 CAFETERI A	0	0	517, 265	0	4, 586	
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0	2, 184, 050 0	0	2, 271 0	13.0 14.0
	01500 PHARMACY	0	0	0	0	0	14.0
	01600 MEDICAL RECORDS & LIBRARY	Ő	0	1, 285, 028	0	2, 504	
	01700 SOCIAL SERVICE	0	0	0	0	0	17.0
19.00	01900 NONPHYSI CI AN ANESTHETI STS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	19.0
30.00	03000 ADULTS & PEDIATRICS	93, 274, 878	0	22, 679, 553	0	77, 515	30. 0
	03100 I NTENSI VE CARE UNI T	6, 635, 753	0	3, 937, 471	0	9, 231	
	04000 SUBPROVI DER – I PF	0	0	0	0	0	40.0
	04100 SUBPROVIDER - IRF	6, 621, 150	0	2, 649, 785	0	12, 154	
13.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 697, 030	0	635, 479	0	482	43.0
50.00	05000 OPERATING ROOM	44, 180, 397	0	7, 099, 940	0	21, 414	50.00
	05100 RECOVERY ROOM	7, 332, 460	0	1, 379, 841	0	7, 035	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 562, 087	0	1, 374, 560	0	8, 053	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	7, 106, 556 20, 310, 332	0	717, 254 3, 482, 974	0	320 7, 334	
	05500 RADI OLOGY - THERAPEUTI C	7, 305, 103	0	642, 582	0	4, 196	
56.00	05600 RADI OI SOTOPE	5, 342, 360	0	875, 262	0	1, 542	56.0
57.00	05700 CT SCAN	32,069,749	0	1, 299, 839	0	1, 213	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	10, 340, 637 20, 059, 193	0	572, 491 2, 023, 735	0	1, 879 6, 180	
50.00	06000 LABORATORY	64, 901, 472	0	7, 061, 338	0	9, 883	
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.0
	06300 BLOOD STORING, PROCESSING, & TRANS.	2, 626, 612	0	793, 636	0	736	
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	4, 423, 458 5, 778, 074	0	846, 355 1, 844, 066		6, 320 1, 716	
	06600 PHYSI CAL THERAPY	9, 182, 494	0	2, 690, 261	0	9, 813	
57.00	06700 OCCUPATI ONAL THERAPY	5, 379, 111	0	1, 463, 120	0	2, 703	
	06800 SPEECH PATHOLOGY	1, 518, 537	0	469, 509	0	565	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	15, 349, 384 7, 257, 957	0	1, 156, 743 681, 638	0	2, 115 3, 011	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 345, 168	0	3, 004, 144	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 251, 229	o	2, 807, 945	-	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	71, 031, 999	О	10, 306, 938		3, 987	
	07400 RENAL DI ALYSI S 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 489, 699	0	688, 986		842	
	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 07697 CARDIAC REHABILITATION	323, 413 701, 176	0	157, 989 536, 474	0	2, 245 5, 550	•
0. 77	OUTPATIENT SERVICE COST CENTERS	701, 170	0	550, 474	0	5, 550	1 /0. /
	09000 CLI NI C	4, 111, 479	0	1, 496, 443		2, 047	90.0
	09100 EMERGENCY	68, 383, 817	0	5, 788, 769	0	9, 854	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.0
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 0
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	546, 892, 764	-20, 492, 719	109, 238, 624	0	248, 308	118. 0
	NONREI MBURSABLE COST CENTERS			(500		4 447	100.0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0	6, 588 40, 350		1, 117	190. 0 191. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	194, 412		30, 876	
	07950 OTHER NONREI MBURSEABLE	0	0	220, 992		16, 546	
194.01	07951 ADVERTI SI NG	О	0	216, 217	0	1, 265	194. 0 [.]
10/ 02	07952 RETAIL PHARMACY	0	0	7, 520, 199	0	1, 071	194.0
200.00	Cross Foot Adjustments		1				200.0

Heal th F	inancial Systems	ST. CATHERI NE	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALL	LOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					rom 07/01/2021 o 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Cost Center Description	CASHI ERI NG/ACC			MAINTENANCE &		
		OUNTS		ADMI NI STRATI VE	E 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, 639, 633		20, 492, 719	0	9, 143, 165	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 002998		0. 174499	0. 000000	30. 560443	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	4, 052		385, 048	0	787, 667	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 000007		0.003279	0. 000000	2. 632726	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 CO	CN: 15-0008 Pe	In Lie	u of Form CMS-2 Worksheet B-1	552-10
				rom 07/01/2021 06/30/2022	Date/Time Prep	
	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPI NG (HOUSEKEEP HOURS)	DI ETARY (MEALS SERVED)	CAFETERI A (FTES)	11/22/2022 9: 2 WAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	<u>4 am</u>
GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	12.00	
I. 00 O0100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00560 PURCHASI NG RECEI VI NG AND STORES 5. 02 00570 ADMI TTI NG Stores	33, 549 0 0 0 0 0 0 0 0 0 0 0 0 0 0	294, 422 10, 280 3, 360 0 1, 180 0 1, 800		595 0 26 0 0 0 0	0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ \end{array}$
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
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	26, 368 2, 160 0 4, 234 787	71, 264 13, 804 0 15, 180 560	2, 829 0	208 24 0 22 5	0 0 0	30.00 31.00 40.00 41.00 43.00
ANCI LLARY SERVICE COST CENTERS	0	36, 420	0	32	0	50,00
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY - DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 64.00 06400 I NTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 70.00 07000 </td <td></td> <td>36, 420 1, 400 12, 740 0 12, 900 4, 020 800 0 560 7, 900 8, 890 0 0 1, 720 11, 530 0 700 1, 700 11, 000 0 990 3000 1, 440 900</td> <td>84 3, 283 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>32 11 11 7 28 2 3 6 3 7 44 0 2 2 8 10 20 11 3 8 6 0 20 11 3 8 6 0 0 20 11 3 5</td> <td></td> <td>50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 55. 00 57. 00 58. 00 59. 00 60. 00 62. 00 63. 00 64. 00 65. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00</td>		36, 420 1, 400 12, 740 0 12, 900 4, 020 800 0 560 7, 900 8, 890 0 0 1, 720 11, 530 0 700 1, 700 11, 000 0 990 3000 1, 440 900	84 3, 283 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32 11 11 7 28 2 3 6 3 7 44 0 2 2 8 10 20 11 3 8 6 0 20 11 3 8 6 0 0 20 11 3 5		50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 55. 00 57. 00 58. 00 59. 00 60. 00 62. 00 63. 00 64. 00 65. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST	0	1, 300 40, 896		13 43		90. 00 91. 00 92. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 1	101.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	33, 549	263, 834	118, 451	589	0 1	18.00
NONREI MBURSABLE COST CENTERS190.0019000GIFT, FLOWER, COFFEE SHOP & CANTEEN191.0019100RESEARCH192.0019200PHYSI CI ANS' PRI VATE OFFI CES194.0007950OTHER NONREI MBURSEABLE194.0107951ADVERTI SI NG194.0207952RETAI L PHARMACY200.00Cross Foot Adj ustments201.00Negati ve Cost Centers	0 0 0 0 0	1, 260 0 620 27, 928 300 480	0 0 11, 270 0	0 0 0 0 6	0 1 0 1 0 1 0 1 0 1 2	190.00 191.00 192.00 194.00 194.01 194.02 200.00 201.00

Heal th 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 07/01/2021	Worksheet B-1	
					To 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	
		LINEN SERVICE	•	(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)	766, 877	3, 935, 732	3, 418, 01	9 792, 592	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	22. 858416	13. 367656	26. 34900	3 1, 332. 087395	0. 000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	15, 989	102, 643	156, 21	5 66, 027	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 476586	0. 348625	1. 20423	8 110. 969748	0.00000	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	CN: 15-0008	Pe	In Lie riod:	u of Form CMS-2 Worksheet B-1	2552-10
						om 07/01/2021	Date/Time Pre	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		MEDI CAL	11/22/2022 9: SOCI AL SERVI CE	24 am
	·	ADMI NI STRATI ON (DI RECT	SERVICES & SUPPLY (COSTED	(COSTED REQUIS.)		RECORDS & LI BRARY (GROSS REVE	(TIME SPENT)	
		NURSING HRS) 13.00	REQUIS.) 14.00	15.00		NUE) 16.00	17.00	
GE	NERAL SERVICE COST CENTERS	13.00	14.00	13.00		10.00	17:00	
	100 CAP REL COSTS-BLDG & FIXT							1.00
	200 CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT							2.00 4.00
	560 PURCHASING RECEIVING AND STORES							5.01
	570 ADMI TTI NG							5.02
	580 CASHI ERI NG/ACCOUNTS RECEI VABLE							5.03
	590 OTHER ADMINISTRATIVE & GENERAL 600 MAINTENANCE & REPAIRS							5.04 6.00
	700 OPERATION OF PLANT							7.00
	800 LAUNDRY & LINEN SERVICE							8.00
	900 HOUSEKEEPI NG							9.00
	000 DI ETARY 100 CAFETERI A							10.00 11.00
	200 MAINTENANCE OF PERSONNEL							12.00
	300 NURSI NG ADMI NI STRATI ON	791, 646						13.00
	400 CENTRAL SERVICES & SUPPLY	0	0					14.00
	500 PHARMACY	0	0		0			15.00
	600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVI CE	0	0		0	546, 892, 764 0	0	16.00 17.00
	900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	0	19.00
IN	PATIENT ROUTINE SERVICE COST CENTERS	1						
	000 ADULTS & PEDIATRICS	433, 346	0		0	93, 274, 878	0	30.00
	100 I NTENSI VE CARE UNI T 000 SUBPROVI DER – I PF	50, 156 0	0		0	6, 635, 753 0	0	31.00 40.00
	100 SUBPROVIDER – IRF	44, 965	0		0	6, 621, 150	0	41.00
43.00 04	300 NURSERY	10, 639	0		0	1, 697, 030	0	43.00
	CILLARY SERVICE COST CENTERS	((104	0			44 100 207	0	F0 00
	000 OPERATING ROOM 100 RECOVERY ROOM	66, 134 22, 811	0 0		0	44, 180, 397 7, 332, 460	0	50.00 51.00
	200 DELIVERY ROOM & LABOR ROOM	22, 354	0		0	3, 562, 087	0	52.00
	300 ANESTHESI OLOGY	0	0		0	7, 106, 556	0	53.00
	400 RADI OLOGY - DI AGNOSTI C	0	0		0	20, 310, 332	0	54.00
	500 RADI OLOGY – THERAPEUTI C 600 RADI OI SOTOPE	0	0		0	7, 305, 103 5, 342, 360	0	55.00 56.00
	700 CT SCAN	0	0		0	32, 069, 749	0	57.00
	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	10, 340, 637	0	58.00
	900 CARDI AC CATHETERI ZATI ON	14, 232	0		0	20, 059, 193	0	59.00
	000 LABORATORY 200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	64, 901, 472 0	0	60.00 62.00
	300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	2, 626, 612	0	63.00
	400 INTRAVENOUS THERAPY	0	0		0	4, 423, 458	0	64.00
	500 RESPI RATORY THERAPY	0	0		0	5, 778, 074	0	65.00
	600 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY	0	0		0	9, 182, 494 5, 379, 111	0	66.00 67.00
	800 SPEECH PATHOLOGY	0	0		0	1, 518, 537	0	68.00
	900 ELECTROCARDI OLOGY	0	0		0	15, 349, 384	0	69.00
		0	0		0	7, 257, 957	0	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT 200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	10, 345, 168 6, 251, 229	0	71.00 72.00
	300 DRUGS CHARGED TO PATIENTS	0	0		0	71, 031, 999	0	73.00
	400 RENAL DI ALYSI S	0	0		0	3, 489, 699	0	74.00
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	323, 413		76.00
	697 CARDI AC REHABI LI TATI ON TPATI ENT SERVI CE COST CENTERS	10, 320	0		0	701, 176	0	76.97
		27, 825	0		0	4, 111, 479	0	90.00
	100 EMERGENCY	88, 864	0		0	68, 383, 817	0	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART							92.00
	HER REIMBURSABLE COST CENTERS 100 HOME HEALTH AGENCY	0	0		0	0	0	101.00
	ECIAL PURPOSE COST CENTERS	<u> </u>	0	1	<u> </u>	0	0	101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	791, 646	0		0	546, 892, 764	0	118.00
	NREI MBURSABLE COST CENTERS				~		-	100.00
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 100 RESEARCH	0	0		0	0		190. 00 191. 00
	200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0		191.00
194.0007	950 OTHER NONREI MBURSEABLE	0	0		0	0	0	194.00
	951 ADVERTI SI NG	0	0		0	0		194.01
194.0207 200.00	952 RETAIL PHARMACY Cross Foot Adjustments	0	0		0	0	0	194. 02 200. 00
200.00	Negative Cost Centers							200.00
	, •				1			

Heal th I	-inancial Systems	ST. CATHERINE	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 07/01/2021 Fo 06/30/2022	Date/Time Pre 11/22/2022 9:	
	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, 684, 976	0	(1, 609, 849	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3. 391637	0. 000000	0.00000	0. 002944	0.00000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	89, 133	0	(26, 202	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 112592	0. 000000	0.00000	0. 000048	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

	Financial Systems ALLOCATION - STATISTICAL BASIS	ST. CATHERINE	Provi der CCN: 15-0008	Peri od:	u of Form CMS-2552- Worksheet B-1
				From 07/01/2021 To 06/30/2022	Date/Time Prepared
	Cost Center Description	NONPHYSICIAN			11/22/2022 9:24 an
		ANESTHETI STS (ASSI GNED			
		TI ME)			
		19.00			
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT				1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.0
5.01 5.02	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING				5.0
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE				5.0
5.04	00590 OTHER ADMINI STRATI VE & GENERAL				5.0
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT				6. 0
8.00	00800 LAUNDRY & LINEN SERVICE				8.0
9.00	00900 HOUSEKEEPI NG				9.1
10.00 11.00	01000 DI ETARY 01100 CAFETERI A				10.0
	01200 MAINTENANCE OF PERSONNEL				12.
	01300 NURSING ADMINISTRATION				13.
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY				14.0
	01600 MEDICAL RECORDS & LIBRARY				16.0
	01700 SOCIAL SERVICE				17.0
19.00	01900 NONPHYSI CI AN ANESTHETI STS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0			19. (
30.00	03000 ADULTS & PEDIATRICS	0			30. (
	03100 I NTENSI VE CARE UNI T	0			31.
40.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	0			40.0
	04100 SUBPROVIDER - TRF	0			41.
	ANCILLARY SERVICE COST CENTERS				
50.00 51.00	05000 OPERATING ROOM	0			50.0
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0			51.0
53.00	05300 ANESTHESI OLOGY	0			53.
54.00	05400 RADI OLOGY - DI AGNOSTI C	0			54.0
55.00 56.00	05500 RADI OLOGY - THERAPEUTI C 05600 RADI OI SOTOPE	0			55.0
57.00	05700 CT SCAN	0			57.
58.00 59.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			58.0
60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0			60.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			62.
	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	0			63.
	06500 RESPIRATORY THERAPY	0			64.0
	06600 PHYSI CAL THERAPY	0			66.
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0			67.0
	06900 ELECTROCARDI OLOGY	0			69.
70.00	07000 ELECTROENCEPHALOGRAPHY	0			70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0			72.
74.00	07400 RENAL DI ALYSI S	0			74.
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			76.0
/0.9/	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0			/0.
90.00	09000 CLINIC	0			90. (
	09100 EMERGENCY	0			91.0
72. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				92.
101.00	10100 HOME HEALTH AGENCY	0			101. (
110 00	SPECIAL PURPOSE COST CENTERS				110
118.00	SUBTOTALS SUB OF LINES 1 through 117 NONREI MBURSABLE COST CENTERS	0			118. (
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. (
	19100 RESEARCH	0			191.
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSEABLE	0			192. (194. (
	07951 ADVERTI SI NG	0			194.
194.02	07952 RETAIL PHARMACY	0			194. 200.
200.00	Cross Foot Adjustments				

Health Fi	nancial Systems	ST. CATHERI NE	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLC	OCATION - STATISTICAL BASIS		Provider CCN: 15-0008	Period: From 07/01/2021	Worksheet B-1
				To 06/30/2022	Date/Time Prepared: 11/22/2022 9:24 am
	Cost Center Description	NONPHYSI CI AN			
		ANESTHETI STS			
		(ASSI GNED			
		TIME)			
	1	19.00			
202.00	Cost to be allocated (per Wkst. B, Part I)	0			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

	al Systems F RATIO OF COSTS TO CHARGES	ST. CATHERIN	Provider C	CN: 15-0008	Peri od:	u of Form CMS Worksheet C	2002 1
	I NATE OF COSTS TO CHARGES			on. 13-0000	From 07/01/2021 To 06/30/2022	Part I Date/Time Pre 11/22/2022 9:	
			Title	e XVIII	Hospi tal	PPS	
					Costs	·	
C	ost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INT ROUTINE SERVICE COST CENTERS						
	DULTS & PEDIATRICS	35, 115, 350		35, 115, 35		35, 115, 350	
	NTENSIVE CARE UNIT	5, 436, 718		5, 436, 71		5, 436, 718	
	UBPROVIDER – IPF	0			0 0	0	
	UBPROVIDER – IRF	4, 335, 684		4, 335, 68		4, 335, 684	
13.00 04300 N		834, 315		834, 31	15 0	834, 315	43.00
	RY SERVICE COST CENTERS			1			
	PERATING ROOM	9, 877, 140		9, 877, 14		9, 877, 140	
	ECOVERY ROOM	1, 970, 150		1, 970, 15		1, 970, 150	
	ELIVERY ROOM & LABOR ROOM	2, 218, 287		2, 218, 28		2, 218, 287	
	NESTHESI OLOGY	882, 440		882, 44		882, 440	
	ADI OLOGY-DI AGNOSTI C	4, 584, 414		4, 584, 41		4, 584, 414	
	ADIOLOGY - THERAPEUTIC	960, 852		960, 85		960, 852	
	ADI OI SOTOPE	1, 105, 536		1, 105, 53		1, 105, 536	
57.00 05700 C		1, 666, 136		1, 666, 13		1, 666, 136	
	AGNETIC RESONANCE IMAGING (MRI)	771, 738		771, 73		771, 738	
	ARDI AC CATHETERI ZATI ON	2, 787, 992		2, 787, 99		2, 787, 992	
	ABORATORY	8, 964, 083		8, 964, 08		8, 964, 083	
	HOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	0	
	LOOD STORING, PROCESSING, & TRANS.	965, 014		965, 01		965, 014	
	NTRAVENOUS THERAPY	1, 210, 865		1, 210, 86		1, 210, 865	
	ESPI RATORY THERAPY	2, 271, 620	0	_,,		2, 271, 620	
	HYSI CAL THERAPY	3, 667, 403		-,,		3, 667, 403	
	CCUPATIONAL THERAPY	1, 831, 527	0	.,		1, 831, 527	
	PEECH PATHOLOGY	577, 172	0	577, 17		577, 172	
	LECTROCARDI OLOGY	1, 488, 431		1, 488, 43		1, 488, 431	
	LECTROENCEPHALOGRAPHY	935, 328		935, 32		935, 328	
	EDICAL SUPPLIES CHARGED TO PATIENT	3, 558, 820		3, 558, 82		3, 558, 820	
	MPL. DEV. CHARGED TO PATIENTS	3, 316, 333		3, 316, 33		3, 316, 333	
	RUGS CHARGED TO PATIENTS	12, 476, 326		12, 476, 32		12, 476, 326	
	ENAL DIALYSIS	849, 229		849, 22		849, 229	
	SYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	275, 699		275, 69		275, 699	
	ARDIAC REHABILITATION	855, 455		855, 45	55 0	855, 455	76. 9
	ENT SERVICE COST CENTERS						
90.00 09000 C		1, 961, 299		1, 961, 29		1, 961, 299	
	MERGENCY	8, 280, 714		8, 280, 7		8, 280, 714	
	BSERVATION BEDS (NON-DISTINCT PART	5, 110, 444		5, 110, 44	44	5, 110, 444	92.00
	EIMBURSABLE COST CENTERS	-		1			
	OME HEALTH AGENCY	0			0		101.0
	ubtotal (see instructions)	131, 142, 514				131, 142, 514	
	ess Observation Beds	5, 110, 444		5, 110, 44		5, 110, 444	
202.00 T	otal (see instructions)	126, 032, 070	0	126, 032, 07	70 0	126, 032, 070	202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2021	Worksheet C Part I	
				To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared
		Title	XVIII	Hospi tal	PPS	21 011
		Charges		_		
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	-
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	-
D. 00 03000 ADULTS & PEDI ATRI CS	79, 484, 310		79, 484, 31	0		30.0
1.00 03100 INTENSIVE CARE UNIT	6, 635, 753		6, 635, 75			31.0
D. 00 04000 SUBPROVIDER - IPF	0			0		40.0
1. 00 04100 SUBPROVIDER - IRF	6, 621, 150		6, 621, 15	0		41.0
3. 00 04300 NURSERY	1,697,030		1, 697, 03	0		43.0
ANCI LLARY SERVI CE COST CENTERS						
D. 00 05000 OPERATI NG ROOM	12, 693, 189	31, 487, 208	44, 180, 39	0. 223564	0.000000	50.
1.00 05100 RECOVERY ROOM	972, 966	6, 359, 494	7, 332, 46	0. 268689	0.000000	51.
2.00 05200 DELIVERY ROOM & LABOR ROOM	2, 762, 570	799, 517	3, 562, 08	0. 622749	0.000000	52.
3. 00 05300 ANESTHESI OLOGY	1, 741, 303	5, 365, 253	7, 106, 55	0. 124173	0.00000	53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2,909,309	17, 401, 023	20, 310, 33	0. 225718	0.00000	54.
5. 00 05500 RADI OLOGY - THERAPEUTI C	8, 540	7, 296, 563	7, 305, 10	0. 131532	0. 000000	55.
5. 00 05600 RADI OI SOTOPE	1, 103, 062	4, 239, 298			0. 000000	
7.00 05700 CT SCAN	7, 024, 826	25,044,923			0.00000	
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 723, 839	8, 616, 798			0.00000	
9. 00 05900 CARDI AC CATHETERI ZATI ON	9, 374, 758	10, 684, 435			0.00000	
D. 00 06000 LABORATORY	20, 899, 865	44, 001, 607	64, 901, 47		0.000000	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0.000000	0.00000	
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	1, 586, 901	1,039,711	2, 626, 61		0.00000	
4. 00 06400 I NTRAVENOUS THERAPY	12,607	4, 410, 851	4, 423, 45		0.000000	
	5,068,551	709, 523			0.000000	
5. 00 06600 PHYSI CAL THERAPY	3, 599, 073	5, 583, 421	9, 182, 49		0.000000	
7. 00 06700 OCCUPATI ONAL THERAPY 3. 00 06800 SPEECH PATHOLOGY	3, 816, 312 756, 397	1, 562, 799			0. 000000 0. 000000	
2. 00 06900 ELECTROCARDI OLOGY	4, 710, 604	762, 140 10, 638, 780			0.000000	
D. 00 07000 ELECTROENCEPHALOGRAPHY	256, 899	7, 001, 058			0.000000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 802, 882	4, 542, 286			0. 000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 205, 572	4, 045, 657			0.000000	
3. 00 07300 DRUGS CHARGED TO PATIENTS	25, 357, 501	45, 674, 498			0.000000	
4. 00 07400 RENAL DIALYSIS	2, 948, 344	541, 355			0.000000	
5. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 116	320, 297			0.000000	
5. 97 07697 CARDI AC REHABI LI TATI ON	81, 720	619, 456			0.000000	
OUTPATIENT SERVICE COST CENTERS	01,720	01.7, 100	, , , , , , , , , , , , , , , , , , , ,		21 000 000	1
D. 00 09000 CLINIC	702, 554	3, 408, 925	4, 111, 47	0. 477030	0.00000	90.
1. 00 09100 EMERGENCY	15, 774, 049	52, 609, 768			0.000000	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 111, 918	11, 678, 650	13, 790, 56	0. 370575	0. 000000	92.
OTHER REIMBURSABLE COST CENTERS	_					
D1.00 10100 HOME HEALTH AGENCY	0	0		0		101.
00.00 Subtotal (see instructions)	230, 447, 470	316, 445, 294	546, 892, 76	4		200.
D1.00 Less Observation Beds						201.
D2.00 Total (see instructions)	230, 447, 470	316, 445, 294	546, 892, 76	4		202.

A	inancial Systems	ST. CATHERINE			u of Form CMS-255
OMPUTAT	ION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0008	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepar 11/22/2022 9:24
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient Ratio			
		11.00			
	NPATIENT ROUTINE SERVICE COST CENTERS				
	3000 ADULTS & PEDIATRICS				30
	3100 I NTENSI VE CARE UNI T				3
	4000 SUBPROVI DER – I PF				40
	4100 SUBPROVI DER – I RF				4
	4300 NURSERY				43
	VCILLARY SERVICE COST CENTERS				
	5000 OPERATING ROOM	0. 223564			50
	5100 RECOVERY ROOM	0. 268689			5
	5200 DELIVERY ROOM & LABOR ROOM	0. 622749			52
	5300 ANESTHESI OLOGY	0. 124173			5
4.00 05	5400 RADI OLOGY-DI AGNOSTI C	0. 225718			5
5.00 05	5500 RADI OLOGY – THERAPEUTI C	0. 131532			5
5.00 05	5600 RADI OI SOTOPE	0. 206938			5
7.00 05	5700 CT SCAN	0. 051954			5
3.00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 074632			5
0. 00 05	5900 CARDI AC CATHETERI ZATI ON	0. 138988			59
0. 00 00	6000 LABORATORY	0. 138118			6
2.00 00	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			6
3.00 00	6300 BLOOD STORING, PROCESSING, & TRANS.	0. 367399			6
4.00 00	6400 INTRAVENOUS THERAPY	0. 273737			6
5.00 00	6500 RESPI RATORY THERAPY	0. 393145			6
	6600 PHYSI CAL THERAPY	0. 399391			6
	6700 OCCUPATIONAL THERAPY	0. 340489			6
	6800 SPEECH PATHOLOGY	0. 380084			6
	6900 ELECTROCARDI OLOGY	0. 096970			6
	7000 ELECTROENCEPHALOGRAPHY	0. 128869			70
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 344008			7
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 530509			7:
	7300 DRUGS CHARGED TO PATIENTS	0. 175644			7
	7400 RENAL DI ALYSI S	0. 243353			7
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 852467			7
	7697 CARDI AC REHABI LI TATI ON	1. 220029			7
_	JTPATIENT SERVICE COST CENTERS				
	9000 CLINIC	0. 477030			90
	9100 EMERGENCY	0. 121092			9
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 370575			9:
	THER REIMBURSABLE COST CENTERS	0.070070			//
	D100 HOME HEALTH AGENCY				10
	Subtotal (see instructions)				200
00.00 01.00	Less Observation Beds				20

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0008	Period:	Worksheet C	
				From 07/01/2021	Part I	
				To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 24 am
		Ti tl	e XIX	Hospi tal	PPS	24 011
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26) 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	35, 115, 350		35, 115, 3	50 0	35, 115, 350	30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 436, 718		5, 436, 7		5, 436, 718	
40. 00 04000 SUBPROVI DER - I PF	0			0 0	0	1
41.00 04100 SUBPROVIDER - IRF	4, 335, 684		4, 335, 68	34 0	4, 335, 684	41.00
43. 00 04300 NURSERY	834, 315		834, 31	15 0	834, 315	43.00
ANCI LLARY SERVICE COST CENTERS			-			
50.00 05000 OPERATI NG ROOM	9, 877, 140		9, 877, 14		9, 877, 140	
51.00 05100 RECOVERY ROOM	1, 970, 150		1, 970, 1		1, 970, 150	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 218, 287		2, 218, 28		2, 218, 287	
53. 00 05300 ANESTHESI OLOGY	882, 440		882, 44		882, 440	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	4, 584, 414		4, 584, 4		4, 584, 414	
55. 00 05500 RADI OLOGY - THERAPEUTI C	960, 852		960, 85		960, 852	
56. 00 05600 RADI 0I SOTOPE	1, 105, 536		1, 105, 53		1, 105, 536	
57.00 05700 CT_SCAN 58.00 05800 MAGNETI C_RESONANCE_I MAGI NG_(MRI)	1, 666, 136 771, 738		1, 666, 13 771, 73		1, 666, 136 771, 738	
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 787, 992		2, 787, 9		2, 787, 992	
60. 00 06000 LABORATORY	8, 964, 083		8, 964, 08		8, 964, 083	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0, 701, 000		0, 701, 00	0 0	0, 701, 000	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	965, 014		965, 0 ⁻	14 0	965, 014	
64.00 06400 INTRAVENOUS THERAPY	1, 210, 865		1, 210, 80		1, 210, 865	
65. 00 06500 RESPI RATORY THERAPY	2, 271, 620	C	2, 271, 62	20 0	2, 271, 620	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 667, 403	C	3, 667, 40	03 0	3, 667, 403	66.00
67.00 06700 OCCUPATIONAL THERAPY	1, 831, 527	C	1, 831, 52	27 0	1, 831, 527	67.00
68.00 06800 SPEECH PATHOLOGY	577, 172	C	577, 1	72 0	577, 172	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 488, 431		1, 488, 43		1, 488, 431	
70. 00 07000 ELECTROENCEPHALOGRAPHY	935, 328		935, 32		935, 328	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	3, 558, 820		3, 558, 82		3, 558, 820	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	3, 316, 333		3, 316, 33		3, 316, 333	
73. 00 07300 DRUGS CHARGED TO PATIENTS	12, 476, 326		12, 476, 32		12, 476, 326	
74.00 07400 RENAL DIALYSIS	849, 229		849, 22		849, 229	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 97 07697 CARDI AC REHABI LI TATI ON	275, 699		275, 69		275, 699	
OUTPATIENT SERVICE COST CENTERS	855, 455	<u> </u>	855, 45		855, 455	/0.9/
90. 00 09000 CLINIC	1, 961, 299		1, 961, 20	79 0	1, 961, 299	90.00
91. 00 09100 EMERGENCY	8, 280, 714		8, 280, 7		8, 280, 714	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 110, 444		5, 110, 44		5, 110, 444	
OTHER REIMBURSABLE COST CENTERS						1
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
200.00 Subtotal (see instructions)	131, 142, 514	C	131, 142, 5 [.]	14 0	131, 142, 514	200.00
201.00 Less Observation Beds	5, 110, 444		5, 110, 44		5, 110, 444	
202.00 Total (see instructions)	126, 032, 070	C	126, 032, 0	70 0	126, 032, 070	202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0008	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre	narod
				10 00/30/2022	11/22/2022 9:	
			e XIX	Hospi tal	PPS	
		Charges			TEEDA	
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other Ratio	TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6.00	7.00	8.00	9,00	10.00	+
INPATIENT ROUTINE SERVICE COST CENTERS	0.00		0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100	-
0. 00 03000 ADULTS & PEDIATRICS	79, 484, 310		79, 484, 3	10		30. 0
1.00 03100 INTENSIVE CARE UNIT	6, 635, 753		6, 635, 7	53		31.0
0. 00 04000 SUBPROVIDER - IPF	0			0		40.0
1.00 04100 SUBPROVIDER - IRF	6, 621, 150		6, 621, 15	50		41.0
3. 00 04300 NURSERY	1, 697, 030		1, 697, 03	30		43. C
ANCI LLARY SERVI CE COST CENTERS				-		
0.00 05000 OPERATING ROOM	12, 693, 189	31, 487, 208			0. 000000	
1.00 05100 RECOVERY ROOM	972, 966	6, 359, 494			0. 000000	
2.00 05200 DELIVERY ROOM & LABOR ROOM	2, 762, 570	799, 517			0.00000	
3. 00 05300 ANESTHESI OLOGY	1, 741, 303	5, 365, 253			0.00000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 909, 309	17, 401, 023			0.00000	
5. 00 05500 RADI OLOGY - THERAPEUTI C	8, 540	7, 296, 563			0.00000	
6. 00 05600 RADI OI SOTOPE	1, 103, 062	4, 239, 298			0.00000	
7. 00 05700 CT SCAN	7,024,826	25, 044, 923			0.00000	
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 723, 839	8, 616, 798			0. 000000	
9. 00 05900 CARDI AC CATHETERI ZATI ON 0. 00 06000 LABORATORY	9, 374, 758	10, 684, 435			0.00000	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	20, 899, 865	44, 001, 607 0		72 0. 138118 0 0. 000000	0. 000000 0. 000000	
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	1, 586, 901	1, 039, 711			0. 000000	
4. 00 06400 I NTRAVENOUS THERAPY	1, 580, 901	4, 410, 851			0. 000000	
5. 00 06500 RESPIRATORY THERAPY	5, 068, 551	709, 523			0. 000000	
6. 00 06600 PHYSI CAL THERAPY	3, 599, 073	5, 583, 421			0. 000000	
7. 00 06700 OCCUPATI ONAL THERAPY	3, 816, 312	1, 562, 799			0. 000000	
8. 00 06800 SPEECH PATHOLOGY	756, 397	762, 140			0. 000000	
9. 00 06900 ELECTROCARDI OLOGY	4, 710, 604	10, 638, 780			0. 000000	
0.00 07000 ELECTROENCEPHALOGRAPHY	256, 899	7,001,058			0.00000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 802, 882	4, 542, 286			0. 000000	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 205, 572	4,045,657			0.00000	
3.00 07300 DRUGS CHARGED TO PATIENTS	25, 357, 501	45, 674, 498	71, 031, 99	0. 175644	0. 000000	73.
4.00 07400 RENAL DIALYSIS	2, 948, 344	541, 355	3, 489, 69	0. 243353	0. 000000	74.
6. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 116	320, 297	323, 4	0. 852467	0. 000000	76.
6. 97 07697 CARDI AC REHABILI TATI ON	81, 720	619, 456	701, 1	1. 220029	0. 000000	76.
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	702, 554	3, 408, 925			0. 000000	
1.00 09100 EMERGENCY	15, 774, 049	52, 609, 768			0.00000	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 111, 918	11, 678, 650	13, 790, 50	0. 370575	0.00000	92.
OTHER REIMBURSABLE COST CENTERS	-r		1	- T		
01.00 10100 HOME HEALTH AGENCY	0	0		0		101.
00.00 Subtotal (see instructions)	230, 447, 470	316, 445, 294	546, 892, 76	54		200.
01.00 Less Observation Beds		04/ 115 55	F 4 4 999 -			201.
02.00 Total (see instructions)	230, 447, 470	316, 445, 294	546, 892, 76	04		202.

alth Financial Systems DMPUTATION OF RATIO OF COSTS TO CHARGES	ST. CATHERINE			u of Form CMS-2552
MPUTATION OF RATIO OF COSIS TO CHARGES		Provider CCN: 15-0008	Peri od: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepar 11/22/2022 9:24
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
D. 00 03000 ADULTS & PEDIATRICS				30
1.00 03100 INTENSIVE CARE UNIT				31
D. 00 04000 SUBPROVIDER - IPF				40
1.00 04100 SUBPROVIDER – IRF				41
3. 00 04300 NURSERY				43
ANCI LLARY SERVI CE COST CENTERS				
D. 00 05000 OPERATI NG ROOM	0. 223564			50
1.00 05100 RECOVERY ROOM	0. 268689			51
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 622749			52
3. 00 05300 ANESTHESI OLOGY	0. 124173			53
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 225718			54
5. 00 05500 RADIOLOGY - THERAPEUTIC	0. 131532			55
5. 00 05600 RADI OI SOTOPE	0. 206938			56
2.00 05700 CT SCAN	0.051954			57
8. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.074632			58
0. 00 05900 CARDI AC CATHETERI ZATI ON	0. 138988			59
0. 00 06000 LABORATORY	0. 138118			60
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 367399			63
4. 00 06400 I NTRAVENOUS THERAPY	0. 273737			64
5. 00 06500 RESPIRATORY THERAPY	0. 393145			65
5. 00 06600 PHYSI CAL THERAPY	0. 399391			66
7. 00 06700 OCCUPATI ONAL THERAPY	0. 340489			67
3. 00 06800 SPEECH PATHOLOGY	0. 380084			68
2. 00 06900 SPEECH PATHOLOGY 2. 00 06900 ELECTROCARDI OLOGY	0. 096970			69
0. 00 07000 ELECTROENCEPHALOGRAPHY	0. 128869			70
I. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.344008			71
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 530509			72
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 175644			73
4. 00 07400 RENAL DI ALYSI S	0. 243353			74
6. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.852467			76
5. 97 07697 CARDI AC REHABI LI TATI ON	1. 220029			76
OUTPATIENT SERVICE COST CENTERS				
0. 00 09000 CLINIC	0. 477030			90
1.00 09100 EMERGENCY	0. 121092			91
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 370575			92
OTHER REIMBURSABLE COST CENTERS				
D1.00 10100 HOME HEALTH AGENCY				101
00.00 Subtotal (see instructions)				200
01.00 Less Observation Beds				201
02.00 Total (see instructions)				202

leal th Fi	inancial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-1
	ION OF OUTPATIENT SERVICE COST TO CHARGE R. NS FOR MEDICAID ONLY	ATIOS NET OF	Provider CC	CN: 15-0008	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part II Date/Time Pre 11/22/2022 9:	pared: 24 am
			Ti tl	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	
	VCILLARY SERVICE COST CENTERS						
50.00 05	5000 OPERATI NG ROOM	9, 877, 140	1, 218, 312	8, 658, 82	28 0	0	50.0
51.00 05	5100 RECOVERY ROOM	1, 970, 150	75, 406	1, 894, 74	44 0	0	51.0
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	2, 218, 287	127, 160	2, 091, 12	27 0	0	52.0
53.00 05	5300 ANESTHESI OLOGY	882, 440	87, 592	794, 84	48 0	0	53.0
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	4, 584, 414	262, 362	4, 322, 05	52 0	0	54.0
55.00 05	5500 RADI OLOGY - THERAPEUTI C	960, 852	48, 219	912, 63	33 0	0	55. C
56.00 05	5600 RADI OI SOTOPE	1, 105, 536	119, 102	986, 43	34 0	0	56. C
	5700 CT SCAN	1, 666, 136	55, 201	1, 610, 93		0	57. C
	5800 MAGNETIC RESONANCE IMAGING (MRI)	771, 738	21, 227			0	58.0
	5900 CARDI AC CATHETERI ZATI ON	2, 787, 992	640, 944			0	59.0
	5000 LABORATORY	8, 964, 083	256, 123			0	60.0
	5200 WHOLE BLOOD & PACKED RED BLOOD CELL	0, 904, 005	230, 123		0 0	0	62.0
	5300 BLOOD STORING, PROCESSING, & TRANS.	965,014	17, 372			0	63.0
	6400 I NTRAVENOUS THERAPY	1, 210, 865	67, 420			0	64.0
	5500 RESPIRATORY THERAPY	2, 271, 620	109, 483			0	65.0
					-	0	66.0
	6600 PHYSI CAL THERAPY 5700 OCCUPATI ONAL THERAPY	3, 667, 403	142, 559			-	
		1, 831, 527	41, 422			0	67.0
	5800 SPEECH PATHOLOGY	577, 172	12, 898		-	0	68.0
	5900 ELECTROCARDI OLOGY	1, 488, 431	193, 979			0	69.0
	7000 ELECTROENCEPHALOGRAPHY	935, 328	51, 535			0	70.0
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 558, 820	10, 813			0	71. (
	7200 IMPL. DEV. CHARGED TO PATIENTS	3, 316, 333	9, 789			0	72. (
	7300 DRUGS CHARGED TO PATIENTS	12, 476, 326	166, 372			0	73. (
	7400 RENAL DIALYSIS	849, 229	9, 934	839, 29		0	74.0
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	275, 699	20, 339	255, 36		0	76.
	7697 CARDI AC REHABI LI TATI ON	855, 455	64, 291	791, 16	64 0	0	76. 9
	JTPATIENT SERVICE COST CENTERS						
0.00 09	9000 CLINIC	1, 961, 299	36, 692	1, 924, 60	0 07	0	90.0
	9100 EMERGENCY	8, 280, 714	206, 606	8, 074, 10	0 80	0	91. (
2.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART	5, 110, 444	159, 589	4, 950, 85	55 0	0	92. (
ТО	THER REIMBURSABLE COST CENTERS			-			
01.0010	D100 HOME HEALTH AGENCY	0	0		0 0	0	101. (
00.00	Subtotal (sum of lines 50 thru 199)	85, 420, 447	4, 232, 741	81, 187, 70	0 0	0	200. 0
201.00	Less Observation Beds	5, 110, 444	159, 589			0	201.0
202.00	Total (line 200 minus line 201)	80, 310, 003					202.0

ealth Financial Systems	ST. CATHERINE				eu of Form CMS-2	2552-
ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE EDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet C Part II Date/Time Pre 11/22/2022 9:	parec 24 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		(Worksheet C,				
	Operating CostF			6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			<u> </u>
ANCI LLARY SERVI CE COST CENTERS						4
0. 00 05000 OPERATI NG ROOM	9, 877, 140	44, 180, 397				50.0
1.00 05100 RECOVERY ROOM	1, 970, 150	7, 332, 460				51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	2, 218, 287	3, 562, 087	0. 6227	49		52.0
3. 00 05300 ANESTHESI OLOGY	882, 440	7, 106, 556		73		53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 584, 414	20, 310, 332	0. 2257	18		54.0
5. 00 05500 RADIOLOGY - THERAPEUTIC	960, 852	7, 305, 103	0. 1315	32		55.0
6. 00 05600 RADI 0I SOTOPE	1, 105, 536	5, 342, 360	0. 2069	38		56.
7.00 05700 CT SCAN	1, 666, 136	32,069,749	0. 0519	54		57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	771, 738	10, 340, 637	0. 0746	32		58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	2, 787, 992	20, 059, 193		88		59.
0. 00 06000 LABORATORY	8, 964, 083	64, 901, 472	0. 1381			60.
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.0000			62.
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	965, 014	2, 626, 612	0.3673			63.
4. 00 06400 I NTRAVENOUS THERAPY	1, 210, 865	4, 423, 458				64.
5. 00 06500 RESPIRATORY THERAPY	2, 271, 620	5, 778, 074				65.
6. 00 06600 PHYSI CAL THERAPY	3, 667, 403	9, 182, 494				66.
7. 00 06700 OCCUPATI ONAL THERAPY	1, 831, 527	5, 379, 111	0.3404			67.
8. 00 06800 SPEECH PATHOLOGY	577, 172	1, 518, 537	0.3800			68.
9. 00 06900 ELECTROCARDI OLOGY	1, 488, 431	15, 349, 384				69.
0. 00 07000 ELECTROCARDIOLOGI 0. 00 07000 ELECTROENCEPHALOGRAPHY		7, 257, 957				70.
	935, 328					
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	3, 558, 820	10, 345, 168				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 316, 333	6, 251, 229				72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	12, 476, 326	71, 031, 999				73.
4.00 07400 RENAL DIALYSIS	849, 229	3, 489, 699				74.
6. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	275, 699	323, 413				76.
6. 97 07697 CARDI AC REHABI LI TATI ON	855, 455	701, 176	1. 2200	29		76.
OUTPATIENT SERVICE COST CENTERS						4
0. 00 09000 CLINIC	1, 961, 299	4, 111, 479				90.
1.00 09100 EMERGENCY	8, 280, 714	68, 383, 817				91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 110, 444	13, 790, 568	0. 3705	75		92.
OTHER REIMBURSABLE COST CENTERS						
01.00 10100 HOME HEALTH AGENCY	0	0	0.0000	00		101.
00.00 Subtotal (sum of lines 50 thru 199)	85, 420, 447	452, 454, 521				200.
01.00 Less Observation Beds	5, 110, 444	0				201.
02.00 Total (line 200 minus line 201)	80, 310, 003	452, 454, 521				202. (

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provider C		Period: From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 24 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		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	T	-		- F	1	
30. 00 ADULTS & PEDIATRICS	1, 096, 565		1, 096, 56	5 30, 859	35.53	30.00
31.00 INTENSIVE CARE UNIT	247, 917		247, 91	7 2, 160	114. 78	31.00
40. 00 SUBPROVIDER - IPF	0	0		0 0	0.00	40.00
41.00 SUBPROVIDER – IRF	190, 326	0	190, 32	6 4, 234	44.95	41.00
43.00 NURSERY	28, 422		28, 42	2 787	36.11	43.00
200.00 Total (lines 30 through 199)	1, 563, 230		1, 563, 23	38, 040		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	5, 714					30.00
31.00 INTENSIVE CARE UNIT	600	68, 868	8			31.00
40. 00 SUBPROVIDER - IPF	0	C				40.00
41. 00 SUBPROVI DER – I RF	2, 271	102, 081				41.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	8, 585	373, 967	,			200.00

Health Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 07/01/2021 To 06/30/2022		pared: 24 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(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	1	1	- 1		
50. 00 05000 OPERATI NG ROOM	1, 218, 312					•
51.00 05100 RECOVERY ROOM	75, 406					
52.00 05200 DELIVERY ROOM & LABOR ROOM	127, 160					
53. 00 05300 ANESTHESI OLOGY	87, 592					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	262, 362				10, 705	
55. 00 05500 RADI OLOGY – THERAPEUTI C	48, 219				-	55.00
56. 00 05600 RADI OI SOTOPE	119, 102	5, 342, 360	0. 02229	401, 486	8, 951	56.00
57.00 05700 CT SCAN	55, 201	32, 069, 749	0.00172	1, 967, 634	3, 386	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	21, 227	10, 340, 637	0.00205	53 433, 566	890	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	640, 944	20, 059, 193	0. 03195	3, 058, 976	97, 743	59.00
60. 00 06000 LABORATORY	256, 123	64, 901, 472	0.00394	6 5, 120, 856	20, 207	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.0000	0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	17, 372	2, 626, 612	0.0066	4 355, 200	2, 349	63.00
64.00 06400 INTRAVENOUS THERAPY	67, 420	4, 423, 458	0. 01524	1 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	109, 483	5, 778, 074	0. 01894	1, 385, 077	26, 244	65.00
66. 00 06600 PHYSI CAL THERAPY	142, 559	9, 182, 494	0. 01552	609, 472	9, 462	66.00
67.00 06700 OCCUPATI ONAL THERAPY	41, 422			585, 628	4, 510	67.00
68.00 06800 SPEECH PATHOLOGY	12, 898	1, 518, 537	0.00849	118,002	1,002	68.00
69. 00 06900 ELECTROCARDI OLOGY	193, 979	15, 349, 384	0. 01263	1, 511, 667	19, 104	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	51, 535	7, 257, 957	0.00710	67,608	480	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 813			1, 717, 247	1, 795	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 789	6, 251, 229	0.00156	886, 473	1, 388	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	166, 372	71,031,999	0.00234	5, 741, 807	13, 447	73.00
74.00 07400 RENAL DIALYSIS	9,934	3, 489, 699	0.00284			74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	20, 339	323, 413	0.06288	965	61	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	64, 291					76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	36, 692	4, 111, 479	0.00892	121, 249	1, 082	90.00
91.00 09100 EMERGENCY	206, 606					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	159, 589					
200.00 Total (lines 50 through 199)	4, 232, 741			34, 517, 376		

Health Financial Systems	ST. CATHERI NE	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVIC	E OTHER PASS THROUGH COSTS		-	Period: From 07/01/2021 Fo 06/30/2022	11/22/2022 9:	
			2 XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursing Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATI ENT ROUTI NE SERVICE COST CENT 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0				31.00 40.00 41.00
Cost Center Description	Amount (see instructions) r 4.00	Total Costs (sum of cols. 1 through 3, <u>minus col. 4)</u> 5.00	Total Patient Days 6.00	Per Diem (col. 5 ÷ col. 6) 7.00	Inpatient Program Days 8.00	
INPATIENT ROUTINE SERVICE COST CENT				T		
30. 00 03000 ADULTS PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY	0 0 0	0 0 0 0 0 0	30, 85 2, 16 (4, 23 78	0.00 0.00 4 0.00	600 0 2, 271	31.00 40.00 41.00
200.00 Total (lines 30 through 199) Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	0	38, 04)	8, 585	200. 00
INPATI ENT ROUTI NE SERVI CE COST CENT 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)	TERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					30. 00 31. 00 40. 00 41. 00 43. 00 200. 00

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Li	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			Period: From 07/01/202 To 06/30/2022	2 Date/Time Pre 11/22/2022 9:	pared: 24 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist	Nursing Program	Nursing Program	Allied Health Post-Stepdown	Allied Health	
	Cost	Post-Stepdown Adjustments		Adj ustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 (0 0	50.00
51.00 05100 RECOVERY ROOM	0	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	
56. 00 05600 RADI OI SOTOPE	0	0		0 (0 0	
57.00 05700 CT SCAN	0	0		0 0	0 0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0 0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0 0	1
60. 00 06000 LABORATORY	0	0		0 0	0 0	
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	
64.00 06400 I NTRAVENOUS THERAPY	0	0		0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0 0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0 0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0 0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 0	0 0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
74.00 07400 RENAL DIALYSIS	0	0		0	0	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0 0	1
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 (0 0	76.97
	0	0		0		00.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0	0		0		1
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				
200.00 Total (lines 50 through 199)	0	o		0 (-	200.00
200.00 Total (Thes so through 199)	l U	0	I	U U	ט וי	I200. 00

Health Financial Systems	ST. CATHERIN			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0008	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/22/2022 9:	pared: 24 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent			
	Education Cost	1, 2, 3, and	Cost (sum o		(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						
50. 00 05000 OPERATI NG ROOM	0	C		0 44, 180, 397		
51.00 05100 RECOVERY ROOM	0	0		0 7, 332, 460		•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 562, 087		
53.00 05300 ANESTHESI OLOGY	0	0		0 7, 106, 556		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 20, 310, 332		
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 7, 305, 103		
56. 00 05600 RADI OI SOTOPE	0	0		0 5, 342, 360		
57.00 05700 CT SCAN	0	0		0 32, 069, 749		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 10, 340, 637		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 20, 059, 193		
60. 00 06000 LABORATORY	0	0		0 64, 901, 472		
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, 626, 612	0. 000000	•
64.00 06400 INTRAVENOUS THERAPY	0	0		0 4, 423, 458		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 5, 778, 074		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 9, 182, 494		•
67.00 06700 OCCUPATIONAL THERAPY	0	C		0 5, 379, 111		
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 518, 537		
69.00 06900 ELECTROCARDI OLOGY	0	C		0 15, 349, 384		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 7, 257, 957		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 10, 345, 168		•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 6, 251, 229		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 71, 031, 999		
74.00 07400 RENAL DIALYSIS	0	0		0 3, 489, 699		
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 323, 413		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 701, 176	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS	-	-	1	al	0.000	
90. 00 09000 CLINIC	0	-		0 4, 111, 479		
91.00 09100 EMERGENCY	0			0 68, 383, 817		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 13, 790, 568		
200.00 Total (lines 50 through 199)	0	0		0 452, 454, 521		200.00

Health Financial Systems	ST. CATHERINE	HOSPITAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider CC	CN: 15-0008		riod: om 07/01/2021 06/30/2022	Worksheet D Part IV Date/Time Pre 11/22/2022 9:3	pared:
		Title	XVIII		Hospi tal	PPS	24 аш
Cost Center Description	Outpati ent	Inpatient	I npati ent		Outpatient	Outpati ent	
	Ratio of Cost	Program	Program		Program	Program	
	to Charges	Charges	Pass-Throug	h	Charges	Pass-Through	
	(col. 6 ÷ col.	5	Costs (col.	8	5	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	3, 403, 979		0	4, 164, 494	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	216, 844		0	852, 875	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	10, 045		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	414, 840		0	632, 535	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	828, 676		0	1, 576, 777	0	54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	0. 000000	0		0	3, 247, 740	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	401, 486		0	857, 778	0	56.00
57.00 05700 CT SCAN	0. 000000	1, 967, 634		0	3, 759, 196	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	433, 566		0	1, 533, 003	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	3, 058, 976		0	1, 967, 216	0	59.00
60. 00 06000 LABORATORY	0. 000000	5, 120, 856		0	2, 492, 197	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	355, 200		0	84, 054	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0	1, 520, 903	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 385, 077		0	64, 159	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	609, 472		0	28, 296	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	585, 628		0	23, 517	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	118,002		0	48, 637	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 511, 667		0	1, 914, 459	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	67,608		0	804, 876	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 717, 247		0	685, 663	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	886, 473		0	462, 789	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	5, 741, 807		0	14, 344, 106	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	889, 760		0	170,000	0	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	965		0	74, 763	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	24, 190		0	188, 786	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0. 000000	121, 249		0	537, 701	0	90.00
91. 00 09100 EMERGENCY	0.000000	3, 996, 362		0	4, 369, 621	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	649, 767		0	1, 408, 180	0	92.00
200.00 Total (lines 50 through 199)	1	34, 517, 376		0	47, 814, 321		200.00

Health Fina	ancial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTI ONM	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0008	Period: From 07/01/2021	Worksheet D Part V	
					To 06/30/2022		pared:
						11/22/2022 9:	24 am
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Services	Services Not		
		Part I, col. 9		Subject To Ded. & Coins	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5.00	
ANCI	LLARY SERVICE COST CENTERS						
	O OPERATI NG ROOM	0. 223564	4, 164, 494		0 14,904	931, 031	50.00
	O RECOVERY ROOM	0. 268689	852, 875		0 0	229, 158	51.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM	0. 622749			0 0	0	52.00
53.00 0530	0 ANESTHESI OLOGY	0. 124173	632, 535		0 0	78, 544	53.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0. 225718			0 0	355, 907	54.00
55.00 0550	0 RADI OLOGY - THERAPEUTI C	0. 131532	3, 247, 740		0 0	427, 182	55.00
56.00 0560	0 RADI OI SOTOPE	0. 206938	857, 778		0 0	177, 507	56.00
57.00 0570	O CT SCAN	0. 051954			0 0	195, 305	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0. 074632	1, 533, 003		0 0	114, 411	58.00
59.00 0590	O CARDI AC CATHETERI ZATI ON	0. 138988	1, 967, 216		0 0	273, 419	59.00
	O LABORATORY	0. 138118			0 0	344, 217	1
	0 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			0 0	0	
	0 BLOOD STORING, PROCESSING, & TRANS.	0. 367399			0 0	30, 881	1
	0 INTRAVENOUS THERAPY	0. 273737			0 0	416, 327	
	0 RESPI RATORY THERAPY	0. 393145			0 0	25, 224	
	0 PHYSI CAL THERAPY	0. 399391			0 0	11, 301	
	O OCCUPATIONAL THERAPY	0. 340489			0 0	8, 007	1
	O SPEECH PATHOLOGY	0. 380084			0 0	18, 486	
	0 ELECTROCARDI OLOGY	0. 096970			0 0	185, 645	1
		0. 128869			0 0	103, 724	1
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 344008			0 0	235, 874	1
	O IMPL. DEV. CHARGED TO PATIENTS	0. 530509			0 0	245, 514	1
	0 DRUGS CHARGED TO PATIENTS	0. 175644			0 13, 940	2, 519, 456	1
	0 RENAL DI ALYSI S	0. 243353			0 0	41, 370	1
	0 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 852467			0 0	63, 733	1
	27 CARDIAC REHABILITATION ATIENT SERVICE COST CENTERS	1. 220029	188, 786		0 0	230, 324	76.97
	OCLINIC	0. 477030	537, 701		0 0	256, 500	90.00
	0 EMERGENCY	0. 477030			0 140	529, 126	
	0 OBSERVATION BEDS (NON-DISTINCT PART	0. 370575			0 0	527, 120	
200.00	Subtotal (see instructions)	0. 370373	47, 814, 321		0 28, 984	8, 570, 009	
200.00	Less PBP Clinic Lab. Services-Program		47,014,321		0 20, 984	0, 370, 009	200.00
201.00	Only Charges						201.00
202.00	Net Charges (line 200 - line 201)		47, 814, 321		0 28, 984	8, 570, 009	202.00
'			,				

	Financial Systems	ST. CATHERIN				u of Form CMS-	-2552-10
APPORI	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0008	Peri od: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pre 11/22/2022 9:	
			Title	XVIII	Hospi tal	PPS	
		Co	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				_
	ANCI LLARY SERVICE COST CENTERS		0.000				
	05000 OPERATING ROOM	0					50.00
	05100 RECOVERY ROOM	0					51.00
	05200 DELIVERY ROOM & LABOR ROOM	0					52.00
	05300 ANESTHESI OLOGY	0	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0					54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0				55.00
56.00	05600 RADI OI SOTOPE	0	0				56.00
	05700 CT SCAN	0	0				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
	06000 LABORATORY	0					60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0					62.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0					63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		0				64.00
	06600 PHYSI CAL THERAPY	0					65.00 66.00
	06700 OCCUPATIONAL THERAPY						67.00
	06800 SPEECH PATHOLOGY	0	0				68.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS		0				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	2, 448				73.00
	07400 RENAL DIALYSIS	0					74.00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0					76.00
	07697 CARDI AC REHABI LI TATI ON	0					76.97
/0. //	OUTPATIENT SERVICE COST CENTERS			1			, 0. , ,
90.00	09000 CLINIC	0	0				90.00
	09100 EMERGENCY	0					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
200.00		0					200.00
200.00		0					201.00
2.1.00	Only Charges						
202.00	5 5	0	5, 797				202.00

Health Financial Systems		u of Form CMS-	2552-10			
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0008	Period:	Worksheet D	
		Commente	20N 15 T000	From 07/01/2021	Part II	
		component	CCN: 15-T008	To 06/30/2022	Date/Time Pre 11/22/2022 9:	24 am
		Title	XVIII	Subprovider -	PPS	
			-	I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(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					
50.00 05000 OPERATING ROOM	1, 218, 312	44, 180, 397			2, 945	50.00
51.00 05100 RECOVERY ROOM	75, 406	7, 332, 460	0. 0102	34 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	127, 160	3, 562, 087	0. 0356	98 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	87, 592	7, 106, 556	0. 0123	26 9, 676	119	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	262, 362			18 87, 212	1, 127	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	48, 219	7, 305, 103	0.0066	01 0	0	55.00
56. 00 05600 RADI OI SOTOPE	119, 102			94 15, 984	356	56.00
57.00 05700 CT SCAN	55, 201	32, 069, 749	0.00172	49,690	86	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	21, 227				7	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	640, 944				0	
60. 00 06000 LABORATORY	256, 123				2, 025	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				0	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	17, 372	-			77	
64. 00 06400 I NTRAVENOUS THERAPY	67,420				0	
65. 00 06500 RESPI RATORY THERAPY	109, 483				2,650	
66. 00 06600 PHYSI CAL THERAPY	142, 559				16, 745	1
67. 00 06700 OCCUPATI ONAL THERAPY	41, 422				8, 469	
68. 00 06800 SPEECH PATHOLOGY	12, 898				1, 418	
69. 00 06900 ELECTROCARDI OLOGY	193, 979				346	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	51, 535				15	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 813				148	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	9, 789				7	
73. 00 07300 DRUGS CHARGED TO PATIENTS	166, 372				2, 261	
74.00 07400 RENAL DIALYSIS	9, 934				621	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	20, 339				0	
76. 97 07697 CARDI AC REHABI LI TATI ON	64, 291	701, 176	0.0916	90 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	36, 692				0	
91.00 09100 EMERGENCY	206, 606				8	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00 Total (lines 50 through 199)	4,073,152	452, 454, 521	1	4, 644, 611	39, 430	1200 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCIELLARY SERVICE OTHER PASS Provider CCN: 15-0008 Provider CCN: 15-000 Provide	Health Financial Systems	th Financial Systems ST. CATHERINE HOSPITAL						2552-10
Ancode Store Component CCN: 15-TO08 To 06/30/2021 Date/Time Prepared: 12/22/2022 Date/Time Prepared: 12/22/2022 Date/Time Prepared: 12/22/2022 Image: Start Construction of the start		RVICE OTHER PASS	S Provider C	CN: 15-0008				
Cost Center Description Non Physician Anesthetist Cost Nursing Program Adjustments Nursing Program Adjustments Ilied Healt h Alied Healt h Post-Stepdown Adjustments MACLLLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 50.00 05000 DPERATING ROOM 0 0 0 0 51.00 05000 DPERATING ROOM 0 0 0 0 0 52.00 05000 DPERATING ROOM 0 0 0 0 0 0 0 53.00 05000 DPERATING ROOM 0	THROUGH COSTS		Component	CCN: 15-T008				nared
Cost Center Description Non Physician Nursing Program			oomponent	0011. 10 1000		, 00,00,2022		
Cost Center Description Non Physician Anesthetist Cost Nursing Program Post-Stepdown Adjustments Nursing Program Post-Stepdown Adjustments I lied Health Post-Stepdown Adjustments 0.00 05000 OPERATING ROM 0			Titl∈	e XVIII	S			
ANCI LLARY SERVICE COST CENTERS Ansethet ist Cost Program Program Program Adjustments ANCI LLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 (PERATING ROOM 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
Adjustments Adjustments 1.00 2A 2.00 3A 3.00 50.00 05000 OPERATING ROOM 0	Cost Center Description						Allied Health	
Adj ustments Adj ustments Adj ustments ANCI LLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 RECOVERY ROM 0								
I.00 2A 2.00 3A 3.00 50.00 05000 OPERATING ROOM 0		COST				Aujustments		
ANCI LLARY SERVICE COST CENTERS 0 <t< td=""><td></td><td>1.00</td><td></td><td>2 00</td><td></td><td>30</td><td>3 00</td><td></td></t<>		1.00		2 00		30	3 00	
50.00 0 <td>ANCLLLARY SERVICE COST CENTERS</td> <td>1.00</td> <td>2/1</td> <td>2.00</td> <td></td> <td>54</td> <td>3.00</td> <td></td>	ANCLLLARY SERVICE COST CENTERS	1.00	2/1	2.00		54	3.00	
51:00 OS100 RECOVERY ROM 0		0	C		0	0	0	50.00
53.00 05300 ANESTHESI OLOGY 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td>		0	0		0	0	0	
54.00 05400 RADI OLOGY - JI AGNOSTI C 0 0 0 0 0 55.00 55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 0 0 55.00 57.00 05600 RADI OLOGY - THERAPEUTI C 0 0 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 0 57.00 58.00 05800 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 05900 CABDI AC CATHETERI ZATI ON 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0	0	0	52.00
55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 0 55.00 56.00 05600 RADI OLOGY - THERAPEUTI C 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 <td< td=""><td>53. 00 05300 ANESTHESI OLOGY</td><td>0</td><td>C</td><td></td><td>0</td><td>0</td><td>0</td><td>53.00</td></td<>	53. 00 05300 ANESTHESI OLOGY	0	C		0	0	0	53.00
56.00 05600 RADI 0I SOTOPE 0 0 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 57.00 58.00 00 05900 CARDI AC CATHETERI ZATI 0N 0 0 0 0 59.00 60.00 05900 CARDI AC CATHETERI ZATI 0N 0	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0	0	0	54.00
57.00 05700 CT SCAN 0 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 59.00 05900 CARDIA C. CATHETERIZATION 0 0 0 0 59.00 60.00 06000 LABORATORY 0 0 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 63.00 0 63.00 0 63.00 0 0 63.00 0 64.00 64.00 64.00 64.00 64.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 66.00 65.00 66.00 65.00 66.00 67.00 0 0 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 67.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00<	55. 00 05500 RADI OLOGY – THERAPEUTI C	0	C		0	0	0	55.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 0 0 0 0 59.00 59.00 05900 CARDIAC CATHETERIZATION 0	56. 00 05600 RADI OI SOTOPE	0	C		0	0	0	56.00
59.00 OS900 CARDI AC CATHETERI ZATI ON 0	57.00 05700 CT SCAN	0	C		0	0	0	57.00
60.00 LABORATORY 0		0	C		0	0	0	58.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 62.00 63.00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06600 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 ELECTROCARDI OLOGY 0 0 0 0 0 0 70.00 O7100 RELECTROENCEPHALOGRAPHY 0 0 0 0 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 73.00 07300 DURGS CHARGED TO PATI ENTS 0 0		0	0		0	0	-	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 0 0 63.00 64.00 06400 INTRAVENUUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 66.00 68.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 69.00 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 ELECTROCARDI OLOGY 0 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72		0	0		0	0	0	
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 66.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 74.00 74.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 <		0	C		0	0		
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 73.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 76.07 76.07 07697 CARDI AC REHABI LLTATI ON 0 <		0	C)	0	0	-	
66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 67.00 67.00 67.00 68.00 0 0 0 0 0 0 67.00 68.00 0 0 0 0 0 0 0 67.00 68.00 0 0 0 0 0 0 0 68.00 69.00 0 0 0 0 0 0 0 69.00 0 0 0 0 0 0 69.00 0 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>-</td> <td></td>		0	0	0	0	0	-	
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 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 CARDI AC REHABI LI TATI ON 0 0 0 0 <		0	0	0	0	0	-	
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 VT100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 04970 CARDI AC REHABI LI TATI ON 0 0 0 0 0 90.00 91.00 090000 CLI NI C 0<		0	0)	0	0	-	
69.00 06900 ELECTROCARDIOLOGY 0<		0	0		0	0		
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03505 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76.00 76.97 OARDI AC REHABI LI TATI ON 0 0 0 0 0 0 76.97 00 09000 CLI NI C O 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0		0	0		0	0	-	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03500 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76.00 76.07 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76.97 00000 CLI NI C 0 0 0 0 0 0 90.00 90.00 09000 CLI NI C 0 0 0 0 90.00 91.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 92.00		0	0		0	0	-	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 0 74.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76.00 76.07 07697 CARDI AC REHABILI TATI ON 0 0 0 0 0 76.97 0000 CLINIC 09000 CLINIC 0 0 0 90.00 90.00 90.00 91.00 92.00		0	0	,	0	0		
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 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 OT697 CARDI AC REHABILI TATI ON 0 0 0 0 0 76.00 70.07 CARDI AC REHABILI TATI ON 0 0 0 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 92.00		0	0		0	0	-	
74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 90.00 90.00 09100 EMERGENCY 0 0 0 91.00 92.00 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 92.00		0	0		0	0	U U	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76. 00 90. 00 90. 00 91. 00 91. 00 91. 00 91. 00 91. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00		0	0		0	0	-	
76. 97 07697 CARDI AC_REHABILITATION 0 0 0 0 76. 97 OUTPATI ENT_SERVICE_COST_CENTERS 0 0 0 0 0 90.00 90.00 0 00 0 90.00 90.00 90.00 91.00 90.00 91.00 91.00 92.00 0 0 0 0 92.00 92.00 00 0 0 92.00 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0		0	0		
OUTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT_PART 0 0 0 92. 00		0	C		0	0	0	76.97
91.00 09100 EMERGENCY 0 0 0 91.00 91.00 92.00 0 92.00 0 92.00 0 92.00 0 0 0 92.00 92.00 0 92.00 0 0 0 92.00 0 92.00 0 92.00 0 0 0 92.00 0 92.00 0 92.00 0 92.00 0 0 0 0 92.00 0 0 0 0 92.00 <								1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00	90. 00 09000 CLI NI C	0	C)	0	0	0	90.00
		0	C		0	0	0	
200.00 Total (lines 50 through 199) 0 0 0 0 0 200.00		0			0		e e	
	200.00 Total (lines 50 through 199)	0	0		0	0	0	200. 00

Medical (s	Provider CC Component C Title		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV	
Cost Center Description All Other Medical (s Education Cost					
Medical (s Education Cost 1		CN: 15-1008	10 06/30/2022		
Medical (s Education Cost 1	Title			Date/Time Prep 11/22/2022 9:2	pared: 24 am
Medical (s Education Cost 1		Title XVIII		PPS	<u>24 am</u>
Medical (s Education Cost 1			Subprovider - IRF		
Education Cost 1	Total Cost	Total	Total Charges		
	sum of cols.	Outpati ent	(from Wkst. C,	to Charges	1
4.00	, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
4.00	4)	col s. 2, 3,	8)	7)	
4.00		and 4)		(see	1
	5.00	(00		instructions)	ļ
	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0	0		0 44 180 397	0,000000	50.00
50. 00 05000 OPERATI NG ROOM 0 51. 00 05100 RECOVERY ROOM 0	0		,,,	0.000000 0.000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0	0			0.000000	
53. 00 05300 ANESTHESI OLOGY 0	0		0 3, 562, 087 0 7, 106, 556		
54. 00 05400 RADI 0L0GY - DI AGNOSTI C 0	0		0 20, 310, 332	0.000000	
55. 00 05500 RADI OLOGY - THERAPEUTI C 0	0		0 7, 305, 103		
56. 00 05600 RADI 0LOGI - THERAPEOTIC	0		0 5, 342, 360		
57. 00 05700 CT SCAN 0	0		0 32, 069, 749	0.000000	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0 10, 340, 637	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON 0	0		0 20, 059, 193		
60. 00 06000 LABORATORY 0	0		0 64, 901, 472	0.000000	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0	0		0 0	0.000000	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 0	o		0 2, 626, 612	0.000000	
64.00 06400 INTRAVENOUS THERAPY 0	0		0 4, 423, 458	0.000000	
65. 00 06500 RESPI RATORY THERAPY 0	0		0 5, 778, 074	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY 0	0		0 9, 182, 494	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY 0	0		0 5, 379, 111	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY 0	0		0 1, 518, 537	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY 0	0		0 15, 349, 384	0.00000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0	0		0 7, 257, 957	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0	0		0 10, 345, 168		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0	0		0 6, 251, 229	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0	0		0 71, 031, 999		
74. 00 07400 RENAL DI ALYSI S 0	0		0 3, 489, 699		
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0	0		0 323, 413		
76. 97 07697 CARDI AC REHABI LI TATI ON 0	0		0 701, 176	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS				0.000055	00.00
90. 00 09000 CLINIC 0	0		0 4, 111, 479		
91.00 09100 EMERGENCY 0	0		0 68, 383, 817		
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 200.00 Total (Lines 50 through 199) 0	0		0 13, 790, 568		
200.00 Total (lines 50 through 199) 0	0		0 452, 454, 521	I	200.00

Health Financial Systems	ST. CATHERINE	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	Provider C Component (CN: 15-0008 CCN: 15-T008	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/22/2022 9:	
		Title	XVIII	Subprovider -	PPS	21 411
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpatient	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	106, 781		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	9, 676		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	87, 212		0 0	0	54.00
55. 00 05500 RADIOLOGY - THERAPEUTIC	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	15, 984		0 0	0	56.00
57.00 05700 CT SCAN	0.000000	49, 690		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	3, 238		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	513, 168		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	11, 587		0 0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0.000000	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0.000000	139, 876		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0.000000	1, 078, 590		0 0	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	0, 000000	1, 099, 681		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0.000000	166, 954		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0.000000	27, 417		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000	2,098		0 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	141, 778		0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0.000000	4, 773		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000	965, 316		0 0	0	
74. 00 07400 RENAL DIALYSIS	0.000000	218, 117		0 0	0	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.000000	210, 117		0 0	0	1
76. 97 07697 CARDIAC REHABILITATION	0.000000	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.000000	0	I	0	0	/0. 7/
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 00 109000 CET NTC 91. 00 09100 EMERGENCY	0.000000	-		0 0	0	
		2, 675				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)	0. 000000	U 4 4 4 4 4 1 1		0 0 0 0	0	200.00
200.00 TOTAL (TITLES SO THEOUGH 199)	I I	4, 644, 611	I	0	0	I200. 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 07/01/2021 Fo 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 24 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		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 CENTER	S					
30. 00 ADULTS & PEDIATRICS	1, 096, 565	C	1, 096, 56	5 30, 859	35.53	30.00
31.00 INTENSIVE CARE UNIT	247, 917		247, 91	7 2, 160	114.78	31.00
40.00 SUBPROVIDER - IPF	0	0		0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	190, 326	0	190, 320	6 4, 234	44.95	41.00
43.00 NURSERY	28, 422		28, 422	2 787	36.11	43.00
200.00 Total (lines 30 through 199)	1, 563, 230		1, 563, 230	38, 040		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
	5 5	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTER	S		•			
30. 00 ADULTS & PEDIATRICS	1, 689	60, 010)			30.00
31.00 INTENSIVE CARE UNIT	315					31.00
40.00 SUBPROVIDER - IPF	0	0	1			40.00
41.00 SUBPROVIDER - IRF	38	1, 708				41.00
43.00 NURSERY	101	3, 647				43.00
200.00 Total (lines 30 through 199)	2, 143		•			200.00
	1 27.10	101,021	i.			

Health Financial Systems	ST. CATHERIN	IE HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 07/01/2021 To 06/30/2022		pared: 24 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(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	1		1	r	
50. 00 05000 OPERATI NG ROOM	1, 218, 312					
51.00 05100 RECOVERY ROOM	75, 406					
52.00 05200 DELIVERY ROOM & LABOR ROOM	127, 160					
53. 00 05300 ANESTHESI OLOGY	87, 592					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	262, 362				1, 999	
55. 00 05500 RADI OLOGY – THERAPEUTI C	48, 219				-	55.00
56. 00 05600 RADI OI SOTOPE	119, 102	5, 342, 360	0. 02229	33, 186	740	56.00
57.00 05700 CT SCAN	55, 201					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	21, 227	10, 340, 637	0.00205	53 92, 477	190	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	640, 944	20, 059, 193	0. 03195	53 210, 704	6, 733	59.00
60. 00 06000 LABORATORY	256, 123	64, 901, 472			4, 765	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C	0.0000	0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	17, 372	2, 626, 612	0.0066	4 30, 855	204	63.00
64.00 06400 INTRAVENOUS THERAPY	67, 420	4, 423, 458	0. 01524	1 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	109, 483	5, 778, 074	0. 01894	8 209, 708	3, 974	65.00
66. 00 06600 PHYSI CAL THERAPY	142, 559	9, 182, 494	0. 01552	137, 525	2, 135	66.00
67.00 06700 OCCUPATI ONAL THERAPY	41, 422			67, 931	523	67.00
68.00 06800 SPEECH PATHOLOGY	12, 898	1, 518, 537	0.00849	43, 696	371	68.00
69. 00 06900 ELECTROCARDI OLOGY	193, 979	15, 349, 384	0. 01263	216, 523	2, 736	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	51, 535	7, 257, 957	0.00710	31, 152	221	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 813			267, 295	279	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 789	6, 251, 229	0.00156	47, 165	74	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	166, 372	71, 031, 999	0.00234	1, 314, 464	3, 078	73.00
74.00 07400 RENAL DIALYSIS	9, 934	3, 489, 699	0.00284	7 75, 890	216	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	20, 339	323, 413	0.06288	39 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	64, 291			2, 879	264	76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	36, 692	4, 111, 479	0.00892	24 0	0	90.00
91.00 09100 EMERGENCY	206, 606				1, 987	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	159, 589					
200.00 Total (lines 50 through 199)	4, 232, 741			6, 183, 424		200.00
		•				

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P		S Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part III Date/Time Pre 11/22/2022 9:	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0		31.00 40.00 41.00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	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 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	000000000000000000000000000000000000000	0 0 0 0 0 0 0	30, 85 2, 16 4, 23 78 38, 04	0 0.00 0 0.00 4 0.00 7 0.00	315 0 38 101	31.00 40.00 41.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x <u>col. 8)</u> 9.00					
30.00 03000 ADULTS PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IFF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0 0 0 0 0					30. 00 31. 00 40. 00 41. 00 43. 00 200. 00

Health Financial Systems ST. CATHERINE HOSPITAL In Lieu of For						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 24 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist	Nursing Program	Nursing Program	Allied Health Post-Stepdown	Allied Health	
	Cost	Post-Stepdown Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS		271	2100	0.11	0.00	
50. 00 05000 OPERATI NG ROOM	0	C)	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	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	0	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	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		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 68. 00 06800 SPEECH PATHOLOGY	0	0			0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0			0	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0			0	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0 0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0 0		76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	C		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	C		0 0	0	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT AND THROUGH COSTS Cost Center Description Cost Center Cen		ST. CATHERIN		CN: 15 0009	Period:	eu of Form CMS-: Worksheet D	2002-10
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 51.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM 52.00 05200 DELIVERY ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE IMAGI NG (M 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06600 PHYSI CAL THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 <td>JILLART SE</td> <td>KVICE UINEK PAS</td> <td>S PIOVIDEI C</td> <td>CN. 15-0006</td> <td>From 07/01/2021</td> <td>Part IV</td> <td></td>	JILLART SE	KVICE UINEK PAS	S PIOVIDEI C	CN. 15-0006	From 07/01/2021	Part IV	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OLOGY - THERAPEUTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (M 69. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOO 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 65. 00 06600 PHYSI CAL THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY					To 06/30/2022		pared:
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OLOGY - THERAPEUTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (M 69. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOO 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 65. 00 06600 PHYSI CAL THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY						11/22/2022 9:	24 am
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OLOGY - THERAPEUTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (M 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOO 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 65. 00 06600 PHYSI CAL THERAPY 66. 00 06600 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY				e XIX	Hospi tal	PPS	
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OLOGY - THERAPEUTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE IMAGING (M 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOO 63. 00 06300 BLOOD STORI NG, PROCESSING, & 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 65. 00 06600 PHYSI CAL THERAPY 65. 00 06600 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 70. 00 07000 <t< td=""><td></td><td>All Other</td><td>Total Cost</td><td>Total</td><td></td><td>Ratio of Cost</td><td></td></t<>		All Other	Total Cost	Total		Ratio of Cost	
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OLOGY - THERAPEUTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE IMAGING (M 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOO 63. 00 06300 BLOOD STORI NG, PROCESSING, & 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 65. 00 06600 PHYSI CAL THERAPY 65. 00 06600 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 70. 00 07000 <t< td=""><td></td><td>Medi cal</td><td>(sum of cols.</td><td>Outpati ent</td><td>(from Wkst. C,</td><td></td><td></td></t<>		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY - DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (M 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 65.00 06600 SPECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 70.00 07100 MEDI CAL SUPPLI		Education Cost	1, 2, 3, and	Cost (sum o	f Part I, col.	(col. 5 ÷ col.	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY - DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (M 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 65.00 06600 SPECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 70.00 07100 MEDI CAL SUPPLI			4)	cols. 2, 3,	8)	7)	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY - DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOG 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 06600 SPEECH PATHOLOGY 67.00 06700 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY				and 4)		(see	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY - DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (M 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 65.00 06600 SPECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 70.00 07100 MEDI CAL SUPPLI						instructions)	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY - DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOG 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 06600 SPEECH PATHOLOGY 67.00 06700 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY		4.00	5.00	6.00	7.00	8.00	
51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOC 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 65.00 06600 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY - DI AGNOSTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 56.00 05700 CT SCAN 58.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 06600 SPECH PATHOLOGY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 6900 ELECTROCARDI OLOGY 70.00 07100 MEDI CAL SUPPLI ES CHARGED TO F 71.00 07100 MED		0	C)	0 44, 180, 397	0.00000	50.00
53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY - DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 70.00 07000 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 73.00 07300 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0 7, 332, 460</td><td>0. 000000</td><td>51.00</td></td<>		0	0		0 7, 332, 460	0. 000000	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOG 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 06400 SPECH PATHOLOGY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL		0	C		0 3, 562, 087		52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOG 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 06400 SPECH PATHOLOGY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL		0	C		0 7, 106, 556		53.00
55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OI SOTOPE 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (M 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 06600 SPECH PATHOLOGY 69.00 06600 SPECH PATHOLOGY 69.00 06700 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 70.00 07100 MEDI CAL SUPPLIES CHARGED TO F 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENT 74.00 07400 RENAL DI ALYSI S 76.97 CARDI AC REHABI LI T		0	0		0 20, 310, 332		
56.00 05600 RADI 0I SOTOPE 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (M 59.00 05900 CARDI AC CATHETERI ZATI 0N 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 70.00 07100 MEDI CAL SUPPLIES CHARGED TO F 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.97 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS 90.00<		0	0		0 7, 305, 103		
57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (M 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06700 CCUPATI ONAL THERAPY 65.00 06700 CCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.97 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVICE COST CENTERS 90.00 90.00 O9000 CLI NI C		0	0		0 5, 342, 360		•
58.00 05800 MAGNETIC RESONANCE I MAGING (M 59.00 05900 CARDIAC CATHETERIZATION 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORING, PROCESSING, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSICAL THERAPY 66.00 06600 PHYSICAL THERAPY 68.00 06600 SPECH PATHOLOGY 69.00 06900 ELECTROCARDIOLOGY 70.00 07000 ELECTROCARDIOLOGY 70.00 07100 MEDICAL SUPPLIES CHARGED TO FATIENTS 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DI ALYSIS 76.97 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 90.00					0 32, 069, 749		
59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71.00 07100 MEDI CAL SUPPLI S CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SEF 76.97 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVICE COST CENTERS 90.00	MDL)	0			0 10, 340, 637		
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SEF 76.97 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 90.00	WICI)	0			0 20, 059, 193		
62.00 06200 WHOLE BLOOD & PACKED RED BLOO 63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 I NTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO F 72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 73.00 07300 RUGS CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SEF 76.97 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVICE COST CENTERS 90.00 09000		0			0 64, 901, 472		
63.00 06300 BLOOD STORI NG, PROCESSI NG, & 64.00 06400 I NTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO F 72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.97 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVICE COST CENTERS 90.00 09000		0			0 04, 901, 472		
64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO F 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.97 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVICE COST CENTERS 90.00 09000		0	-		0	0.000000	
65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO F 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.97 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVICE COST CENTERS 90.00 09000	TRANS.	0	0		0 2, 626, 612		•
66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 73.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SEF 76.97 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVICE COST CENTERS 90.00		0	0		0 4, 423, 458		
67.00 06700 0CCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO F 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SEF 70.00 00000 CLI NI C		0	0		0 5, 778, 074		•
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO F 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SEF 76. 97 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVICE COST CENTERS 90. 00 09000		0	0		0 9, 182, 494		
69.00 06900 ELECTROCARDIOLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO F 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS 76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SEF 76.97 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 90.00 09000		0	C		0 5, 379, 111		
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO F 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DI ALYSIS 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SEF 76.97 07697 CARDI AC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 90.00 09000		0	0		0 1, 518, 537		
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO F 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DI ALYSI S 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SEF 76.97 07697 CARDI AC REHABILI TATI ON 0UTPATIENT SERVICE COST CENTERS 90.00 O9000 CLI NI C		0	0		0 15, 349, 384		
72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DI ALYSI S 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SEF 76.97 07697 CARDI AC REHABI LI TATI ON 0UTPATIENT SERVICE COST CENTERS 90.00 O9000		0	0		0 7, 257, 957		
73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS 76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SEF 76.97 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 90.00 09000		0	C		0 10, 345, 168	0.00000	71.00
74.00 07400 RENAL DI ALYSI S 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SEF 76.97 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 90.00 09000	TS	0	C)	0 6, 251, 229	0.00000	72.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SEF 76.97 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 90.00 09000 CLI NI C		0	0		0 71, 031, 999	0. 000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C CLI NI C		0	0)	0 3, 489, 699	0. 000000	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C CLI NI C	RVI CES	0	C		0 323, 413		76.00
0UTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC		0			0 701, 176		
90. 00 09000 CLINIC							1
		0	C		0 4, 111, 479	0.000000	90.00
91.00 09100 EMERGENCY		0			0 68, 383, 817		
92.00 09200 OBSERVATION BEDS (NON-DISTING	CT PART	0			0 13, 790, 568		
200.00 Total (lines 50 through 199)	ST TAKT	0	-		0 452, 454, 521		200.00

Health Financial Systems	ST. CATHERI NE	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-0008	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/22/2022 9:	pared: 24 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	Inpati 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 OPERATI NG ROOM	0. 000000	586, 498		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	45, 616		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	185, 220	1	0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	109, 371	1	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	154, 755	1	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	33, 186		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	343, 379		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	92, 477		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	210, 704		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	1, 207, 670		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	30, 855		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	209, 708		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	137, 525		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	67, 931		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0.000000	43, 696		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0, 000000	216, 523		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000	31, 152		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	267, 295		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0, 000000	47, 165		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 314, 464		0 0	0	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	75, 890		0 0	0	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	, 0, 0,0		0 0	-	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	2, 879		0 0		76.97
OUTPATIENT SERVICE COST CENTERS	0.000000	2, 077	1	- 0		1
90. 00 09000 CLINIC	0, 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	657, 620		0 0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	111, 845		0 0		92.00
200.00 Total (lines 50 through 199)	0.000000	6, 183, 424		0 0		200.00
	I I	0, 100, 424	I		0	1200.00

Health Financial Systems ST. CATHERINE HOSPITAL In Lieu of Form CMS-25							
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0008	Peri od:	Worksheet D		
		Component	CCN: 15-T008	From 07/01/2021 To 06/30/2022	Part II Date/Time Pre	narodi	
		component	CCN. 15-1006	To 06/30/2022	11/22/2022 9:	24 am	
		Titl	e XIX	Subprovi der –	PPS		
				I RF			
Cost Center Description	Capi tal	Total Charges			Capital Costs		
		(from Wkst. C,		Program	(column 3 x		
	(from Wkst. B,		(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							
50.00 05000 OPERATI NG ROOM	1, 218, 312				0		
51.00 05100 RECOVERY ROOM	75, 406				0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	127, 160				0	52.00	
53. 00 05300 ANESTHESI OLOGY	87, 592	7, 106, 556	0. 01232		0	53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	262, 362	20, 310, 332	0. 0129	1, 778	23	54.00	
55. 00 05500 RADI OLOGY - THERAPEUTI C	48, 219	7, 305, 103	0.00660	01 0	0	55.00	
56. 00 05600 RADI OI SOTOPE	119, 102	5, 342, 360	0. 02229	94 0	0	56.00	
57.00 05700 CT SCAN	55, 201	32, 069, 749	0.00172	21 0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	21, 227	10, 340, 637	0.00205	53 0	0	58.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	640, 944	20, 059, 193	0.0319	53 0	0	59.00	
60. 00 06000 LABORATORY	256, 123	64, 901, 472	0.00394	16 7, 394	29	60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				0	62.00	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	17, 372	2, 626, 612	0.0066	14 0	0	63.00	
64.00 06400 INTRAVENOUS THERAPY	67, 420				0	64.00	
65. 00 06500 RESPIRATORY THERAPY	109, 483				340	•	
66.00 06600 PHYSI CAL THERAPY	142, 559				325	66.00	
67. 00 06700 OCCUPATI ONAL THERAPY	41, 422				183		
68. 00 06800 SPEECH PATHOLOGY	12, 898				5	68.00	
69. 00 06900 ELECTROCARDI OLOGY	193, 979				5	69.00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	51, 535				0		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 813				13		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 789				0		
73. 00 07300 DRUGS CHARGED TO PATIENTS	166, 372				55		
74. 00 07400 RENAL DIALYSIS	9,934				0	•	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	20, 339				0	76.00	
76. 97 07697 CARDIAC REHABILITATION	64, 291				0	76.97	
	04, 291	701, 176	0.0916	0 0	0	/0.9/	
	24 (02	4 111 470	0.0000	24	0	00.00	
90. 00 09000 CLINIC	36, 692				0		
91.00 09100 EMERGENCY	206, 606				0		
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0				0		
200.00 Total (lines 50 through 199)	4, 073, 152	452, 454, 521	I	108, 841	978	200.00	

Health Financial Systems	th Financial Systems ST. CATHERINE HOSPITAL						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C	CN: 15-0008		ri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T008	To	om 07/01/2021 06/30/2022	Part IV Date/Time Pre	pared:
		•				11/22/2022 9:	
		Titl	e XIX	S	ubprovider -	PPS	
Cost Conton Description	New Divertet et	No	Numetar		I RF		
Cost Center Description	Non Physician Anesthetist	Nursing Program	Nursing Program		Post-Stepdown	Allied Health	
	Cost	Post-Stepdown			Adjustments		
	0031	Adjustments			naj as tilion ts		
	1.00	2A	2.00		3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	C		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	C		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 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 60. 00 06000 LABORATORY	0	0		0	0	0	59.00 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	0			0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	Ő		Ő	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	C		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	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
90. 00 09000 CLINIC	0	0	1	0	0	0	90.00
91. 00 09100 EMERGENCY	0			0	0	0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	0	92.00
200.00 Total (lines 50 through 199)	0	C		õ	0	0	200.00
				-1	0		

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 07/01/2021		
		Component	CCN: 15-T008	To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 24 am
		Titl	e XIX	Subprovider -	PPS	24 011
				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		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	(00	7.00	instructions)	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATING ROOM	0	0		0 44, 180, 397	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0			0 7, 332, 460		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 3, 562, 087		
53. 00 05300 ANESTHESI OLOGY	0			0 7, 106, 556		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 20, 310, 332		1
55. 00 05500 RADI OLOGY - THERAPEUTI C	0			0 7, 305, 103		
56. 00 05600 RADI OI SOTOPE	0	0		0 5, 342, 360		
57. 00 05700 CT SCAN	0	0		0 32, 069, 749		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 10, 340, 637		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 20, 059, 193		
60. 00 06000 LABORATORY	0	c c		0 64, 901, 472		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	c		0 0		62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0)	0 2, 626, 612	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 4, 423, 458	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 5, 778, 074		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 9, 182, 494		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 5, 379, 111		
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 518, 537		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 15, 349, 384		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 7, 257, 957		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 10, 345, 168		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0 6, 251, 229		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 71, 031, 999		
74.00 07400 RENAL DIALYSIS	0	0		0 3, 489, 699		
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 323, 413		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C	1	0 701, 176	0.00000	76.97
90. 00 09000 CLINIC	0	0		0 4, 111, 479	0.00000	00.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0	-		0 4, 111, 479 0 68, 383, 817		
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0 13, 790, 568		1
200.00 Total (lines 50 through 199)				0 452, 454, 521		200.00
	1 0	1 0	Т		I	1200.00

Health Financial Systems	ST. CATHERINE	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVI CE OTHER PASS	Provider CO	CN: 15-0008 CCN: 15-T008	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/22/2022 9:	
		Ti tl	e XIX	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)	10.00	x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.00000					
50.00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 778		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	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (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	7, 394		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 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	17, 955		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	20, 958		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	23, 803		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	531		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	366		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0 0	0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	12, 537		0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0.000000	0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000	23, 519		0 0	0	1
74. 00 07400 RENAL DI ALYSI S	0.000000	20, 01,		0 0	0	1
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.000000	0		0 0	0	1
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.000000	0	I	<u> </u>	0	1
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0.000000	0		0 0	0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0 0	0	
200.00 Total (lines 50 through 199)	0.000000	108, 841		0 0		200.00
200.00 [10tal (11163 30 through 177)	1 1	100, 041	I	U U	0	I∠00. 00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0008	Period: From 07/01/2021 To 06/30/2022 Hospital	Worksheet D-1 Date/Time Prep 11/22/2022 9:2 PPS	pare
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
~~	INPATIENT DAYS			00.050	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-	š		30, 859 30, 859	
00	Private room days (excluding swing-bed and observation bed da		ivate room davs	30, 839	
	do not complete this line.	joj. Il jou liuve on j pi	rvato room days,	0	
00	Semi-private room days (excluding swing-bed and observation b			26, 368	
00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davs) 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 roo	m days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	m dava) often December (1 of the east	0	8
50	reporting period (if calendar year, enter 0 on this line)	in days) al tel becember s	ST OF THE COST	0	
00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	5, 714	ģ
~ ~	newborn days) (see instructions)				
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	nter 0 on this line)	<i>,</i>		
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X 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 XI	X only (including privat	e room days)	0	13
00	after December 31 of the cost reporting period (if calendar y			0	
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 d	of the cost	0.00	17
	reporting period	5			
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19
	reporting period			0100	
. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	5)		35, 115, 350	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	35, 115, 350	
	5 x line 17)			-	
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19)		ng period (inne	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
00	x line 20) Total aving had aget (age instructions)			0	2
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 35, 115, 350	
. 00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			00, 110, 000	'
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges)			0	
00 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35 36
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	35, 115, 350	
	27 minus line 36)]
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 127 02	38
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 137. 93 6, 502, 132	
	Medically necessary private room cost applicable to the Progr			0, 302, 132	
. 00	medically necessary private room cost appricable to the rrogi			6, 502, 132	

OMPUTATION OF INPATIENT OPE	RATING COST		Provider C		Period:	Worksheet D-1	1
					From 07/01/2021 To 06/30/2022		
			Title	xviii	Hospi tal	11/22/2022 9: PPS	24 8
Cost Center Desc	cription	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Costl		col. 2)		(col. 3 x col. 4)	
.00 NURSERY (title V & XI	X only)	1.00	2.00 C	3.00	4.00 0 0	5.00 C) 42
Intensi ve Care Type I				0.0	<u> </u>		
00 INTENSIVE CARE UNIT	· · ·	5, 436, 718	2, 160	2, 517. 0	0 600	1, 510, 200	
. 00 CORONARY CARE UNIT							44
. 00 BURN INTENSIVE CARE U . 00 SURGICAL INTENSIVE CA							45
00 OTHER SPECIAL CARE (S							40
Cost Center Desc				1			
00 Program inpatient and	illary service cost (Wkst D_3 col 3	Line 200)			1.00 6,831,158	3 48
00 Total Program inpatie				ns)		14, 843, 490	
PASS THROUGH COST ADJ		- ··· ··· ···· ···				.,	
.00 Pass through costs ap	plicable to Program i	npatient routine s	ervices (from	wkst. D, sum	of Parts I and	271, 886	50
.00 Pass through costs ap	plicable to Program i	nnatient ancillary	services (fr	om Wkst D s	m of Parts II	348, 719	51
and IV)			20. 11 003 (11			510,717	
.00 Total Program excluda						620, 605	
5.00 Total Program inpatie			ated, non-phy	sician anesth	etist, and	14, 222, 885	5 53
medical education cos TARGET AMOUNT AND LIM		e 32)					
. 00 Program di scharges						C	54
.00 Target amount per dis						0.00	
.00 Target amount (line 5					50)	C	
.00 Difference between ad .00 Bonus payment (see in		ating cost and tar	get amount (I	ine 56 minus	line 53)		
. 00 Lesser of Lines 53/54		reporting period e	nding 1996, u	pdated and co	mpounded by the		
market basket		·					
00 Lesser of lines 53/54						0.00	
.00 If line 53/54 is less which operating costs						C) 61
amount (line 56), oth			(111e3 54 X	00), 01 1% 01	the target		
.00 Relief payment (see i		,				C	
. 00 Allowable Inpatient c		yment (see instruc	tions)			C	0 63
. 00 Medicare swing-bed SN		osts through Decem	her 31 of the	cost reporti	na period (See	C	64
instructions) (title X							
. 00 Medicare swing-bed SN	•	osts after Decembe	er 31 of the c	ost reporting	period (See	C	65
instructions)(title X .00 Total Medicare swing-		tino costs (lino 6	A plus lipo 4	5) (+i +l o XV/II		c	66
.00 Total Medicare swing- CAH (see instructions		time costs (inne d	4 prus rine d	s)(title xvii	i uniy). Fui	L L	
.00 Title V or XIX swing-	·	ine costs through	December 31 c	of the cost re	porting period	C	67
(line 12 x line 19)							
8.00 Title V or XIX swing- (line 13 x line 20)	bed NF inpatient rout	The costs after De	cemper 31 of	the cost repo	rting period	Ĺ	68
0.00 Total title V or XIX	swing-bed NF inpatien	t routine costs (I	ine 67 + line	68)		C	69
PART III - SKILLED NU							1
0.00 Skilled nursing facil .00 Adjusted general inpa							70
.00 Program routine servi			ne /o ÷ rine	<i>~</i>)			72
. 00 Medically necessary p	•		(line 14 x li	ne 35)			73
.00 Total Program general	•						74
26, line 45)	allocated to inpatien	t routine service	costs (from W	orksheet B, P	art II, column		75
.00 Per diem capital-rela	ted costs (line 75 ÷	line 2)					76
. 00 Program capital -relat	•	,					77
00 Inpatient routine ser	-	,					78
.00 Aggregate charges to				•	is line 70		80
.00 Total Program routine .00 Inpatient routine ser		•	st i i initati Of		us IIIe /9)		81
. 00 Inpatient routine ser	•						82
.00 Reasonable inpatient	routine service costs	(see instructions					83
.00 Program inpatient and			`				84
.00 Utilization review -							85
.00 Total Program inpatie PART IV - COMPUTATION			ouyii oo)				86
2.00 Total observation bed						4, 491	87
3.00 Adjusted general inpa			line 2)			1, 137. 93	
.00 Observation bed cost						5, 110, 444	

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2021	Worksheet D-1	
				To 06/30/2022	Date/Time Pre 11/22/2022 9:	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, 096, 565	35, 115, 350	0. 03122	8 5, 110, 444	159, 589	90.00
91.00 Nursing Program cost	0	35, 115, 350	0.00000	0 5, 110, 444	0	91.00
92.00 Allied health cost	0	35, 115, 350	0. 00000	0 5, 110, 444	0	92.00
93.00 All other Medical Education	0	35, 115, 350	0. 00000	0 5, 110, 444	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0008	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T008	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:2	
		Title XVIII	Subprovider - IRF	PPS	21 0
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
~ ~	INPATIENT DAYS				
. 00	Inpatient days (including private room days and swing-bed day			4,234	1.
00 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed days)		ivato room dave	4, 234 0	2.
00	do not complete this line.	ays). If you have only pr	i vate i ooni uays,	0	3.
00	Semi-private room days (excluding swing-bed and observation I	bed days)		4, 234	4
00	Total swing-bed SNF type inpatient days (including private re	oom days) through Decembe	r 31 of the cost	0	5
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	am daya) through December	21 of the east	0	-
00	Total swing-bed NF type inpatient days (including private roor reporting period	Sill days) through becember	31 OF the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	om davs) 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, 271	9
	newborn days) (see instructions)			_	
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, o		oom days) arter	0	''
2. 00	Swing-bed NF type inpatient days applicable to titles V or X		e room days)	0	12
	through December 31 of the cost reporting period		•		
. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13
00	after December 31 of the cost reporting period (if calendar			0	11
. 00 5. 00	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	ram (excluding swing-bed	uays)	0	14 15
	Nursery days (title V or XIX only)			0	16
	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
	reporting period			0.00	
3. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
9.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
/. 00	reporting period	es through becchiber 51 of		0.00	' '
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
	reporting period				
1.00	Total general inpatient routine service cost (see instruction			4, 335, 684	
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) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	a period (line 6	0	23
3 00	x line 18)		g period (Time o	0	
3. 00					
	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	
	Swing-bed cost applicable to NF type services through December 7 x line 19) $% \left({\left[{{{\rm{T}}_{\rm{T}}} \right]_{\rm{T}}} \right)$		-		24
4. 00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December		-	0	24
4. 00 5. 00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20)		-	0	24 25
4.00 5.00 5.00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions)	31 of the cost reporting	-	0	24 25 26
4.00 5.00 5.00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	31 of the cost reporting	-	0	24 25 26
4.00 5.00 5.00 7.00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions)	31 of the cost reporting (line 21 minus line 26)	period (line 8	0	24 25 26 27
 a. 00 b. 00 c. 00 c. 00 c. 00 d. 00 d. 00 d. 00 d. 00 	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	31 of the cost reporting (line 21 minus line 26)	period (line 8	0 4, 335, 684 0 0	24 25 26 27 28 29
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch	period (line 8	0 4, 335, 684 0 0 0 0	24 25 26 27 28 29 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch	period (line 8	0 4, 335, 684 0 0 0 0 0 0. 000000	24 25 26 27 28 29 30 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch	period (line 8	0 4, 335, 684 0 0 0 0. 000000 0. 000000 0. 00	24 25 26 27 28 29 30 31 32
4.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch ÷ line 28)	period (line 8 arges)	0 4, 335, 684 0 0 0 0 0. 000000 0. 000000 0. 00 0. 00	24 25 26 27 28 29 30 31 32 33
4.00 5.00 5.00 6.00 7.00 8.00 9.00 <t< td=""><td>Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 32 m)</td><td>31 of the cost reporting (line 21 minus line 26) ed and observation bed ch + line 28) inus line 33)(see instruct</td><td>period (line 8 arges)</td><td>0 4, 335, 684 0 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00</td><td>24 25 26 27 28 29 30 31 32 33 34</td></t<>	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 32 m)	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch + line 28) inus line 33)(see instruct	period (line 8 arges)	0 4, 335, 684 0 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00	24 25 26 27 28 29 30 31 32 33 34
4.00 5.00 5.00 7.00 3.00 7.00 3.00 1.00 2.00 3.00 4.00 5.00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 32 m Average per diem private room cost differential (line 34 x li	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch + line 28) inus line 33)(see instruct	period (line 8 arges)	0 4, 335, 684 0 0 0 0 0. 000000 0. 000000 0. 00 0. 00	24 25 26 27 28 29 30 31 32 33
4.00 5.00 6.00 7.00 8.00 7.00 9.00 9.00 1.00 2.00 3.00 4.00 5.00 6.00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 32 m)	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch + line 28) inus line 33)(see instruc- ine 31)	period (line 8 arges) tions)	0 4, 335, 684 0 0 0 0.000000 0.00 0.00 0.00 0.00 0.	24 25 26 27 28 29 30 31 32 33 34 35 36
4. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch + line 28) inus line 33)(see instruc- ine 31)	period (line 8 arges) tions)	0 4, 335, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24 25 26 27 28 29 30 31 32 33 34 35 36
4. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential aj ustment (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	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch ÷ line 28) inus line 33)(see instruction 31) and private room cost di	period (line 8 arges) tions)	0 4, 335, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24 25 26 27 28 29 30 31 32 33 34 35 36
1. 00 5. 00 5. 00 5. 00 6. 00 7. 00 3. 00 0. 00 1. 00 2. 00 3. 00 5. 00 5. 00 5. 00 5. 00 5. 00 7. 00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x li 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.	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch ÷ line 28) inus line 33)(see instruc- ine 31) and private room cost di JUSTMENTS	period (line 8 arges) tions)	0 4, 335, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24 25 26 27 28 29 30 31 32 33 34 35 36 37
1. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 7. 00 3. 00 3. 00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line Average per diem private room cost differential (line 34 x line Average per diem private room cost differential (line 34 x line Average per diem private room cost differential (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 (see	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch + line 28) inus line 33)(see instruc- ine 31) and private room cost di <u>JUSTMENTS</u> e instructions)	period (line 8 arges) tions)	0 4, 335, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24 25 26 27 28 29 30 31 32 33 34 35 36 37 38
4. 00 5. 00 5. 00 7. 00 3. 00 2. 00 3. 00 4. 00 5. 00 7. 00 3. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 6. 00 7. 00 3. 00 9. 00	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x li 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.	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch + line 28) inus line 33)(see instruc- ine 31) and private room cost di <u>JUSTMENTS</u> e instructions) e 38)	period (line 8 arges) tions)	0 4, 335, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24 25 26 27 28 29 30 31 32 33 34 35

	Financial Systems ATION OF INPATIENT OPERATING COST	ST. CATHERINE	Provider C	CN: 15-0008	Period:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-T008	From 07/01/2021 To 06/30/2022	Date/Time Pre	
			Title	e XVIII	Subprovider -	11/22/2022 9: PPS	24 8
	Cost Center Description	Total Inpatient Costl	Total	Average Per Diem (col 1	IRF Program Days	Program Cost (col. 3 x col.	
				col. 2)		4)	-
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00 00 0	5.00 0) 42
~~	Intensive Care Type Inpatient Hospital Units	0					
00 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0.0	00 0	C	43
00	BURN INTENSIVE CARE UNIT						45
00	SURGI CAL I NTENSI VE CARE UNI T						46
00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	·					1.00	
00 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			uns)		1, 326, 871 3, 652, 420	
	PASS THROUGH COST ADJUSTMENTS						
00	Pass through costs applicable to Program inp	atient routine :	services (from	ı Wkst. D, sun	of Parts I and	102, 081	50
00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	39, 430	51
00	and IV) Total Program excludable cost (sum of lines	50 and 51				141, 511	50
. 00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	etist, and	3, 510, 909	
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)	ing post and to	raat amount (1	ing E(minug	Line E2)	0	
00 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (i	The so minus	TThe 53)		
00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	pdated and co	mpounded by the		
00	market basket Lesser of lines 53/54 or 55 from prior year	cost report up	dated by the m	arkat baskat		0.00	60
. 00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				c	62
. 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 Dece	mber 31 of the	cost reporti	ng period (See) 64
	instructions)(title XVIII only)	0			0.1		
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reporting	period (See	C) 65
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line)	64 plus line 6	5)(title XVII	l only). For	0	66
00	CAH (see instructions)		December 21	£ 16			
00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 C	or the cost re	porting period	C	67
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period	0	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	68)		C	69
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID	ONLY		-	
00 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70
00	Program routine service cost (line 9 x line			-)			72
. 00	Medically necessary private room cost applic	Ũ	•				73
00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II column		74
	26, line 45)				are ir, corumn		
00 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	Aggregate charges to beneficiaries for exces	s costs (from p					79
00 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitatior	ı (line 78 mir	us line 79)		80
00	Inpatient routine service cost per drem fining Inpatient routine service cost limitation (I)				82
00	Reasonable inpatient routine service costs (see instruction					83
. 00	Program inpatient ancillary services (see in		nc)				84
. 00 . 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per					0.00	
. 00							

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2021	Worksheet D-1	
		Component (To 06/30/2022	Date/Time Prep 11/22/2022 9:2	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	190, 326	4, 335, 684	0. 04389	0 8	0	90.00
91.00 Nursing Program cost	0	4, 335, 684	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 335, 684	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 335, 684	0.00000	0 0	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0008	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Pre 11/22/2022 9:	pare
	Cost Center Description	Title XIX	Hospi tal	PPS	
	-			1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				+
00	Inpatient days (including private room days and swing-bed day	vs, excluding newborn)		30, 859	1.
00	Inpatient days (including private room days, excluding swing-			30, 859	
00	Private room days (excluding swing-bed and observation bed da	iys). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		26, 368	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	20,000	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro	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 roo	m days) through December	31 of the cost	0	7
00	reporting period	in days) through becember	ST OF the cost	0	'
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8
~~	reporting period (if calendar year, enter 0 on this line)			1 (00	
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	the program (excluding	swing-bed and	1, 689	9
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	room days)	0	10
	through December 31 of the cost reporting period (see instruc	tions)			
I. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		oom days) after	0	11
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		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 XI			0	13
I. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)		uujo)	787	
b. 00	Nursery days (title V or XIX only)			101	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ac through December 21 c	f the cost	0.00	1 17
. 00	reporting period	es thiough becember si c	I the cost	0.00	
8. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
. 00	reporting period	the second Descended of the		0.00	10
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through becember 31 of	the cost	0.00	
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
00	reporting period	- >			1 21
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	35, 115, 350 0	
2.00	5 x line 17)		ing period (inic	0	
3.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
1 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 21 of the cost reporti	ng pariod (line	0	24
1.00	7 x line 19)	a si oi the cost reporti	ng period (inne	0	24
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
00	x line 20) Total swing-bed cost (see instructions)			0	24
5.00 7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 35, 115, 350	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			0011101000	1 -
3. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	÷ Trhe 20)		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	
5.00	Average per diem private room cost differential (line $34 \times 1i$) Private room cost differential adjustment (line $3 \times 1i$)	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 35, 115, 350	
	27 minus line 36)				ٽ ا
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 137. 93	20
	Program general inpatient routine service cost per drem (see	-		1, 137. 93	
	Medically necessary private room cost applicable to the Progr			0	
	Total Program general inpatient routine service cost (line 39	1 + 1 + 1 = 10		1, 921, 964	1 1-

MPUTATI (ON OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	1
					From 07/01/2021 To 06/30/2022	Date/Time Pre	
				e XIX	Hospi tal	11/22/2022 9: PPS	24 a
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 · col. 2)	-	(col. 3 x col. 4)	
0.0		1.00	2.00	3.00	4.00	5.00	
	RSERY (title V & XIX only) ensive Care Type Inpatient Hospital Units	834, 315	787	1,060.12	2 101	107, 072	2 42
	ENSIVE CARE UNIT	5, 436, 718	2, 160	2, 517. 00	315	792, 855	5 43
	RONARY CARE UNIT	-,,	_,	_,		,	44
. 00 BUF	RN INTENSIVE CARE UNIT						45
	RGICAL INTENSIVE CARE UNIT						46
. 00 01F	HER SPECIAL CARE (SPECIFY) Cost Center Description						47
	•					1.00	
	ogram inpatient ancillary service cost (Wks					1, 239, 298	
	<u>tal Program inpatient costs (sum of lines 4</u> S THROUGH COST ADJUSTMENTS	11 through 48)(see instructio	ns)		4, 061, 189	49
	as through costs applicable to Program inpa	atient routine :	services (from	Wkst. D, sum	of Parts I and	99, 813	50
111							
	ss through costs applicable to Program inpa d IV)	atient ancillar	y services (fr	om Wkst. D, si	um of Parts II	56, 976	51
	tal Program excludable cost (sum of lines 5	50 and 51)				156, 789	52
3. 00 Tot	al Program inpatient operating cost exclud	ding capital re	lated, non-phy	sician anesthe	etist, and	3, 904, 400	
	dical education costs (line 49 minus line 5	52)					
	GET AMOUNT AND LIMIT COMPUTATION					0	54
	get amount per discharge					0.00	
	get amount (line 54 x line 55)					0	
	ference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus l	ine 53)	0	
	nus payment (see instructions)					0	
	sser of lines 53/54 or 55 from the cost rep rket basket	porting period	ending 1996, u	pdated and cor	npounded by the	0.00	59
	sser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	arket basket		0.00	60
	line 53/54 is less than the lower of lines					0	61
	ch operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
	bunt (line 56), otherwise enter zero (see i ief payment (see instructions)	instructions)				0	62
	owable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
	GRAM INPATIENT ROUTINE SWING BED COST					-	
	dicare swing-bed SNF inpatient routine cost structions)(title XVIII only)	ts through Dece	mber 31 of the	cost reportir	ng period (See	0	64
	dicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65
i ns	structions)(title XVIII only)						
	tal Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66
	H (see instructions) t∣e V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost rer	orting period	0	67
	ne 12 x line 19)	o ooo co cini ougri			for thig pointed		
	tle V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repor	ting period	0	68 (
	ne 13 x line 20) tal title V or XIX swing-bed NF inpatient r	coutine costs (ling 67 ± ling	68)		0	69
	TIII - SKILLED NURSING FACILITY, OTHER NU			,			1 07
. 00 Ski	<pre>Iled nursing facility/other nursing facili</pre>	ty/ICF/IID rou	tine service c	ost (line 37)			70
	usted general inpatient routine service co		ine 70 ÷ line	2)			71
	ogram routine service cost (line 9 x line 7 dically necessary private room cost applica		(lino 14 v li	no 25)			72
	tal Program general inpatient routine servi			ne 33)			74
	pital-related cost allocated to inpatient r	•		orksheet B, Pa	art II, column		75
	line 45)	2)					
	⁻ diem capital-related costs (line 75 ÷ lir ogram capital-related costs (line 9 x line	· ·					76
	patient routine service cost (line 74 minus						78
	gregate charges to beneficiaries for excess	,	rovi der record	s)			79
00 Tot	al Program routine service costs for compa		ost limitation	(line 78 minu	us line 79)		80
	patient routine service cost per diem limit		`				81
	patient routine service cost limitation (li asonable inpatient routine service costs (s		· .				82
	ogram inpatient ancillary services (see ins		3)				83
	lization review - physician compensation (ns)				85
. 00 Tot	al Program inpatient operating costs (sum	of lines 83 th					86
	T IV - COMPUTATION OF OBSERVATION BED PASS					4 401	07
	tal observation bed days (see instructions) usted general inpatient routine cost per o		line 2)			4, 491 1, 137. 93	
S. UU LANI							

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2021	Worksheet D-1	
				To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 24 am
		Titl	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, 096, 565	35, 115, 350	0.03122	8 5, 110, 444	159, 589	90.00
91.00 Nursing Program cost	0	35, 115, 350	0.00000	0 5, 110, 444	0	91.00
92.00 Allied health cost	0	35, 115, 350	0.00000	0 5, 110, 444	0	92.00
93.00 All other Medical Education	0	35, 115, 350	0. 00000	0 5, 110, 444	0	93.00

	Financial Systems ST. CATHERINE ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0008	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T008	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		Title XIX	Subprovider - IRF	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS			4.004	1 1
00 00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			4, 234 4, 234	
00	Private room days (excluding swing-bed and observation bed of		ivate room dave	4,234	
00	do not complete this line.	days). It you have only pr	rvate room days,	0	J .
00	Semi-private room days (excluding swing-bed and observation	bed days)		4, 234	4.
00	Total swing-bed SNF type inpatient days (including private r	room days) through Decembe	er 31 of the cost	0	
	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 dave) 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 davs) 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	38	9.
	newborn days) (see instructions)			_	
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.
. 00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		nom days) after	0	11.
. 00	December 31 of the cost reporting period (if calendar year,		oom days) arter	0	
2. 00	Swing-bed NF type inpatient days applicable to titles V or >		e room days)	0	12.
	through December 31 of the cost reporting period		-		
. 00	Swing-bed NF type inpatient days applicable to titles V or >			0	13
00	after December 31 of the cost reporting period (if calendar			0	14
. 00	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	gram (excluding swing-bed	uays)	787	
	Nursery days (title V or XIX only)			101	
	SWING BED ADJUSTMENT				1
. 00	Medicare rate for swing-bed SNF services applicable to servi	ices through December 31 c	of the cost	0.00	17
	reporting period			0.00	10
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	Ices after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service	res 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.
	reporting period				
. 00	Total general inpatient routine service cost (see instruction			4, 335, 684	
2.00	Swing-bed cost applicable to SNF type services through Decem 5 x line 17)	mber 31 of the cost report	ing period (line	0	22
8. 00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reportin	a period (line 6	0	23
	x line 18)		.9	-	
. 00	Swing-bed cost applicable to NF type services through Decemb	ber 31 of the cost reporti	ng period (line	0	24
	7 x line 19)			_	
5.00	Swing-bed cost applicable to NF type services after December	r 31 of the cost reporting	period (line 8	0	25
b. 00	x line 20) 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, 335, 684	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		I	.,	
. 00	General inpatient routine service charges (excluding swing-b	bed and observation bed ch	arges)	0	28
0. 00	Private room charges (excluding swing-bed charges)			0	
	Semi -private room charges (excluding swing-bed charges)			0	
. 00 . 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	/ ÷ IINE 28)		0.000000	
. 00	Average semi-private room per diem charge (line 29 ÷ line 3) 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	
. 00	Average per diem private room cost differential (line 34 x l		ŕ	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	t and private room cost di	fferential (line	4, 335, 684	37
7.00	27 minus line 36)				-
					1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AE			1 024 02	38
7.00 3.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AL Adjusted general inpatient routine service cost per diem (se	ee instructions)		1, 024. 02 38, 913	
7.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AE	ee instructions) ne 38)		1, 024. 02 38, 913 0	39.

	Financial Systems ATION OF INPATIENT OPERATING COST	ST. CATHERIN	E HOSPITAL Provider C	CN: 15-0008	Period:	eu of Form CMS- Worksheet D-1	
				CCN: 15-T008	From 07/01/2021 To 06/30/2022	Date/Time Pre	epare
			Titl	e XIX	Subprovider -	11/22/2022 9: PPS	24 a
					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
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	(0	00 0) 43
. 00	CORONARY CARE UNI T	Ŭ					44
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	·					1.00	
	Program inpatient ancillary service cost (Wk					33, 637	
. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ons)		72, 550	<u>)</u> 49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	Wkst D su	m of Parts I and	1, 708	3 50
	(111)	attone routine		. mtst. D, Su		1,700	30
. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	978	3 51
. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51				2, 686	E 2
2.00	Total Program excludable cost (sum of lines) Total Program inpatient operating cost exclu		lated, non-phy	sician anest	hetist, and	69, 864	
	medical education costs (line 49 minus line						
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, ι	updated and c	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year o	cost report. up	dated by the m	narket basket		0.00	60
	If line 53/54 is less than the lower of line					0	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% o	f the target		
2.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				0	62
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	•					
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost report	ing period (See	0	64
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reportin	q period (See	0	65
	instructions)(title XVIII only)				5 1		
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVI	II only). For	0	66
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 d	of the cost r	eporting period	0	67
. 00	(line 12 x line 19)		becomber of c		opor tring por rou		
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	0	68
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routino costa (ling 47 . ling	× 40)		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU						1 07
0. 00	Skilled nursing facility/other nursing facil)		70
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
	Program routine service cost (line 9 x line Medically necessary private room cost applic		(lipo 14 v li	po 25)			72
. 00	Total Program general inpatient routine service	U	•				74
. 00	Capital-related cost allocated to inpatient				Part II, column		75
0.0	26, line 45)						
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76
	Inpatient routine service cost (line 74 minu:						78
. 00	Aggregate charges to beneficiaries for excess		rovi der record	ls)			79
00	Total Program routine service costs for compa		ost limitatior	n (line 78 mi	nus line 79)		80
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81
	Reasonable inpatient routine service cost inmitation (i						82
	Program inpatient ancillary services (see ins		- /				84
. 00	Utilization review - physician compensation	(see instructio					85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
7.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87
	Adjusted general inpatient routine cost per		line 2)			0.00	
3.00							

Health Financial Systems	ST. CATHERIN	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2021	Worksheet D-1	
		Component (To 06/30/2022	Date/Time Pre 11/22/2022 9:2	pared: 24 am
		Titl	e XIX	Subprovider - IRF	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	190, 326	4, 335, 684	0. 04389	8 0	0	90.00
91.00 Nursing Program cost	0	4, 335, 684	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 335, 684	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 335, 684	0. 00000	0 0	0	93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0008	Period:	Worksheet D-3	
			From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared
	Title	e XVIII	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	11 510 150		
00 03000 ADULTS & PEDIATRICS			14, 519, 458		30.0
00 03100 I NTENSI VE CARE UNI T			1, 795, 731		31.0
00 04000 SUBPROVIDER - IPF			0		40.0
00 04100 SUBPROVIDER - IRF			0		41.0
					43. C
		0.2225	4 2 402 070	7/1 007	
00 05000 0PERATING ROOM 00 05100 RECOVERY ROOM		0. 22350		761,007	
				58, 264	
00 05200 DELIVERY ROOM & LABOR ROOM		0. 62274		6, 256	
		0. 1241		51, 512	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 2257		187, 047	
00 05500 RADI OLOGY - THERAPEUTI C		0. 13153		0	
00 05600 RADI OI SOTOPE		0. 20693		83, 083	
00 05700 CT SCAN		0.0519		102, 226	
00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.07463		32, 358	
00 05900 CARDIAC CATHETERIZATION		0. 13898		425, 161	
		0. 1381		707, 282	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
00 06300 BLOOD STORING, PROCESSING, & TRANS.		0.36739		130, 500	
00 06400 I NTRAVENOUS THERAPY		0. 27373		0	
00 06500 RESPI RATORY THERAPY		0. 39314		544, 536	
00 06600 PHYSI CAL THERAPY		0.3993		243, 418	
00 06700 OCCUPATI ONAL THERAPY		0. 34048		199, 400	
		0.38008		44, 851	
00 06900 ELECTROCARDI OLOGY		0.0969		146, 586	
00 07000 ELECTROENCEPHALOGRAPHY		0. 12880		8, 713	
00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0.34400		590, 747	
00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.53050		470, 282	
00 07300 DRUGS CHARGED TO PATIENTS		0. 17564		1,008,514	
00 07400 RENAL DI ALYSI S		0. 2433		216, 526	
00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.85240		823	
97 07697 CARDI AC REHABI LI TATI ON		1. 22002	29 24, 190	29, 513	76. 9
		0 4770	101 040	E7 000	
		0.47703			
00 09100 EMERGENCY		0. 1210		483, 927	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3705		240, 787	
D. 00 Total (sum of lines 50 through 94 and 96 through 98 1.00 Less PBP Clinic Laboratory Services-Program only ch			34, 517, 376	6, 831, 158	
1.00 Less PBP Clinic Laboratory Services-Program only ch	arnes (LINE 61)	1	0		201.

PATIENT ANCILL	Systems ST. CATHERIN ARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0008	Peri od:	Worksheet D-3	1
				From 07/01/2021		
		Component	CCN: 15-T008	To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		Title	e XVIII	Subprovider -	PPS	
				I RF		
Cost	Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2.00	3.00	
	ROUTINE SERVICE COST CENTERS					
	TS & PEDIATRICS					30
	NSI VE CARE UNI T					31
	ROVIDER - IPF					40
	ROVIDER - IRF			3, 610, 300		41
. 00 04300 NURS						43
	SERVI CE COST CENTERS					
	ATING ROOM		0. 2235		23, 872	
. 00 05100 RECO			0. 2686			
	VERY ROOM & LABOR ROOM		0. 6227		0	
	THESI OLOGY		0. 1241			
	OLOGY-DI AGNOSTI C		0. 2257		19, 685	
	OLOGY - THERAPEUTIC		0. 1315		-	
. 00 05600 RADI			0. 2069		3, 308	
.00 05700 CT S			0.0519		2, 582	
	ETIC RESONANCE IMAGING (MRI)		0.0746			
	I AC CATHETERI ZATI ON		0. 1389		-	
. 00 06000 LABO			0. 1381			
	E BLOOD & PACKED RED BLOOD CELL		0.0000		0	
	D STORING, PROCESSING, & TRANS.		0.3673		4, 257	
	AVENOUS THERAPY		0. 27373		0	
	I RATORY THERAPY		0. 3931		54, 992	
	I CAL THERAPY PATI ONAL THERAPY		0. 3993		430, 779 374, 429	
	CH PATHOLOGY		0. 3404			
	TROCARDI OLOGY		0. 0969		2, 659	
	TROEARDFOLOGT		0. 1288			
	CAL SUPPLIES CHARGED TO PATIENT		0. 3440			
	DEV. CHARGED TO PATIENTS		0. 53050		2, 532	
. 00 07200 TMPL	S CHARGED TO PATIENTS		0. 1756		169, 552	
	L DIALYSIS		0. 1758		53, 079	
	HI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 8524			
	I AC REHABI LI TATI ON		1. 22002			
	SERVICE COST CENTERS		1. 2200.		0	
00 09000 CLIN			0.4770	30 0	0	90
. 00 09100 EMER			0. 1210			
	RVATION BEDS (NON-DISTINCT PART		0. 3705		021	
	I (sum of lines 50 through 94 and 96 through 98)			4, 644, 611	1, 326, 871	
	BPBP Clinic Laboratory Services-Program only char	aes (line 61)		., ,	., 525, 671	201
	charges (line 200 minus line 201)			4, 644, 611		202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0008	Period:	u of Form CMS-: Worksheet D-3	
			From 07/01/2021		
			To 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Ti †I	e XIX	Hospi tal	PPS	24 ali
Cost Center Description		Ratio of Cos		Inpatient	
		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			4, 755, 377		30.
. 00 03100 I NTENSI VE CARE UNI T			299, 955		31.
0. 00 04000 SUBPROVIDER - IPF			0		40.
. 00 04100 SUBPROVIDER - IRF			0		41.
0.00 04300 NURSERY			186, 763		43.
ANCI LLARY SERVI CE COST CENTERS		0.2225	(4 EQ (400	121 120	1 50
0. 00 05000 OPERATING ROOM . 00 05100 RECOVERY ROOM		0. 22350			
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 20800		12, 257 115, 346	
00 05300 ANESTHESI OLOGY		0. 1241		13, 581	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2257			
00 05500 RADIOLOGY - THERAPEUTIC		0. 13153		34, 931	
0. 00 05600 RADI OLOGI - THERAPEOTIC		0. 20693		-	
2. 00 05700 CT SCAN		0. 05195			
B. OO OSSOO MAGNETIC RESONANCE IMAGING (MRI)		0.07463		6, 902	
0. 00 05900 CARDI AC CATHETERI ZATI ON		0. 13898			
0. 00 06000 LABORATORY		0. 1381			
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	
00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 36739		11, 336	
. 00 06400 I NTRAVENOUS THERAPY		0. 27373		0	
00 06500 RESPI RATORY THERAPY		0. 39314		82, 446	
00 06600 PHYSI CAL THERAPY		0. 3993		54, 926	
00 06700 OCCUPATI ONAL THERAPY		0. 34048		23, 130	
00 06800 SPEECH PATHOLOGY		0. 38008			
. 00 06900 ELECTROCARDI OLOGY		0.0969			
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 12886		4, 015	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.34400			
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 53050			
0. 00 07300 DRUGS CHARGED TO PATIENTS		0. 17564		230, 878	
. 00 07400 RENAL DIALYSIS		0. 2433		18, 468	
0. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 85240		0	76.
0. 97 07697 CARDI AC REHABI LI TATI ON		1. 22002	29 2, 879	3, 512	76.
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLI NI C		0. 47703		-	
. 00 09100 EMERGENCY		0. 1210			
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3705			
0.00 Total (sum of lines 50 through 94 and 96 through			6, 183, 424	1, 239, 298	
11.00 Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201.
2.00 Net charges (line 200 minus line 201)			6, 183, 424		202.

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0008	Period:	Worksheet D-3	3
	Component	CCN: 15-T008	From 07/01/2021 To 06/30/2022	Date/Time Pre	nar
	Component	CCN. 15-1006	10 00/30/2022	11/22/2022 9:	
	Titl	e XIX	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
•		To Charges	Program	Program Costs	
		_	Charges	(col. 1 x col.	
		1.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
0. 00 03000 ADULTS & PEDIATRICS					30
. 00 03100 I NTENSI VE CARE UNI T					31
0. 00 04000 SUBPROVIDER - IPF					40
. 00 04100 SUBPROVIDER - IRF			76, 345		41
. 00 04300 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
. 00 05000 OPERATING ROOM		0. 22356			
. 00 05100 RECOVERY ROOM		0. 26868		-	
. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 62274		0	
. 00 05300 ANESTHESI OLOGY		0. 12417			
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 22571			
00 05500 RADI OLOGY - THERAPEUTI C		0. 13153			
00 05600 RADI OI SOTOPE		0. 20693			
00 05700 CT SCAN		0.05195		0	
. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.07463		0	
. 00 05900 CARDIAC CATHETERIZATION . 00 06000 LABORATORY		0. 13898		0	
.00 06000 LABORATORY .00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 13811		1, 021 0	
. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 36739		0	
. 00 06400 INTRAVENOUS THERAPY		0. 27373		0	
. 00 06500 RESPIRATORY THERAPY		0. 39314			
. 00 06600 PHYSI CAL THERAPY		0. 39939			
. 00 06700 OCCUPATI ONAL THERAPY		0. 34048		8, 105	
. 00 06800 SPEECH PATHOLOGY		0. 38008		202	
. 00 06900 ELECTROCARDI OLOGY		0.09697			
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 12886		0	70
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT		0.34400		4, 313	71
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 53050	09 0	0	72
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 17564	4 23, 519	4, 131	73
. 00 07400 RENAL DIALYSIS		0. 24335	53 0	0	74
. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 85246	67 0	0	76
. 97 07697 CARDIAC REHABILITATION		1. 22002	29 0	0	76
OUTPATIENT SERVICE COST CENTERS		1	1		
. 00 09000 CLINIC		0. 47703			
. 00 09100 EMERGENCY		0. 12109			
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 37057		0	
0.00 Total (sum of lines 50 through 94 and 96 thro			108, 841	33, 637	
11.00 Less PBP Clinic Laboratory Services-Program o	nıy charges (line 61)		0		201
2.00 Net charges (line 200 minus line 201)			108, 841		202

	Financial Systems ST. CATHERINE ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0008	Peri od: From 07/01/2021 To 06/30/2022	u of Form CMS-: Worksheet E Part A Date/Time Pre	pared:
		Title XVIII	Hospi tal	11/22/2022 9: PPS	24 am
	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 2, 768, 670	1.0 1.0
. 02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	8, 113, 084	1.0
. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	prior to October	0	1.0
. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	on or after	0	1.0
. 00 . 01	October 1 (see instructions) Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.0 2.0
. 01	Outlier payment for discharges for Model 4 BPCI (see instruct	ions)		0	2.0
. 03	Outlier payments for discharges occurring prior to October 1	-		17, 906	
. 04	Outlier payments for discharges occurring on or after October	1 (see instructions)		33, 203	2.0
. 00	Managed Care Simulated Payments			0	
. 00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	orting period (see instru	uctions)	106.61	4.0
. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t 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 5503 reduction amount to the IME cap as specified under			0.00 0.00	7.0 7.0
. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa	thic and osteopathic pro	ograms for	0.00	8.0
	affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	79(c)(2)(iv), 64 FR 2634	40 (May 12,		
. 01	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
. 02	The amount of increase if the hospital was awarded FTE cap sI under § 5506 of ACA. (see instructions)		o .	0.00	
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)			0.00	
0.00 1.00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	rent year from your reco	rds	0.00 0.00	
2.00	Current year allowable FTE (see instructions)			0.00	
3.00	Total allowable FTE count for the prior year.			0.00	13.0
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	14.0
	Sum of lines 12 through 14 divided by 3.				15.0
	Adjustment for residents in initial years of the program				16.0
7.00 8.00	Adjustment for residents displaced by program or hospital clc Adjusted rolling average FTE count	sure		0.00 0.00	
	Current year resident to bed ratio (line 18 divided by line 4			0.000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
	IME payment adjustment (see instructions)			0	
	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42		NED 412 105	0	1
3.00 4.00	Number of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)	ient cap stots under 42 (ν ΓΚ 4ΙΖ. Ι ΟΌ	0.00	
	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	
8.00	IME add-on adjustment amount (see instructions)			0	
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 Dispropertional Share Adjustment	01)		0	29. 29.
0. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	atient davs (see instru	ctions)	11.50	30.
	Percentage of Medicaid patient days (see instructions)	actione days (see finstilled		44.12	
2.00	Sum of Lines 30 and 31			55.62	
	Allowable disproportionate share percentage (see instructions	5)		35.10	33.
	Disproportionate share adjustment (see instructions)			954, 874	34

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0008	Peri od:	Worksheet E	
			From 07/01/2021 To 06/30/2022	Part A Date/Time Pre	
		Ti the XV/111	llooni tol	11/22/2022 9:2	24 a
		Title XVIII	Hospital Prior to 10/1	PPS	
			1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		8, 290, 014, 521		
	Factor 3 (see instructions)		0.000210935	0.000170182	35
5.02	Hospital uncompensated care payment (If line 34 is zero, enterinstructions)	er zero on this line) (see	1, 748, 651	1, 223, 948	35
5.03	Pro rata share of the hospital uncompensated care payment among	ount (see instructions)	440, 756	915, 446	35
	Total uncompensated care (sum of columns 1 and 2 on line 35.0	. ,	1, 356, 202	713, 440	36
0.00	Additional payment for high percentage of ESRD beneficiary di				00
0. 00	Total Medicare discharges (see instructions)		0		40
	· · · · · · · · · · · · · · · · · · ·		Before 1/1	On/After 1/1	
			1.00	1.01	
1. 00	Total ESRD Medicare discharges (see instructions)		0	0	41
	Total ESRD Medicare covered and paid discharges (see instruc		0	0	41
	Divide line 41 by line 40 (if less than 10%, you do not quali	ify for adjustment)	0.00		42
	Total Medicare ESRD inpatient days (see instructions)	here there and alterial and here 7	0		43
4.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by /	0.00000		44
5.00	days) Average weekly cost for dialysis treatments (see instructions	e)	0.00	0.00	45
	Total additional payment (line 45 times line 44 times line 47		0.00	0.00	46
7.00	Subtotal (see instructions)		13, 243, 939		47
	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only. (see instructions)	•			
				Amount	
0 00		-)		1.00	10
9.00 0.00	Total payment for inpatient operating costs (see instructions Payment for inpatient program capital (from Wkst. L, Pt. I a			13, 243, 939 925, 864	49 50
	Exception payment for inpatient program capital (Wkst. L, Pt. 1 a)			^{925, 804}	51
	Direct graduate medical education payment (from Wkst. E-4, li			0	52
3.00	Nursing and Allied Health Managed Care payment			0	53
	Special add-on payments for new technologies			147, 784	54
4.01	Islet isolation add-on payment				
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line (0	54
5.00	5 I I I I I I I I I I I I I I I I I I I	-		0 0	55
6. 00	Cost of physicians' services in a teaching hospital (see inti	ructions)			55 56
6. 00 7. 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. 1	ructions) III, column 9, lines 30 th	nrough 35).	0 0 0	55 56 57
5.00 7.00 3.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt.	ructions) III, column 9, lines 30 th	nrough 35).	0 0 0	55 56 57 58
5.00 7.00 3.00 9.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	ructions) III, column 9, lines 30 th	nrough 35).	0 0 0	55 56 57 58 59
5.00 7.00 3.00 9.00 0.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments	ructions) III, column 9, lines 30 th IV, col. 11 line 200)	nrough 35).	0 0 0 14, 317, 587 0	55 56 57 58 59 60
6.00 7.00 8.00 9.00 0.00 1.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus	ructions) III, column 9, lines 30 th IV, col. 11 line 200)	nrough 35).	0 0 0 14, 317, 587 0 14, 317, 587	55 57 58 59 60 61
5.00 7.00 3.00 9.00 0.00 1.00 2.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	ructions) III, column 9, lines 30 th IV, col. 11 line 200)	nrough 35).	0 0 0 14, 317, 587 0 14, 317, 587 1, 037, 448	55 57 58 59 60 61 62
5. 00 7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus	ructions) III, column 9, lines 30 th IV, col. 11 line 200)	nrough 35).	0 0 0 14, 317, 587 0 14, 317, 587	55 57 58 59 60 61 62 63
5.00 7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	ructions) III, column 9, lines 30 th IV, col. 11 line 200)	nrough 35).	0 0 0 14, 317, 587 14, 317, 587 1, 037, 448 92, 976	55 57 58 59 60 61 62 63 64
6.00 7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60)	nrough 35).	0 0 14, 317, 587 1, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052	55 57 58 59 60 61 62 63 64 65 66
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63)	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions)	-	0 0 14, 317, 587 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710	55 57 58 59 60 61 62 63 64 65 66
5.00 7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 3.00 4.00 5.00 6.00 7.00 3.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se	e instructions)	0 0 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052 13, 444, 873 0	555 566 57 588 59 600 61 62 63 64 65 64 65 668
5.00 7.00 3.00 9.00 9.00 1.00 2.00 3.00 4.00 5.00 7.00 3.00 9.00 9.00 9.00 9.00 9.00 9.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst 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).	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se	e instructions)	0 0 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052 13, 444, 87 0 0	555 566 57 586 59 60 61 62 63 64 65 66 67 68 69
5.00 7.00 3.00 9.00 9.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 3.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) 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)	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se .(For SCH see instructions	ee instructions)	0 0 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052 13, 444, 873 0 0	555 56 57 58 59 60 61 62 63 64 65 64 65 66 67 68 67 68 67 70
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst 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 Demonst	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se .(For SCH see instructions tration) adjustment (see i	ee instructions)	0 0 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052 13, 444, 873 0 0 0	555 566 577 588 599 600 611 622 633 644 655 666 677 688 699 700 700
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 50 0. 87	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst 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	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se .(For SCH see instructions tration) adjustment (see i	ee instructions)	0 0 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052 13, 444, 873 0 0 0 0 0	555 566 57 58 59 60 61 62 63 64 65 66 67 68 67 70 70 70 70
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87 0.88	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst 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 Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se .(For SCH see instructions tration) adjustment (see i	ee instructions)	0 0 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052 13, 444, 873 0 0 0	555 566 57 58 59 60 61 62 63 64 65 64 65 66 67 70 70 70 70 70 70
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 500	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst 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 Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se .(For SCH see instructions tration) adjustment (see i	ee instructions)	0 0 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052 13, 444, 873 0 0 0 0 0 0 0 0 0 0 0 0 0 0	555 56 57 58 59 60 61 62 63 64 65 66 67 68 67 70 70 70 70 70 70
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 6. 00 6. 00 0. 50 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst 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 Demonst 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)	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se .(For SCH see instructions tration) adjustment (see i	ee instructions)	0 0 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052 13, 444, 87 0 0 0 0 0 0 0	555 567 578 599 600 61 62 633 644 655 666 677 688 699 700 700 700 700 700 700
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 0. 00 0. 00 0. 50 0. 00 0. 00 0. 50 0. 88 0. 89 0. 90 0. 90	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst 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 HRR adjustment amount (see instructions)	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se .(For SCH see instructions tration) adjustment (see i	ee instructions)	0 0 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052 13, 444, 873 0 0 0 0 0 0 0 0 0 0 0 0 0 0	555 57 58 59 60 61 62 63 64 65 64 65 66 67 70 70 70 70 70 70 70 70 70 70 70
6.00 7.00 8.00 9.00 0.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.50 0.50 0.87 0.87 0.87 0.89 0.90 0.91 0.92	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) 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 Demonst 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) Bundled Model 1 discount amount (see instructions)	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se .(For SCH see instructions tration) adjustment (see i	ee instructions)	0 0 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052 13, 444, 873 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	555 56 57 58 59 60 61 62 63 64 65 66 67 68 67 70 70 70 70 70 70 70 70 70 70 70 70 70
9.00 0.00 1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 0.50 0.50 0.87 0.88 0.90 0.91 0.92 0.93	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst 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 HRR adjustment amount (see instructions)	ructions) III, column 9, lines 30 th IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (se .(For SCH see instructions tration) adjustment (see i	ee instructions)	0 0 0 14, 317, 587 1, 037, 448 92, 976 396, 477 257, 710 138, 052 13, 444, 873 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	63 64 65 66

	Financial Systems ST. CATHERINE TION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0008	Peri od:	u of Form CMS-2 Worksheet E	
				From 07/01/2021 To 06/30/2022		
			e XVIII	Hocpi tal	11/22/2022 9: PPS	24
		Intre		Hospi tal	Amount	
				0	1.00	
	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70
	the corresponding federal year for the period prior to 10/1)			0		1 70
	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or a			0	0	70
	Low Volume Payment-3				0	70
	HAC adjustment amount (see instructions)				0	70
. 00 /	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			13, 431, 470	71
	Sequestration adjustment (see instructions)				33, 579	
	Demonstration payment adjustment amount after sequestration				0	
	Sequestration adjustment-PARHM pass-throughs Interim payments				12, 739, 282	71
	Interim payments				12, 737, 202	72
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM (for contractor use only)					73
	Balance due provider/program (line 71 minus lines 71.01, 71.0	02, 72, and			658, 609	74
	73) Palanas dua pravidar (program DADUM (cos i potructiona)					<u>-</u> .
	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	anco with			417, 386	74
	CMS Pub. 15-2, chapter 1, §115.2				417, 500	'`
Г	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90
	plus 2.04 (see instructions)					
	Capital outlier from Wkst. L, Pt. I, line 2 Operating outlier reconciliation adjustment amount (see inst	ructions)			0	9
	Capital outlier reconciliation adjustment amount (see instru				0	
	The rate used to calculate the time value of money (see inst				0.00	
	Time value of money for operating expenses (see instructions)				0	95
. 00	Time value of money for capital related expenses (see instru	ctions)			0	96
				1.00	0n/After 10/1 2.00	
H						
	HSP Bonus Payment Amount					
o. oo[i	HSP bonus amount (see instructions)			0	0	100
0. 00 I F	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment					
). 00 	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0.000000000	0. 0000000000	10'
0. 00 	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	ns)			0. 0000000000	10'
0.00 .00 2.00 	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	ns)		0.000000000	0.0000000000000000000000000000000000000	10 ⁻ 10:
0.00 1.00 2.00 H 3.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction			0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000	10 ⁻ 10: 10:
D. 00 	HSP bonus amount (see instructions) HSP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst	s) tration) Adju		0. 000000000 0 0. 0000	0. 000000000 0 0. 0000	10 ⁻ 102
D. 00 	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration pr	s) tration) Adju		0. 000000000 0 0. 0000	0. 000000000 0 0. 0000	10 ⁻ 102 103
D. 00 	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration pro Century Cures Act? Enter "Y" for yes or "N" for no.	s) tration) Adju		0. 000000000 0 0. 0000	0. 000000000 0 0. 0000	10 ⁻ 102 103
D. 00 	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) tration) Adju eriod under t		0. 000000000 0 0. 0000	0. 000000000 0 0. 0000	10 ⁷ 102 103 104
D. 00 1 1. 00 1 2. 00 1 4. 00 1 4. 00 1 5. 00 1 1. 00 1	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) Community Hospital Demonstration Project (§410A Demonstration project (§410A Demonstration project (§410A Demonstration project) Is this the first year of the current 5-year demonstration project (see instructions) Century Cures Act? Enter "Y" for yes or "N" for no. Dost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, III)	s) tration) Adju eriod under t		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000	10 ⁻ 102 103 104 200
D. 00 1 H 1. 00 1 2. 00 1 4. 00 1 5. 00 1 6 7. 00 1 1. 00 1 1. 00 1 1. 00 1 1. 00 1 1. 00 1 2. 00 1 3. 00 1	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction IRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	s) tration) Adju eriod under t ne 49)	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	10 ⁻ 102 102 200 200
). 00 1 1. 00 1 2. 00 1 3. 00 1 4. 00 1 5. 00 1 6 7. 00 1 8. 00 1 1. 00 1 2. 00 1 3. 00 1 3. 00 1 3. 00 1 3. 00 1	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration pro- Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	s) tration) Adju eriod under t ne 49)	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	10 ⁻ 102 102 200 200
). 00 . 00 2. 00 . 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	s) tration) Adju eriod under t ne 49)	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	10° 102 102 200 200 202 202
0.001 H 1.001 H 2.001 H 3.001 H 4.001 H 0.001 H 0.001 <td< td=""><td>HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration protect Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount</td><td>s) tration) Adju eriod under t ne 49)</td><td>he 21st</td><td>0. 000000000 0 0. 0000 0</td><td>0. 000000000 0 0. 0000 0</td><td>10° 102 102 200 202 203 203</td></td<>	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration protect Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	s) tration) Adju eriod under t ne 49)	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	10° 102 102 200 202 203 203
0.001 H 1.001 H 2.001 H 3.001 H 4.001 H 0.001 H 0.001 <td< td=""><td>HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)</td><td>s) tration) Adju eriod under t ne 49) n first year</td><td>he 21st</td><td>0. 000000000 0 0. 0000 0</td><td>0. 000000000 0 0. 0000 0</td><td>101 102 103 104 200 201 202 203</td></td<>	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	s) tration) Adju eriod under t ne 49) n first year	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202 203
). 00 1 1. 00 1 2. 00 1 4. 00 1 4. 00 1 7. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, III Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in Deriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	s) tration) Adju eriod under t ne 49) n first year)	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	102 103 104 200 201 202 203 204 205 206
). 00 1 1. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction fRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare inpatient routine cost cap (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	s) tration) Adju eriod under t ne 49) n first year) tructions)	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101 102 103 104 200 203 203 204 205 206
D. 00 I I. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in beriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. A	s) tration) Adju eriod under t ne 49) n first year) tructions)	he 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202 203 204 205 206 207 207 207
b 00 I 1 00 I I 2 00 I I I 3 00 I I I I 3 00 I <td>HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonsi Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Dost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in beriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins: Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions)</td> <td>s) tration) Adju eriod under t ne 49) n first year) tructions)</td> <td>he 21st</td> <td>0. 000000000 0 0. 0000 0</td> <td>0. 0000000000 0 0. 0000 0 0 trati on</td> <td>101 102 103 104 200 203 203 205 206 205 206 207 208 207 208 207</td>	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonsi Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Dost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in beriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins: Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions)	s) tration) Adju eriod under t ne 49) n first year) tructions)	he 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 trati on	101 102 103 104 200 203 203 205 206 205 206 207 208 207 208 207
b. 00 I I. 00 I I I. 00 I I I I. 00 I I I I I. 00 I <td< td=""><td>HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in Seriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see insimedicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) Reserved for future use</td><td>s) tration) Adju eriod under t ne 49) n first year) tructions) , line 59)</td><td>he 21st</td><td>0. 000000000 0 0. 0000 0</td><td>0. 0000000000 0 0. 0000 0 0 trati on</td><td>101 102 103 200 203 203 203 203 204 205 204 205 206 206 206 206 206 207 208 206 207 208 207 208 207 207 207 207 207 207 207 207 207 207</td></td<>	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in Seriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see insimedicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	s) tration) Adju eriod under t ne 49) n first year) tructions) , line 59)	he 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 trati on	101 102 103 200 203 203 203 203 204 205 204 205 206 206 206 206 206 207 208 206 207 208 207 208 207 207 207 207 207 207 207 207 207 207
D. 00 I I. 00 I	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonsi Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Dost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in beriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins: Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions)	s) tration) Adju eriod under t ne 49) n first year) tructions) , line 59)	he 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 trati on	101 102 103 200 203 203 203 203 204 205 204 205 206 206 206 206 206 207 208 206 207 208 207 208 207 207 207 207 207 207 207 207 207 207
0. 00 1 1. 00 1 2. 00 1 3. 00 1 4. 00 1 4. 00 1 7. 00 1 4. 00 1 6. 00 1 7. 00 1 4. 00 1 7.	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	s) tration) Adju eriod under t ne 49) n first year) tructions) , line 59))	he 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 trati on	101 102 103 104 200 201 202 203 204 205 206 206 207 208 209 210 211 212
0. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, III Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in Deriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) tration) Adju eriod under t ne 49) n first year) tructions) , line 59)) 211)	of the currer	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0 trati on	101 102 102 201 202 203 204 205 206 207 208 207 208 207 208 207 208 207 208 207

CALCUL	ATI ON OF REIMBURSEMENT SETTLEMENT Provi	ider CCN: 15-0008	Period: From 07/01/2021 To 06/30/2022		
		Title XVIII	Hospi tal	11/22/2022 9: PPS	24 am
			noopritai		
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			5, 797	1.00
2.00	Medical and other services (see finited under OPPS (see instructions)			8, 570, 009	
3.00	OPPS payments			6, 888, 291	3.00
4.00	Outlier payment (see instructions)			2, 330	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions	:)		0.000	
6.00	Line 2 times line 5	·)		0.000	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, co Organ acquisitions	I. 13, line 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 797	
	COMPUTATION OF LESSER OF COST OR CHARGES			0, , , ,	
	Reasonabl e charges				
	Ancillary service charges			28, 984	
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69 Total reasonable charges (sum of lines 12 and 13))		0 28, 984	
14.00	Customary charges			20, 704	14.00
15.00	Aggregate amount actually collected from patients liable for paymen	it for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for paym	ent for services o	n a chargebasis	0	16.00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0,00000	17 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 28, 984	
19.00	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds li	ne 11) (see	23, 187	1
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only if	line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			5, 797	21.00
	Interns and residents (see instructions)			0,777	
23.00	Cost of physicians' services in a teaching hospital (see instructio	ins)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			6, 890, 621	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instr	uctions)	1, 265, 783	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus t			5, 630, 635	
~~ ~~	instructions)				
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, line 50 ESRD direct medical education costs (from Wkst. E-4, line 36))		0	
30.00	Subtotal (sum of lines 27 through 29)			5, 630, 635	
31.00	Primary payer payments			7, 766	31.00
32.00	Subtotal (line 30 minus line 31)			5, 622, 869	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			349, 857	
35.00	Adjusted reimbursable bad debts (see instructions)			227, 407	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructio	ins)		145, 360	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			5, 850, 276 9	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			9	
	Pioneer ACO demonstration payment adjustment (see instructions)			Ū	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	
39.98	Partial or full credits received from manufacturers for replaced de	vices (see instruc	tions)	0	
39.99 40.00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 5, 850, 267	
40.00	Sequestration adjustment (see instructions)			14, 626	
40.02	Demonstration payment adjustment amount after sequestration			0	
40.03	Sequestration adjustment-PARHM pass-throughs				40.03
	Interim payments			5, 869, 009	
41.01	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			Ū	42.01
43.00	Balance due provider/program (see instructions)			-33, 368	
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	chapter 1,	0	43.01 44.00
00 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			-	92.00
93.00	Time Value of Money (see instructions)			0	93.00
01 00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	ST. CATHERINE H	IOSPI TAL	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0008	Period:	Worksheet E	
			From 07/01/2021 To 06/30/2022	Part B Date/Time Pre	norod.
			10 06/30/2022	11/22/2022 9:	
		Title XVIII	Hospi tal	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 07/01/2021 To 06/30/2022	Date/Time Prep 11/22/2022 9:2	
		Title		Hospi tal	PPS	
		Inpatien ⁻	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		12, 470, 11 269, 16		5, 608, 699 260, 310	1. 2. 3.
	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					
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03 04				0	0	3
04				0	0	3
	Provider to Program	I I				
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52 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)		12, 739, 28	32	5, 869, 009	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
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5
01				0	0	5
03				0	0	5
	Provider to Program					
50 51	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
99	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
01	SETTLEMENT TO PROVIDER		658, 60		0	6
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		13, 397, 89	0	33, 368 5, 835, 641	6
50			10, 377, 07	Contractor Number	NPR Date (Mo/Day/Yr)	/
		0		1.00	2.00	

ANALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-0008 CCN: 15-T008	Period: From 07/01/202 To 06/30/2022	Worksheet E-1 Part I Date/Time Prep 11/22/2022 9:2	pared:
		Title	XVIII	Subprovider - IRF	PPS	21 0111
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	Tabel interim promote and to provide	1.00	2.00	3.00	4.00	1.00
1.00 2.00	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		4, 547, 6	0	0	1.00 2.00
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					3.00
01	ADJUSTMENTS TO PROVIDER		[0	0	3.0
02 03 04 05	ADJUSTMENTS TO PROVIDER			0 0 0	0	3. 02 3. 03 3. 04
05	Provider to Program		I	0	0	0.0
50	ADJUSTMENTS TO PROGRAM			0	0	3.50
51 52 53 54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0 0 0 0 0	0 0 0 0	3.5 [:] 3.5: 3.5: 3.5:
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		4, 547, 6	79	0	4.0
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					5.0
01	TENTATI VE TO PROVIDER			0	0	5.0
. 02 . 03				0 0	0	5.0 5.0
	Provider to Program					
. 50 . 51 . 52	TENTATI VE TO PROGRAM			0 0 0	0 0 0	5.5 5.5
99 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on			0	0	5.9 6.0
01	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6. C
. 02 . 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		17, 9 4, 529, 7		0 0 NPR Date	6.0 7.0
)	Number 1.00	(Mo/Day/Yr) 2.00	

Heal th	Financial Systems ST. CATHERINE I	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0008	Peri od:	Worksheet E-1	
			From 07/01/2021	Part II	
			To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		Title XVIII	Hospi tal	PPS	24 0111
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	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	14		1.00
2.00	.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost				2.00
	reporting periods beginning on or after 10/01/2013, line 32)				3.00
3.00					
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	plus for cost		4.00
	reporting periods beginning on or after 10/01/2013, line 32)				
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				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	0.00 Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0008	Peri od:	Worksheet E-3	
		Component CCN: 15-T008	From 07/01/2021 To 06/30/2022	Part III Date/Time Pre 11/22/2022 9:1	
		Title XVIII	Subprovider -	PPS	210
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
00	Net Federal PPS Payment (see instructions)			4, 279, 316	1 1
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0704	2
00	Inpatient Rehabilitation LIP Payments (see instructions)			271, 309	3
00	Outlier Payments			36, 088	4
00	Unweighted intern and resident FTE count in the most recent	cost reporting period en	ding on or prior	0.00	5
71	to November 15, 2004 (see instructions)		a all and a seal law.	0.00	
01	Cap increases for the unweighted intern and resident FTE co			0.00	5
	program or hospital closure, that would not be counted with CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	iout a temporary cap adjust	ment under 42		
00	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FTEs i	0.00			
	teaching program" (see instructions)	··· •··· P· •g· •··· g· •··· P			
00	Current year's unweighted I&R FTE count for residents withi	eriod of a "new	0.00	8	
	teaching program" (see instructions)				
00	Intern and resident count for IRF PPS medical education adj	ustment (see instructions)		0.00 11.600000	
00	5 5 7				
00	Teaching Adjustment Factor (see instructions) Teaching Adjustment (see instructions)				
00 00		0 1 EQ4 712	1:		
00	Total PPS Payment (see instructions) Nursing and Allied Health Managed Care payments (see instru		4, 586, 713 0		
00	Organ acquisition (DO NOT USE THIS LINE)			0	1
00	Cost of physicians' services in a teaching hospital (see in	ustructions)		0	
00	Subtotal (see instructions)			4, 586, 713	
00	Primary payer payments			0	1
00	Subtotal (line 17 less line 18).			4, 586, 713	10
00	Deducti bl es			13, 860	20
00	Subtotal (line 19 minus line 20)			4, 572, 853	2
00	Coinsurance			35, 688	
00	Subtotal (line 21 minus line 22)			4, 537, 165	
00	Allowable bad debts (exclude bad debts for professional ser	vices) (see instructions)		6, 030	
00	Adjusted reimbursable bad debts (see instructions)	vetrueti ene)		3, 920	
00 00	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (sum of lines 23 and 25)	istructions)		0 4, 541, 085	2
00	Direct graduate medical education payments (from Wkst. E-4,	line (10)		4, 341, 065	2
00	Other pass through costs (see instructions)	1111e 47)		0	2
00	Outlier payments reconciliation			0	30
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
50	Pioneer ACO demonstration payment adjustment (see instructi	ons)		0	3
98	Recovery of accelerated depreciation.			0	3
99	Demonstration payment adjustment amount before sequestratio	n		0	
00	Total amount payable to the provider (see instructions)			4, 541, 085	
01	Sequestration adjustment (see instructions)			11, 353	
02	Demonstration payment adjustment amount after sequestration	1		0	
00 00	Interim payments Tentative settlement (for contractor use only)			4, 547, 679 0	
00	Balance due provider/program (line 32 minus lines 32.01, 32	02 33 and 34		-17, 947	34
00	Protested amounts (nonallowable cost report items) in accor		chapter 1	0	
00	§115. 2				
~~	TO BE COMPLETED BY CONTRACTOR			04,000	-
00	Original outlier amount from Wkst. E-3, Pt. III, line 4			36, 088	
00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	51
00	Time Value of Money (see instructions)			0.00	
00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 A	ND BEGINNING REFORE THE EN	D OF THE COVID-19		1 00
00	Teaching Adjustment Factor for the cost reporting period im			0. 000000	99
	Calculated Teaching Adjustment Factor for the current year.	5 . 0		0.000000	

	nancial Systems ST. CATHERIN SHEET (If you are nonproprietary and do not maintain e accounting records, complete the General Fund column	Provi der C	CN: 15-0008 Pe	eriod: rom 07/01/2021	u of Form CMS-2 Worksheet G	
ilu-type ily)			Te		Date/Time Pre 11/22/2022 9:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
CU		1.00	2.00	3.00	4.00	
	RRENT ASSETS ish on hand in banks	1, 163	0	0	0	1
	emporary investments		0	0	0	
	ites recei vabl e	0	0	0	0	
00 Ac	counts receivable	14, 771, 299	0	0	0	
00 Ot	her recei vabl e	585, 340	0	0	0	
	lowances for uncollectible notes and accounts receivable	0	0	0	0	
	iventory	6, 388, 458	0	0	0	
	repaid expenses	0 0 0 0 0 0 0	0	0	0	
	her current assets Ne from other funds	2, 319, 379	0	0	0	
	ntal current assets (sum of lines 1-10)	24, 065, 639		0	0	
	XED ASSETS	24,005,039	0	U	0	1'
00 La		0	0	0	0	1:
	und improvements			0	0	
	cumulated depreciation	C	0	0	0	
. 00 Bu	i I di ngs	37, 721, 351	0	0	0	1!
	cumulated depreciation	0	0	0	0	1
	easehold improvements	0	0	0	0	1
	cumulated depreciation	0	0	0	0	
	xed equipment	0	0	0	0	
	cumulated depreciation	0	0	0	0	
	itomobiles and trucks		0	0	0	1 -
	cumulated depreciation jor movable equipment		0	0	0	
	cumulated depreciation		0	0	0	
	nor equipment depreciable		0	0	0	
	cumulated depreciation		0	0	0	
	T designated Assets		0	0	0	
	cumulated depreciation	C	0	0	0	
. 00 Mi	nor equipment-nondepreciable	0	0	0	0	2
. 00 <u>To</u>	otal fixed assets (sum of lines 12-29)	37, 721, 351	0	0	0	30
	HER ASSETS		1			
	vestments	0	0	0	0	
	eposits on Leases	0	0	0	0	
	e from owners/officers her assets		0	0	0	1 -
	ner assets otal other assets (sum of lines 31-34)	2, 077, 660 2, 077, 660		0	0	
	tal assets (sum of lines 11, 30, and 35)	63, 864, 650		0	0	
	RRENT LIABILITIES	05,004,050	10	0	0	- "
	counts payable	618, 034	0	0	0	3
	I aries, wages, and fees payable	7, 353, 632	0	0	0	
	yroll taxes payable	0	0	0	0	3
. 00 No	ites and loans payable (short term)	0	0	0	0	4
.00 De	ferred income	0	0	0	0	4
	celerated payments	0				42
	e to other funds	0	0	0	0	
	her current liabilities	23, 891, 771	0	0	0	
	ntal current liabilities (sum of lines 37 thru 44) NG TERM LIABILITIES	31, 863, 437	0	0	0	4
	ortgage payable	0	0	0	0	4
	itgage payable		0	0	0	
	isecured Loans			0	0	
	ther long term liabilities	1, 782, 328	0	0	0	
	otal long term liabilities (sum of lines 46 thru 49)	1, 782, 328		0	0	
	tal liabilities (sum of lines 45 and 50)	33, 645, 765		0	0	
	PI TAL ACCOUNTS					1
00 Ge	eneral fund balance	30, 218, 885				5
	ecific purpose fund		0			5
	nor created - endowment fund balance - restricted			0		5
	nor created - endowment fund balance - unrestricted			0		5
	overning body created - endowment fund balance			0	-	5
	ant fund balance - invested in plant				0	
	ant fund balance - reserve for plant improvement, placement, and expansion				0	5
	placement, and expansion Ital fund balances (sum of lines 52 thru 58)	30, 218, 885	0	o	0	5
	otal liabilities and fund balances (sum of lines 51 and	63, 864, 650		0	0	-
		1 20,007,000	0	9	0	1

Heal th	Financial Systems	ST. CATHERI NE	HOSPI TAL		In Li	eu of Form CMS-	2552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CO	CN: 15-0008	Period: From 07/01/202 To 06/30/202		
					10 00/ 30/ 202	11/22/2022 9:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-9, 164, 736			0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,079,241			0	2.00
3.00 4.00	Total (sum of line 1 and line 2)	0	-2,085,495			0	3.00
4.00 5.00	Additions (credit adjustments) (specify) RESTRICTED CONTRIBUTIONS	2, 245, 651			0		
6.00	INVESTMENT INCOME	14,064			0		
7.00	TRANSFERRED TO/FROM AFFILIATES	30, 523, 805			0		
8.00	NET ASSETS RELEASED	63, 562			0		
9.00		0			0		
10.00	Total additions (sum of line 4-9)		32,847,082		-	0	10.00
11.00	Subtotal (line 3 plus line 10)		30, 761, 587			0	11.00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00	NET ASSETS RELEASED	542, 702			0	0	13.00
14.00		0			0	0	14.00
15.00		0			0	0	15.00
16.00		0			0	0	16.00
17.00		0			0	0	
	Total deductions (sum of lines 12–17)		542, 702			0	18.00
19.00	Fund balance at end of period per balance		30, 218, 885			0	19.00
	sheet (line 11 minus line 18)	Endowmont Fund	Dlont	Fund			
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	RESTRI CTED CONTRI BUTI ONS		0				5.00
6.00	INVESTMENT INCOME		0				6.00
7.00	TRANSFERRED TO/FROM AFFILIATES		0				7.00
8.00 9.00	NET ASSETS RELEASED		0				8.00 9.00
9.00 10.00	Total additions (sum of line 4-9)	0	0		0		9.00
11.00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00	Deductions (debit adjustments) (specify)	0	0		0		12.00
13.00	NET ASSETS RELEASED		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0	-		0		18.00
19.00	Fund balance at end of period per balance	0			0		19.00
	sheet (line 11 minus line 18)						

Heal th	n Financi	al Systems
---------	-----------	------------

ST. CATHERINE HOSPITAL

In Lieu of Form CMS-2552-10

lear th	Financial Systems ST. CATHERIN	IE HUSPITAL		In Lie	u of Form CMS-2	2552-1
STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet G-2 Parts I & II Date/Time Pre	
				10 00/30/2022	11/22/2022 9:	
	Cost Center Description		Inpati ent	Outpati ent	Total	
	·		1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
. 00	Hospi tal		81, 360, 42	20	81, 360, 420	1.00
2.00	SUBPROVIDER - IPF			0	0	2.00
. 00	SUBPROVIDER - IRF		6, 453, 51	15	6, 453, 515	
. 00	SUBPROVIDER				_	4.0
. 00	Swing bed - SNF			0	0	5.0
. 00	Swing bed - NF			0	0	6.0
. 00	SKILLED NURSING FACILITY					7.0
8.00	NURSING FACILITY					8.0
9.00	OTHER LONG TERM CARE		07 012 02) F	07 012 025	9.0
10.00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		87, 813, 93	50	87, 813, 935	10.0
1.00	INTENSIVE CARE UNIT		6, 765, 78	00	6, 765, 788	11.0
2.00	CORONARY CARE UNIT		0,705,70	50	0,705,788	12.0
3.00	BURN INTENSIVE CARE UNIT					13.0
4.00	SURGI CAL I NTENSI VE CARE UNI T					14.0
5.00	OTHER SPECIAL CARE (SPECIFY)					15.0
6.00	Total intensive care type inpatient hospital services (sum	oflines	6, 765, 78	38	6, 765, 788	
	11-15)	01 11100			0,,00,,00	
17.00	Total inpatient routine care services (sum of lines 10 and	16)	94, 579, 72	23	94, 579, 723	17.0
8.00	Ancillary services		135, 867, 74		135, 867, 747	18.0
9.00	Outpatient services			0 312, 139, 996	312, 139, 996	19.0
20.00	RURAL HEALTH CLINIC			0 0	0	20.0
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.0
22.00	HOME HEALTH AGENCY			0	0	22.0
23.00	AMBULANCE SERVICES					23.0
24.00	СМНС					24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.0
26.00	HOSPICE					26.0
27.00	PHYSI CI AN OFFI CES		1, 950, 83		7, 185, 037	27.0
27.01	TAXABLE LAB			0 1, 200, 584	1, 200, 584	
27.02	REGENCY	0 1 111 1		0 4, 317, 994	4, 317, 994	27.0
28.00	Total patient revenues (sum of lines 17-27)(transfer column	n 3 to WKST.	232, 398, 30	07 322, 892, 774	555, 291, 081	28.0
	G-3, Line 1) PART II - OPERATING EXPENSES					-
9.00	Operating expenses (per Wkst. A, column 3, line 200)			150, 379, 705		29.0
0.00	ADD (SPECIFY)			0		30.0
1.00				0		31.0
2.00				0		32.0
3.00				0		33.0
4.00				0		34.0
5.00				0		35.0
6.00	Total additions (sum of lines 30-35)			0		36.0
7.00	DEDUCT (SPECIFY)			0		37.0
8. 00				0		38.0
9.00				0		39.0
0. 00				0		40.0
1. 00				0		41.0
2.00	Total deductions (sum of lines 37-41)			0		42.0
3.00	Total operating expenses (sum of lines 29 and 36 minus line	e 42)(transfer		150, 379, 705		43.0
	to Wkst. G-3, line 4)		1	1		1

STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0008	Peri od:	Worksheet G-3	
	ENT OF REVENUES AND EXTENSES		From 07/01/2021	Nor Kaneet 0 5	
			To 06/30/2022		
				11/22/2022 9:2	24 am
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	ne 28)		555, 291, 081	1.00
2.00	Less contractual allowances and discounts on patients' accounts	nts		422, 035, 501	2.00
3.00	Net patient revenues (line 1 minus line 2)			133, 255, 580	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		150, 379, 705	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-17, 124, 125	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			3, 091, 800	6.00
7.00	Income from investments			96, 309	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		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	11.00
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			734, 749	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
	Revenue from sale of drugs to other than patients			10, 721, 418	
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			4, 835	
	Rental of hospital space			1, 289, 818	
	Governmental appropriations			0	23.00
	CAPITATION REVENUE			0	24.00
	GRANT I NCOME			7, 247, 541	
	OTHER I NCOME			537, 758	
	CLASSES			0	24.03
	TEMP RESTRI CTED			479, 138	
	COVID-19 PHE Funding			0	24.50
	Total other income (sum of lines 6-24)			24, 203, 366	
	Total (line 5 plus line 25)			7, 079, 241	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			7, 079, 241	29.00

Health Financial Systems	I th Financial Systems ST. CATHERINE HOSPITAL		In Lieu of Form CMS-25		
CALCULATION OF CAPITAL PAYMENT	Provi de	r CCN: 15-0008	Period: From 07/01/2021 To 06/30/2022	Worksheet L Parts I-III Date/Time Prepared: 11/22/2022 9:24 am	
	· · · · · · · · · · · · · · · · · · ·	Fitle XVIII	Hospi tal	PPS	

		Title XVIII	Hospi tal	PPS	
				1.00	
0	ART I - FULLY PROSPECTIVE METHOD				
	APITAL FEDERAL AMOUNT				
	Capital DRG other than outlier			826, 318	
	Nodel 4 BPCI Capital DRG other than outlier			0	
	Capital DRG outlier payments			1, 049	
	<i>N</i> odel 4 BPCI Capital DRG outlier payments			0	2.01
	Fotal inpatient days divided by number of days in the cost rep	porting period (see inst	ructions)	78. 41	3.00
	Number of interns & residents (see instructions)			0.00	
	ndirect medical education percentage (see instructions)			0.00	5.00
	ndirect medical education adjustment (multiply line 5 by the I.01) (see instructions)	, columns 1 and	0	6.00	
7.00 P	Percentage of SSI recipient patient days to Medicare Part A pa	, part A line	11. 50	7.00	
	30) (see instructions)				0.00
	Percentage of Medicaid patient days to total days (see instruc	ctions)		44. 12 55. 62	
					1
					10.00
					11.00
12.00 T	Total prospective capital payments (see instructions)			925, 864	12.00
				1.00	
	ART II – PAYMENT UNDER REASONABLE COST				
	Program inpatient routine capital cost (see instructions)			0	
2.00 P	Program inpatient ancillary capital cost (see instructions)				2.00
3.00 T	Fotal inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00 C	Capital cost payment factor (see instructions)			0	4.00
5.00 T	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1.00	
D	ART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
	Program inpatient capital costs (see instructions)			0	1.00
	Program inpatient capital costs (see instructions)	os (soo instructions)		0	
	Net program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2)	es (see filstructrons)		0	
	Applicable exception percentage (see instructions)			0,00	
	Capital cost for comparison to payments (line 3 x line 4)			0.00	
	Percentage adjustment for extraordinary circumstances (see ins	structions)		0.00	
	Adjustment to capital minimum payment level for extraordinary		ling ()	0.00	
		circulistances (irrie 2 x	TTHE 0)	0	
	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic			0	
	Current year comparison of capital minimum payment level to ca		Lass Line ()	0	
	Carryover of accumulated capital minimum payment level over ca			0	
	Vorksheet L, Part III, line 14)	or year	0	11.00	
	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)				12.00
	Current year exception payment (if line 12 is positive, enter the amount on this line)				13.00
	Carryover of accumulated capital minimum payment level over ca		0		
	(if line 12 is negative, enter the amount on this line)		poindu	Ŭ	
	Current year allowable operating and capital payment (see inst	tructions)		0	15.00
	Current year operating and capital costs (see instructions)	/		0	1
	Current year exception offset amount (see instructions)			0	