ST. MARY MEDICAL CENTER. INC. In Lieu of Form CMS-2552-10 Health Financial Systems This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 Worksheet S HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0034 Period: From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 11/20/2023 2:29 pm PART I - COST REPORT STATUS Provider 1.[ X ] Electronically prepared cost report Date: 11/20/2023 Time: 2:29 pm ] Manually prepared cost report use only 2.Γ 3.  $\begin{bmatrix} 0 \end{bmatrix}$  If this is an amended report enter the number of times the provider resubmitted this cost report 4.  $\begin{bmatrix} F \end{bmatrix}$  Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. 6. Date Received: Contractor 5. [ 1 ]Cost Report Status 10.NPR Date: (2) Settled without Audit 8. [ N ] Initial Report for this Provider CCN | 11. Contractor's Vendor Code: 4 | 12. [ 0 ] If line 5, column 1 is 4: Enter | 13. Settled with Audit | 9. [ N ] Final Report for this Provider CCN | 12. [ 0 ] If line 5, column 1 is 4: Enter | 14. Separated | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report for this Provider CCN | 15. [ N ] Final Report f

## PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened (5) Amended

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY MEDICAL CENTER, INC. ( 15-0034 ) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC	
		1	2	SIGNATURE STATEMENT	
1	Mary	ı F. Sudicky	Υ	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Mary F. Sudicky			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		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	HOSPITAL	0	195,110	-82,748	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	-27,320	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	1		0	9.00
200.00	) TOTAL	0	167,790	-82,747	0	0	200.00
The al	nove amounts represent "due to" or "due from"	the annlicable	nrogram for th	a alament of t	he shove compl	av indicated	

from" the applicable program for the element of 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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

use only

Health Financial Systems ST. MARY MEDICAL CENTER, INC. In Lieu of Form CMS-2552-10

Health	Financial Systems	S	T. MARY MEDICAL	CENTER,	INC.			I	n Lieu	of For	m CMS-2	2552-10
HOSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX :	IDENTIFIC	TATION DATA	Provid	der Co	CN: 1		Period: From 07/01/ To 06/30/	2022 2023	Workshe Part I Date/Ti 11/20/2	me Pre	pared:
	1.00		2.00		3.00	)		4	4.00	11, 20, 2	023 2.	23 piii
	Hospital and Hospital Health Care Co	mplex Ad		_								
1.00	Street: 1500 SOUTH LAKE PARK AVENUE		PO Box:	L	4.0	2.42						1.00
2.00	City: HOBART	Com	State: IN	Zip Cod CCN		342 SA	Provider	y: LAKE Date	Day (ma)	nt Syst	am (D	2.00
		Colli	oonent Name	Number	1	ber	Type	Certified		0, or		
				Humber	110		1,700	cererrea	V ,	XVIII		
			1.00	2.00	3.	00	4.00	5.00	6.00	7.00		
	Hospital and Hospital-Based Componen											
3.00	Hospital	ST. MARY		150034	238	844	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	CENTER,	INC.									4.00
5.00	Subprovider - IRF	SMMC REH	ABILITATION	15T034	238	844	5	01/01/2001	N	P	P	5.00
3.00	Subprovider IN	UNIT	ABILITATION	131034	230	044		01/01/2001	"	'	· '	3.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
	Hospital-Based NF Hospital-Based OLTC											10.00 11.00
	Hospital-Based HHA	SMMC HOM	E HEALTH AGENCY	157313	238	844		02/08/1996	N	P	N	12.00
	Separately Certified ASC	Similar Tion	E HEALTH AGENCY	137313		0 1 1		02,00,1330				13.00
	Hospital-Based Hospice											14.00
	Hospital-Based Health Clinic - RHC											15.00
	Hospital-Based Health Clinic - FQHC											16.00
	Hospital-Based (CMHC) I											17.00
19.00	Renal Dialysis											18.00 19.00
13.00	other						<u> </u>	From:		То	:	13.00
								1.00		2.0		
	Cost Reporting Period (mm/dd/yyyy)							07/01/2	022	06/30/	2023	20.00
21.00	Type of Control (see instructions)							2				21.00
							1.00	2.00		3.0	00	
	Inpatient PPS Information											
22.00	Does this facility qualify and is it						Υ	N				22.00
	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			nument								
22.01	Did this hospital receive interim UC	Ps, inclu	uding supplement				Υ	Y				22.01
	this cost reporting period? Enter in											
	for the portion of the cost reportin											
	1. Enter in column 2, "Y" for yes or cost reporting period occurring on o			ion of ti	ne							
	instructions)	i aitei t	october 1. (see									
22.02	Is this a newly merged hospital that	requires	s a final UCP to	be			N	N				22.02
	determined at cost report settlement				lumn							
	1, "Y" for yes or "N" for no, for th											
	period prior to October 1. Enter in for the portion of the cost reportin				no,							
22.03	Did this hospital receive a geograph	J 1			)		N	N		N		22.03
	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				er							
	reporting period occurring on or aft											
	Does this hospital contain at least				as							
	counted in accordance with 42 CFR 41											
	yes or "N" for no.											
22.04	Did this hospital receive a geograph											22.04
	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in											
	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	2.105)?	Enter in column	3, "Y" 1	tor							
23.00	yes or "N" for no. Which method is used to determine Me	dicaid da	avs on lines 24	and/or 2	5			3 N				23.00
	below? In column 1, enter 1 if date							-				
	if date of discharge. Is the method				cost							
	reporting period different from the											
	reporting period? In column 2, ente	ı. A., ‡01	yes or "N" tor	no.				1				I

In Lieu of Form CMS-2552-10 Health Financial Systems ST. MARY MEDICAL CENTER. INC. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0034 Period: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/20/2023 2:29 pm Out-of Medicaid In-State In-State Out-of Medicaid Medicaid Medicaid State State HMO days paid days eligible Medicaid Medicaid days unpaid paid days eligible days unpaid 1.00 2.00 3.00 4.00 5.00 6.00 173 24.00 If this provider is an IPPS hospital, enter the 851 150 4,687 106 24.00 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. 25.00 If this provider is an IRF, enter the in-state 53 0 0 0 369 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the 26.00 cost reporting period. Enter "1" for urban or "2" for rural. Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 1 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Beginning: Endina: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37.01 instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν 40.00 'N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Ν Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν 48.00 Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For 56.00 56.00 Ν cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y"

residents start training in the first month of this cost reporting period? Enter "Y" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N"

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

" for ves or

Ν

58.00

	cial Systems ST. MARY   D HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CO	CN: 15-0034	Period:	u of Form CMS-2 Worksheet S-2	
					From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 11/20/2023 2:	pareo 29 pr
					V 1.0	XVIII XIX 0 2.00 3.00	
9.00 Are c	osts claimed on line 100 of Worksheet A? If yes	, comple	te Wkst. D-2	, Pt. I.	N N	3 2.00 3.00	59.
				NAHE 413.8 Y/N	5 Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
any p instr is "Y adjus ).01 If li	ou claiming nursing and allied health education rograms that meet the criteria under 42 CFR 413. uctions) Enter "Y" for yes or "N" for no in col", are you impacted by CR 11642 (or subsequent C tment? Enter "Y" for yes or "N" for no in columne 60 is yes, complete columns 2 and 3 for each	85? (se umn 1. R) NAHE In 2.	e If column 1 MA payment	Y	Y 23.00	1	60.
nstr	uctions)	Y/N	IME	Direct GM	IME	Direct GME	
		1.00	2.00	2.00	4.00	5.00	
secti	our hospital receive FTE slots under ACA on 5503? Enter "Y" for yes or "N" for no in n 1. (see instructions)	1.00 N	2.00	3.00	4.00	5.00	61.
FTEs endin	the average number of unweighted primary care from the hospital's 3 most recent cost reports g and submitted before March 23, 2010. (see uctions)						61
.02 Enter FTE c and p	the current year total unweighted primary care ount (excluding OB/GYN, general surgery FTEs, rimary care FTEs added under section 5503 of						61
.03 Enter and/o deter	(see instructions) the base line FTE count for primary care r general surgery residents, which is used for mining compliance with the 75% test. (see uctions)						61
.04 Enter	the number of unweighted primary care/or ry allopathic and/or osteopathic FTEs in the nt cost reporting period.(see instructions).						61
.05 Enter and/o prima 61.04	the difference between the baseline primary r general surgery FTEs and the current year's ry care and/or general surgery FTE counts (line minus line 61.03). (see instructions)						61
used	the amount of ACA §5503 award that is being for cap relief and/or FTEs that are nonprimary or general surgery. (see instructions)						61
		Prog	gram Name	Program Coo	FTE Count	Direct GME FTE Count	
.10 Of th	e FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61
for e colum progr unwei FTE u	alty, if any, and the number of FTE residents ach new program. (see instructions) Enter in n 1, the program name. Enter in column 2, the am code. Enter in column 3, the IME FTE ghted count. Enter in column 4, the direct GME numeighted count.				0.000	0.00	61
progr resid instr Enter 3, th	e FTEs in line 61.05, specify each expanded am specialty, if any, and the number of FTE ents for each expanded program (see uctions) Enter in column 1, the program name. in column 2, the program code. Enter in column e IME FTE unweighted count. Enter in column 4, irect GME FTE unweighted count.				0.00	0.00	61
						1.00	
	rovisions Affecting the Health Resources and Ser				oniod for which		63
your 01 Enter	the number of FTE residents that your hospital hospital received HRSA PCRE funding (see instructhe number of FTE residents that rotated from a	tions) Teachir	g Health Cen	ter (THC) in		0.00	
	g in this cost reporting period of HRSA THC prog ing Hospitals that Claim Residents in Nonprovide			15)			
00 Has V	our facility trained residents in nonprovider se	ttinas d	urina this co	ost reportin	g period? Enter	N	63

OSPITAL AND HOSPITAL HEALTH CARE COMPL		TA Provi	INC. der CCN: 15-0034	Period:	Worksheet S-2	2552-1
				From 07/01/2022 To 06/30/2023		
			Unweighted		Ratio (col. 1/	
			FTEs Nonprovide	FTEs in Hospital	(col. 1 + col. 2))	
			Site	Ποσριται	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Base Yea			ingsThis base ye			
period that begins on or after J Enter in column 1, if line 63 is in the base year period, the numl resident FTEs attributable to ro- settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column)	yes, or your facilit per of unweighted non tations occurring in number of unweighted ur hospital. Enter in	y trained resion primary care all nonprovider non-primary ca column 3 the r	lents 0. ure	0.00	0.000000	64.0
or (cordiiir i divided by (cordiiir)	Program Name	Program Cod	de Unweighted	l Unweighted	Ratio (col. 3/	,
			FTES	FTES in	(col. 3 + col.	
			Nonprovide	r Hospital	4))	
			Site			
	1.00	2.00	3.00	4.00	5.00	
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 FTEs	Unweighted	Ratio (col. 1/	
			Nonprovide		2))	
			Site			
			1.00	2.00	3.00	1
Section 5504 of the ACA Current	Year FTE Residents in	Nonprovider Se	ettingsEffective	for cost report	ing periods	
beginning on or after July 1, 20						
5.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTES that trained in your hospit: (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	ovider settings y care resident the ratio of	s.	0.00	0.000000	66.0
	Program Name	Program Cod			Ratio (col. 3/	
			FTES	FTES in	(col. 3 + col.	
			Nonprovide Site	r Hospital	4))	
	1.00	2.00	3.00	4.00	5.00	
7.00 Enter in column 1, the program	1.00	2.00		00 0.00		67.0
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						

	Financial Systems ST. MARY MEDICAL CENTER, INC. AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCI	N: 15_0034   D	In eriod:	ı Lie	u of Form Workshee		
3FI 17	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		rom 07/01/		Part I	ne Pre	pared:
					1.00	)	
.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-490 For a cost reporting period beginning prior to October 1, 2022, did you ob MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fina (August 10, 2022)?	tain permissio	on from you		N		68.00
	(Mydde 10) Edil).			1.00	2.00	3.00	
	<b>Inpatient Psychiatric Facility PPS</b> Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta	in an IDE cubi	novidon?	N	7 7	3.00	70.00
.00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teachin recent cost report filed on or before November 15, 2004? Enter "Y" for ye 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ye Column 3: If column 2 is Y, indicate which program year began during this (see instructions)	g program in t s or "N" for r in a new teach s or "N" for r	the most no. (see ning	IN.		0	71.00
.00	<pre>Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it co</pre>	ntain an IRF		Y			75.00
.00	subprovider? Enter "Y" for yes and "N" for no.  If line 75 is yes: Column 1: Did the facility have an approved GME teachin recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If indicate which program year began during this cost reporting period. (see	"Y" for yes on in accordance column 2 is Y	"N" for with 42	N	N	0	76.00
					1.00	)	
.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for noise this a LTCH co-located within another hospital for part or all of the country "Y" for yes and "N" for no.		period? En	nter	N N		80.00 81.00
.00	TEFRA Providers  1s this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.  20 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section						
.00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified u 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	nder section			N		87.0
	2000(d)(2)(b)(vv). Enter v 101 yes or iv 101 iio.		Approved Permane Adjustme (Y/N)	nt ent	Number Approv Perman Adjustm	ved ent	
	Column 1: Is this hospital approved for a permanent adjustment to the TEFR. amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		1.00		2.00		88.00
		Wkst. A Line No.	Effective	Date	Approv Perman Adjustm Amount Discha	ent ment Per	
	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based.  Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.	1.00	2.00		3.00		89.0
	Column 3: Enter the amount of the approved permanent adjustment to the						
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		V 1.00		XIX		
	TEFRA target amount per discharge.  Title V and XIX Services		1.00		2.00		
.00	TEFRA target amount per discharge.  Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column.						
.00	Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column.  Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column.	either in	1.00		2.00 Y		91.0
.00	Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column.  Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificationstructions) Enter "Y" for yes or "N" for no in the applicable column.	either in on)? (see	N N		2.00 Y N		91.0
.00	Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column.  Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column.  Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.	either in on)? (see XIX? Enter	1.00		2.00 Y		91.0
.00	Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column.  Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificatinistructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and	either in on)? (see  XIX? Enter in the	1.00 N N		Y N N N	)	90.00 91.00 92.00 93.00 94.00 95.00

Health Financial Systems ST. MARY MEDICAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CN: 15-0034	Period: From 07/01/2022 To 06/30/2023		repared:	
			V	11/20/2023 XIX	2:29 pm	
			1.00	2.00		
98.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	nterns and res for yes or "N"	idents post for no in	N	N	98.00	
98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.				Y	98.01	
98.02 Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.	or "N" for no	in column 1	N	Y	98.02	
98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.				N	98.03	
98.04 Does title v or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N N	N	98.04	
98.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance o Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D.					
Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			N	N	98.06	
Rural Providers  105.00 Does this hospital qualify as a CAH?  106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	hod of paymer	N nt		105.00 106.00	
107.00 Column 1: If line 105 is Y, is this facility eligible for c 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 I	n 1. (see ins you train I&R PF and/or IRF	tructions) s in an			107.00	
Enter "Y" for yes or "N" for no in column 2. (see instruct 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche				108.00	
	Physical 1.00	Occupationa 2.00	Speech 3.00	Respirator	У	
109.00 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.		2100	3.00	1100	109.00	
				1.00		
110.00 Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	If yes,	1.00 N	110.00	
			1.00	2.00		
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the column 2.	N		111.00	
		1.00	2.00	3.00		
112.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable.	eporting olumn 1 is pating in the	N			112.00	
Miscellaneous Cost Reporting Information  115.00  Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub.15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes rs) based on	N			0115.00	
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00	
117.00 Is this facility legally-required to carry malpractice insu	ranco? Entor	Y		1	117.00	

117.00 118.00

117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems ST. MARY M	EDICAL CENTER, INC.		In Lie	u of Form CMS	-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT			Period:	Worksheet S-		
			From 07/01/2022 To 06/30/2023	Part I Date/Time Pr	epared:	
				11/20/2023 2		
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01 List amounts of malpractice premiums and paid losses:		1.00	1 2.00	3.00	0118.01	
110 02 km malaractics are minuted and acid laces are area in a	. cost conton other	+622 +62	1.00	2.00	110 02	
118.02 Are malpractice premiums and paid losses reported in a Administrative and General? If yes, submit supporting			N		118.02	
and amounts contained therein.	,					
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatier	+ Hold Hammloss and	vicion in ACA	N	N	119.00 120.00	
§3121 and applicable amendments? (see instructions) Er			IN IN	IN IN	120.00	
"N" for no. Is this a rural hospital with < 100 beds t						
Hold Harmless provision in ACA §3121 and applicable an Enter in column 2, "Y" for yes or "N" for no.	nendments? (see inst	ructions)				
121.00 Did this facility incur and report costs for high cost	implantable device	s charged to	Y		121.00	
patients? Enter "Y" for yes or "N" for no.	as defined in \$1002	(w) (2) of the	N		122.00	
	.22.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2					
the Worksheet A line number where these taxes are incl	uded.					
123.00 Did the facility and/or its subproviders (if applicables services, e.g., legal, accounting, tax preparation, bo			Y	Y	123.00	
management/consulting services, from an unrelated orga						
for yes or "N" for no.						
If column 1 is "Y", were the majority of the expenses, professional services expenses, for services purchased						
located in a CBSA outside of the main hospital CBSA? I						
"N" for no.	·					
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transp	lant center? Enter	"V" for ves	N		125.00	
and "N" for no. If yes, enter certification date(s) (n		1 101 yes	IN IN		123.00	
126.00 If this is a Medicare-certified kidney transplant program 1		ification date	e		126.00	
in column 1 and termination date, if applicable, in co 127.00 If this is a Medicare-certified heart transplant progr		fication date			127.00	
in column 1 and termination date, if applicable, in co	olumn 2.					
128.00 If this is a Medicare-certified liver transplant progr		fication date			128.00	
in column 1 and termination date, if applicable, in co 129.00If this is a Medicare-certified lung transplant progra		ication date			129.00	
in column 1 and termination date, if applicable, in co						
130.00 If this is a Medicare-certified pancreas transplant produced date in column 1 and termination date, if applicable,		rtification			130.00	
131.00 If this is a Medicare-certified intestinal transplant		certification			131.00	
date in column 1 and termination date, if applicable,		£::			122 00	
132.00 If this is a Medicare-certified islet transplant progr in column 1 and termination date, if applicable, in co		rication date			132.00	
133.00 Removed and reserved					133.00	
134.00 If this is a hospital-based organ procurement organization column 1 and termination date, if applicable, in co		he OPO number			134.00	
All Providers	Tumin 2.					
140.00 Are there any related organization or home office cost			Y	15н054	140.00	
chapter 10? Enter "Y" for yes or "N" for no in column are claimed, enter in column 2 the home office chain r						
1.00	2.00		3.00	·		
If this facility is part of a chain organization, enter			ame and address	of the		
home office and enter the home office contractor name 141.00 Name: COMMUNITY FOUNDATION OF NW IN, Contractor's Na			or's Number: 0800	1	141.00	
INC.			. 5	_		
142.00 Street: 10010 DONALD S POWERS DRIVE STE PO Box:					142.00	
201 143.00 City: MUNSTER State:	IN	Zip Code	: 4632	1	143.00	
144.00 Are provider based physicians' costs included in Works	shoot A?			1.00	144.00	
144.00 Are provider based physicians costs included in works	sneet A?			Y	144.00	
			1.00	2.00		
145.00 If costs for renal services are claimed on Wkst. A, li			Y		145.00	
inpatient services only? Enter "Y" for yes or "N" for no, does the dialysis facility include Medicare utiliz	no in column 1. If zation for this cost	reportina				
period? Enter "Y" for yes or "N" for no in column 2.						
146.00 Has the cost allocation methodology changed from the p Enter "Y" for yes or "N" for no in column 1. (See CMS			N		146.00	
yes, enter the approval date (mm/dd/yyyy) in column 2.		.0, 37020/ 11				

Health Financial Systems	ST. MARY MEDICAL	CENTER. INC.		In Li	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		Provider CC	CN: 15-0034	Period: From 07/01/2022 To 06/30/2023		epared:
					1.00	
147.00 was there a change in the statist	ical basis? Enter "Y" for v	es or "N" for	no.		N N	147.00
148.00 was there a change in the order o					N	148.00
149.00 was there a change to the simplif	ied cost finding method? En	iter "Y" for ye	es or "N" fo		N	149.00
		Part A	Part B	Title V	Title XIX	
6 .7		1.00	2.00	3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or						
155.00 Hospital	N 101 110 101 each compone	N N	N N	N (See 42 CFK 941	N N	155.00
156.00 Subprovider - IPF		N	N N	N N	N	156.00
157.00 Subprovider - IRF		N	N	N	N	157.00
158.00 SUBPROVIDER						158.00
159.00 SNF		N	N	N	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 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has one	or more campu	uses in diff	erent CBSAs?	N	165.00
Elicel 1 101 yes 01 N 101 IIO.	Name	County	State Z	ip Code CBSA	FTE/Campus	
	0	1.00	2.00	3.00 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)					0.0	00 166.00
	-> ->				1.00	
Health Information Technology (HI 167.00 Is this provider a meaningful use				ent ACT	Y	167.00
168.00 If this provider is a CAH (line 1 reasonable cost incurred for the	05 is "Y") and is a meaning	ful user (line		), enter the	T T	168.00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, does	this provide				168.01
169.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y") and				9.9	99169.00
				Beginning	Ending	
				1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and ending d	late for the re	eporting			170.00
				1.00	2.00	
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, co	l. 6? Enter	on		0171.00

	Financial Systems ST. MARY MEDICA			In Lie	u of Form CMS-	
HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0034	Period: From 07/01/2022 To 06/30/2023	11/20/2023 2:	epared:
				Y/N 1.00	Date 2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT OUESTION	IAIRE	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in 1	the	
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in o	e beginning of column 2. (see	instructions			1.00
			1.00	Date 2.00	V/I 3.00	
2.00	Has the provider terminated participation in the Medicare Payes, enter in column 2 the date of termination and in columy voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provious officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
			Y/N	Туре	Date	
	Financial Data and Daysets		1.00	2.00	3.00	
4.00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A		4.00
5.00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit rec		N			5.00
			1	Y/N 1.00	Legal Oper. 2.00	
6.00	Approved Educational Activities  Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, is	s the provide	r N		6.00
7.00 8.00	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 th	e N		7.00 8.00
9.00	Are costs claimed for Interns and Residents in an approved		cal education	N		9.00
10.00	program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated of		the current	N		10.00
11.00	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.	ι& R in an Αρμ	proved	N		11.00
					Y/N	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p	'		ost reporting	Y N	12.00 13.00
14.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurations.	ance amounts wa	aived? If yes	, see	N	14.00
15.00	<pre>Bed Complement Did total beds available change from the prior cost report</pre>	ing period? If	yes, see ins	tructions.	N	15.00
			t A		t B	
		1.00	Date	Y/N 3.00	Date 4 00	
	PS&R Data	1.00	2.00	3.00	4.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16.00
17.00	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 in columns 2 and 4. (see instructions)	Y	09/26/2023	Y	09/26/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

Hool+h	Financial Systems ST MADY MEDICA	I CENTED INC		Tn Lio	u of Form CMS-	2552_10			
	Financial Systems ST. MARY MEDICA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	:N: 15-0034	Period: From 07/01/2022 To 06/30/2023					
					11/20/2023 2:				
		Descri		Y/N	Y/N				
20.00	-0.71 40 47 1	0		1.00	3.00	20.00			
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		N		21.00			
					1.00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS HO	SPITALS)						
	Capital Related Cost					1			
	Have assets been relifed for Medicare purposes? If yes, see					22.00			
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to appraisa	als made dur	ing the cost		23.00			
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period?								
25.00	Have there been new capitalized leases entered into during instructions.	the cost report	ting period?	If yes, see		25.00			
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period? I	f yes, see		26.00			
	Has the provider's capitalization policy changed during the copy.	e cost reporting	g period? If	yes, submit		27.00			
	Interest Expense  Were new loans, mortgage agreements or letters of credit entered into during the cost reporting								
29.00	period? If yes, see instructions.    Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)								
30.00	treated as a funded depreciation account? If yes, see instructions  O Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see								
	instructions.  O Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see								
	instructions. Purchased Services					31.00			
	Have changes or new agreements occurred in patient care se		d through co	ntractual		32.00			
33.00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		g to competi	tive bidding? If		33.00			
	no, see instructions.								
	Provider-Based Physicians								
	Were services furnished at the provider facility under an a If yes, see instructions.	-				34.00			
35.00	If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see in		ts with the	provider-based		35.00			
				Y/N	Date				
				1.00	2.00				
	Home Office Costs					1			
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu	repared by the I	nome office?			36.00 37.00			
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of			38.00			
	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other	d of the home o	ffice.			39.00			
	see instructions.	·	-	,					
40.00	If line 36 is yes, did the provider render services to the instructions.	nome office? .	it yes, see			40.00			
		1.0	00	2.	00	-			
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CATHERINE		WOERNER		41.00			
42.00	Enter the employer/company name of the cost report	COMMUNITY FOUND	DATION OF NW			42.00			
	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	IN, INC. 12197031267		CATHERINE.R.WO	ERNER@COMHS.OR	43.00			

Health	Financial Systems ST. MA	RY MEDICA	L CENTER, INC.		In Lieu of Form CMS-2552-10			
HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NAIRE	Provider (	F	Period: From 07/01/2022 Fo 06/30/2023	Worksheet S-2 Part II Date/Time Pre 11/20/2023 2:	pared:	
			3	.00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/posheld by the cost report preparer in columns 1, 2, respectively.		REIMBURSEMENT	MANAGER			41.00	
42.00	Enter the employer/company name of the cost report	t					42.00	
43.00	preparer. Enter the telephone number and email address of the large report preparer in columns 1 and 2, respectively.						43.00	

Health Financial Systems ST. MARY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0034

					0 06/30/2023	11/20/2023 2:2	
						I/P Days / O/P	2.5 piii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Line No.		Available	,		
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA			<u> </u>	•		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	160	58,400	0.00	0	1.00
	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)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		160	58,400	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	20	7,300	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		180	65,700	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	20	7,300		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		200				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	(	)		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	(	)	0	34.00

Health Financial SystemsST. MARYHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Period: Worksheet S-3 From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

Component   Title XVIII   Title XIX					'	0 00/30/2023	11/20/2023 2:	29 pm
PART I - STATISTICAL DATA   6.00   7.00   8.00   9.00   10.00			I/P Days	/ O/P Visits	/ Trips	Full Time		
PART I - STATISTICAL DATA		Component	Title XVIII	Title XIX				
PART I - STATISTICAL DATA   1.00   8 exclude swring Bed, observation Bed and 8 exclude swring Bed, observation Bed and Hospice days)(See instructions)   13,055   5,080   2,000   13,000   13,005   13,005   13,005   13,005   13,005   13,000   14,			6.00	7.00				
Sexclude Swing Bed, Observation Bed and Hospice days)(See instructions for col. 2 for the portion of LOP room available beds)		PART I - STATISTICAL DATA						
Hospice days)(see instructions for col. 2   for the portion of LDP room available beds)   13,055   5,080     2.00	1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11,226	497	29,980			1.00
For the portion of LDP room available beds)   13,055   5,080   2.00		8 exclude Swing Bed, Observation Bed and	,		•			
2.00		Hospice days)(see instructions for col. 2						
3.00   HMO IPF Subprovider		for the portion of LDP room available beds)						
4.00   MOD TRF Subprovider   992   369   0   5.00   6.00	2.00	HMO and other (see instructions)	13,055	5,080				2.00
5.00	3.00	HMO IPF Subprovider	0	0				3.00
6.00   Hospital Adults & Peds. Swing Bed NF   11,226   497   29,980   7.00   1.00	4.00	HMO IRF Subprovider	992	369				4.00
7.00   Total Adults and Peds. (exclude observation beds) (see instructions)   11,226   497   29,980   8.00   7.00	5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
7.00   Total Adults and Peds. (exclude observation beds) (see instructions)   11,226   497   29,980   8.00   7.00	6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
8.00 INTENSIVE CARE UNIT	7.00		11,226	497	29,980			7.00
9.00   CORONARY CARE UNIT   10.00   BURN INTENSIVE CARE UNIT   11.00   SURGICAL INTENSIVE CARE UNIT   11.00		beds) (see instructions)	,		•			
9.00   CORONARY CARE UNIT   10.00   BURN INTENSIVE CARE UNIT   11.00   SURGICAL INTENSIVE CARE UNIT   11.00	8.00	INTENSIVE CARE UNIT	1,289	304	5,370			8.00
11.00   SURGICAL INTENSIVE CARE UNIT   12.00   12.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00	9.00	CORONARY CARE UNIT	,		•			9.00
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 12.515 851 36.676 0.00 1,090.00 14.00 15.00 CAH visits 15.00 CAH visits 15.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 19.00 HOME HEALTH AGENCY 21.00 HOME HEALTH AGENCY 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.05 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Ambulance Trips 29.00 Ambulance Trips 20.00 Lober vation Bed Days 20.00 Lober delivery days (see instruction) 31.00 Employee discount days - IRF 21.00 SUBPROVE delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges	10.00	BURN INTENSIVE CARE UNIT						10.00
13.00   NURSERY	11.00	SURGICAL INTENSIVE CARE UNIT						11.00
13.00   NURSERY	12.00	1						12.00
14.00   Total (see instructions)   12,515   851   36,676   0.00   1,090.00   14.00   15.00   15.00   16.00   15.00   17.00				50	1.326			
15.00 CAH visits			12.515		,		1.090.00	
15.10   REH hours and visits		1 .	,,,	0	0		_,,,,,,,,	
16.00   SUBPROVIDER - IPF				1	·			
17.00   SUBPROVIDER - IRF   3,065   53   4,984   0.00   24.00   17.00   18.00   19.00   SUBPROVIDER   19.00   SKILLED NURSING FACILITY   20.00   21.00   22.00   NURSING FACILITY   20.00   21.00   22.00   HOME HEALTH AGENCY   21.00   22.00   HOME HEALTH AGENCY   24.00		1						
18.00 19.00			3.065	53	4.984	0.00	24.00	
19.00   SKILLED NURSING FACILITY		1	,,,,,,		.,			
20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   22.00   4.00   22.00   4.00   22.00   4.00   22.00   4.00   22.00   4.00   22.00   4.00   22.00   4.00   22.00   4.00   22.00   4.00   22.00   4.00   22.00   22.00   4.00   4.00   22.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00   24.00   22.00		1						
21.00		1						
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 4.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  11,155 0 25,921 0.00 25,921 0.00 25,921 0.00 25,921 0.00 0 0,00 0 0,00 0 0,00 0 0.00 0 0,00 0 0 0 0 0,00 0 0,00 0 0,00 0 0 0 0,00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1						
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 29.00 Employee discount days - IRF 29.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges  23.00 24.00 24.00 24.00 24.00 24.00 26.00 0.00 0.00 26.25 0.00 0.00 0.00 26.25 0.00 0.00 0.00 26.25 0.00 0.00 0.00 0.00 26.25 0.00 0.00 0.00 0.00 26.25 0.00 0.00 0.00 0.00 26.25 0.00 0.00 0.00 0.00 0.00 26.25 0.00 0.00 0.00 0.00 0.00 0.00 26.25 0.00 0.00 0.00 0.00 0.00 0.00 26.25 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0			11.155	0	25.921	0.00	24.00	
24.00		1	,_,	1	,,			
24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.05 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 30.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges								
25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 30.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH site neutral days and discharges  25.00 26.00 0 0 0 0.00 0.00 26.25 0 0.00 0 0.00 1,138.00 27.00 0 0 0 0 0 0 0.00 0.00 26.25 0 0.00 0 0.00 0.00 0.00 26.25 0 0.00 0 0 0.00 0.00 0.00 26.25 0 0.00 0 0.00 0.00 0.00 26.25 0 0.00 0 0.00 0.00 0.00 26.25 0 0.00 0 0.00 0.00 0.00 26.25 0 0.00 0 0.00 0.00 0.00 26.25 0 0.00 0 0.00 0.00 0.00 26.25 0 0.00 0 0.00 0.00 0.00 26.25 0 0.00 0.00 0.00 0.00 0.00 26.25 0 0.00 0.00 0.00 0.00 0.00 26.25 0 0.00 0.00 0.00 0.00 0.00 26.25 0 0.00 0.00 0.00 0.00 0.00 26.25 0 0.00 0.00 0.00 0.00 0.00 0.00 26.25 0 0.00 0.00 0.00 0.00 0.00 0.00 26.25 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0					1			
26.00   RURAL HEALTH CLINIC   26.00   26.25   27.00   Total (sum of lines 14-26)   28.00   28.00   29.00   20.00   27.00   28.00   29.		· · ·			_			
26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26.25 27.00 Total (sum of lines 14-26) 0.00 1,138.00 27.00 28.00 Observation Bed Days 0 4,545 28.00 29.00 Ambulance Trips 0 29.00 Employee discount days (see instruction) Employee discount days - IRF 0 31.00 206 206 206 200 200 200 200 200 200 2								
27.00   Total (sum of lines 14-26)   0.00   1,138.00   27.00   28.00   0   4,545   0   28.00   29.00   30.00   Employee discount days (see instruction)   Employee discount days - IRF   0   31.00   32.00   32.01   33.00   LTCH non-covered days   0   106   33.00   33.01   LTCH site neutral days and discharges   0   0   0   0   0   0   0   0   0			0	0	0	0.00	0.00	
28.00   Observation Bed Days   28.00   29.00   30.00   Employee discount days (see instruction)   30.00   Employee discount days - IRF   0   31.00   32.00   32.01   32.01   106   1				1	·		l	
29.00   Ambulance Trips   0   29.00   30.00   Employee discount days (see instruction)   30.00   31.00   Employee discount days - IRF   0   31.00   32.00   32.01   32.01   33.00   LTCH non-covered days   0   33.01   LTCH site neutral days and discharges   0   30.00   30				0	4.545		_,	
30.00   Employee discount days (see instruction)   30.00   31.00   31.00   32.00   32.00   32.01   32.01   33.00   LTCH site neutral days and discharges   0   30.00			0	1	.,			
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  31.00 Site of the provided HTCH and the provided HTC					0			ı
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  32.00 206 206 32.00 32.01								
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00 LTCH site neutral days and discharges 0 33.01			0	106	206			
outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges 0 33.01				100	0			
33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.00 33.01	32.32				· ·			
33.01 LTCH site neutral days and discharges 0 33.01	33.00		0					33.00
			0					
34.00 Temporary Expansion COVID-19 PHE Acute Care 0 0 0 34.00			0	o	0			34.00

| Period: | Worksheet S-3 | From 07/01/2022 | Part I | To 06/30/2023 | Date/Time Prepared: Provider CCN: 15-0034

				To	06/30/2023	Date/Time Pre 11/20/2023 2:	
		Full Time	<u>'</u>	Disch	arges	, ==, ==, =============================	,
		Equivalents					
	Component	Nonpaid	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	11.00	Patients	
		11.00	12.00	13.00	14.00	15.00	
4 00	PART I - STATISTICAL DATA			2 622	42=	T 426	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	2,632	137	7,436	1.00
	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)			2,128	1,036		2.00
3.00	HMO IPF Subprovider			2,120	1,030		3.00
4.00	HMO IRF Subprovider				34		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				34		5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	C	2,632	137	7,436	14.00
15.00	CAH visits			,		,	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	C	306	5	482	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						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	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

Provider CCN: 15-0034

						00/30/2023	11/20/2023 2:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries			Average Hourly Wage (col. 4 ÷	
		Number	керот сец	(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
	DART IT WASS DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200.00	85,025,800	0	85,025,800	2,367,007.34	35.92	1.00
2.00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0.00	2.00
	A							
3.00	Non-physician anesthetist Part  B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01 5.00	Physicians - Part A - Teaching Physician and Non		0 3,041	0	0 3,041	0.00 144.00		
	Physician-Part B		3,041					
6.00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6.00
7.00	services Interns & residents (in an	21.00	0	0	0	0.00	0.00	7.00
7.01	approved program) Contracted interns and		0	0	0	0.00	0.00	7.01
	residents (in an approved programs)							
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0		0.00		
10.00	Excluded area salaries (see instructions)		4,740,929	0	4,740,929	107,863.47	43.95	10.00
11 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		0 244 505	0	0 244 505	124 549 00	66.30	11.00
11.00	Care		8,244,585		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
12.00	Contract labor: Top level management and other		0	0	0	0.00	0.00	12.00
	management and administrative services							
13.00	Contract labor: Physician-Part		803,098	0	803,098	5,088.41	157.83	13.00
14.00	A - Administrative Home office and/or related organization salaries and		0	0	0	0.00	0.00	14.00
14 01	wage-related costs		11 466 506		11 466 506	202 005 00	27.74	14 01
14.01 14.02			11,466,596	0	11,466,596	303,805.00		14.01 14.02
15.00	Home office: Physician Part A		0	Ö	0	0.00		15.00
16 00	- Administrative Home office and Contract		0			0.00	0.00	16.00
16.00	Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract		0	0	0	0.00	0.00	16.02
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see		21,027,431	0	21,027,431			17.00
18.00	instructions) Wage-related costs (other)							18.00
19.00			1,004,025	0	1,004,025			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01 23.00			0 1,340	0	0 1,340			22.01 23.00
24.00	1 -		1,340	0	1,340			24.00
25.00	Interns & residents (in an		0	Ö	o			25.00
25.50			2,904,270	0	2,904,270			25.50
25.51	(core) Related organization		0	0	0			25.51
25.52	wage-related (core)		^					25.52
43.34	- Administrative - wage-related (core)		0					23.32
		·			,			

In Lieu of Form CMS-2552-10
Period: Worksheet S-3
From 07/01/2022 Part II
TO 06/30/2023 Part /Time Propaged: Provider CCN: 15-0034

					Т	o 06/30/2023	Date/Time Pre 11/20/2023 2:	
		Wkst. A Line	Amount	Reclassificati	Adjusted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries			wage (col. 4 ÷	
				(from Wkst.	$(col.2 \pm col.$	Salaries in	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 - DIRECT SALARI							
26.00	Employee Benefits Department	4.00	631,720		631,720	· '		26.00
27.00	Administrative & General	5.00	9,275,600	l .	9,275,600	·		27.00
28.00	Administrative & General under		1,866,294	0	1,866,294	16,088.00	116.01	28.00
20.00	contract (see inst.)							20.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00		29.00
30.00	Operation of Plant	7.00	2,538,977	l .	2,538,977			30.00
31.00	Laundry & Linen Service	8.00	105,545	l .	105,545	· '		31.00
32.00	Housekeeping	9.00	2,063,356	0	2,063,356	· '		32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	2,223,361	-979,534	1,243,827	·		34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
26.00	instructions)	11 00		070 534	070 534	47 061 00	20. 42	26.00
36.00	Cafeteria	11.00	0	979,534	979,534			36.00
37.00	Maintenance of Personnel	12.00	4 551 043	0	4 551 043	0.00		37.00
38.00	Nursing Administration	13.00	4,551,042	0	4,551,042	· '		38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00		39.00
40.00	Pharmacy	15.00	0	0	0	0.00		40.00
41.00	Medical Records & Medical	16.00	0	0	0	0.00	0.00	41.00
42.00	Records Library	17.00	_	_			0.00	42.00
42.00	Social Service	17.00	0	0	0	0.00		42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

Health Financial Systems ST. MARY MEDICAL CENTER, INC. In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0034 Period: From 07/01/2022 From 07/01/2022 Period: Period: Provider CCN: 15-0034 Period: Period:

					i	го 06/30/2023	Date/Time Pre 11/20/2023 2:	
		Worksheet A	Amount	Reclassificati	Adjusted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Salaries	Related to	wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		86,889,053	0	86,889,053	2,382,951.34	36.46	1.00
	instructions)							
2.00	Excluded area salaries (see		4,740,929	0	4,740,929	107,863.47	43.95	2.00
	instructions)							
3.00	Subtotal salaries (line 1		82,148,124	. 0	82,148,124	2,275,087.87	36.11	3.00
	minus line 2)							
4.00	Subtotal other wages & related		20,514,279	0	20,514,279	433,441.41	47.33	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		23,931,701	. 0	23,931,703	0.00	29.13	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		126,594,104	- 0	126,594,104	2,708,529.28	46.74	6.00
7.00	Total overhead cost (see		23,255,895	0	23,255,895	746,840.00	31.14	7.00
	instructions)							

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0034	Period: Worksheet S-3
		From 07/01/2022 Part IV

	10 00/30/2023	11/20/2023 2:2	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	2,556,626	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
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 Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	11,955,824	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	624,751	
11.00	Life Insurance (If employee is owner or beneficiary)	69,473	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	. ,	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	,	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumulative portion)		
17.00	TAXES	4 000 710	17.00
	FICA-Employers Portion Only	4,998,719	
18.00	Medicare Taxes - Employers Portion Only		
19.00	Unemployment Insurance	36,361	19.00 20.00
20.00	State or Federal Unemployment Taxes	0	20.00
21 00	OTHER	0	21.00
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	ı V	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00		0	23.00
24.00		22,032,796	24.00
24.00	Part B - Other than Core Related Cost	22,032,790	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00
23.00	OTHER WAGE RELATED COSTS (SPECIFI)	ı	23.00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0034	From 07/01/2022	Worksheet S-3 Part V Date/Time Prepared:

		10 06/30/2023	11/20/2023 2:	
	Cost Center Description	Contract Labor		
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	8,244,585	22,032,796	1.00
2.00	Hospital	8,244,585	22,032,796	2.00
3.00	SUBPROVIDER - IPF			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	Hospital-Based Hospice			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

Health	Financial Systems S	T. MARY MEDICA	I CENTER THE		Tn Lie	eu of Form CMS-	2552-10
	EALTH AGENCY STATISTICAL DATA	T. MARIE MEDICAL	Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet S-4	pared:
					Agency I		
					1.	00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
1.00	Home Health Aide Hours	0	527	1 1	8 267	812	1.00
2.00	Unduplicated Census Count (see instructions)	0.00		l .			
			•	Number of Emp	oloyees (Full Ti		
			er of hours in	Staff	Contract	Total	
			l work week	1.00	2.00	2.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	(	0	1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		40.00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		.5.00	1.0	2 0.00	1.02	1
5.00	Other Administrative Personnel			7.3	5 0.00	7.35	5.00
6.00	Direct Nursing Service			7.5		l .	1
7.00	Nursing Supervisor			0.0		l .	1
8.00 9.00	Physical Therapy Service Physical Therapy Supervisor			3.1		l .	1
10.00	Occupational Therapy Service			1.3		1	1
11.00	Occupational Therapy Supervisor			0.4		l .	1
12.00	Speech Pathology Service			0.0		0.08	12.00
	Speech Pathology Supervisor			0.4			
	Medical Social Service			0.0			14.00
15.00	Medical Social Service Supervisor Home Health Aide			0.0			15.00 16.00
17.00	Home Health Aide Supervisor			0.0		l	17.00
	Other (specify)			0.0		1	18.00
	The state of the s					CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES  Enter in column 1 the number of CBSAs where the column 1 serviced first code).	, ,			5 1	23844	19.00
			oisodes				
		Without	With Outliers	LUPA Episodes		Total (cols.	
		Outliers 1.00	2.00	3.00	Episodes 4.00	1-4) 5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	4,375				. ,	1
	Skilled Nursing Visit Charges	961,960					
	Physical Therapy Visits Physical Therapy Visit Charges	2,352 606,203		1	9 52 4 13,104	· '	1
	Occupational Therapy Visits	816			0 31		
	Occupational Therapy Visit Charges	209,896		1		· '	
27.00	Speech Pathology Visits	86	170		0 7	263	27.00
	Speech Pathology Visit Charges	22,101	· '		0 1,764	1	
	Medical Social Service Visits Medical Social Service Visit Charges	0	0		0 0	0	
	Home Health Aide Visits	202			1 2	371	1
32.00	Home Health Aide Visit Charges	33,444		1			
33.00	Total visits (sum of lines 21, 23, 25, 27,	7,831	2,984	18	4 156	11,155	33.00
24 00	29, and 31)			J		_	34.00
	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	1,833,604	716,019	1	0 6 36,981		1
55.00	30, 32, and 34)	1,033,004	710,019	41,78	30,361	2,020,390	33.00
	Total Number of Episodes (standard/non outlier)	839		12	6 8	973	
	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	39,909	145 10,975		6 4 155	149 52,475	37.00 38.00

HOSPIT	Financial Systems ST. MARY MEDICAL CENT	ER, INC.		In Lie	u of Form CMS-2	552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CCN: 15-003			Worksheet S-10	)
			Fron	07/01/2022 06/30/2023	Date/Time Pre	arod:
			10	00/30/2023	11/20/2023 2:2	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided Medicaid (see instructions for each line)	ded by line 202 co	lumn 8)		0.190453	1.00
2.00	Net revenue from Medicaid				15,572,625	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N 13,372,023	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa	l payments from Me	dicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from				0	5.00
6.00	Medicaid charges				167,003,899	6.00
7.00	Medicaid cost (line 1 times line 6)				31,806,394	
8.00	Difference between net revenue and costs for Medicaid program (1	ine 7 minus sum of	lines 2	and 5; if	16,233,769	8.00
	<pre>&lt; zero then enter zero) children's Health Transporter (SUTE) (con instructions for</pre>	anah Tima)				
9.00	Children's Health Insurance Program (CHIP) (see instructions for Net revenue from stand-alone CHIP	each line)			0	9.00
10.00	Stand-alone CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				Ö	
12.00	Difference between net revenue and costs for stand-alone CHIP (1)	ine 11 minus line	9: if <	zero then	ő	
	enter zero)		-,			
	Other state or local government indigent care program (see instru	uctions for each 1	ine)			
	Net revenue from state or local indigent care program (Not include					13.00
14.00	Charges for patients covered under state or local indigent care p	program (Not inclu	ded in 1	ines 6 or	381	14.00
15 00	10)				73	15 00
15.00 16.00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indic	aont cano nnoanam	(lino 10	: minus lino	73	15.00 16.00
10.00	13; if < zero then enter zero)	gent care program	(TIME I.	millius Tille	ľ	10.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/local in	ndigent	care program	ns (see	
	instructions for each line)					
	Private grants, donations, or endowment income restricted to fund					17.00
18.00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i	spital operations				
		dan dan arang merengan arang dan	(		0	18.00
19.00		indigent care prog	rams (sı	ım of lines	16,233,769	18.00
19.00	8, 12 and 16)	indigent care prog Uninsur		ım of lines Insured		18.00
19.00		Uninsur patien	red	Insured patients	16,233,769  Total (col. 1 + col. 2)	18.00
19.00	8, 12 and 16)	Uninsur	red	Insured	16,233,769 Total (col. 1	18.00
	8, 12 and 16) Uncompensated Care (see instructions for each line)	Uninsur patien 1.00	red ts	Insured patients 2.00	16,233,769  Total (col. 1 + col. 2) 3.00	18.00 19.00
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili	Uninsur patien 1.00	red	Insured patients	16,233,769  Total (col. 1 + col. 2) 3.00	18.00 19.00
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions)	Uninsur patien 1.00	red ts	Insured patients 2.00 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227	18.00 19.00
	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili	Uninsur patien 1.00	red ts	Insured patients 2.00	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227	18.00 19.00
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of	Uninsur patien 1.00 lity 6,56 ts (see 1,25	red ts	Insured patients 2.00 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911	18.00 19.00 20.00 21.00
20.00 21.00 22.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	Uninsur patien 1.00 lity 6,56 ts (see 1,25	5,790 0,474	Insured patients 2.00 414,437 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0	18.00 19.00 20.00 21.00 22.00
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of	Uninsur patien 1.00 lity 6,56 ts (see 1,25	red ts 5,790 0,474	Insured patients 2.00 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0	18.00 19.00 20.00 21.00 22.00
20.00 21.00 22.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	Uninsur patien 1.00 lity 6,56 ts (see 1,25	5,790 0,474	Insured patients 2.00 414,437 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0 1,664,911	18.00 19.00 20.00 21.00 22.00
20.00 21.00 22.00 23.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	Uninsur patien 1.00 lity 6,56 ts (see 1,25 ff as 1,25	5,790 0,474 0	Insured patients 2.00 414,437 414,437 0 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0	18.00 19.00 20.00 21.00 22.00
20.00 21.00 22.00 23.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care presented in the control of the control o	Uninsur patien 1.00 lity 6,56 ts (see 1,25 ff as 1,25 days beyond a lengram?	5,790 0,474 0gth of s	Insured patients 2.00 414,437 414,437 0 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0 1,664,911	20.00 21.00 22.00 23.00
20.00 21.00 22.00 23.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient	Uninsur patien 1.00 lity 6,56 ts (see 1,25 ff as 1,25 days beyond a lengram?	5,790 0,474 0gth of s	Insured patients 2.00 414,437 414,437 0 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0 1,664,911	20.00 21.00 22.00 23.00
20.00 21.00 22.00 23.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the second content of the charges for patient days beyond the	Uninsur patien 1.00 lity 6,56 ts (see 1,25 ff as 1,25 days beyond a lengram? indigent care pro-	5,790 0,474 0gth of s	Insured patients 2.00 414,437 414,437 0 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0 1,664,911 1.00 N 0 7,497,204	20.00 21.00 22.00 23.00 24.00 25.00
20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the second stay limit total bad debt expense for the entire hospital complex (see instructions)	Uninsur patien 1.00 lity 6,56 ts (see 1,25 ff as 1,25 days beyond a lengrogram? indigent care productions) (see instructions)	5,790 0,474 0gth of s	Insured patients 2.00 414,437 414,437 0 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0 1,664,911 1.00 N 0 7,497,204 418,049	20.00 21.00 23.00 24.00 25.00 26.00 27.00
20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01	Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilities (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit total bad debt expense for the entire hospital complex (see instructions)  Medicare reimbursable bad debts for the entire hospital complex (see	Uninsur patien 1.00 lity 6,56 ts (see 1,25 ff as 1,25 days beyond a lengrogram? indigent care productions) (see instructions)	5,790 0,474 0gth of s	Insured patients 2.00 414,437 414,437 0 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0 1,664,911 1.00 N 0 7,497,204 418,049 643,152	18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01
20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilisee instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	Uninsur patien 1.00 lity 6,56 ts (see 1,25 ff as 1,25  days beyond a lenguage rogram? indigent care program:	5,790 0,474 0 0,474 gth of s	Insured patients 2.00 414,437 414,437 0 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0 1,664,911 1.00 N 0 7,497,204 418,049 643,152 6,854,052	20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00
20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00 29.00	Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilisee instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit in the charges for patient days beyond the stay limit in the charges for the entire hospital complex (see instructions)  Medicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)  Cost of non-Medicare and non-reimbursable Medicare bad debt expense	Uninsur patien 1.00 lity 6,56 ts (see 1,25 ff as 1,25  days beyond a lenguage rogram? indigent care program:	5,790 0,474 0 0,474 gth of s	Insured patients 2.00 414,437 414,437 0 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0 1,664,911 1.00 N 0 7,497,204 418,049 643,152 6,854,052 1,530,478	20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00 29.00
20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00 29.00 30.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilisee instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	Uninsurpatien 1.00 lity 6,56 ts (see 1,25 ff as 1,25  days beyond a lengragram? indigent care program? indigent care program: indigent ca	5,790 0,474 0 0,474 gth of s	Insured patients 2.00 414,437 414,437 0 414,437	16,233,769  Total (col. 1 + col. 2) 3.00  6,980,227 1,664,911 0 1,664,911 1.00 N 0 7,497,204 418,049 643,152 6,854,052	20.00 21.00 22.00 23.00 24.00 25.00 27.00 27.01 28.00 29.00 30.00

Health	Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider C	CN: 15-0034 F	eriod:	Worksheet A	
					rom 07/01/2022		
				דן	o 06/30/2023	Date/Time Pre	
	Cost Conton Description	Salaries	Othon	To+ol (col 1	Reclassificati	11/20/2023 2: Reclassified	29 pm
	Cost Center Description	Salaries	Other	+ col. 2)	ons (See A-6)		
				+ (01. 2)	ons (see A-6)		
						(col. 3 +-	
		1.00	2.00	2.00	4.00	col. 4)	
	CENTERAL CERVICE COCT CENTERS	1.00	2.00	3.00	4.00	5.00	
4 00	GENERAL SERVICE COST CENTERS		0.640.076	0.640.074	100.000	0.000.000	
1.00	00100 CAP REL COSTS-BLDG & FIXT		8,642,976		1		
2.00	00200 CAP REL COSTS-MVBLE EQUIP		8,723,788	8,723,788	15,680		
3.00	00300 OTHER CAP REL COSTS		0		0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	631,720	11,827,090			12,458,810	1
5.01	00560 PURCHASING RECEIVING AND STORES	555,652	193,067	1		748,719	
5.02	00570 ADMITTING	2,876,901	447,766	3,324,667	0	3,324,667	
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	0	-2			-2	
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	5,843,047	57,444,868	63,287,915	-209,540	63,078,375	5.04
7.00	00700 OPERATION OF PLANT	2,538,977	9,382,046	11,921,023	0	11,921,023	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	105,545	1,269,502	1,375,047	0	1,375,047	8.00
9.00	00900 HOUSEKEEPING	2,063,356	925,070	2,988,426	0	2,988,426	9.00
10.00	01000 DIETARY	2,223,361	2,277,349	4,500,710	-1,982,854	2,517,856	10.00
11.00	01100 CAFETERIA	0	0	(	1,982,854	1,982,854	11.00
13.00	01300 NURSING ADMINISTRATION	4,551,042	3,487,191	8,038,233	0	8,038,233	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0	0	14.00
15.00	01500 PHARMACY	0	0		0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	1
17.00	01700 SOCIAL SERVICE	0	0		0	0	1
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	d	0	0	1
	02300 PARAMEDICAL EDUCATION PROGRAM EMS	261,151	36,461	297,612	o o	297,612	1
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	201,131	30,101		·1	237,012	23.00
30.00	03000 ADULTS & PEDIATRICS	13,818,860	4,207,362	18,026,222	668,577	18,694,799	30.00
	03100 INTENSIVE CARE UNIT	4,390,580	1,315,464		1		1
41.00	04100 SUBPROVIDER - IRF	1,850,485	879,123				
	04300 NURSERY	1,050,105	0,3,123	1			1
43.00	ANCILLARY SERVICE COST CENTERS	<u> </u>			1,310,200	1,310,200	43.00
50.00	05000 OPERATING ROOM	7,935,736	20,547,119	28,482,855	0	28,482,855	50.00
51.00	05100 RECOVERY ROOM	2,884,534	647,085			3,531,619	
	05200 DELIVERY ROOM & LABOR ROOM	2,717,547	962,526				
	05300 ANESTHESIOLOGY	0	4,277,380	4,277,380		4,277,380	
	05400 RADIOLOGY-DIAGNOSTIC	3,540,559	2,780,089			6,320,648	
	05500 RADIOLOGY - THERAPEUTIC	627,410	742,423			1,369,833	1
56.00	05600 RADIOISOTOPE	592,939	996,345			1,589,284	
	05700 CT SCAN	1,177,948	1,019,846			2,197,794	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	653,530	881,966			1,535,496	
	05900 CARDIAC CATHETERIZATION	1,778,308	2,363,725			4,142,033	
60.00	06000 LABORATORY	4,261,181	5,748,169			10,009,350	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	322,627	1,641,810			1,964,437	
64.00	06400 INTRAVENOUS THERAPY	432,831	159,198			592,029	
65.00	06500 RESPIRATORY THERAPY	2,180,470	683,137			1	
	06600 PHYSICAL THERAPY	40,536				, ,	
	06700 OCCUPATIONAL THERAPY		3,962,433				
		11,950	1,308,554			_,,	
	06800 SPEECH PATHOLOGY	188,254	666,731				
	06900 ELECTROCARDIOLOGY	856,989	583,065			, .,	
	07000 ELECTROENCEPHALOGRAPHY	455,950	156,400			612,350	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,667,773			, ,	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14,074,751			14,074,751	
	07300 DRUGS CHARGED TO PATIENTS	2,730,581	11,470,062			, ,	1
	07400 RENAL DIALYSIS	0	1,026,369			, ,	
76.97	07697 CARDIAC REHABILITATION	507,942	135,592	643,534	1 0	643,534	76.97
	OUTPATIENT SERVICE COST CENTERS	4 472 224	047.074	2 204 205		2 204 205	
	09000 CLINIC	1,473,331	917,874			, ,	1
	09100 EMERGENCY	5,314,677	1,777,960	7,092,637	0	7,092,637	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	2,616,038	613,888	3,229,926	5 0	3,229,926	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117]	85,012,545	202,871,391	287,883,936	5 0	287,883,936	]118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
	19100 RESEARCH	13,255	3,046				191.00
	19200 PHYSICIANS' PRIVATE OFFICES	13,233	8,550				192.00
	07950 OTHER NON-REIMBURSABLE COST CENTER	0	411,948				
	07952 ADVERTISING	0	482,913				
200.00		85,025,800	203,777,848				
			•		•		

Provider CCN: 15-0034

Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/20/2023 2:29 pm

				11/20/2023 2:29 pm
	Cost Center Description		Net Expenses	
			or Allocation	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT	-77,770	8,759,066	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1,336,673	10,076,141	2.00
3.00	00300 OTHER CAP REL COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1,801,024	14,259,834	4.00
5.01	00560 PURCHASING RECEIVING AND STORES	0	748,719	5.01
5.02	00570 ADMITTING	-8	3,324,659	5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	3,076,336	3,076,334	5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	-32,693,552	30,384,823	5.04
7.00	00700 OPERATION OF PLANT	0	11,921,023	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1,375,047	8.00
9.00	00900 HOUSEKEEPING	0	2,988,426	9.00
10.00	01000 DIETARY	-6,910	2,510,946	10.00
11.00	01100 CAFETERIA	-1,355,147	627,707	11.00
13.00	01300 NURSING ADMINISTRATION	-2,223,445	5,814,788	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00		0	0	15.00
16.00		2,372,811	2,372,811	16.00
17.00		0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	19.00
23.00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	-49,465	248,147	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
	03000 ADULTS & PEDIATRICS	-318	18,694,481	30.00
31.00		-59,088	5,646,956	31.00
	04100 SUBPROVIDER - IRF	0	2,729,608	41.00
43.00		0	1,518,268	43.00
	ANCILLARY SERVICE COST CENTERS			
	05000 OPERATING ROOM	-32	28,482,823	50.00
51.00		-26	3,531,593	51.00
	05200 DELIVERY ROOM & LABOR ROOM	-345,000	1,148,228	52.00
53.00		-3,821,357	456,023	53.00
	05400 RADIOLOGY-DIAGNOSTIC	-7,692	6,312,956	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	1,369,833	55.00
56.00	05600 RADIOISOTOPE	0	1,589,284	56.00
57.00		-5,950	2,191,844	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,535,496	58.00
59.00	05900 CARDIAC CATHETERIZATION	-1,935	4,140,098	59.00
60.00	06000 LABORATORY	-684,094	9,325,256	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	-152,959	1,811,478	63.00
64.00	06400 INTRAVENOUS THERAPY	0	592,029	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,863,607	65.00
66.00	06600 PHYSICAL THERAPY	0	4,002,969	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,320,504	67.00
68.00	06800 SPEECH PATHOLOGY	0	854,985	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,440,054	69.00
70.00		0	612,350	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,667,773	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14,074,751	72.00
	07300 DRUGS CHARGED TO PATIENTS	-164,056	14,036,587	73.00
	07400 RENAL DIALYSIS	0	1,026,369	74.00
76.97	07697 CARDIAC REHABILITATION	-44,313	599,221	76.97
	OUTPATIENT SERVICE COST CENTERS			
	09000 CLINIC	-3,539	2,387,666	90.00
	09100 EMERGENCY	-115	7,092,522	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
404 00	OTHER REIMBURSABLE COST CENTERS	4 000	2 225 426	101.00
101.00	10100 HOME HEALTH AGENCY	-4,800	3,225,126	101.00
110 00	SPECIAL PURPOSE COST CENTERS	22 444 72	254 700 200	110.00
118.00	,	-33,114,727	254,769,209	118.00
100.00	NONREIMBURSABLE COST CENTERS			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
	19100 RESEARCH	0	16,301	191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	8,550	192.00
	07950 OTHER NON-REIMBURSABLE COST CENTER	0	411,948	194.00
	107952 ADVERTISING	0	482,913	194.01
200.00	TOTAL (SUM OF LINES 118 through 199)	-33,114,727	255,688,921	200.00

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lieu of Form CMS-2552-10
RECLASSIFICATIONS	Provider CCN	From 07/01/2022
		To 06/30/2023 Date/Time Prepared:

					11/20/2	023 2:29 pm
		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS PROPERTY INSURANCE	Œ				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	193,860		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,680		2.00
	0		0	209,540		
	B - CAFETERIA EXPENSES RECLAS	SS				
1.00	CAFETERIA	11.00	979,534	1,003,320		1.00
	0		979,534	1,003,320		
	C - RECLASS LDRP COSTS					
1.00	ADULTS & PEDIATRICS	30.00	493,710	174,867		1.00
2.00	NURSERY	43.00	1,121,164	397,104		2.00
	0		1,614,874	571,971		
500.00	Grand Total: Increases		2,594,408	1,784,831		500.00

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lieu of Form CMS-2552-10		
RECLASSIFICATIONS	Provider CCN: 15-0034	Period: From 07/01/2022	Worksheet A-6	
			Date/Time Prenared:	

							11/20/2023 2	
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - RECLASS PROPERTY INSURANCE	E						
1.00	OTHER ADMINISTRATIVE &	5.04	0	209,540	12			1.00
	GENERAL							
2.00	L		0	0	12			2.00
	0		0	209,540				
	B - CAFETERIA EXPENSES RECLAS	S						
1.00	DIETARY	<u>10.</u> 00	97 <u>9,5</u> 34	<u>1,003,3</u> 20	0	)		1.00
	0		979,534	1,003,320				
	C - RECLASS LDRP COSTS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,614,874	571,971	. 0			1.00
2.00		0.00	0	0	0			2.00
	0		1,614,874	571,971				
500.00	Grand Total: Decreases		2,594,408	1,784,831				500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034

In Lieu of Form CMS-2552-10

| Period: | Worksheet A-7 |
| From 07/01/2022 | Part I |
| To 06/30/2023 | Date/Time Prepared:

				То	06/30/2023	Date/Time Pre 11/20/2023 2:	
				Acquisitions		122,20,2023	
		Beginning	Purchases	Donation	Total	Disposals and	
		Balances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	18,663,251	0	0	0	0	1.00
2.00	Land Improvements	8,196,639	90,718	0	90,718		2.00
3.00	Buildings and Fixtures	158,320,776	110,000		110,000		3.00
4.00	Building Improvements	88,465,849	6,735,396	0	6,735,396	3,572,326	
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	90,248,627	7,036,058	0	7,036,058	1,735,841	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	363,895,142	13,972,172	0	13,972,172	27,637,059	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	363,895,142	13,972,172	0	13,972,172	27,637,059	10.00
		Ending Balance	Fully				
			Depreciated				
			Assets				
		6.00	7.00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						4 00
1.00	Land	18,663,251	0				1.00
2.00	Land Improvements	8,287,357	0				2.00
3.00	Buildings and Fixtures	136,101,884	0				3.00
4.00	Building Improvements	91,628,919	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	95,548,844	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	350,230,255	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	350,230,255	0				10.00

Health Financial Systems	ST. MARY MEDICAL	T. MARY MEDICAL CENTER, INC.			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0034		Period: From 07/01/2022 To 06/30/2023	Worksheet A-7 Part II Date/Time Pre 11/20/2023 2:	pared:	
		SUMMARY OF CAPITAL					
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		

						11/20/2023 2:	29 pm
		SUMMARY OF CAPITAL					
				ı	_		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	,	
					instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	8,838,775	-195,799	(	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,002,462	2,721,326		0	0	2.00
3.00	Total (sum of lines 1-2)	14,841,237	2,525,527		0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	8,642,976				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,723,788				2.00
3.00	Total (sum of lines 1-2)	0	17,366,764				3.00
2.00	PART II - RECONCILIATION OF AMOUNTS FROM WORK CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	Capital-Relate d Costs (see instructions) 14.00	of cols. 9 through 14) 15.00 N 2, LINES 1 a 8,642,976 8,723,788	nd 2			2.00

Health	n Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet A-7 Part III Date/Time Prep 11/20/2023 2:2	oared: 29 pm
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS (						
1.00	CAP REL COSTS-BLDG & FIXT	254,681,411	l .	254,681,41		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	95,548,844	l .	95,548,84		0	2.00
3.00	Total (sum of lines 1-2)	350,230,255		350,230,25			3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				F CAPITAL			
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	f Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS (	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 8,761,005	-195,799	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 7,339,135	2,721,326	2.00
3.00	Total (sum of lines 1-2)	0	0		0 16,100,140	2,525,527	3.00
			SI	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions	Capital-Relate		
					d Costs (see instructions)	through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS O		12.00	13.00	17.00	13.00	
1.00	CAP REL COSTS-BLDG & FIXT	0	193,860		0 0	8,759,066	1.00
2.00	CAP REL COSTS-MVBLE EOUIP	0	15,680		0 0	10,076,141	2.00
3.00	Total (sum of lines 1-2)	0	1		0 0	18,835,207	
3.00	1 ( 0 2. 2)	1		ı	-1		3.00

То 06/30/2023 Date/Time Prepared: 11/20/2023 2:29 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 1.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL O CAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4.00 0 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 0 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Telephone services (pay 7.00 7.00 0.00 stations excluded) (chapter 21) 8.00 Television and radio service 0.00 0 8.00 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 -6.678.757 10.00 Provider-based physician A-8-2 10.00 adiustment 11.00 11.00 Sale of scrap, waste, etc. 0.00 (chapter 23) Related organization 12.00 A-8-1 -23,826,679 12.00 transactions (chapter 10) Laundry and linen service 0.00 13.00 13.00 0 14.00 Cafeteria-employees and guests 0 0.00 0 14.00 0 15.00 15.00 Rental of quarters to employee 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than patients 17.00 Sale of drugs to other than 0 0.00 0 17.00 patients 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing and allied health 19.00 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 22.00 Interest expense on Medicare 0.00 0 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A - 8 - 3OPHYSICAL 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 OCAP REL COSTS-BLDG & FIXT 1.00 0 26.00 COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL O CAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 28.00 19.00 28.00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS 29.00 29.00 Physicians' assistant 0.00 30.00 Adjustment for occupational A-8-3 OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 0 SPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest -164,056 DRUGS CHARGED TO PATIENTS 33.00 COVID DRUG DONATIONS 73.00 0 33.00 R

				Te	0 06/30/2023	Date/Time Pre 11/20/2023 2:	
				Expense Classification on	Worksheet A	12,20,2025	
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	OTHER REVENUE	В	-376,510	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01
33.02	OTHER REVENUE	В	-130	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	OTHER REVENUE	В	-8	ADMITTING	5.02	0	33.03
33.04	OTHER REVENUE	В	-21,647	OTHER ADMINISTRATIVE &	5.04	0	33.04
				GENERAL			
33.05	OTHER REVENUE	В	-6,910	DIETARY	10.00	0	33.05
33.06	OTHER REVENUE	В	-1,355,147	CAFETERIA	11.00	0	33.06
33.07	OTHER REVENUE	В	-4	NURSING ADMINISTRATION	13.00	0	33.07
33.08	OTHER REVENUE	В	-49,465	PARAMEDICAL EDUCATION	23.00	0	33.08
				PROGRAM EMS			
33.09	OTHER REVENUE	В	-318	ADULTS & PEDIATRICS	30.00	0	33.09
33.10	OTHER REVENUE	В	-11	INTENSIVE CARE UNIT	31.00	0	33.10
33.11	OTHER REVENUE	В	-32	OPERATING ROOM	50.00	0	33.11
33.12	OTHER REVENUE	В	-26	RECOVERY ROOM	51.00	0	33.12
33.13	OTHER REVENUE	В	-2,112	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	OTHER REVENUE	В	-1,935	CARDIAC CATHETERIZATION	59.00	0	33.14
33.15	OTHER REVENUE	В	-215,680	LABORATORY	60.00	0	33.15
33.16	OTHER REVENUE	В	-10	CLINIC	90.00	0	33.16
33.17	OTHER REVENUE	В	-115	EMERGENCY	91.00	0	33.17
33.18	OTHER REVENUE	В	-4,800	HOME HEALTH AGENCY	101.00	0	33.18
33.19	PRE-MERGER ASSETS DEPRECIATION	A	211,358	CAP REL COSTS-BLDG & FIXT	1.00	9	33.19
33.20	TAXABLE LABS	A	-468,414	LABORATORY	60.00	0	33.20
33.21	TAXABLE LABS	A	-152,959	BLOOD STORING, PROCESSING, &	63.00	0	33.21
				TRANS.			
33.22	PATIENT TV DEPRECIATION	A	-360	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.22
33.23	PATIENT TV PURCHASES	A	0	OPERATION OF PLANT	7.00	0	33.23
50.00	TOTAL (sum of lines 1 thru 49)		-33,114,727				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

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

<sup>(2)</sup> 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.

OFFICE	COSTS			From 0//01/2022					
				To 06/30/2023					
				1	11/20/2023 2:	29 pm			
	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 ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								
	HOME OFFICE COSTS:	_							
1.00		OTHER ADMINISTRATIVE & GENER		0	16,939,802	1.00			
2.00		OTHER ADMINISTRATIVE & GENER		1	33,722,994	2.00			
3.00		CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOC-BLDG	87,382	0	3.00			
3.01	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOC-EQUIP	1,337,033		3.01			
3.02	5.04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-SALARIES	8,238,718	0	3.02			
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOC-BENEFITS	1,801,895	0	3.03			
3.04	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOC-MEDICAL RE	2,372,811	0	3.04			
3.05	5.04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-REIMBURSEM	88,663	0	3.05			
3.06	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE ALLOC-PATIENT AC	3,076,336	0	3.06			
3.07	5.04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-OTHER NON	10,048,341	0	3.07			
3.08	5.04	OTHER ADMINISTRATIVE & GENER	CANCER CARE ALLOCATION PER G	0	552,389	3.08			
3.09	5.04	OTHER ADMINISTRATIVE & GENER	CANCER CARE ALLOC-ADMIN	61,004	0	3.09			
3.10	13.00	NURSING ADMINISTRATION	CANCER CARE ALLOC-REGISTRY	132,872	0	3.10			
3.11	5.04	OTHER ADMINISTRATIVE & GENER	CANCER CARE ALLOC-NAVIGATORS	143,451	0	3.11			
4.00	0.00			0	0	4.00			
5.00	TOTALS (sum of lines 1-4).			27,388,506	51,215,185	5.00			
	Transfer column 6, line 5 to								
	Worksheet A-8, column 2,								
	line 12.								
* Tho	amounts on lines 1-4 (and sub	occrinto ao annronriato) aro t	ransformed in detail to work	shoot A solumn	6 lines as				

\* 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.

has not been posted to worksheet A; cordinis I and/or I; the amount arrowable should be mareaced in cordinir i or this part.									
			Related Organization(s) and/	or Home Office					
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownership		Ownership					
1.00	2.00	3.00	4.00	5.00					
	Symbol (1) 1.00	Symbol (1) Name 1.00 2.00	Symbol (1) Name Percentage of Ownership	Symbol (1)  Name  Percentage of Ownership  1.00  2.00  Related Organization(s) and/ Ownership  4.00	Symbol (1)  Name Percentage of Ownership  1.00  Name Percentage of Ownership  3.00  4.00  Percentage of Ownership  5.00				

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	В	0.00 CFNI 100.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health	Financial Syste	ems	ST. MARY MEDICAL	CENTER, INC.	In Lie	u of Form CMS-2	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0034	Period:	Worksheet A-8	-1
OFFICE	COSTS				From 07/01/2022		
					To 06/30/2023	Date/Time Pre 11/20/2023 2:	
	Net	Wkst. A-7 Ref.				11/20/2023 21	L3 piii
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
			MENTS REQUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED (	ORGANIZATIONS OR (	CLAIMED	
	HOME OFFICE CO						
1.00	-16,939,802	0					1.00
2.00	-33,722,994	0					2.00
3.00	87,382	9	9				3.00
3.01	1,337,033	9	9				3.01
3.02	8,238,718	0					3.02
3.03	1,801,895	0					3.03
3.04	2,372,811	0					3.04
3.05	88,663	0					3.05
3.06	3,076,336	0					3.06
3.07	10,048,341	0					3.07
3.08	-552,389	0					3.08
3.09	61.004	0					3.09

\* 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.

3.10

3.11

4.00

5.00

1105	c been posted to worksheet A,	corumnis i ana, or i,	circ amount	arrowabic biloura be	. Indicacca in colu	mi i oi ciiis paici	
	Related Organization(s)						
	and/or Home Office						
	Type of Business						
	6.00						
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S)	AND/OR HOME	OFFTCF:			

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.

	HOME OFFICE	6	6.00
7.00		7	7.00
8.00		8	8.00
9.00			9.00
10.00		10	LO.00
8.00 9.00 10.00 100.00		100	00.00

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

0

0

- 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.

3.10

3.11

4.00

5.00

132.872

143,451

-23,826,679

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0034 Period: Worksheet A-8-2 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					]	ro 06/30/2023	Date/Time Pre 11/20/2023 2:	
	Wkst. A Line #	Cost Center/Physician	Total	Professional	Provider	RCE Amount	Physician/Prov	•
		Identifier	Remuneration	Component	Component		ider Component	
				·			Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		CLINIC	3,041	3,041		0	0	1.00
2.00		CLINIC	488			0	0	2.00
3.00		EMPLOYEE BENEFITS DEPARTMENT	741			0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	2,356,313	2,356,313	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	345,000	345,000	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	3,821,357	3,821,357	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	5,580			0	0	7.00
8.00	57.00	CT SCAN	5,950	5,950	0	0	0	8.00
9.00	76.97	CARDIAC REHABILITATION	44,313	44,313	0	0	0	9.00
10.00	5.04	OTHER ADMINISTRATIVE &	114,583	0	114,583	211,500	764	10.00
		GENERAL						
11.00	31.00	INTENSIVE CARE UNIT	183,333		183,333	211,500		11.00
200.00			6,880,699					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provider	Physician Cost	
		Identifier	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1.00	3.00	0.00	0.00	Education	12	14.00	
1.00	1.00	2.00 CLINIC	8.00	9.00	12.00	13.00	14.00	1.00
2.00		CLINIC	0	0	-	0	0	2.00
3.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	-	0	0	3.00
4.00		NURSING ADMINISTRATION	0	0		0	0	4.00
5.00		DELIVERY ROOM & LABOR ROOM	0	0		0	0	5.00
6.00		ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00		RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00		CT SCAN	0		0	0	0	8.00
9.00		CARDIAC REHABILITATION	0	0	0	, o	0	9.00
10.00	•	OTHER ADMINISTRATIVE &	77,686	3,884	0	, o	0	10.00
10.00	]	GENERAL	77,000	3,001		Ĭ	Ĭ	10.00
11.00	31.00	INTENSIVE CARE UNIT	124,256	6,213	0	0	0	11.00
200.00			201,942	10,097	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provider	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Disallowance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		CLINIC	0	1		3,041		1.00
2.00		CLINIC	0	0	_	488		2.00
3.00		EMPLOYEE BENEFITS DEPARTMENT	0	1	_	741		3.00
4.00		NURSING ADMINISTRATION	0	0		2,356,313		4.00
5.00	•	DELIVERY ROOM & LABOR ROOM	0	0	0	345,000		5.00
6.00		ANESTHESIOLOGY	0	0	-	3,821,357		6.00
7.00	•	RADIOLOGY-DIAGNOSTIC	0	0	· ·	5,580		7.00
8.00		CT SCAN	0	0	0	5,950		8.00
9.00	•	CARDIAC REHABILITATION	0	0	0	44,313		9.00
10.00	5.04	OTHER ADMINISTRATIVE &	0	77,686	36,897	36,897		10.00
11 00	21 00	GENERAL	_	124 250	FO 077	F0 077		11 00
11.00	31.00	INTENSIVE CARE UNIT	0			59,077		11.00
200.00	l	1	0	201,942	95,974	6,678,757		200.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 07/01/2022 Part I Provider CCN: 15-0034

						o 06/30/2023	Date/Time Pre	pared:
				CAPTTAL REI	LATED COSTS		11/20/2023 2:	29 pm
				CALLIAE REL				
		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	PURCHASING	
			for Cost Allocation			BENEFITS DEPARTMENT	RECEIVING AND STORES	
			(from Wkst A			DEPARTMENT	STORES	
			col. 7)					
			0	1.00	2.00	4.00	5.01	
1.00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT	8,759,066	8,759,066				1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP	10,076,141	0,733,000	10,076,141			2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	14,259,834	38,353				4.00
5.01	1	PURCHASING RECEIVING AND STORES	748,719	67,734	1		1	5.01
5.02		ADMITTING	3,324,659	87,103		-	1	5.02
5.03 5.04	1	CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMINISTRATIVE & GENERAL	3,076,334 30,384,823	10,502 417,306		_	1	5.03 5.04
7.00		OPERATION OF PLANT	11,921,023	1,191,701	1		1	
8.00		LAUNDRY & LINEN SERVICE	1,375,047	14,483	(	17,883	0	8.00
9.00		HOUSEKEEPING	2,988,426	56,282			1	9.00
10.00 11.00	1	DIETARY CAFETERIA	2,510,946 627,707	134,131 45,097			1	
13.00		NURSING ADMINISTRATION	5,814,788		1		1	
14.00	1	CENTRAL SERVICES & SUPPLY	0	0	1	1	0	14.00
15.00	1	PHARMACY	0	0	1	0	0	15.00
16.00		MEDICAL RECORDS & LIBRARY	2,372,811	31,386	i e	0	0	16.00
17.00 19.00		SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	0		0	0	17.00 19.00
23.00	1	PARAMEDICAL EDUCATION PROGRAM EMS	248,147	6,595	1	44,247		
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	18,694,481	1,173,817				
31.00 41.00		INTENSIVE CARE UNIT SUBPROVIDER - IRF	5,646,956 2,729,608					
43.00	1	NURSERY	1,518,268					
		LARY SERVICE COST CENTERS						
50.00	1	OPERATING ROOM	28,482,823	706,705			1	
51.00 52.00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	3,531,593 1,148,228	222,319 201,300				
53.00		ANESTHESIOLOGY	456,023	4,798				
54.00	1	RADIOLOGY-DIAGNOSTIC	6,312,956	182,035	794,837	599,884	19,598	
55.00		RADIOLOGY - THERAPEUTIC	1,369,833	49,181	1			
56.00 57.00		RADIOISOTOPE CT SCAN	1,589,284 2,191,844	87,549 60,366				
58.00	1	MAGNETIC RESONANCE IMAGING (MRI)	1,535,496		1		1	
59.00		CARDIAC CATHETERIZATION	4,140,098		1			
60.00	1	LABORATORY	9,325,256				1	
63.00 64.00		BLOOD STORING, PROCESSING, & TRANS. INTRAVENOUS THERAPY	1,811,478 592,029	13,250 48,676	1	1	1	
65.00	1	RESPIRATORY THERAPY	2,863,607	54,781			1	
66.00		PHYSICAL THERAPY	4,002,969	326,742	1			
67.00	1	OCCUPATIONAL THERAPY	1,320,504	30,822				
68.00		SPEECH PATHOLOGY	854,985	13,071				
69.00 70.00		ELECTROCARDIOLOGY ELECTROENCEPHALOGRAPHY	1,440,054 612,350	53,593 39,779				
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	11,667,773	0	1		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,074,751	0	C	0	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	14,036,587	53,430		462,648		
74.00 76.97		RENAL DIALYSIS CARDIAC REHABILITATION	1,026,369 599,221	4,634 116,410		0 86,062	0 298	
70.97		TIENT SERVICE COST CENTERS	399,221	110,410	20,400	00,002	290	76.97
90.00		CLINIC	2,387,666	202,370	171,640	249,629	9,849	90.00
91.00		EMERGENCY	7,092,522	277,308	140,878	900,476	40,290	
92.00		OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	3,225,126	0	2,021	443,241	0	101.00
101.00		AL PURPOSE COST CENTERS	3,223,120	0	2,021	-		101.00
118.00	)	SUBTOTALS (SUM OF LINES 1 through 117)	254,769,209	6,833,890	10,025,810	14,296,790	913,848	118.00
100 00		IMBURSABLE COST CENTERS		40 ===	-		-	100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	0 16,301	10,576 0	1			190.00 191.00
		PHYSICIANS' PRIVATE OFFICES	8,550	1,901,380		0	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	411,948	0	49,938	0	1,094	194.00
		ADVERTISING	482,913	13,220	393	0		194.01
200.00		Cross Foot Adjustments		•	,	_	_	200.00 201.00
201.00		Negative Cost Centers TOTAL (sum lines 118 through 201)	255,688,921	0 8,759,066	1			
00	1	,	, ,	_,,		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,-12	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0034

Period: Worksheet B From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/20/2023 2:29 pm

						11/20/2023 2:	29 pm
	Cost Center Description	ADMITTING	CASHIERING/ACC	Subtotal	OTHER	OPERATION OF	
			OUNTS		ADMINISTRATIVE	PLANT	
			RECEIVABLE		& GENERAL		
		5.02	5.03	5A.03	5.04	7.00	
1 00	GENERAL SERVICE COST CENTERS						1 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	2 000 125					5.01
5.02	00570 ADMITTING	3,908,125	2 000 020				5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	0	3,086,836	22 606 620	22 606 620		5.03
5.04 7.00	00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	0	32,696,639		l e	5.04
8.00	1 1	0	0	13,864,832			1
9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	0	1,407,413 3,432,516	1	l '	
10.00	01000 DIETARY	0	0	2,914,478			
11.00	01100 CAFETERIA	0	0	863,907			
13.00	01300 NURSING ADMINISTRATION	0	0	6,758,110			
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0,730,110		1	1
15.00	01500 PHARMACY	0	0	0		0	1
16.00	01600 MEDICAL RECORDS & LIBRARY	0		2,404,197	352,520	1	1
17.00	01700 SOCIAL SERVICE	0	0	2,404,137		0	1
19.00	01900 NONPHYSICIAN ANESTHETISTS	0		0		Ö	1
	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	ő	303,418	44,489	1	1
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	Ŭ	ŭ,	303,110	11,105	13,031	23.00
30.00	03000 ADULTS & PEDIATRICS	242,861	191,809	22,959,770	3,366,522	2,686,455	30.00
31.00	03100 INTENSIVE CARE UNIT	53,051	41,899	6,844,272	1 ' ' 1		
41.00	04100 SUBPROVIDER - IRF	25,603		3,268,356			
43.00	04300 NURSERY	13,631		1,836,606		l '	
	ANCILLARY SERVICE COST CENTERS			_,,		,	
50.00	05000 OPERATING ROOM	557,254	440,361	36,272,796	5,318,526	1,617,400	50.00
51.00	05100 RECOVERY ROOM	67,540		4,446,749			
52.00	05200 DELIVERY ROOM & LABOR ROOM	13,392		1,643,295			
53.00	05300 ANESTHESIOLOGY	111,559		678,481			
54.00	05400 RADIOLOGY-DIAGNOSTIC	233,951	184,772	8,328,033			1
55.00	05500 RADIOLOGY - THERAPEUTIC	70,946		1,673,547			1
56.00	05600 RADIOISOTOPE	63,148		1,914,901			1
57.00	05700 CT SCAN	291,936		3,558,269		138,157	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	124,229		2,270,483			
59.00	05900 CARDIAC CATHETERIZATION	316,544	250,002	6,018,045	882,408		
60.00	06000 LABORATORY	437,794	345,765	11,265,907	1,651,886	384,182	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	19,162	15,134	1,978,554	290,109	30,324	63.00
64.00	06400 INTRAVENOUS THERAPY	14,819	11,704	743,945	109,082	111,403	64.00
65.00	06500 RESPIRATORY THERAPY	43,970	34,727	3,473,764	509,348	125,375	65.00
66.00	06600 PHYSICAL THERAPY	63,824	50,407	4,490,266	658,394	747,797	66.00
67.00	06700 OCCUPATIONAL THERAPY	20,456	16,156	1,391,986	204,103	70,541	67.00
68.00	06800 SPEECH PATHOLOGY	8,502	6,715	968,657	142,031	29,916	68.00
69.00	06900 ELECTROCARDIOLOGY	128,112	101,181	2,058,966	301,900	122,655	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	34,797	27,482	820,895		91,040	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	102,136		11,850,574			
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	109,531		14,270,788			
	07300 DRUGS CHARGED TO PATIENTS	302,369		15,332,318			
	07400 RENAL DIALYSIS	14,495		1,056,946			
76.97	07697 CARDIAC REHABILITATION	7,606	6,007	842,072	123,470	266,422	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00		31,072		3,076,766			
91.00	09100 EMERGENCY	367,045	289,888	9,108,407		634,661	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
	OTHER REIMBURSABLE COST CENTERS						4
101.00	10100 HOME HEALTH AGENCY	16,790	13,260	3,700,438	542,584	0	101.00
440.00	SPECIAL PURPOSE COST CENTERS	2 000 125	2 000 020	252 700 262	22 274 622	44 404 740	
118.00		3,908,125	3,086,836	252,790,362	32,271,633	11,491,749	1118.00
100.00	NONREIMBURSABLE COST CENTERS	0		10 570	4 554	24 205	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	10,576			190.00
	19100 RESEARCH	0	0	18,547			191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0		1,909,930			192.00
	07950 OTHER NON-REIMBURSABLE COST CENTER	0	٥	462,980			194.00
	07952 ADVERTISING	0	ا	496,526	1		
200.00		0		0	1		200.00
201.00		3,908,125	3,086,836	255,688,921	1		
202.00	TOTAL (Sum Times IIO CHIOUGH 201)	3,300,123	3,000,030	233,000,321	. 52,050,039	13,037,731	1202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0034

Period: Worksheet B From 07/01/2022 Part I Date/Time Prepared: 11/20/2023 2:29 pm

					, ,	11/20/2023 2:	29 pm
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING	
		LINEN SERVICE				ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS					T	
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						5.01
5.02	00570 ADMITTING						5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5.04
7.00	00700 OPERATION OF PLANT	1 646 024					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1,646,924	4 064 625				8.00
9.00	00900 HOUSEKEEPING	0	4,064,625	2 720 002			9.00
10.00	01000 DIETARY	0	79,294	3,728,092	1 120 440		10.00
11.00	01100 CAFETERIA	0	26,660	0	1,120,449		11.00
13.00	01300 NURSING ADMINISTRATION	0	42,922	0	74,606		
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	0	10.555	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	18,555	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	2 000	0	5 426	0	19.00
23.00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	3,899	0	5,426	0	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1 105 104	CO2 021	2 (42 020	245 521	2 027 050	30.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1,185,184	693,921	2,643,028 242,369	245,521	, ,	
		212,290	116,622		62,398		
41.00	04100 SUBPROVIDER - IRF	197,030 52,420	97,611	385,057	32,555		1
43.00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	52,420	11,442	U	16,278	197,253	43.00
50.00	05000 OPERATING ROOM	0	417,781	0	139,717	1,731,471	50.00
51.00	05100 RECOVERY ROOM	0	131,427	167,698	44,764		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	119,002	94,060	16,278	,	
53.00	05300 ANESTHESIOLOGY	0	2,836	0	10,270	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	107,613	Ö	67,824		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	29,074	Ö	9,495		55.00
56.00	05600 RADIOISOTOPE	0	51,756	0	8,139		56.00
57.00	05700 CT SCAN	0	35,687	Ö	18,991		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	33,535	0	10,852	1	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	77,643	0	25,773		59.00
60.00	06000 LABORATORY	0	99,236	0	94,953	1	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	7,833	0	5,426	1	63.00
64.00	06400 INTRAVENOUS THERAPY	0	28,776	0	8,139	1	64.00
65.00	06500 RESPIRATORY THERAPY	0	32,385	0	36,625		65.00
66.00	06600 PHYSICAL THERAPY	0	193,159	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	18,221	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	7,727	0	4,069	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	31,682	0	13,565	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	23,516	0	9,495	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	31,586	0	37,981	0	73.00
74.00	07400 RENAL DIALYSIS	0	2,740		0	1	74.00
76.97	07697 CARDIAC REHABILITATION	0	68,818		8,139	104,637	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	119,634	0	27,130	0	90.00
91.00	09100 EMERGENCY	0	163,935	195,880	85,458	1,052,482	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	10,852	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	,	1,646,924	2,926,528	3,728,092	1,120,449	8,032,729	118.00
	NONREIMBURSABLE COST CENTERS	_		_			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,252	0	0		190.00
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	1,124,030	0	0		192.00
	07950 OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0		194.00
	L 07952 ADVERTISING	0	7,815	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	1,646,924	4,064,625	3,728,092	1,120,449	8,032,729	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0034

Period: Worksheet B From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/20/2023 2:29 pm

					0 00/30/2023	11/20/2023 2:	29 pm
	Cost Center Description	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE		
		SERVICES &		RECORDS &		ANESTHETISTS	
		SUPPLY		LIBRARY			
		14.00	15.00	16.00	17.00	19.00	
	GENERAL SERVICE COST CENTERS						
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						5.01
5.02	00570 ADMITTING						5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5.04
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0					14.00
15.00	01500 PHARMACY	0	0				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	2,847,104	ı		16.00
17.00	01700 SOCIAL SERVICE	o o	0	2,017,10	5		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		0		ol ol	0	1
23.00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	0			l	23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	U U			<u>,                                    </u>		23.00
30.00	03000 ADULTS & PEDIATRICS	0	0	176,912	2 0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	38,645		1	
41.00	04100 SUBPROVIDER - IRF		0				
43.00	04300 NURSERY		0	18,651 9,929		1	
43.00		U U	U	9,925	, 0	0	43.00
50.00	ANCILLARY SERVICE COST CENTERS	0	0	406 167	0	0	FO 00
51.00	05000 OPERATING ROOM		0	406,167			
	05100 RECOVERY ROOM		0	49,199			
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	9,756			
53.00	05300 ANESTHESIOLOGY	0	0	81,265		0	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	170,421		0	
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	51,680		0	
56.00	05600 RADIOISOTOPE	0	0	46,000		0	
57.00	05700 CT SCAN	0	0	212,661		0	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	90,495		0	
59.00	05900 CARDIAC CATHETERIZATION	0	0	230,586		0	
60.00	06000 LABORATORY	0	0	318,910		0	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	13,959	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	10,795	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	32,030	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	46,492	2 0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	14,901		0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	6,193	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	93,323	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	25,348	o o	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	74,401	L o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	79,787	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	220,260	0	0	73.00
	07400 RENAL DIALYSIS	0	0			0	74.00
	07697 CARDIAC REHABILITATION	0	0	5,541		0	76.97
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		, , , , , , , , , , , , , , , , , , ,	<u>'</u>		1
90.00	09000 CLINIC	0	0	22,634	0	0	90.00
91.00	09100 EMERGENCY	0	0	267,373		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			'		1
101.00	10100 HOME HEALTH AGENCY	0	0	12,231	. 0	0	101.00
	SPECIAL PURPOSE COST CENTERS		-,		-1		1
118.00		0	0	2,847,104	0	0	118.00
	NONREIMBURSABLE COST CENTERS		-	, , , ,	· · · · · · · · · · · · · · · · · · ·		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0	0	190.00
	19100 RESEARCH	l ol	n		ol ol		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	ا	n		ol ől		192.00
	07950 OTHER NON-REIMBURSABLE COST CENTER	ام	n				194.00
	L 07952 ADVERTISING		0				194.01
200.00		١	o i		ή "		200.00
201.00		٥	n	(	ار ا		201.00
202.00			0	2,847,104			202.00
202.00	1.01/12 (Juli 11/103 110 till ough 201)	١	۷	2,077,107	٠, ۷	,	1-02.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 07/01/2022 | Part I | To 06/30/2023 | Date/Time Prepared: COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0034

					i	o 06/30/2023	Date/Time Prepared: 11/20/2023 2:29 pm
		Cost Center Description	PARAMEDICAL	Subtotal	Intern &	Total	11/20/2023 2:23 piii
		·	EDUCATION		Residents Cost		
			PROGRAM EMS		& Post Stepdown		
					Adjustments		
			23.00	24.00	25.00	26.00	
1 00		AL SERVICE COST CENTERS			1		1.00
1.00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP					1.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01		PURCHASING RECEIVING AND STORES					5.01
5.02		ADMITTING					5.02
5.03 5.04	1	CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMINISTRATIVE & GENERAL					5.03
7.00	1	OPERATION OF PLANT					7.00
8.00		LAUNDRY & LINEN SERVICE					8.00
9.00	1	HOUSEKEEPING					9.00
10.00 11.00	1	DIETARY					10.00
13.00	1	CAFETERIA NURSING ADMINISTRATION					13.00
14.00	1	CENTRAL SERVICES & SUPPLY					14.00
15.00	1	PHARMACY					15.00
16.00	1	MEDICAL RECORDS & LIBRARY					16.00
17.00 19.00		SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS					17.00
23.00		PARAMEDICAL EDUCATION PROGRAM EMS	372,326				23.00
23.00		IENT ROUTINE SERVICE COST CENTERS	3.2,320				23100
30.00		ADULTS & PEDIATRICS	0	36,984,372		, ,	
31.00		INTENSIVE CARE UNIT	0	9,743,145	1	, ,	
41.00 43.00	1	SUBPROVIDER - IRF NURSERY	0	5,260,365 2,437,520		, ,	
43.00		LARY SERVICE COST CENTERS	<u> </u>	2,437,320	'1	2,437,320	43.00
50.00		OPERATING ROOM	0	45,903,858	3 (	45,903,858	50.00
51.00	1	RECOVERY ROOM	0	6,551,003	1	.,,	
52.00 53.00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	2,778,048	1		
54.00	1	RADIOLOGY-DIAGNOSTIC	0	873,047 10,311,619	1	, -	l I
55.00	1	RADIOLOGY - THERAPEUTIC	Ö	2,121,742		-,-,-	
56.00		RADIOISOTOPE	0	2,501,941	. (	2,501,941	
57.00		CT SCAN	0	4,485,503	1	, ,	
58.00 59.00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0	2,868,108 7,535,043	1	2,000,200	
60.00	1	LABORATORY	0	13,815,074		, ,	
63.00		BLOOD STORING, PROCESSING, & TRANS.	0	2,326,205			
64.00	1	INTRAVENOUS THERAPY	0	1,012,140		, . ,	
65.00	1	RESPIRATORY THERAPY	0	4,209,527	1	.,,	
66.00 67.00		PHYSICAL THERAPY OCCUPATIONAL THERAPY	0	6,136,108 1,699,752	1	., ,	
68.00	1	SPEECH PATHOLOGY	Ö	1,158,593	1		l I
69.00	06900	ELECTROCARDIOLOGY	0	2,622,091			69.00
		ELECTROENCEPHALOGRAPHY	0	1,090,659	1	1,090,659	
71.00 72.00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	13,662,589 16,443,058		, ,	
73.00		DRUGS CHARGED TO PATIENTS	0	17,992,559			
		RENAL DIALYSIS	0	1,235,829			
76.97		CARDIAC REHABILITATION	0	1,419,099	) (	1,419,099	76.97
00 00		TIENT SERVICE COST CENTERS	0	4 100 455		4 100 455	20.00
		CLINIC EMERGENCY	0 372,326	4,160,455 13,216,060	1	, ,	
		OBSERVATION BEDS (NON-DISTINCT PART	372,320	13,210,000		, ,	92.00
	OTHER	REIMBURSABLE COST CENTERS					
101.00		HOME HEALTH AGENCY	0	4,266,105	i (	4,266,105	101.00
118.00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	372,326	246,821,217	, (	246,821,217	118.00
110.00		IMBURSABLE COST CENTERS	312,320	270,021,21/		, 270,021,21/	110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42,584	. (	42,584	190.00
		RESEARCH	0	21,266		,	
		PHYSICIANS' PRIVATE OFFICES	0	7,665,588		7,665,588	
		OTHER NON-REIMBURSABLE COST CENTER ADVERTISING	0	530,865 607,401		530,865 607,401	
200.00		Cross Foot Adjustments	Ö	0		0	200.00
201.00		Negative Cost Centers	0	0			201.00
202.00	)	TOTAL (sum lines 118 through 201)	372,326	255,688,921	.  (	255,688,921	202.00

					То	06/30/2023	Date/Time Prep 11/20/2023 2:2	
				CAPITAL REI	ATED COSTS		11/20/2023 2.2	29 piii
			517					
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capital				DEPARTMENT	
			Related Costs	1.00	2.00	2.	4.00	
	GENER	AL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01		EMPLOYEE BENEFITS DEPARTMENT	0	38,353		39,202	39,202	4.00
5.01	1	PURCHASING RECEIVING AND STORES ADMITTING	0	67,734 87,103		72,078 94,535	258 1,338	5.01 5.02
5.03	1	CASHIERING/ACCOUNTS RECEIVABLE	0	10,502		10,502	0	5.03
5.04		OTHER ADMINISTRATIVE & GENERAL	0	417,306		1,320,623	2,717	5.04
7.00 8.00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	1,191,701		1,511,834	1,181 49	7.00 8.00
9.00		HOUSEKEEPING	0	14,483 56,282		14,483 91,904	959	9.00
10.00		DIETARY	0	134,131		186,521	578	
11.00	1	CAFETERIA	0	45,097		67,550	455	
13.00		NURSING ADMINISTRATION	0	72,606		165,764 0	2,116	
14.00 15.00	1	CENTRAL SERVICES & SUPPLY PHARMACY	0	0 0	1	0	0	14.00 15.00
16.00	1	MEDICAL RECORDS & LIBRARY	0	31,386	1	31,386	0	16.00
17.00		SOCIAL SERVICE	0	0		0	0	17.00
19.00 23.00		NONPHYSICIAN ANESTHETISTS	0	0	1	0 10,925	0	19.00 23.00
23.00		PARAMEDICAL EDUCATION PROGRAM EMS  IENT ROUTINE SERVICE COST CENTERS	l ol	6,595	4,330	10,923	121	23.00
30.00		ADULTS & PEDIATRICS	0	1,173,817	185,853	1,359,670	6,617	30.00
31.00	1	INTENSIVE CARE UNIT	0	197,275		336,575	2,042	
41.00 43.00	1	SUBPROVIDER - IRF NURSERY	0	165,116 19,355		175,812 99,703	860 521	
43.00	_	LARY SERVICE COST CENTERS	U O	15,555	00,540	33,703	321	43.00
50.00	05000	OPERATING ROOM	0	706,705		4,956,939	3,690	
51.00		RECOVERY ROOM	0	222,319		295,196	1,341	
52.00 53.00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	201,300 4,798		280,092 8,863	513 0	52.00 53.00
54.00	1	RADIOLOGY-DIAGNOSTIC	Ö	182,035		976,872	1,646	
55.00	1	RADIOLOGY - THERAPEUTIC	0	49,181		69,936	292	
56.00	1	RADIOISOTOPE	0	87,549		111,039	276	
57.00 58.00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	60,366 56,727		633,396 398,333	548 304	
59.00		CARDIAC CATHETERIZATION	ő	131,338		976,374	827	59.00
60.00		LABORATORY	0	167,864		292,852	1,981	
63.00 64.00		BLOOD STORING, PROCESSING, & TRANS. INTRAVENOUS THERAPY	0	13,250		70,656	150	
65.00	1	RESPIRATORY THERAPY	0	48,676 54,781		48,676 151,772	201 1,014	
66.00	1	PHYSICAL THERAPY	0	326,742		362,219	19	
67.00		OCCUPATIONAL THERAPY	0	30,822		32,646	6	67.00
68.00 69.00		SPEECH PATHOLOGY ELECTROCARDIOLOGY	0	13,071		66,360	88	
		ELECTROCARDIOLOGY	0	53,593 39,779		242,428 66,128	398 212	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 74.00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	53,430 4,634		288,127 4,634	1,270	73.00 74.00
		CARDIAC REHABILITATION	0	116,410		142,878	236	
	OUTPA	TIENT SERVICE COST CENTERS						
90.00		CLINIC	0	202,370		374,010	685	90.00
91.00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	0	277,308	140,878	418,186	2,471	91.00 92.00
32.00		REIMBURSABLE COST CENTERS				<u> </u>		32.00
101.00		HOME HEALTH AGENCY	0	0	2,021	2,021	1,216	101.00
118.00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	6,833,890	10,025,810	16,859,700	39,196	118.00
	NONRE	IMBURSABLE COST CENTERS		.,,				
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,576	0	10,576		190.00
		RESEARCH PHYSICIANS' PRIVATE OFFICES	0	0 1,901,380	0	0 1,901,380		191.00 192.00
		OTHER NON-REIMBURSABLE COST CENTER	Ö	0	49,938	49,938	0	194.00
194.01	07952	ADVERTISING	0	13,220		13,613		194.01
200.00		Cross Foot Adjustments		_		0		200.00 201.00
201.00		Negative Cost Centers TOTAL (sum lines 118 through 201)	0	8,759,066	0 10,076,141	18,835,207	39,202	
	1	,	۱ ۲	-,.55,500	,	, , , , , , , , , , , , , , , , , , ,	33,202	

Provider CCN: 15-0034

Period: Worksheet B From 07/01/2022 Part II Date/Time Prepared: 11/20/2023 2:29 pm

							11/20/2023 2:	29 pm
		Cost Center Description	PURCHASING	ADMITTING	CASHIERING/ACC	OTHER	OPERATION OF	
			RECEIVING AND			ADMINISTRATIVE	PLANT	
			STORES	F 02	RECEIVABLE	& GENERAL	7.00	
	CENED	AL CERVICE COCT CENTERS	5.01	5.02	5.03	5.04	7.00	
1.00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT			I			1.00
2.00	1	CAP REL COSTS-BLDG & FIXT						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01		PURCHASING RECEIVING AND STORES	72,336					5.01
5.02		ADMITTING	118	95,991				5.02
5.03	1	CASHIERING/ACCOUNTS RECEIVABLE	0	03,331				5.03
5.04	1	OTHER ADMINISTRATIVE & GENERAL	94	0		1,323,434		5.04
7.00		OPERATION OF PLANT	142	0	1	82,288	1,595,445	•
8.00	1	LAUNDRY & LINEN SERVICE	0	0		8,353	3,326	1
9.00	1	HOUSEKEEPING	204	0	0	20,372	12,927	9.00
10.00	01000	DIETARY	496	0	0	17,297	30,807	10.00
11.00	01100	CAFETERIA	212	0	0	5,127	10,358	11.00
13.00	01300	NURSING ADMINISTRATION	511	0	0	40,109	16,676	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	14,269	7,209	16.00
17.00	1	SOCIAL SERVICE	0	0		0	0	17.00
19.00		NONPHYSICIAN ANESTHETISTS	0	0		0	0	19.00
23.00		PARAMEDICAL EDUCATION PROGRAM EMS	8	0	0	1,801	1,515	23.00
20.00		IENT ROUTINE SERVICE COST CENTERS	2 624	5 050	C 4 4	126 266	260 602	30.00
30.00	1	ADULTS & PEDIATRICS	3,634	5,959		136,266	269,603	ł
31.00	1	INTENSIVE CARE UNIT	1,730	1,302		40,621	45,310	
41.00 43.00	1	SUBPROVIDER - IRF	283	628		19,398	37,924	ł
43.00		NURSERY  LARY SERVICE COST CENTERS	338	334	30	10,900	4,445	43.00
50.00		OPERATING ROOM	38,808	13,773	1,612	215,255	162,316	50.00
51.00	1	RECOVERY ROOM	818	1,657		26,391	51,062	
52.00	1	DELIVERY ROOM & LABOR ROOM	330	329		9,753	46,235	1
53.00		ANESTHESIOLOGY	1,101	2,737		4,027	1,102	1
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,549	5,740		49,427	41,810	1
55.00		RADIOLOGY - THERAPEUTIC	39	1,741	188	9,933	11,296	55.00
56.00	05600	RADIOISOTOPE	87	1,549	168	11,365	20,108	56.00
57.00	05700	CT SCAN	865	7,163	774	21,118	13,865	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	283	3,048	330	13,475	13,029	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,666	7,767	840	35,717	30,166	59.00
60.00		LABORATORY	11,247	10,742		66,863	38,555	1
63.00		BLOOD STORING, PROCESSING, & TRANS.	590	470		11,743	3,043	1
64.00	1	INTRAVENOUS THERAPY	267	364	•	4,415	11,180	ı
65.00		RESPIRATORY THERAPY	810	1,079		20,617	12,582	ı
66.00	1	PHYSICAL THERAPY	315	1,566		26,650	75,046	
67.00	1	OCCUPATIONAL THERAPY	16	502		8,261	7,079	ı
68.00	1	SPEECH PATHOLOGY	16	209		5,749	3,002	1
69.00 70.00	1	ELECTROCARDIOLOGY	157 228	3,143 854		12,220	12,309	ı
70.00	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,506		4,872 70,333	9,136 0	1
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	2,687		84,697	0	
		DRUGS CHARGED TO PATIENTS	299	7,419		90,997		73.00
		RENAL DIALYSIS	0	356			1,064	
		CARDIAC REHABILITATION	24	187		4,998	26,737	
		TIENT SERVICE COST CENTERS	= -,			.,		
90.00	09000	CLINIC	779	762	82	18,261	46,480	90.00
		EMERGENCY	3,185	9,006	974	54,058	63,692	
92.00		OBSERVATION BEDS (NON-DISTINCT PART						92.00
		REIMBURSABLE COST CENTERS	-1					
101.00		HOME HEALTH AGENCY	0	412	45	21,962	0	101.00
118.00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	72,249	95,991	10,502	1,306,231	1,153,266	110 00
110.00		IMBURSABLE COST CENTERS	72,249	93,991	10,302	1,300,231	1,133,200	1110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	0	n	63	2.429	190.00
		RESEARCH	ő	0		110	2, .23	191.00
	1	PHYSICIANS' PRIVATE OFFICES	ol	0		11,335	436,714	
		OTHER NON-REIMBURSABLE COST CENTER	87	0	1	2,748	0	194.00
		ADVERTISING	0	0		2,947		194.01
200.00		Cross Foot Adjustments				·	,	200.00
201.00		Negative Cost Centers	0	0	0	o		201.00
202.00	)	TOTAL (sum lines 118 through 201)	72,336	95,991	10,502	1,323,434	1,595,445	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0034

Period: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared:

11/20/2023 2:29 pm Cost Center Description LAUNDRY & HOUSEKEEPING CAFETERIA **DIETARY** NURSING LINEN SERVICE ADMINISTRATION 9.00 10.00 11.00 13.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00560 PURCHASING RECEIVING AND STORES 5.01 5.02 00570 ADMITTING 5.02 00580 CASHIERING/ACCOUNTS RECEIVABLE 5.03 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 26,211 8.00 9.00 00900 HOUSEKEEPING 0 126,366 9.00 01000 DIETARY 2,465 238.164 10.00 10.00 0 11.00 01100 CAFETERIA 0 829 84,531 11.00 13.00 01300 NURSING ADMINISTRATION 0 1.334 0 5,629 232,139 13.00 01400 CENTRAL SERVICES & SUPPLY 0 0 14.00 14.00 0 0 01500 PHARMACY 0 0 15.00 C 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 577 0 0 0 16.00 0 0 17.00 17.00 01700 SOCIAL SERVICE 0 0 0 0 19.00 01900 NONPHYSICIAN ANESTHETISTS C 0 0 19.00 02300 PARAMEDICAL EDUCATION PROGRAM EMS 23.00 121 0 409 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 18,862 21,573 168,846 18,524 87,480 30.00 03100 INTENSIVE CARE UNIT 31.00 3,379 3,626 15,483 4,708 22,296 31.00 41.00 04100 SUBPROVIDER - IRF 3,136 3,035 24,599 2,456 11,675 41.00 43.00 04300 NURSERY 834 356 1,228 5,700 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 12,988 10,541 50,038 50.00 51.00 05100 RECOVERY ROOM 0 4,086 10,713 3,377 15,904 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 3,700 6,009 1,228 5,606 52.00 0 05300 ANESTHESIOLOGY 53.00 88 0 0 0 53.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 54.00 3,346 5,117 0 54.00 0 55.00 | 05500 RADIOLOGY - THERAPEUTIC 0 904 716 0 55.00 0 0 56.00 05600 RADIOISOTOPE 1,609 614 0 56.00 0 57.00 05700 CT SCAN 1.109 0 1.433 0 57.00 0 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,043 819 0 58.00 05900 CARDIAC CATHETERIZATION 0 2,414 0 1,944 0 59.00 59.00 0 60.00 06000 LABORATORY 3,085 0 0 60.00 7.164 0 0 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 244 409 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 895 0 614 0 64.00 0 0 65.00 06500 RESPIRATORY THERAPY 1,007 2,763 0 65.00 66.00 06600 PHYSICAL THERAPY 0 6.005 0 0 66.00 0 0 0 67.00 06700 OCCUPATIONAL THERAPY 566 0 0 67.00 06800 SPEECH PATHOLOGY 0 307 68.00 68.00 240 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 985 0 1,023 0 69.00 0 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 731 716 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT C 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 2,865 73.00 73.00 982 0 0 0 07400 RENAL DIALYSIS 74.00 85 0 74.00 76.97 07697 CARDIAC REHABILITATION 0 2,139 0 614 3,024 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 3,719 2,047 90.00 0 0 09000 CLINIC 0 30,416 91.00 09100 EMERGENCY 0 5,097 12.514 6,447 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 819 0 101.00 SPECIAL PURPOSE COST CENTERS 26,211 90,983 84,531 232,139 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 238,164 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 194 0 0 190.00 0 191.00 19100 RESEARCH 0 C 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 34,946 0 0 0 192.00 194.00 07950 OTHER NON-REIMBURSABLE COST CENTER 0 0 194.00 0 0 194.01 07952 ADVERTISING 0 243 0 0 0 194.01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 0 TOTAL (sum lines 118 through 201) 26.211 126,366 238.164 84.531 232,139 202.00 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0034

Period: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared:

11/20/2023 2:29 pm Cost Center Description CENTRAL PHARMACY SOCIAL SERVICE **MEDICAL NONPHYSICIAN** SERVICES & RECORDS & **ANESTHETISTS** SUPPLY LIBRARY 15.00 17.00 19.00 14.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00560 PURCHASING RECEIVING AND STORES 5.01 5.02 00570 ADMITTING 5.02 5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPING 9.00 9.00 01000 DIETARY 10.00 10.00 11.00 01100 CAFETERIA 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 53,441 16.00 0 17.00 01700 SOCIAL SERVICE 0 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 19.00 0 0 23.00 02300 PARAMEDICAL EDUCATION PROGRAM EMS 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0 0 3,301 0 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 0 0 721 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 0 348 0 41.00 43.00 04300 NURSERY 0 0 185 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 7,892 0 50.00 51.00 | 05100 RECOVERY ROOM 0 0 918 0 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 182 52.00 05300 ANESTHESIOLOGY 0 0 53.00 0 1,517 53.00 0 0 54.00 | 05400 RADIOLOGY-DIAGNOSTIC 0 3,180 54.00 0 55.00 05500 RADIOLOGY - THERAPEUTIC 0 964 0 0 55.00 0 56.00 05600 RADTOTSOTOPE 0 858 56.00 57.00 05700 CT SCAN 0 3,969 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 1,689 0 58.00 58.00 0 0 59.00 05900 CARDIAC CATHETERIZATION 0 4,303 59.00 0 0 06000 LABORATORY 0 60.00 5.951 60.00 0 0 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 260 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 201 65.00 06500 RESPIRATORY THERAPY 0 0 598 0 65.00 0 0 06600 PHYSICAL THERAPY 66.00 0 868 66.00 0 0 67.00 06700 OCCUPATIONAL THERAPY 0 278 67.00 68.00 06800 SPEECH PATHOLOGY 0 116 0 68.00 0 0 69.00 06900 ELECTROCARDIOLOGY 0 69.00 1,742 70.00 07000 ELECTROENCEPHALOGRAPHY 0 473 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 1,388 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 1,489 0 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 4,110 73.00 73.00 74.00 07400 RENAL DIALYSIS 0 0 197 0 74.00 07697 CARDIAC REHABILITATION ol 76.97 0 103 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0 0 422 0 91.00 09100 EMERGENCY 0 C 4,990 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 228 0 101.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 0 53,441 0 0 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 0 191.00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 194.00 07950 OTHER NON-REIMBURSABLE COST CENTER 0 0 0 194.00 0 194.01 07952 ADVERTISING 0 0 0 0 194.01 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0 ol 0 201.00 0 0 0 202.00 TOTAL (sum lines 118 through 201) 53,441 0 202.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 07/01/2022 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0034

						To 06/30/2023	Date/Time Prepared:
		Cost Center Description	PARAMEDICAL	Subtotal	Intern &	Total	11/20/2023 2:29 pm
		·	EDUCATION		Residents Cos	t	
			PROGRAM EMS		& Post Stepdown		
					Adjustments		
	CENED	AL CERVICE COST CENTERS	23.00	24.00	25.00	26.00	
1.00	-	AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT					1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 5.02		PURCHASING RECEIVING AND STORES ADMITTING					5.01
5.02		CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04		OTHER ADMINISTRATIVE & GENERAL					5.04
7.00		OPERATION OF PLANT					7.00
8.00		LAUNDRY & LINEN SERVICE					8.00
9.00 10.00	1	HOUSEKEEPING DIETARY					9.00
11.00	1	CAFETERIA					11.00
13.00		NURSING ADMINISTRATION					13.00
14.00	1	CENTRAL SERVICES & SUPPLY					14.00
15.00		PHARMACY					15.00
16.00 17.00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE					16.00 17.00
19.00		NONPHYSICIAN ANESTHETISTS					19.00
23.00		PARAMEDICAL EDUCATION PROGRAM EMS	14,900				23.00
20.00		IENT ROUTINE SERVICE COST CENTERS		2 100 070		0 2,100,979	20.00
30.00 31.00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT		2,100,979 477,934	1	0 2,100,979 0 477,934	30.00 31.00
41.00	1	SUBPROVIDER - IRF		280,222		0 280,222	41.00
43.00		NURSERY		124,580	)	0 124,580	43.00
FO 00	-	LARY SERVICE COST CENTERS		F 472 0F2	.1	0 5.473.852	F0.00
50.00 51.00	1	OPERATING ROOM RECOVERY ROOM		5,473,852 411,642	1	0 5,473,852 0 411,642	50.00 51.00
52.00	1	DELIVERY ROOM & LABOR ROOM		354,013	1	0 354,013	52.00
53.00		ANESTHESIOLOGY		19,731		0 19,731	53.00
54.00	1	RADIOLOGY-DIAGNOSTIC		1,089,308	1	0 1,089,308	54.00
55.00 56.00	1	RADIOLOGY - THERAPEUTIC RADIOISOTOPE		96,009 147,673	1	0 96,009 0 147,673	55.00 56.00
57.00	1	CT SCAN		684,240	1	0 684,240	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		432,353	;	0 432,353	58.00
59.00	1	CARDIAC CATHETERIZATION		1,063,018		0 1,063,018	59.00
60.00	1	LABORATORY BLOOD STORING, PROCESSING, & TRANS.		439,601 87,616		0 439,601 0 87,616	60.00
64.00		INTRAVENOUS THERAPY		66,852	1	0 66,852	64.00
65.00		RESPIRATORY THERAPY		192,359		0 192,359	65.00
66.00	1	PHYSICAL THERAPY		472,857		0 472,857	66.00
67.00		OCCUPATIONAL THERAPY		49,408	1	0 49,408	67.00
68.00 69.00		SPEECH PATHOLOGY ELECTROCARDIOLOGY		76,110 274,745	1	0 76,110 0 274,745	68.00 69.00
		ELECTROENCEPHALOGRAPHY		83,442	II.	0 83,442	70.00
		MEDICAL SUPPLIES CHARGED TO PATIENT		74,498	3	0 74,498	71.00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS		89,164	1	0 89,164	72.00
73.00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS		409,143 12,647		0 409,143 0 12,647	73.00 74.00
		CARDIAC REHABILITATION		180,960	1	0 180,960	74.00
	OUTPA	TIENT SERVICE COST CENTERS					
	1	CLINIC		447,247	1	0 447,247	90.00
91.00 92.00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART		611,036		0 611,036 0	91.00 92.00
32.00		REIMBURSABLE COST CENTERS			1	0	32.00
101.00		HOME HEALTH AGENCY		26,703	1	0 26,703	101.00
118.00		AL PURPOSE COST CENTERS	0	16,349,942	1	0 16,349,942	118.00
110.00		SUBTOTALS (SUM OF LINES 1 through 117)   IMBURSABLE COST CENTERS	U <sub>I</sub>	10,349,942	·I	0, 10, 343, 342	110.00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		13,262		0 13,262	190.00
		RESEARCH		116		0 116	191.00
		PHYSICIANS' PRIVATE OFFICES OTHER NON-REIMBURSABLE COST CENTER		2,384,375 52,773		0 2,384,375 0 52,773	192.00 194.00
		ADVERTISING		19,839	II.	0 19,839	194.00
200.00	)	Cross Foot Adjustments	14,900	14,900		0 14,900	200.00
201.00	1	Negative Cost Centers	0	10 035 307		0 0	201.00
202.00	ין	TOTAL (sum lines 118 through 201)	14,900	18,835,207	T	0 18,835,207	202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034

					o 06/30/2023	Date/Time Pre	
		CAPITAL REI	LATED COSTS			11/20/2023 2:	29 pm
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	PURCHASING RECEIVING AND STORES (COSTED REQ)	ADMITTING (GROSS REVE NUE)	
		1.00	2.00	SALARIES) 4.00	5.01	5.02	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	3.01	3.02	
1.00	00100 CAP REL COSTS-BLDG & FIXT	589,680					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		26,454,172				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2,582	2,230	84,394,080			4.00
5.01	00560 PURCHASING RECEIVING AND STORES	4,560		555,652			5.01
5.02	00570 ADMITTING	5,864	19,513	2,876,901		1,295,965,949	5.02
5.03 5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMINISTRATIVE & GENERAL	707	2 271 506	[ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [	0	0	5.03
7.00	00700 OPERATION OF PLANT	28,094 80,228		5,843,047 2,538,977		0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	975		105,545		0	8.00
9.00	00900 HOUSEKEEPING	3,789	1			0	9.00
10.00	01000 DIETARY	9,030	137,546	1,243,827	63	0	10.00
11.00	01100 CAFETERIA	3,036				0	11.00
13.00	01300 NURSING ADMINISTRATION	4,888	244,579	4,551,042		0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0		0	0	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	2,113	0		0	0	16.00
17.00	01700 SOCIAL SERVICE	0			o o	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	ď	0	0	19.00
23.00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	444	11,367	261,151	. 1	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	79,024				80,524,305	
31.00 41.00	03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	13,281 11,116		4,390,580 1,850,485		17,589,789 8,489,156	
43.00	04300 NURSERY	1,303	,			4,519,408	
.5.00	ANCILLARY SERVICE COST CENTERS	1,505	220,5.5	2,222,20		.,525,.00	
50.00	05000 OPERATING ROOM	47,577	11,158,660	7,935,736	4,934	184,934,650	50.00
51.00	05100 RECOVERY ROOM	14,967	191,334	2,884,534		22,393,835	
52.00	05200 DELIVERY ROOM & LABOR ROOM	13,552				4,440,378	
53.00	05300 ANESTHESIOLOGY	323				36,989,116	
54.00 55.00	05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY - THERAPEUTIC	12,255 3,311		3,540,559 627,410		77,569,910 23,523,213	
56.00	05600 RADIOISOTOPE	5,894				20,937,597	
57.00	05700 CT SCAN	4,064				96,795,911	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3,819	896,863	653,530	36	41,190,073	58.00
59.00	05900 CARDIAC CATHETERIZATION	8,842				104,954,817	
60.00	06000 LABORATORY	11,301				145,157,229	
63.00 64.00	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	892 3,277		322,627 432,831		6,353,495 4,913,372	
65.00	06500 RESPIRATORY THERAPY	3,688				14,578,814	
66.00	06600 PHYSICAL THERAPY	21,997	93,143	40,536		21,161,708	
67.00	06700 OCCUPATIONAL THERAPY	2,075	4,788			6,782,358	67.00
	06800 SPEECH PATHOLOGY	880		188,254		2,819,061	
	06900 ELECTROCARDIOLOGY	3,608				42,477,500	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,678		455,950	1	11,537,516 33,864,594	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0				36,316,479	
73.00	07300 DRUGS CHARGED TO PATIENTS	3,597	616,180	2,730,581	-	100,254,968	
74.00	07400 RENAL DIALYSIS	312		' ' (	0	4,806,078	
76.97	07697 CARDIAC REHABILITATION	7,837	69,491	507,942	3	2,521,880	76.97
00.00	OUTPATIENT SERVICE COST CENTERS	42.55	450.655	4 4=2 555	1 22	10 202 455	00.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	13,624 18,669				10,302,451 121,699,339	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	10,009	309,000	5,314,677	403	121,699,559	92.00
32.00	OTHER REIMBURSABLE COST CENTERS						32.00
101.00	10100 HOME HEALTH AGENCY	0	5,305	2,616,038	0	5,566,949	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	1	460,073	26,322,032	84,380,825	9,186	1,295,965,949	118.00
100 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	712			ار	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	712			1		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	128,005	-	15,25	1		192.00
	07950 OTHER NON-REIMBURSABLE COST CENTER	0			1		194.00
194.01	07952 ADVERTISING	890			1	0	194.01
200.00							200.00
201.00		0.750.000	10.070.4:	14 200 000	01.0:=	2 000 15-	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	8,759,066	10,076,141	14,299,036	914,942	3,908,125	202.00
203.00		14.853931	0.380890	0.169432	99.482657	0.003016	203.00
	1 cose mare prior (moer b) fure 1)			31103732	331 102037	3.003010	1-00.00

Health Financial Systems		ST. MARY MEDICAL CENTER, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provider CCN: 15-0034		Period: From 07/01/2022	Worksheet B-1		
					го 06/30/2023	Date/Time Pre 11/20/2023 2:		
		CAPITAL REI	LATED COSTS					
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	PURCHASING	ADMITTING		
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS	RECEIVING AND	(GROSS REVE		
				DEPARTMENT	STORES	NUE)		
				(GROSS	(COSTED REQ)			
				SALARIES)				
		1.00	2.00	4.00	5.01	5.02		
204.00	Cost to be allocated (per Wkst. B, Part II)			39,20	72,336	95,991	204.00	
205.00	Unit cost multiplier (Wkst. B, Part			0.00046	7.865173	0.000074	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 Provider CCN: 15-0034 Period: Worksheet B-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					Т	o 06/30/2023	Date/Time Pre 11/20/2023 2:	
		Cost Center Description	CASHIERING/ACC	Reconciliation	OTHER	OPERATION OF	LAUNDRY &	25 piii
			OUNTS RECEIVABLE		ADMINISTRATIVE		LINEN SERVICE	
			(GROSS REVE		& GENERAL (ACCUM. COST)	(SQUARE FEET)	(TOTAL PATIENT DAYS)	
			NUE)		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		271107	
			5.03	5A.04	5.04	7.00	8.00	
1.00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT					I	1.00
2.00	1	CAP REL COSTS-BEDG & FIXT						2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	1	PURCHASING RECEIVING AND STORES						5.01
5.02	1	ADMITTING	1 205 005 040					5.02
5.03 5.04		CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMINISTRATIVE & GENERAL	1,295,965,949	-32,696,639	222,992,282			5.03 5.04
7.00	1	OPERATION OF PLANT	Ö	0				7.00
8.00	1	LAUNDRY & LINEN SERVICE	0	0				8.00
9.00		HOUSEKEEPING	0	0				9.00
10.00	1	DIETARY	0	0	2,914,478			10.00
11.00 13.00	1	CAFETERIA NURSING ADMINISTRATION	0	0	,			11.00 13.00
14.00	1	CENTRAL SERVICES & SUPPLY	o o	0	0,750,110	0		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00		MEDICAL RECORDS & LIBRARY	0	0	2,404,197	2,113		16.00
17.00	1	SOCIAL SERVICE	0	0		0		17.00
19.00 23.00		NONPHYSICIAN ANESTHETISTS PARAMEDICAL EDUCATION PROGRAM EMS	0	0		444	0	19.00 23.00
23.00		IENT ROUTINE SERVICE COST CENTERS	<u> </u>		303,410			23.00
30.00	_	ADULTS & PEDIATRICS	80,524,305	0	22,959,770	79,024	29,980	30.00
31.00	1	INTENSIVE CARE UNIT	17,589,789	0				
41.00	1	SUBPROVIDER - IRF	8,489,156	0		,	1	
43.00		NURSERY  LARY SERVICE COST CENTERS	4,519,408	0	1,836,606	1,303	1,326	43.00
50.00		OPERATING ROOM	184,934,650	0	36,272,796	47,577	0	50.00
51.00	05100	RECOVERY ROOM	22,393,835	0	4,446,749	14,967	0	51.00
52.00	1	DELIVERY ROOM & LABOR ROOM	4,440,378	0	, ,			52.00
53.00 54.00	1	ANESTHESIOLOGY RADIOLOGY-DIAGNOSTIC	36,989,116	0				53.00 54.00
55.00	1	RADIOLOGY - THERAPEUTIC	77,569,910 23,523,213	0	.,,			55.00
56.00	1	RADIOISOTOPE	20,937,597	0	1,914,901			56.00
57.00	05700	CT SCAN	96,795,911	0	1		0	57.00
58.00	1	MAGNETIC RESONANCE IMAGING (MRI)	41,190,073	0	_,,			58.00
59.00 60.00	1	CARDIAC CATHETERIZATION LABORATORY	104,954,817 145,157,229	0	.,,.			59.00 60.00
63.00		BLOOD STORING, PROCESSING, & TRANS.	6,353,495	0	1			63.00
64.00		INTRAVENOUS THERAPY	4,913,372	0	, ,			64.00
65.00		RESPIRATORY THERAPY	14,578,814	0	. , . , .		1	65.00
66.00		PHYSICAL THERAPY	21,161,708	0	, ,		1	66.00
67.00 68.00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	6,782,358 2,819,061	0	1,391,986 968,657			67.00 68.00
69.00		ELECTROCARDIOLOGY	42,477,500	0	,		1	69.00
	1	ELECTROENCEPHALOGRAPHY	11,537,516	0	820,895	2,678		
		MEDICAL SUPPLIES CHARGED TO PATIENT	33,864,594	0		0	0	
		IMPL. DEV. CHARGED TO PATIENTS	36,316,479	0			0	
73.00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	100,254,968 4,806,078	0	-,,-			73.00 74.00
		CARDIAC REHABILITATION	2,521,880	0				76.97
	OUTPA	TIENT SERVICE COST CENTERS						
		CLINIC	10,302,451	0		,		90.00
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	121,699,339	0	9,108,407	18,669	0	
92.00		REIMBURSABLE COST CENTERS						92.00
101.00		HOME HEALTH AGENCY	5,566,949	0	3,700,438	0	0	101.00
	SPECI	AL PURPOSE COST CENTERS						
118.00	_	SUBTOTALS (SUM OF LINES 1 through 117)	1,295,965,949	-32,696,639	220,093,723	338,038	41,660	118.00
100 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	ما	0	10,576	712	0	190.00
		RESEARCH		0				191.00
		PHYSICIANS' PRIVATE OFFICES	0	0	1,909,930		0	192.00
		OTHER NON-REIMBURSABLE COST CENTER	0	0	462,980			194.00
		ADVERTISING	0	0	496,526	890		194.01
200.00	1	Cross Foot Adjustments Negative Cost Centers						200.00 201.00
202.00		Cost to be allocated (per Wkst. B,	3,086,836		32,696,639	15,897,791	1,646,924	
		Part I)						
203.00	1	Unit cost multiplier (Wkst. B, Part I)	0.002382		0.146627			
204.00	,	Cost to be allocated (per Wkst. B, Part II)	10,502		1,323,434	1,595,445	26,211	204.00
	T.	· · · · · · · · · · · · · · · · · · ·	ı J		l .	1	I	

Health Finar	ncial Systems	ST. MARY MEDICAL CENTER, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provider Co	CN: 15-0034	Period: From 07/01/2022	Worksheet B-1		
					To 06/30/2023	Date/Time Pre 11/20/2023 2:		
	Cost Center Description	CASHIERING/ACCR	econciliation	OTHER	OPERATION OF	LAUNDRY &		
		OUNTS		ADMINISTRATI\	E PLANT	LINEN SERVICE		
		RECEIVABLE		& GENERAL	(SQUARE FEET)	(TOTAL PATIENT		
		(GROSS REVE		(ACCUM. COST	)	DAYS)		
		NUE)						
		5.03	5A.04	5.04	7.00	8.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000008		0.00593	3.411658	0.629165	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 Provider CCN: 15-0034 Period: Worksheet B-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

				Γ	го 06/30/2023	Date/Time Pre 11/20/2023 2:	
	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING	CENTRAL	23 piii
		(SQUARE FEET)	(MEALS SERVED)	(NUMBER OF	ADMINISTRATION	SERVICES &	
				FTES)	(NURSING HO	SUPPLY (COSTED	
					URS)	REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	<u> </u>	1		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						5.03
5.02	00570 ADMITTING						5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04 7.00	00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING	462,881					9.00
10.00	01000 DIETARY	9,030	144,590				10.00
11.00	I I	3,036	1	826			11.00
13.00 14.00	I I	4,888	1	5.5		0	13.00
15.00	I I	0		(		0	1
16.00		2,113		(		0	1
17.00	I I	0	1	Ċ	o o	0	1
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	(	o	0	19.00
23.00		444	0		1 0	0	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	70.024	102 507	101	275 062		30.00
30.00		79,024 13,281	1	181 46		0	
41.00		11,116		24		0	
43.00	1	1,303		12		0	
	ANCILLARY SERVICE COST CENTERS						
50.00		47,577	1	103		0	
51.00		14,967	1	33		0	
52.00 53.00	1	13,552	1	12		0	
54.00		12,255	1	50	1	0	
55.00		3,311		7	7 0	0	
56.00		5,894		6	5 0	0	56.00
57.00	05700 CT SCAN	4,064	0	14	1 0	0	
58.00		3,819		8		0	
59.00		8,842		19		0	
60.00	I I	11,301 892	1	70		0	
64.00		3,277	1	-		0	
65.00		3,688	1	27		0	1
66.00		21,997		(	o	0	66.00
67.00		2,075	0	(	o o	0	67.00
68.00	06800 SPEECH PATHOLOGY	880	1	. 3	0	0	1
69.00		3,608	1	10	0	0	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,678	1	,		0	
72.00				(	1	0	1
		3,597	0	28	1	0	
	07400 RENAL DIALYSIS	312		(		0	
76.97	07697 CARDIAC REHABILITATION	7,837	0		12,996	0	76.97
00.00	OUTPATIENT SERVICE COST CENTERS	12 624		27		^	00.00
90.00		13,624 18,669		20 63		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	10,009	7,397	0.3	130,719	0	92.00
32.00	OTHER REIMBURSABLE COST CENTERS						32.00
101.00	0 10100 HOME HEALTH AGENCY	0	0	3	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	1	333,274	144,590	826	997,671	0	118.00
190 00	NONREIMBURSABLE COST CENTERS 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	712	n n	(	) 0	0	190.00
191.00	0 19100 RESEARCH	0	1	(	1		191.00
	0 19200 PHYSICIANS' PRIVATE OFFICES	128,005		(	ol ol		192.00
194.00	0 07950 OTHER NON-REIMBURSABLE COST CENTER	0	0	(	이		194.00
	1 07952 ADVERTISING	890	0	(	0	0	194.01
200.00							200.00
201.00		4 004 035	2 720 002	1 120 444	0 022 720	^	201.00
202.00	O Cost to be allocated (per Wkst. B, Part I)	4,064,625	3,728,092	1,120,449	8,032,729	0	202.00
203.00		8.781145	25.783885	1,356.475787	8.051481	0.000000	203.00
		126,366	1	84,531			204.00
204.00	cost to be arrocated (per wkst. b.	120,300	230,104				

Health Finar	ncial Systems S	ST. MARY MEDICAL CENTER, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provider Co	Provider CCN: 15-0034		Worksheet B-1		
					то 06/30/2023	Date/Time Pre 11/20/2023 2:		
	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING	CENTRAL		
		(SQUARE FEET)	(MEALS SERVED)	(NUMBER OF	ADMINISTRATION	SERVICES &		
				FTES)		SUPPLY		
					(NURSING HO	(COSTED		
					URS)	REQUIS.)		
		9.00	10.00	11.00	13.00	14.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.272999	1.647168	102.33777	2 0.232681	0.000000	205.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034 Period: Worksheet B-1 From 07/01/2022 TO 06/30/2023 Date/Time Prepared: 11/20/2023 2:29 pm

PHARMACY MEDICAL SOCIAL SERVICE NONPHYSICIAN PARAMEDICAL

	Cost Center Description	PHARMACY	MEDICAL	SOCIAL SERVICE	NONPHYSICIAN	PARAMEDICAL	,
		(COSTED	RECORDS &	(TTME CDENT)	ANESTHETISTS	EDUCATION	
		REQUIS.)	LIBRARY	(TIME SPENT)	(ASSIGNED	PROGRAM EMS	
			(GROSS REVE NUE)		TIME)	(ASSIGNED TIME)	
		15.00	16.00	17.00	19.00	23.00	
	GENERAL SERVICE COST CENTERS						
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 5.02	00560 PURCHASING RECEIVING AND STORES						5.01
5.02	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5.04
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY	0					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1,295,965,949				16.00
	01700 SOCIAL SERVICE	0	0	0	_		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0		l .	19.00
23.00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	0	0		1,000	23.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	80 524 305	0	0	0	30.00
	03100 INTENSIVE CARE UNIT	0	80,524,305 17,589,789			1	
41.00	04100 SUBPROVIDER - IRF	0	8,489,156	•		l	41.00
	04300 NURSERY	0	4,519,408			l .	43.00
13100	ANCILLARY SERVICE COST CENTERS		1,515,100				13.00
50.00	05000 OPERATING ROOM	0	184,934,650	0	0	0	50.00
	05100 RECOVERY ROOM	0	22,393,835		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4,440,378	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	36,989,116	0	0	0	53.00
	05400 RADIOLOGY-DIAGNOSTIC	0	77,569,910	0	0	0	54.00
	05500 RADIOLOGY - THERAPEUTIC	0	23,523,213			0	55.00
56.00	05600 RADIOISOTOPE	0	20,937,597		_	0	56.00
	05700 CT SCAN	0	96,795,911		_	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	41,190,073		_	0	58.00
	05900 CARDIAC CATHETERIZATION	0	104,954,817	1	_	0	
60.00	06000 LABORATORY	0	145,157,229			0	
63.00 64.00	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	0	6,353,495 4,913,372		_		63.00
65.00	06500 RESPIRATORY THERAPY	0	14,578,814			0	65.00
66.00	06600 PHYSICAL THERAPY	0	21,161,708	1	-	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	6,782,358			0	67.00
68.00	06800 SPEECH PATHOLOGY	o o	2,819,061		_	Ö	68.00
69.00	06900 ELECTROCARDIOLOGY	0	42,477,500	1	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	11,537,516		0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,864,594	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	36,316,479	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	100,254,968		0	0	
	07400 RENAL DIALYSIS	0	4,806,078				
76.97	07697 CARDIAC REHABILITATION	0	2,521,880	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS		40 202 454	1			
	09000 CLINIC	0	.,,			l .	
	09100 EMERGENCY	0	121,699,339	0	0	1,000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101 00	10100 HOME HEALTH AGENCY	0	5,566,949	0	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	3,300,343	0	0	0	101.00
118.00		0	1,295,965,949	0	0	1,000	118.00
	NONREIMBURSABLE COST CENTERS			_		_,-,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19100 RESEARCH	0	0	i e		l	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0	0	194.00
	07952 ADVERTISING	0	0	0	0	0	194.01
200.00							200.00
201.00			_				201.00
202.00		0	2,847,104	0	0	372,326	202.00
202.00	Part I)	0.00000	0 003107	0 000000	0.00000	272 220000	202 00
203.00		0.000000			0.000000		203.00
204.00	Part II)		53,441			14,900	204.00
	1. 4. 6. 117	I	I	I .	I	I	1

Health Financial Systems		ST. MARY MEDICAL CENTER, INC.			In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS			Provider C		Period: From 07/01/2022	Worksheet B-1	
					то 06/30/2023	Date/Time Pre 11/20/2023 2:	
	Cost Center Description	PHARMACY	MEDICAL	SOCIAL SERVICE	E NONPHYSICIAN	PARAMEDICAL	
		(COSTED	RECORDS &		ANESTHETISTS	EDUCATION	
		REQUIS.)	LIBRARY	(TIME SPENT)	(ASSIGNED	PROGRAM EMS	
			(GROSS REVE		TIME)	(ASSIGNED	
			NUE)			TIME)	
		15.00	16.00	17.00	19.00	23.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000041	0.00000	0.000000	14.900000	205.00
206.00	NAHE adjustment amount to be allocated (per wkst. B-2)	t				0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

Date/Time Prepared: 06/30/2023 11/20/2023 2:29 pm Title XVIII Hospital Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs (from Wkst. B, Adj. Disallowance Part I, col. 26) 4.00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 36,984,372 36,984,372 0 36,984,372 03100 INTENSIVE CARE UNIT 9,743,145 9,743,145 59,077 9,802,222 31.00 31.00 41.00 04100 SUBPROVIDER - IRF 5,260,365 5,260,365 0 5,260,365 41.00 43.00 04300 NURSERY 43.00 2,437,520 2,437,520 2,437,520 ANCILLARY SERVICE COST CENTERS 45,903,858 45,903,858 50.00 05000 OPERATING ROOM 45,903,858 50.00 51.00 | 05100 RECOVERY ROOM 6,551,003 6,551,003 0 6,551,003 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 2,778,048 2,778,048 0 2,778,048 52.00 53.00 05300 ANESTHESIOLOGY 873,047 873,047 0 873,047 53.00 54.00 | 05400 RADIOLOGY-DIAGNOSTIC 10,311,619 10,311,619 0 10,311,619 54.00 0 55.00 05500 RADIOLOGY - THERAPEUTIC 2.121.742 2.121.742 2.121.742 55.00 0 56.00 | 05600 RADIOISOTOPE 2,501,941 2,501,941 2,501,941 56.00 57.00 05700 CT SCAN 4,485,503 4,485,503 0 4,485,503 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2,868,108 2,868,108 2,868,108 58.00 0 59.00 05900 CARDTAC CATHETERTZATTON 7.535.043 7.535.043 7,535,043 59.00 60.00 06000 LABORATORY 13,815,074 13,815,074 0 13,815,074 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 2,326,205 2,326,205 0 2,326,205 63.00 63.00 0 64.00 06400 INTRAVENOUS THERAPY 1,012,140 1,012,140 1,012,140 64.00 4,209,527 0 4,209,527 65.00 06500 RESPIRATORY THERAPY 4,209,527 0 65.00 66.00 06600 PHYSICAL THERAPY 6,136,108 0 6,136,108 0 6,136,108 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 1,699,752 1,699,752 1,699,752 67.00 0 68.00 06800 SPEECH PATHOLOGY 1,158,593 1,158,593 68.00 1.158.593 0 69.00 06900 ELECTROCARDIOLOGY 2,622,091 2,622,091 2,622,091 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1,090,659 1,090,659 0 1,090,659 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 13,662,589 13,662,589 13,662,589 71.00 0 16,443,058 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 16.443.058 16.443.058 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 17,992,559 17,992,559 17,992,559 73.00 1,235,829 07400 RENAL DIALYSIS 1,235,829 0 1,235,829 74.00 74.00 76.97 07697 CARDIAC REHABILITATION 1.419.099 1,419,099 1,419,099 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 4,160,455 4,160,455 0 4,160,455 90.00 91.00 09100 EMERGENCY 13,216,060 13,216,060 13,216,060 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 4,868,740 4,868,740 4,868,740 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 4,266,105 4,266,105 4,266,105 101.00 200.00 Subtotal (see instructions) 251,689,957 0 251,689,957 59,077 251,749,034 200.00 4,868,740 201.00 Less Observation Beds 201.00 4.868.740 4,868,740

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246,821,217

59.077

246,880,294 202.00

202.00

Total (see instructions)

Health Financial Systems	NTER, INC.	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0034		Worksheet C
			From 07/01/2022	Part I

					rom 07/01/2022 o 06/30/2023	Part I Date/Time Pre 11/20/2023 2:	
				XVIII	Hospital	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		•			
30.00	03000 ADULTS & PEDIATRICS	63,975,835		63,975,835			30.00
31.00	03100 INTENSIVE CARE UNIT	17,589,789		17,589,789			31.00
41.00	04100 SUBPROVIDER - IRF	8,489,156		8,489,156			41.00
43.00	04300 NURSERY	4,519,408		4,519,408			43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	44,814,853	140,119,797	184,934,650	0.248217	0.000000	50.00
51.00	05100 RECOVERY ROOM	4,594,895	17,798,940	22,393,835	0.292536	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,925,535	1,514,843	4,440,378	0.625633	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	8,139,544	28,849,572	36,989,116	0.023603	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,369,347	69,200,563	77,569,910	0.132933	0.000000	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	270,937	23,252,276		0.090198	0.000000	55.00
56.00	05600 RADIOISOTOPE	1,801,537	19,136,060	20,937,597	0.119495	0.000000	56.00
57.00	05700 CT SCAN	21,333,852	75,462,059	96,795,911	0.046340	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	6,119,906	35,070,167	41,190,073	0.069631	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	26,840,478	78,114,339	104,954,817	0.071793	0.000000	59.00
60.00	06000 LABORATORY	38,808,771	106,348,458	145,157,229	0.095173	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	3,522,435	2,831,060	6,353,495	0.366130	0.000000	63.00
	06400 INTRAVENOUS THERAPY	22,554	4,890,818	4,913,372	0.205997	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	12,329,629	2,249,185	14,578,814	0.288743	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	4,571,015	16,590,693	21,161,708	0.289963	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,932,356	2,850,002	6,782,358	0.250614	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	1,122,001	1,697,060	2,819,061	0.410985	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	10,508,411	31,969,089	42,477,500	0.061729	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	291,112	11,246,404	11,537,516	0.094532	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15,026,418	18,838,176	33,864,594	0.403448	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14,805,007	21,511,472	36,316,479	0.452771	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	45,571,773	54,683,195	100,254,968	0.179468	0.000000	73.00
74.00	07400 RENAL DIALYSIS	4,469,934	336,144	4,806,078	0.257139	0.000000	74.00
76.97	07697 CARDIAC REHABILITATION	360,315	2,161,565	2,521,880	0.562715	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,			
90.00	09000 CLINIC	371,833	9,930,618	10,302,451	0.403832	0.000000	90.00
91.00	09100 EMERGENCY	33,595,527	88,103,812			0.000000	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,160,949	14,387,521	16,548,470	0.294211	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>	· · · · · · · · · · · · · · · · · · ·	, ,			1
	10100 HOME HEALTH AGENCY	0	5,566,949	5,566,949			101.00
200.00	Subtotal (see instructions)	411,255,112	884,710,837	1,295,965,949			200.00
201.00	Less Observation Beds			' '			201.00
202.00	Total (see instructions)	411,255,112	884,710,837	1,295,965,949			202.00

Health Financial Systems

ST. MARY MEDICAL CENTER, INC.

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0034

Period:
From 07/01/2022
To 06/30/2023
Date/Time Prepared:
11/20/2022 2-20 pm

				10 00/30/2023	11/20/2023 2:29 pm
			Title XVIII	Hospital	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.248217			50.00
51.00	05100 RECOVERY ROOM	0.292536			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.625633			52.00
53.00	05300 ANESTHESIOLOGY	0.023603			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.132933			54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.090198			55.00
56.00	05600 RADIOISOTOPE	0.119495			56.00
57.00	05700 CT SCAN	0.046340			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.069631			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.071793			59.00
60.00	06000 LABORATORY	0.095173			60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.366130			63.00
64.00	06400 INTRAVENOUS THERAPY	0.205997			64.00
65.00	06500 RESPIRATORY THERAPY	0.288743			65.00
66.00	06600 PHYSICAL THERAPY	0.289963			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.250614			67.00
68.00	06800 SPEECH PATHOLOGY	0.410985			68.00
69.00	06900 ELECTROCARDIOLOGY	0.061729			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.094532			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.403448			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.452771			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179468			73.00
74.00	07400 RENAL DIALYSIS	0.257139			74.00
	07697 CARDIAC REHABILITATION	0.562715			76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.403832			90.00
91.00	09100 EMERGENCY	0.108596			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.294211			92.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY				101.00
200.00	Subtotal (see instructions)				200.00
201.00					201.00
202.00					202.00
		. '			•

Date/Time Prepared: 06/30/2023 11/20/2023 2:29 pm Title XIX Hospital Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs (from Wkst. B, Adj. Disallowance Part I, col. 26) 4.00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 36,984,372 36,984,372 0 36,984,372 03100 INTENSIVE CARE UNIT 9,743,145 9,743,145 59,077 9,802,222 31.00 31.00 41.00 04100 SUBPROVIDER - IRF 5,260,365 5,260,365 0 5,260,365 41.00 43.00 04300 NURSERY 43.00 2,437,520 2,437,520 2,437,520 ANCILLARY SERVICE COST CENTERS 45,903,858 45,903,858 50.00 05000 OPERATING ROOM 45,903,858 50.00 51.00 | 05100 RECOVERY ROOM 6,551,003 6,551,003 0 6,551,003 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 2,778,048 2,778,048 0 2,778,048 52.00 53.00 05300 ANESTHESIOLOGY 873,047 873,047 0 873,047 53.00 54.00 | 05400 RADIOLOGY-DIAGNOSTIC 10,311,619 10,311,619 0 10,311,619 54.00 0 55.00 05500 RADIOLOGY - THERAPEUTIC 2.121.742 2.121.742 2.121.742 55.00 0 56.00 | 05600 RADIOISOTOPE 2,501,941 2,501,941 2,501,941 56.00 57.00 05700 CT SCAN 4,485,503 4,485,503 0 4,485,503 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2,868,108 2,868,108 2,868,108 58.00 0 59.00 05900 CARDTAC CATHETERTZATTON 7.535.043 7.535.043 7,535,043 59.00 60.00 06000 LABORATORY 13,815,074 13,815,074 0 13,815,074 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 2,326,205 2,326,205 0 2,326,205 63.00 63.00 0 64.00 06400 INTRAVENOUS THERAPY 1,012,140 1,012,140 1,012,140 64.00 4,209,527 0 4,209,527 65.00 06500 RESPIRATORY THERAPY 4,209,527 0 65.00 66.00 06600 PHYSICAL THERAPY 6,136,108 0 6,136,108 0 6,136,108 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 1,699,752 1,699,752 1,699,752 67.00 0 68.00 06800 SPEECH PATHOLOGY 1,158,593 1,158,593 68.00 1.158.593 0 69.00 06900 ELECTROCARDIOLOGY 2,622,091 2,622,091 2,622,091 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1,090,659 1,090,659 0 1,090,659 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 13,662,589 13,662,589 13,662,589 71.00 0 16,443,058 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 16.443.058 16.443.058 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 17,992,559 17,992,559 17,992,559 73.00 1,235,829 07400 RENAL DIALYSIS 1,235,829 0 1,235,829 74.00 74.00 76.97 07697 CARDIAC REHABILITATION 1.419.099 1,419,099 1,419,099 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 4,160,455 4,160,455 0 4,160,455 90.00 91.00 09100 EMERGENCY 13,216,060 13,216,060 13,216,060 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 4,868,740 4,868,740 4,868,740 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 4,266,105 4,266,105 4,266,105 101.00 200.00 Subtotal (see instructions) 251,689,957 0 251,689,957 59,077 251,749,034 200.00 4,868,740 201.00 Less Observation Beds 201.00 4.868.740 4,868,740

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202.00

Total (see instructions)

Health Financial Systems	ST. MARY MEDICAL CENTER,	INC.	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi	der CCN: 15-0034		Worksheet C	
			From 07/01/2022		

					from 07/01/2022 to 06/30/2023	Part I Date/Time Pre 11/20/2023 2:	
				e XIX	Hospital	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
30.00	03000 ADULTS & PEDIATRICS	63,975,835		63,975,835			30.00
31.00	03100 INTENSIVE CARE UNIT	17,589,789		17,589,789			31.00
41.00	04100 SUBPROVIDER - IRF	8,489,156		8,489,156	i l		41.00
43.00	04300 NURSERY	4,519,408		4,519,408	3		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	44,814,853	140,119,797		0.248217	0.000000	50.00
51.00	05100 RECOVERY ROOM	4,594,895	17,798,940	22,393,835	0.292536	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,925,535	1,514,843	4,440,378	0.625633	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	8,139,544	28,849,572	36,989,116	0.023603	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,369,347	69,200,563	77,569,910	0.132933	0.000000	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	270,937	23,252,276	23,523,213	0.090198	0.000000	55.00
56.00	05600 RADIOISOTOPE	1,801,537	19,136,060	20,937,597	0.119495	0.000000	56.00
57.00	05700 CT SCAN	21,333,852	75,462,059	96,795,911	0.046340	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	6,119,906	35,070,167	41,190,073	0.069631	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	26,840,478	78,114,339	104,954,817	0.071793	0.000000	59.00
60.00	06000 LABORATORY	38,808,771	106,348,458	145,157,229	0.095173	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	3,522,435	2,831,060	6,353,495	0.366130	0.000000	63.00
64.00	06400 INTRAVENOUS THERAPY	22,554	4,890,818	4,913,372	0.205997	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	12,329,629	2,249,185	14,578,814	0.288743	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	4,571,015	16,590,693	21,161,708	0.289963	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,932,356	2,850,002	6,782,358	0.250614	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	1,122,001	1,697,060	2,819,061	0.410985	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	10,508,411	31,969,089	42,477,500	0.061729	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	291,112	11,246,404	11,537,516	0.094532	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15,026,418	18,838,176	33,864,594	0.403448	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14,805,007	21,511,472	36,316,479	0.452771	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	45,571,773	54,683,195	100,254,968	0.179468	0.000000	73.00
74.00	07400 RENAL DIALYSIS	4,469,934	336,144	4,806,078	0.257139	0.000000	74.00
76.97	07697 CARDIAC REHABILITATION	360,315	2,161,565			0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	371,833	9,930,618	10,302,451	0.403832	0.000000	90.00
91.00	09100 EMERGENCY	33,595,527	88,103,812	121,699,339	0.108596	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,160,949	14,387,521	16,548,470	0.294211	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	0	5,566,949				101.00
200.00		411,255,112	884,710,837	1,295,965,949			200.00
201.00							201.00
202.00	Total (see instructions)	411,255,112	884,710,837	1,295,965,949	)		202.00

Health Financial Systems

ST. MARY MEDICAL CENTER, INC.

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0034

Period:
From 07/01/2022
To 06/30/2023
Date/Time Prepared:

				10 00/30/2023	11/20/2023 2:	
			Title XIX	Hospital	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
4	03000 ADULTS & PEDIATRICS					30.00
4	03100 INTENSIVE CARE UNIT					31.00
	04100 SUBPROVIDER - IRF					41.00
<u> </u>	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	O5000 OPERATING ROOM	0.248217				50.00
	05100 RECOVERY ROOM	0.292536				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0.625633				52.00
	05300 ANESTHESIOLOGY	0.023603				53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.132933				54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.090198				55.00
56.00	05600 RADIOISOTOPE	0.119495				56.00
57.00	05700 CT SCAN	0.046340				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.069631				58.00
59.00	05900 CARDIAC CATHETERIZATION	0.071793				59.00
60.00	06000 LABORATORY	0.095173				60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.366130				63.00
64.00	06400 INTRAVENOUS THERAPY	0.205997				64.00
65.00	06500 RESPIRATORY THERAPY	0.288743				65.00
66.00	06600 PHYSICAL THERAPY	0.289963				66.00
67.00	06700 OCCUPATIONAL THERAPY	0.250614				67.00
68.00	06800 SPEECH PATHOLOGY	0.410985				68.00
69.00	06900 ELECTROCARDIOLOGY	0.061729				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.094532				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.403448				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.452771				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179468				73.00
74.00	07400 RENAL DIALYSIS	0.257139				74.00
76.97	07697 CARDIAC REHABILITATION	0.562715				76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.403832				90.00
	09100 EMERGENCY	0.108596				91.00
_	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.294211				92.00
_	OTHER REIMBURSABLE COST CENTERS					
	10100 HOME HEALTH AGENCY					101.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	ENTER, INC.	In Lie	u of Form CMS-2552-10	
CALCULATION OF OUTPATIENT SERVICE CO	ST TO CHARGE RATIOS NET OF	Provider CCN: 15-0034		Worksheet C
REDUCTIONS FOR MEDICAID ONLY			From 07/01/2022	Part II

REDUCT	RESCRICTOR FOR MESSECIES ONE!			Т	o 06/30/2023	Date/Time Pre 11/20/2023 2:	
				e XIX	Hospital	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capital	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	45,903,858	5,473,852			1	
	05100 RECOVERY ROOM	6,551,003	411,642			1	
	05200 DELIVERY ROOM & LABOR ROOM	2,778,048	354,013			0	
	05300 ANESTHESIOLOGY	873,047	19,731			0	53.00
	05400 RADIOLOGY-DIAGNOSTIC	10,311,619	1,089,308			0	54.00
	05500 RADIOLOGY - THERAPEUTIC	2,121,742	96,009			0	55.00
	05600 RADIOISOTOPE	2,501,941	147,673		0	0	
57.00	05700 CT SCAN	4,485,503	684,240	3,801,263	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,868,108	432,353	2,435,755	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	7,535,043	1,063,018	6,472,025	0	0	59.00
60.00	06000 LABORATORY	13,815,074	439,601	13,375,473	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	2,326,205	87,616	2,238,589	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	1,012,140	66,852	945,288	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	4,209,527	192,359	4,017,168	0	0	65.00
66.00	06600 PHYSICAL THERAPY	6,136,108	472,857	5,663,251	. 0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,699,752	49,408	1,650,344	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1,158,593	76,110		0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,622,091	274,745	2,347,346	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,090,659	83,442		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	13,662,589	74,498	13,588,091	. 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	16,443,058	89,164	16,353,894	. 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	17,992,559	409,143	17,583,416	0	0	73.00
74.00	07400 RENAL DIALYSIS	1,235,829	12,647	1,223,182	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	1,419,099	180,960	1,238,139	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS		·				1
90.00	09000 CLINIC	4,160,455	447,247	3,713,208	0	0	90.00
91.00	09100 EMERGENCY	13,216,060	611,036	12,605,024	. 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4,868,740	276,579	4,592,161	. 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	4,266,105	26,703	4,239,402	0	0	101.00
200.00	Subtotal (sum of lines 50 thru 199)	197,264,555	13,642,806	183,621,749	0	0	200.00
201.00	Less Observation Beds	4,868,740	276,579	4,592,161	. 0	0	201.00
202.00	Total (line 200 minus line 201)	192,395,815	13,366,227	179,029,588	0	0	202.00

Health Financial Systems

ST. MARY MEDICAL CENTER, INC.

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

ST. MARY MEDICAL CENTER, INC.

Provider CCN: 15-0034

Period:
From 07/01/2022
To 06/30/2023

Period:
Part II
Date/Time Prepared:
11/20/2023 2:29 pm

Cost Center Description							, ,	11/20/2023 2:29 pm
Capital and   Operating Cost   Part I, column   Ratio (col. 6   Reduction   8)   6.00   7.00   8.00   8.00   8.00   8.00   7.00   8.0					Titl	e XIX	Hospital	PPS
ANCILLARY SERVICE COST CENTERS   6.00   7.00   8.00		Cos	st Center Description					
Reduction   8)			·		(Worksheet C,	Cost to Charg	ge	
ANCILLARY SERVICE COST CENTERS						Ratio (col.	6	
ANCTILIARY SERVICE COST CENTERS   S0.00				Reduction	8)	/ col. 7)		
S0.00   OSD00   OSD00   OSD00   RECOVERY ROOM   6,551,003   22,393,835   0.292536   51.00   51.00   05100   RECOVERY ROOM   6,551,003   22,393,835   0.292536   51.00   51.00   52.00   DELIVERY ROOM & LABOR ROOM   2,778,048   4,440,378   0.625633   52.00   53.00   05200   DELIVERY ROOM & LABOR ROOM   2,778,048   4,440,378   0.625633   52.00   53.00   53.00   ANESTHESIOLOGY   873,047   36,989,116   0.023603   53.00   54.00   05400   RADIOLOGY - THERAPEUTIC   2,121,742   23,523,213   0.090198   55.00   65.00   05500   RADIOLOGY - THERAPEUTIC   2,121,742   23,523,213   0.090198   55.00   65.00   05500   RADIOLOGY - THERAPEUTIC   2,121,742   23,523,213   0.090198   55.00   65.00   05500   RADIOLOGY - THERAPEUTIC   2,868,108   41,190,073   0.046340   57.00   57.00   57.00   CT SCAN   4,485,503   96,795,911   0.046340   57.00   58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   2,868,108   41,190,073   0.069631   58.00   59.00   05900   CARDIAC CATHETERIZATION   7,535,043   104,945,817   0.071793   59.00   60.00				6.00	7.00	8.00		
S1.00   05100   RECOVERY ROOM   6,511,003   22,393,835   0.292536   52.00   05200   DELEVERY ROOM & LABOR ROOM   2,778,048   4,440,378   0.625633   52.00   05300   ANESTHESIOLOGY   873,047   36,989,116   0.023603   53.00   05300   ANESTHESIOLOGY   1,311,619   77,569,910   0.132933   54.00   05400   RADIOLOGY-DIAGNOSTIC   10,311,619   77,569,910   0.132933   55.00   05500   RADIOLOGY - THERAPEUTIC   2,121,742   23,523,213   0.090198								
S2.00   05200   05200   05200   05200   05200   05200   05200   0530	50.00	05000 OPE	ERATING ROOM	45,903,858	184,934,650	0.24821	L7	50.00
S3.00   OS300   ANESTHESIOLOGY   S73,047   36,989,116   0.023603   53.00	51.00	05100 REC	COVERY ROOM	6,551,003	22,393,835	0.29253	36	51.00
S4.00   05400   RADIOLOGY-DIAGNOSTIC   10,311,619   77,569,910   0.132933   54.00   05500   RADIOLOGY - THERAPEUTIC   2,121,742   23,523,213   0.090198   55.00   05600   RADIOLOGY - THERAPEUTIC   2,121,742   23,523,213   0.090198   55.00   05600   RADIOLOGY - THERAPEUTIC   2,501,941   20,937,597   0.119495   56.00   05700   CT SCAN   4,485,503   96,795,911   0.046340   57.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   2,868,108   41,190,073   0.069631   58.00   05900   CARDIAC CATHETERIZATION   7,535,043   104,954,817   0.071793   59.00   05900   CARDIAC CATHETERIZATION   7,535,043   104,954,817   0.071793   59.00   06000   LABORATORY   13,815,074   145,157,229   0.095173   60.00   06000   LABORATORY   13,815,074   145,157,229   0.095173   60.00   06000   CARDIAC CATHETERIZATION   61.00   06000   INTRAVENOUS THERAPY   1,021,140   4,913,372   0.205997   64.00   66.00   06600   PHYSICAL THERAPY   4,209,527   14,578,814   0.288743   65.00   66.00   06600   PHYSICAL THERAPY   6,136,108   21,161,708   0.289963   66.00   66.00   06000   CCUPATIONAL THERAPY   1,699,752   6,782,358   0.250614   67.00   68.00   06000   ELECTROCARDIOLOGY   2,622,091   4,477,500   0.061729   69.00   00000   ELECTROCARDIOLOGY   2,622,091   4,477,500   0.061729   69.00   07000   ELECTROCARDIOLOGY   2,622,091   4,2477,500   0.061729   69.00   07200   IMPL. DEV. CHARGED TO PATIENTS   16,443,058   36,316,479   0.40348   71.00   77.00   MEDICAL SUPPLIES CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   73.00   07400   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   76.97   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   0.000   0.000   CLUTC   0.0000   CLUTC   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000	52.00	05200 DEL	LIVERY ROOM & LABOR ROOM	2,778,048	4,440,378	0.62563	33	52.00
55.00   05500   RADIOLOGY - THERAPEUTIC   2,121,742   23,523,213   0.090198   55.00   05600   RADIOISOTOPE   2,501,941   20,937,597   0.119495   56.00   57.00   05700   CT SCAN   4,485,503   96,795,911   0.046340   57.00   58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   2,868,108   41,190,073   0.069631   58.00   59.00   05900   CARDIAC CATHETERIZATION   7,535,043   04,954,817   0.071793   59.00   06000   LABORATORY   13,815,074   145,157,229   0.095173   60.00   63.00   60.00	53.00	05300 ANE	ESTHESIOLOGY	873,047	36,989,116	0.02360	03	53.00
56.00   05600   RADIOISOTOPE   2,501,941   20,937,597   0.119495   56.00	54.00	05400 RAD	DIOLOGY-DIAGNOSTIC	10,311,619	77,569,910	0.13293	33	54.00
57.00   05700   CT SCAN   4,485,503   96,795,911   0.046340   57.00   58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   2,868,108   41,190,073   0.069631   58.00   05900   CARDIAC CATHETERIZATION   7,535,048,170   104,954,817   0.071793   59.00   06000   LABORATORY   13,815,074   145,157,229   0.095173   60.00   63.00   06300   BLOOD STORING, PROCESSING, & TRANS.   2,326,205   6,353,495   0.366130   0.66040   DITRAVENOUS THERAPY   1,012,140   4,913,372   0.205997   64.00   06500   RESPIRATORY THERAPY   4,209,527   14,578,814   0.288743   0.58963   0.6600   0.6000   0.6000   PHYSICAL THERAPY   6,136,108   21,161,708   0.289963   0.6600   0.60000   0.6000   0.60000   0.60000   0.60000	55.00	05500 RAD	DIOLOGY - THERAPEUTIC	2,121,742	23,523,213	0.09019	98	55.00
\$8.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   2,868,108   41,190,073   0.069631   59.00   05900   CARDIAC CATHETERIZATION   7,535,043   104,954,817   0.071793   59.00   60.00   CARDIAC CATHETERIZATION   7,535,043   104,954,817   0.071793   60.00   60.00   CARDIAC CATHETERIZATION   7,535,043   104,954,817   0.071793   69.00   60.00   60.00   CARDIAC CATHETERIZATION   7,535,043   104,954,817   0.071793   69.00   60.00   60.00   CARDIAC CATHETERIZATION   7,535,043   104,954,817   0.071793   69.00   60.00   60.00   CARDIAC PROCESSING, & TRANS.   2,326,205   6,353,495   0.366130   63.00   64.00   65.00   CARDIAC PROCESSING, & TRANS.   2,326,205   6,353,495   0.366130   63.00   66.00   66.00   CARDIAC PROCESSING, & TRANS.   4,209,527   14,578,814   0.288743   65.00   66.00   66.00   6600   PHYSICAL THERAPY   4,209,527   14,578,814   0.288743   65.00   66.00   6600   PHYSICAL THERAPY   1,699,752   6,782,358   0.250614   67.00   68.00   68.00   SPEECH PATHOLOGY   1,518,593   2,819,061   0.410985   68.00   69.00   69.00   ELECTROCARDIOLOGY   2,622,091   42,477,500   0.061729   69.00   69.00   ELECTROENCEPHALOGRAPHY   1,090,659   11,537,516   0.094532   70.00   71.00   MEDICAL SUPPLIES CHARGED TO PATIENT   13,662,889   33,864,594   0.403448   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   73.00   DRUGS CHARGED TO PATIENTS   17,992,559   100,254,968   0.179468   73.00   74.00   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   0.007141NT SERVICE COST CENTERS   10,302,451   0.403832   90.00   91.00   MERGENCY   13,216,060   121,699,339   0.108596   91.00   92.00   DSERVATION BEDS (NON-DISTINCT PART   4,868,740   16,548,470   0.294211   92.00   0.00	56.00	05600 RAD	DIOISOTOPE	2,501,941	20,937,597	0.11949	95	56.00
59.00   05900   CARDIAC CATHETERIZATION   7,535,043   104,954,817   0.071793   59.00	57.00	05700 CT	SCAN	4,485,503	96,795,911	0.04634	10	57.00
60.00   06000   LABORATORY   13,815,074   145,157,229   0.095173   60.00   63.00   63.00   6300   BLOOD STORING, PROCESSING, & TRANS.   2,326,205   6,353,495   0.366130   63.00   64.00   06400   INTRAVENOUS THERAPY   1,012,140   4,913,372   0.205997   64.00   65.00   06500   RESPIRATORY THERAPY   4,209,527   14,578,814   0.288743   65.00   66.00   06600   PHYSICAL THERAPY   6,136,108   21,161,708   0.28963   66.00   67.00   06700   OCCUPATIONAL THERAPY   1,699,752   6,782,358   0.250614   67.00   68.00   06800   SPEECH PATHOLOGY   1,518,593   2,819,061   0.410985   68.00   69.00   06900   ELECTROCARDIOLOGY   2,622,091   42,477,500   0.061729   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   1,090,659   11,537,516   0.094532   70.00   71.00   07000   MEDICAL SUPPLIES CHARGED TO PATIENT   13,662,589   33,864,594   0.403448   71.00   72.00   7300   DRUGS CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   74.00   74.00   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   76.97   C7097   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   OUTPATIENT SERVICE COST CENTERS   13,216,060   121,699,339   0.108596   91.00   91.00   9000   CLINIC   4,160,455   10,302,451   0.403832   90.00   90.00   CLINIC   92.00   OUTPATIENT SERVICE COST CENTERS   13,216,060   121,699,339   0.108596   91.00   92.00   OUTPATIENT SERVICE COST CENTERS   1,201,391,761   92.00   0.00	58.00	05800 MAG	GNETIC RESONANCE IMAGING (MRI)	2,868,108	41,190,073	0.06963	31	58.00
63.00   06300   BLOOD STORING, PROCESSING, & TRANS.   2,326,205   6,353,495   0.366130   64.00   64.00   06400   INTRAVENOUS THERAPY   1,012,140   4,913,372   0.205997   64.00   66.00   06500   RESPIRATORY THERAPY   4,209,527   14,578,814   0.288743   65.00   66.00   06600   PHYSICAL THERAPY   6,136,108   21,161,708   0.289963   66.00   67.00   06700   0CCUPATIONAL THERAPY   1,699,752   6,782,358   0.250614   67.00   68.00   06900   SPECCH PATHOLOGY   1,158,593   2,819,061   0.410985   68.00   69.00   06900   ELECTROCARDIOLOGY   2,622,091   42,477,500   0.061729   69.00   70.00   70.00   REDICAL SUPPLIES CHARGED TO PATIENT   13,662,589   33,864,594   0.403448   71.00   72.00   7200   MPL. DEV. CHARGED TO PATIENTS   16,443,058   36,16,479   0.452771   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   17,992,559   100,254,968   0.179468   73.00   74.00   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   74.00   76.97   OUTPATIENT SERVICE COST CENTERS   1,235,829   4,806,078   0.257139   74.00   70.00   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   OUTPATIENT SERVICE COST CENTERS   10,302,451   0.403832   90.00   90.00   EMERGENCY   13,216,060   121,699,339   0.108596   91.00   92.00   OBERRAGENCY   13,216,060   121,699,339   0.108596   91.00   OTHER REIMBURSABLE COST CENTERS   10,000,400   10,000   1000   EMERGENCY   13,216,060   121,699,339   0.108596   91.00   OTHER REIMBURSABLE COST CENTERS   10,000,400   10,000	59.00	05900 CAR	RDIAC CATHETERIZATION	7,535,043	104,954,817	0.07179	93	59.00
64.00   06400   INTRAVENOUS THERAPY   1,012,140   4,913,372   0.205997   66.00   66.00   RESPIRATORY THERAPY   4,209,527   14,578,814   0.288743   65.00   66.00   06600   PHYSICAL THERAPY   6,136,108   21,161,708   0.289963   66.00   67.00   06700   0cCUPATIONAL THERAPY   1,699,752   6,782,358   0.250614   67.00   68.00   06800   SPEECH PATHOLOGY   1,158,593   2,819,061   0.410985   68.00   69.00   ELECTROCARDIOLOGY   2,622,091   42,477,500   0.061729   69.00   07000   ELECTROENCEPHALOGRAPHY   1,090,659   11,537,516   0.094532   70.00   71.00   07100   Medical Supplies Charged To Patient   13,662,589   33,864,594   0.403448   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENT   16,443,058   36,316,479   0.452771   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   73.00   07400   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   76.97   07697   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   07697   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   09000   CLINIC   4,160,455   10,302,451   0.403832   90.00   91.00   09000   EMERGENCY   13,216,060   121,699,339   0.108596   91.00   09000   EMERGENCY   13,216,060   121,699,339   0.108596   91.00   07000   0000   0000   00000   00000   00000   00000   00000   00000   00000   00000   000000	60.00	06000 LAB	BORATORY	13,815,074	145,157,229	0.09517	73	60.00
65.00   06500   RESPIRATORY THERAPY   4,209,527   14,578,814   0.288743   0.66.00   06600   PHYSICAL THERAPY   6,136,108   21,161,708   0.289963   0.66.00   06700   0CCUPATIONAL THERAPY   1,699,752   6,782,358   0.250614   0.700   0.60000   0.60000   0.60000   0.60000   0.60000   0.60000   0.60000	63.00	06300 BLO	OOD STORING, PROCESSING, & TRANS.	2,326,205	6,353,495	0.36613	30	63.00
66.00   06600   PHYSICAL THERAPY   6,136,108   21,161,708   0.289963   66.00   67.00   06700   OCCUPATIONAL THERAPY   1,699,752   6,782,358   0.250614   67.00   68.00   06800   SPEECH PATHOLOGY   1,158,593   2,819,061   0.410985   68.00   69.00   06900   ELECTROCARDIOLOGY   2,622,091   42,477,500   0.061729   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   1,090,659   11,537,516   0.094532   70.00   71.00   MEDICAL SUPPLIES CHARGED TO PATIENT   13,662,589   33,864,594   0.403448   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   17,992,559   100,254,968   0.179468   73.00   74.00   07400   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   76.97   O7697   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   OUTPATIENT SERVICE COST CENTERS   13,216,060   121,699,339   0.108596   99.00   99.00   O9900   CINIC   4,160,455   10,302,451   0.403832   90.00   99.00   O9900   DEBERGENCY   13,216,060   121,699,339   0.108596   99.00   O9900   DEBERGENCY   13,216,060   121,699,339   0.108596   99.00   O9900   DEBERGENCY   13,216,060   121,699,339   0.108596   99.00   OTHER REIMBURSABLE COST CENTERS	64.00	06400 INT	TRAVENOUS THERAPY	1,012,140	4,913,372	0.20599	97	64.00
67.00   06700   OCCUPATIONAL THERAPY   1,699,752   6,782,358   0.250614   67.00   68.00   06800   SPEECH PATHOLOGY   1,158,593   2,819,061   0.410985   68.00   69.00   06900   ELECTROCARDIOLOGY   2,622,091   42,477,500   0.061729   69.00   70.00   70.00   70700   ELECTROENCEPHALOGRAPHY   1,090,659   11,537,516   0.094532   70.00   71.00   70100   MEDICAL SUPPLIES CHARGED TO PATIENT   13,662,589   33,864,594   0.403448   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   17,992,559   100,254,968   0.179468   73.00   74.00   07400   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   76.97   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   00179ATIENT SERVICE COST CENTERS   13,216,060   121,699,339   0.108596   91.00   99.00   09100   EMERGENCY   13,216,060   121,699,339   0.108596   91.00   09100   EMERGENCY   13,216,060   121,699,339   0.108596   91.00   09100   EMERGENCY   0.000   09100   EMERGENCY   0.000   09100   HOME HEALTH AGENCY   4,266,105   5,566,949   0.766327   101.00   10100   HOME HEALTH AGENCY   4,266,105   5,566,949   0.766327   101.00   10100   Less Observation Beds   4,868,740   0   0   00.00   00.000   00.000   00.000   00.000   00.0000   00.0000   00.00000000	65.00	06500 RES	SPIRATORY THERAPY	4,209,527	14,578,814	0.28874	13	65.00
68.00   06800   SPEECH PATHOLOGY   1,158,593   2,819,061   0.410985   68.00   69.00   06900   ELECTROCARDIOLOGY   2,622,091   42,477,500   0.061729   69.00   07000   ELECTROENCEPHALOGRAPHY   1,090,659   11,537,516   0.094532   70.00   71.00   MEDICAL SUPPLIES CHARGED TO PATIENT   13,662,589   33,864,594   0.403448   71.00   72.00   IMPL. DEV. CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   17,992,559   100,254,968   0.179468   73.00   74.00   07400   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   76.97   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   0000   CLINIC   09000   CLINIC   09000   CLINIC   09000   CLINIC   09100   EMERGENCY   13,216,060   121,699,339   0.108596   91.00   09200   OBSERVATION BEDS (NON-DISTINCT PART   4,868,740   16,548,470   0.294211   92.00   0000   CONDON   CLINIC   00000   CLINIC   00000   00000   000000   000000   000000	66.00	06600 PHY	YSICAL THERAPY	6,136,108	21,161,708	0.28996	53	66.00
69.00   06900   ELECTROCARDIOLOGY   2,622,091   42,477,500   0.061729   69.00   70.00   70.00   70.00   70.00   70.00   ELECTROENCEPHALOGRAPHY   1,090,659   11,537,516   0.094532   70.00   71.00   71.00   MEDICAL SUPPLIES CHARGED TO PATIENT   13,662,589   33,864,594   0.403448   71.00   72.00   72.00   MPL. DEV. CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   73.00   73.00   DRUGS CHARGED TO PATIENTS   17,992,559   100,254,968   0.179468   73.00   74.00   74.00   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   76.97   76.	67.00	06700 occ	CUPATIONAL THERAPY	1,699,752	6,782,358	0.25061	L4	67.00
70.00   07000   ELECTROENCEPHALOGRAPHY   1,090,659   11,537,516   0.094532   70.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   13,662,589   33,864,594   0.403448   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   17,992,559   100,254,968   0.179468   73.00   74.00   74.00   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   76.97   07697   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   0017471ENT SERVICE COST CENTERS   10,302,451   0.403832   90.00   91.00   09000   EMERGENCY   13,216,060   121,699,339   0.108596   91.00   92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART   4,868,740   16,548,470   0.294211   92.00   0000   0000   00000   00000   00000   000000	68.00	06800 SPE	EECH PATHOLOGY	1,158,593	2,819,061	0.41098	35	68.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   13,662,589   33,864,594   0.403448   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   17,992,559   100,254,968   0.179468   0.257139   74.00   07400   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   07697   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   0.000   0000   CLINIC   0.000   0.000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.00000000	69.00	06900 ELE	ECTROCARDIOLOGY	2,622,091	42,477,500	0.06172	29	69.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   16,443,058   36,316,479   0.452771   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   17,992,559   100,254,968   0.179468   73.00   74.00   07400   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   76.97   07697   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   0000   00000   CLINIC   4,160,455   10,302,451   0.403832   90.00   09100   EMERGENCY   13,216,060   121,699,339   0.108596   91.00   09200   OBSERVATION BEDS (NON-DISTINCT PART   4,868,740   16,548,470   0.294211   92.00   00000   00000   000000   000000   000000	70.00	07000 ELE	ECTROENCEPHALOGRAPHY	1,090,659	11,537,516	0.09453	32	70.00
73.00   07300   DRUGS CHARGED TO PATIENTS   17,992,559   100,254,968   0.179468   73.00   74.00   07400   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   76.97   07697   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   0000   09100   EMERGENCY   09000   CLINIC   4,160,455   10,302,451   0.403832   90.00   09100   EMERGENCY   13,216,060   121,699,339   0.108596   91.00   09200   095ervation Beds   (Non-DISTINCT PART   4,868,740   16,548,470   0.294211   92.00   09100   HOME HEALTH AGENCY   4,266,105   5,566,949   0.766327   101.00   10100   Home Health Agency   Subtotal (sum of lines 50 thru 199)   197,264,555   1,201,391,761   Less observation Beds   4,868,740   0   201.00   201.00	71.00	07100 MED	DICAL SUPPLIES CHARGED TO PATIENT	13,662,589	33,864,594	0.40344	18	71.00
74.00   07400   RENAL DIALYSIS   1,235,829   4,806,078   0.257139   74.00   76.97   07697   CARDIAC REHABILITATION   1,419,099   2,521,880   0.562715   76.97   00000   00000   00000   00000	72.00	07200 IMP	PL. DEV. CHARGED TO PATIENTS	16,443,058	36,316,479	0.45277	71	72.00
76.97 O7697 CARDIAC REHABILITATION 1,419,099 2,521,880 0.562715 76.97 OUTPATIENT SERVICE COST CENTERS  90.00 09000 CLINIC 4,160,455 10,302,451 0.403832 90.00 91.00 EMERGENCY 13,216,060 121,699,339 0.108596 91.00 091.00 O91.00 EMERGENCY 4,868,740 16,548,470 0.294211 92.00 OTHER REIMBURSABLE COST CENTERS  101.00 10100 HOME HEALTH AGENCY 4,266,105 5,566,949 0.766327 101.00 Subtotal (sum of lines 50 thru 199) 197,264,555 1,201,391,761 200.00 Less Observation Beds 4,868,740 0 201.00	73.00	07300 DRU	JGS CHARGED TO PATIENTS	17,992,559	100,254,968	0.17946	58	73.00
OUTPATIENT SERVICE COST CENTERS           90.00         09000 CLINIC         4,160,455         10,302,451         0.403832         90.00           91.00         09100 EMERGENCY         13,216,060         121,699,339         0.108596         91.00           92.00         09200 OBSERVATION BEDS (NON-DISTINCT PART         4,868,740         16,548,470         0.294211         92.00           OTHER REIMBURSABLE COST CENTERS           101.00 IONG HEALTH AGENCY         4,266,105         5,566,949         0.766327         101.00           200.00 Subtotal (sum of lines 50 thru 199)         197,264,555         1,201,391,761         200.00           201.00 Less Observation Beds         4,868,740         0         201.00	74.00	07400 REN	NAL DIALYSIS	1,235,829	4,806,078	0.25713	39	74.00
90.00   09000   CLINIC   4,160,455   10,302,451   0.403832   90.00   91.00   91.00   92.00   92.00   09200   085ERVATION BEDS (NON-DISTINCT PART   4,868,740   16,548,470   0.294211   92.00   0700	76.97	07697 CAR	RDIAC REHABILITATION	1,419,099	2,521,880	0.56271	L5	76.97
91.00   09100   EMERGENCY   13,216,060   121,699,339   0.108596   92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART   4,868,740   16,548,470   0.294211   92.00   00000   0000   00000   00000   00000   00000   0000   0000   0000   0000   0000   0		OUTPATIEN	NT SERVICE COST CENTERS					
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART   4,868,740   16,548,470   0.294211   92.00	90.00	09000 CLI	INIC	4,160,455	10,302,451	0.40383	32	90.00
OTHER REIMBURSABLE COST CENTERS           101.00         10100         HOME HEALTH AGENCY         4,266,105         5,566,949         0.766327         101.00           200.00         Subtotal (sum of lines 50 thru 199)         197,264,555         1,201,391,761         200.00           201.00         Less Observation Beds         4,868,740         0         201.00	91.00	09100 EME	ERGENCY	13,216,060	121,699,339	0.10859	96	91.00
OTHER REIMBURSABLE COST CENTERS           101.00         10100         HOME HEALTH AGENCY         4,266,105         5,566,949         0.766327         101.00           200.00         Subtotal (sum of lines 50 thru 199)         197,264,555         1,201,391,761         200.00           201.00         Less Observation Beds         4,868,740         0         201.00	92.00	09200 OBS	SERVATION BEDS (NON-DISTINCT PART	4,868,740	16,548,470	0.29421	11	92.00
200.00   Subtotal (sum of lines 50 thru 199)   197,264,555   1,201,391,761   200.00   201.00   Less Observation Beds   4,868,740   0   201.00								
200.00   Subtotal (sum of lines 50 thru 199)   197,264,555   1,201,391,761   200.00   201.00   Less Observation Beds   4,868,740   0   201.00	101.00	10100 HOM	ME HEALTH AGENCY	4,266,105	5,566,949	0.76632	27	101.00
201.00 Less Observation Beds 4,868,740 0 201.00	200.00	Sub	ototal (sum of lines 50 thru 199)					200.00
202.00   Total (line 200 minus line 201)   192,395,815   1,201,391,761   202.00	201.00	Les	ss Observation Beds			i		201.00
	202.00	) Tot	tal (line 200 minus line 201)	192,395,815	1,201,391,761			202.00

Health	Financial Systems	ST. MARY MEDICAL	L CENTER, INC.			u of Form CMS-2	2552-10
APPORT	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL				Period: From 07/01/2022 To 06/30/2023		
				XVIII	Hospital	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
		Part II, col.		(col. 1 - col 2)			
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	•			<u>"</u>		
30.00	ADULTS & PEDIATRICS	2,100,979	0	2,100,97	9 34,525	60.85	30.00
31.00	INTENSIVE CARE UNIT	477,934		477,93	5,370	89.00	31.00
41.00	SUBPROVIDER - IRF	280,222	0	280,22	4,984	56.22	41.00
43.00	NURSERY	124,580		124,58	1,326	93.95	43.00
200.00	Total (lines 30 through 199)	2,983,715		2,983,71	5 46,205		200.00
	Cost Center Description	Inpatient	Inpatient				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
		6.00	6) 7.00	-			
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30.00	ADULTS & PEDIATRICS	11,226	683,102				30.00
31.00	INTENSIVE CARE UNIT	1,289					31.00
41.00	SUBPROVIDER - IRF	3,065		1			41.00
	NURSERY	0	0	1			43.00
	Total (lines 30 through 199)	15,580	970,137				200.00

	Form CMS-2552-10
From 07/01/2022 Part To 06/30/2023 Date,	
Title XVIII Hospital	PPS
	al Costs

					To 06/30/2023	Date/Time Pre 11/20/2023 2:	
				2 XVIII	Hospital	PPS	
	Cost Center Description	Capital	Total Charges		Inpatient	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	5,473,852	184,934,650				
	05100 RECOVERY ROOM	411,642	22,393,835				
	05200 DELIVERY ROOM & LABOR ROOM	354,013	4,440,378		- , -		
	05300 ANESTHESIOLOGY	19,731	36,989,116		' '		
	05400 RADIOLOGY-DIAGNOSTIC	1,089,308					
	05500 RADIOLOGY - THERAPEUTIC	96,009	23,523,213				
	05600 RADIOISOTOPE	147,673	20,937,597			4,511	56.00
	05700 CT SCAN	684,240	96,795,911		, , , ,	54,016	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	432,353	41,190,073	0.01049	7 2,010,316	21,102	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,063,018	104,954,817	0.01012	9,648,282	97,718	59.00
60.00	06000 LABORATORY	439,601	145,157,229	0.00302	8 13,221,669	40,035	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	87,616	6,353,495	0.01379	0 1,128,323	15,560	63.00
64.00	06400 INTRAVENOUS THERAPY	66,852	4,913,372	0.01360	6 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	192,359	14,578,814	0.01319	4,202,665	55,450	65.00
66.00	06600 PHYSICAL THERAPY	472,857	21,161,708	0.02234	5 849,087	18,973	66.00
67.00	06700 OCCUPATIONAL THERAPY	49,408	6,782,358	0.00728	5 604,762	4,406	67.00
68.00	06800 SPEECH PATHOLOGY	76,110	2,819,061	0.02699	8 266,255	7,188	68.00
69.00	06900 ELECTROCARDIOLOGY	274,745	42,477,500	0.00646	3,848,686	24,893	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	83,442	11,537,516	0.00723	2 89,155	645	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	74,498	33,864,594	0.00220	0 5,087,639	11,193	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	89,164	36,316,479	0.00245	5,790,161	14,215	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	409,143	100,254,968	0.00408	1 14,355,465	58,585	73.00
74.00	07400 RENAL DIALYSIS	12,647	4,806,078	0.00263	1,557,445	4,098	74.00
76.97	07697 CARDIAC REHABILITATION	180,960	2,521,880	0.07175			76.97
	OUTPATIENT SERVICE COST CENTERS		· · · · · ·		,	<u> </u>	
90.00	09000 CLINIC	447,247	10,302,451	0.04341	2 65,362	2,837	90.00
	09100 EMERGENCY	611,036		0.00502	1 12,949,441	65,019	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	276,579	16,548,470	0.01671	887,651	14,835	92.00
200.00			1,195,824,812		105,964,672		

Health Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS			Period: From 07/01/2022 To 06/30/2023		pared: 29 pm
		Title	XVIII	Hospital	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdowr 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	0	0		0 0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	
41.00   04100   SUBPROVIDER - IRF 43.00   04300   NURSERY	0	0		0	0	1
43.00   04300   NURSERY 200.00   Total (lines 30 through 199)	0	0		0	1	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Dations	Per Diem (col.		200.00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)					
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	34,52		, ,	
31.00 03100 INTENSIVE CARE UNIT		0	5,37		,	
41.00  04100  SUBPROVIDER - IRF	0	0	4,98		. ,	
43.00 04300 NURSERY		0	1,32			
200.00   Total (lines 30 through 199)		0	46,20	5	15,580	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through Cost (col. 7 x					
	cost (cor. 7 x					
	9.00					
TARRATTENT ROUTING CERVICE COCT CENTERS	3.00					

30.00 31.00 41.00 43.00 200.00

30.00 | 03000 | ADULTS & PEDIATRICS | 03100 | O3100 | INTENSIVE CARE UNIT | 04100 | O4400 | SUBPROVIDER - IRF | 043.00 | O4300 | O4300

Health Financial Systems

ST. MARY MEDICAL CENTER, INC.

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

THOUGH COSTS

ST. MARY MEDICAL CENTER, INC.

In Lieu of Form CMS-2552-10

Period:
From 07/01/2022
To 06/30/2023

Part IV
Date/Time Prepared:

				1	0 06/30/2023	Date/Time Pre 11/20/2023 2:	
			Title	XVIII	Hospital	PPS	
	Cost Center Description	Non Physician	Nursing	Nursing	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	C	0	0	50.00
	05100 RECOVERY ROOM	0	0	C	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
	05300 ANESTHESIOLOGY	0	0	r) C	0	0	53.00
	05400 RADIOLOGY-DIAGNOSTIC	0	0	r) C	0	0	54.00
	05500 RADIOLOGY - THERAPEUTIC	0	0	) C	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	C	0	0	56.00
57.00	05700 CT SCAN	0	0	C	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	C	0	0	59.00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	C	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	ol c	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	ol c	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	ol c	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	ol c	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	ol c	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	ol c	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	ol c	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	l c	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	ol c	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	d	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	d	0	0	74.00
	07697 CARDIAC REHABILITATION	0	0	d	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	C	0	0	90.00
91.00	09100 EMERGENCY	0	0	d	0	372,326	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	1
200.00		0	0	l d	0	372,326	
				'	•	, , , ,	

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0034	Period:	Worksheet D
THROUGH COSTS			From 07/01/2022	
Tilloodii costs			To 06/30/2023	Date/Time Prenared:

THROUG	H COSTS				го 06/30/2023		
				XVIII	Hospital	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATING ROOM	0	0		184,934,650		1
	05100 RECOVERY ROOM	0	0	1	22,393,835		
	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	4,440,378		
	05300 ANESTHESIOLOGY	0	0	1	36,989,116		
	05400 RADIOLOGY-DIAGNOSTIC	0	0	1	77,569,910		
	05500 RADIOLOGY - THERAPEUTIC	0	0		23,523,213		1
	05600 RADIOISOTOPE	0	0	(	20,937,597		
57.00	05700 CT SCAN	0	0	(	96,795,911	0.000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		41,190,073	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0		104,954,817	0.000000	59.00
60.00	06000 LABORATORY	0	0		145,157,229	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		6,353,495	0.000000	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0		4,913,372	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0		14,578,814	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0		21,161,708	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		6,782,358	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		2,819,061	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		42,477,500	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		11,537,516	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		33,864,594	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0		36,316,479	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		100,254,968	0.000000	73.00
	07400 RENAL DIALYSIS	o	0		4,806,078		1
	07697 CARDIAC REHABILITATION	o	0		2,521,880		1
	OUTPATIENT SERVICE COST CENTERS	-1			, , , , , , , , , , , , , , , , , , , ,		
	09000 CLINIC	0	0		10,302,451	0.000000	90.00
	09100 EMERGENCY	o	372,326				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	, , , , ,	16,548,470		
200.00	,	0	372,326	372,32	1,195,824,812		200.00

Health Financial Systems	ST. MARY MEDICAL C	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0034	From 07/01/2022	Worksheet D Part IV Date/Time Prepared:

					то 06/30/2023	Date/Time Pre 11/20/2023 2:	
			Title	XVIII	Hospital	PPS	25 p
	Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0.000000	13,891,864		0 35,769,347	ł .	50.00
	05100 RECOVERY ROOM	0.000000	1,503,596		0 4,519,343	1	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0.000000	10,547		0	0	52.00
	05300 ANESTHESIOLOGY	0.000000	2,595,155		0 7,227,417		53.00
	05400 RADIOLOGY-DIAGNOSTIC	0.000000	2,974,718		0 15,832,956		54.00
	05500 RADIOLOGY - THERAPEUTIC	0.000000	39,593		0 6,092,236		55.00
	05600 RADIOISOTOPE	0.000000	639,570		0 6,216,770		56.00
	05700 CT SCAN	0.000000	7,641,181		0 18,488,984		57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,010,316		0 8,412,077		58.00
	05900 CARDIAC CATHETERIZATION	0.000000	9,648,282		0 27,285,977		59.00
60.00	06000 LABORATORY	0.000000	13,221,669		0 9,913,230		60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	1,128,323		0 958,323		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0		0 1,952,002	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	4,202,665		0 475,886	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	849,087		0 49,192	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	604,762		0 3,997	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	266,255		0 153,615	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,848,686		0 10,084,584	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	89,155		0 2,741,168	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,087,639		0 5,672,161	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,790,161		7,066,504	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	14,355,465		0 21,094,222	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	1,557,445		0 151,019	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	106,084		0 764,671	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0.000000	65,362		0 3,325,308		
	09100 EMERGENCY	0.003059	12,949,441				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	887,651		0 2,983,560		92.00
200.00	Total (lines 50 through 199)		105,964,672	39,61	2 211,165,163	42,614	200.00

From 07/01/2022 Date/Time Prepared: 06/30/2023 11/20/2023 2:29 pm Title XVIII Hospital Charges Costs Cost Center Description Cost to Charge PPS Reimbursed Cost Cost PPS Services Ratio From Services (see Reimbursed Reimbursed (see inst.) Worksheet C, inst.) Services Services Not Subject To Part I, col. 9 Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.248217 35,769,347 29,250 8,878,560 50.00 51.00 05100 RECOVERY ROOM 0.292536 4,519,343 0 51.00 0 1,322,071 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.625633 52.00 0 0 53.00 | 05300 | ANESTHESIOLOGY 0.023603 7,227,417 0 170,589 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.132933 15,832,956 0 0 2,104,722 54.00 6,092,236 549,508 55.00 05500 RADIOLOGY - THERAPEUTIC 0.090198 0 ol 55.00 0 56.00 05600 RADIOISOTOPE 0.119495 6,216,770 0 742,873 56.00 57.00 05700 CT SCAN 0.046340 18,488,984 0 856,780 57.00 8,412,077 0 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.069631 585,741 58.00 0 0 59.00 05900 CARDIAC CATHETERIZATION 0.071793 27.285,977 1.958.942 59.00 0 60.00 | 06000 | LABORATORY 0.095173 9,913,230 0 943,472 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0.366130 958,323 0 0 350,871 63.00 63.00 64.00 06400 INTRAVENOUS THERAPY 0.205997 1,952,002 0 0 402,107 64.00 0 0 65.00 65.00 06500 RESPIRATORY THERAPY 0.288743 475,886 137,409 66.00 06600 PHYSICAL THERAPY 0.289963 49,192 0 0 14,264 66.00 3,997 0 67.00 06700 OCCUPATIONAL THERAPY 0.250614 1,002 67.00 06800 SPEECH PATHOLOGY 153,615 0 0 63,133 68.00 0.410985 68.00 0 69.00 06900 ELECTROCARDIOLOGY 0.061729 10,084,584 0 622,511 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.094532 2,741,168 0 0 259,128 70.00 0 ol 2,288,422 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.403448 5,672,161 71.00 0 7,200 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.452771 7,066,504 3,199,508 72.00 21,094,222 0 3,785,738 73.00 07300 DRUGS CHARGED TO PATIENTS 0.179468 25,030 73.00 07400 RENAL DIALYSIS 0.257139 151,019 0 38,833 74.00 74.00 76.97 07697 CARDIAC REHABILITATION 0.562715 0 0 430,292 76.97 764.671 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.403832 3,325,308 0 0 1,342,866 90.00 91.00 09100 EMERGENCY 0.108596 13,930,614 0 0 1,512,809 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.294211 2,983,560 0 877,796 92.00 200.00 Subtotal (see instructions) 0 200.00 211,165,163 61,480 33,439,947 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 211,165,163 0 61,480 33,439,947 202.00

Health Financial Systems ST. MARY MEDICAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST In Lieu of Form CMS-2552-10 ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034

Period: Worksheet D From 07/01/2022 Part V To 06/30/2023 Date/Time Prepared:

					10 06/30/2023	11/20/2023 2:29	
			Title	XVIII	Hospital	PPS	<u> </u>
		Cos					
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Services	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
F0 00	ANCILLARY SERVICE COST CENTERS		7.200	1			F0 00
50.00		0	7,260				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00		0	0				52.00
53.00		0	0				53.00
54.00		0	0				54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0			II.	55.00
56.00		0	0			II.	56.00
57.00		0	0				57.00
58.00		0	0				58.00
59.00		0	0				59.00
60.00		0	0				60.00
63.00		0	0				63.00
64.00	06400 INTRAVENOUS THERAPY	0	0				64.00
65.00		0	0				65.00
66.00		0	0				66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0				67.00
68.00		0	0				68.00
69.00		0	0				69.00
70.00		0	0				70.00
71.00		0	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3,260				72.00
73.00		0	4,492	1			73.00
74.00		0	0	1			74.00
76.97	1 11 1	0	0				76.97
00 00	OUTPATIENT SERVICE COST CENTERS		0	1			90.00
		0		1			
91.00 92.00		0	0				91.00 92.00
200.00		0	15 012				200.00
200.00		0	15,012				201.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	١				2	.01.00
202.00		0	15,012			2	202.00
202.00	INEC Charges (Time 200 - Time 201)	ı V	13,012	I		2	.02.00

PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	L CENTER,	der Co	CN: 15-	-0034	Period:	In Lie	Worksheet D	
			nent (			From 07	7/01/2022 5/30/2023	Part II	pared 29 pm
			Title	XVIII	Ε	Subpro	vider -	PPS	
							RF		
Cost Center Description	Capital	Total Cha					atient	Capital Costs	
	Related Cost						ogram	(column 3 x	
	(from Wkst. B,		col.	(col.		Ch.	arges	column 4)	
	Part II, col.	8)			2)				
	26)	2.00			2 00			5.00	
	1.00	2.00	)	;	3.00	4	1.00	5.00	
ANCILLARY SERVICE COST CENTERS	F 472 0F2	104 03	24 650		0.02050	20	60. 220	2.052	
.00 05000 OPERATING ROOM	5,473,852				0.02959		69,328	·	
00 05100 RECOVERY ROOM	411,642		93,835		0.01838		5,476	101	
.00 05200 DELIVERY ROOM & LABOR ROOM	354,013		10,378		0.07972		0	0	1 -
00 05300 ANESTHESIOLOGY	19,731		39,116		0.00053		5,668	3	53.
00 05400 RADIOLOGY-DIAGNOSTIC	1,089,308		59,910		0.01404	-	108,754	1,527	
.00 05500 RADIOLOGY - THERAPEUTIC	96,009		23,213		0.00408		0	0	
.00 05600 RADIOISOTOPE	147,673		37,597		0.00705		3,240	23	
.00 05700 CT SCAN	684,240		95,911		0.00706		121,447	859	
.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	432,353		90,073		0.01049		29,292	307	
.00 05900 CARDIAC CATHETERIZATION	1,063,018	,	,		0.01012		0	0	
.00   06000   LABORATORY	439,601				0.00302		613,510	1,858	
00 06300 BLOOD STORING, PROCESSING, & TRANS.	87,616	,	3,495		0.01379		11,204	155	
.00 06400 INTRAVENOUS THERAPY	66,852		L3,372		0.01360		0	0	1 ~ .
.00 06500 RESPIRATORY THERAPY	192,359		78,814		0.01319		335,552	4,427	
.00 06600 PHYSICAL THERAPY	472,857		51,708		0.02234		L,426,446		
00 06700 OCCUPATIONAL THERAPY	49,408		32,358		0.00728		L,435,667	10,459	
00 06800 SPEECH PATHOLOGY	76,110		L9,061		0.02699		255,014	6,885	
00 06900 ELECTROCARDIOLOGY	274,745		77,500		0.00646		40,069	259	
.00 07000 ELECTROENCEPHALOGRAPHY	83,442		37,516		0.00723		264 720	0	1
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	74,498		54,594		0.00220		264,738	582	
.00 07200 IMPL. DEV. CHARGED TO PATIENTS	89,164		L6,479		0.00245		7,133		72
00 07300 DRUGS CHARGED TO PATIENTS	409,143				0.00408		L,165,893	4,758	
00 07400 RENAL DIALYSIS	12,647		06,078		0.00263		162,941	429	
97 07697 CARDIAC REHABILITATION	180,960	2,52	21,880		0.07175	וספ	0	0	76
OUTPATIENT SERVICE COST CENTERS 00 09000 CLINIC	447 247	10.30	22 451		0 04241	12	ام	0	00
	447,247		02,451		0.04341		0		
.00 09100 EMERGENCY	611,036				0.00502		0	0	
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	13,339,524		18,470		0.00000		0 5,061,372	0 66,576	92

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0034	Period:	Worksheet D
THROUGH COSTS		Common to CCN 15 T024	From 07/01/2022	

		Component	CCN: 15-T034	То	06/30/2023	Date/Time Pre 11/20/2023 2:	
		Title	e XVIII	Sub	provider - IRF	PPS	
Cost Center Description	Non Physician	Nursing	Nursing	All	lied Health	Allied Health	
	Anesthetist	Program	Program	Pos	st-Stepdown		
	Cost	Post-Stepdown		Ad	djustments		
		Adjustments					
	1.00	2A	2.00		3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0		0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0		0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	1	0	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	1	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	1	0	0	0	56.00
57.00 05700 CT SCAN	0	0	1	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	1	0	0	0	59.00
60.00   06000   LABORATORY	0	0	1	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	1	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	1	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	1	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	1	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	1	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	1	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74.00   07400   RENAL DIALYSIS	0	0		0	0	0	74.00
76.97 O7697 CARDIAC REHABILITATION	0	0	1	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					ما	^	00.00
90.00   09000   CLINIC		0	1	0	0	0	
91.00 09100 EMERGENCY			1	0	U	372,326	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		272 226	92.00
200.00  Total (lines 50 through 199)	1	ıl O	1	0	0	372,326	1200.00

uoal+h	Financial Systems	ST. MARY MEDICAI	CENTED INC		Tn Lie	u of Form CMS_1	2552_10
Health Financial Systems S APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF					In Lieu of Form CMS-2 Period: Worksheet D		2332-10
THROUGH COSTS		RVICE OTHER PAS.			From 07/01/2022 To 06/30/2023	Part IV	pared: 29 pm
			Title	Title XVIII		PPS	
					IRF		
Cost Center Description		All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost	1 1 1 1	Cost (sum of		(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
		1.00	5.00		7.00	instructions)	
		4.00	5.00	6.00	7.00	8.00	
FO 00	ANCILLARY SERVICE COST CENTERS			1	0 104 024 650	0.000000	F0 00
	05000 OPERATING ROOM	0	1	1	0 184,934,650		
	05100 RECOVERY ROOM	0	0	l .	0 22,393,835		
	05200 DELIVERY ROOM & LABOR ROOM	0	0	l .	0 4,440,378		
53.00	05300 ANESTHESIOLOGY	0	0	l .	0 36,989,116		
	05400 RADIOLOGY-DIAGNOSTIC	0	0	i .	0 77,569,910		
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0		0 23,523,213		
56.00	05600 RADIOISOTOPE	0	0		0 20,937,597		
57.00	05700 CT SCAN	0	0	1	0 96,795,911		
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	l .	0 41,190,073 0 104.954.817		
59.00	05900 CARDIAC CATHETERIZATION	0	0				
60.00	06000 LABORATORY	0	0		1.3,137,223		
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 6,353,495		
64.00 65.00	06400 INTRAVENOUS THERAPY	0	0		0 4,913,372 0 14,578,814	0.000000	
66.00	06500 RESPIRATORY THERAPY	0	0		1.,5.0,01.		ı
67.00	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	0	0		,,		
68.00	06800 SPEECH PATHOLOGY	0	0		0 6,782,358		
69.00		0	0		0 2,819,061		
70.00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0		0 42,477,500 0 11.537.516		
		0	0		,		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 33,864,594		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 36,316,479		
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS	0			0 100,254,968		
	07400 RENAL DIALYSIS	0			0 4,806,078 0 2 521 880		
70.97	07697 CARDIAC REHABILITATION	1 0	<u> </u>	1	0 2,521,880	0.000000	70.97
90.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 10,302,451	0.000000	90.00
	09100 EMERGENCY	0		1			
	00200 ORSEDVATION REDS (NON-DISTINCT DART	0			0 121,099,339		

0 0 0

372,326

0 10,302,451 372,326 121,699,339 0 16,548,470 372,326 1,195,824,812

0.000000 92.00 200.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)

Health Financial Systems	ST. MARY MEDICAL C	u of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS		Period: From 07/01/2022	Worksheet D Part IV
Through Costs		Component CCN: 15-T034		
		Title XVIII	Subprovider -	PPS
			IRF	

			Title	XVIII	Subprovider - IRF	PPS		
Cost Center Description		Outpatient	Inpatient	Inpatient	Outpatient	Outpatient		
cose contain sesser iperon		Ratio of Cost	Program	Program	Program	Program		
		to Charges	Charges	Pass-Through	Charges	Pass-Through		
		(col. 6 ÷ col.	_	Costs (col. 8	3	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 OPERATING ROOM	0.000000	69,328		0	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	5,476		0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	5,668		0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	108,754		0 385	0	54.00	
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0		0	0	55.00	
56.00	05600 RADIOISOTOPE	0.000000	3,240		0	0	56.00	
57.00	05700 CT SCAN	0.000000	121,447		0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	29,292		0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0		0	0	59.00	
60.00	06000 LABORATORY	0.000000	613,510		0	0	60.00	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	11,204		0	0	63.00	
64.00	06400 INTRAVENOUS THERAPY	0.000000	0		0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	335,552		0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	1,426,446		0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,435,667		0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	255,014		0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	40,069		0	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	264,738		0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,133		0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,165,893		0	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	162,941		0	0	74.00	
76.97	07697 CARDIAC REHABILITATION	0.000000	0		0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.000000	0		0	0	90.00	
91.00	09100 EMERGENCY	0.003059	0		0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0	0	92.00	
200.00	Total (lines 50 through 199)		6,061,372		0 385	0	200.00	

Health Financial Systems		ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provider CCN: 15-0034	Period: From 07/01/2022	Worksheet D
			Component CCN: 15-T034		

11/20/2023 2:29 pm Title XVIII Subprovider -IRF Charges Costs Cost to Charge PPS Reimbursed Cost Center Description PPS Services Cost Cost Ratio From Services (see Reimbursed Reimbursed (see inst.) Worksheet C, inst.) Services Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.248217 0 50.00 51.00 05100 RECOVERY ROOM 0.292536 0 51.00 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0.625633 52.00 52.00 0 0 53.00 05300 ANESTHESIOLOGY 0.023603 0 53.00 05400 RADIOLOGY-DIAGNOSTIC 0.132933 0 0 51 54.00 385 54.00 0 0 55.00 05500 RADIOLOGY - THERAPEUTIC 0.090198 0 55.00 56.00 | 05600 | RADIOISOTOPE 0.119495 0 0 56.00 57.00 05700 CT SCAN 0.046340 0 0 0 0 0 0 0 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.069631 58.00 0 0 0 59.00 05900 CARDIAC CATHETERIZATION 0.071793 0 59.00 60.00 06000 LABORATORY 0.095173 0 0 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0.366130 63.00 0 64.00 06400 INTRAVENOUS THERAPY 0.205997 0 64.00 |06500|RESPIRATORY THERAPY 0 65.00 0.288743 0 65.00 66.00 06600 PHYSICAL THERAPY 0.289963 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.250614 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.410985 68.00 0 69.00 06900 ELECTROCARDIOLOGY 69.00 0.061729 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.094532 0 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.403448 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.452771 0 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.179468 0 0 73.00 07400 RENAL DIALYSIS 0.257139 0 74.00 74.00 0 76.97 07697 CARDIAC REHABILITATION 0.562715 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0.403832 0 0 0 0 09100 EMERGENCY 0.108596 0 0 91.00 91.00 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0.294211 0 0 51 200.00 200.00 Subtotal (see instructions) 385 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 385 0 51 202.00

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.			In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH				From 07/01/2022	Worksheet D Part V Date/Time Prepared: 11/20/2023 2:29 pm
		Title	XVIII	Subprovider - IRF	PPS
	Costs				

						11/20/2023 2:	.29 pm_
			Title	e XVIII	Subprovider - IRF	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Services	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	)			50.00
	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	05300 ANESTHESIOLOGY	0	0				53.00
	05400 RADIOLOGY-DIAGNOSTIC	0	0				54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0				55.00
56.00	05600 RADIOISOTOPE	0	0				56.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0				59.00
60.00	06000 LABORATORY	0	0				60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0				63.00
64.00	06400 INTRAVENOUS THERAPY	0	0				64.00
65.00	06500 RESPIRATORY THERAPY	0	0				65.00
66.00	06600 PHYSICAL THERAPY	0	0				66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0				67.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	)			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00	07400 RENAL DIALYSIS	0	0				74.00
76.97	07697 CARDIAC REHABILITATION	0	0				76.97
	OUTPATIENT SERVICE COST CENTERS						Ī
90.00	09000 CLINIC	0	0				90.00
91.00	09100 EMERGENCY	0	0	)			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	)			92.00
200.00	Subtotal (see instructions)	0	0	)			200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0	)			202.00
				-			•

Health	Financial Systems	ST. MARY MEDICAL	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provider C		Period: From 07/01/2022 To 06/30/2023		
				le XIX	Hospital	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
		Part II, col. 26)		(col. 1 - col 2)			
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,100,979	0	2,100,97	9 34,525	60.85	30.00
31.00	INTENSIVE CARE UNIT	477,934		477,93	4 5,370	89.00	31.00
41.00	SUBPROVIDER - IRF	280,222	0	280,22	4,984	56.22	41.00
43.00	NURSERY	124,580		124,58	0 1,326	93.95	43.00
200.00	Total (lines 30 through 199)	2,983,715		2,983,71	5 46,205		200.00
	Cost Center Description	Inpatient	Inpatient				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
		6.00	6) 7.00	+			
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30.00	ADULTS & PEDIATRICS	497	30,242	•			30.00
31.00	INTENSIVE CARE UNIT	304	,				31.00
41.00	SUBPROVIDER - IRF	53					41.00
	NURSERY	50					43.00
	Total (lines 30 through 199)	904					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS  Provider CCN: 15-0034  Period: Worksheet D From 07/01/2022 Part II	Health Financial Systems	ST. MARY MEDICAL C	In Lie	u of Form CMS-2552-10	
To 06/30/2023 Date/Time Prepare	APPORTIONMENT OF INPATIENT ANCILLARY SERV	CE CAPITAL COSTS	Provider CCN: 15-0034	From 07/01/2022	Part II

					From 07/01/2022 To 06/30/2023	Part II Date/Time Pre 11/20/2023 2:	
				e XIX	Hospital	PPS	
	Cost Center Description	Capital	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	1	1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	5,473,852					50.00
51.00	05100 RECOVERY ROOM	411,642	22,393,835				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	354,013	4,440,378			3,302	52.00
53.00	05300 ANESTHESIOLOGY	19,731	36,989,116				53.00
	05400 RADIOLOGY-DIAGNOSTIC	1,089,308	77,569,910			· · ·	
	05500 RADIOLOGY - THERAPEUTIC	96,009				- 1	55.00
56.00	05600 RADIOISOTOPE	147,673	20,937,597		- ,		56.00
57.00	05700 CT SCAN	684,240				3,364	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	432,353	, ,		-,		58.00
59.00	05900 CARDIAC CATHETERIZATION	1,063,018	104,954,817				59.00
60.00	06000 LABORATORY	439,601	145,157,229				60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	87,616	6,353,495				63.00
64.00	06400 INTRAVENOUS THERAPY	66,852	4,913,372			0	64.00
65.00	06500 RESPIRATORY THERAPY	192,359	14,578,814	0.01319	134,716	1,777	65.00
66.00	06600 PHYSICAL THERAPY	472,857	21,161,708	0.02234	32,880	735	66.00
67.00	06700 OCCUPATIONAL THERAPY	49,408	6,782,358	0.00728	21,309	155	67.00
68.00	06800 SPEECH PATHOLOGY	76,110	2,819,061	0.02699	23,081	623	68.00
69.00	06900 ELECTROCARDIOLOGY	274,745	42,477,500	0.00646	218,906	1,416	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	83,442	11,537,516	0.00723	26,997	195	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	74,498	33,864,594	0.00220	162,214	357	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	89,164	36,316,479	0.00245	33,373	82	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	409,143	100,254,968	0.00408	1,073,181	4,380	73.00
74.00	07400 RENAL DIALYSIS	12,647	4,806,078	0.00263	160,660	423	74.00
76.97	07697 CARDIAC REHABILITATION	180,960	2,521,880	0.07175	2,330	167	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	447,247	10,302,451	0.04341	.2 0	0	90.00
91.00	09100 EMERGENCY	611,036	121,699,339	0.00502	344,896	1,732	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	276,579	16,548,470	0.01671	33,157	554	
200.00	Total (lines 50 through 199)	13,616,103	1,195,824,812		4,554,958	41,892	200.00

Health Financial Systems	ST. MARY MEDICAL	L CENTER, INC.		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 07/01/2022 To 06/30/2023		
			le XIX	Hospital	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdowr Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1 10	1.00	27	2.00	3.00	
30.00 03000 ADULTS & PEDIATRICS	0	C	)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	ĺ		0 0	o o	
41.00 04100 SUBPROVIDER - IRF	0	l d		0 0	0	41.00
43.00   04300   NURSERY	0	l c		0	0	43.00
200.00 Total (lines 30 through 199)	0	C		0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS			24.52	- 0.00	107	20.00
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT	0		34,52 5,37			
41.00   04100   SUBPROVIDER - IRF	0		4,98			
43.00   04300   NURSERY	0		1,32			
200.00 Total (lines 30 through 199)					1	200.00
Cost Center Description	Inpatient		70,20	<u>J</u>	304	200.00
cost center beset iperon	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
TARRATTENT POLITING CERVICE COST CENTERS	9.00					

30.00 31.00 41.00 43.00 200.00

30.00 | 03000 | ADULTS & PEDIATRICS | 03100 | O3100 | INTENSIVE CARE UNIT | 04100 | O4400 | SUBPROVIDER - IRF | 043.00 | O4300 | O4300

Health Financial Systems

ST. MARY MEDICAL CENTER, INC.

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

THROUGH COSTS

ST. MARY MEDICAL CENTER, INC.

In Lieu of Form CMS-2552-10

Period: From 07/01/2022 Form 06/30/2023 Date/Time Prepared:

				7	To 06/30/2023	Date/Time Pre 11/20/2023 2:	
			Titl	e XIX	Hospital	PPS	
	Cost Center Description	Non Physician	Nursing	Nursing	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATING ROOM	0	0		0	0	50.00
	05100 RECOVERY ROOM	0	0	(	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52.00
	05300 ANESTHESIOLOGY	0	0	(	0	0	53.00
	05400 RADIOLOGY-DIAGNOSTIC	0	0	(	0	0	54.00
	05500 RADIOLOGY - THERAPEUTIC	0	0	(	0	0	55.00
	05600 RADIOISOTOPE	0	0	(	0	0	56.00
	05700 CT SCAN	0	0	(	0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(	0	0	58.00
	05900 CARDIAC CATHETERIZATION	0	0	(	0	0	59.00
	06000 LABORATORY	0	0	(	0	0	60.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	(	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	(	0	0	64.00
	06500 RESPIRATORY THERAPY	0	0	(	0	0	65.00
	06600 PHYSICAL THERAPY	0	0	(	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	(	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	(	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0	71.00
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 DIALYSIS	0	0	(	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0		0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	(	0	0	90.00
91.00	09100 EMERGENCY	0	0	(	0	372,326	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
200.00	Total (lines 50 through 199)	0	0	(	0	372,326	200.00
	· · ·	•		•	•	•	

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0034	Period:	Worksheet D
THROUGH COSTS			From 07/01/2022	Part IV

THROUG	H COSTS				ro 06/30/2023		pared: 29 pm
			Titl	e XIX	Hospital	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS				_		
	05000 OPERATING ROOM	0	0		184,934,650		
	05100 RECOVERY ROOM	0	0		22,393,835		
	05200 DELIVERY ROOM & LABOR ROOM	0	0		4,440,378		
	05300 ANESTHESIOLOGY	0	0		36,989,116		
	05400 RADIOLOGY-DIAGNOSTIC	0	0		77,569,910		
	05500 RADIOLOGY - THERAPEUTIC	0	0		23,523,213		
	05600 RADIOISOTOPE	0	0		20,937,597		
57.00	05700  CT SCAN	0	0		96,795,911	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		41,190,073	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0		104,954,817	0.000000	59.00
60.00	06000 LABORATORY	0	0		145,157,229	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		6,353,495	0.000000	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0		4,913,372	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0		14,578,814	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0		21,161,708	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		6,782,358	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		2,819,061	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		42,477,500	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		11,537,516	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		33,864,594	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		36,316,479	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		100,254,968	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0		4,806,078	0.000000	74.00
76.97	07697 CARDIAC REHABILITATION	0	0		2,521,880	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	(	10,302,451	0.000000	90.00
91.00	09100 EMERGENCY	0	372,326	372,320	121,699,339	0.003059	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		16,548,470	0.000000	92.00
200.00	Total (lines 50 through 199)	0	372,326	372,320	1,195,824,812		200.00

Health Financial Systems	ST. MARY MEDICAL C	CENTER, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0034		Worksheet D
THROUGH COSTS			From 07/01/2022	Part IV

THROUGH COSTS			Fi	rom 07/01/2022 o 06/30/2023	Part IV Date/Time Pre	nanodi
			10	0 06/30/2023	11/20/2023 2:2	pareu: 29 nm
		Titl	e XIX	Hospital	PPS	
Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	_	Costs (col. 8	•	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	520,854	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	46,760	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	41,417	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	83,665	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	138,831	0	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.000000	35,096	0	0	0	56.00
57.00 05700 CT SCAN	0.000000	475,867	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MI	RI) 0.000000	73,099	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	67,920	0	0	0	59.00
60.00 06000 LABORATORY	0.000000	783,125	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, &	TRANS. 0.000000	20,624	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.000000	134,716	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	32,880	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	21,309	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	23,081	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	218,906	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	26,997	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PA	ATIENT 0.000000	162,214	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	33,373	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	1,073,181	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	160,660	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0.000000	2,330	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
91.00   09100   EMERGENCY	0.003059	344,896	1,055	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTING	T PART 0.000000	33,157	0	0	0	92.00
200.00 Total (lines 50 through 199)		4,554,958	1,055	0	0	200.00
	·					

Related Cost (from Wkst. B, Part II, col. 26)   1.00   1	Provider Co	CN: 15-0034	Period:	Worksheet D	2552
Related Cost (from Wkst. B, Part II, col. 26)   1.00   1	1	LN: 15-0034	From 07/01/2022		
Related Cost (from Wkst. B, Part II, col. 26)   1.00   1	Component C	CCN: 15-T034	To 06/30/2023	Date/Time Pre	pare
Related Cost (from Wkst. B, Part II, col. 26)   1.00   1				11/20/2023 2:	29 p
Related Cost (from Wkst. B, Part II, col. 26)   1.00   1	Titl	e XIX	Subprovider -	PPS	
Related Cost (from Wkst. B, Part II, col. 26)   1.00   1	otal Charges	Datis of Cos	IRF t Inpatient	Capital Costs	
ANCILLARY SERVICE COST CENTERS			Program	(column 3 x	
Part II, col. 26)   1.00     1.00	Part I, col.			column 4)	
ANCILLARY SERVICE COST CENTERS	8)	2)	i. Charges	Corumii 4)	
1.00	0)	2)			
ANCILLARY SERVICE COST CENTERS	2.00	3.00	4.00	5.00	
00 05100 RECOVERY ROOM 411,642 2.00 05200 DELIVERY ROOM & LABOR ROOM 354,013 3.00 05300 ANESTHESIOLOGY 19,731 3.00 05400 RADIOLOGY-DIAGNOSTIC 1,089,308 3.00 05500 RADIOLOGY - THERAPEUTIC 96,009 3.00 05600 RADIOISOTOPE 147,673 3.00 05700 CT SCAN 684,240 3.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 432,353 3.00 05900 CARDIAC CATHETERIZATION 1,063,018 3.00 05900 CARDIAC CATHETERIZATION 439,601 3.00 06300 BLOOD STORING, PROCESSING, & TRANS. 87,616 3.00 06300 BLOOD STORING, PROCESSING, & TRANS. 87,616 3.00 06400 INTRAVENOUS THERAPY 66,852 3.00 06500 RESPIRATORY THERAPY 192,359 3.00 06600 PHYSICAL THERAPY 472,857 3.00 06600 PHYSICAL THERAPY 472,857 3.00 06900 SPECH PATHOLOGY 76,110 3.00 06900 ELECTROCARDIOLOGY 76,110 3.00 06900 ELECTROCARDIOLOGY 274,745 3.00 07000 ELECTROCARDIOLOGY 274,745 3.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 74,498 3.00 07200 IMPL. DEV. CHARGED TO PATIENT 89,164 3.00 07400 RENAL DIALYSIS 12,647 3.07 07697 CARDIAC REHABILITATION 180,960  OUTPATIENT SERVICE COST CENTERS					
0.00   05200   DELIVERY ROOM & LABOR ROOM   354,013   19,731   19,731   10,00   05400   RADIOLOGY - DIAGNOSTIC   1,089,308   10,00   05500   RADIOLOGY - THERAPEUTIC   96,009   147,673   16,000   05500   RADIOLOGY - THERAPEUTIC   96,009   147,673   16,000   05700   CT SCAN   684,240   16,000   05800   MAGNETIC RESONANCE IMAGING (MRI)   432,353   10,00   05900   CARDIAC CATHETERIZATION   1,063,018   10,000   06300   BLOOD STORING, PROCESSING, & TRANS.   87,616   10,000   10,0	184,934,650	0.02959	99 0	0	50
.00 05300 ANESTHESIOLOGY 19,731 .00 05400 RADIOLOGY-DIAGNOSTIC 1,089,308 .00 05500 RADIOLOGY - THERAPEUTIC 96,009 .00 05600 RADIOISOTOPE 147,673 .00 05700 CT SCAN 684,240 .00 05800 MAGNETIC RESONANCE IMAGING (MRI) 432,353 .00 05900 CARDIAC CATHETERIZATION 1,063,018 .00 06000 LABORATORY 439,601 .00 06300 BLOOD STORING, PROCESSING, & TRANS. 87,616 .00 06400 INTRAVENOUS THERAPY 66,852 .00 06500 RESPIRATORY THERAPY 192,359 .00 06600 PHYSICAL THERAPY 472,857 .00 06600 PHYSICAL THERAPY 49,408 .00 06800 SPEECH PATHOLOGY 76,110 .00 06900 ELECTROCARDIOLOGY 274,745 .00 07000 ELECTROCARDIOLOGY 274,745 .00 07000 ELECTROCARDIOLOGY 274,745 .00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 74,498 .00 07200 IMPL. DEV. CHARGED TO PATIENT 89,164 .00 07400 RENAL DIALYSIS 12,647 .07697 CARDIAC REHABILITATION 180,960 .00 OUTPATIENT SERVICE COST CENTERS	22,393,835	0.01838	32 0	0	51
.00 05400 RADIOLOGY-DIAGNOSTIC 1,089,308 .00 05500 RADIOLOGY - THERAPEUTIC 96,009 .00 05600 RADIOISOTOPE 147,673 .00 05700 CT SCAN 684,240 .00 05800 MAGNETIC RESONANCE IMAGING (MRI) 432,353 .00 05900 CARDIAC CATHETERIZATION 1,063,018 .00 06000 LABORATORY 439,601 .00 06300 BLOOD STORING, PROCESSING, & TRANS. 87,616 .00 06400 INTRAVENOUS THERAPY 66,852 .00 06500 RESPIRATORY THERAPY 192,359 .00 06600 PHYSICAL THERAPY 472,857 .00 06600 PHYSICAL THERAPY 472,857 .00 06800 SPEECH PATHOLOGY 76,110 .00 06800 SPEECH PATHOLOGY 274,745 .00 07000 ELECTROCARDIOLOGY 274,745 .00 07000 ELECTROCARDIOLOGY 274,745 .00 07000 ELECTROCARDIOLOGY 274,745 .00 07000 IMPL. DEV. CHARGED TO PATIENT 74,498 .00 07300 DRUGS CHARGED TO PATIENTS 409,143 .00 07400 RENAL DIALYSIS 12,647 .07697 CARDIAC REHABILITATION 180,960  OUTPATIENT SERVICE COST CENTERS	4,440,378	0.07972	26 0	0	52
.00         05500         RADIOLOGY - THERAPEUTIC         96,009           .00         05600         RADIOISOTOPE         147,673           .00         05700         CT SCAN         684,240           .00         05800         MAGNETIC RESONANCE IMAGING (MRI)         432,353           .00         05900         CARDIAC CATHETERIZATION         1,063,018           .00         06000         LABORATORY         439,601           .00         06300         BLOOD STORING, PROCESSING, & TRANS.         87,616           .00         06400         INTRAVENOUS THERAPY         66,852           .00         06500         RESPIRATORY THERAPY         192,359           .00         06600         PHYSICAL THERAPY         472,857           .00         06700         OCCUPATIONAL THERAPY         472,857           .00         06800         SPEECH PATHOLOGY         76,110           .00         06800         SPEECH PATHOLOGY         274,745           .00         07000         ELECTROCARDIOLOGY         274,745           .00         07000         ELECTROCARDIOLOGY         274,749           .00         07100         MEDICAL SUPPLIES CHARGED TO PATIENT         74,498           .00	36,989,116	0.00053	33 0	0	53
.00 05600 RADIOISOTOPE 147,673 .00 05700 CT SCAN 684,240 .00 05800 MAGNETIC RESONANCE IMAGING (MRI) 432,353 .00 05900 CARDIAC CATHETERIZATION 1,063,018 .00 06000 LABORATORY 439,601 .00 06300 BLOOD STORING, PROCESSING, & TRANS. 87,616 .00 06400 INTRAVENOUS THERAPY 66,852 .00 06500 RESPIRATORY THERAPY 192,359 .00 06600 PHYSICAL THERAPY 472,857 .00 06700 OCCUPATIONAL THERAPY 49,408 .00 06800 SPEECH PATHOLOGY 76,110 .00 06900 ELECTROCARDIOLOGY 274,745 .00 07000 ELECTROCARDIOLOGY 83,442 .00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 74,498 .00 07200 IMPL. DEV. CHARGED TO PATIENT 89,164 .00 07300 DRUGS CHARGED TO PATIENTS 409,143 .00 07400 RENAL DIALYSIS 12,647 .07 07697 CARDIAC REHABILITATION 180,960 .00 UTPATIENT SERVICE COST CENTERS	77,569,910	0.01404	13 0	0	54
.00 05700 CT SCAN 684,240 .00 05800 MAGNETIC RESONANCE IMAGING (MRI) 432,353 .00 05900 CARDIAC CATHETERIZATION 1,063,018 .00 06000 LABORATORY 439,601 .00 06300 BLOOD STORING, PROCESSING, & TRANS. 87,616 .00 06400 INTRAVENOUS THERAPY 66,852 .00 06500 RESPIRATORY THERAPY 192,359 .00 06600 PHYSICAL THERAPY 472,857 .00 06700 OCCUPATIONAL THERAPY 472,857 .00 06800 SPEECH PATHOLOGY 76,110 .00 06800 SPEECH PATHOLOGY 76,110 .00 06900 ELECTROCARDIOLOGY 274,745 .00 07000 ELECTROCARDIOLOGY 274,745 .00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 74,498 .00 07200 IMPL. DEV. CHARGED TO PATIENT 89,164 .00 07300 DRUGS CHARGED TO PATIENTS 409,143 .00 07400 RENAL DIALYSIS 12,647 .97 07697 CARDIAC REHABILITATION 180,960 .00 OUTPATIENT SERVICE COST CENTERS	23,523,213	0.00408	31 0	0	5.5
.00	20,937,597	0.0070	53 0	0	56
.00         05900 CARDIAC CATHETERIZATION         1,063,018           .00         06000 LABORATORY         439,601           .00         06300 BLOOD STORING, PROCESSING, & TRANS.         87,616           .00         06400 INTRAVENOUS THERAPY         66,852           .00         06500 RESPIRATORY THERAPY         192,359           .00         06600 PHYSICAL THERAPY         472,857           .00         06700 OCCUPATIONAL THERAPY         49,408           .00         06700 OCCUPATIONAL THERAPY         76,110           .00         06800 SPEECH PATHOLOGY         274,745           .00         06900 ELECTROCARDIOLOGY         274,745           .00         07000 ELECTROENCEPHALOGRAPHY         83,442           .00         07100 MEDICAL SUPPLIES CHARGED TO PATIENT         74,498           .00         07200 IMPL. DEV. CHARGED TO PATIENTS         89,164           .00         07300 DRUGS CHARGED TO PATIENTS         409,143           .00         07400 RENAL DIALYSIS         12,647           .97         07697 CARDIAC REHABILITATION         180,960           OUTPATIENT SERVICE COST CENTERS	96,795,911	0.0070	59 0	0	57
.00	41,190,073	0.01049	97 0	0	58
.00 06300 BLOOD STORING, PROCESSING, & TRANS. 87,616 .00 06400 INTRAVENOUS THERAPY 66,852 .00 06500 RESPIRATORY THERAPY 192,359 .00 06600 PHYSICAL THERAPY 472,857 .00 06700 OCCUPATIONAL THERAPY 49,408 .00 06800 SPECH PATHOLOGY 76,110 .00 06900 ELECTROCARDIOLOGY 274,745 .00 07000 ELECTROCARDIOLOGY 83,442 .00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 74,498 .00 07200 IMPL. DEV. CHARGED TO PATIENT 89,164 .00 07300 DRUGS CHARGED TO PATIENTS 409,143 .00 07400 RENAL DIALYSIS 12,647 .97 07697 CARDIAC REHABILITATION 180,960 .00 OUTPATIENT SERVICE COST CENTERS	104,954,817	0.01012		0	59
.00     06400 INTRAVENOUS THERAPY     66,852       .00     06500 RESPIRATORY THERAPY     192,359       .00     06600 PHYSICAL THERAPY     472,857       .00     06700 OCCUPATIONAL THERAPY     49,408       .00     06800 SPEECH PATHOLOGY     76,110       .00     06900 ELECTROCARDIOLOGY     274,745       .00     07000 ELECTROENCEPHALOGRAPHY     83,442       .00     07100 MEDICAL SUPPLIES CHARGED TO PATIENT     74,498       .00     07200 IMPL. DEV. CHARGED TO PATIENTS     89,164       .00     07300 DRUGS CHARGED TO PATIENTS     409,143       .00     07400 RENAL DIALYSIS     12,647       .97     07697 CARDIAC REHABILITATION     180,960       OUTPATIENT SERVICE COST CENTERS	145,157,229		. ,	27	60
.00 06500 RESPIRATORY THERAPY 192,359 .00 06600 PHYSICAL THERAPY 472,857 .00 06700 OCCUPATIONAL THERAPY 49,408 .00 06800 SPEECH PATHOLOGY 76,110 .00 06900 ELECTROCARDIOLOGY 274,745 .00 07000 ELECTROCARDIOLOGY 83,442 .00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 74,498 .00 07200 IMPL. DEV. CHARGED TO PATIENTS 89,164 .00 07300 DRUGS CHARGED TO PATIENTS 409,143 .00 07400 RENAL DIALYSIS 12,647 .07 07697 CARDIAC REHABILITATION 180,960 .00 OUTPATIENT SERVICE COST CENTERS	6,353,495			0	63
.00 06600 PHYSICAL THERAPY 472,857 .00 06700 OCCUPATIONAL THERAPY 49,408 .00 06800 SPEECH PATHOLOGY 76,110 .00 06900 ELECTROCARDIOLOGY 274,745 .00 07000 ELECTROENCEPHALOGRAPHY 83,442 .00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 74,498 .00 07200 IMPL. DEV. CHARGED TO PATIENTS 89,164 .00 07300 DRUGS CHARGED TO PATIENTS 409,143 .00 07400 RENAL DIALYSIS 12,647 .97 07697 CARDIAC REHABILITATION 180,960 .00 UTPATIENT SERVICE COST CENTERS	4,913,372	0.01360		0	64
.00         06700         OCCUPATIONAL THERAPY         49,408           .00         06800         SPEECH PATHOLOGY         76,110           .00         06900         ELECTROCARDIOLOGY         274,745           .00         07000         ELECTROENCEPHALOGRAPHY         83,442           .00         07100         MEDICAL SUPPLIES CHARGED TO PATIENT         74,498           .00         07200         IMPL. DEV. CHARGED TO PATIENTS         89,164           .00         07300         DRUGS CHARGED TO PATIENTS         409,143           .00         07400         RENAL DIALYSIS         12,647           .97         07697         CARDIAC REHABILITATION         180,960           OUTPATIENT SERVICE COST CENTERS	14,578,814				
.00 06800 SPEECH PATHOLOGY 76,110 .00 06900 ELECTROCARDIOLOGY 274,745 .00 07000 ELECTROENCEPHALOGRAPHY 83,442 .00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 74,498 .00 07200 IMPL. DEV. CHARGED TO PATIENTS 89,164 .00 07300 DRUGS CHARGED TO PATIENTS 409,143 .00 07400 RENAL DIALYSIS 12,647 .97 07697 CARDIAC REHABILITATION 180,960 .00 OUTPATIENT SERVICE COST CENTERS	21,161,708				
.00     06900     ELECTROCARDIOLOGY     274,745       .00     07000     ELECTROENCEPHALOGRAPHY     83,442       .00     07100     MEDICAL SUPPLIES CHARGED TO PATIENT     74,498       .00     07200     IMPL. DEV. CHARGED TO PATIENTS     89,164       .00     07300     DRUGS CHARGED TO PATIENTS     409,143       .00     07400     RENAL DIALYSIS     12,647       .97     07697     CARDIAC REHABILITATION     180,960       OUTPATIENT SERVICE COST CENTERS	6,782,358	0.00728	19,960		
.00     07000     ELECTROENCEPHALOGRAPHY     83,442       .00     07100     MEDICAL SUPPLIES CHARGED TO PATIENT     74,498       .00     07200     IMPL. DEV. CHARGED TO PATIENTS     89,164       .00     07300     DRUGS CHARGED TO PATIENTS     409,143       .00     07400     RENAL DIALYSIS     12,647       .97     07697     CARDIAC REHABILITATION     180,960       OUTPATIENT SERVICE COST CENTERS	2,819,061	0.02699	,	35	
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 74,498 .00 07200 IMPL. DEV. CHARGED TO PATIENTS 89,164 .00 07300 DRUGS CHARGED TO PATIENTS 409,143 .00 07400 RENAL DIALYSIS 12,647 .97 07697 CARDIAC REHABILITATION 180,960 OUTPATIENT SERVICE COST CENTERS	42,477,500			0	
.00   07200   IMPL. DEV. CHARGED TO PATIENTS   89,164   .00   07300   DRUGS CHARGED TO PATIENTS   409,143   .00   07400   RENAL DIALYSIS   12,647   .97   07697   CARDIAC REHABILITATION   180,960   OUTPATIENT SERVICE COST CENTERS	11,537,516			0	
.00 07300 DRUGS CHARGED TO PATIENTS 409,143 .00 07400 RENAL DIALYSIS 12,647 .97 07697 CARDIAC REHABILITATION 180,960 OUTPATIENT SERVICE COST CENTERS	33,864,594	0.00220		l .	
.00   07400   RENAL DIALYSIS   12,647	36,316,479			0	
.97 07697 CARDIAC REHABILITATION 180,960 OUTPATIENT SERVICE COST CENTERS	100,254,968		,	l	
OUTPATIENT SERVICE COST CENTERS	4,806,078			5	74
	2,521,880	0.0717	56 0	0	76
.00  09000 CLINIC   447.247	10 202 454	0.0121	12		
	10,302,451				
.00   09100   EMERGENCY   611,036	121,699,339				
.00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0   0.00   Total (lines 50 through 199)   13,339,524	16,548,470 1,195,824,812		00 102,799	0 945	

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0034		Worksheet D
THROUGH COSTS		Component CCN 15 T024	From 07/01/2022	

		Component	CCN: 15-T034	То	06/30/2023	Date/Time Prep 11/20/2023 2:2	
		Titl	e XIX	Sub	provider - IRF	PPS	- 1
Cost Center Description	Non Physician	Nursing	Nursing	Al	lied Health	Allied Health	
	Anesthetist	Program	Program	Pos	st-Stepdown		
	Cost	Post-Stepdown		A	djustments		
		Adjustments					
	1.00	2A	2.00		3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	1	0	0	0	50.00
51.00   05100   RECOVERY ROOM	0	0	1	0	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	0	52.00
53.00   05300   ANESTHESIOLOGY	0	0	1	0	0	0	53.00
54.00   05400 RADIOLOGY-DIAGNOSTIC	0	0	1	0	0	0	54.00
55.00   05500 RADIOLOGY - THERAPEUTIC	0	0	1	0	0	0	55.00
56.00   05600 RADIOISOTOPE	0	0	1	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   CARDIAC CATHETERIZATION	0	0		0	0	0	59.00
60.00   06000   LABORATORY	0	0		0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	1	0	0	0	63.00
64.00   06400   INTRAVENOUS THERAPY	0	0		0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0		0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	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 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0		0	0	0	90.00
91.00   09100   EMERGENCY	0	0	1	0	0	372,326	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	92.00
200.00 Total (lines 50 through 199)	0	0	1	0	0	372,326	200.00

Health	Financial Systems	ST. MARY MEDICAI	CENTER THE		Tn Lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN: 15-0034	Period:	Worksheet D	2332 10
	COSTS	KVICE OTHER PAS			From 07/01/2022 To 06/30/2023	Part IV	
			Titl	e XIX	Subprovider -	PPS	
					IRF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from WkstC,		
		Education Cost	' ' '	Cost (sum of	,	(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	5.00	5 00	7.00	instructions)	
		4.00	5.00	6.00	7.00	8.00	
FO 00	ANCILLARY SERVICE COST CENTERS	1			0 104 024 650	0.000000	F0 00
50.00	05000 OPERATING ROOM	0	1		0 184,934,650		
	05100 RECOVERY ROOM	0	0		0 22,393,835		
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 4,440,378		
53.00	05300 ANESTHESIOLOGY	0	0		0 36,989,116 0 77,569,910	<b>l</b>	
	05400 RADIOLOGY-DIAGNOSTIC	0	0		,505,510		
56.00	05500 RADIOLOGY - THERAPEUTIC 05600 RADIOISOTOPE	0	0		0 23,523,213 0 20,937,597		
57.00	05700 CT SCAN	0	0		0 20,937,397		
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 41,190,073		
	05900 CARDIAC CATHETERIZATION	0	0		0 104,954,817		
60.00	06000 LABORATORY	0	0		0 145,157,229		
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0			0 6,353,495		
	06400 INTRAVENOUS THERAPY	0			0 4,913,372	0.000000	
65.00	06500 RESPIRATORY THERAPY	0	١		0 14,578,814		
66.00	06600 PHYSICAL THERAPY	0	١		0 21,161,708		
	06700 OCCUPATIONAL THERAPY	0	0		0 6,782,358		
	06800 SPEECH PATHOLOGY	0	0		0 2,819,061		1
69.00	06900 ELECTROCARDIOLOGY	0	0		0 42,477,500		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 11,537,516		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 33,864,594		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	ĺ		0 36,316,479		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	ĺ		0 100,254,968		
	07400 RENAL DIALYSIS	0	Ö		0 4,806,078		
	07697 CARDIAC REHABILITATION	0	Ö		0 2,521,880		
	OUTPATIENT SERVICE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,		1
90.00	09000 CLINIC	0	0		0 10,302,451	0.000000	90.00
91.00	09100 EMERGENCY	0	372,326	372,32			91.00
	00200 ORSERVATION PEDS (NON-DISTINCT DART	0			0 16 548 470		

0 0 0

372,326

0.000000 92.00 200.00

372,326 121,699,339 0 16,548,470 372,326 1,195,824,812

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS		From 07/01/2022	
		Title VIV	Subprovider -	DDC

			Titl	e XIX	Subprovider - IRF	PPS	<u> </u>
	Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
	, , , , , , , , , , , , , , , , , , ,	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.	<b>.</b>	Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.000000	0	(	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0		0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0		0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0		0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0		0	0	56.00
57.00	05700 CT SCAN	0.000000	0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0		0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0		0	0	59.00
60.00	06000 LABORATORY	0.000000	8,830		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	0		0	0	63.00
	06400 INTRAVENOUS THERAPY	0.000000	0		0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	5,522		0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	21,956		0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	19,960		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	1,290		0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0		0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,055		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	39,224		0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	1,962		0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0		0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	0	(	0	0	90.00
91.00	09100 EMERGENCY	0.003059	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0	0	92.00
200.00	Total (lines 50 through 199)		102,799	(	0	0	200.00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034	From 07/01/2022	Worksheet D-1 Date/Time Prepared: 11/20/2023 2:29 pm
		Title XVIII	Hospital	PPS

PART I - ALL PROVIDER COMPONENTS   1.00			Title XVIII	Hospital	11/20/2023 2: PPS	29 pm
NAME		Cost Center Description	THE AVIII	nospi cai		
DIRAPTIENT DAYS  1.00  1		DART T - ALL PROVIDER COMPONENTS			1.00	
2.00 Impatient days (including private room days, excluding swing-bed and newborn days) 0 Private room days (excluding swing-bed and observation bed days). If you have only private room days. 29,980 4.00 3.00 Private room days (excluding swing-bed and observation bed days). 3.00 The private room days (excluding swing-bed and observation bed days) through becember 31 of the cost reporting period (if calendar year, enter 0 on this line). 3.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 3.00 Total swing-bed SNF (calendar year, enter 0 on this line). 3.01 Total swing-bed SNF (calendar year, enter 0 on this line). 3.02 Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 3.01 Total sing-bed SNF type inpatient days (including private room days) after becamber 31 of the cost reporting period (if calendar year, enter 0 on this line). 3.02 Swing-bed SNF type inpatient days applicable to title VXIII only (including private room days). 3.03 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line). 3.03 Swing-bed SNF type inpatient days applicable to titles VVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line). 3.04 Swing-bed KF type inpatient days applicable to titles VVIII only (including private room days) after becember 31 of the cost reporting period (including private room days). 3.00 Swing-bed KF type inpatient days applicable to titles VVIII only (including private room days). 3.00 Swing-bed KF type inpatient days applicable to titles VVIII only (including private room days). 3.00 Swing-bed KF type inpatient days applicable to Swing-bed Swing-bed days). 3.00 Swing-bed KF type inpatient days applicable t						
private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days)  5.00 Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  8.00 Total swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (it allendar year, enter 0 on this line)  8.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (it allendar year, enter 0 on this line)  8.00 Excember 31 of the cost reporting period (it allendar year, enter 0 on this line)  8.00 Excember 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Excember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Excember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Excember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Excember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Excember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Excember 31 of the cost reporting period (if cal		, , , , , , , , , , , , , , , , , , , ,	,			
do not complete this line.  4.0 Semi-private room days (excluding swing-bed and observation bed days)  5.00 Total swing-bed SNE type inpatient days (including private room days) after December 31 of the cost  7.00 Total swing-bed SNE type inpatient days (including private room days) after December 31 of the cost  7.00 reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed SNE type inpatient days (including private room days) after December 31 of the cost  7.00 Total swing-bed of type inpatient days (including private room days) after December 31 of the cost  8.00 Total swing-bed of type inpatient days (including private room days) after December 31 of the cost  7.00 Total swing-bed SNE type inpatient days (including private room days) after December 31 of the cost  8.00 Total inpatient days including private room days applicable to this line)  9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  9.00 Swing-bed SNE type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNE type inpatient days applicable to titles after the program (excluding swing-bed and newborn days) (see instructions)  10.00 Swing-bed SNE type inpatient days applicable to titles VVIII only (including private room days)  10.00 Swing-bed NE type inpatient days applicable to titles V or XXX only (including private room days)  10.00 Swing-bed NE type inpatient days applicable to titles V or XXX only (including private room days)  10.00 Swing-bed NE type inpatient days applicable to titles V or XXX only (including private room days)  10.00 Swing-bed NE type inpatient days applicable to titles V or XXX only (including private room days)  10.00 Swing-bed NE type inpatient days applicable to services applicable to service shrough December 31 of the cost  10.00 Total swing-bed NE type inpatient days applicable to services after December 31 of the cost  10.00 Total swing-bed NE type inpatient days app					·	
3.00   Semi-private room days (excluding swing-bed and observation bed days)   29,980   4.00	3.00		ys). It you have only pr	ivate room days,	0	3.00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 reporting period (if calendar year, enter 0 on this line) 9.00 Total singuished SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after of through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after obscibled in the proposed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Nover year days (title V or XIX only) 13.00 Nover year days (title V or XIX only) 13.00 Nover year days (title V or XIX only) 13.00 Nover year days (title V or XIX only) 13.00 Nover year year year year year year year ye	4.00		ed days)		29,980	4.00
rotal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11.00 Swing-bed NF type inpatient days applicable to title swing private room days)  11.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  16.00 Nuercy days (title V or XIX only)  17.00 Medicar rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  18.00 Medicar rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room cost applicable to NF type services after December 31 of the cost reporting period (including private room cost applicable t	5.00		om days) through Decembe	r 31 of the cost	0	5.00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost 8.00 Total sings-bed Mr (fr calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborm days) (fr calendar year, enter 0 on this line) 10.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) of through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 0 pecember 31 of the cost reporting period (see instructions) 12.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 0 pecember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed North propartient days applicable to titles V or XXX only (including private room days) 12.00 Swing-bed North propartient days applicable to titles V or XXX only (including private room days) 13.00 Swing-bed North propartient days applicable to titles V or XXX only (including private room days) 14.00 Medically necessary private room days applicable to XXX only (including private room days) 15.00 Total nursery days (title V or XXX only) 16.00 Nursery days (title V or XXX only) 17.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost 0.00 15.00 reporting period (including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 reporting period (including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 reporting period (including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 0 2.00 Total private room days d	6 00		om days) after December	21 of the cost	0	6 00
7.00 rotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost rotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line) rotal inpatient days including private room days applicable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days applicable to the program (excluding swing-bed and private room days) through December 31 of the cost reporting period (see instructions) rotal private room days) after becember 31 of the cost reporting period (see instructions) rotal private room days) after becember 31 of the cost reporting period (see instructions) rotal private room days) after becember 31 of the cost reporting period (see instructions) rotal private room days) rotal private room days applicable to titles V or XIX only (including private room days) private room days) rotal private room days applicable to titles V or XIX only (including private room days) rotal private room days applicable to the Program (excluding swing-bed days) rotal rotal private room days applicable to the Program (excluding swing-bed days) rotal rotal private room days applicable to services through December 31 of the cost reporting period reporting period rotal private room days applicable to services after December 31 of the cost reporting period reporting period rotal private room days applicable to services after December 31 of the cost reporting period reporting period rotal private room days applicable to services after December 31 of the cost reporting period reporting period rotal private room days applicable to services after December 31 of the cost reporting period (line rotal private room days applicable to services after December 31 of the cost reporting period (line rotal private room days applicable to SNF type services through December 31 of the cost reporting period (line rotal private room cost differential rotal	0.00		on days) arter becember	of of the cost	0	0.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost roporting period (if Calendar year, enter 0 on this line)	7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7.00
reporting period (if calendar year, enter 0 on this line)  10.00 trianghatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10.00 swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11.00 swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  11.00 swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  12.00 swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 swing-bed NF type inpatient days applicable to title X or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Nursery days (title v or XIX only)  17.00 SWING BED ADJUSTMENT  17.00 SWING BED ADJUSTMENT  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost cost cost in the cost reporting period (incare rate for swing-bed SNF services applicable to services after December 31 of the cost cost in the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost cost (incare rate for swing-bed NF services applicable to services after December 31 of the cost cost (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 via swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 via swing-bed Cost applicable to SNF type services through December 31 of the cost reporting period (line 6 via swing-bed Cost ap	8.00		n davs) after December 3	L of the cost	0	8.00
newborn days) (see instructions)  10.00 swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) at through December 31 of the cost reporting period (see instructions)  11.00 swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Swing-Bed NF type Swing-bed SNF services applicable to services strough becember 31 of the cost reporting period (including Swing-bed days)  17.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including Swing-bed SNF services)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including Swing-bed SNF services)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including Swing-bed SNF services)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including Swing-bed SNF services)  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including Swing-bed SNF services)  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line SNF type services)  19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line SNF type services)  29.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line S		reporting period (if calendar year, enter 0 on this line)				
10.00   Swring-bed SNR type inpatient days applicable to title XXIII only (including private room days)   10.00	9.00		o the Program (excluding	swing-bed and	11,226	9.00
11.00   Swing-bed SNR type inpatient days applicable to title XVIII only (including private room days) after   December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00   13.	10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00   Synop-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   0   12.00     13.00   Synop-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   0   13.00     15.00   After December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   14.00     15.00   Total nursery days (title V or XIX only)   0   15.00     15.00   Total nursery days (title V or XIX only)   0   15.00     16.00   Nursery days (title V or XIX only)   0   16.00     17.00   More of the Cost of Synophy of the Victor of Synophy of the Cost of Preporting period (incore rate for Swing-bed SNF services applicable to services after December 31 of the cost   0.00   17.00     18.00   More of Synophy of Synop	11 00			oom days) aften	0	11 00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 19)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost (nee 20 still period swing-bed cost reporting period (line 8 x line 29)  28.00 General inpatient routine service cost need swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost need swing-bed cost (line 27 +	11.00			Join days) arter	0	11.00
31.00   Swing-bed NF type inpatient days applicable to titles v or XIX only (including private room days)   13.00   13.00   14.00   14.00   15.00   16.00   10.01	12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Motically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00  17.00 SWING BED ADJUSTMENT  17.00 Moticare rate for swing-bed SNF services applicable to services through December 31 of the cost  17.00 reporting period  18.00 Moticare rate for swing-bed SNF services applicable to services after December 31 of the cost  18.00 Moticare rate for swing-bed SNF services applicable to services through December 31 of the cost  18.00 reporting period  18.00 reporting period  29.00 Moticaid rate for swing-bed NF services applicable to services after December 31 of the cost  29.00 Moticaid rate for swing-bed NF services applicable to services after December 31 of the cost  29.00 Swing-bed cost applicable to SNF type services through December 31 of the cost  29.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line S x line 17)  29.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line S x line 18)  29.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line S x line 18)  29.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line S x line 18)  29.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line S x line 20)  29.00 Total swing-bed cost (see instructions)  20.00 Total swing-bed cost (see charges (excluding swing-bed and observation bed charges)  20.00 Total swing-bed cost (see charges (excluding swing-bed charges)  20.00 Total swing-bed cost (see charges (excluding swing-bed charges)  20.00 Note of the cost reporting period (line S x line 31)  20.00 Semi-private room charges (	12 00		v only (including privat	noom days)	0	12 00
Total nursery days (title v or xxx only)  15.00  16.00  16.00  17.00  18	13.00				0	13.00
16.00   Nursery days (title V or XIX only)   16.00   16.00   SYME RED ADJUSTMENT     17.00   17.00   17.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   19.00   18.00   19.00			am (excluding swing-bed	days)		
SWTNO BED ADJUSTMENT  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 reporting period wedicard rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 reporting period reporting period swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period reporting services applicable to SNF type services through December 31 of the cost reporting period reporting						
reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost one period reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost one period reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (1.00 Total general inpatient routine service cost (see instructions)  21.00 Total general inpatient routine services through December 31 of the cost reporting period (1.00 Ex. Value 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (1.00 Ex. Value 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (1.00 Ex. Value 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (1.00 Ex. Value 19)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (1.00 Ex. Value 19)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost (1.00 Ex. Value 2.00 Ex.	10.00				0	16.00
18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19.00   19.	17.00		es through December 31 o	f the cost	0.00	17.00
Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   20	18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 7 total general inpatient routine service cost (see instructions) 36,984,372 21.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 36,984,372 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 36,984,372 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 36.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 29.00 Average private room per diem charge (line 29 + line 3) 0.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31.00 32.00 Average per diem private room per diem charge (line 30 + line 4) 0.00 33.00 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 36.00 Private room cost differential (line 3 x line 35) 0.00 Private room cost differential adjustment (line 3 x line 35) 0.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 36.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 General inpatient routine service	19.00	' 3'	s through December 31 of	the cost	0.00	19.00
reporting period  Total general inpatient routine service cost (see instructions)  22.00  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  X line 18)  25.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  O Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  30.00  31.00  32.00  Average private room per diem charge (line 29 ÷ line 3)  Average per diem private room per diem charge (line 30 ÷ line 4)  34.00  Average per diem private room cost differential (line 32 minus line 33)(see instructions)  37.00  Average per diem private room cost differential (line 32 minus line 33)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 32 minus line 33)(see instructions)  37.00  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 36,984,372)  Adjusted general inpatient routine service cost ter of them (see instructions)  1.071.23  38.00  Adjusted general inpatient routine service cost ter to the Program (line 14 x line 35)  0 40.00  Medical	20.00		s after December 31 of t	ne cost	0.00	20.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 PRIVATE ROOM DIFFERNIAL ADJUSTMENT  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average per ivate room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  37.00 Forevar one cost differential adjustment (line 3 x line 31)  38.00 Average per diem private room cost differential (line 3 x line 31)  38.00 Applicable to the Program (line 14 x line 35)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		reporting period				
5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 ÷ line 3)  31.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Average per diem private room cost differential (line 34 x line 31)  34.00 Average per diem private room cost differential (line 3 x line 35)  35.00 Private room cost differential adjustment (line 3 x line 35)  36.00 PRAT II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM IMPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost diplicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				ing period (line		
x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00  29.00  30.00  29.00  30.00  30.00  31.00  General inpatient routine service charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  30.00  31.00  32.00  34.00  34.00  Average private room per diem charge (line 29 + line 3)  34.00  Average semi-private room charge differential (line 32 minus line 33)(see instructions)  35.00  36.00  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  36.00  37.00  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36.00 average per diem private room cost differential (line 3 x line 31)  Private room cost differential adjustment (line 3 x line 35)  Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 36.00 average)  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00  40.00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00  40.00  40.00  40.00  40.00	22.00		or the cost report	ing period (Time	Ü	22.00
24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)   24.00   25.00   x line 20)   25.00   x line 20)   26.00   Total swing-bed cost (see instructions)   26.00	23.00		31 of the cost reporting	g period (line 6	0	23.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions) 0 26.00  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 36,984,372  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00  29.00 Private room charges (excluding swing-bed charges) 0 29.00  30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00  32.00 Average private room per diem charge (line 30 ÷ line 3) 0.00  33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 0.00 35.00  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36)  Private room cost differential adjustment (line 3 x line 35) 0 36.00  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 12,025,628 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.00
Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  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 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 33)  Average per diem private room cost differential (line 3 x line 33)  Average per diem private room cost differe	25.00		31 of the cost reporting	period (line 8	0	25.00
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 29 ÷ line 4)  4.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Average per diem private room cost differential (line 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36,984,372)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  27.00 Average per diem private room cost applicable to the Program (line 14 x line 35)				,		
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 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 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36,984,372)  77.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  28.00  40.00			(line 21 minus line 26)		-	
General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  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 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36,984,372)  Throughout the cost of the cost and private room cost differential (line 36,984,372)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  28.00  40.00	27.00		(Title 21 IIITius Title 20)	l	30,964,372	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36,984,372) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 0000000 31.00 0.000 32.00 0.0	28.00		d and observation bed ch	arges)	0	28.00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36,984,372)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.000 0000 32.00  0.000 32.00  0.000 33.00  0.000 34.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 35.00  0.000 36.00						
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36,984,372)  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 36.00 0.0			14 20)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36,984,372)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 33.00  0 0.00 34.00  36.00  37.00 27 minus line 36)  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0.00			: 11ne 28)			
Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36,984,372)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00  34.00  34.00  35.00  36.00  37.00  36.00  36,984,372  37.00  37.00  37.00  37.00  40.00						
Average per diem private room cost differential (line 34 x line 31)  35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36,984,372)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 .00 35.00 36.00 36.00 36.90 37.00 36.90 37.00 36.90 37.00 36.90 37.00 36.90 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 40.00			nus line 33)(see instruc	tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00  36,984,372  37.00  37.00  37.00  37.00  37.00  37.00  37.00  37.00  37.00  37.00  37.00  37.00	35.00	Average per diem private room cost differential (line 34 x line	ne 31)	,		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,071.23 38.00 12,025,628 39.00 40.00	37.00		and private room cost di	fterential (line	36,984,372	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,071.23 38.00 12,025,628 39.00 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  12,025,628 39.00 40.00			JSTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					,	ł
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COMPUT	Financial Systems STATION OF INPATIENT OPERATING COST		Provider Co	CN: 15-0034	In Lie Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Pre	pared
			Title	XVIII	Hospital	11/20/2023 2: PPS	29 pm
	Cost Center Description	Total Inpatient CostI	Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
12.00	NURSERY (title V & XIX only)	0	0				42.0
	Intensive Care Type Inpatient Hospital Units		5 270	4 005	27 4 200	2 252 202	
13.00 14.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	9,802,222	5,370	1,825.	1,289	2,352,902	43.0
15.00	BURN INTENSIVE CARE UNIT						45.0
	SURGICAL INTENSIVE CARE UNIT						46.0
17.00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1.00	
18.00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	line 200)			18,660,782	48.0
18.01	Program inpatient cellular therapy acquisiti			III, line 10	, column 1)	0	1
19.00	Total Program inpatient costs (sum of lines	41 through 48.01	)(see instruc	tions)		33,039,312	49.0
0.00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	ationt nouting o	anvisas (fram	wks+ D su	m of Dants I and	797,823	50.0
0.00	III)	acrent routine s	ervices (IIOII	i wkst. D, su	III OI PAILS I AIIU	797,623	30.0
1.00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	1,045,487	51.0
-2 00	and IV)	FO and F1)				1 042 212	[2 ^
32.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-phy	sician anes+	hetist and	1,843,310 31,196,002	
,,,,,,	medical education costs (line 49 minus line		acca, non pny	STETAIT AIRCS	neerse, and	31,130,002	33.0
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges					-	54.0
55.00	Target amount per discharge Permanent adjustment amount per discharge						55.0
55.02	Adjustment amount per discharge (contractor	use only)					55.0
6.00	Target amount (line 54 x sum of lines 55, 55					0	56.0
7.00	Difference between adjusted inpatient operat	ing cost and tar	get amount (1	ine 56 minus	line 53)	0	
00.8	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	an 1-na FF from	+60 505+ 505		andina 1006	0	58.0
59.00	updated and compounded by the market basket)		the cost repo	orting period	enaing 1996,	0.00	39.0
50.00	Expected costs (lesser of line 53 ÷ line 54,		prior year o	ost report,	updated by the	0.00	60.0
51.00	market basket) Continuous improvement bonus payment (if lin	ne 53 ÷ line 54 i	s less than t	he lowest of:	lines 55 plus	0	61.0
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of th	e amount by w	hich operati	ng costs (line		
52.00	Relief payment (see instructions)					0	
33.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.0
54.00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	ing period (See	0	64.0
	instructions)(title XVIII only)	3		·	3 ,		
55.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportin	g period (See	0	65.0
6.00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 6	4 nlus line 6	SS)(title XVT	TT only): for	0	66.0
	CAH, see instructions	2 2220 (11110 0	p. 35 . The C	., (=, 0, 0, 7, 4, 1	,,, 101	ĺ	55.0
57.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost r	eporting period	0	67.0
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period	0	68.0
-0 00	(line 13 x line 20)		i 67 . 1i	(0)			60 /
59.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.0
70.00	Skilled nursing facility/other nursing facil				)		70.0
71.00	Adjusted general inpatient routine service c		ne 70 ÷ line	2)			71.0
72.00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	(line 14 v li	ne 35)			72.0
4.00	Total Program general inpatient routine serv						74.
5.00	Capital-related cost allocated to inpatient				Part II, column		75.
6 00	26, line 45)	no 3)					70
6.00 7.00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.
8.00	Inpatient routine service cost (line 74 minu						78.
9.00	Aggregate charges to beneficiaries for exces	s costs (from pr					79.
0.00	Total Program routine service costs for comp		st limitation	(line 78 mi	nus line 79)		80.
1.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (1						81.
3.00	Reasonable inpatient routine service costs (						83.
4.00	Program inpatient ancillary services (see in		-				84.
5.00	Utilization review - physician compensation						85.
6.00	Total Program inpatient operating costs (sum		ough 85)				86.
7.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					4,545	87.
			line 2)			1,071.23	1
8.00	Adjusted general inpatient routine cost per	arem (Time 27 .	11110 2)			,	

Health Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider Co		Period:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023	Date/Time Prep 11/20/2023 2:2	
		Title	XVIII	Hospital	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	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	2,100,979	36,984,372	0.05680	7 4,868,740	276,579	90.00
91.00 Nursing Program cost	0	36,984,372	0.00000	4,868,740	0	91.00
92.00 Allied health cost	0	36,984,372	0.00000	4,868,740	0	92.00
93.00 All other Medical Education	0	36,984,372	0.00000	4,868,740	0	93.00

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN:	15-0034 Period: From 07/01/2022	Worksheet D-1
	Component CCN:	To 06/30/2023	Date/Time Prepared: 11/20/2023 2:29 pm
	Title XV	VIII Subprovider -	PPS
		TDE	

		IRF		
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,984	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,984	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only	orivate room days,	0	3.00
	do not complete this line.			
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,984	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December	per 31 of the cost	0	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private room days) after Decembe	21 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	of the cost	U	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December	er 31 of the cost	0	7.00
	reporting period	. 52 0	· ·	1.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			
9.00	Total inpatient days including private room days applicable to the Program (excluding	ng swing-bed and	3,065	9.00
10.00	newborn days) (see instructions)		0	10.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private through December 31 of the cost reporting period (see instructions)	room days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private	room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		· ·	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including priva	ate room days)	0	12.00
	through December 31 of the cost reporting period			
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including priva		0	13.00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this 1			44.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed Total nursery days (title V or XIX only)	d days)	0	14.00 15.00
15.00 16.00			0	16.00
10.00	SWING BED ADJUSTMENT		U	10.00
17.00		of the cost	0.00	17.00
27.100	reporting period	0. 00 0000	0.00	27.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 o	f the cost	0.00	18.00
	reporting period			
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 (	of the cost	0.00	19.00
20.00	reporting period		0.00	20.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of reporting period	the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,260,365	21 00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost repo	rting period (line	0,200,303	22.00
	5 x line 17)	3   1   1		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost report	ing period (line 6	0	23.00
	x line 18)			
24.00		ting period (line	0	24.00
25 00	7 x line 19)	as maniad (line 0	0	25.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reportion (x line 20)	ig period (Tine 8	U	25.00
26.00			0	26.00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	)	5,260,365	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed	charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	
30.00	Semi-private room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	
33.00 34.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instr	ictions)	0.00	
35.00	Average per diem private room charge differential (line 32 minus line 33)(see instri	actions)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost	differential (line	5,260,365	
	27 minus line 36)			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,055.45	
39.00			3,234,954	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		2 224 054	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,234,954	41.00

Health Financial Systems

ST. MARY MEDICAL CENTER, INC.

Provider CCN: 15-0034 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 11/20/2023 2:29 pm |

Cost Center Description | Total | Total | Average Per | Program Days | Program Cost | Total | Tot

Total   Wingser   Program Cost   P				Title	XVIII	Subprovider -	11/20/2023 2:3 PPS	29 pm
		Cook Combon Documentation	T-+-1	T-+-1	A B	IRF	Dun warm Cook	
NUMSERY (TITLE V & XXX only)		Cost Center Description			Diem (col. 1 -		(col. 3 x col.	
Treaselve Care type Inpatient Hospital Units  1.00 INTERS PRICAL CARE LATE  1.00 ONNERS PRICAL CARE (SPECIFY)  1.00 ONNERS SPECIAL CARE (S								
	42.00		0	0	0.00	0	0	42.00
44.00	43 00		٥	٥	0.00	0	0	13 00
45.00   SURPLINTENSIVE CARE UNIT   45.00   47.00   4				o <sub>l</sub>	0.00			
### 46.00    Total Program impatient and International Control Program impatient collular therapy acquisistion cost (Worksheet D-6, Part III, line 10, column 1)								
To set center Description  1.00  1.0								46.00
1.00   1.00   1.00   1.442,707   48.00   1.00   1.442,707   48.00   1.00   1.442,707   48.00   1.00   1.442,707   48.00   1.00   1.442,707   48.00   1.00								47.00
1.442,707   48.00   Program inpatient ancillary service cost (wist. D-3, col. 3, line 200)   1.442,707   48.00   1.442,707		Cost Center Description						
Record   Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)   4,677,681   49,00   Total Program inpatient costs (uno filess 41 Envoyah 48.01)(see instructions)   4,677,681   49,00   Pass ThROUGH COST ADJUSTMENTS   50.00   Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)   50.00   Total Program excludable cost (sum of lines 50 and 51)   50.00   Total Program excludable cost (sum of lines 50 and 51)   50.00   Total Program excludable cost (sum of lines 50 and 51)   50.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   4,438.773   33.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   4,438.773   33.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   4,438.773   33.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   4,438.773   33.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   4,438.773   33.00   Total Program inpatient operating cost and target amount (line 50 minus line 50   55.00   Program and discharge   5.00   55.01   Program anet digistented amount per discharge   5.00   55.01   Program anet digistented amount per discharge   5.00   55.0								
PASS THROUGH COST ADJUSTMENTS  7.00 Total Program excludable cost (sum of lines 50 and 51)  7.00 Total Program excludable cost (sum of lines 50 and 51)  7.00 Total Program excludable cost (sum of lines 50 and 51)  7.00 Part of adjustment and through cost excluding capital related, non-physician anesthetist, and pass pass pass pass pass pass pass pas		, , , , , , , , , , , , , , , , , , , ,	, ,		7: 40	7 4)		
PASS THROUGH COST ADJUSTMENTS  51.00 Pass Through Costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and 172,114 50.00 Filtrough Costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II 66,576 51.00 Filtrough Costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II 66,576 51.00 Filtrough Costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II 66,576 51.00 Filtrough Costs (from parts II 66,576 51.00 Filtrough Costs (from wkst. D, sum of Parts II 66,576 51.00 Filtrough Costs (from ymst. D, sum of Parts II 66,576 51.00 Filtrough Costs (from ymst. D, sum of Parts II 66,576 51.00 Filtrough Costs						column 1)	_	ı
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and 17,314   51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II   66,576   51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II   66,576   51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II   66,576   51.00 Pass through costs (sem of lines 50 and 51)   75.00 Pass and Program and Pass (sem of lines 50 and 51)   76.00 Program discharges	49.00		+1 through 48.01)	(see mstruc	LIONS)		4,077,001	49.00
TII)   Seas through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II   66,976   51.00   and IV)   238,890   52.00   Total Program excludable cost (sum of lines 50 and 51)   238,890   52.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   4,435,771   53.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   4,435,771   53.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   4,435,771   53.00   Total Program inpatient operating cost and target amount per discharge   0.00   55.01   55.00   Target amount per discharge   0.00   55.01   55.00   Target amount (line 34 x sum of lines 35, 55.01, and 55.02)   0.00   55.01   0.00	50.00		atient routine se	rvices (from	Wkst. D. sum	of Parts I and	172.314	50.00
and IV) Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and A,438,771 A400 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and A,438,771 A400 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and A,438,771 A400 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and A,438,771 A400 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and A,438,771 A400 Total Program inpatient operating cost and target amount (line 56 minus line 53) Adjustment amount per discharge (contractor use only) Contract amount (line 54 x sum of lines 55, 55.01, and 55.02) Target amount (line 54 x sum of lines 55, 55.01, and 55.02) Target amount (line 54 x sum of lines 55, 55.01, and 55.02) Total Program excluding cost and target amount (line 56 minus line 53) Contract amount (line 54 x sum of lines 55, 55.01, and 55.02) Contract costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, Continuous improvement bonus payment (il line 53 + line 54 is less than the lowest of lines 55 plus S5.01, or line 59, or line 50, entert the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise experts one see instructions) Continuous improvement bonus payment (see instructions) Continuous improvement bonus payment (s				(11200				
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  TARGET MONNT AND LIMIT COMPUTATION  TARGET MONNT AND LIMIT COMPUTATION  5.00 Program discharges  1.00 S4.00  5.00 Program discharges  1.00 S5.00  5.00 Program about per discharge (contractor use only)  5.00 Program anount per discharge (contractor use only)  6.00 Program anount per discharge (contractor use only)  6.00 Program discharges  6.00 Program anount per discharge (contractor use only)  6.00 Program anount per discharge (contractor)  6.00 Program anount per discharge (contra	51.00		atient ancillary	services (fr	om Wkst. D, sı	ım of Parts II	66,576	51.00
medical education costs (line 49 minus line 52)  15.4.00 Program discharges 5.4.00 Program discharges 5.0.01 Target amount per discharge 5.0.00 S5.00 7.00 S5.00 Target amount per discharge 5.0.00 Adjustment amount per discharge 6.0.00 S5.00 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between deviated inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between deviated by the market basket) 7.00 Difference between borus payment (if line 54 ine 55 from prior year cost report, updated by the market basket) 7.00 Difference between deviated by the market basket) 7.00 Difference between borus payment (if line 53 + line 54 is less than the lowest of lines 55 plus of 55.0, or line 50, or line 60, enter the lesser of 50% of the amount by which operating sorts (line 53) are less than expected costs (line 53 + line 54 is less than the lowest of lines 55 plus 55.0, or line 50, or line 60, enter the lesser of 50% of the amount by which operating sorts (line 53) are less than expected costs (line 53 + line 54 is less than the lowest of lines 55 plus 55.0, or line 50, or line	52.00	Total Program excludable cost (sum of lines	50 and 51)				238,890	52.00
TARGET MOUNT NO LIMIT COMPUTATION  54.00  FORMAL PAPERS AND PROGRAM INCIDENT COMPUTATION  55.00  Target amount per discharge  54.00  55.00  Target amount per discharge  55.01  Adjustment amount per discharge  55.01  Adjustment amount per discharge  55.01  Adjustment amount per discharge  55.00  Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)  62.00  63.00  64.00  64.00  65.00  66.00  67.00  68.00  68.00  69.00  69.00  69.00  60.00	53.00			ted, non-phy:	sician anesthe	etist, and	4,438,771	53.00
Program discharges   0.54.00   55.00   Torget amount per discharge   0.00   55.00   55.00   Torget amount per discharge   0.00   55.00   55.00   2.00   55.00   2.00   55.00   2.00   55.00   2.00   55.00   2.00   55.00   2.00   55.00   2.00   55.00   2.00   55.00   2.00   55.00   2.00   55.00   2.00   55.00   2.00   55.00   2.00   55.00   2.0			52)					
55.00   Target amount per discharge   0.00   55.01   55.01   Permanent adjustment amount per discharge   0.00   55.01   55.02   Adjustment amount per discharge (contractor use only)   0.00   55.01   55.02   October amount (line 54 x sum of lines 55, 55.01, and 55.02)   0.60   0.60   57.00   Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.56.00   58.00   Ostoop Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.57.00   58.00   Ostoop Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.58.00   59.00   Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996,   0.00   59.00   Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)   0.00   60.00   Caster basket   0.00   0.00   60.00   Caster basket   0.00   0.00   60.00   Caster basket   0.00   0.00   61.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   0.00   0.00   61.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   61.00   0.00	F4 00							[ ] [4 00
Permanent adjustment amount per discharge   0.00   55.01							-	
S5.02   Adjustment amount per discharge (contractor use only)   0.00   55.02								
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 57.00 Bonus payment (see instructions) 58.00 Bonus payment (see instructions) 58.00 Bonus payment (see instructions) 59.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53 are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 63.00 Page (see instructions) 63.00 Page (see instructions) 63.00 Page (see instructions) 64.00 Instructions) 65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (stile xVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (stile XVIII only); 67.00 Title Vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (see instructions) (stile Vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 68.00 Title Vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title vor XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 69.00 Total title vor XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 69.00 Total title vor XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 69.00 Total related costs (line 57 + line 79) 69.00 Total related costs (l			use onlv)				1	
S8.00   Bonus payment (see instructions)   0   58.00   59.00   Treded costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,   0.00   59.00   updated and compounded by the market basket)   0.00   60.0								ı
Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	57.00	Difference between adjusted inpatient operat	ing cost and targ	et amount (1	ine 56 minus 1	ine 53)	0	57.00
updated and compounded by the market basket)  60.00 kepted costs (lesser of line 53 * line 54, or line 55 from prior year cost report, updated by the market basket)  61.00 continuous improvement bonus payment (if line 53 * line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 33 are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through becember 31 of the cost reporting period (see instructions) (citile XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (citile XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/other nursing facility/CEF/LID routine service cost (line 37)  71.00 Algusted general inpatient routine service costs (line 67 + line 75)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to program (line 14 x line 35)  73.00 Medically necessary private room cost applicable to program (line 14 x line 35)  73.00 Total Program general inpatient routine service costs (from worksheet 8, Part II, column 26, line 45)  74.00 Total Program general inpatient routine service costs (from provider records)  75.00 Aggregate charges to beneficiaries for exces		' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '					0	58.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)  61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 5,01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Minumable Inpatient cost plus incentive payment (see instructions)  65.00 Minumable Inpatient plus incentive payment (see instructions)  65.00 Minumable Inpatient cost plus incentive payment (see instructions)  65.00 Minumable Inpatient plus incentive payment (see instructions)  65.00 Minumable Inpatient cost plus incentive payment (see instructions)  65.00 Minumable Inpatient plus incentive payment (see instructions)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (see instructions) (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00  69.00 Total title V or XIX swing-bed NF inpatient foutine service cost (line 72 + line 73)  70.00 Silled nursing facility/other nursing facility/tcf/II ordurin service cost (line 37)  71.00 Adjusted general inpatient routine service costs (from worksheet B, Part II, column 75.00  72.00 Total program routine service cost (line 75 + line 2)  73.00 Medically necessary private room cos	59.00		or line 55 from t	he cost repo	rting period e	ending 1996,	0.00	59.00
Signature   Sign	60.00	00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60.00
S5.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	61 00		2 52 · lino 54 ic	loss than th	no lowest of I	inos 55 plus		61 00
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions)  67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/tother nursing facility/tof/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (from worksheet B, Part II, column 26, line 45)  75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)  77.00 Program capital-related costs (line 9 x line 70)  78.00 Program capital-related costs (line 9 x line 70)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Pr	01.00	$55.01$ , or line $59$ , or line $60$ , enter the lesser of $50\%$ of the amount by which operating costs (line $53$ ) are less than expected costs (lines $54 \times 60$ ), or $1 \%$ of the target amount (line $56$ ), otherwise						01.00
Allowable Inpatient cost plus incentive payment (see instructions)   PAGGAM INPATIENT ROUTINE SWING BED COST	62.00						0	62.00
PROGRAM INPATIENT ROUTINE SWING BED COST			ent (see instruct	ions)			_	
instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 Torgam routine service cost (line 9 x line 71) 72.00 Total Program general inpatient routine service costs (line 72 + line 2) 73.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 74.00 Total Program capital-related costs (line 75 ÷ line 2) 75.00 Program capital-related costs (line 9 x line 76) 77.00 Total Program routine service cost (line 78 minus line 79) 78.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 78.00 Total Program inpatient routine service costs (see instructions) 79.00 Total Program inpatient operating costs (see instructions) 79.00 Total Program inpatient operating costs (see instructions) 79.00 Total Program inpatient operating costs (sum of lines 83 through 85) 79.00 Total Program inpatient operating costs (sum of lines 83 through 85) 79.00 Total Program inpatient operating costs (sum of lines 83 through 85) 79.00 Total Program inpatient operating costs (sum of lines 83 through 85)		PROGRAM INPATIENT ROUTINE SWING BED COST						
Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)   Geo. O.	64.00		ts through Decemb	er 31 of the	cost reportir	ng period (See	0	64.00
instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00  70.00 Skilled nursing facility/Other nursing facility/ICF/IID ONLY  70.00 Adjusted general inpatient routine service cost (line 70 + line 2) 71.00 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.00 Total Program inpatient routine service costs (see instructions) 81.00 Reasonable inpatient routine service (see instructions) 82.00 Reasonable inpatient routine service (see instructions) 83.00 Reasonable inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 70 Total Observation bed days (see instructions) 70 71 71 71 71 71 71 71 72 72 73 74 75 75 76 77 77 77 77 77 77 77 77 77 78 78 78 78	65 00		ts after December	21 of the c	act ranantina	nariad (Saa		65 00
Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING FACTLITY, OTHER NURSING FACTLITY, AND ICF/IID ONLY  70.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Program routine service cost (line 9 x line 71)  73.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 9 x line 76)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost funitation (line 78 minus line 79)  81.00 Inpatient routine service cost funitation (line 9 x line 81)  82.00 Reasonable inpatient routine services (see instructions)  84.00 Program inpatient ancillary services (see instructions)  78.00 Program inpatient ancillary services (see instructions)  78.00 Program inpatient routine service (see instructions)  78.00 Program inpatient operating costs (sum of lines 83 through 85)  78.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  70 Total observation bed days (see instructions)	63.00		is after December	21 01 tile C	ost reporting	per rou (see	0	63.00
Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)   Record	66.00		ne costs (line 64	plus line 6	5)(title XVIII	only); for	0	66.00
(line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00  PART III - SKILLED NURSING FACILITY, OTHER MURSING FACILITY, AND ICE/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICE/IID routine service cost (line 37) 70.00  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00  72.00 Program routine service cost (line 9 x line 71) 72.00  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00  74.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00  76.00 Per diem capital-related costs (line 9 x line 76) 77.00  77.00 Program capital-related costs (line 9 x line 76) 77.00  79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.00  81.00 Inpatient routine service cost per diem limitation (line 9 x line 81) 82.00  82.00 Inpatient routine service cost see instructions) 83.00  84.00 Program inpatient ancillary services (see instructions) 85.00  85.00 Utilization review - physician compensation (see instructions) 85.00  86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 70.00 70		CAH, see instructions				,,,		
Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACTLITY, OTHER NURSING FACTLITY, AND ICF/IID ONLY  70.00  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 + line 2)  70.00  Program routine service cost (line 9 x line 71)  70.00  Total Program general inpatient routine service costs (line 72 + line 73)  70.00  71.00  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 75 + line 2)  70.00  71.00  72.00  73.00  74.00  75.00  76.00  77.00  78.00  79.00  79.00  79.00  80.00  Total Program routine service cost (line 74 minus line 77)  79.00  79.00  80.00  Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00  81.00  81.00  82.00  Inpatient routine service cost per diem limitation  81.00  82.00  Reasonable inpatient routine service costs (see instructions)  82.00  83.00  Reasonable inpatient routine service costs (see instructions)  84.00  85.00  Total Program inpatient ancillary services (see instructions)  85.00  Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)	67.00		e costs through D	ecember 31 o	f the cost rep	orting period	0	67.00
(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACTLITY, OTHER NURSING FACTLITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 72.00 Program routine service cost per diem (line 70 + line 2) 72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 1npatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service cost limitation (line 9 x line 81) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Total observation bed days (see instructions)	69.00			amban 21 af .		ating popied		60 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Program capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  78.00 Aggregate charges to beneficiaries for excess costs (from provider records)  70.01 Total Program routine service cost per diem limitation  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine services (see instructions)  82.00 Utilization review - physician compensation (see instructions)  84.00 Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)	68.00		e costs after bec	emper 31 01	the cost repor	rting period	0	08.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total Observation bed days (see instructions)  70.00 Total Program inpatient operating costs (sum of lines 83 through 85)  87.00 Total observation bed days (see instructions)	69.00	Total title V or XIX swing-bed NF inpatient					0	69.00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost per diem limitation 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Total observation bed days (see instructions)	70.00							70.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient ancillary services (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00				e 70 ÷ line :	2)			
Total Program general inpatient routine service costs (line 72 + line 73)  75.00  75.00  76.00  76.00  76.00  77.00  78.00  77.00  79.00  Aggregate charges to beneficiaries for excess costs (from provider records)  80.00  80.00  10  10  10  10  10  10  10  10  10					253			1
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  77.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost per diem limitation  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  75.00  87.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  76.00  76.00  76.00  77.00  77.00  78.00  79.00  79.00  80.00  8		, , , , , , , , , , , , , , , , , , , ,	,		ne 35)			1
26, line 45) Per diem capital-related costs (line 75 ÷ line 2) 76.00 Program capital-related costs (line 9 x line 76) Tinpatient routine service cost (line 74 minus line 77) 78.00 Rogregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Rogregate routine service costs for comparison to the cost limitation (line 78 minus line 79) Rogregate routine service cost per diem limitation Inpatient routine service cost per diem limitation Rogrom Inpatient routine service costs (see instructions) Rogrom inpatient routine service costs (see instructions) Rogram inpatient ancillary services (see instructions) Rogram inpatient routine service costs (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  0 87.00					ankshoot B Da	n+ TT column		1
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 76.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  77.00	73.00		Toutine service co	USES (TIOIII W	JIKSHEEL B, FO	ti C II, COTUIIII		73.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00	76.00		ne 2)					76.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  80.00 Inpatient routine service cost per diem limitation  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Program inpatient ancillary services (see instructions)  84.00 Utilization review - physician compensation (see instructions)  85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  87.00	77.00	Program capital-related costs (line 9 x line	76)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Total observation bed days (see instructions)			•					ı
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  0 87.00						. 11 70		ı
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  87.00 87.00				t ilmitation	(IIne /8 minu	is line /9)		
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 87.00								ı
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 87.00								
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 87.00		· ·						84.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  87.00 87.00				)				85.00
87.00 Total observation bed days (see instructions) 0 87.00		Total Program inpatient operating costs (sum	of lines 83 thro					86.00
	07						-	0=
00.00  Aujusted general impatient routine cost per diem (line 27 ÷ 11Ne 2) 0.00  88.00				ino 2)				
	00.00	Aujusteu generar impattent routine cost per (	arem (Time 27 ÷ 1	1116 2)			0.00	00.00

Health Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
		Component (		From 07/01/2022 To 06/30/2023		pared: 29 pm
		Title	XVIII	Subprovider -	PPS	
				IRF		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88)	(see instructions)				0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	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	GH COST					
90.00 Capital-related cost	280,222	5,260,365	0.05327	0	0	90.00
91.00 Nursing Program cost	0	5,260,365	0.00000	0	0	91.00
92.00 Allied health cost	0	5,260,365	0.00000	0	0	92.00
93.00 All other Medical Education	0	5,260,365	0.00000	0	0	93.00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034	From 07/01/2022	Date/Time Prepared:
				11/20/2023 2:29 pm
		Title XIX	Hospital	PPS

		Title XIX	Hospital	11/20/2023 2: PPS	29 pm
	Cost Center Description	THE NEXT		1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00 2.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-be	34,525			
3.00	Private room days (including private room days, excluding swing-led and observation bed day do not complete this line.		ivate room days,	34,525 0	1
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		29,980	4.00
5.00	Total swing-bed SNF type inpatient days (including private rooreporting period		r 31 of the cost	0	
6.00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable to newborn days) (see instructions)	o the Program (excluding	swing-bed and	497	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)	• •	0	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		•	0	
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)	0	13.00
14.00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 1 326	14.00 15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				16.00
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17.00
18.00	, , ,				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions			36,984,372	
22.00	Swing-bed cost applicable to SNF type services through Decembe 5 x line 17)	·		0	
23.00	Swing-bed cost applicable to SNF type services after December $x$ line 18)	·		0	
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	·		0	
25.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	23.00
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		0 36,984,372	
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	t and observation had ch	argos)	0	28.00
	Private room charges (excluding swing-bed charges)	a and observation bed th	ai ges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 min		tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line)	ne 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and and one	fforonti-1 (1'	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	TTERENTIAL (line	36,984,372	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see			1,071.23	38.00
39.00	Program general inpatient routine service cost per drem (see			532,401	
40.00	Medically necessary private room cost applicable to the Progra			0	1
	Total Program general inpatient routine service cost (line 39	•		532,401	

	· · · · · · · · · · · · · · · · · · ·	ST. MARY MEDICAL		15 005:		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC	N: 15-0034	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prel 11/20/2023 2::	pared:
			Title	XIX	Hospital	PPS	PIII
	Cost Center Description	Total Inpatient CostIn	Total patient 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	
42.00	NURSERY (title V & XIX only)	2,437,520	1,326	1,838.	25 50	91,913	42.00
42.00	Intensive Care Type Inpatient Hospital Units		F 270	1 025	27 204	FF4 012	12.00
43.00 44.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	9,802,222	5,370	1,825.	304	554,912	43.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1 00	
48.00	Program inpatient ancillary service cost (Wk	st D=3 col 3	line 200)			1.00 749,913	48.00
48.01	Program inpatient cellular therapy acquisiti			III, line 10	, column 1)	0	48.0
	Total Program inpatient costs (sum of lines				, ,	1,929,139	
	PASS THROUGH COST ADJUSTMENTS	<del></del>					
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from	Wkst. D, sur	n of Parts I and	61,996	50.00
51.00	Pass through costs applicable to Program inp	natient ancillary	services (fro	om Wkst. D.	sum of Parts II	42,947	51.00
	and IV)			, ·			
52.00	Total Program excludable cost (sum of lines					104,943	
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ited, non-phys	sıcian anestl	netist, and	1,824,196	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program discharges					0	54.0
55.00	Target amount per discharge					0.00	55.0
55.01	Permanent adjustment amount per discharge						55.0
	Adjustment amount per discharge (contractor						55.0 56.0
56.00 57.00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		uet amount (1:	ine 56 minus	line 53)	0	1
58.00	Bonus payment (see instructions)	ing cost and care	jee amourre (1	ine so minus	11116 33)	0	1
59.00	Trended costs (lesser of line 53 ÷ line 54,		he cost repo	rting period	ending 1996,	0.00	59.0
60.00	updated and compounded by the market basket)					0.00	60.0
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 33 from	prior year co	ost report, i	updated by the	0.00	60.0
61.00	Continuous improvement bonus payment (if lir 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of the	amount by wh	nich operati	ng costs (line	0	61.0
62.00	Relief payment (see instructions)					0	62.0
63.00	Allowable Inpatient cost plus incentive paym	ent (see instruct	ions)			0	63.0
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST		24 6				
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	its through Decemb	er 31 of the	cost report	ing period (See	0	64.0
65.00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the co	ost reporting	period (See	0	65.0
	instructions)(title XVIII only)				, ,		
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 6	5)(title XVI	<pre>II only); for</pre>	0	66.0
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	o costs through F	ocombor 31 of	f the cost re	norting poriod	0	67.0
07.00	(line 12 x line 19)	ie costs tillough i	recember 31 0	tile cost it	sporting period		07.0
68.00	Title V or XIX swing-bed NF inpatient routir	ne costs after Dec	ember 31 of	the cost repo	orting period	0	68.0
60.00	(line 13 x line 20)		67 7	60)			60.0
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.0
70.00	Skilled nursing facility/other nursing facil				)		70.0
71.00	Adjusted general inpatient routine service of	ost per diem (lir	ne 70 ÷ line 2	2)			71.0
72.00	Program routine service cost (line 9 x line		71. 44 71	25)			72.0
73.00 74.00	Medically necessary private room cost application of the program general inpatient routine serv	-		ne 35)			73.0
75.00	Capital-related cost allocated to inpatient			orksheet B. I	Part II. column		75.0
	26, line 45)		,	,	,		
76.00	Per diem capital-related costs (line 75 ÷ li						76.0
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.0 78.0
79.00	Aggregate charges to beneficiaries for excess		vider records	5)			79.0
80.00	Total Program routine service costs for comp	arison to the cos			nus line 79)		80.0
81.00	Inpatient routine service cost per diem limi						81.0
82.00 83.00	Inpatient routine service cost limitation () Reasonable inpatient routine service costs (		1				82.0 83.0
84.00	Program inpatient ancillary services (see in		1				84.0
85.00	Utilization review - physician compensation		5)				85.0
86.00	Total Program inpatient operating costs (sum	of lines 83 thro					86.0
07.00	PART IV - COMPUTATION OF OBSERVATION BED PAS					4 545	07.
87.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ino 2)			4,545 1,071.23	
88.00	ANTIISTEN NEMERAL INNATIENT POLITING POST NOT	grem (line // ÷ '					

Health Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider Co		Period:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023		
	,	Titl	e XIX	Hospital	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	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	2,100,979	36,984,372	0.05680	7 4,868,740	276,579	90.00
91.00 Nursing Program cost	0	36,984,372	0.00000	0 4,868,740	0	91.00
92.00 Allied health cost	0	36,984,372	0.00000	0 4,868,740	0	92.00
93.00 All other Medical Education	0	36,984,372	0.00000	4,868,740	0	93.00

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-00	Period: From 07/01/2022	Worksheet D-1
	Component CCN: 15-T0	)34 To 06/30/2023	Date/Time Prepared: 11/20/2023 2:29 pm
	Title XIX	Subprovider -	PPS
		TDC	

		11010 /12/	IRF		
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS			1 221	
	Inpatient days (including private room days and swing-bed days			4,984	
	Inpatient days (including private room days, excluding swing-bervate room days (excluding swing-bed and observation bed day		ivato room days	4,984	1
00	do not complete this line.	73). It you have only pr	ivace room days,	O	١,٠
00	Semi-private room days (excluding swing-bed and observation be	ed days)		4,984	4.
00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	1
	reporting period				
00	Total swing-bed SNF type inpatient days (including private roo	om 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 room	n days) through Docombor	31 of the cost	0	7
00	reporting period	ii days) tiii ougii beceiibei	of the cost	U	'
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	53	9.
	newborn days) (see instructions)				1.0
.00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct		oom days)	0	10.
.00	Swing-bed SNF type inpatient days applicable to title XVIII on		nom days) after	0	11.
	December 31 of the cost reporting period (if calendar year, en		oo uu, o, u. ee.	Ü	
.00	Swing-bed NF type inpatient days applicable to titles V or XIX		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 XIX			0	13
.00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)	am (excluding swing-bed	uays)	1,326	
	Nursery days (title V or XIX only)				16
	SWING BED ADJUSTMENT				
00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17
00	reporting period	os often Desember 21 of	+ha cos+	0.00	10
00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18
.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
	reporting period				
.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20
00	reporting period	->		F 200 20F	21
.00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing pariod (line	5,260,365	1
. 00	5 x line 17)	er 31 or the cost report	ing per rou (Time	O	~~
.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23
	x line 18)	·			
.00	Swing-bed cost applicable to NF type services through December	<sup>-</sup> 31 of the cost reporti	ng period (line	0	24
00	7 x line 19)	of the cost managering	namind (line 9	0	2.5
.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	si of the cost reporting	period (Title 8	U	25
.00	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		5,260,365	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
- 1	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)		28
- 1	Private room charges (excluding swing-bed charges)			0	
.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	lino 28)		0.000000	
- 1	Average private room per diem charge (line 29 ÷ line 3)	- 1111e 28)		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
- 1	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
00	Average per diem private room cost differential (line 34 x lin			0.00	35
00	Private room cost differential adjustment (line 3 x line 35)			0	
00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	5,260,365	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
	Adjusted general inpatient routine service cost per diem (see			1,055.45	38
	Program general inpatient routine service cost (line 9 x line			55,939	
.00					
.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			55,939	

Health Financial Systems

COMPUTATION OF INPATIENT OPERATING COST In Lieu of Form CMS-2552-10 ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034 Period: From 07/01/2022 To 06/30/2023 Worksheet D-1 Date/Time Prepared: 11/20/2023 2:29 pm Component CCN: 15-T034 Title XIX Subprovider -PPS

Total   Total   Average Per   Inpatient Cost Impatient Days Diem (col. 1 ÷ col. 2)   Program   Total   Total   Average Per   Impatient Days Diem (col. 1 ÷ col. 2)   Total   Total   Total   Total   Average Per   Impatient Days Diem (col. 1 ÷ col. 2)   Total   Total   Total   Total   Average Per   Impatient Days Diem (col. 1 ÷ col. 2)   Total   Tot	(col. 3 x col. 4) 0 5.00	
Col. 2)   1.00   2.00   3.00   4.00	4) 5.00	
42.00   NURSERY (title V & XIX only)   0   0   0.00		
Intensive Care Type Inpatient Hospital Units  43.00 INTENSIVE CARE UNIT 0 0 0.00		
43.00 INTENSIVE CARE UNIT 0 0.00	0 0	42.00
	0 0	43.00
44.00 CORONARY CARE UNIT		44.00
45.00 BURN INTENSIVE CARE UNIT		45.00
46.00 SURGICAL INTENSIVE CARE UNIT		46.00
47.00 OTHER SPECIAL CARE (SPECIFY)		47.00
Cost Center Description	1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	23,512	48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1		1
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	79,451	49.00
PASS THROUGH COST ADJUSTMENTS		
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts	I and 2,980	50.00
III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Par	ts II 945	51.00
and IV)	23 11 343	31.00
52.00 Total Program excludable cost (sum of lines 50 and 51)	3,925	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, an	d 75,526	53.00
medical education costs (line 49 minus line 52)		_
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges	0	54.00
55.00 Target amount per discharge		55.00
55.01 Permanent adjustment amount per discharge	0.00	55.01
55.02 Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00   Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions)	0	
58.00   Bonus payment (see instructions) 59.00   Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 19	96 0 00	59.00
updated and compounded by the market basket)	0.00	33.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by	the 0.00	60.00
market basket)	_	
61.00   Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55   55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (		61.00
53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherw		
enter zero. (see instructions)	.50	
62.00 Relief payment (see instructions)	0	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period	(See 0	64.00
instructions)(title XVIII only)	(See   0	04.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (	See 0	65.00
instructions)(title XVIII only)		
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only);	for 0	66.00
CAH, see instructions 67.00   Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting p	eriod 0	67.00
(Tine 12 x line 19)	ci iou	07.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting per	iod 0	68.00
(line 13 x line 20)		
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00 Program routine service cost (line 9 x line 71)		72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)	a1m	74.00
75.00   Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, c   26. line 45)	o i umn	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00 Program capital-related costs (line 9 x line 76)		77.00
78.00 Inpatient routine service cost (line 74 minus line 77)		78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)	0)	79.00
80.00   Total Program routine service costs for comparison to the cost limitation (line 78 minus line 7 81.00   Inpatient routine service cost per diem limitation	9)	80.00
82.00 Inpatient routine service cost per diem rimitation 82.00 Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00   Reasonable inpatient routine service costs (see instructions)		83.00
84.00 Program inpatient ancillary services (see instructions)		84.00
85.00 Utilization review - physician compensation (see instructions)		85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  27 00 Total ebservation had days (see instructions)	0	87.00
87.00  Total observation bed days (see instructions)		88.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		,

Health Finar	ncial Systems	ST. MARY MEDICAL CENTER, INC. In Lieu					2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provider CO		Period:	Worksheet D-1	
			Component C		From 07/01/2022 To 06/30/2023	Date/Time Pre 11/20/2023 2:	
			Titl	e XIX	Subprovider -	PPS	
					IRF		
	Cost Center Description						
						1.00	
89.00 Obser	rvation bed cost (line 87 x line 88) (se	e instructions)				0	89.00
	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
			(from line 21)	column 2	Observation	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	
COMPU	JTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capit	tal-related cost	280,222	5,260,365	0.05327	0	0	90.00
91.00 Nursi	ing Program cost	0	5,260,365	0.00000	0	0	91.00
92.00 Allie	ed health cost	0	5,260,365	0.00000	0	0	92.00
93.00 All d	other Medical Education	0	5,260,365	0.00000	0	0	93.00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider Co		Period: From 07/01/2022 To 06/30/2023		pared:
		Title	XVIII	Hospital	PPS	p
Cost Center Description			Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col.	

	Title XVIII	Hospital	PPS	
Cost Center Description	Ratio of Cost	Inpatient	Inpatient	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	·			
30.00 03000 ADULTS & PEDIATRICS		21,753,429		30.00
31.00 03100 INTENSIVE CARE UNIT		5,523,538		31.00
41.00   04100   SUBPROVIDER - IRF		0		41.00
43.00   04300   NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0.248217	13,891,864	3,448,197	50.00
51.00 05100 RECOVERY ROOM	0.292536	1,503,596	439,856	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.625633	10,547	6,599	52.00
53.00 05300 ANESTHESIOLOGY	0.023603	2,595,155		
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.132933	2,974,718		
55.00 05500 RADIOLOGY - THERAPEUTIC	0.090198	39,593		
56.00 05600 RADIOISOTOPE	0.119495	639,570	76,425	
57.00 05700 CT SCAN	0.046340	7,641,181	354,092	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.069631	2,010,316		
59.00 05900 CARDIAC CATHETERIZATION	0.071793	9,648,282	692,679	
60.00   06000   LABORATORY	0.095173	13,221,669	1,258,346	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0.366130	1,128,323	413,113	
64.00 06400 INTRAVENOUS THERAPY	0.205997	1,120,323	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.288743	4,202,665	1,213,490	
66.00 06600 PHYSICAL THERAPY	0.289963	849,087	246,204	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.250614	604,762	151,562	
68.00 06800 SPEECH PATHOLOGY	0.230614	266,255		
69.00 06900 ELECTROCARDIOLOGY	0.061729			
		3,848,686		
	0.094532	89,155		
	0.403448	5,087,639		
	0.452771	5,790,161	2,621,617	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.179468	14,355,465	2,576,347	
74.00   07400   RENAL DIALYSIS	0.257139	1,557,445		
76.97 O7697 CARDIAC REHABILITATION	0.562715	106,084	59,695	76.97
OUTPATIENT SERVICE COST CENTERS	0.403033	65.262	26.225	
90.00 09000 CLINIC	0.403832	65,362		
91.00   09100   EMERGENCY	0.108596	12,949,441	1,406,257	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.294211	887,651		
Total (sum of lines 50 through 94 and 96 through 98)		105,964,672	18,660,782	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)	0		201.00
202.00 Net charges (line 200 minus line 201)		105,964,672		202.00

	Financial Systems ST. MARY MEDICAL ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0034	In Lie	worksheet D-3	
INFAII	LENT ANCIELARY SERVICE COST APPORTIONMENT			From 07/01/2022		
		Component	CCN: 15-T034	то 06/30/2023	Date/Time Pre 11/20/2023 2:	
		Title	e XVIII	Subprovider -	PPS	
			1	IRF		
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs	
			10 Charges	Charges	(col. 1 x col.	
				charges	2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				T	
30.00	03000 ADULTS & PEDIATRICS					30.00
41.00	03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF			5,205,387		31.00 41.00
	04300 NURSERY			3,203,367		43.00
43.00	ANCILLARY SERVICE COST CENTERS					43.00
50.00			0.2482	17 69,328	17,208	50.00
51.00	05100 RECOVERY ROOM		0.2925			
52.00	05200 DELIVERY ROOM & LABOR ROOM		0.6256	33 0	0	52.00
53.00	05300 ANESTHESIOLOGY		0.0236	5,668	134	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		0.1329			
	05500 RADIOLOGY - THERAPEUTIC		0.0901		0	
56.00	05600 RADIOISOTOPE		0.1194			
	05700 CT SCAN		0.0463			
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION		0.0696	· · · · · · · · · · · · · · · · · · ·	1	
60.00	06000 LABORATORY		0.0717			
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.		0.3661	· · · · · · · · · · · · · · · · · · ·		1
	06400 INTRAVENOUS THERAPY		0.2059		0	1
65.00	06500 RESPIRATORY THERAPY		0.2887			
66.00	06600 PHYSICAL THERAPY		0.2899	1,426,446	413,617	66.00
67.00	06700 OCCUPATIONAL THERAPY		0.2506	1,435,667	359,798	
68.00	06800 SPEECH PATHOLOGY		0.4109			
69.00	06900 ELECTROCARDIOLOGY		0.0617	· · · · · · · · · · · · · · · · · · ·	1	
70.00	07000 ELECTROENCEPHALOGRAPHY		0.0945		0	1
71.00			0.4034	· · · · · · · · · · · · · · · · · · ·	1	1
72.00	07200   IMPL. DEV. CHARGED TO PATIENTS   07300   DRUGS CHARGED TO PATIENTS		0.4527		1	1
74.00	07400 RENAL DIALYSIS		0.1794	, ,		1
	07697 CARDIAC REHABILITATION		0.5627			
, 0.57	OUTPATIENT SERVICE COST CENTERS		0.3027			1
90.00	09000 CLINIC		0.4038	32 0	0	90.00
91.00	09100 EMERGENCY		0.1085	96 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0.2942			
200 00	Total (sum of lines 50 through 94 and 96 through 98)		1	6 061 372	1 442 707	200 00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

6,061,372

6,061,372

1,442,707 200.00 201.00 202.00

200.00

202.00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0034	Period:	Worksheet D-3
			From 07/01/2022	
			To 06/30/2023	Data/Time Dranarad:

INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	rovider Co	IN: 15-0034	From 07/01/2022 To 06/30/2023	Date/Time Pre	pared:
		Titl	e XIX	Hospital	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			1 262 276		30.00
	03000 ADULTS & PEDIATRICS			1,362,376		30.00
	03100 INTENSIVE CARE UNIT			224,715		31.00
	04100 SUBPROVIDER - IRF			0		41.00
43.00	04300 NURSERY			127,115		43.00
50.00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM		0.2482	17 520,854	129,285	50.00
	05100 RECOVERY ROOM		0.2482			
	05200 DELIVERY ROOM & LABOR ROOM		0.2923			
					25,912	
	05300 ANESTHESIOLOGY		0.0236			
	05400 RADIOLOGY-DIAGNOSTIC		0.1329			
	05500 RADIOLOGY - THERAPEUTIC		0.0901		,	
	05600 RADIOISOTOPE		0.1194	,	·	
57.00	05700 CT SCAN		0.0463		22,052	
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0696			
59.00	05900 CARDIAC CATHETERIZATION		0.0717			
60.00	06000 LABORATORY		0.0951			
	06300 BLOOD STORING, PROCESSING, & TRANS.		0.3661			
64.00	06400 INTRAVENOUS THERAPY		0.2059		ĭ	64.00
	06500 RESPIRATORY THERAPY		0.2887			
66.00	06600 PHYSICAL THERAPY		0.2899			
67.00	06700 OCCUPATIONAL THERAPY		0.2506			
	06800 SPEECH PATHOLOGY		0.4109			
	06900 ELECTROCARDIOLOGY		0.0617			
70.00	07000 ELECTROENCEPHALOGRAPHY		0.0945		2,552	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.4034			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.4527			
	07300 DRUGS CHARGED TO PATIENTS		0.1794			
	07400 RENAL DIALYSIS		0.2571		· '	
76.97	07697 CARDIAC REHABILITATION		0.5627	15 2,330	1,311	76.97
	OUTPATIENT SERVICE COST CENTERS			1		
	09000 CLINIC		0.4038		0	
	09100 EMERGENCY		0.1085		· '	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0.2942			
200.00				4,554,958		1
201.00		line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			4,554,958		202.00

	Financial Systems ST. MARY ENT ANCILLARY SERVICE COST APPORTIONMENT	MEDICAL CENTER, INC. Provider C	CN: 15-0034	Period:	worksheet D-3	
			45	From 07/01/2022		
		Component	CCN: 15-T034	то 06/30/2023	Date/Time Pre 11/20/2023 2:	
		Tit	le XIX	Subprovider -	PPS	
				IRF		
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0.00	03000 ADULTS & PEDIATRICS					30.
	03100 INTENSIVE CARE UNIT					31.
	04100 SUBPROVIDER - IRF			79,110		41.
	04300 NURSERY			,		43.
	ANCILLARY SERVICE COST CENTERS					ĺ
	05000 OPERATING ROOM		0.24821	17 0	0	50.
.00	05100 RECOVERY ROOM		0.29253	36 0	0	
.00	05200 DELIVERY ROOM & LABOR ROOM		0.62563	33 0	0	52
	05300 ANESTHESIOLOGY		0.02360	03	0	53
	05400 RADIOLOGY-DIAGNOSTIC		0.13293		0	54
	05500 RADIOLOGY - THERAPEUTIC		0.09019		0	
	05600 RADIOISOTOPE		0.11949		0	56
	05700 CT SCAN		0.04634		0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.06963		0	
.00	05900 CARDIAC CATHETERIZATION		0.07179		0	
	06000 LABORATORY		0.09517		840	
.00	06300 BLOOD STORING, PROCESSING, & TRANS.		0.36613			63
.00	06400 INTRAVENOUS THERAPY		0.20599		0	
.00	06500 RESPIRATORY THERAPY		0.28874	- , -		
.00	06600 PHYSICAL THERAPY		0.28996			
	06700 OCCUPATIONAL THERAPY		0.25061	- ,		
.00	06800 SPEECH PATHOLOGY		0.41098		530 0	
	06900 ELECTROCARDIOLOGY		0.06172		0	69
.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.09453			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.40342		1,636	
	07300 DRUGS CHARGED TO PATIENTS		0.4327			
	07400 RENAL DIALYSIS		0.25713		505	
	07697 CARDIAC REHABILITATION		0.56271			
	OUTPATIENT SERVICE COST CENTERS		0.3027			1 ' 0
.00	09000 CLINIC		0.40383	32 0	0	90
	09100 EMERGENCY		0.10859		1	
	00300 ORSERVATION REDS (NON DISTINCT DART		0.2003			

0.294211

102,799

0 92.00

23,512 200.00 201.00 202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

200.00 201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 11/20/2023 2:29 pm

	Title XVIII	Hospital	11/20/2023 2: PPS	29 pm
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1.00	
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (s	ee	0 7,598,609	1.00 1.01
1.02	<pre>instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 instructions)</pre>	(see	22,100,294	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring p 1 (see instructions)	rior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring o October 1 (see instructions)	n or after	0	1.04
2.00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		0	2.00
2.02 2.03 2.04	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)		0 36,315 100,174	
3.00 4.00	Managed Care Simulated Payments  Bed days available divided by number of days in the cost reporting period (see instruc	tions)	167.55	3.00
5.00	Indirect Medical Education Adjustment  FTE count for allopathic and osteopathic programs for the most recent cost reporting p		0.00	
5.01	or before 12/31/1996.(see instructions)  FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instruction		0.00	
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on new programs in accordance with 42 CFR 413.79(e)		0.00	
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed the CAA 2021 (see instructions)	-	0.00	
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)( ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv cost report straddles July 1, 2011 then see instructions.		0.00 0.00	
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation track programs with a rural track for Medicare GME affiliated programs in accordance w and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic prog affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the A report straddles July 1, 2011, see instructions.	CA. If the cost	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teachin under § 5506 of ACA. (see instructions)		0.00	
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA instructions)		0.00	
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)  FTE count for allopathic and osteopathic programs in the current year from your record		0.00	9.00
11.00 12.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
13.00 14.00	Total allowable FTE count for the prior year.	ombor 30 1997	0.00	13.00 14.00
15.00	otherwise enter zero.	elliber 30, 1997,		15.00
	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
18.00				17.00 18.00
19.00			0.000000	
21.00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)		0.000000	
	IME payment adjustment (see instructions)		0	1
	IME payment adjustment - Managed Care (see instructions)		0	
23.00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CF	p. 412, 105	0.00	23.00
	(f)(1)(iv)(C).	K 412.103		
24.00 25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line	24 (see	0.00 0.00	
26.00			0.000000	
27.00 28.00			0.000000	
28.01			0	
29.00			0	29.00 29.01
	Disproportionate Share Adjustment			]
30.00 31.00		ions)	3.50 16.37	30.00 31.00
32.00			19.87	
33.00	Allowable disproportionate share percentage (see instructions)		5.67	33.00
34.00	Disproportionate share adjustment (see instructions)		420,982	34.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0034	Period:	u of Form CMS-2 Worksheet E	
			From 07/01/2022 To 06/30/2023	Part A	nand
			To 06/30/2023	Date/Time Pre 11/20/2023 2:	
		Title XVIII	Hospital	PPS 10./1	
			Prior to 10/1 1.00	2.00	
	Uncompensated Care Payment Adjustment		2.00	2.00	
.00	Total uncompensated care amount (see instructions)			6,874,403,459	
.01	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is zero	o. enter zero on this lin	0.000165425 e) 1,189,736	0.000148207 1,018,837	
	(see instructions)		2,200,100	1,010,000	
03	Pro rata share of the hospital UCP, including supplemental UTOtal UCP adjustment (sum of columns 1 and 2 on line 35.03)	JCP (see instructions)	299,879 1,061,913		35
.00	Additional payment for high percentage of ESRD beneficiary d	lischarges (lines 40 thro			30
.00	Total Medicare discharges (see instructions)		0		40
			Before 1/1	On/After 1/1	
.00	Total ESRD Medicare discharges (see instructions)		1.00	1.01	41
01	Total ESRD Medicare covered and paid discharges (see instruc	ctions)	0	0	
.00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42
.00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided	d hy line 41 divided hy 7	0.000000		43
00	days)	i by Time II divided by 7	0.00000		
.00	Average weekly cost for dialysis treatments (see instruction		0.00	0.00	45
00	Total additional payment (line 45 times line 44 times line 4 Subtotal (see instructions)	11.01)	31,318,287		46
00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only.(see instructions)			Amount	
				Amount 1.00	
00	Total payment for inpatient operating costs (see instruction			31,318,287	
00	Payment for inpatient program capital (from Wkst. L, Pt. I a Exception payment for inpatient program capital (Wkst. L, Pt		)	2,344,297 0	
00	Direct graduate medical education payment (from Wkst. E-4, 1			0	
00	Nursing and Allied Health Managed Care payment			33,383	
00	Special add-on payments for new technologies Islet isolation add-on payment			126,776 0	
00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	1
01	Cellular therapy acquisition cost (see instructions)			0	1 -
00	Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt.		through 35)	0	1
00	Ancillary service other pass through costs from Wkst. D, Pt.		ciii ougii 55).	39,612	
00	Total (sum of amounts on lines 49 through 58)			33,862,355	
00	Primary payer payments Total amount payable for program beneficiaries (line 59 minu	is line 60)		0 33,862,355	1 -
00	Deductibles billed to program beneficiaries	13 Tille 00)		2,942,172	
00	Coinsurance billed to program beneficiaries			107,935	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			164,270 106,776	
00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		31,696	
00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			30,919,024	6
00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)			0	
00 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (FOI SCH SEE HISTIUCTIO	15)	0	
50	Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	70
75 87	N95 respirator payment adjustment amount (see instructions)			0	1
88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	ı		0	
89	Pioneer ACO demonstration payment adjustment amount (see ins	structions)			70
. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
. 91	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	
				0	1,0
.92	HVBP payment adjustment amount (see instructions)			0	70

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared:

				From 07/01/2022 To 06/30/2023	Part A Date/Time Pre 11/20/2023 2:	pared: 29 pm
	<u> </u>	Title	XVIII	Hospital	PPS	
			FFY	(yyyy)	Amount	
70.00				0	1.00	70.00
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70.96
70.97	the corresponding federal year for the period prior to 10/1)	0		0	0	70.97
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70.97
70.98	the corresponding federal year for the period ending on or aft Low Volume Payment-3	.ei 10/1)		0	0	70.98
70.98	HAC adjustment amount (see instructions)			0	0	70.98
	Amount due provider (line 67 minus lines 68 plus/minus lines 6	(0 8 70)			30,239,274	
	Sequestration adjustment (see instructions)	19 Q 70)			604,785	
	Demonstration payment adjustment amount after sequestration				004,783	l .
	Sequestration adjustment-PARHM pass-throughs				0	71.02
	Interim payments				29,439,379	
	Interim payments-PARHM				23,433,373	72.00
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM (for contractor use only)				0	73.00
	Balance due provider/program (line 71 minus lines 71.01, 71.02	72 and			195,110	
74.00	73)	., 72, and			193,110	74.00
74.01	Balance due provider/program-PARHM (see instructions)					74.01
	Protested amounts (nonallowable cost report items) in accordan	sco with			520,509	
73.00	CMS Pub. 15-2, chapter 1, §115.2	ice with			320,309	73.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					1
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2 03			0	90.00
30.00	plus 2.04 (see instructions)	71 2.03			O	30.00
91 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see instru	ictions)			0	
	Capital outlier reconciliation adjustment amount (see instruct				0	
	The rate used to calculate the time value of money (see instru				0.00	
	Time value of money for operating expenses (see instructions)	iccions)			0.00	l .
	Time value of money for capital related expenses (see instructions)	ions)			0	96.00
30.00	Time value of money for capital refaced expenses (see mistrace	.10113)	-	Prior to 10/1	On/After 10/1	30.00
				1.00	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
101.00						
	HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	101.00
	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	;)		0.0000000000		
	HVBP adjustment amount for HSP bonus payment (see instructions	5)				
102.00	HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment	5)				102.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0	0.0000	102.00 103.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)		ıstment	0.0000	0.0000	102.00 103.00
102.00 103.00 104.00	HVBP adjustment amount for HSP bonus payment (see instructions 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 DEMONSTR	ation) Adju		0.0000	0.0000	102.00 103.00 104.00
102.00 103.00 104.00	HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	ation) Adju		0.0000	0.0000	102.00 103.00 104.00
102.00 103.00 104.00	HVBP adjustment amount for HSP bonus payment (see instructions 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 Demonstr Is this the first year of the current 5-year demonstration per	ation) Adju		0.0000	0.0000	102.00 103.00 104.00
102.00 103.00 104.00 200.00	HVBP adjustment amount for HSP bonus payment (see instructions 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 Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	a <b>tion) Adju</b> riod under t		0.0000	0.0000	102.00 103.00 104.00 200.00
102.00 103.00 104.00 200.00	HVBP adjustment amount for HSP bonus payment (see instructions 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 Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	a <b>tion) Adju</b> riod under t		0.0000	0.0000	102.00 103.00 104.00 200.00
102.00 103.00 104.00 200.00 201.00 202.00	HVBP adjustment amount for HSP bonus payment (see instructions 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 Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	a <b>tion) Adju</b> riod under t		0.0000	0.0000	102.00 103.00 104.00 200.00 201.00 202.00
102.00 103.00 104.00 200.00 201.00 202.00	HVBP adjustment amount for HSP bonus payment (see instructions 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 Demonstr  Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	ration) Adju riod under t	che 21st	0.0000	0.0000	102.00 103.00 104.00 200.00 201.00 202.00
102.00 103.00 104.00 200.00 201.00 202.00	HVBP adjustment amount for HSP bonus payment (see instructions 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 Demonstr  Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)	ration) Adju riod under t	che 21st	0.0000	0.0000	102.00 103.00 104.00 200.00 201.00 202.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00	HVBP adjustment amount for HSP bonus payment (see instructions 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 Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	ration) Adju riod under t	che 21st	0.0000	0.0000	102.00 103.00 104.00 200.00 201.00 202.00 203.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00	HVBP adjustment amount for HSP bonus payment (see instructions) 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) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	ration) Adju riod under t	che 21st	0.0000	0.0000 0	102.00 103.00 104.00 200.00 201.00 202.00 203.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00	HVBP adjustment amount for HSP bonus payment (see instructions)  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)  Rural Community Hospital Demonstration Project (§410A Demonstr  Is this the first year of the current 5-year demonstration per  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in  period)  Medicare target amount	ration) Adju riod under t	che 21st	0.0000	0.0000 0	102.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00	HVBP adjustment amount for HSP bonus payment (see instructions)  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 Demonstr  Is this the first year of the current 5-year demonstration per  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line  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)	ration) Adju riod under t	che 21st	0.0000	0.0000 0	102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00	HVBP adjustment amount for HSP bonus payment (see instructions)  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 Demonstr  Is this the first year of the current 5-year demonstration per  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line  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)	ration) Adju riod under t e 49) first year	che 21st	0.0000	0.0000 0	102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00	HVBP adjustment amount for HSP bonus payment (see instructions)  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 Demonstr  Is this the first year of the current 5-year demonstration per  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line  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	ration) Adjuriod under to 49)  first year	che 21st	0.0000	0.0000 0.0000	102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00	HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (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) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 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 instructions)	ration) Adjuriod under to 49)  first year	che 21st	0.0000	0.0000 0.ration	102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 210.00	HVBP adjustment amount for HSP bonus payment (see instructions)  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 Demonstr  Is this the first year of the current 5-year demonstration per  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line  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 instructions)  Redicare Part A inpatient service costs (from Wkst. E, Pt. A,  Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use	ration) Adjuriod under to 49)  first year	che 21st	0.0000	0.0000 0	102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 210.00	HVBP adjustment amount for HSP bonus payment (see instructions)  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 Demonstr  Is this the first year of the current 5-year demonstration per  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line  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 instructions)  Redicare Part A inpatient service costs (from Wkst. E, Pt. A,  Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use	ration) Adjuriod under to 49)  first year	che 21st	0.0000	0.0000 0	102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 210.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 210.00	HVBP adjustment amount for HSP bonus payment (see instructions)  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)  Rural Community Hospital Demonstration Project (§410A Demonstr  Is this the first year of the current 5-year demonstration per  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line  Medicare discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in  period)  Medicare target amount  Case-mix adjustment factor (see instructions)  Medicare inpatient routine cost cap (line 202 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)	ration) Adjuriod under to 49)  first year	che 21st	0.0000	0.0000 0	102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 210.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 211.00	HVBP adjustment amount for HSP bonus payment (see instructions)  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 Demonstr  Is this the first year of the current 5-year demonstration per  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 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 instructions)  Redicare 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)	ration) Adjuriod under to the 49)  first year  ructions) line 59)	che 21st	0.0000	0.0000 0	102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 210.00 211.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 210.00 211.00	HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (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) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 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 instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ration) Adjuriod under to the 49)  first year  ructions) line 59)	che 21st	0.0000	0.0000 0.ration	102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 207.00 208.00 209.00 211.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 211.00 212.00 213.00	HVBP adjustment amount for HSP bonus payment (see instructions) 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) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 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 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 20	ration) Adjuriod under to the 49)  first year  ructions) line 59)	of the curren	0.0000	0.0000 0.ration	102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 211.00 212.00 213.00	HVBP adjustment amount for HSP bonus payment (see instructions)  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)  Rural Community Hospital Demonstration Project (§410A Demonstr  Is this the first year of the current 5-year demonstration per  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line  Medicare discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in  period)  Medicare target amount  Case-mix adjustment factor (see instructions)  Medicare inpatient routine cost cap (line 202 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)  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 2  Low-volume adjustment (see instructions)	ration) Adjuriod under to the 49)  first year  ructions) line 59)	of the curren	0.0000	0.0000 0.ration	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211. 212. 213.

Health Financial Systems	ST. MARY MEDICAL CENT	TER, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	P		Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/20/2023 2:29 pm
		Ti+la YV/TTT	⊎ocni+al	DDC

	Title	XVIII	Hospital	11/20/2023 2: PPS	29 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
.00	Medical and other services (see instructions)			15,012	
.00	Medical and other services reimbursed under OPPS (see instructions)			33,397,333	
.00	OPPS or REH payments			33,280,929	
.00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			15,409 0	1
.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	1
.00	Line 2 times line 5			0	1
.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.0
.00	Transitional corridor payment (see instructions)			0	
.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13,	line 200		42,614	
.0.00	Organ acquisitions			15.013	10.0
1.00	Total cost (sum of lines 1 and 10) (see instructions)  COMPUTATION OF LESSER OF COST OR CHARGES			15,012	11.0
	Reasonable charges				1
2.00	Ancillary service charges			61,480	12.0
3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.0
4.00	y i			61,480	14.0
F 00	Customary charges				1.5 0
.5.00 .6.00	Aggregate amount actually collected from patients liable for payment for s			0	
.6.00	Amounts that would have been realized from patients liable for payment for had such payment been made in accordance with 42 CFR §413.13(e)	services of	n a Chargebasis	0	16.0
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.0
8.00	Total customary charges (see instructions)			61,480	
9.00	Excess of customary charges over reasonable cost (complete only if line 18	exceeds li	ne 11) (see	46,468	
	instructions)				
0.00	Excess of reasonable cost over customary charges (complete only if line 11	exceeds li	ne 18) (see	0	20.0
1.00	instructions) Lesser of cost or charges (see instructions)			15,012	21 0
2.00				0	
3.00	Cost of physicians' services in a teaching hospital (see instructions)			ő	
4.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			33,338,952	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
5.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	
6.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH			5,870,786	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum	of lines 22	and 23] (see	27,483,178	27.0
8.00	instructions)   Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28.0
8.50	REH facility payment amount				28.5
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	1
0.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			27,483,178	30.0
1.00				13,199	1
2.00				27,469,979	32.0
3.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  Composite rate ESRD (from Wkst. I-5, line 11)			0	33.0
4.00				478,882	1
5.00				311,273	
6.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			302,235	
7.00	Subtotal (see instructions)			27,781,252	
8.00	MSP-LCC reconciliation amount from PS&R			387	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.5
9.75				0	
9.97	Demonstration payment adjustment amount before sequestration	soo insta	tions)	0 7,888	
9.98 9.99	Partial or full credits received from manufacturers for replaced devices ( RECOVERY OF ACCELERATED DEPRECIATION	see mstruc	LIUIIS)	7,888	
0.00	Subtotal (see instructions)			27,780,865	1
0.01				555,617	
0.02	Demonstration payment adjustment amount after sequestration			0	1
0.03					40.
1.00	Interim payments			27,307,996	41.
1.01					41.
2.00	Tentative settlement (for contractors use only)			0	
2.01	1			02 740	42.
3.00 3.01				-82,748	43.
4.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS	Puh 15-2	chanter 1	0	1
1.00	§115.2	. ab. 13-2,	ap.c. 1,		'
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92.
	Time Value of Money (see instructions)			0	
	Total (sum of lines 91 and 93)			1 0	94.

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Pre 11/20/2023 2:	
		Title XVIII	Hospital	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2022	Worksheet E Part B	
		Component CCN: 15-T034	To 06/30/2023	Date/Time Prepared: 11/20/2023 2:29 pm	
		Title XVIII	Subprovider -	PPS	
			TRF		

	IRF	113				
		1.00				
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00				
)	Medical and other services (see instructions)	0				
)	Medical and other services reimbursed under OPPS (see instructions)	51				
)	OPPS or REH payments	103				
)	Outlier payment (see instructions)	0				
1 )	Outlier reconciliation amount (see instructions)  Enter the hospital specific payment to cost ratio (see instructions)					
)	Line 2 times line 5	0.000	1			
)	Sum of lines 3, 4, and 4.01, divided by line 6	0.00				
О	Transitional corridor payment (see instructions)	0	1			
0	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0				
00	Organ acquisitions	0	1			
00	Total cost (sum of lines 1 and 10) (see instructions)					
	COMPUTATION OF LESSER OF COST OR CHARGES		+			
<b>Λ</b> Λ	Reasonable charges Ancillary service charges	0	1			
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0				
	Total reasonable charges (sum of lines 12 and 13)	0				
00	Customary charges		1 -			
00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	1			
	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	1			
	had such payment been made in accordance with 42 CFR §413.13(e)					
	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000				
	Total customary charges (see instructions)	0				
00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	1			
00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	2			
•	instructions)	ŭ	-			
00	Lesser of cost or charges (see instructions)	0	2			
00	Interns and residents (see instructions)	0	2			
	Cost of physicians' services in a teaching hospital (see instructions)	0	-			
00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	103	2			
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		,			
	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0 21	-			
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	82				
00	instructions)	02	-			
00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	2			
50	REH facility payment amount		2			
00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	2			
	Subtotal (sum of lines 27, 28, 28.50 and 29)	82				
	Primary payer payments	0	1			
00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	82	3			
00	Composite rate ESRD (from Wkst. I-5, line 11)	0	3			
	Allowable bad debts (see instructions)	0	1 -			
	Adjusted reimbursable bad debts (see instructions)	0	1 -			
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	3			
00	Subtotal (see instructions)	82	3			
00	MSP-LCC reconciliation amount from PS&R	0				
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	1 -			
	Pioneer ACO demonstration payment adjustment (see instructions)		3			
	N95 respirator payment adjustment amount (see instructions)	0	1 -			
	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions)	0	1 -			
	RECOVERY OF ACCELERATED DEPRECIATION	0	1 -			
	Subtotal (see instructions)	82				
	Sequestration adjustment (see instructions)	2				
	Demonstration payment adjustment amount after sequestration	0				
	Sequestration adjustment-PARHM pass-throughs		4			
	Interim payments	80	4			
	Interim payments-PARHM		4			
	Tentative settlement (for contractors use only)	0	1			
	Tentative settlement-PARHM (for contractor use only)	=	4			
	Balance due provider/program (see instructions)	0				
	Balance due provider/program-PARHM (see instructions)	^	4			
UÜ	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	4			
	TO BE COMPLETED BY CONTRACTOR		1			
00	Original outlier amount (see instructions)	0	9			
	Outlier reconciliation adjustment amount (see instructions)	0	1 -			
	The rate used to calculate the Time Value of Money	0.00				
UU	Time Value of Money (see instructions)		9			

Health Financial Systems	ST. MARY MEDICAL C	CENTER, INC.	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period:	Worksheet E		
		Common or the CON 15 TO 24	From 07/01/2022			
		Component CCN: 15-T034	To 06/30/2023	Date/Time Prepared: 11/20/2023 2:29 pm		
		Title XVIII	Subprovider -	PPS		
			IRF			
				1.00		
94.00 Total (sum of lines 91 and 93)				0	94.00	
				1.00		
MEDICARE PART B ANCILLARY COSTS						
200.00 Part B Combined Billed Days					200.00	

Health Financial Systems ST. MARY MEDICAL CENTER, INC. In Lieu of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0034 Period: Worksheet E-1

From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/20/2023 2:29 pm Title XVIII Hospital PPS Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 29,439,379 27,307,996 1.00 Interim payments payable on individual bills, either 2.00 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 3.02 0 3.02 0 3.03 0 0 3.03 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 0 3.53 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50 - 3.98)4.00 29,439,379 27,307,996 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 0 0 5.50 0 0 5.51 5.51 0 5.52 0 5.52 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 0 5.99 5.50 - 5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 195,110 0 6.01 6.02 82,748 SETTLEMENT TO PROGRAM 6.02 7.00 Total Medicare program liability (see instructions) 29,634,489 27,225,248 7.00

Contractor

Number

1.00

0

NPR Date (Mo/Day/Yr)

2.00

8.00

8.00 Name of Contractor

Health Financial Systems ST. MA
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 ST. MARY MEDICAL CENTER, INC. Period: Worksheet E-1
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/20/2023 2:29 pm
Subprovider - PPS Provider CCN: 15-0034

Component CCN: 15-T034

Subprovider -Title XVIII

		Title	. XVIII	Subprovider - IRF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,464,753		80	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05	Provider to Program		0		U	3.05
3.50	ADJUSTMENTS TO PROGRAM		T 0		0	3.50
3.51	ADJUSTMENTS TO TROGRAM		Ö		0	3.51
3.52			l o		ا	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3.99
	3.50-3.98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		6,464,753		80	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
F F0	Provider to Program					0
5.50 5.51	TENTATIVE TO PROGRAM		0		0	5.50 5.51
5.52					0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5.99
3.33	5.50-5.98)				Ĭ	3.33
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		27,320		0	6.02
7.00	Total Medicare program liability (see instructions)		6,437,433		80	7.00
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr)	
8.00	Name of Contractor		J	1.00	2.00	8.00
3.00	Name of Contractor			l	ı l	0.00

Health	Financial Systems	ST. MARY MEDICAL O	CENTER, INC.	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT					L
				From 07/01/2022		
				To 06/30/2023	Date/Time Pre	
			T:+1- NO/TTT	11	11/20/2023 2:	29 pm
			Title XVIII	Hospital	PPS	
					1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA					4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECT					1.00
1.00						
2.00	2.00   Medicare days (see instructions)					
3.00	Medicare HMO days from Wkst. S-3, Pt. I, co	ol. 6. line 2				3.00
4.00	Total inpatient days (see instructions)					4.00
5.00	Total hospital charges from Wkst C, Pt. I,	col. 8 line 200				5.00
6.00	Total hospital charity care charges from w		ine 20			6.00
7.00	CAH only - The reasonable cost incurred for	,		Wkst. S-2. Pt. T		7.00
	line 168	che pui chase or c				'''
8.00	Calculation of the HIT incentive payment (	see instructions)				8.00
9.00	Sequestration adjustment amount (see instri					9.00
10.00	Calculation of the HIT incentive payment a		(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS	& CAH				1
30.00	Initial/interim HIT payment adjustment (see	instructions)				30.00
	Other Adjustment (specify)	ŕ				31.00
	) Palance due provider (line 8 (or line 10) minus line 30 and line 21) (see instructions)					

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

32.00

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0034 Component CCN: 15-T034	From 07/01/2022	
	Title XVIII	Subprovider - IRF	PPS

	IRF		
		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
0	Net Federal PPS Payment (see instructions)	6,396,025	] 1
0	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0182	2
0	Inpatient Rehabilitation LIP Payments (see instructions)	202,114	3
0	Outlier Payments	18,333	4
0	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	
1	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	ī
)	New Teaching program adjustment. (see instructions)	0.00	
)	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	
)	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	
)	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	
00	Average Daily Census (see instructions)	13.654795	1
00	Teaching Adjustment Factor (see instructions)	0.000000	1
00	Teaching Adjustment (see instructions)	0	1
00	Total PPS Payment (see instructions)	6,616,472	1
00	Nursing and Allied Health Managed Care payments (see instruction)	0	1
00	Organ acquisition (DO NOT USE THIS LINE)		1
00	Cost of physicians' services in a teaching hospital (see instructions)	0	1
00	Subtotal (see instructions)	6,616,472	1
00	Primary payer payments	0	1
00	Subtotal (line 17 less line 18).	6,616,472	1
00	Deductibles	37,828	
00	Subtotal (line 19 minus line 20)	6,578,644	
00	Coinsurance	9,835	
00	Subtotal (line 21 minus line 22)	6,568,809	2
00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	
00	Adjusted reimbursable bad debts (see instructions)	0	2
00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	2
00	Subtotal (sum of lines 23 and 25)	6,568,809	
00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	2
00	Other pass through costs (see instructions)	0	
00	Outlier payments reconciliation	0	3
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	3
50	Pioneer ACO demonstration payment adjustment (see instructions)	0	3
98	Recovery of accelerated depreciation.	0	
99	Demonstration payment adjustment amount before sequestration	0	3
00	Total amount payable to the provider (see instructions)	6,568,809	32
01	Sequestration adjustment (see instructions)	131,376	
02	Demonstration payment adjustment amount after sequestration	0	
00	Interim payments	6,464,753	
00	Tentative settlement (for contractor use only)	0	3,
00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-27,320	
00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	3
	TO BE COMPLETED BY CONTRACTOR		
00	Original outlier amount from Wkst. E-3, Pt. III, line 4	18,333	
00	Outlier reconciliation adjustment amount (see instructions)	0	
00	The rate used to calculate the Time Value of Money	0.00	
00	Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE	0 END OF	5
	THE COVID-19 PHE)		
	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	
Λ1	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	I a

Health Financial Systems ST. MARY MEDICAL CENTER, INC.		In Lie	u of Form CMS-2	552-10	
OUTLIE	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0034	Period:	Worksheet E-5	
			From 07/01/2022	Data /=: D	
			To 06/30/2023	Date/Time Prep 11/20/2023 2:2	
		Title XVIII		PPS	
	·				
	1.00				
1.00	instructions)	0	1.00		
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instr	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instruc	tions)		0	4.00
5.00   The rate used to calculate the time value of money (see instructions)					5.00
6.00	Time value of money for operating expenses (see instructions)			0	6.00
7.00	0	7.00			

	Financial Systems ST. MARY MEDICAL	L CENTER, INC.		In Lie	u of Form CMS-	2552-10
	E SHEET (If you are nonproprietary and do not maintain	Provider Co		eriod:	Worksheet G	
	ype accounting records, complete the General Fund column			rom 07/01/2022 o 06/30/2023	Date/Time Pre	pared:
only)					11/20/2023 2:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,663		1	0	
2.00	Temporary investments	0	C	1	0	
3.00 4.00	Notes receivable Accounts receivable	37,023,935	C		0	
5.00	Other receivable	1,014,183			0	
6.00	Allowances for uncollectible notes and accounts receivable	0		ol ol	0	
7.00	Inventory	7,709,969	d	Ö	0	
8.00	Prepaid expenses	0	C	0	0	8.00
9.00	Other current assets	2,245,860		0	0	
10.00	Due from other funds	0	C	1	0	1
11.00	Total current assets (sum of lines 1-10)	47,996,610	C	0	0	11.00
12.00	FIXED ASSETS Land	0		ol	0	12.00
13.00	Land improvements	0		1	0	
14.00	Accumulated depreciation	o o	ĺ	ol ol	0	
15.00	Buildings	146,077,987	d	0	0	1
16.00	Accumulated depreciation	0	C	0	0	16.00
17.00	Leasehold improvements	0	C	0	0	
18.00	Accumulated depreciation	0	C	0	0	
19.00	Fixed equipment	0		0	0	
20.00	Accumulated depreciation Automobiles and trucks	0			0	
22.00	Accumulated depreciation	0			0	
23.00	Major movable equipment	0			0	
24.00	Accumulated depreciation	0	d	Ö	0	
25.00	Minor equipment depreciable	0	C	0	0	25.00
26.00	Accumulated depreciation	0	C	0	0	
27.00	HIT designated Assets	0	C	0	0	
28.00	Accumulated depreciation	0		0	0	
29.00 30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	146,077,987			0	1
30.00	OTHER ASSETS	140,077,987		n o <sub>l</sub>	0	30.00
31.00	Investments	0	С	0	0	31.00
32.00	Deposits on leases	0	c	0	0	32.00
33.00	Due from owners/officers	0	C	0	0	33.00
34.00	Other assets	10,936,284		0	0	
35.00	Total other assets (sum of lines 31-34)	10,936,284			0	
36.00	Total assets (sum of lines 11, 30, and 35)	205,010,881	<u>C</u>	0	0	36.00
37.00	CURRENT LIABILITIES  Accounts payable	1,225,799		ol	0	37.00
38.00	Salaries, wages, and fees payable	6,413,862	•		0	
39.00	Payroll taxes payable	0,113,002	ĺ	ol ol	0	
40.00	Notes and loans payable (short term)	0	d	0	0	1
41.00	Deferred income	0	C	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	C	1	0	1
44.00	Other current liabilities	3,546,069		1	0	
45.00	Total current liabilities (sum of lines 37 thru 44)  LONG TERM LIABILITIES	11,185,730	C	0	0	45.00
46.00	Mortgage payable	0		0	0	46.00
47.00	Notes payable	o o	ĺ		0	1
48.00	Unsecured loans	0	d	0	0	
49.00	Other long term liabilities	4,262,122	[ c	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,262,122		1	0	
51.00	Total liabilities (sum of lines 45 and 50)	15,447,852	<u> </u>	0	0	51.00
F2 00	CAPITAL ACCOUNTS	100 562 020	1			F2 00
52.00 53.00	General fund balance Specific purpose fund	189,563,029				52.00
54.00	Donor created - endowment fund balance - restricted		١	<u></u>		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			o		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement,				0	58.00
F0 00	replacement, and expansion	100 500 000	_		-	F0 00
59.00 60.00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	189,563,029 205,010,881	•	1	0	
00.00	10tal liabilities and fund balances (sum of lines 51 and   59)	203,010,081		ή	U	00.00
	1	1	1			1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10 ST. MARY MEDICAL CENTER, INC.

Provider CCN: 15-0034 Period: Worksheet G-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					То	06/30/2023	Date/Time 11/20/2023		
		General	Fund	Special	Purpo	se Fund	Endowment Fu	und	
		1.00	2.00	3.00		4.00	5.00		
1.00 2.00 3.00 4.00 5.00 6.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RESTRICTED CONTRIBUTIONS	79,614 0 0	170,476,292 33,899,191 204,375,483		0 0 0	0		0 0 0	1.00 2.00 3.00 4.00 5.00 6.00
7.00 8.00 9.00 10.00	Total additions (sum of line 4-9)	0 0	79,614		0 0 0	0		0 0 0	7.00 8.00 9.00 10.00
11.00 12.00 13.00 14.00 15.00 16.00 17.00	Subtotal (line 3 plus line 10) NET ASSETS RELEASED TRANSFERRED TO/FROM AFFILIATES	21,956 14,870,112 0 0 0	204,455,097		0 0 0 0	0		0 0 0 0 0	11.00 12.00 13.00 14.00 15.00 16.00 17.00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		14,892,068 189,563,029			0			18.00 19.00
		Endowment Fund	Plant	Fund					
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RESTRICTED CONTRIBUTIONS	0	0		0				1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00 9.00			0 0 0 0						5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) NET ASSETS RELEASED TRANSFERRED TO/FROM AFFILIATES	0	0 0 0 0 0		0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0				18.00 19.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet G-2 | From 07/01/2022 | Parts I & II |
| To 06/30/2023 | Date/Time Prepared: | Health Financial Systems ST.
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0034

			То	06/30/2023	Date/Time Prep 11/20/2023 2:3	pared: 29 pm
	Cost Center Description	Inpatient	:	Outpatient	Total	
		1.00		2.00	3.00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospital	68,227,	215		68,227,215	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF	8,415,	375		8,415,375	3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)	76,642,	590		76,642,590	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	17,957,	820		17,957,820	11.00
12.00	CORONARY CARE UNIT					12.00
13.00						13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	17.057	020		17 057 030	15.00
16.00	Total intensive care type inpatient hospital services (sum of li	nes 17,957,	820		17,957,820	16.00
17.00	11-15)   Total inpatient routine care services (sum of lines 10 and 16)	94,600,	410		94,600,410	17.00
18.00	Ancillary services	316,654,		0	316,654,702	18.00
19.00	Outpatient services	310,034,	0	879,171,578	879,171,578	
20.00	RURAL HEALTH CLINIC		0	075,171,570	0/5,1/1,5/0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22.00	HOME HEALTH AGENCY		J	5,566,949	5,566,949	22.00
23.00	AMBULANCE SERVICES			3,300,313	3,300,313	23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)					25.00
26.00						26.00
27.00	PHYSICIAN REVENUE		0	88,898	88,898	27.00
27.01	TAXABLE LAB		0	5,146,187	5,146,187	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	wkst. 411,255,	112	889,973,612	1,301,228,724	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			288,803,648		29.00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)		_	0		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38.00			0			38.00
39.00			0			39.00
40.00			0			40.00
41.00	Total deductions (sum of lines 37 41)		0			41.00
42.00 43.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(	transfor		288,803,648		42.00 43.00
43.00	to Wkst. G-3, line 4)	. (1 0115161		200,003,040		43.00
	To most of a fille ty	I	I	'	l	

	Financial Systems ST. MARY MEDICAL	· · · · · · · · · · · · · · · · · · ·		u of Form CMS-2	
STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0034	Period: From 07/01/2022	Worksheet G-3	
			To 06/30/2023		
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li		1,301,228,724 982,026,892		
2.00 Less contractual allowances and discounts on patients' accounts					2.00 3.00
3.00					
4.00					
5.00	Net income from service to patients (line 3 minus line 4)		30,398,184	5.00	
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			164,336	6.00
7.00	Income from investments			190,275	7.00
8.00	Revenues from telephone and other miscellaneous communicatio	n services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase discounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			1,354,653	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
			_		

17.00

18.00

22.00

23.00

24.00

24.01

24.02

24.03

24.04

24.05

24.50

25.00

26.00

0 27.00

0 28.00 33,899,191 29.00

0 19.00

0 20.00

0

51,160

20,956

215,493

49,655

125,366

27,582

35,447

3,501,007

33,899,191

1,246,693

19,391 21.00

17.00 Revenue from sale of drugs to other than patients

18.00 Revenue from sale of medical records and abstracts

20.00 Revenue from gifts, flowers, coffee shops, and canteen

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

19.00 Tuition (fees, sale of textbooks, uniforms, etc.)

TEMP ASSETS RELEASED FROM RESTRICTIO

Total other income (sum of lines 6-24)

21.00 Rental of vending machines

23.00 Governmental appropriations

26.00 Total (line 5 plus line 25)

27.00 OTHER EXPENSES (SPECIFY)

22.00 Rental of hospital space

24.04 GAIN ON SALE OF ASSETS

24.50 COVID-19 PHE Funding

24.00 OTHER INCOME

24.05 GRANT INCOME

24.02 UBI INCOME

24.03 CLASSES

24.01

25.00

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20.00 21.00

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17.00

18.00

19.00

20.00

21.00

22.00

23.00

23.50

Clinic

Private Duty Nursing

Day Care Program

Homemaker Service

Telemedicine

All Others (specify)

24.00 Total (sum of lines 1-23)

Health Promotion Activities

Home Delivered Meals Program

Health Financial Systems

ST. MARY MEDICAL CENTER, INC.

Provider CCN: 15-0034
HHA CCN: 15-7313

Period: From 07/01/2022 Part I Date/rime Prepared: 11/20/2023 2:29 pm

Home Health From 07/01/2022 Part I Date/rime Prepared: 11/20/2023 2:29 pm

Realth Financial Systems

Provider CCN: 15-0034
HHA CCN: 15-7313

Realted Costs

Net Expenses for Cost Fixtures Fixtures Equipment Operation & Maintenance Maintenance

Maintenance

Maintenance

							11/20/2023 2:	29 pm
						Home Health	PPS	
			Capital Rela	ited Costs		Agency I		
			Capital Kela	iteu costs				
		Net Expenses	Bldgs &	Movable	Plant	Transportation	Subtotal	
		for Cost	Fixtures	Equipment	Operation &		(cols. 0-4)	
		Allocation			Maintenance			
		(from Wkst. H,						
		col. 10) 0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	4A.00	
1.00	Capital Related - Bldg. &	0	0				0	1.00
	Fixtures							
2.00	Capital Related - Movable	0		0			0	2.00
	Equipment			_				
3.00	Plant Operation & Maintenance	0	0	0		0	0	
4.00 5.00	Transportation Administrative and General	835,785	0	0		0 0	835,785	4.00 5.00
3.00	HHA REIMBURSABLE SERVICES	[ 655,765	<u> </u>		1	0 0	033,703	3.00
6.00	Skilled Nursing Care	1,108,698	0	0		0 0	1,108,698	6.00
7.00	Physical Therapy	841,506	0	0		0	841,506	1
8.00	Occupational Therapy	250,122	0	0		0	250,122	
9.00	Speech_Pathology	59,778	0	0		0	59,778	ı
10.00	Medical Social Services	0	0	0	1	0	0	10.00
11.00	Home Health Aide	34,083	0	0		0 0	34,083	
12.00 13.00	Supplies (see instructions) Drugs	95,154	0	0		0	95,154 0	
14.00	DME		0	0		0 0	0	1
11100	HHA NONREIMBURSABLE SERVICES	<u> </u>	<u> </u>		1	<u> </u>		1 11.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0	0	16.00
17.00	Private Duty Nursing	0	0	0		0	0	
18.00	Clinic	0	0	0	1	0	0	18.00
19.00	Health Promotion Activities	0	0	0		0	0	19.00
20.00	Day Care Program Home Delivered Meals Program	0	0	0			0	20.00
22.00	Homemaker Service	0	0	0		0 0	0	1
23.00	All Others (specify)	O	o	0	,	0 0	Ö	23.00
23.50	Telemedicine	0	0	0	)	0	0	
24.00	Total (sum of lines 1-23)	3,225,126	0	0		0 0	3,225,126	24.00
		Administrative						
		& General 5.00	4A + 5) 6.00					
	GENERAL SERVICE COST CENTERS	3.00	0.00					
1.00	Capital Related - Bldg. &							1.00
	Fixtures							
2.00	Capital Related - Movable							2.00
2 00	Equipment							2 00
3.00 4.00	Plant Operation & Maintenance Transportation							3.00 4.00
5.00	Administrative and General	835,785						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	387,820	1,496,518					6.00
7.00	Physical Therapy	294,356	1,135,862					7.00
8.00	Occupational Therapy	87,492	337,614					8.00
9.00	Speech Pathology Medical Social Services	20,910	80,688					9.00
10.00 11.00	Home Health Aide	11,922	0 46,005					10.00 11.00
12.00	Supplies (see instructions)	33,285	128,439					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00 18.00	Private Duty Nursing	0	0					17.00 18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program		o					20.00
21.00	Home Delivered Meals Program	0	o					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
	4	0	2 225 126					23.50
24.00	Total (sum of lines 1-23)	1	3,225,126					24.00

HHA CCN:

							11/20/2023 2:	29 pm_
						Home Health	PPS	
						Agency I		
		Capital Re	lated Costs					
		7.1		_				
		Bldgs &	Movable	Plant		nReconciliation		
		Fixtures	Equipment	Operation &	(MILEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance			(ACCUM. COST)	
		1.00	2.00	(SQUARE FEET) 3.00	4.00	FA 00	Г 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5A.00	5.00	
1.00	Capital Related - Bldg. &	100			1	0		1.00
1.00	Fixtures	100				U		1.00
2.00	Capital Related - Movable		0			0		2.00
2.00	Equipment		0					2.00
3.00	Plant Operation & Maintenance	0	0	100		0		3.00
4.00	Transportation (see	0	o o	100	1	0		4.00
4.00	instructions)				1			7.00
5.00	Administrative and General	100	0	100	,	-835,785	2,389,341	5.00
	HHA REIMBURSABLE SERVICES						,,.	
6.00	Skilled Nursing Care	0	0	0		0 0	1,108,698	6.00
7.00	Physical Therapy	0	0	0		0	841,506	
8.00	Occupational Therapy	0	0	0		0	250,122	8.00
9.00	Speech Pathology	0	0	0		0	59,778	9.00
10.00	Medical Social Services	0	0	0	)	0	0	10.00
11.00	Home Health Aide	0	0	0		0	34,083	11.00
12.00	Supplies (see instructions)	0	0	0	)	0	95,154	12.00
13.00	Drugs	0	0	0	)	0	0	13.00
14.00	DME	0	0	0		0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0		0	0	
16.00	Respiratory Therapy	0	0	0	1	0	0	16.00
17.00	Private Duty Nursing	0	0	0	1	0	0	17.00
18.00	Clinic	0	0	0		0	0	18.00
19.00	Health Promotion Activities	0	0	0		0	0	19.00
20.00	Day Care Program	0	0	0	1	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	1	0	0	21.00
22.00	Homemaker Service	0	0	0	1	0	0	22.00
23.00	All Others (specify)	0	0	0	1	0	0	23.00
23.50	Telemedicine	0	0	0	1	0	0	23.50
24.00	Total (sum of lines 1-23)	100	0	100		-835,785	2,389,341	
25.00	Cost To Be Allocated (per	0	0	0		0	835,785	25.00
26.05	Worksheet H-1, Part I)			0.000			0 246	20.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.00000	U	0.349797	26.00

Worksheet H-2 Part I Date/Time Prepared: 11/20/2023 2:29 pm Period: From 07/01/2022 To 06/30/2023 HHA CCN: 15-7313

Home Health PPS

						Agency I		
			CAPITAL REL	LATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	PURCHASING RECEIVING AND	ADMITTING	
		0	1.00	2.00	DEPARTMENT 4.00	STORES 5.01	5.02	
1.00	Administrative and General	0	0		110.970			1.00
2.00	Skilled Nursing Care	1,496,518	0		159,042		0	1
3.00	Physical Therapy	1,135,862	0	0	134,043	0	0	3.00
4.00	Occupational Therapy	337,614	0	0	26,220		0	ı
5.00	Speech Pathology	80,688	0	0	7,847	0	0	
6.00 7.00	Medical Social Services Home Health Aide	46,005	0	0	5,119	0	0	
8.00	Supplies (see instructions)	128,439	0	0	0,113	0	0	
9.00	Drugs	0	0	0	0	0	0	
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0		0	0	0	
12.00 13.00	Respiratory Therapy Private Duty Nursing	0	0	0	0	0	0	12.00 13.00
14.00	Clinic	0	0	0	0	0	0	ł
	Health Promotion Activities	0	0	Ö	Ö	0	Ö	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
	Home Delivered Meals Program	0	0	1	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	
19.00	All Others (specify) Telemedicine	0	0	0	0	0	0	19.00 19.50
20.00	Total (sum of lines 1-19) (2)	3,225,126	0	2,021	443,241	0	16,790	1
21.00	Unit Cost Multiplier: column							21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	CASHIERING/ACC		OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPING	
		OUNTS		ADMINISTRATIVE	PLANT	LINEN SERVICE		
		RECEIVABLE 5.03	5A.03	& GENERAL 5.04	7.00	8.00	9.00	
1.00	Administrative and General	13,260	143,041		0			1.00
2.00	Skilled Nursing Care	0	1,655,560	242,749	0	0	0	2.00
3.00	Physical Therapy	0	1,269,905		0	0	0	
4.00 5.00	Occupational Therapy Speech Pathology	0	363,834		0	0	0	
6.00	Medical Social Services	0	88,535 0	12,982	0	0	0	
7.00	Home Health Aide	0	51,124	7,496	Ö	0	Ö	
8.00	Supplies (see instructions)	0	128,439	18,833	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	
10.00 11.00	DME Home Dialysis Aide Services	0	0	0	0	0	0	10.00 11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	
13.00	1	0	0	Ö	Ö	0	Ö	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	
	Day Care Program Home Delivered Meals Program	0	0	0		0	0	ł
18.00	Homemaker Service	0	0	0	0	0	0	
	All Others (specify)	0	0	0	0	0	0	1
	Telemedicine	0	0	0	0	0	0	
20.00	Total (sum of lines 1-19) (2)	13,260			0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum		0.000000					21.00
	of column 26, line 20 minus							
	or corumn zo, rine zo minus							l
	column 26, line 1, rounded to 6 decimal places.							

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Provider CCN: 15-0034 Period: Worksheet H-2 From 07/01/2022 Part I Date/Time Prepared: HHA CCN: 15-7313 То 06/30/2023 11/20/2023 2:29 pm

Home Health PPS Agency I Cost Center Description DIETARY CAFETERIA NURSING CENTRAL PHARMACY MEDICAL RECORDS & ADMINISTRATION SERVICES & SUPPLY LIBRARY 13.00 10.00 11.00 14.00 15.00 16.00 Administrative and General 10,852 12,231 1.00 0 0 0 2.00 Skilled Nursing Care 0 2.00 0 0 3.00 Physical Therapy 0 0 3.00 0 0 0 0 4.00 Occupational Therapy 0 0 4.00 Speech Pathology 0 0 0 0 0 5.00 5.00 Medical Social Services 0 0 0 0 6.00 6.00 0 0 0 0 0 7.00 Home Health Aide 0 7.00 0 0 8.00 Supplies (see instructions) 0 0 0 0 8.00 9.00 Drugs 0 0 0 0 9.00 0 0 0 0 0 10.00 DMF 0 10.00 0 0 0 Home Dialysis Aide Services 11.00 0 11.00 12.00 Respiratory Therapy 0 0 12.00 0 0 0 13.00 Private Duty Nursing 0 0 0 13.00 0 0 0 14.00 14.00 Clinic 0 0 15.00 Health Promotion Activities 0 0 0 15.00 0 0 0 16.00 Day Care Program 0 0 16.00 0 0 0 17.00 17.00 Home Delivered Meals Program 18.00 Homemaker Service 0 0 0 0 18.00 19.00 All Others (specify) 0 0 0 0 19.00 19.50 Telemedicine 0 0 0 0 19.50 12,231 20.00 Total (sum of lines 1-19) (2) 10,852 0 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description SOCIAL SERVICE NONPHYSICIAN PARAMEDICAL Subtotal Subtotal Intern & **ANESTHETISTS EDUCATION** Residents Cost PROGRAM EMS & Post Stepdown Adjustments 17.00 19.00 23.00 24.00 25.00 26.00 1.00 Administrative and General 0 187,098 187,098 1.00 2.00 Skilled Nursing Care 0 0 1,898,309 0 1,898,309 2.00 0 0 3.00 Physical Therapy 0 1,456,107 0 1,456,107 3.00 0 0 0 0 417,182 4.00 Occupational Therapy 417,182 4.00 5.00 Speech Pathology 0 0 101,517 0 101,517 5.00 Medical Social Services 0 0 0 6.00 6.00 0 0 0 7.00 Home Health Aide 58,620 58,620 7.00 0 8.00 0 147,272 Supplies (see instructions) 147,272 8.00 9.00 0 0 0 9.00 Drugs 0 0 0 0 10.00 10.00 0 0 0 Home Dialysis Aide Services 0 0 11.00 11.00 0 0 12.00 Respiratory Therapy 0 12.00 0 0 13.00 Private Duty Nursing 0 0 0 13.00 0 14.00 Clinic 14.00 0 0 0 15.00 Health Promotion Activities 0 15.00 0 0 0 0 16.00 Day Care Program 0 16.00 17.00 Home Delivered Meals Program 0 0 17.00 0 0 0 0 18.00 Homemaker Service 0 18.00 All Others (specify) 0 0 0 19.00 19.00 0 0 0 19.50 Telemedicine 0 19.50 20.00 Total (sum of lines 1-19) (2) 4,266,105 4,266,105 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

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

Home Health PPS Agency I Total HHA Cost Center Description Allocated HHA A&G (see Part Costs II) 28.00 27.00 1.00 Administrative and General 1.00 1,985,381 2.00 Skilled Nursing Care 87,072 2.00 Physical Therapy 66,790 3.00 1,522,897 3.00 4.00 Occupational Therapy 19,136 436,318 4.00 5.00 Speech Pathology 4,656 106,173 5.00 6.00 Medical Social Services 6.00 2,689 61,309 7.00 Home Health Aide 7.00 8.00 Supplies (see instructions) 6,755 154,027 8.00 9.00 Drugs 9.00 0 0 10.00 10.00 DMF Home Dialysis Aide Services 0 0 11.00 11.00 12.00 Respiratory Therapy 0 12.00 Private Duty Nursing 0 0 13.00 13.00 0 0 14.00 14.00 Clinic 15.00 | Health Promotion Activities 15.00 16.00 Day Care Program 0 0 16.00 0 0 17.00 Home Delivered Meals Program 17.00 0 0 18.00 Homemaker Service 18.00 19.00 All Others (specify) 0 0 19.00 Telemedicine 19.50 19.50 0 0 Total (sum of lines 1-19) (2) 187,098 4,266,105 20.00 20.00 Unit Cost Multiplier: column 21.00 0.045869 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

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

HHA CCN: 15-7313

Period: Worksheet H-2
From 07/01/2022 Part II
Date/Time Prepared: 11/20/2023 2:29 pm

Home Health PPS

						Agency I		
		CAPITAL REI	LATED COSTS					
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (COSTED REQ)	ADMITTING (GROSS REVE NUE)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVE NUE)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	0	5,305	654,955	0	5,566,949	5,566,949	1.00
2.00	Skilled Nursing Care	0	0	938,671	0	0	0	2.00
3.00	Physical Therapy	0	0	791,132	0	0	0	3.00
4.00	Occupational Therapy	0	0	154,755	0	0	0	4.00
5.00	Speech Pathology	0	0	46,314	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	30,211	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0		0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0		0	0	12.00
13.00	Private Duty Nursing	0	0	0		0	0	
14.00	Clinic	0	0	0	1	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00 18.00	Home Delivered Meals Program	0	0	0	0	0	0	
19.00	Homemaker Service All Others (specify)	0	0	0	0	0	0	18.00 19.00
19.50	Telemedicine		0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	5,305	2,616,038		5,566,949	5,566,949	
21.00	Total cost to be allocated	0	2,021	443,241	0	16,790		
22.00	Unit cost multiplier	0.000000	0.380961	0.169432	0.000000			
		Reconciliation	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	
	·		ADMINISTRATIVE	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
			& GENERAL	(SQUARE FEET)	(TOTAL PATIENT			
			(ACCUM. COST)		DAYS)			
1 00		5A.04	5.04	7.00	8.00	9.00	10.00	1 00
1.00	Administrative and General	0	143,041	0	•	0	0	1
2.00	Skilled Nursing Care Physical Therapy	0	1,655,560 1,269,905	0	0	0	0	
4.00	Occupational Therapy		363,834	0		0	0	
5.00	Speech Pathology	0	88,535	0		0	0	
6.00	Medical Social Services	0	00,333	0	1	0	0	
7.00	Home Health Aide	0	51,124	0		0	o o	
8.00	Supplies (see instructions)	0	128,439	0		0	0	
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0		0	0	1
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0		0	0	16.00
17.00	Home Delivered Meals Program	0	0	0		0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	10.00
19.00	All Others (specify)	0	0	0	0	0	0	
19.50	Telemedicine	0	3 700 430	0		0	0	19.50
20.00	Total (sum of lines 1-19)	1	3,700,438 542,584	0		0	0	20.00
21.00	Total cost to be allocated	i contract of the contract of	1 247.284	. ()	1 0	ı U	. 0	LT.00
22.00	Unit cost multiplier		0.146627	0.000000	0.000000	0.000000	0.000000	22 00

Health Financial Systems ST. MARY MEDICAL CENTER, INC.
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-0034 In Lieu of Form CMS-2552-10

Period: Worksheet H-2
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared: 11/20/2023 2:29 pm HHA CCN: 15-7313

								11/20/2023 2:	29 pm_
							Home Health	PPS	
		1			1	L	Agency I		
	Cost Center Description	CAFETERIA	NURSING	CENTRAL	PHARMACY		MEDICAL	SOCIAL SERVICE	
		(NUMBER OF	ADMINISTRATION	SERVICES &	(COSTED		RECORDS &		
		FTES)		SUPPLY	REQUIS.)		LIBRARY	(TIME SPENT)	
			(NURSING HO	(COSTED			(GROSS REVE		
		11.00	URS)	REQUIS.)	45.00	_	NUE)	47.00	
1 00	1.	11.00	13.00	14.00	15.00	_	16.00	17.00	1.00
1.00	Administrative and General	8		0	1	0	5,566,949		1.00
2.00	Skilled Nursing Care	0	0	0	1	0	0	0	2.00
3.00	Physical Therapy	0	0	0		0	0	0	3.00
4.00	Occupational Therapy	0	0	0	1	0	0	0	4.00
5.00	Speech Pathology	0	0	0		0	0	0	5.00
6.00	Medical Social Services	0	0	0		0	0		6.00
7.00	Home Health Aide	0	0	0		0	0		7.00
8.00	Supplies (see instructions)	0	0	0		0	0	0	8.00
9.00	Drugs	0	0	0		0	0	_	9.00
10.00	DME	0	0	0		0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	1	0	0		11.00
12.00	Respiratory Therapy	0	0	0		0	0	_	12.00
13.00	Private Duty Nursing	0	0	0	1	0	0		13.00
14.00	Clinic	0	0	0	1	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	1	0	0	0	15.00
16.00	Day Care Program	0	0	0		0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0		0	0	0	17.00
18.00	Homemaker Service	0	0	0	1	0	0	0	18.00
19.00	All Others (specify)	0	0	0	1	0	0	0	19.00
19.50	Telemedicine	0	0	0		0	T TCC 040	0	19.50
20.00	Total (sum of lines 1-19)	10.053	0	0		0	5,566,949		20.00 21.00
21.00	Total cost to be allocated	10,852		0.000000	0.0000	0	12,231		
22.00	Unit cost multiplier Cost Center Description	1,356.500000 NONPHYSICIAN	0.000000 PARAMEDICAL	0.000000	0.0000	00	0.002197	0.000000	22.00
	cost center bescription	ANESTHETISTS	EDUCATION						
		(ASSIGNED	PROGRAM EMS						
		TIME)	(ASSIGNED						
			TIME)						
		19.00	23.00						
1.00	Administrative and General	0							1.00
2.00	Skilled Nursing Care	0	0						2.00
3.00	Physical Therapy	0	0						3.00
4.00	Occupational Therapy	0	0						4.00
5.00	Speech Pathology	0	0						5.00
6.00	Medical Social Services	0	0						6.00
7.00	Home Health Aide	0	0						7.00
8.00	Supplies (see instructions)	0	0						8.00
9.00	Drugs	0	0						9.00
10.00	DME	0	0						10.00
11.00	Home Dialysis Aide Services	0	0						11.00
12.00	Respiratory Therapy	0	0						12.00
13.00	Private Duty Nursing	0	0						13.00
14.00	Clinic	0	0						14.00
15.00	Health Promotion Activities	0	0						15.00
16.00	Day Care Program	0	0						16.00
17.00	Home Delivered Meals Program	0	0						17.00
18.00	Homemaker Service	0	0						18.00
19.00	All Others (specify)	0	0						19.00
19.50		0	0						19.50
20.00		0	0						20.00
21.00	Total cost to be allocated	0	0						21.00
22.00	Unit cost multiplier	0.000000	0.000000						22.00

NI I OIK	TIONMENT OF PATIENT SERVICE COST		T. MARY MEDICAL	Provider C	CN: 15-0034	Period:	u of Form CMS-2 Worksheet H-3	255Z-I
	TIONMENT OF PATIENT SERVICE COST	3		HHA CCN:		From 07/01/2022 To 06/30/2023	Part I Date/Time Prep	
				Title	2 XVIII	Home Health	11/20/2023 2:2 PPS	29 piii
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LIM	ITATION COST, OF	2	
	Cost Per Visit Computation							
.00	Skilled Nursing Care	2.00			1,985,38	13,440	147.72	1.0
.00	Physical Therapy	3.00	' '		_,,			
.00	Occupational Therapy	4.00	·		,			
.00	Speech Pathology	5.00	106,173	0	106,17	3 535	198.45	
.00	Medical Social Services	6.00				0	0.00	
.00	Home Health Aide	7.00	61,309		61,30	9 567	108.13	6.0
.00	Total (sum of lines 1-6)		4,112,078	0	-,,			7.0
			ı		Program Visit			
						ırt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to Deductibles			
					Coinsurance			
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation	T	T	_		.1		
.00	Skilled Nursing Care		23844	0	-,			8.0
.00	Physical Therapy		23844	0				9.0
0.00			23844	0	_,			10.0
1.00			23844	0	26			11.0
2.00			23844	0	1	0		12.00
L3.00			23844	0	1			13.00
L4.00	Total (sum of lines 8-13) Cost Center Description	Erom Wkst 4-2	Facility Costs		11,15 Total HHA	Total Charges	Ratio (col. 3	14.00
	cost center bescription	Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)	- (01. 4)	
		20,	2, 2)	Part II)	/			
		0	1.00	2.00	3.00	4.00	F 00	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput		1.00	2.00	3.00	4.00		
5.00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 8.00	154,027					15.00
		ations	154,027 0	0	154,02		2.271282	
	Cost of Medical Supplies	ations 8.00	154,027	0	154,02 Cost of	7 67,815	2.271282	
	Cost of Medical Supplies	ations 8.00	154,027 0	0	154,02	7 67,815	2.271282 0.000000	
	Cost of Medical Supplies	8.00 9.00	154,027 0 Program Visits	0 0	154,02 Cost of	7 67,815 0 0	2.271282 0.000000	
	Cost of Medical Supplies Cost of Drugs	8.00 9.00	154,027 0 Program Visits	0 0 t B Subject to	154,02 Cost of Services	7 67,815 0 0	2.271282 0.000000	
	Cost of Medical Supplies Cost of Drugs	8.00 9.00 Part A	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance	t B Subject to Deductibles & Coinsurance	154,02 Cost of Services	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance	2.271282 0.000000 Subject to Deductibles & Coinsurance	
	Cost of Medical Supplies Cost of Drugs  Cost Center Description	8.00 9.00 Part A	154,027 0 Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	
	Cost of Medical Supplies Cost of Drugs	8.00 9.00 Part A	154,027 0 Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	
	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER	8.00 9.00 Part A	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	
.6.00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	8.00 9.00 Part A	154,027 0 Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	16.0
00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	8.00 9.00 Part A	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.0
1.00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	8.00 9.00 Part A	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.00
1.00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	8.00 9.00 Part A	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	
00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	8.00 9.00 Part A	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 5,664 3,375 1,482 263 0	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OR 0 836,686 0 636,660 0 195,594	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.00 2.00 3.00
	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	8.00 9.00 Part A	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 5,664 3,375 1,482 263	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.00 2.00 3.00 4.00
00 2.00 3.00 3.00 5.00 5.00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	8.00 9.00 Part A	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 5,664 3,375 1,482 263 0	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00  ITATION COST, OF  0 836,686 0 636,660 0 195,594 0 52,192 0 0	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.00 2.00 3.00 4.00 5.00
00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	### A #### A ### A ### A ### A ### A #### A ######	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 5,664 3,375 1,482 263 0 371 11,155	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A  9.00 PROGRAM LIM	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF 0 836,686 0 636,660 0 195,594 0 52,192 0 0 0 40,116 0 1,761,248	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.00 2.00 3.00 4.00 5.00 6.00
00 2.00 3.00 3.00 5.00 5.00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	8.00 9.00 Part A	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 5,664 3,375 1,482 263 0 371	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF 0 836,686 0 636,660 0 195,594 0 52,192 0 0 40,116	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.00 2.00 3.00 4.00 5.00 6.00
00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation	### A #### A ### A ### A ### A ### A #### A ######	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 5,664 3,375 1,482 263 0 371 11,155	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A  9.00 PROGRAM LIM	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF 0 836,686 0 636,660 0 195,594 0 52,192 0 0 0 40,116 0 1,761,248	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.00 2.00 3.00 4.00 5.00 7.00
1.00 2.00 3.00 4.00 5.00 5.00 5.00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care	### A #### A ### A ### A ### A ### A #### A ######	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 5,664 3,375 1,482 263 0 371 11,155	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A  9.00 PROGRAM LIM	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF 0 836,686 0 636,660 0 195,594 0 52,192 0 0 0 40,116 0 1,761,248	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.00 2.00 3.00 4.00 5.00 6.00 7.00
	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Physical Therapy	### A #### A ### A ### A ### A ### A #### A ######	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 5,664 3,375 1,482 263 0 371 11,155	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A  9.00 PROGRAM LIM	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF 0 836,686 0 636,660 0 195,594 0 52,192 0 0 0 40,116 0 1,761,248	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.00 2.00 3.00 4.00 5.00 7.00
00 00 00 00 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)  Cost Center Description  Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy	### A #### A ### A ### A ### A ### A #### A ######	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 5,664 3,375 1,482 263 0 371 11,155	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A  9.00 PROGRAM LIM	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF 0 836,686 0 636,660 0 195,594 0 52,192 0 0 0 40,116 0 1,761,248	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.0 2.0 3.0 4.0 7.0 8.0 9.0 10.0
	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	### A #### A ### A ### A ### A ### A #### A ######	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 5,664 3,375 1,482 263 0 371 11,155	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A  9.00 PROGRAM LIM	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF 0 836,686 0 636,660 0 195,594 0 52,192 0 0 0 40,116 0 1,761,248	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.00 2.00 3.00 4.00 5.00 6.00 7.00 10.00 11.00
00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	### A #### A ### A ### A ### A ### A #### A ######	154,027 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 5,664 3,375 1,482 263 0 371 11,155	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A  9.00 PROGRAM LIM	7 67,815 0 0 Part B Not Subject to Deductibles & Coinsurance 10.00 ITATION COST, OF 0 836,686 0 636,660 0 195,594 0 52,192 0 0 0 40,116 0 1,761,248	2.271282 0.000000 Subject to Deductibles & Coinsurance 11.00	1.0 2.0 3.0 4.0 5.0 7.0

AFFORI	TIONMENT OF PATIENT SERVICE COST	rs .		Provider Co	IS-7313	Period: From 07/01/2022 To 06/30/2023	Worksheet H-3 Part I Date/Time Pre 11/20/2023 2:	pared:
				Title	XVIII	Home Health	PPS	
		Duoa	ram Covered Cha	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Cost of	Agency I		
		Prog	Talli Covereu Cita	ai ges	Services			
			Par	t B		Part B		
	Cost Center Description	Part A		Deductibles &	Part A	Not Subject to Deductibles &	Subject to Deductibles &	
		6.00	Coinsurance 7.00	Coinsurance 8.00	9.00	Coinsurance 10.00	Coinsurance 11.00	
	Supplies and Drugs Cost Comput		7.00	8.00	9.00	10.00	11.00	
15.00		1 0	52,475	0		0 119,186	0	15.0
	Cost of Drugs	Ĭ	0			0	•	16.0
	Cost Center Description	Total Program		-			-	
	·	Cost (sum of						
		cols. 9-10)						
	1	12.00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							-
1.00	Skilled Nursing Care	836,686	3					1.0
2.00	Physical Therapy	636,660						2.0
3.00	Occupational Therapy	195,594	II .					3.0
4.00	Speech Pathology	52,192						4.0
5.00	Medical Social Services	0	)					5.0
5.00	Home Health Aide	40,116	5					6.0
7.00	Total (sum of lines 1-6)	1,761,248	3					7.0
	Cost Center Description							
	1	12.00						
	Limitation Cost Computation	1						
3.00	Skilled Nursing Care							8.0
0.00	Physical Therapy Occupational Therapy							9.0
	Speech Pathology							11.0
	I Speecii Patiiu luuy	I	1					
11.00	Medical Social Services							l 12 f
11.00 12.00 13.00								12.0

Health Financial Systems ST. MARY MEDICAL CENTER, INC.						In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	Provider C	CN: 15-0034	Period:	Worksheet H-3			
					15 7313	From 07/01/2022		
				HHA CCN:	15-7313	то 06/30/2023	Date/Time Pre 11/20/2023 2:	pared: 29 pm
						Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provider	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVI	CES FURNISHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physical Therapy	66.00	0.289963	0	)	0 col. 2, line 2	.00	1.00
2.00	Occupational Therapy	67.00	0.250614	0		0 col. 2, line 3	.00	2.00
3.00	Speech Pathology	68.00	0.410985	0		0 col. 2, line 4	.00	3.00
4.00	Cost of Medical Supplies	71.00	0.403448	0		0 col. 2, line 1	5.00	4.00
5.00	Cost of Drugs	73.00	0.179468	0		0 col. 2, line 1	6.00	5.00

Health	Financial Systems ST. MARY MEDICAL CE	ENTER. INC.		In Lie	u of Form CMS-	2552-10
	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider Co	CN: 15-0034	Period:	Worksheet H-4	
		HHA CCN:	15-7313	From 07/01/2022 To 06/30/2023	Part I-II Date/Time Pre	pared:
		T:+1.	V//TTT	Home Heelth	11/20/2023 2:	29 pm
		IITIE	XVIII	Home Health Agency I	PPS	
					t B	
			Part A	Not Subject to	Subject to	
				Deductibles &	Deductibles &	
				Coinsurance	Coinsurance	
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGE	S			
	Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)			0 0	0	1.00
2.00	Total charges			0	0	2.00
	Customary Charges			<u>'</u>		
3.00	Amount actually collected from patients liable for payment for	services		0 0	0	3.00
	on a charge basis (from your records)					
4.00	Amount that would have been realized from patients liable for	payment		0	0	4.00
	for services on a charge basis had such payment been made in a	ccordance				
- 00	with 42 CFR §413.13(b)					- 00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000			
6.00	Total customary charges (see instructions)			0	0	
7.00	Excess of total customary charges over total reasonable cost (	complete		0	0	7.00
0 00	only if line 6 exceeds line 1)	: 4 1:		0 0	0	0 00
8.00	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	y II IIne		0	0	8.00
9.00	Primary payer amounts			0 0	0	9.00
3.00	Trimary payer amountes			Part A	Part B	3.00
				Services	Services	
				1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)			0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers			0	1,824,513	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers			0	337,018	12.00
13.00	Total PPS Reimbursement - LUPA Episodes			0	31,902	13.00
14.00	Total PPS Reimbursement - PEP Episodes			0	18,350	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	86,642	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes			0	3,127	16.00
17.00	Total Other Payments			0	0	17.00
18.00	DME Payments			0	0	18.00
19.00	Oxygen Payments			0	0	19.00
20.00	Prosthetic and Orthotic Payments			0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsu	rance)			0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)			0	2,301,552	22.00
23.00	Excess reasonable cost (from line 8)			0	0	23.00
24.00	Subtotal (line 22 minus line 23)			0	2,301,552	24.00
25.00	Coinsurance billed to program patients (from your records)				0	25.00
26.00	Net cost (line 24 minus line 25)			0	2,301,552	26.00
27.00	Allowable bad debts (from your records)				0	
27.01	Adjusted reimbursable bad debts (see instructions)				0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)				0	28.00
29.00	Total costs - current cost reporting period (see instructions)			0	2,301,552	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions	;)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration			0	0	30.99
31.00	Subtotal (see instructions)			0	2,301,552	31.00

46,031

0

2,255,520

31.01

0 31.02

31.75 32.00 33.00

34.00

35.00

34.00

31.01 | Sequestration adjustment (see instructions)

33.00 | Tentative settlement (for contractor use only)

32.00 Interim payments (see instructions)

chapter 1, §115.2

31.02 Demonstration payment adjustment amount after sequestration

31.75 | Sequestration adjustment for non-claims based amounts (see instructions)

Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)

35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,

Health Financial Systems ST. MARY MEDICAL CENTER, INC.
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED Provider C In Lieu of Form CMS-2552-10 Period: | WORKSHEEL | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 11/20/2023 2:29 pm | PPS

TO PROGRAM BENEFICIARIES

Provider CCN: 15-0034

HHA CCN: 15-7313

				Home Health	PPS	
		Tnnation	t Part A	Agency I	rt B	
		Impacten	L Pail A	Pai	ГВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	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		(		2,255,520	1.00
3.00	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)					3.00
2 01	Program to Provider	ı				2 01
3.01			(		0	3.01
3.02					0	3.03
3.04						3.04
3.05					0	3.0
3.03	Provider to Program			1	Ū	3.0.
3.50			(	)	0	3.50
3.51			(	)	0	3.5
3.52			(	)	0	3.5
3.53			(	)	0	3.5
3.54			(		0	3.5
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		(		0	3.9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		C		2,255,520	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			(		0	5.01
5.02			(		0	5.02
5.03	Due vides to Due sues			)	0	5.03
5.50	Provider to Program	I			0	5.50
5.51						5.51
5.52					0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		Č		0	5.9
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		į c	)	1	6.0
6.02	SETTLEMENT TO PROGRAM		d	)	0	6.0
7.00	Total Medicare program liability (see instructions)		(	)	2,255,521	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
			)	1.00	2.00	
8.00	Name of Contractor					8.00

	Financial Systems ST. MARY MEDICAL			u of Form CMS-2	2552-
ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0034	Period: From 07/01/2022	Worksheet L	
			To 06/30/2023	Parts I-III Date/Time Pre	nared
			10 00, 30, 2023	11/20/2023 2:	
		Title XVIII	Hospital	PPS	•
		·			
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
.00	Capital DRG other than outlier			2,244,768	1.
.01	Model 4 BPCI Capital DRG other than outlier			0	1.
.00	Capital DRG outlier payments			7,494	2.0
.01	Model 4 BPCI Capital DRG outlier payments			0	2.0
.00	Total inpatient days divided by number of days in the cost r	reporting period (see ins	tructions)	97.41	3.
.00	Number of interns & residents (see instructions)			0.00	4.
.00	Indirect medical education percentage (see instructions)			0.00	5.
.00	Indirect medical education adjustment (multiply line 5 by the	ne sum of lines 1 and 1.03	1, columns 1 and	0	6.
	1.01)(see instructions)				
.00	Percentage of SSI recipient patient days to Medicare Part A	patient days (Worksheet I	E, part A line	3.50	7.
	30) (see instructions)				
.00	Percentage of Medicaid patient days to total days (see instr	uctions)		16.37	8.
.00	Sum of lines 7 and 8	19.87	9.		
.0.00	Allowable disproportionate share percentage (see instruction		10.0		
1.00	Disproportionate share adjustment (see instructions)			92,035	
2.00	Total prospective capital payments (see instructions)			2,344,297	12.
				1.00	
00	PART II - PAYMENT UNDER REASONABLE COST			0	1
.00	Program inpatient routine capital cost (see instructions)			0	1
.00	Program inpatient ancillary capital cost (see instructions)			0	
.00	Total inpatient program capital cost (line 1 plus line 2)				1
.00	Capital cost payment factor (see instructions)			0	
.00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
.00	Program inpatient capital costs (see instructions)			0	1.
.00	Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	2.
.00	Net program inpatient capital costs (line 1 minus line 2)	ices (see mistructions)		0	1
.00	Applicable exception percentage (see instructions)			0.00	
.00	Capital cost for comparison to payments (line 3 x line 4)			0.00	1
.00	Percentage adjustment for extraordinary circumstances (see i	netructions)		0.00	
.00	Adjustment to capital minimum payment level for extraordinar		v line 6)	0.00	
.00	Capital minimum payment level (line 5 plus line 7)	y cricumstances (Tille 2	\ 1111E U)	0	1
.00	Current year capital payments (from Part I, line 12, as appl	icablo)		0	9.
0.00	Current year capital payments (from Part 1, fine 12, as application of capital minimum payment level to		loss lino 0)	0	10.
1 00	Cannyoyen of accumulated capital minimum nayment level to			U	11

11.00

14.00

0 16.00

0 17.00

0 12.00

0 13.00

0

0 15.00

11.00 | Carryover of accumulated capital minimum payment level over capital payment (from prior year

Carryover of accumulated capital minimum payment level over capital payment for the following period

12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

13.00 | Current year exception payment (if line 12 is positive, enter the amount on this line)

(if line 12 is negative, enter the amount on this line)

16.00 | Current year operating and capital costs (see instructions)

17.00 Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)

Worksheet L, Part III, line 14)

14.00