Health Financial Systems ST. MARY MEDICAL CENTER, INC. In Lieu of Form CMS-2552-10 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 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0034 Worksheet S Peri od. From 07/01/2019 Parts I-III AND SETTLEMENT SUMMARY 06/30/2020 Date/Time Prepared: То 11/25/2020 2:58 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/25/2020 Time: 2:58 pm] Manually prepared cost report use only 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF 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 the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY MEDICAL CENTER, INC. (15-0034) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 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. [X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. MARY F. SUDICKY (Signed) Officer or Administrator of Provider(s) VP OF FINANCE/CFO Title 11/25/2020 02: 58: 27 PM Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	162, 835	-201, 654	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	79, 241	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00) Total	0	242, 076	-201, 654	0	0	200. 00

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

							From 07/01 To 06/30	/2019 /2020	Part I Date/Ti	me Pre	pare
	1.00		2.00	_	3.00			4.00	11/25/2		
	Hospital and Hospital Health Care Cor	mplex Add			3.00			4.00			
00	Street: 1500 SOUTH LAKE AVENUE		PO Box:	7 n Cou	10. 112	12					1.
00	City: HOBART		State: IN oonent Name	Zip Coo CCN	CBS		nty: LAKE er Date	Payme	ent Syst	em (P,	2.
				Number	Numb	ber Type	Certified	-	<u>, 0, or</u>	1	4
	-		1.00	2.00	3.0	00 4.00	5.00	V 6.00	XVIII 7.00	XI X 8.00	-
	Hospital and Hospital-Based Component		i cati on:	2.00			1				
00	•	ST. MARY CENTER,		150034	238	44 1	07/01/1966	5 N	P	P	3.
00	Subprovider - IPF	CLNTLK,	NG.								4.
00	•		ABI LI TATI ON	15T034	238	44 5	01/01/2001	I N	P	P	5.
00	Subprovider - (Other)	UNI T									6.
00	Swing Beds - SNF										7.
00	Swing Beds - NF										8.
00 . 00	Hospital-Based SNF Hospital-Based NF										9.
. 00	Hospi tal -Based OLTC										11.
. 00		SMMC HOMI	E HEALTH AGENCY	157313	238	44	02/08/1996	5 N	P	N	12.
. 00 . 00	Separately Certified ASC Hospital-Based Hospice										13.
. 00	Hospital-Based Health Clinic - RHC										15.
. 00	Hospital-Based Health Clinic - FQHC										16.
00	Hospital-Based (CMHC) I Renal Dialysis										17.
00	Other										19.
							From 1.00		To 2. (-
00	Cost Reporting Period (mm/dd/yyyy)						07/01/2		06/30		20
00	Type of Control (see instructions)						2				21
					-	1.00	2.00)	3. (00	1
	Inpatient PPS Information						I.				
00	Does this facility qualify and is it disproportionate share hospital adjus					Y	N				22.
	§412. 106? In column 1, enter "Y" for				N						
	facility subject to 42 CFR Section §4			ndment							
01	hospital?) In column 2, enter "Y" for Did this hospital receive interim und	r yes or compensat	ed care payment	s for th	is	Y	Y				22.
	cost reporting period? Enter in colum	nn 1, "Y"	for yes or "N"	for no	for						
	the portion of the cost reporting per Enter in column 2, "Y" for yes or "N"										
	reporting period occurring on or afte										
02	Is this a newly merged hospital that					Ν	N				22
	payments to be determined at cost rep Enter in column 1, "Y" for yes or "N"	ort sett ' for no	lement? (see in	structio n of the	ns)						
	cost reporting period prior to Octobe										
	or "N" for no, for the portion of the	e cost re	porting period	on or af	ter						
03	October 1. Did this hospital receive a geographi	c reclas	sification from	urban t	0	Ν	N		N		22
00	rural as a result of the OMB standard	ds for de	lineating stati	stical a	reas						
	adopted by CMS in FY2015? Enter in co for the portion of the cost reporting										
	in column 2, "Y" for yes or "N" for r										
	reporting period occurring on or afte	er Octobe	r 1. (see instr	uctions)							
	Does this hospital contain at least 1 counted in accordance with 42 CFR 412										
	yes or "N" for no.			0, 1 1							
00	Which method is used to determine Med		5				3 N				23.
	below? In column 1, enter 1 if date of if date of discharge. Is the method of										
	reporting period different from the m	nethod us	ed in the prior	cost							
_	reporting period? In column 2, enter	Y" for	yes or "N" for In-Sta		State	Out-of	Out-of	Medi ca	id 0	ther	
			Medi ca	id Medi	cai d	State	State	HMO da	ys Med	li cai d	
			paid da		gible baid	Medicaid paid days	Medicaid eligible		0	lays	
					ays	para days	unpai d				
0.7			1.00		00	3.00	4.00	5.00		5.00	
00	If this provider is an IPPS hospital, in-state Medicaid paid days in columr			610	205	65	3	4,	936	C	24.
	Medicaid eligible unpaid days in colum										
									1		1
	out-of-state Medicaid paid days in co										
		d days in									

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	MEDICAL CEI TA	NIER, INC. Provider CC	N: 15-0034	Peri od:			et S-2	
				From 07/0	01/2019 80/2020	Part I Date/Ti 11/25/2	me Pre	parec
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	iys Med	ther Ji cai d Jays	
00 If this provider is an LDE opton the in state	1.00	2.00	3.00	4.00	5.00	449	5.00	25
00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0		0					25.
				Urban/F		Date of 2.0		-
00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for	rural.			ne	1	2. ,		26.
 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the 	"2" for r cation in	ural. If ap column 2.	ppl i cabl e,		1			27.
effect in the cost reporting period.		perrous su						35.
				Begi n 1.		Endi 2.		-
00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb		00	2.	0	36.
00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ls MDH statu	5	0			37.
01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37.
 instructions) 00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. 								38.
				Y/		Y/ 2. (-
00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)	, (ii), or he mileage	(iii)? Ent requiremen	er in colum nts in	ne N ו		N		39.
00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. Ente	r "Y" for y				XVIII	XIX	40.
					1.00	2.00	3.00	1
Prospective Payment System (PPS)-Capital 00 Does this facility qualify and receive Capital paymen	t for disp	roporti onat	e share in a	accordance	N	Y	N	45.
<pre>with 42 CFR Section \$412.320? (see instructions) 00 Is this facility eligible for additional payment exce pursuant to 42 CFR \$412.348(f)? If yes, complete Wkst Pt. III.</pre>	ption for	extraordi na	ary circumsta	ances	N	N	N	46.
00 Is this a new hospital under 42 CFR §412.300(b) PPS c 00 Is the facility electing full federal capital payment					N N	N N	N N	47. 48.
Teaching Hospitals 00 Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for	mpacted by	CR 11642 (56.
00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	eriod duri yes or "N h of this ", complet , if appli	ng which re " for no in cost report e Worksheet cable.	n column 1. ing period? E-4. If co	f column Enter "Y umn 2 is				57.
00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		s as	N			58.
00 Are costs claimed on line 100 of Worksheet A? If yes	;, complete	Wkst. D-2,	Pt. I. NAHE 413.8 Y/N	5 Worksh Lin		Pass-T Qualifi Criteri	cation	
				2	00	3.	00	1
			1.00					60.
OO Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu 01 If line 60 is yes, complete columns 2 and 3 for each	85? (see umn 1. If R) NAHE MA mn 2.	column 1 payment	<u>1.00</u> Y)	23. 00	1		60.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider C	F	eriod: rom 07/01/2019 o 06/30/2020	11/25/2020 2:	parec
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 	N			0.00	0. OC	61. (
 Instructions/ Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 						61.0
 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 						61.0
 D4 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.0
 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 1.06 Enter the appunct of ACA SEE03 owerd that is being 						61.0
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	-
		1.00	2.00	3.00	4.00	1
 1.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program name. Enter in column 4, the direct GME is the for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0.00) 61.
					1.00	1
ACA Provisions Affecting the Health Resources and Ser						
 2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide 	ctions) a Teachi gram. (s	ng Health Cen see instructio	ter (THC) into			62. 62.
B. OD Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes or "N" for "N" for no in column 1. If yes or "N" for "N" for "N" for	ettings	during this c		uctions)	N	63.
			Unweighted FTEs Nonprovider Site	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onnrovia	ler Settings	1.00 This base year	2.00	<u>3.00</u>	
 bectroit source of the AcA base fear Fig Residents fin and period that begins on or after July 1, 2009 and befor D0 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see 	re June ty train a-primar all non d non-pr n column	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00			64.

	EX IDENTIFICATION DA	TA Provider		eriod:	worksheet S-2	2
			FI Te	rom 07/01/2019 p 06/30/2020	Date/Time Pre	pared:
	Program Name	Program Code	Unweighted	Unweighted	11/25/2020 2: Ratio (col. 3/	
	FT Ogt allt Malle		FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	(4))	
			Si te			
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	
5.00 Enter in column 1, if line 63 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 FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der	Hospital	(2))	
			Si te	·		
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 207		n Nonprovider Settin	gsEffective fo	or cost reporti	ing periods	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column 3	S the ratio of	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	Si te 3. 00	4.00	5.00	_
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00				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 divided by (column 3 + column	1.00	2.00	3.00		0. 000000	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 divided by (column 3 + column 4)). (see instructions)	25		3.00 0.00	0.00	0 2.00 3.00	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	≥S rchiatric Facility (I		3.00 0.00	0.00	0 2.00 3.00	
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	2S /chiatric Facility (I the facility have ar 2Fore November 15, 2C umn 2: Did this faci ≷ 412.424 (d)(1)(iii) ;ate which program ye	PF), or does it con n approved GME teach 004? Enter "Y" for lity train resident (D)? Enter "Y" for	3.00 0.00 tain an IPF subp ing program in t yes or "N" for r s in a new teach yes or "N" for r	0.00 1.0 provi der? N the most to. (see i ng to.	0 2.00 3.00	70. 0
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	2S cchiatric Facility (I the facility have ar efore November 15, 2C umn 2: Did this faci 2 412.424 (d)(1)(iii) cate which program ye y PPS nabilitation Facility	PF), or does it con n approved GME teach 204? Enter "Y" for lity train resident (D)? Enter "Y" for ear began during thi	3.00 0.00 tain an IPF subp ing program in t yes or "N" for r s in a new teach yes or "N" for r s cost reporting	0.00 1.0 provi der? N the most to. (see i ng to.	0.000000	- 67. 00 67. 00 70. 00 71. 00 75. 00

Health Financial Systems ST. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider (Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Pro	epared:
				11/25/2020 2:	58 pm
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye 81.00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.			g period? Enter	N N	80.00 81.00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i86.00Did this facility establish a new Other subprovider (exclude)	·	5		Ν	85. 00 86. 00
 §413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87. 00 Is this hospital an extended neoplastic disease care hospit 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 	al classified	under section		Ν	87.00
			V 1.00	XI X 2.00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospit	al services? E	Enter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N	Ν	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (c instructions) Enter "Y" for yes or "N" for no in the applic	ual certificat			Ν	92.00
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		nd XIX? Enter	N	Ν	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for r	no in the	N	Ν	94.00
 95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yeapplicable column. 			0. 00 N	0. 00 N	95.00 96.00
 97.00 If line 96 is "Y", enter the reduction percentage in the ap 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" col umn 1 for title V, and in column 2 for title XIX. 	nterns and res	sidents post	0. 00 N	0. 00 N	97.00 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			. N	Y	98.01
 title XIX. 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 			Ν	Y	98. 02
 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y 			N	Ν	98.03
 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAP- outpatient services cost? Enter "Y" for yes or "N" for no i 			Ν	Ν	98.04
<pre>in column 2 for title XIX. 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 advance of for title XIX.</pre>				Y	98.05
 column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX. 			N	Ν	98.06
Rural Providers 105.00Does this hospital qualify as a CAH?			N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for c			t		106.00
training programs? Enter "Y" for yes or "N" for no in colum 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&F PF and/or IRF	structions) Rs 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.		edul e? See 42	N		108.00
	Physi cal 1.00	Occupationa 2.00	I Speech 3.00	Respi ratory 4.00	-
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.		N	N	N	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.	lf yes,	Ν	110.00

lealth Financial Systems ST. MARY MEDICAL CENTER, INC. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC	N: 15-0034 F	Period:	eu of Form CMS Worksheet S-	
		rom 07/01/2019 o 06/30/2020		epared:
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	1.00 N	2.00	111.00
	1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.00
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	Ν			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
17.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
18.00 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.		1		118.00
In the poincy is channemade. Enter 2 in the poincy is occurrence.	Premiums	Losses	Insurance	
	1.00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:		1 (0118.0
10.00 km and an interpreting and a side barren arrented in a part parton other t		1.00 N	2.00	118.0
18. 02 Are mal practice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing cc and amounts contained therein. 19. 00 DO NOT USE THIS LINE		N		119.0
20.001s this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.	for yes or ne Outpatient	N	N	120. 0
21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	charged to	Y		121.0
22.00Does the cost report contain healthcare related taxes as defined in §1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter		Ν		122. C
the Worksheet A line number where these taxes are included. Transplant Center Information				
25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.	for no. If	N		125.0
26.00 If this is a Medicare certified kidney transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.	ication date			126. C
27.00 If this is a Medicare certified heart transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.	cation date			127.0
28.00 f this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.	cation date			128.0
29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.	ation date in			129. 0
	i fi cati on			130. C
	rtification			131. C
date in column 1 and termination date, if applicable, in column 2. 31.00 f this is a Medicare certified intestinal transplant center, enter the ce	rtification	1		132.0
date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2. 32.00 If this is a Medicare certified islet transplant center, enter the certifi				152.0
31.00 If this is a Medicare certified intestinal transplant center, enter the ce	cation date			133. 0 134. 0

	COMPLEX IDENTIFICATION [DATA F	<u>TER, INC.</u> rovider CC	CN: 15-0034	Peri od		u of Form CMS Worksheet S	-2
						7/01/2019 6/30/2020		
1.00		2.00				3.00	11/25/2020 2	2:58 pr
If this facility is part of a	a chain organization, e		5 141 thro	ugh 143 the	name and		of the	
home office and enter the hor 1.00 Name: COMMUNITY FOUNDATION (ictor numbe		tor's Nu	mber: 0800)1	141.
INC. 2.00 Street: STREET: STREET: 100	10 DONALD PO Box:	201						142.
POWER 3.00 City: MUNSTER	State:	I N		Zip Cod	le:	4632	1	143.
							1.00	_
4.00 Are provider based physicians	s' costs included in Wo	rkshoot 12					1.00 Y	144.
		i Kaneet A:						144.
						1.00	2.00	
5.00 If costs for renal services a inpatient services only? Enter no, does the dialysis facilit	er "Y" for yes or "N" f	or no in colu	mn 1. lf o	column 1 is		Y	N	145.
period? Enter "Y" for yes or			1113 0031	reporting				
6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date	odology changed from th no in column 1. (See C	e previously MS Pub. 15-2,			f	Ν		146.
					1		1.00	
7.00 Was there a change in the sta	atistical basis? Enter	"Y" for yes o	r "N" for	no.			N	147.
8.00Was there a change in the ord							N	148.
9.00Was there a change to the sim	mplified cost finding m		5			·· + - \/	N Title XIX	149.
			Part A 1.00	Part B 2.00	1	itle V 3.00	4.00	_
Does this facility contain a or charges? Enter "Y" for yes	provider that qualifie	es for an exer	ption from	m the applid	cation of	f the lowe	r of costs	
5. 00Hospi tal			N	N		N	N	155.
6.00 Subprovider – IPF			Ν	N		Ν	N	156.
7.00 Subprovider - IRF			N	N		Ν	N	157.
8. 00 SUBPROVI DER 9. 00 SNF			N	N		N	N	158. 159.
0.00 HOME HEALTH AGENCY			N	N		N	N	160.
1.00 CMHC				N		Ν	N	161.
							1.00	_
							1.00	
Multicampus							1	_
Multicampus	no.						N	165.
Multicampus 5.00 s this hospital part of a Mu	no. Name	Cc	unty	State Z	Zip Code	CBSA	N FTE/Campus	
Multicampus 5.00 s this hospital part of a Mu Enter "Y" for yes or "N" for	no. Name O	Cc					N FTE/Campus 5.00	_
Multicampus 5.00 s this hospital part of a Mu Enter "Y" for yes or "N" for	no. Name 0	Cc	unty	State Z	Zip Code	CBSA	N FTE/Campus 5.00	_
Multicampus 5.00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state	no. Name Name 0	Cc	unty	State Z	Zip Code	CBSA	N FTE/Campus 5.00	_
Multicampus 5.00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column	no. Name 0 Jumn i n 3,	Cc	unty	State Z	Zip Code	CBSA	N FTE/Campus 5.00	
 Multicampus 5.00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus 	no. Name 0 Jumn i n 3,	Cc	unty	State Z	Zip Code	CBSA	N FTE/Campus 5.00	
Multicampus 5.00 Is this hospital part of a Multicampus Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in coluticampus of the name in colutication of the name in colutin of the name in colutication of the name in coluticati	no. Name 0 Jumn i n 3,	Cc	unty	State Z	Zip Code	CBSA	N FTE/Campus 5.00 0.0	
Multicampus 5.00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions)	no. Name 0 umn i n 3, i n		unty . 00	State Z 2.00	<u>7 p Code</u> 3.00	CBSA	N FTE/Campus 5.00	_
Multicampus 5.00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Health Information Technology	no. Name 0 umn in 3, in y (HIT) incentive in th	Cc 1	unty .00 ecovery and	State Z 2.00 d Reinvestme	<u>7 p Code</u> 3.00	CBSA	N FTE/Campus 5.00 0.0	00 166.
Multicampus 5.00 Is this hospital part of a Multicampus Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Heal th Information Technology 7.00 Is this provider a meaningful 8.00 If this provider is a CAH (li	no. Name 0 Jumn in 3, in y (HIT) incentive in th user under §1886(n)? ine 105 is "Y") and is	ne American Ro Enter "Y" fo a meaningful	unty .00 ecovery and r yes or '	State Z 2.00 d Rei nvestme 'N" for no.	<u>ip Code</u> 3.00	CBSA 4.00	N FTE/Campus 5.00 0.0	167.
Multicampus 5.00 Is this hospital part of a Multicampus Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Heal th Information Technol ogy 7.00 Is this provider a meaningful 8.00 If this provider is a CAH (li reasonable cost incurred for	no. Name 0 umn in 3, in y (HIT) incentive in th user under §1886(n)? ine 105 is "Y") and is the HIT assets (see in	ne American Ro Enter "Y" fo a meaningful structions)	unty .00 covery and r yes or ' user (line	d Reinvestme 'N" for no. e 167 is "Y"	<u>Cip Code</u> 3.00 ent Act	CBSA 4.00	N FTE/Campus 5.00 0.0	00 166. 167. 168.
Multicampus Multicampus 5.00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 5.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Health Information Technology 1.00 Is this provider a meaningful 3.00 If this provider is a CAH (li reasonable cost incurred for 3.01 If this provider is a CAH and	no. Name 0 umn in 3, in y (HIT) incentive in th user under \$1886(n)? ine 105 is "Y") and is the HIT assets (see in d is not a meaningful u	ne American Ro Enter "Y" fo a meaningful structions) ser, does thi	unty .00 covery and r yes or ' user (line s provider	d Reinvestme 'N" for no. e 167 is "Y" r qualify fo	<u>rip Code</u> 3.00 ent Act), enter or a harc	CBSA 4.00	N FTE/Campus 5.00 0.0	00 166. 167. 168.
Multicampus 5.00 Is this hospital part of a Multicampus Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Heal th Information Technology 7.00 Is this provider a meaningful 3.00 If this provider is a CAH (li reasonable cost incurred for 3.01 If this provider is a CAH and exception under §413.70(a) (6) 9.00 If this provider is a meaningful	no. Name 0 umn in 3, in y (HIT) incentive in th user under §1886(n)? ine 105 is "Y") and is the HIT assets (see in d is not a meaningful u (ii)? Enter "Y" for ye gful user (line 167 is	ne American Ro Enter "Y" fo a meaningful structions) ser, does thi s or "N" for	unty .00 covery and r yes or ' user (line s provider no. (see i	State Z 2.00 2.00 d Reinvestme 'N" for no. 167 is "Y" r qualify for instructions	<u>ent Act</u>), enter s)	CBSA 4.00	N FTE/Campus 5.00 0.0	00 166. 167. 168. 168.
Multicampus 5.00 Is this hospital part of a Multicampus Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Heal th Information Technology 7.00 Is this provider a meaningful 8.00 If this provider is a CAH (li reasonable cost incurred for 8.01 If this provider is a CAH and exception under §413.70(a)(6)	no. Name 0 umn in 3, in y (HIT) incentive in th user under §1886(n)? ine 105 is "Y") and is the HIT assets (see in d is not a meaningful u (ii)? Enter "Y" for ye gful user (line 167 is	ne American Ro Enter "Y" fo a meaningful structions) ser, does thi s or "N" for	unty .00 covery and r yes or ' user (line s provider no. (see i	State Z 2.00 2.00 d Reinvestme 'N" for no. 167 is "Y" r qualify for instructions	<u>ent Act</u>), enter s "N"), e	CBSA 4.00	N FTE/Campus 5.00 0.1 1.00 Y 0. Endi ng	167.
Multicampus 5.00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Health Information Technology 7.00 Is this provider a meaningful 8.00 If this provider is a CAH (li reasonable cost incurred for 8.01 If this provider is a CAH and exception under §413.70(a)(6) 9.00 If this provider is a meaning transition factor. (see instruct	no. Name 0 Jumn in 3, in y (HIT) incentive in th l user under §1886(n)? ine 105 is "Y") and is the HIT assets (see in d is not a meaningful u)(ii)? Enter "Y" for ye gful user (line 167 is ructions)	ne American R Enter "Y" fo a meaningful structions) ser, does thi s or "N" for "Y") and is r	unty .00 r yes or ' user (line s provider no. (see i ot a CAH (State Z 2.00 2.00 d. Reinvestme 'N" for no. e 167 is "Y" r qualify for instructions (line 105 is	<u>ent Act</u>), enter s "N"), e	CBSA 4.00	N FTE/Campus 5.00 0.0 1.00 Y 0.	00 166. 167. 168. 168. 00 169.
Multicampus 5.00 Is this hospital part of a Multicampus Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Heal th Information Technology 7.00 Is this provider a meaningful 8.00 If this provider is a CAH (li reasonable cost incurred for exception under §413.70(a)(6) 9.00 If this provider is a meaning transition factor. (see instruction)	no. Name 0 Jumn in 3, in y (HIT) incentive in th l user under §1886(n)? ine 105 is "Y") and is the HIT assets (see in d is not a meaningful u)(ii)? Enter "Y" for ye gful user (line 167 is ructions) EHR beginning date and	ne American R Enter "Y" fo a meaningful structions) ser, does thi s or "N" for "Y") and is r	unty .00 r yes or ' user (line s provider no. (see i ot a CAH (State Z 2.00 2.00 d. Reinvestme 'N" for no. e 167 is "Y" r qualify for instructions (line 105 is	<u>ent Act</u>), enter s "N"), e	CBSA 4.00	N FTE/Campus 5.00 0.1 1.00 Y 0. Endi ng	00 166. 167. 168. 168. 00 169.
Multicampus 5.00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) 7.00 Is this provider a meaningful reasonable cost incurred for 8.01 If this provider is a CAH and exception under §413.70(a)(6) 9.00 If this provider is a meaning transition factor. (see instructions)	no. Name 0 Jumn in 3, in y (HIT) incentive in th l user under §1886(n)? ine 105 is "Y") and is the HIT assets (see in d is not a meaningful u)(ii)? Enter "Y" for ye gful user (line 167 is ructions) EHR beginning date and	ne American R Enter "Y" fo a meaningful structions) ser, does thi s or "N" for "Y") and is r	unty .00 r yes or ' user (line s provider no. (see i ot a CAH (State Z 2.00 2.00 d. Reinvestme 'N" for no. e 167 is "Y" r qualify for instructions (line 105 is	<u>ent Act</u>), enter s "N"), e	CBSA 4.00	N FTE/Campus 5.00 0.1 1.00 Y 0. Endi ng	00 166. 167. 168. 168.
Multicampus 5.00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 6.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) 7.00 Is this provider a meaningful reasonable cost incurred for 8.01 If this provider is a CAH and exception under §413.70(a) (6) 9.00 If this provider is a meaning transition factor. (see instructions)	no. Name 0 Jumn in 3, in y (HIT) incentive in th user under §1886(n)? ine 105 is "Y") and is the HIT assets (see in d is not a meaningful u)(ii)? Enter "Y" for ye gful user (line 167 is ructions) EHR beginning date and yyy) s provider have any day	te American Re Enter "Y" for a meaningful structions) ser, does thi ss or "N" for "Y") and is r ending date	unty .00 covery and r yes or ' user (line s provider no. (see i ot a CAH (for the re uals enrol	State Z 2.00 d Reinvestme 'N" for no. e 167 is "Y" r qualify for instructions (line 105 is eporting	<u>ent Act</u>), enter s "N"), e	CBSA 4.00	N FTE/Campus 5.00 0.0 1.00 Y 0. Endi ng 2.00	00 166. 167. 168. 168. 00 169.

Health Financial Systems ST. MARY MEDICAL CENTER, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0034 Peri od: Worksheet S-2 From 07/01/2019 Part II Date/Time Prepared: То 06/30/2020 11/25/2020 2:58 pm Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost 1.00 Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Туре 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 γ 7.00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions. Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? 16.00 Ν 16.00 Ν If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 10/12/2020 Y 10/12/2020 17.00 totals and the provider's records for allocation? If

Ν

Ν

18.00

19.00

either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)
18.00 If line 16 or 17 is yes, were adjustments made to PS&R N 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.
19.00 If line 16 or 17 is yes, were adjustments made to PS&R N

Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th I	Financial Systems ST. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-	2552-10
HOSPI TA	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0034	Period: From 07/01/2019 To 06/30/2020		epared:
			ption	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R	()	1.00 N	3.00 N	20.00
	Report data for Other? Describe the other adjustments:			IN IN	i N	20.00
·		Y/N	Date	Y/N	Date	
01 00 1	M 11 1 1 1 1 1 1 1 1 1 1 1 1 1	1.00	2.00	3.00	4.00	01.00
	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 H	OSPI TALS)			-
	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions				22.00
	Have changes occurred in the Medicare depreciation expense		als made duri	na the cost		22.00
	reporting period? If yes, see instructions.			ing the cost		20.00
	Were new leases and/or amendments to existing leases entere	ed into during	this cost rep	orting period?		24.00
	If yes, see instructions					
	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25.00
	Nere assets subject to Sec.2314 of DEFRA acquired during th	ne cost reporti	na period? If	Ves. see		26.00
	instructions.			,50, 000		20.00
27.00 H	Has the provider's capitalization policy changed during the	e cost reportin	g period? If	yes, submit		27.00
	copy.					-
	nterest Expense Were new Loans, mortgage agreements or letters of credit er	ntered into dur	ing the cost	reporting		28.00
	period? If yes, see instructions.		ing the cost	reporting		20.00
	Did the provider have a funded depreciation account and/or	bond funds (De	bt Service Re	eserve Fund)		29.0
	treated as a funded depreciation account? If yes, see instr					
	Has existing debt been replaced prior to its scheduled matu	urity with new	debt? If yes,	see		30.00
	instructions. Has debt been recalled before scheduled maturity without is	suanco of now	dobt? If yos	500		31.00
	instructions.		debt? IT yes,	366		31.00
	Purchased Servi ces				1	
	Have changes or new agreements occurred in patient care ser		d through cor	ntractual		32.00
	arrangements with suppliers of services? If yes, see instru					
	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	bired pertainin	g to competit	ive bloding? II		33.00
	Provi der-Based Physi ci ans					
	Are services furnished at the provider facility under an ar	rangement with	provi der-bas	ed physi ci ans?		34.00
	lf yes, see instructions.					
	If line 34 is yes, were there new agreements or amended exi		ts with the p	provi der-based		35.00
	physicians during the cost reporting period? If yes, see in	ISTRUCTIONS.		Y/N	Date	
				1.00	2.00	
	Home Office Costs					
	Nere home office costs claimed on the cost report?					36.00
	If line 36 is yes, has a home office cost statement been pr	repared by the	nome office?			37.00
	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off	fice different	from that of			38.00
	the provider? If yes, enter in column 2 the fiscal year end					30.00
	If line 36 is yes, did the provider render services to othe					39.00
	see instructions.					
5			IT yes, see		1	40.00
40. 00 I	If line 36 is yes, did the provider render services to the	home office?				
40. 00 I		home office?	-			
10. 00 1	If line 36 is yes, did the provider render services to the		00	2.	00	-
40. 00 i	If line 36 is yes, did the provider render services to the		00		00	_
10.00 1 1 1.00 1	If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position		00	2. WOERNER	00	41.00
40. 00 	If line 36 is yes, did the provider render services to the instructions.	1.	00		00	41.00
10.00 1 1.00 1 1.00	If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	1. CATHERI NE			00	
40. 00 i i 41. 00 42. 00	If line 36 is yes, did the provider render services to the instructions.	1.			00	41.00
40. 00 	If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	1. CATHERI NE		WOERNER	00 ERNER@COMHS. OR	42.00

Heal th	Financial Systems ST. MARY MEDI	CAI	L CENTER, INC.			In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN	N: 15-0034	Peri		Worksheet S-2	2
					To		Part II Date/Time Pre 11/25/2020 2:	
			3.0	0				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position		REIMBURSEMENT SI	UPERVI SOR				41.00
	held by the cost report preparer in columns 1, 2, and 3,							
	respecti vel y.							
42.00	Enter the employer/company name of the cost report							42.00
	preparer.							
43.00	Enter the telephone number and email address of the cost							43.00
	report preparer in columns 1 and 2, respectively.							

					From 07/01/2019	Part I	
					To 06/30/2020	Date/Time Prep 11/25/2020 2:	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Available 3.00	4.00	5.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	2.00	58, 56		5.00	1.00
. 00	8 exclude Swing Bed, Observation Bed and	50.00	100	50, 50	0.00	0	1.00
	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
1.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
5.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		160	58, 56	0 0.00	0	7.00
	beds) (see instructions)						
3.00	INTENSIVE CARE UNIT	31.00	20	7, 32	0 0.00	0	8.00
9.00	CORONARY CARE UNI T						9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)	40.00					12.00
3.00	NURSERY	43.00	100	(5.00		0	13.00
4.00	Total (see instructions)		180	65, 88	0 0.00	0	14.00
15.00 16.00	CAH visits SUBPROVIDER - IPF					0	15.00 16.00
17.00	SUBPROVIDER - TPF SUBPROVIDER - TRF	41.00	20	7, 32	0	0	17.00
18.00	SUBPROVI DER	41.00	20	1, 32	0	0	18.00
9.00	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.)	101100					23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	СМНС – СМНС						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		0		32.00
32. 01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

IOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet S-3 Part I Date/Time Pre 11/25/2020 2:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	16, 879	1, 331	38, 38	37		1.00
. 00	HMO and other (see instructions)	10, 234	5, 119				2.00
. 00	HMO I PF Subprovi der	0	0, 11,				3.00
. 00	HMO I RF Subprovider	640	449				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	16, 879	1, 331	38, 38	37		7.00
. 00	INTENSIVE CARE UNIT	1, 707	38	5, 13	37		8.00
. 00	CORONARY CARE UNIT						9.00
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY		227	1, 41			13.00
4.00	Total (see instructions)	18, 586	1, 596	44, 94		1, 097. 99	
5.00	CAH visits	0	0		0		15.0
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF	3, 787	0	5, 99	0.00	29.33	
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19. C
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY	14, 939	0	25, 30	0.00	26.90	
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPI CE			-			24.0
4.10	HOSPICE (non-distinct part)			5	50		24.1
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.0
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)				0.00	1, 154. 22	
8.00	Observation Bed Days		0	5,44	10		28.0
9.00	Ambul ance Trips	0					29.0
0.00	Employee discount days (see instruction)				0		30.0
1.00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	0	104	22			32.0
2. 01	Total ancillary labor & delivery room				0		32. C
2 00	outpatient days (see instructions)						
3.00	LTCH non-covered days LTCH site neutral days and discharges	0					33.0 33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet S-3 Part I Date/Time Pre 11/25/2020 2:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	11.00	Patients	
1 00	Userital Adulta & Dada (aslumas E. (. 7 and	11.00	12.00	13.00	14.00	15.00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3, 84		9, 227	1.00
2.00	HMO and other (see instructions)			1, 6			2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO I RF Subprovi der				45		4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGICAL INTENSIVE CARE UNIT						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	3, 89	93 278	9, 227	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0			500	16.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER	0.00	0	3!	50 0	533	17.00 18.00
19.00	SUBPROVIDER SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY	0.00					22.0
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00	HOSPICE						24.0
4. 10	HOSPICE (non-distinct part)						24.1
25.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.2
7.00	Total (sum of lines 14-26)	0.00					27. C
8.00	Observation Bed Days						28.0
29.00	Ambul ance Trips						29.0
30.00	Employee discount days (see instruction)						30.0
31.00	Employee discount days - IRF						31.0
32.00	Labor & delivery days (see instructions)						32.0
32.01	Total ancillary labor & delivery room						32.0
33.00	outpatient days (see instructions) LTCH non-covered days				0		33.0
	LTCH site neutral days and discharges				0		33.0

PIT	Financial Systems AL WAGE INDEX INFORMATION			L CENTER, INC. Provider CO		eriod:	Worksheet S-3	
						rom 07/01/2019 o 06/30/2020	Date/Time Pre	par
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)		11/25/2020 2: Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
0	SALARIES Total salaries (see	200.00	73, 311, 813	0	73, 311, 813	2, 400, 785.00	30. 54	
0	instructions) Non-physician anesthetist Part		C	0	C			
0	A Non-physician anesthetist Part		C	0	C	0.00	0. 00	
0	в Physician-Part A - Administrative		C	0	C	0.00	0.00	
1 0	Physicians - Part A - Teaching Physician and Non		C 191, 985	0	C 191, 985	0.00 3,975.00		
0	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	0	С	0.00	0. 00	
0	services Interns & residents (in an	21.00	C	0	C	0.00	0.00	
1	approved program) Contracted interns and residents (in an approved		C	0	C	0.00	0. 00	
0	programs) Home office and/or related organization personnel		C	0	C	0.00	0.00	
0 00	SNF Excluded area salaries (see	44.00	0 4, 325, 440	0 61, 782	C 4, 387, 222	0.00 125,068.00		
	instructions) OTHER WAGES & RELATED COSTS		., 020,		.,,	120,000100		
00	Contract Labor: Direct Patient		4, 291, 840	0	4, 291, 840	85, 368. 72	50. 27	1
00	Care Contract labor: Top level management and other management and administrative		C	0	С	0.00	0. 00	1
00	services Contract Labor: Physician-Part		724, 878	0	724, 878	4, 643. 00	156. 12	1
00	A - Administrative Home office and/or related organization salaries and		С	0	С	0.00	0. 00	1
	wage-related costs							
01	Home office salaries		9, 898, 955	0	9, 898, 955			
02 00	Related organization salaries Home office: Physician Part A		(0		0.00		
	- Administrative Home office and Contract			0				
00	Physicians Part A - Teaching		Ĺ	0	L L	0.00		
01	Home office Physicians Part A - Teaching		C	0	C	0.00	0.00	1
02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		C	0	C	0.00	0.00	1
00	Wage-related costs (core) (see instructions)		18, 094, 712	0	18, 094, 712			1
00	Wage-related costs (other) (see instructions)							1
00 00	Excluded areas Non-physician anesthetist Part		1, 062, 423 0	0	1, 062, 423 C			1 2
00	A Non-physician anesthetist Part B		C	О	с			2
00	Physician Part A - Administrative		C	0	С			2
01	Physician Part A - Teaching		0	0	0			2
00 00 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		40, 714 C C		40, 714 C C			2 2 2
50	approved program) Home office wage-related		2, 596, 422	О	2, 596, 422			2
51	(core) Related organization wage-related (core)		C	О	С			2
52	Home office: Physician Part A - Administrative -		C	0	C			2

Heal th	Financial Systems	ST	. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 07/01/2019 To 06/30/2020		pared:
		Wkst. A Line		Reclassi fi cati		Paid Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE			-				
26.00	Employee Benefits Department	4.00	1, 109, 417		1, 109, 41			
27.00	Administrative & General	5.00	6, 442, 193		6, 442, 19			
28.00	Administrative & General under		1, 460, 521	0	1, 460, 52	1 11, 242. 00	129. 92	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	1, 890, 098		1, 890, 09			29.00
30.00	Operation of Plant	7.00	1,082,079		1, 082, 07			
31.00	Laundry & Linen Service	8.00	101, 542		101, 54			
32.00	Housekeepi ng	9.00	2, 070, 586	0	2, 070, 58			
33.00	Housekeeping under contract		0	0		0 0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	1, 943, 452	-756, 202	1, 187, 25			34.00
35.00	Dietary under contract (see		0	0		0 0.00	0.00	35.00
	instructions)		_					
36.00	Cafeteri a	11.00	0	756, 202				
37.00	Maintenance of Personnel	12.00	0	0		0 0.00		
38.00	Nursing Administration	13.00	2, 763, 078		2, 763, 07			
39.00	Central Services and Supply	14.00	483, 614		483, 61			
40.00	Pharmacy	15.00	2, 767, 043	-467, 932	2, 299, 11			
41.00	Medical Records & Medical Records Library	16.00	0	0		0 0.00	0.00	41.00
42.00	Soci al Service	17.00	0	0		0 0.00	0.00	42.00
	Other General Service	18.00	0	0		0 0.00		43.00
		10.00	0	1 0	I	0.00	0.00	1 .0.00

Heal th	n Financial Systems	S	T. MARY MEDICAI	_ CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
HOSPI	TAL WAGE INDEX INFORMATION			Provider CC		Period: From 07/01/2019 To 06/30/2020		
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	/	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		74, 580, 349	0	74, 580, 34	9 2, 408, 052. 00	30. 97	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		4, 325, 440	61, 782	4, 387, 22	2 125, 068. 00	35.08	2.00
3.00	Subtotal salaries (line 1		70, 254, 909	-61, 782	70, 193, 12	7 2, 282, 984. 00	30. 75	3.00
	minus line 2)			_				
4.00	Subtotal other wages & related costs (see inst.)		14, 915, 673	0	14, 915, 67	3 387, 295. 72	38. 51	4.00
5.00	Subtotal wage-related costs (see inst.)		20, 691, 134	0	20, 691, 13	4 0.00	29. 48	5.00
6.00	Total (sum of lines 3 thru 5)		105, 861, 716	-61, 782	105, 799, 93	4 2,670,279.72	39, 62	6.00
7.00	Total overhead cost (see instructions)		22, 113, 623					7.00

Heal th	Financial Systems ST. MARY MEDICAL	CENTER, INC.	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Provi der CCN: 15-0034	Peri od: From 07/01/2019 To 06/30/2020		pared:
				Amount	
				Reported 1.00	
	PART IV - WAGE RELATED COSTS			1.00	
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			2, 265, 514	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
0.00	HEALTH AND INSURANCE COST				0.00
8.00	Heal th Insurance (Purchased or Self Funded)			0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administ			0	
8.02	Health Insurance (Self Funded with a Third Party Administrate Health Insurance (Purchased)	or)		9, 888, 146	
8.03 9.00	Prescription Drug Plan			0	
9.00 10.00	Dental, Hearing and Vision Plan			719, 542	
11.00	Life Insurance (If employee is owner or beneficiary)			67, 781	
12.00	Accident Insurance (If employee is owner or beneficiary)			07,781	
13.00	Disability Insurance (If employee is owner or beneficiary)			54, 472	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary	V)		0	
15.00	'Workers' Compensation Insurance	<i>y</i> ,		702, 908	
16.00	Retirement Health Care Cost (Only current year, not the extra	aordinary accrual require	ed by FASB 106	,02,,00	
	Non cumulative portion)			Ū	10100
	TAXES				
17.00	FICA-Employers Portion Only			4, 294, 921	17.00
18.00	Medicare Taxes - Employers Portion Only			1, 016, 464	18.00
19.00	Unemployment Insurance			188, 101	19.00
20.00	State or Federal Unemployment Taxes			0	20.00
	OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost I instructions))	Reported on lines 1 throu	igh 4 above. (see	0	21.00
	Day Care Cost and Allowances			0	22.00
	Tuition Reimbursement			0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			19, 197, 849	24.00
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)				25.00

Heal t	n Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lie	u of Form CMS-2	2552-10
HOSPI	TAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0034	Peri od:	Worksheet S-3	
			From 07/01/2019 To 06/30/2020	Part V Date/Time Pre	narod
			10 00/30/2020	11/25/2020 2:	
	Cost Center Description		Contract Labor		
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Ident				
1.00	Total facility's contract labor and benefit	cost	4, 291, 840		
2.00	Hospi tal		4, 291, 840	19, 197, 849	
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF		0	0	
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	1.00
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00					10.00
11.00			0	0	
12.00					12.00
13.00					13.00
14.00					14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC				16.00
17.00			0	0	17.00
18.00	Other		0	0	18.00

	Financial Systems S HEALTH AGENCY STATISTICAL DATA	T. MARY MEDICAL			Period:	u of Form CMS-2 Worksheet S-4	
			Component		From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 2:	
					Home Health	PPS	50 piii
					Agency I		
					1.	00	
0. 00	County				0.11		0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	<u> </u>	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	3.00	
1.00	Home Health Aide Hours	0	1, 255		0 487	1,742	
2.00	Unduplicated Census Count (see instructions)	0.00	584.00		0 988.00 ployees (Full Tir	1,572.00 me Equivalent)	2.00
		Enter the numbe	er of hours in	Staff	Contract	Total	
		your normal	work week				
				1.00	2.00	2.02	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		40.00			0.00	
4.00 5.00	Director(s) and Assistant Director(s) Other Administrative Personnel			1.0 10.7		1. 01 10. 71	4.0 5.0
5.00	Direct Nursing Service			7.2		7.25	•
7.00	Nursing Supervisor			0.0		0.00	7.0
3.00 9.00	Physical Therapy Service Physical Therapy Supervisor			4.1		4.31 0.00	
10.00	Occupational Therapy Service			0.6		0.86	
11.00	Occupational Therapy Supervisor			0.0		0.00	
12.00 13.00	Speech Pathol ogy Servi ce Speech Pathol ogy Supervi sor			0.5		0.63 0.00	
14.00	Medical Social Service			0.2		0. 22	
15.00	Medical Social Service Supervisor			0.0			15.00
16.00 17.00	Home Health Aide Home Health Aide Supervisor			2.6			16.00 17.00
18.00	Other (specify)			0.0			18.00
19.00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where	1		1	1		19.00
19.00	you provided services during the cost				1		19.0
00 00	reporting period.			22044			20.0
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			23844			20.0
	contains the first code).						
		Full Ep Without		LUPA Epi sodes	s PEP Only	Total (cols.	
		Outliers			Epi sodes	1-4)	
	PPS ACTI VI TY DATA	1.00	2.00	3.00	4.00	5.00	
21.00	Skilled Nursing Visits	4, 861	1, 686	14	5 132	6, 824	
22.00	Skilled Nursing Visit Charges	927, 589	323, 141			1, 303, 436	
23.00 24.00	Physical Therapy Visits Physical Therapy Visit Charges	3, 615 802, 146	944 211, 939		6 82 4 17, 969	4, 677 1, 040, 048	
25.00	Occupational Therapy Visits	1, 257	552		6 39	1, 854	25.0
26.00 27.00	Occupational Therapy Visit Charges Speech Pathology Visits	278, 308 187	124, 012 103		6 8, 552 4 2	412, 208 306	
	Speech Pathology Visit Charges	41, 272	23, 316			68, 103	
28.00	Medical Social Service Visits	17	6		0 0	23	
29.00		4, 259	1, 507		0 0	5, 766 1, 255	
29.00 30.00	Medical Social Service Visit Charges Home Health Aide Visits		564		. 0		
29.00 30.00 31.00	Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges	677 96, 355	569 81, 102		0 1, 127	178, 724	32.0
29.00 30.00 31.00 32.00	Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	677		14			
29.00 30.00 31.00 32.00 33.00	Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	677 96, 355	81, 102	2 14 20		178, 724	33.0
29.00 30.00 31.00 32.00 33.00 34.00	Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28,	677 96, 355	81, 102	2 14 20	2 263 0 0	178, 724 14, 939	33. 0 34. 0
29.00 30.00 31.00 32.00 33.00 34.00 35.00	Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	677 96, 355 10, 614 0 2, 149, 929	81, 102 3, 860 0	14 20 37, 92	2 263 0 0 1 55, 418	178, 724 14, 939 0 3, 008, 285	33. 00 34. 00 35. 00
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28,	677 96, 355 10, 614 0	81, 102 3, 860 0	2 14 20	2 263 0 0 1 55, 418	178, 724 14, 939 0	33. 00 34. 00 35. 00

Heal th	Financial Systems ST. MARY MEDICAL CEN	NTER, INC.		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-0034	Peri od:	Worksheet S-1	C
				From 07/01/2019 To 06/30/2020	Date/Time Pre	aarad
				To 06/30/2020	11/25/2020 2:	58 pm
			1			
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by lir	ne 202 column	8)	0. 200776	1.00
0.00	Medicaid (see instructions for each line)				0 704 044	0.00
2.00	Net revenue from Medicaid				9, 724, 046 N	2.00
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplement		from Modios	: 42	IN	3.00 4.00
4.00 5.00	If line 4 is no, then enter DSH and/or supplemental payments fr			iu?	0	4.00 5.00
6.00	Medicaid charges		J		131, 608, 408	6.00
7.00	Medicaid cost (line 1 times line 6)				26, 423, 810	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minu	us sum of lin	es 2 and 5 [.] if	16, 699, 764	8.00
0.00	<pre>< zero then enter zero)</pre>				10,077,704	0.00
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line	e)			
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 mir	nus line 9; i	f < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see inst			、		10.00
13.00	Net revenue from state or local indigent care program (Not incl				23	13.00
14.00	Charges for patients covered under state or local indigent care	e program (N	NOT INCIUDED	in lines 6 or	66	14.00
15.00	10) State or local indigent care program cost (line 1 times line 14)			13	15.00
16.00	Difference between net revenue and costs for state or local ind		program (lin	o 15 minus lino	0	16.00
10.00	13; if < zero then enter zero)	ingent care		e is minus i me	0	10.00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indio	ent care program	ns (see	
	instructions for each line)		0	1 3		
17.00	Private grants, donations, or endowment income restricted to fu	ındi ng chari	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of h				0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent o	care programs	(sum of lines	16, 699, 764	19.00
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
		-	1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire fac	ility	8, 210, 28	6 1, 251, 066	9, 461, 352	20.00
	(see instructions)					
21.00	Cost of patients approved for charity care and uninsured discou	ints (see	1, 648, 42	8 1, 251, 066	2, 899, 494	21.00
~~ ~~	instructions)					
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00
23.00	charity care		1, 648, 42	8 1, 251, 066	2, 899, 494	23.00
23.00	Cost of charity care (line 21 minus line 22)		1, 040, 42	0 1,251,000	2, 099, 494	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	it days bevo	ond a length	of stav limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care					
25.00	If line 24 is yes, enter the charges for patient days beyond th	ie indigent	care program	's length of	0	25.00
	stay limit			-		
26.00	Total bad debt expense for the entire hospital complex (see ins				9, 007, 003	
27.00	Medicare reimbursable bad debts for the entire hospital complex				687, 833	
27.01	Medicare allowable bad debts for the entire hospital complex (s	ee instruct	tions)		1, 058, 204	
28.00	Non-Medicare bad debt expense (see instructions)				7, 948, 799	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	nstructions)		1, 966, 299	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	20)			4, 865, 793	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			21, 565, 557	31.00

	CATION AND ADJUSTMENTS OF TRIAL BALANCE OF			CN: 15-0034 P F T	rom 07/01/2019 o 06/30/2020		nard
						11/25/2020 2:	58 p
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
				+ COI. 2)	UIIS (See A-0)	(col. 3 +-	
						col. 4)	
CEN		1.00	2.00	3.00	4.00	5.00	
	ERAL SERVICE COST CENTERS		9, 388, 955	9, 388, 955	387, 790	9, 776, 745	1 1
	00 CAP REL COSTS-MVBLE EQUIP		8, 127, 951				
	00 OTHER CAP REL COSTS		0	0	0	0	3
	00 EMPLOYEE BENEFITS DEPARTMENT	151, 458	10, 466, 446				
	01 MAI NTENANCE OF PERSONNEL 40 NONPATI ENT TELEPHONES	957, 959	301, 616	1, 259, 575	0	1, 259, 575 0	
-	60 PURCHASING RECEIVING AND STORES	398, 106	137, 456	535, 562	0		
	70 PATIENT REGISTRATION	1, 651, 618	287, 733				
	80 PATIENT ACCOUNTING	0	-5			-	
	90 ADMI NI STRATI VE & GENERAL	4, 392, 469	49, 667, 153				
	00 MAINTENANCE & REPAIRS 00 OPERATION OF PLANT	1, 890, 098 1, 082, 079	3, 614, 963 4, 038, 046		0		
	00 LAUNDRY & LINEN SERVICE	101, 542	720, 116			821, 658	
	00 HOUSEKEEPI NG	2, 070, 586	796, 268			2, 866, 854	
	00 DI ETARY	1, 943, 452	1, 598, 705				
		0	0	-			
	00 MAI NTENANCE OF PERSONNEL 00 NURSI NG ADMI NI STRATI ON	2, 763, 078	0 2, 385, 327	0 5, 148, 405	-	0 5, 148, 405	
	00 CENTRAL SERVICES & SUPPLY	483, 614	514, 331	997, 945		997, 945	
	00 PHARMACY	2, 767, 043	13, 975, 821	16, 742, 864	-13, 055, 357		
	00 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	
	00 SOCIAL SERVICE	0	0	0	0	0	
	00 NONPHYSICIAN ANESTHETISTS 00 PARAMEDICAL EDUCATION PROGRAM EMS	0 234, 915	0 68, 872	303, 787	0	0 303, 787	
	ATIENT ROUTINE SERVICE COST CENTERS	234, 713	00, 072	303,787	0		2.
	00 ADULTS & PEDIATRICS	16, 719, 474	4, 110, 357	20, 829, 831	-2, 244, 399	18, 585, 432	30
	00 INTENSIVE CARE UNIT	3, 606, 023	1, 122, 918				
	00 SUBPROVIDER - IRF	1, 712, 441	902, 778				
	00 NURSERY	0	0	0	1, 321, 930	1, 321, 930	43
00 050	00 OPERATI NG ROOM	4, 669, 120	11, 675, 672	16, 344, 792	0	16, 344, 792	50
	OO RECOVERY ROOM	1, 771, 353	435, 624				
	OO DELIVERY ROOM & LABOR ROOM	0	0	-			
	00 ANESTHESI OLOGY	0	3, 786, 306			3, 786, 306	
	00 RADI OLOGY-DI AGNOSTI C 30 ULTRA SOUND	3, 193, 061 819, 208	2, 863, 494 478, 208			6, 066, 148 1, 297, 416	
	00 RADI OI SOTOPE	530, 126	1,034,307				
	OO CT SCAN	934, 160	1, 017, 121		0	1, 951, 281	57
	00 CARDI AC CATHETERI ZATI ON	2, 415, 884	1, 547, 293				
	00 LABORATORY 00 WHOLE BLOOD & PACKED RED BLOOD CELL	3, 616, 484 200, 559	4, 984, 392				
	50 BLOOD CLOTTING FOR HEMOPHILIACS	200, 559	1, 160, 792 0	1, 361, 351 0	0	1, 361, 351 0	
	00 RESPIRATORY THERAPY	2,062,177	585, 430	2, 647, 607	0	2, 647, 607	
	00 PHYSI CAL THERAPY	0	2, 891, 018	2, 891, 018	0	2, 891, 018	66
	00 OCCUPATIONAL THERAPY	0	1, 013, 671		0	1, 013, 671	
	00 SPEECH PATHOLOGY	0 E04 04E	449, 642		0	449, 642	
	00 ELECTROENCEPHALOGRAPHY 00 MEDICAL SUPPLIES CHARGED TO PATIENT	584,065	810, 216 8, 729, 320		0	1, 394, 281 8, 729, 320	
	00 IMPL. DEV. CHARGED TO PATIENTS	0	14, 414, 025			14, 414, 025	
	00 DRUGS CHARGED TO PATIENTS	Ō	0	0			
00 074	00 RENAL DIALYSIS	0	874, 044			874, 044	
	97 CARDI AC REHABI LI TATI ON	539, 926	155, 727				
	98 HYPERBARI C OXYGEN THERAPY 99 LI THOTRI PSY	0	0	0		0	
	PATIENT SERVICE COST CENTERS	5	0	. 0	0	. 0	1 ''
	00 CLINIC	2, 738, 274	1, 259, 671	3, 997, 945	103, 952	4, 101, 897	90
	00 EMERGENCY	3, 933, 377	1, 547, 010	5, 480, 387	100, 904	5, 581, 291	
	00 OBSERVATI ON BEDS (NON-DI STI NCT PART					l	92
	ER REI MBURSABLE COST CENTERS	2, 378, 084	591, 378	2, 969, 462	0	2, 969, 462	101
	CIAL PURPOSE COST CENTERS	2, 370, 004	571, 576	2,707,402	0	2,707,402	1,01
. 00	SUBTOTALS (SUM OF LINES 1 through 117)	73, 311, 813	174, 530, 168	247, 841, 981	-6, 666	247, 835, 315]118
	REIMBURSABLE COST CENTERS						
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190
	00 RESEARCH	0	0 3 780	-	6, 666		
	00 PHYSICIANS' PRIVATE OFFICES 50 OTHER NON-REIMBURSEABLE COST CENTER		3, 780 961, 621			3, 780 961, 621	
	51 OTHER NON-REIMBURSABLE	0	901, 021 0		0		194
1.010/9						248, 807, 382	

ECLASSI F	nancial Systems S FICATION AND ADJUSTMENTS OF TRIAL BALANCE O	T. MARY MEDICA F EXPENSES	Provider CO	CN: 15-0034	Peri od:	u of Form CMS Worksheet A	2002
					From 07/01/2019 To 06/30/2020	Date/Time Pr	epare
	Cost Center Description	Adjustments	Net Expenses			11/25/2020 2	:58 p
	cost center bescription	(See A-8)	For Allocation				
		6.00	7.00]			
	NERAL SERVICE COST CENTERS	474 540	0 000 005	1			
	100 CAP REL COSTS-BLDG & FIXT	-476, 540		1			1
	200 CAP REL COSTS-MVBLE EQUIP	978, 335		1			2
	300 OTHER CAP REL COSTS	1 212 070	-	•			3
	400 EMPLOYEE BENEFITS DEPARTMENT 401 MAINTENANCE OF PERSONNEL	1, 312, 970		1			4
	540 NONPATIENT TELEPHONES	527, 290	1, 259, 575 527, 290	1			5
	540 PURCHASING RECEIVING AND STORES	527, 290		1			5
	570 PATIENT REGISTRATION			1			5
	580 PATIENT ACCOUNTING	3, 387, 756					5
	590 ADMINI STRATI VE & GENERAL	-28, 833, 378					5
	600 MAI NTENANCE & REPAI RS	20,000,070					6
	700 OPERATION OF PLANT						7
	800 LAUNDRY & LINEN SERVICE			1			8
	900 HOUSEKEEPI NG	C					9
	000 DI ETARY	-3, 516		1			10
	100 CAFETERI A	-272, 968		1			11
00 01:	200 MAI NTENANCE OF PERSONNEL	C	0				12
. 00 01:	300 NURSING ADMINISTRATION	-2, 015, 274	3, 133, 131				13
. 00 014	400 CENTRAL SERVICES & SUPPLY	C	997, 945				14
. 00 01!	500 PHARMACY	C	3, 687, 507				15
. 00 010	600 MEDICAL RECORDS & LIBRARY	2, 643, 574	2, 643, 574				16
. 00 01	700 SOCIAL SERVICE	C	0 0				17
. 00 01	900 NONPHYSICIAN ANESTHETISTS	C	0 0				19
	300 PARAMEDICAL EDUCATION PROGRAM EMS	-34, 734	269, 053				23
	PATIENT ROUTINE SERVICE COST CENTERS	1	1				
	000 ADULTS & PEDI ATRI CS	-366, 018		1			30
	100 I NTENSI VE CARE UNI T	-9, 038		1			31
	100 SUBPROVIDER - IRF	C		1			41
	300 NURSERY	C	1, 321, 930				43
	CILLARY SERVICE COST CENTERS	75 (10		1			
	000 OPERATING ROOM	-75, 643		1			50
	100 RECOVERY ROOM	-8					51
	200 DELIVERY ROOM & LABOR ROOM		.,,	1			52
	300 ANESTHESI OLOGY	-3, 366, 586		1			53
	400 RADI OLOGY-DI AGNOSTI C 630 ULTRA SOUND	-16, 564 C		1			54
	600 RADI OI SOTOPE			1			54
	700 CT SCAN	-175		1			57
	900 CARDI AC CATHETERI ZATI ON	-6, 487					59
	000 LABORATORY	-198, 055		1			60
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	-190,000					62
	250 BLOOD CLOTTING FOR HEMOPHILIACS						62
	500 RESPI RATORY THERAPY	-747	, s				65
	600 PHYSI CAL THERAPY	0		1			66
	700 OCCUPATIONAL THERAPY			1			67
	800 SPEECH PATHOLOGY			1			68
	000 ELECTROENCEPHALOGRAPHY	-14, 738		1			70
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	C		1			71
	200 I MPL. DEV. CHARGED TO PATIENTS	C		1			72
	300 DRUGS CHARGED TO PATIENTS		12, 494, 405	1			73
	400 RENAL DI ALYSI S	C		1			74
	697 CARDI AC REHABI LI TATI ON	-64, 424		1			76
98 07	698 HYPERBARI C OXYGEN THERAPY	C		1			76
99 07	699 LI THOTRI PSY	C	0 0				76
OU	TPATIENT SERVICE COST CENTERS						
	000 CLINIC	-287, 871	3, 814, 026				90
	100 EMERGENCY	-370	5, 580, 921				91
	200 OBSERVATION BEDS (NON-DISTINCT PART						92
	HER REIMBURSABLE COST CENTERS						
1.0010	100 HOME HEALTH AGENCY	-6, 472	2, 962, 990				101
SPE	ECIAL PURPOSE COST CENTERS						
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	-27, 199, 681	220, 635, 634				
NON	NREI MBURSABLE COST CENTERS						
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0 0				190
	100 RESEARCH	C	6, 666				191
2.00 192	200 PHYSICIANS' PRIVATE OFFICES	C	3, 780				192
	950 OTHER NON-REIMBURSEABLE COST CENTER	C	961, 621				194
4.0107	951 OTHER NONREI MBURSABLE	C	0				194
0.00	TOTAL (SUM OF LINES 118 through 199)	-27, 199, 681	221, 607, 701	1			200

RECLAS	SSIFICATIONS			Provider CCN: 15-0034	Peri od:	Worksheet A-6
					From 07/01/2019 To 06/30/2020	Date/Time Prepared: 11/25/2020 2:58 pm
		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	159, 823		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	<u>0</u>	<u>8, 4</u> 16		2.00
	TOTALS		0	168, 239		
	B - RECLASS DRUG COSTS					
1.00	DRUGS_CHARGED_TO_PATIENTS	73.00	0	<u>12, 494, 4</u> 05		1.00
	TOTALS		0	12, 494, 405		
	C - CAFETERIA EXPENSES RECLASS					
1.00		<u>11.</u> 00	756, 202	<u>622, 0</u> 60		1.00
	TOTALS		756, 202	622, 060		
	D - RESEARCH RECLASS					
1.00	RESEARCH	191.00	5, 799	867		1.00
	TOTALS		5, 799	867		
	E - RECLASS FLOAT NURSES	I				
1.00	INTENSIVE CARE UNIT	31.00	54, 629	0		1.00
2.00	SUBPROVIDER - IRF	41.00	33, 230	0		2.00
3.00	NURSERY	43.00	15, 123	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	14, 124	0		4.00
5.00	EMERGENCY		66, 493	0		5.00
	TOTALS		183, 599	ō		
	F - RECLASS LDRP COSTS					
1.00	NURSERY	43.00	935, 020	371, 787		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	87 <u>3, 2</u> 78	34 <u>7, 2</u> 37		2.00
	TOTALS		1, 808, 298	719, 024		
	G - RECLASS IV COSTS					
1.00	ADULTS & PEDIATRICS	30.00	298, 000	168, 522		1.00
2.00	INTENSIVE CARE UNIT	31.00	33, 201	18, 775		2.00
3.00	SUBPROVIDER - IRF	41.00	22, 753	12, 867		3.00
4.00	RECOVERY ROOM	51.00	15, 229	8, 612		4.00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	6, 128	3, 465		5.00
6.00	CARDI AC CATHETERI ZATI ON	59.00	2, 776	1, 570		6.00
7.00	LABORATORY	60.00	1, 462	827		7.00
8.00	CLINIC	90.00	66, 402	37, 550		8.00
9.00	EMERGENCY	<u>91.00</u>	2 <u>1, 9</u> 81	1 <u>2,4</u> 30		9.00
	TOTALS		467, 932	264, 618		
	H - INTEREST EXPENSE RECLASS		1	Т		
1.00	CAP REL COSTS-BLDG & FIXT		0	<u>227,9</u> 67		1.00
	TOTALS		0	227, 967		
	I - RECLASS COVID COSTS					
1.00	PHARMACY	15.00	0	171, 598		1.00
2.00	LABORATORY		0	137,666		2.00
	TOTALS		0	309, 264		
500.00) Grand Total: Increases		3, 221, 830	14, 806, 444		500.00

	Financial Systems	J	T. MARY MEDICAL		CCN: 15-0034	Peri od:	u of Form CMS-2552 Worksheet A-6
LOLA					50N. 13 0034	From 07/01/2019 To 06/30/2020	Date/Time Prepare 11/25/2020 2:58 pt
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Re	f.	
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS PROPERTY INSURANC	E					
. 00	ADMI NI STRATI VE & GENERAL	5.05	0	168, 239		12	1.
. 00		0.00	0	0)	12	2.
	TOTALS		0	168, 239			
	B - RECLASS DRUG COSTS						
. 00	PHARMACY	15.00	0	12, 494, 405		0	1.
	TOTALS		0	12, 494, 405			
	C - CAFETERIA EXPENSES RECLAS	S					
. 00	DI ETARY		756, 202	62 <u>2,0</u> 60		Q	1.
	TOTALS		756, 202	622,060			
	D - RESEARCH RECLASS				T		
. 00	CARDI AC REHABI LI TATI ON		5, 799	867		Q	1.
	TOTALS		5, 799	867			
	E - RECLASS FLOAT NURSES		I		T		
. 00	ADULTS & PEDIATRICS	30.00	183, 599	0		0	1.
. 00		0.00	0	0		0	2.
. 00		0.00	0	0		0	3.
. 00		0.00	0	0		0	4.
. 00		0.00	0	0	·	Q	5.
	TOTALS		183, 599	0			
	F - RECLASS LDRP COSTS				1	-	
. 00	ADULTS & PEDIATRICS	30.00	935, 020	371, 787		0	1.
. 00	ADULTS & PEDIATRICS		<u>873, 2</u> 78	347,237		<u>0</u>	2.
	TOTALS		1, 808, 298	719, 024			
	G - RECLASS IV COSTS	45.00	117 000				
. 00	PHARMACY	15.00	467, 932	264, 618		0	1.
. 00		0.00	0	0		0	2.
. 00		0.00	0	0		0	3.
. 00		0.00	0	0		0	4.
. 00		0.00	0	0		8	5.
. 00		0.00	0	0		0	6.
. 00		0.00	0	0		8	7.
. 00		0.00	0	0		0	8.
. 00	TOTALS	0.00	467, 932	264, 618		<u>u</u>	9.
			407, 932	204, 010	1		
. 00	H - INTEREST EXPENSE RECLASS ADMINISTRATIVE & GENERAL	5.05	0	227, 967	1	11	1.
. 00	TOTALS	<u> </u>		227,967		' <u>'</u>	1.
	I - RECLASS COVID COSTS		U	221,901			
. 00	ADMINI STRATI VE & GENERAL	5.05	0	171, 598		0	1.
. 00	ADMINISTRATIVE & GENERAL	5.05	0	137, 666		0	2.
. 00	TOTALS		— — — /			5	² .
~~ ~) Grand Total: Decreases		3, 221, 830	14, 806, 444			500.

Heal th	Financial Systems S	T. MARY MEDICAL	CENTER, INC.			In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0034		riod: om 07/01/2019 06/30/2020	Worksheet A-7 Part I Date/Time Pre 11/25/2020 2:	pared:
				Acqui si ti on	IS		1172072020 2.	
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	11, 734, 736	1, 302, 739		0	1, 302, 739	0	1.00
2.00	Land Improvements	7, 644, 673	219, 050		0	219, 050	0	2.00
3.00	Buildings and Fixtures	124, 547, 835	4, 590, 543		0	4, 590, 543	0	3.00
4.00	Building Improvements	66, 601, 754	7, 300, 626		0	7, 300, 626	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	71, 405, 857	6, 710, 302		0	6, 710, 302	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	281, 934, 855	20, 123, 260		0	20, 123, 260	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	281, 934, 855	20, 123, 260		0	20, 123, 260	0	10.00
		Endi ng Bal ance	Fully					
		-	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	13, 037, 475	0					1.00
2.00	Land Improvements	7, 863, 723	0					2.00
3.00	Buildings and Fixtures	129, 138, 378	0					3.00
4.00	Building Improvements	73, 902, 380	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	78, 116, 159	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	302, 058, 115	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	302, 058, 115	0					10.00

Heal th	Financial Systems	ST. MARY MEDICAL	_ CENTER, INC.		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0034	Peri od:	Worksheet A-7	
					From 07/01/2019 To 06/30/2020		nared
					10 00/ 30/ 2020	11/25/2020 2:	
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR						
1.00	CAP REL COSTS-BLDG & FIXT	8, 257, 626			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6, 104, 716			0 0	0	2.00
3.00	Total (sum of lines 1-2)	14, 362, 342			0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM					
1.00	CAP REL COSTS-BLDG & FIXT	0	9, 388, 955				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8, 127, 951				2.00
3.00	Total (sum of lines 1-2)	0	17, 516, 906				3.00

	T. MARY MEDICAL				u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	F	Period: From 07/01/2019 Fo 06/30/2020		bared:
	COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	223, 941, 956 78, 116, 158 302, 058, 114	0	223, 941, 956 78, 116, 158 302, 058, 114 CAPI TAL	0. 258613	0 0 F CAPITAL	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS 0	0		8,009,053	1, 131, 329	1.00
2.00 CAP REL COSTS-BLOG & FIAT 3.00 Total (sum of lines 1-2)	0	-		7, 083, 051 15, 092, 104	2, 023, 235	2.00
	5	SL	JMMARY OF CAPI		0,101,001	01 00
Cost Center Description	Interest	Insurance (see instructions)			Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	NTERS 0 0			0 0	9, 300, 205 9, 114, 702	1.00 2.00
3.00 Total (sum of lines 1-2)	0			0 0	18, 414, 907	3.00

ST. MARY MEDICAL CENTER, INC.

Heal th	Financial Systems	ST	. MARY MEDICAL	L CENTER, INC.	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period: From 07/01/2019 To 06/30/2020	Worksheet A-8	pared:
				Expense Classification or To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0	CAF REL COSTS-WUBLE EQUIF	0.00		
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)				5.04		
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-121, 549	NONPATIENT TELEPHONES	5. 01	0	7.00
8.00	Television and radio service (chapter 21)	А	-11, 008	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00 10.00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -246, 972		0.00	0 0	
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-3, 471, 254			0	12.00
13.00	Laundry and linen service		0		0.00		13.00
14.00	Cafeteria-employees and guests		-272, 968	CAFETERI A	11.00		
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	о	18.00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.) Vending machines	В	-3 127	DI ETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty		0, 127		0.00		1
22.00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
22.00	overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL	А	-349, 988	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00		
20.00	COSTS-MVBLE EQUIP				10.00		
28.00 29.00	Non-physician Anesthetist Physicians'assistant		0	NONPHYSICIAN ANESTHETISTS	19.00 0.00		28.00 29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
52.00	Depreciation and Interest		0		0.00		52.00

Heal th	Fi nanci a	l Systems
	MENTS TO	EXPENSES

ST. MARY MEDICAL CENTER, INC.

In Lieu of Form CMS-2552-10

ADJUSTMENTS TO EXPENSES Provider COX: 15-0034 Period 07/01/2010 From 07/01/2010 To 07/01/2010 Moresheet A.s. Expense: Classification on Worksheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Moresheet A.s. To FFrom Which the Amount 1s to be Adjusted Adjusted Adjusted Adjusted Adjusted Adjusted 33. 01 OFFSFT CRMAVMESTHES OLOGIST A -3.366, bbowerSHESIGUE OLOGIST 4djusted 3djusted Adjusted Adjusted	<u>Heal th</u>	Financial Systems	ST	T. MARY MEDICA	L CENTER, INC.	In Lie	eu of Form CMS-	<u>2552-10</u>
To 0 00/50/2020 Discription Display Cost Center Description Hasts/Code (2) Amount Expense Classification on Worksheet A. 11/23/2020 2.8 m 33.00 OFFSET CREA/ARESTHESI OLOGIST A 2.366.584/AEETHESI OLOGY 53.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 <td>ADJUST</td> <td>MENTS TO EXPENSES</td> <td></td> <td></td> <td>Provider CCN: 15-0034</td> <td>Peri od:</td> <td>Worksheet A-8</td> <td></td>	ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0034	Peri od:	Worksheet A-8	
Lopense Classification on Workheet A Lopense Classification on Workheet A Lopense Classification on Workheet A 33.00 OFIST CRMAVMESTHESIOLOGIST A To/From Which the Amount is to be Adjusted 33.00 OFIST CRMAVMESTHESIOLOGIST A -3.366. SHAMESTHESIOLOGY 5.3.00 33.01 MALLIFE 1991 PHILLIPS ED A -5.750CAP REL COSTS-MMBLE EOUP 2.00 9.30 9.3.01 33.01 PMO ASSTS INSTALMENTS A -1.3970AP REL COSTS-MMBLE EOUP 2.00 9.33.01 34.03 OFFSET OTHER OF REV B -1.3970AP REL COSTS-MMBLE EOUP 2.00 9.33.01 34.03 OFFSET OTHER OF REV B -1.1970AP REL COSTS-MMBLE EOUF 5.60 0.34.03 35.00 OFFSET OTHER OF REV B -1.47474PARUESTRE 30.00 0.34.03 35.00 OFFSET OTHER NOP REVE B -1.322784AWIN ISS RETIVE & GENERAL 5.05 0 33.00 0.35.00 0.35.00 0.35.00 0.35.00 0.35.00 0.35.00 0.35.00 0.35.00 0.35.00 0.35.00 0.35.00 0.35.00 0.35.00 0.3						From 07/01/2019	Data /Tima Dir-	nared.
Exponse Classification on Norkheet A Exponse Classification on Norkheet A 0 Cost Center Description Basis/Code (2) Amount Cost Center Line # Nicst. A-7 Ref. 33.00 OFFSET CRM/AMFSTHESIOLOGIST A -3.366.58MMESTHESIOLOGY 53.00 93.00 33.00 93.00 33.00 93.00<						10 06/30/2020		
To/From Which the Amount is to be Adjusted Cost: Center Description Basis #/Code (2) Amount Cost: Center Line # Wist. A-7 Bef. 33.00 OFFSET CRWAMESTHESI OLOCIST A 3.366, BeAWESTHESI OLOCY 5.00 4.00 5.00 33.01 31.01 AHA, LIE T9YT, PHILLIPS CONST. A 5.700CAP REL COSTS-MWRE ECUIP 2.00 93.01 32.01 MAR, LIE T9YT, PHILLIPS CONST. A 5.700CAP REL COSTS-MWRE ECUIP 2.00 93.01 33.01 MORSSETST STREET A -1.97/DAMENE COSTS-MWRE ECUIP 2.00 93.01 34.01 POST AMESTHESTI OTHER OP REV B -1.97/DAMENE COSTS 51.00 63.40 35.00 OFFSET OTHER I NCOME B -1.722.298/AUM INSTRATIVE & GENERAL 5.00 36.00 36.00 36.00 36.00 36.00 35.10 35.10 36.00 35.10 35.10 37.00 35.10 37.00 35.10 36.00 35.10 35.10 35.10 35.10 35.10 35.10					Expense Classification or	Worksheet A	1172372020 2.	
Cost Center Description Best s//Code 200 Cost Center Line # Most A- 7 Ref. 33.00 OFFSET CRN/AMESTHESIOLOGIST A -3.366, SRAMESTHESIOLOGY 5.00 9.00 9.30 0 9.30 0 9.00 9.30 0 9.00 9.33.01 0 9.00 9.33.01 9.00 9.33.01 9.00 9.33.01 9.00 9.33.01 9.33.01 9.00 9.33.01<								
1.00 2.00 3.00 4.00 5.00 33.00 32.00 0 PEST CRNA/ANESTHESI LOGIST FE -3.364, BRA/NESTHESI LOCY 53.00 0 33.00 33.01 AHA LIFE 1971 PHILLIPS ED A -5.364, BRA/NESTHESI LOCY 50.00 93.01 33.01 1900 ASSETS - INSTALLENTS A -1.397/CAP REL COSTS-MVBLE EQUIP 2.00 93.01 34.01 PHOTOGRAPHIC FEES B -1.397/CAP REL COSTS-MVBLE EQUIP 2.00 93.40 34.01 POST ANESINESI A INCOME B -842/COVERY ROAM 51.00 0.34.00 34.01 OFFSET OTHER O NERV B -476/DULTS A PEDIATRICS 30.00 0.34.03 35.00 OFFSET IN SALARIES A -191.998/CLINIC 90.00 0.35.03 35.00 OFFSET INSING OFFSET A -2136, 110/NURSING ADMINISTRATION 13.00 0.35.00 35.10 OFFSET INSENTRES A -2136, 110/NURSING ADMINISTRATION 33.00 0.35.12 37.00 OFFSET INSENTRES A -2136, 010/NURSING ADMINISTRATION 33.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>to be haj astea</td><td></td><td></td></t<>						to be haj astea		
1.00 2.00 3.00 4.00 5.00 33.00 32.00 0 PEST CRNA/ANESTHESI LOGIST FE -3.364, BRA/NESTHESI LOCY 53.00 0 33.00 33.01 AHA LIFE 1971 PHILLIPS ED A -5.364, BRA/NESTHESI LOCY 50.00 93.01 33.01 1900 ASSETS - INSTALLENTS A -1.397/CAP REL COSTS-MVBLE EQUIP 2.00 93.01 34.01 PHOTOGRAPHIC FEES B -1.397/CAP REL COSTS-MVBLE EQUIP 2.00 93.40 34.01 POST ANESINESI A INCOME B -842/COVERY ROAM 51.00 0.34.00 34.01 OFFSET OTHER O NERV B -476/DULTS A PEDIATRICS 30.00 0.34.03 35.00 OFFSET IN SALARIES A -191.998/CLINIC 90.00 0.35.03 35.00 OFFSET INSING OFFSET A -2136, 110/NURSING ADMINISTRATION 13.00 0.35.00 35.10 OFFSET INSENTRES A -2136, 110/NURSING ADMINISTRATION 33.00 0.35.12 37.00 OFFSET INSENTRES A -2136, 010/NURSING ADMINISTRATION 33.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
1.00 2.00 3.00 4.00 5.00 33.00 32.00 0 PEST CRNA/ANESTHESI LOGIST FE -3.364, BRA/NESTHESI LOCY 53.00 0 33.00 33.01 AHA LIFE 1971 PHILLIPS ED A -5.364, BRA/NESTHESI LOCY 50.00 93.01 33.01 1900 ASSETS - INSTALLENTS A -1.397/CAP REL COSTS-MVBLE EQUIP 2.00 93.01 34.01 PHOTOGRAPHIC FEES B -1.397/CAP REL COSTS-MVBLE EQUIP 2.00 93.40 34.01 POST ANESINESI A INCOME B -842/COVERY ROAM 51.00 0.34.00 34.01 OFFSET OTHER O NERV B -476/DULTS A PEDIATRICS 30.00 0.34.03 35.00 OFFSET IN SALARIES A -191.998/CLINIC 90.00 0.35.03 35.00 OFFSET INSING OFFSET A -2136, 110/NURSING ADMINISTRATION 13.00 0.35.00 35.10 OFFSET INSENTRES A -2136, 110/NURSING ADMINISTRATION 33.00 0.35.12 37.00 OFFSET INSENTRES A -2136, 010/NURSING ADMINISTRATION 33.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
1.00 2.00 3.00 4.00 5.00 33.00 32.00 0 PEST CRNA/ANESTHESI LOGIST FE -3.364, BRA/NESTHESI LOCY 53.00 0 33.00 33.01 AHA LIFE 1971 PHILLIPS ED A -5.364, BRA/NESTHESI LOCY 50.00 93.01 33.01 1900 ASSETS - INSTALLENTS A -1.397/CAP REL COSTS-MVBLE EQUIP 2.00 93.01 34.01 PHOTOGRAPHIC FEES B -1.397/CAP REL COSTS-MVBLE EQUIP 2.00 93.40 34.01 POST ANESINESI A INCOME B -842/COVERY ROAM 51.00 0.34.00 34.01 OFFSET OTHER O NERV B -476/DULTS A PEDIATRICS 30.00 0.34.03 35.00 OFFSET IN SALARIES A -191.998/CLINIC 90.00 0.35.03 35.00 OFFSET INSING OFFSET A -2136, 110/NURSING ADMINISTRATION 13.00 0.35.00 35.10 OFFSET INSENTRES A -2136, 110/NURSING ADMINISTRATION 33.00 0.35.12 37.00 OFFSET INSENTRES A -2136, 010/NURSING ADMINISTRATION 33.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
1.00 2.00 3.00 4.00 5.00 33.00 32.00 0 PEST CRNA/ANESTHESI LOGIST FE -3.364, BRA/NESTHESI LOCY 53.00 0 33.00 33.01 AHA LIFE 1971 PHILLIPS ED A -5.364, BRA/NESTHESI LOCY 50.00 93.01 33.01 1900 ASSETS - INSTALLENTS A -1.397/CAP REL COSTS-MVBLE EQUIP 2.00 93.01 34.01 PHOTOGRAPHIC FEES B -1.397/CAP REL COSTS-MVBLE EQUIP 2.00 93.40 34.01 POST ANESINESI A INCOME B -842/COVERY ROAM 51.00 0.34.00 34.01 OFFSET OTHER O NERV B -476/DULTS A PEDIATRICS 30.00 0.34.03 35.00 OFFSET IN SALARIES A -191.998/CLINIC 90.00 0.35.03 35.00 OFFSET INSING OFFSET A -2136, 110/NURSING ADMINISTRATION 13.00 0.35.00 35.10 OFFSET INSENTRES A -2136, 110/NURSING ADMINISTRATION 33.00 0.35.12 37.00 OFFSET INSENTRES A -2136, 010/NURSING ADMINISTRATION 33.00 <t< td=""><td></td><td>Cost Center Description</td><td>Basis/Code (2)</td><td>Amount</td><td>Cost Center</td><td>Line #</td><td>Wkst. A-7 Ref.</td><td></td></t<>		Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
33.00 OFFSET CRUMANESTHESIOLOGIST A -3,366.586/AMESTHESIOLOGY 53.00 0 33.00 33.01 AIA LIFE 1991 PHILLIPS CO 9 33.01 33.01 AIA LIFE 1991 PHILLIPS CO 9 33.01 33.00 AIA LIFE 1991 PHILLIPS CO 9 33.01 34.00 PHOTOGRAPHIC FEES B -1, 397CARD COSTS-WIBLE EQUIP 2.00 9 33.00 34.01 34.01 POSTSET OTHER NOOME B -1, 397CARD CALEDICATION 23.00 34.01 34.03 OFFSET OTHER NOOME B -747ARDULTS SECOVERY SECON 35.00 25.00 25.00 25.00 23.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
FE FE Control State State <thstate< th=""> State Stat</thstate<>	33.00	OFFSET CRNA/ANESTHESI OLOGI ST						33.00
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32. 07 1990 ASSETS-INSTALLMENTS A -1, 397/CAP REL COSTS-WOBLE COUP 2. 00 9 32. 07 34. 00 PORTARESTHESA I INCOME B -987C0VERY ROOM 51. 00 0 34. 00 34. 01 OPESET OTHER 0P REV B -987C0VERY ROOM 51. 00 0 34. 03 34. 04 OPESET OTHER 0P REV B -34. 734 PARMETICAL EDUCATION 23. 00 0 34. 04 35. 04 OPESET OTHER 1NCOME B -476/40ULTS & PEDI ATRICS 30. 00 0 35. 03 36. 00 OFESET OTHER INSTALL A -732, 298/ADMINI STRATIVE & GENERAL 5. 05 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 35. 00 0 <td>33.01</td> <td>AHA LIFE 1991 PHILLIPS EQ</td> <td>А</td> <td>5,750</td> <td>CAP REL COSTS-MVBLE EQUIP</td> <td>2.00</td> <td>9</td> <td>33.01</td>	33.01	AHA LIFE 1991 PHILLIPS EQ	А	5,750	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.01
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35. 00 AUVERTI SING OFFSET A -732. 298/ADMINI STRATIVE & GENERAL 5. 05 0 35. 00 55. 00	34.04	OFFSET OTHER INCOME	В	-476		30.00	0	34.04
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42.03 OTHER INCOME B -49,772 ADMI NI STRATI VE & GENERAL 5.05 0 42.03 42.05 OFFSET DI ETARY I NCOME B -389 DI ETARY 10.00 0 42.05 42.06 OFFSET OTHER I NCOME B -91 NTENSI VE CARE UNI T 31.00 0 42.06 43.00 OFFSET OTHER I NCOME B -370 DEMERGENCY 91.00 0 43.03 43.04 OFFSET CONTRI BUTI ON EXPENSE A -33,700 ADMI NI STRATI VE & GENERAL 5.05 0 43.03 43.05 OFFSET CONTRI BUTI ON EXPENSE A -28 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 43.03 44.00 PHONE OFFSET A -13,983 NONPATI ENT TELEPHONES 5.01 0 44.00 44.00 OHER INCOME RESP THERAPY B -263 RESPI RATORY THERAPY 5.00 0 46.00 45.00 OTFSET CARDI AC INCOME B -46,640 CARDI AC REHABI LI TATI ON 76.97 0 46.01 47.01 BARI ATRIC COSTS/DEPT 4266 A -27,1967 CAP REL COSTS-BLOG & FI XT 1.00 11 47.00 47.02 OFFSET PHYSICIAN FEES <td>41.03</td> <td>OFFSET OTHER INCOME</td> <td>В</td> <td>-520</td> <td>EMPLOYEE BENEFITS DEPARTMEN</td> <td>Г 4.00</td> <td>0</td> <td>41.03</td>	41.03	OFFSET OTHER INCOME	В	-520	EMPLOYEE BENEFITS DEPARTMEN	Г 4.00	0	41.03
42.05 OFFSET DI ETARY INCOME B -389 DI ETARY 10.00 0 42.05 42.06 OFFSET OTHER INCOME B -9(INTENSIVE CARE UNIT 31.00 0 42.06 43.00 OFFSET OTHER INCOME B -370 EMERGENCY 91.00 0 43.00 43.03 OFFSET CONTRIBUTION EXPENSE A -33,700 ADMI NI STRATI VE & GENERAL 5.05 0 43.03 43.04 OFFSET CONTRIBUTION EXPENSE A -23,700 ADMI NI STRATI VE & GENERAL 5.05 0 43.03 43.05 OFFSET CONTRIBUTION EXPENSE A -23,893 NONPATI ENT TELEPHONES 5.01 0 44.00 46.00 OTHER INCOME RESP THERAPY B -263 RESPI RATORY THERAPY 65.00 0 46.00 46.01 OFFSET CARDIAC INCOME B -46,640 CARDIAC REHABI LI TATI ON 76.97 0 46.00 47.00 OFFSET PHERAPY B -227,967 CAP REL COSTS-BLDG & FIXT 1.00 11 47.00 47.01 BARI ATRI C COSTS/DEPT 4266 A -57,710 CLINI C 90.00 0 47.02 0FFSET PHYSICIAN FEES A	42.01	OFFSET PHO REVENUE	В	-14,000	ADMI NI STRATI VE & GENERAL	5.05	0	42.01
42.06 OFFSET OTHER INCOME B -9 INTENSIVE CARE UNIT 31.00 0 42.06 43.00 OFFSET OTHER INCOME B -370 EMERGENCY 91.00 0 43.00 43.03 OFFSET CONTRIBUTION EXPENSE A -33,700 ADMINISTRATIVE & GENERAL 5.05 0 43.03 43.04 OFFSET CONTRIBUTION EXPENSE A -228 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 43.04 43.05 OFFSET CONTRIBUTION EXPENSE A -645 NURSING ADMINISTRATION 13.00 0 43.04 44.00 PHONE OFFSET A -13,983 NONPATIENT TELEPHONES 5.01 0 44.00 46.01 OFFSET CARDIAC INCOME B -263 RESPI RATORY THERAPY 65.00 0 46.00 47.00 OFFSET TINTEREST EXPENSE A -227,967 CAP REL COSTS-BLDG & FIXT 1.00 11 47.00 47.01 BARIATRIC COSTS/DEPT 4266 A -57,710 CLINIC 90.00 0 47.02 0FFSET PHYSICIAN FEES A -17,312 CARDIAC REHABILITATION 76.97 0 47.02 47.04 OFFSET PHYSICIAN FEES A -1	42.03	OTHER INCOME	В			5.05	0	42.03
43.00 OFFSET OTHER INCOME B -370 EMERGENCY 91.00 0 43.00 43.03 OFFSET CONTRI BUTI ON EXPENSE A -33,700 ADMI NI STRATI VE & GENERAL 5.05 0 43.03 43.04 OFFSET CONTRI BUTI ON EXPENSE A -28 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 43.04 43.05 OFFSET CONTRI BUTI ON EXPENSE A -645 NURSI NG ADMI NI STRATI ON 13.00 0 43.05 44.00 PHONE OFFSET A -13,983 NONPATI ENT TELEPHONES 5.01 0 44.00 46.00 OTHER INCOME RESP THERAPY B -263 RESPI RATORY THERAPY 65.00 0 46.00 47.00 OFFSET CARDI AC INCOME B -46,640 CARDI AC REHABI LI TATI ON 76.97 0 46.01 47.00 OFFSET INTEREST EXPENSE A -227,967 CAP REL COSTS-BLDG & FIXT 1.00 11 47.00 47.01 BARI ATRI C COSTS/DEPT 4266 A -57,710 CLI NI C 90.00 0 47.01 47.02 OFFSET PHYSI CI AN FEES A -17,312<	42.05	OFFSET DIETARY INCOME	В	-389	DI ETARY	10.00	0	42.05
43.03 OFFSET CONTRIBUTION EXPENSE A -33,700 ADMINISTRATIVE & GENERAL 5.05 0 43.03 43.04 OFFSET CONTRIBUTION EXPENSE A -28 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 43.04 43.05 OFFSET CONTRIBUTION EXPENSE A -645 NURSING ADMINISTRATION 13.00 0 43.05 44.00 PHONE OFFSET A -13,983 NONPATIENT TELEPHONES 5.01 0 44.00 46.00 OTHER INCOME RESP THERAPY B -263 RESPIRATORY THERAPY 65.00 0 46.00 47.00 OFFSET CARDIAC INCOME B -46,640 CARDIAC REHABILITATION 76.97 0 46.01 47.01 BARIATRIC COSTS/DEPT 4266 A -57,710 CLINIC 90.00 0 47.01 47.02 OFFSET PHYSICIAN FEES A -17,312 CARDIAC REHABILITATION 76.97 0 47.02 47.03 OFFSET PHYSICIAN FEES A -17,312 CARDIAC REHABILITATION 76.97 0 47.03 47.04 OFFSET PHYSICIAN FEES A -17,505 <td< td=""><td>42.06</td><td>OFFSET OTHER INCOME</td><td>В</td><td>-9</td><td>INTENSIVE CARE UNIT</td><td>31.00</td><td>0</td><td>42.06</td></td<>	42.06	OFFSET OTHER INCOME	В	-9	INTENSIVE CARE UNIT	31.00	0	42.06
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43.04 OFFSET CONTRIBUTION EXPENSE A -28 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 43.04 43.05 OFFSET CONTRIBUTION EXPENSE A -645 NURSING ADMINISTRATION 13.00 0 43.05 44.00 PHONE OFFSET A -13,983 NONPATIENT TELEPHONES 5.01 0 44.00 46.00 OTHER INCOME RESP THERAPY B -263 RESPI RATORY THERAPY 65.00 0 46.00 46.01 OFFSET CARDIAC INCOME B -46,640 CARDIAC REHABILITATION 76.97 0 46.01 47.02 OFFSET PHYSICIAN FEES A -17,312 CARDIAC REHABILITATION 76.97 0 47.02 47.02 OFFSET PHYSICIAN FEES A -17,312 CARDIAC REHABILITATION 76.97 0 47.02 47.03 OFFSET PHYSICIAN FEES A -17,505 OPERATING ROOM 50.00 0 47.03 47.04 OFFSET PHYSICIAN FEES A -71,505 OPERATING ROOM 50.00 0 47.03 47.05 OFFSET PHYSICIAN FEES A -71,505 OPERATING ROOM 50.00 0 47.05 47.04 OFFSET PHYSICIAN FEES	43.03		А	-33,700	ADMI NI STRATI VE & GENERAL	5.05	0	43.03
43.05 OFFSET CONTRIBUTION EXPENSE A -645 NURSING ADMINISTRATION 13.00 0 43.05 44.00 PHONE OFFSET A -13,983 NONPATIENT TELEPHONES 5.01 0 44.00 46.00 OTHER INCOME RESP THERAPY B -263 RESPIRATORY THERAPY 65.00 0 46.00 46.01 OFFSET CARDIAC INCOME B -46,640 CARDIAC REHABILITATION 76.97 0 46.01 47.00 OFFSET INTEREST EXPENSE A -227,967 CAP REL COSTS-BLDG & FIXT 1.00 11 47.00 47.01 BARIATRIC COSTS/DEPT 4266 A -57,710 CLINIC 90.00 0 47.01 47.02 OFFSET PHYSICIAN FEES A -71,505 OPERATING ROOM 50.00 47.02 47.03 OFFSET PHYSICIAN FEES A -71,505 OPERATING ROOM 50.00 47.03 47.04 OFFSET PHYSICIAN FEES A -71,505 OPERATING ROOM 50.00 47.03 47.05 OFFSET PHYSICIAN FEES A -71,505 OPERATING ROOM 50.00 47.04 47.05 OFFSET PHYSICIAN FEES A -71,505 OPERATING ROOM 50.00 47.05 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
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46.00 OTHER INCOME RESP THERAPY B -263 RESPIRATORY THERAPY 65.00 0 46.00 46.01 OFFSET CARDIAC INCOME B -46,640 CARDIAC REHABILITATION 76.97 0 46.01 47.00 OFFSET INTEREST EXPENSE A -227,967 CAP REL COSTS-BLDG & FIXT 1.00 11 47.00 47.01 BARIATRIC COSTS/DEPT 4266 A -57,710 CLINIC 90.00 0 47.01 47.03 OFFSET PHYSICIAN FEES A -17,312 CARDIAC REHABILITATION 76.97 0 47.02 47.03 OFFSET PHYSICIAN FEES A -71,505 OPERATING ROOM 50.00 0 47.03 47.04 OFFSET PHYSICIAN FEES A -71,505 OPERATING ROOM 50.00 0 47.03 47.05 OFFSET PHYSICIAN FEES A -71,505 OPERATING ROOM 50.00 0 47.03 47.04 OFFSET PHYSICIAN FEES A -175 CT SCAN 51.00 0 47.05 49.01 OFFSET PHYSICIAN FEES A -15,211,922 ADMINISTRATIVE & GENERAL 5.05 0 49.01 ALLOCATIO O -27,199,681 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
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47. 02 0FFSET PHYSICIAN FEES A -17, 312 CARDIAC REHABILITATION 76. 97 0 47. 02 47. 03 0FFSET PHYSICIAN FEES A -71, 505 OPERATING ROOM 50. 00 0 47. 03 47. 04 0FFSET PHYSICIAN FEES A -71, 505 OPERATING ROOM 50. 00 0 47. 03 47. 05 0FFSET PHYSICIAN FEES A -3, 900 RADIOLOGY-DIAGNOSTIC 54. 00 0 47. 05 49. 01 0FFSET PHYSICIAN FEES A -175, 211, 922 ADMINISTRATIVE & GENERAL 57. 00 0 49. 01 40. 0FFSET PHYSICIAN CORP A -15, 211, 922 ADMINISTRATIVE & GENERAL 5. 05 0 49. 01 50. 00 TOTAL (sum of lines 1 thru 49) -27, 199, 681 50. 00 50. 00 50. 00 50. 00								
47. 03 0FFSET PHYSICIAN FEES A -71, 505 0PERATING ROOM 50. 00 0 47. 03 47. 04 0FFSET PHYSICIAN FEES A -3, 900 RADIOLOGY-DIAGNOSTIC 54. 00 0 47. 04 47. 05 0FFSET PHYSICIAN FEES A -175 CT SCAN 57. 00 0 47. 05 49. 01 0FFSET PHYSICIAN CORP A -15, 211, 922 ADMINISTRATIVE & GENERAL 5. 05 0 49. 01 50. 00 TOTAL (sum of lines 1 thru 49) -27, 199, 681 -27, 199, 681 50. 00 50. 00 50. 00								
47. 04 0FFSET PHYSI CI AN FEES A -3,900 RADI OLOGY-DI AGNOSTI C 54.00 0 47.04 47. 05 0FFSET PHYSI CI AN FEES A -175 CT SCAN 57.00 0 47.05 49. 01 0FFSET PHYSI CI AN CORP A -15, 211, 922 ADMI NI STRATI VE & GENERAL 5.05 0 49.01 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, -27, 199, 681 -27, 199, 681 50.00 50.00								
47. 05 0FFSET PHYSICIAN FEES A -175 CT SCAN 57. 00 0 47. 05 49. 01 0FFSET PHYSICIAN CORP A -15, 211, 922 ADMINISTRATIVE & GENERAL 5. 05 0 49. 01 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, -27, 199, 681 -27, 199, 681 50. 00 50. 00								
49. 01OFFSET PHYSI CI AN CORP ALLOCATI 0A-15, 211, 922ADMI NI STRATI VE & GENERAL5. 05049. 0150. 00TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,-27, 199, 681-27, 199, 68150. 0050. 00								
ALLOCATIO50.00TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,50.00								
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, -27, 199, 681 50.00						5.00	Ĭ	
(Transfer to Worksheet A,	50.00			-27, 199, 681		1		50.00

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

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	ST. MARY MEDICA	AL CENTER, INC.	In Lie	eu of Form CMS-2	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	-1
OFFI CE	COSTS			From 07/01/2019		norod.
				To 06/30/2020	Date/Time Pre 11/25/2020 2:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	00 pm
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:			- 1		
1.00			OTHER NONCAPI TAL COSTS	8, 181, 260	27, 390, 399	1.00
2.00			BLDG DEPR	101, 415	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	EQ DEPR	984, 990	0	3.00
3.01	5. 01	NONPATIENT TELEPHONES	TELECOMMUNI CATI ONS	662, 822	0	3. 01
3.02	16.00	MEDICAL RECORDS & LIBRARY	MEDI CAL RECORDS	2, 643, 574	0	3. 02
3.03	5.04	PATIENT ACCOUNTING	PATIENT ACCTING	3, 387, 756	0	3.03
3.04	13.00	NURSING ADMINISTRATION	CANCER REGISTRY COSTS	145, 801	0	3.04
3.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	ALLOCATED FRINGE BENEFITS CO	1, 313, 518	0	3.05
4.00	5.05	ADMINISTRATIVE & GENERAL	ALLOCATED SALARY COSTS	6, 498, 009	0	4.00
5.00	TOTALS (sum of lines 1-4).			23, 919, 145	27, 390, 399	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1.00	2.00	3.00	4.00	5.00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

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

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED OFFICE COSTS	O ORGANIZATIONS AND HOME Provider CCN: 15-0034	Period: From 07/01/2019 To 06/30/2020 Date/Time Prepared: 11/07/07/07/07/07/07/07/07/07/07/07/07/07/

					11/25/2020 2:	58 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED O	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	-19, 209, 139	0				1.00
2.00	101, 415	9				2.00
3.00	984, 990	9				3.00
3.01	662, 822	0				3. 01
3.02	2, 643, 574	0				3. 02
3.03	3, 387, 756	0				3.03
3.04	145, 801	0				3.04
3.05	1, 313, 518	0				3.05
4.00	6, 498, 009	0				4.00
5.00	-3, 471, 254					5.00

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

Related Organization(s) and/or Home Office		
Type of Business		
6.00		
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

reriibur	Sement under title Aviii.	
6.00 7.00 8.00 9.00		6.00
7.00		7.00
8.00		8.00
9.00		9.00
10. 00 100. 00		10.00
100.00		100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

	FINANCIAL SYSTE		ST. MARY MEDICA		001 45 0004		eu or Form CMS-	
PROVI DE	ER BASED PHYSIC	IAN ADJUSIMENI		Provider (Period: From 07/01/2019 To 06/30/2020	Worksheet A-8 D Date/Time Pre 11/25/2020 2:	epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4. 01	AGGREGATE-MAINTENANCE OF	12, 500	0	12, 500	211, 500	125	1.00
2.00	5. 05	PERSONNEL AGGREGATE-ADMI NI STRATI VE & GENERAL	318, 333	0	318, 333	211, 500	2, 186	2.00
3.00	13.00	AGGREGATE - NURSI NG ADMI NI STRATI ON	50, 688	0	50, 688	211, 500	269	3.00
4.00		AGGREGATE - ADULTS & PEDI ATRI CS	34, 167	0	34, 167	211, 500	134	4.00
5.00		AGGREGATE - I NTENSI VE CARE UNI T	37, 500		37, 500			5.00
6.00 7.00		AGGREGATE-OPERATI NG ROOM AGGREGATE-RADI OLOGY-DI AGNOST I C	10, 417 25, 000					6.00 7.00
8.00	59.00	AGGREGATE-CARDI AC CATHETERI ZATI ON	17, 500	0	17, 500	260, 300	88	8.00
9. 00 10. 00		AGGREGATE - LABORATORY AGGREGATE - RESPI RATORY THERAPY	70, 833 7, 500		70, 833 7, 500			9. 00 10. 00
11.00		AGGREGATE-ELECTROENCEPHALOGR	15, 000	0	15,000	211, 500	120	11.00
12.00 200.00		AGGREGATE-CLI NI C	125, 440 724, 878				860 4, 643	12.00 200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		AGGREGATE-MAINTENANCE OF PERSONNEL	12, 710					1.00
2.00		AGGREGATE-ADMI NI STRATI VE & GENERAL	222, 278	11, 114	C	C	0	2.00
3.00		AGGREGATE - NURSI NG ADMI NI STRATI ON	27, 353	1, 368	C	C	0	3.00
4.00		AGGREGATE - ADULTS & PEDI ATRI CS	13, 625	681	C	O	0	4.00
5.00		AGGREGATE-INTENSIVE CARE	28, 471					5.00
6.00 7.00		AGGREGATE-OPERATI NG ROOM AGGREGATE-RADI OLOGY-DI AGNOST I C	6, 279 13, 726					6.00 7.00
8.00		AGGREGATE-CARDI AC CATHETERI ZATI ON	11, 013		C			8.00
9. 00 10. 00		AGGREGATE - LABORATORY AGGREGATE - RESPI RATORY THERAPY	35, 996 7, 016		C	-	0	9. 00 10. 00
11.00		AGGREGATE-ELECTROENCEPHALOGR APHY	12, 202	610	С	C	0	11.00
12.00 200.00	90.00	AGGREGATE-CLINIC	87, 447 478, 116				-	12.00 200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col.	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
	1.00	2.00	14 15.00	16.00	17.00	18.00		
1.00		AGGREGATE-MAINTENANCE OF PERSONNEL	0					1.00
2.00	5.05	AGGREGATE-ADMI NI STRATI VE & GENERAL	0	222, 278	96, 055	96, 055		2.00
3.00		AGGREGATE - NURSI NG ADMI NI STRATI ON	0	27, 353	23, 335	23, 335		3.00
4.00		AGGREGATE - ADULTS & PEDI ATRI CS	0	13, 625				4.00
5.00		AGGREGATE - I NTENSI VE CARE	0	28, 471	9, 029			5.00
6.00 7.00		AGGREGATE-OPERATI NG ROOM AGGREGATE-RADI OLOGY-DI AGNOST I C	0	6, 279 13, 726				6.00 7.00
8.00	59.00	AGGREGATE-CARDI AC CATHETERI ZATI ON	0	11, 013	6, 487	6, 487		8.00
9.00 10.00		AGGREGATE - LABORATORY AGGREGATE - RESPI RATORY THERAPY	0	35, 996 7, 016			1	9. 00 10. 00
11.00		AGGREGATE-ELECTROENCEPHALOGR APHY	0					11.00
12.00	90.00	AGGREGATE-CLI NI C	0	87, 447	37, 993	37, 993		12.00

ST. MARY MEDICA	AL CENTER, INC.		In Lieu of Form CMS-2552-10			
	Provider (3-2	
				Date/Time Pre		
Provi der	Adjusted RCE	RCE	Adjustment			
Component	Limit	Di sal I owance				
Share of col.						
14						
15.00	16.00	17.00	18.00			
0	478, 116	246, 972	2 246, 972		200.00	
	Provider Component Share of col. 14	Provi der C Component Share of col. 14 15.00 16.00	Provi der Component Share of col .Adj usted RCE Li mi tRCE Di sal I owance1415.0016.0017.00	Provi der Component Share of col.Adj usted RCE Li mi tRCE Di sal I owanceAdj ustment1415.0016.0017.0018.00	Provi der CCN: 15-0034 Peri od: From 07/01/2019 To 06/30/2020 Worksheet A-8 Date/Time Provi der 11/25/2020 2: Provi der Component Share of col. Adj usted RCE Li mit RCE Di sal I owance Adj ustment Date/Time Provi 11/25/2020 2: 14 15.00 16.00 17.00 18.00	

leal th Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS		<u>CENTER, INC.</u> Provider C		eri od:	wof Form CMS-: Worksheet B	2002-1
			T	rom 07/01/2019 p 06/30/2020	Date/Time Pre	pared:
		CAPI TAL RELATED COSTS			11/25/2020 2:	<u>58 pm</u>
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	MAINTENANCE OF	
cost center bescription	for Cost	DEDG & TIXI	WVDEL EQUIT	BENEFITS	PERSONNEL	
	Allocation			DEPARTMENT		
	(from Wkst A col. 7)					
	0	1.00	2.00	4.00	4.01	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP	9, 300, 205 9, 114, 702	9, 300, 205	9, 114, 702			1.0
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	9, 114, 702	7, 211	9, 114, 702	11, 945, 153		4.0
4.01 00401 MAI NTENANCE OF PERSONNEL	1, 259, 575	62, 358		156, 410		
5. 01 00540 NONPATI ENT TELEPHONES	527, 290	35, 096	34, 396	0	-	
5. 02 00560 PURCHASING RECEIVING AND STORES 5. 03 00570 PATIENT REGISTRATION	535, 562 1, 939, 351	76, 831 49, 688	75, 299 48, 697	65, 000 269, 666		
5. 04 00580 PATIENT ACCOUNTING	3, 387, 751	11, 912	48, 697	209,000		
5. 05 00590 ADMI NI STRATI VE & GENERAL	24, 520, 774	477, 786	468, 256	717, 176	75, 899	5.0
6. 00 00600 MAI NTENANCE & REPAI RS	5, 505, 061	881, 049		308, 604		1
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	5, 120, 125 821, 658	392, 985 16, 428	385, 147 16, 100	176, 675 16, 579		
9. 00 00900 HOUSEKEEPI NG	2, 866, 854	72, 130		338, 073		
10. 00 01000 DI ETARY	2, 160, 379	121, 144	118, 728	193, 847		
	1, 105, 294	81, 600	79, 972	123, 468		
12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON	3, 133, 131	0 69, 435	0 68, 050	0 451, 139	-	
14. 00 01400 CENTRAL SERVICES & SUPPLY	997, 945	67, 227	65, 886	78, 962		
15. 00 01500 PHARMACY	3, 687, 507	74, 321	72, 838	375, 385		
16. 00 01600 MEDI CAL RECORDS & LI BRARY	2, 643, 574	35, 602	34, 892	0	-	
17.00 01700 SOCIAL SERVICE 19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
23. 00 02300 PARAMEDICAL EDUCATION PROGRAM E	MS 269, 053	7, 481	7, 332	38, 356	-	
INPATIENT ROUTINE SERVICE COST CENTER						
30. 00 03000 ADULTS & PEDIATRICS	18, 219, 414	1, 535, 412		2, 453, 254		
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF	4, 826, 508 2, 684, 069	221, 378 184, 344		603, 110 288, 738		
43. 00 04300 NURSERY	1, 321, 930	82, 728	81, 078	155, 134		
ANCI LLARY SERVICE COST CENTERS					1	
50. 00 05000 OPERATING ROOM	16, 269, 149	549, 141	538, 188	762, 346 291, 702		
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 230, 810 1, 234, 639	107, 075 77, 269	104, 939 75, 728	291, 702 144, 890		
53. 00 05300 ANESTHESI OLOGY	419, 720	5, 594	5, 482	0		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 049, 584	299, 642	293, 665	522, 344		
54. 01 03630 ULTRA SOUND 56. 00 05600 RADI OI SOTOPE	1, 297, 416	47, 750 98, 516	46, 798 96, 551	133, 755 86, 556		
57. 00 05700 CT SCAN	1, 564, 433 1, 951, 106	54, 961	53, 865	152, 524		
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 961, 036			394, 904		
50. 00 06000 LABORATORY	8, 542, 776	189, 652		590, 717		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		15, 029	14, 729	32, 746	4,027	
65. 00 06500 RESPI RATORY THERAPY	2, 646, 860	61, 600	60, 371	336, 700		
66. 00 06600 PHYSI CAL THERAPY	2, 891, 018		284, 864	0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	1, 013, 671	13, 361	13, 095	0	0	
68.00 06800 SPEECH PATHOLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY	449, 642 1, 379, 543	3, 976 56, 225	3, 897 55, 104	0 95, 363	0 11, 269	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0, 223	0	93, 303 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 414, 025	0	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	12, 494, 405	0	0	0	0	73.0
74. 00 07400 RENAL DI ALYSI S 76. 97 07697 CARDI AC REHABI LI TATI ON	874, 044 624, 563	0 132, 045	0 129, 412	0 87, 209	9, 702	74.0
76. 98 07698 HYPERBARI C OXYGEN THERAPY	024, 303	132, 043	0	0,,20,	0	
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76.9
OUTPATIENT SERVICE COST CENTERS	2 014 02/	447 (00	420 (01	457.001	F2 020	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	3, 814, 026 5, 580, 921	447, 609 313, 778		457, 931 656, 664		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT		010,770	007,020	000,001	10,707	92.0
OTHER REIMBURSABLE COST CENTERS					1	
101.00 10100 HOME HEALTH AGENCY	2, 962, 990	0	0	388, 279	36, 348	101.0
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 throu	gh 117) 220, 635, 634	7, 505, 163	7, 355, 471	11, 944, 206	1, 539, 281	118 0
NONREI MBURSABLE COST CENTERS			.,			1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CAN		11, 996	11, 757	0		190.0
191. 00 19100 RESEARCH	6, 666	1 500 104	0	947		191.0
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 OTHER NON-REIMBURSEABLE COST CE	3, 780 NTER 961, 621	1, 598, 196 184, 850		0		192. 0 194. 0
194. 01 07951 OTHER NONREI MBURSABLE	0	0	0	0		194.0
	i 1					200.0

Health Financial Systems	ST. MARY MEDICA	CENTER, INC.		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0034		eriod:	Worksheet B		
				rom 07/01/2019 0 06/30/2020		arod	
				0 00/30/2020	11/25/2020 2:	58 pm	
		CAPITAL RELATED COSTS					
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP		MAINTENANCE OF		
	for Cost			BENEFITS	PERSONNEL		
	Allocation			DEPARTMENT			
	(from Wkst A						
	col . 7)	1.00	2.00	4.00	4 01		
	0	1.00	2.00	4.00	4.01		
201.00 Negative Cost Centers		0	[C	0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	221, 607, 701	9, 300, 205	9, 114, 702	11, 945, 153	1, 539, 457	202.00	

1.00 2.00 4.00 5.01 5.02 5.03 5.04 5.05	Cost Center Description GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 MAINTENANCE OF PERSONNEL	NONPATI ENT TELEPHONES 5. 01	Provi der Co PURCHASI NG RECEI VI NG AND STORES 5. 02		Pri od: fom 07/01/2019 0 06/30/2020 PATI ENT ACCOUNTI NG	Worksheet B Part I Date/Time Pre 11/25/2020 2: Subtotal	pared: 58 pm
1.00 2.00 4.00 4.01 5.01 5.02 5.03 5.04 5.05	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 MAINTENANCE OF PERSONNEL	TELEPHONES	RECEI VI NG AND STORES	PATI ENT	PATI ENT	11/25/2020 2:	58 pm
1.00 2.00 4.00 4.01 5.01 5.02 5.03 5.04 5.05	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 MAINTENANCE OF PERSONNEL	TELEPHONES	RECEI VI NG AND STORES			Subtotal	
1.00 2.00 4.00 4.01 5.01 5.02 5.03 5.04 5.05	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 MAINTENANCE OF PERSONNEL	5.01					
1.00 2.00 4.00 4.01 5.01 5.02 5.03 5.04 5.05	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 MAINTENANCE OF PERSONNEL			5.03	5.04	5A. 04	
2.00 4.00 4.01 5.01 5.02 5.03 5.04 5.05	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 MAINTENANCE OF PERSONNEL						1.00
4.00 4.01 5.01 5.02 5.03 5.04 5.05	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 MAINTENANCE OF PERSONNEL						2.00
5.01 5.02 5.03 5.04 5.05							4.00
5.02 5.03 5.04 5.05							4.01
5. 03 5. 04 5. 05	00540 NONPATI ENT TELEPHONES	596, 782					5.01
5.04 5.05	00560 PURCHASING RECEIVING AND STORES 00570 PATIENT REGISTRATION	0 11, 276					5. 02 5. 03
	00580 PATIENT ACCOUNTING	0	0		3, 411, 338		5.04
	00590 ADMI NI STRATI VE & GENERAL	121, 872			0	26, 383, 309	
6.00	00600 MAINTENANCE & REPAIRS	10, 843			0	7, 605, 517	
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	5, 204 434		0	0	6, 114, 618 875, 646	
9.00	00900 HOUSEKEEPING	9, 108			0	3, 445, 193	
10. 00	01000 DI ETARY	6, 506		0	0	2, 650, 971	10.00
11.00		0			0	1, 418, 818	
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0 3, 470	-	0	0	0 3, 772, 926	
	01400 CENTRAL SERVICES & SUPPLY	4, 771			0	1, 235, 401	
	01500 PHARMACY	8, 674			0	4, 268, 215	
	01600 MEDICAL RECORDS & LIBRARY	0	-	-	0	2, 714, 068	
	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
	02300 PARAMEDICAL EDUCATION PROGRAM EMS	867	1, 356		0	329, 526	
201 00	INPATIENT ROUTINE SERVICE COST CENTERS		1,000			0277020	20100
30.00	03000 ADULTS & PEDI ATRI CS	154, 399			243, 320	24, 672, 106	
	03100 I NTENSI VE CARE UNI T	19, 517			42, 830	6, 050, 067	
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	16, 915 0			24, 587 13, 074	3, 440, 907 1, 680, 912	
101.00	ANCI LLARY SERVI CE COST CENTERS			,,,,,,	10/07/1	1,000,712	10100
50.00	05000 OPERATING ROOM	32, 094			391, 911	19, 231, 174	
51.00	05100 RECOVERY ROOM	3, 903			48, 216	2, 860, 515	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 867	-	8, 514 54, 573	12, 243 78, 477	1, 569, 984 578, 960	
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 517			282, 493	7, 743, 537	
	03630 ULTRA SOUND	4, 771			67, 838	1, 668, 223	
56.00	05600 RADI OI SOTOPE	9, 542			58, 325	1, 963, 061	
57.00 59.00	05700 CT SCAN 05900 CARDI AC CATHETERI ZATI ON	5, 204 13, 879			245, 782 296, 564	2, 660, 373 5, 292, 035	
60.00	06000 LABORATORY	12, 578			412, 863	10, 429, 998	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 735	7, 586	12, 613	18, 137	1, 467, 953	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 735 10, 843			66, 404 53, 118	3, 272, 530 3, 570, 075	
	06700 OCCUPATI ONAL THERAPY	3, 903			23, 096	1, 083, 564	
	06800 SPEECH PATHOLOGY	1, 301			4, 353	466, 291	
	07000 ELECTROENCEPHALOGRAPHY	6, 506	29, 489		71, 524	1, 754, 760	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	59, 754 80, 350	85, 927 115, 546	8, 875, 001 14, 609, 921	
	07300 DRUGS CHARGED TO PATIENTS	0	0	248, 157	356, 856	13, 099, 418	
74.00	07400 RENAL DI ALYSI S	0	0	8, 979	12, 912	895, 935	74.00
	07697 CARDI AC REHABI LI TATI ON	7, 373			6, 665	1,001,977	
	07698 HYPERBARI C 0XYGEN THERAPY 07699 LI THOTRI PSY	0	0	0	0	0	
. 0. 77	OUTPATIENT SERVICE COST CENTERS	0	0	. 0	О	0	, 0. 77
	09000 CLI NI C	42,070			53, 552	5, 360, 247	
	09100 EMERGENCY	26, 022	44, 980	215, 059	309, 260	7, 533, 143	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92.00
	10100 HOME HEALTH AGENCY	11, 710	117	10, 754	15, 465	3, 425, 663	101.00
	SPECIAL PURPOSE COST CENTERS		-				
118.00		589, 409	767, 945	2, 372, 555	3, 411, 338	217, 072, 538	118.00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	o	23, 753	100 00
	19100 RESEARCH	0	-	-	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	-	0	3, 168, 287	
	07950 OTHER NON-REIMBURSEABLE COST CENTER	7, 373	327	0	0	1, 335, 334	
	07951 OTHER NONREI MBURSABLE	0	0	0	0		194.01
200. 00 201. 00		Ω	0	0	0		200.00 201.00
201.00	5	596, 782	768, 272	2, 372, 555	3, 411, 338		

	LLOCATION - GENERAL SERVICE COSTS	T. MARY MEDICAL	Provider CC	Fr Tc	eriod: com 07/01/2019 0 06/30/2020	Worksheet B Part I Date/Time Pre 11/25/2020 2:	epared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	REPAI RS		LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.05	6.00	7.00	8.00	9.00	
1.00 2.00 4.00 4.01 5.01 5.02 5.03	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 MAINTENANCE OF PERSONNEL 00540 NONPATIENT TELEPHONES 00560 PURCHASING RECEIVING AND STORES 00570 PATIENT REGISTRATION						1.00 2.00 4.00 4.01 5.01 5.02 5.03
5.04 5.05 6.00 7.00 8.00 9.00 10.00	00580 PATIENT ACCOUNTING 00580 PATIENT ACCOUNTING 00590 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	26, 383, 309 1, 027, 840 826, 354 118, 338 465, 597 358, 263 191, 745 0	8, 633, 357 440, 720 18, 423 80, 892 135, 859 91, 511 0	7, 381, 692 16, 600 72, 885 122, 411 82, 450 0	1, 029, 007 0 0 0 0 0 0	4, 064, 567 68, 230 45, 958	5. 04 5. 05 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
14.00 15.00 16.00 17.00 19.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02300 PARAMEDI CAL EDUCATI ON PROGRAM EMS	509, 888 166, 957 576, 824 366, 790 0 0 44, 533	77, 869 75, 393 83, 348 39, 926 0 0 8, 390	35, 974 0 0	0 0 0 0 0 0 0 0 0 0	39, 107 37, 863 41, 859 20, 051 0 0 4, 213	14.00 15.00 16.00 17.00 19.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				070.044		
31. 00 41. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY ANCILLARY SERVICE COST CENTERS	3, 334, 193 817, 630 465, 018 227, 165	1, 721, 913 248, 269 206, 736 92, 777	223, 694	372, 844 49, 857 45, 972 8, 201	864, 766 124, 684 103, 825 46, 594	31.00 41.00
50.00	05000 OPERATI NG ROOM	2, 598, 978	615, 844	554, 885	145, 000	309, 284	50.00
52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	386, 581 212, 174	120, 081 86, 655	108, 195 78, 077	0 9, 623	60, 306 43, 519	52.00
54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	78, 243 1, 046, 493	6, 273 336, 038		0 67, 397	3, 151 168, 763	54.00
56.00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	225, 450 265, 296	53, 550 110, 482	48, 249 99, 546	19, 077 8, 594	26, 893 55, 486	56.00
59.00	05700 CT SCAN 05900 CARDI AC CATHETERI ZATI ON	359, 533 715, 187	61, 637 198, 649	55, 536 178, 986	20, 581 35, 162	30, 955 99, 764	59.00
60.00 62.00 62.30	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 409, 552 198, 385 0	212, 688 16, 855 0	191, 635 15, 186 0	6, 353 0 0	106, 815 8, 465 0	62.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	442, 263 482, 474	69, 082 325, 967	293, 701	0 19, 449		66.00
68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	146, 437 63, 016	14, 984 4, 459		6, 437 1, 474	7, 525 2, 240	68.00
71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	237, 145 1, 199, 403 1, 974, 443	63, 054 0 0	56, 813 0 0	0 0 0	31, 667 0 0	71.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 770, 308 121, 080	0 0	0 0	0 0	0	
76. 98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	135, 411 0	148, 084 0	133, 426 0	945 0	74, 370 0	76. 98
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.99
	09000 CLINIC 09100 EMERGENCY	724, 405 1, 018, 059	501, 979 351, 892		31, 539 178, 894	252, 100 176, 724	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	., ,		0177000			92.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	462, 958	0	0	0	0	101.00
118.00		25, 770, 409	6, 620, 279	5, 567, 879	1, 027, 399	3, 053, 576	118.00
191.00 192.00 194.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CIANS' PRI VATE OFFI CES 07950 OTHER NON-REI MBURSEABLE COST CENTER 07951 OTHER NONREI MBURSABLE	3, 210 1, 053 428, 175 180, 462 0	13, 454 0 1, 792, 321 207, 303 0	12, 122 0 1, 614, 908 186, 783 0	0 0 1, 608 0 0	0 900, 124 104, 110	
201.00 202.00	Negative Cost Centers	0 26, 383, 309	0 8, 633, 357	0 7, 381, 692	0 1, 029, 007		201.00

Heal th	Financial Systems S	T. MARY MEDICAL	CENTER, INC.			In Lieu	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-0034	Peri From	od: 07/01/2019	Worksheet B Part I	
					То	06/30/2020	Date/Time Pre 11/25/2020 2:	pared: 58 pm
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE		NURSI NG	CENTRAL	
				PERSONNEL	ADM	II NI STRATI ON	SERVICES & SUPPLY	
		10.00	11.00	12.00		13.00	14.00	
1 00	GENERAL SERVICE COST CENTERS					I		1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP							1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
4.01	00401 MAINTENANCE OF PERSONNEL							4.01
5.01 5.02	00540 NONPATIENT TELEPHONES 00560 PURCHASING RECEIVING AND STORES							5. 01 5. 02
5.03	00570 PATIENT REGISTRATION							5.03
5.04								5.04
5.05 6.00	00590 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS							5.05 6.00
7.00	00700 OPERATION OF PLANT							7.00
8.00	00800 LAUNDRY & LINEN SERVICE							8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 335, 734						9.00 10.00
11.00	01100 CAFETERI A	0	1, 830, 485					11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0	4 544 000		12.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	74, 871 20, 086		0	4, 544, 822 0	1, 603, 630	13.00 14.00
15.00	01500 PHARMACY	0	57, 320		0	Ő	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	0	16.00
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	0	17.00 19.00
23.00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	8, 009		0	0	0	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 704 774	E40.044			0.400.050		
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	2, 721, 771 192, 463	518, 241 102, 605		0 0	2, 192, 059 433, 993	0	30.00 31.00
41.00	04100 SUBPROVI DER – I RF	353, 480	62, 475		0	264, 256	0	41.00
43.00	04300 NURSERY	0	28, 181		0	119, 205	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	147, 911	[0	625, 661	0	50.00
51.00	05100 RECOVERY ROOM	0	48, 991		0	207, 248	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	26, 327		0	111, 330	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 104, 479		0	0	0	53.00 54.00
54.00 54.01	03630 ULTRA SOUND	0	20, 938		0	0	0	54.00
56.00	05600 RADI OI SOTOPE	0	11, 801		0	0	0	56.00
57.00 59.00	05700 CT SCAN 05900 CARDI AC CATHETERI ZATI ON	0	26, 967 63, 774		0	0	0	57.00 59.00
60.00	06000 LABORATORY	0	139, 370		0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	6, 348		0	0	0	62.00
62.30 65.00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0	0 42 454		0	0	0	62.30 65.00
66. 00	06600 PHYSI CAL THERAPY	0	63, 454 0		0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 70.00	06800 SPEECH PATHOLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0 17 745		0	0	0	68.00 70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	17, 765 0		0	0	604, 863	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	998, 767	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0	0	0	73.00 74.00
76.97	07400 RENAL DIALTSIS	0	15, 294		0	64, 701	0	76.97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	0	76. 98
76.99		0	0		0	0	0	76.99
90.00	OUTPATIENT SERVICE COST CENTERS	0	83, 264		0	0	0	90.00
91.00	09100 EMERGENCY	68, 020	124, 438		0	526, 369	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART							92.00
101 00	OTHER REIMBURSABLE COST CENTERS	0	57, 299		0	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	0		I	<u> </u>	0	0	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 335, 734	1, 830, 208		0	4, 544, 822	1, 603, 630	118.00
190 00	NONREIMBURSABLE COST CENTERS	0	0		0	∩	0	190.00
191.00	19100 RESEARCH	0	277		0	0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0	0		192.00
	07950 OTHER NON-REI MBURSEABLE COST CENTER 07951 OTHER NONREI MBURSABLE	0	0		0	0		194. 00 194. 01
200.00		0	0		0	0	0	200.00
201.00	Negative Cost Centers	0	0		0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	3, 335, 734	1, 830, 485	I	0	4, 544, 822	1, 603, 630	202.00

	ancial Systems ST ATION - GENERAL SERVICE COSTS	. MARY MEDICAL	Provider C	CN: 15-0034 F	Peri od:	u of Form CMS-2 Worksheet B	2002-
				F	From 07/01/2019 To 06/30/2020	Part I Date/Time Pre	parec
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	E NONPHYSI CI AN ANESTHETI STS	11/25/2020 2: PARAMEDI CAL EDUCATI ON PROGRAM EMS	58 pm
0515		15.00	16.00	17.00	19.00	23.00	
	RAL SERVICE COST CENTERS						1.0
	O CAP REL COSTS-BEDG & TTXT						2.0
	O EMPLOYEE BENEFITS DEPARTMENT						4.0
	1 MAINTENANCE OF PERSONNEL						4. (
	O NONPATIENT TELEPHONES						5.0
02 0056	O PURCHASING RECEIVING AND STORES						5.0
03 0057	O PATIENT REGISTRATION						5.
1	80 PATIENT ACCOUNTING						5.
	O ADMINISTRATIVE & GENERAL						5.
	00 MAINTENANCE & REPAIRS 00 OPERATION OF PLANT						6.
1	00 LAUNDRY & LINEN SERVICE						7. 8.
1	O HOUSEKEEPI NG						9.
1	DO DI ETARY						10.
	O CAFETERI A						11.
2.00 0120	OO MAINTENANCE OF PERSONNEL						12.
8.00 0130	OO NURSING ADMINISTRATION						13.
	00 CENTRAL SERVICES & SUPPLY						14.
	00 PHARMACY	5, 102, 664	0 474 000				15.
	00 MEDICAL RECORDS & LIBRARY 00 SOCIAL SERVICE	0	3, 176, 809 0				16.
	00 NONPHYSICIAN ANESTHETISTS	0	0				17. 19.
	0 PARAMEDICAL EDUCATION PROGRAM EMS	0	0			402, 230	
	TI ENT ROUTI NE SERVI CE COST CENTERS					102,200	20.
	00 ADULTS & PEDIATRICS	0	226, 557	(0 0	44, 031	30.
1.00 0310	OO INTENSIVE CARE UNIT	0	39, 879	(0 0	21, 421	31.
	00 SUBPROVI DER – I RF	0	22, 893			0	
	00 NURSERY	0	12, 173	(0 0	0	43.
	LLARY SERVICE COST CENTERS	0	264 012		0 0	12 0/1	1 50
	00 OPERATING ROOM 00 RECOVERY ROOM	0	364, 912 44, 894			42, 841 0	1
1	O DELIVERY ROOM & LABOR ROOM	0	11, 400			0	
1	O ANESTHESI OLOGY	0	73, 071			0	
1	00 RADI OLOGY-DI AGNOSTI C	0	263, 032	(0	54.
1.01 0363	O ULTRA SOUND	0	63, 164	0	0 0	0	54.
	00 RADI OI SOTOPE	0	54, 307		0 0	0	56.
	DO CT SCAN	0	228, 849	(-	0	
	00 CARDI AC CATHETERI ZATI ON	0	276, 133		0 0	0	
1		0	384, 903			0	60.
	00 WHOLE BLOOD & PACKED RED BLOOD CELL 50 BLOOD CLOTTING FOR HEMOPHILIACS	0	16, 888 0			0	62. 62.
	00 RESPIRATORY THERAPY	0	61, 829			23, 801	65.
	00 PHYSI CAL THERAPY	0	49, 459		0	20,001	1
	00 OCCUPATI ONAL THERAPY	0	21, 505		0 0	0	
	00 SPEECH PATHOLOGY	0	4, 053		o o	0	68.
0.00 0700	0 ELECTROENCEPHALOGRAPHY	0	66, 597		0 0	0	70.
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	80, 008		0 0	0	
	00 IMPL. DEV. CHARGED TO PATIENTS	0	107, 586	(0 0	0	
	00 DRUGS CHARGED TO PATIENTS	5, 102, 664	332, 272			0	
	00 RENAL DIALYSIS 07 CARDIAC REHABILITATION	0	12, 022			0	
	8 HYPERBARIC OXYGEN THERAPY	0	6, 206			0	76.
	9 LI THOTRI PSY	0	0		0	0	
	ATIENT SERVICE COST CENTERS	0	0	· · · · · · · · · · · · · · · · · · ·	- 0	0	1
	DO CLINIC	0	49, 863	(0 0	0	90.
	DO EMERGENCY	0	287, 955		0 0	270, 136	
	00 OBSERVATION BEDS (NON-DISTINCT PART						92.
	R REIMBURSABLE COST CENTERS		14.000			^	101
	00 HOME HEALTH AGENCY	0	14, 399	. (0 0	0	101.
8. 00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 102, 664	3, 176, 809	(0 0	402, 230	118
	EIMBURSABLE COST CENTERS	5, 102, 004	5, 170, 007		- 0	102,230	1.10.
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190.
	00 RESEARCH	Ō	0	(191.
2.00 1920	0 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.
	O OTHER NON-REIMBURSEABLE COST CENTER	0	0	(0 0		194.
	1 OTHER NONREI MBURSABLE	0	0	(0 0		194.
0.00	Cross Foot Adjustments				0		200.
							1001
1.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0 5, 102, 664	0 3, 176, 809			0 402, 230	201.

Dest. Conter Description Subtolal Mail observed Support Intern & Substant Sectors Support Total Support 0 0000 (AP REL_OOST CENTERS 0000 (AP REL_OOST CENTERS 00000 (AP REL_OOST CENTERS 000000 (AP REL_OOST CENTERS 00000 (AP REL_OOST CENTERS 00000 (AP REL_OOST CENTERS 000000 (AP REL_OOST CENTERS 0000000 (AP REL_OOST CENTERS 000000 (AP REL_OOST CENT	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0034		rksheet B	
Cost Center Description Subtrain Finitian Total Cost Center Description 24.00 26.00 26.00 Cost Centers Centers 24.00 26.00 26.00 Cost Centers Centers 24.00 26.00 26.00 Cost Centers Centers 24.00 26.00 26.00 Cost Centers Cost Centers 20.00 26.00 Cost Control Centers Cost Centers 20.00 26.00 Cost Control Centers Cost Centers 20.00 26.00 Cost Control Centers Cost Control Centers 20.00 26.00 Cost Control Center Centers Cost Control Centers 20.00 20.00 Cost Control Centers Cost Control Centers 20.00 Cost Contres							
Besidents Description Package 0 Setupped Setupped Diversition 24,00 26,00 26,00 0 Diversition 26,00 26,00 26,00 0 Diversition 27,00 26,00 2,00 2,00	Cost Costor Description	Cultated		T-+-1	11	/25/2020 2:58 p	
Break Singuption All Dott Singuption 0 Diric (LAP FR) COST CHITES 24:00 26:00 26:00 0 Diric (LAP FR) COSTS - RIFIG FR COSTS - RIFIG FR 0 Diric (LAP FR) COSTS - RIFIG FR FR FR 0 DOOD (VAL REC) FR FR FR FR 0 DIOD (VAL REC) FR FR FR FR 0 DIOD (VAL REC) <	Cost Center Description			Total			
Adjustments Adjustments 00 24.00 24.00 26.00 01 00000 (AP RT) COSTS RUDE A ELYT PERSONEL 24.00 26.00 01 00000 (AP RT) COSTS RUDE A ELYT PERSONEL 20.00 26.00 01 00000 (AP RT) COSTS RUDE A ELYT PERSONEL 20.00 26.00 01 00001 (AP RT) COSTS RUDE A ELYT PERSONEL 20.00 26.00 01 00001 (AP RE) COSTS AVEL E EQUIP PERSONEL 20.00 20.00 01 00001 (AP RE) RESISTATU & SCHEREL 20.00 20.00 01 00000 (AP RE) RESISTATU & SCHEREL 20.00 20.00 01 00000 (AP RE) RESISTATU & SCHEREL 20.00 20.00 01 0001 (AP RE) RESISTATU & SCHEREL 20.00 20.00 01 0001 (AP RE) RESISTATU & SCHEREL 20.00 20.00 01 0001 (AP RE) RESISTATU & SCHEREL 20.00 38.219, 952 01 10.00 (AP RE) RESISTATU & SCHEREL 20.00 38.219, 952 01 0000 (AP RE) RESISTATU & SCHEREL 20.00 38.219, 952 01							
LINE ALL SLAVICE COST CANTERS 24.00 25.00 26.00 0 CODING CAP RET COSTS HIRE & FLXTP 0			Stepdown				
CEREBAL SERVICE COST CENTERS 00 0000 CAP REL COST STATUE EQUIP 00 0000 CAP REL COST STATUE EXERTS 00 0000 CAP REL COST STATUE 00 0000 CAP REL COST STATUE 00 0000 CAP REL COST STATUE 00 0000 CAP REL AS NOT RECEIVE NO AND STORES 00 0000 CAP REL AS NOT RECEIVE 00 01100 CAP RELATION OF PRANT 00 01100 CAP RELATION OF REAT 00 01100 CAP RELATION OF REAT 00 01100 CAP REAT RECORD S A LIBRARY 00 01100 CAP READ CAL RECORDS COST CENTERS 00 01100 CAP READ CAL RECORDS A LIBRARY							
00 DOD CAP REL COSTS-RUDE & FIXT 00 DODD CAP REL COSTS-RUDE & FIXT 00 DODD CAP REL COSTS-RUDE & EDUIP 00 DOSTS APPLICATION IN THE THE INSTRUE SET STATUS 00 DOSTO CAP REL COSTS-RUDE & EDUIP 00 DOSTO CAP REL COSTS - WRITE TO STATUS 00 DOSTO CONTRAL SERVICES & SUPPLY 00 DOSTO CAP REAGE 00 DOSTO REAGE		24.00	25.00	26.00			
00 00200 CAP REL COST S-MVBLE EQUIP 01 00400 LAUNCHE BRIEFT ISS ENATION 01 00400 LAUNCHE BRIEFT ISS ENATION 01 00400 LAUNCHE SING TESE SUPPLY 01 01101 CACFERIA 01 01101 CACFERIA 01 01000 LAUNCHE SING TESE SUPPLY 01 01101 CACFERIA 01 01000 LAUNCHE SING TESE SUPPLY 01 011000 LAUNCHE SING TESE SUPPLY 01 01000 LAUNCHE SING TESE SUPPLY 010 01000 LAUNCHE SING TESE SUPPLY						1.	
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01 0101 MAINTEAUNCE OF PERSONNEL Image: Constraint of the Developes						4.	
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202 0550 PURCURASING RECEIVING AND STORES 2030 0550 PURCURASING RECEIVING AND STORES 2030 0550 PURCURASING RECEIVING RECEIVING 2030 0550 PURCURASING RECEIVING RECEIVING 2030 05500 PURCURASING RECEIVING 2030 05500 PURCURASING RECEIVING 20300 05000 PURCURASING RECEIVING 20300 05000 PURCURASING RECEIVING 20300 PURCURASING RECEIVING PURCURASING RECEIV						5.	
03 00570 PATLENT REGISTRATION Image: Comparison of the compariso						5.	
05 00500 AUMINISTRATIVE & CENERAL Image: Ceneral Control operation of plant 00 00500 MORENT ALLINES STRUCE Image: Ceneral Control operation of plant 00 00500 MORENT ALLINES STRUCE Image: Ceneral Control operation of plant 00 01000 LINES Image: Ceneral Control operation of plant 00 01000 LINES Image: Ceneral Control operation of plant 00 01000 LINES Status 00 01000 LINES Status 00 01000 MORENTINES Status 00 01000 MORENTINES Status 00 01000 Status Status 00 01000 MORENTINES Status 00 01000 Status Status 00 01000 Status Status 00 0100 Status Status 00 0100 Status Status 00 Status Status Status 00 Status						5.	
000 00000 MAINTELANCE & REPAIRS Image: Comparison of the PLANT 000 00000 LINEN SERVICE Image: Comparison of the PLANT 000 00000 LINEN SERVICE Image: Comparison of the PLANT 00000 01100 CAFERRA Image: Comparison of the PLANT Image: Comparison of the PLANT 001100 CAFERRA 01100 CAFERRA Image: Comparison of the PLANT Image: Comparison of the PLANT 001100 CAFERRA 01100 CAFERRA Image: Comparison of the PLANT Image: Comparison of the PLANT 001100 CAFERRA 01100 CAFERRA Image: Comparison of the PLANT Image: Comparison of the PLANT 001100 CAFERRA FUEX NOTE Image: Comparison of the PLANT Image: Comparison of the PLANT 001100 CAFERRA FUEX NOTE Image: Comparison of the PLANT Image: Comparison of the PLANT Image: Comparison of the PLANT 001100 CAFERRA FUEX NOTE SIB 219, 952 Image: Comparison of the PLANT Image: Comparison of the PLANT 001100 CAFERRA SIB 219, 952 Image: Comparison of the PLANT Image: Comparison of the PLANT Image: Comparison of the PLANT 001100 COMERT NOL RECORD SECONT 24, 636, 490	00580 PATIENT ACCOUNTING					5.	
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D0 D00000 LUNDRY & LINEN SERVICE Image: Constraint of the service o	00600 MAI NTENANCE & REPAI RS					6.	
D0 D0000 FULSERVEPING Image: Construct of the construction of the constr	00700 OPERATION OF PLANT					7.	
00 01000 DETARY 01100 DETARY 00 01100 CAFETERIA 01000 DETARY 01000 00 01300 MINTENANCE OF PERSONNEL 01000 DETARY 01000 00 01300 MERAMACY 01000 DETARY 01000 00 01000 MERAMACY 01100 DETARY 01100 00 01000 MERAMACY 01100 DETARY 01100 00 01000 MERAME DETARY 01100 DETARY 00 010100 MERTHEN DETARY 01100 DETARY 00 010100 MERTHEN DETARY 01100 DETARY 00 01000 MERTHEN DETARY 298, 802 0 2, 298, 802 00 01000 MERTHEN DETARY 2, 298, 802 DETARY 2, 298, 802 00 01000 MERTHEN NON 2, 4, 636, 490 0 2, 4, 636, 490 DETARY 2, 298, 801 DETARY	00800 LAUNDRY & LINEN SERVICE					8.	
00 0100 CAFETERIA Image: Construction of the constru						9.	
00 01200 MAINTENANCE OF PERSONNEL 01300 00 01300 MENRAMOCY 0300 00 01300 MENRAMOCA ELECORDS & LIBRARY 00 01300 MENREPICAL EDUCAL Statistics 00 01300 MENREPICAL EDUCAL Statistics 0 00 03000 AUX ANSA Statistics 0 Statistics 00 03000 AUX AUX Statistics 0 Statistics Statistics 00 05000 PERCAPERTING ROM 2,4636,490 0 2,468,490 0 2,149,089 0 2,149,089 0 2,149,089 0 1,149,089 0 1,032,515						10.	
00 101400 CHORSING ADMINISTRATION 00 101400 CHATAL SERVICE & SUPPLY 00 101500 PHARMACY 00 101500 PHARMACY 00 101500 PHARMACY 00 101500 PHARMACHICAL EDUCATION PROCEASE ENSIGE 00 101500 PHARMACHICAL EDUCATION PROCEASE ENSIGE 00 03100 PHARMACHICAL EDUCATION PROCEASE ENSIGE 00 03100 PHOLITS & PEOLATRICE COST CENTERES 00 03100 PHARMACHICAL EDUCATION ROOM 24, 636, 490 0 41300 HURSERV 2, 298, 802 0 05000 PEOLATING ROOM 3, 852, 919 0 0 05000 PEOLATING ROOM 3, 852, 919 0 2, 868, 609 0 05000 PEOLATING ROOM 3, 852, 919 0 2, 856, 609 0 05000 PEOLATING ROOM 2, 853, 919 0 2, 856, 573 0 05000 PEOLATING ROOM 2, 255, 544 0 2, 272, 554 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td> 11.</td>						11.	
00 10100 CHITRAL SERVICES & SUPPLY 00 101500 HEDICAL RECORDS & LIBRARY 00 01000 NOMPHYSICLAN ARSTHETISS 00 02000 PARAMEDICAL EQUICATION PROCEAM LWS INPART ENT ROUTING SERVICE COST CENTERS						12.	
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00 07300 DRUGS CHARGED TO PATIENTS 20, 304, 662 0 20, 304, 662 00 07400 RENAL DI ALYSIS 1, 029, 037 0 1, 029, 037 97 07697 CARDIAC REHABILITATION 1, 580, 414 0 1, 580, 414 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 90 07699 LITHOTRIPSY 0 0 0 00 09000 CLINIC 7, 455, 688 0 7, 455, 688 00 09100 EMERGENCY 10, 852, 690 0 10, 852, 690 00 0000 OUTPATIENT SERVATION BEDS (NON-DI STINCT PART 0 3, 960, 319 3, 960, 319 010100 HOME HEALTH AGENCY 3, 960, 319 0 3, 960, 319 3, 960, 319 010100 HOME HEALTH AGENCY 3, 960, 319 0 3, 960, 319 3 3, 960, 319 3, 960, 319 010100 HOME HEALTH AGENCY 3, 960, 319 0 3, 960, 319 3 3, 960, 319 3, 960, 319 3, 960, 319 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>72</td>						72	
00 07400 RENAL DI ALYSI S 1,029,037 0 1,029,037 97 07697 CARDI AC REHABI LI TATI ON 1,580,414 0 1,580,414 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 90 07699 LI THOTRI PSY 0 0 0 00 07609 LI THOTRI PSY 0 0 0 00 09000 CLI NI C 7,455,688 0 7,455,688 00 09100 EMERGENCY 10,852,690 0 10,852,690 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 3,960,319 0 3,960,319 01 01010 HOME HEALTH AGENCY 3,960,319 0 3,960,319 0 3,960,319 SPECI AL PURPOSE COST CENTERS						73	
97 07697 CARDI AC REHABI LI TATI ON 1, 580, 414 0 1, 580, 414 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 99 07699 LI THOTRI PSY 0 0 0 00 09000 CLI NI C 7, 455, 688 0 7, 455, 688 00 09000 CLI NI C 7, 455, 688 0 7, 455, 688 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 01000 EMERGENCY 10, 852, 690 0 10, 852, 690 0 010100 HOME HEALTH AGENCY 3, 960, 319 0 3, 960, 319 010100 HOME HEALTH AGENCY 3, 960, 319 0 3, 960, 319 SPECIAL PURPOSE COST CENTERS 3 0 211, 619, 871 0 10000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 59, 296 0 59, 296 0.0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9, 119 0 9, 119 2.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 7, 905, 423 0 7, 905, 423 <td></td> <td></td> <td></td> <td></td> <td></td> <td>74</td>						74	
98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 99 07699 LI THOTRI PSY 0 0 00 00000 CLI NI C 7, 455, 688 0 7, 455, 688 00 09100 EMERGENCY 10, 852, 690 0 10, 852, 690 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0100 HMERGENCY 3, 960, 319 0 3, 960, 319 01100 HOME HEALTH AGENCY 3, 960, 319 0 3, 960, 319 01100 HOME HEALTH AGENCY 3, 960, 319 0 211, 619, 871 0100 HOME HEALTH AGENCY 3, 960, 319 0 211, 619, 871 0100 HURPOSE COST CENTERS 59, 296 0 59, 296 0.00 IPONORE IMBURSABLE COST CENTERS 59, 296 0 59, 296 0.00 IPONORE IMBURSABLE COST CENTERS 59, 296 0 59, 296 0.00 IPONO GIFT, FLOWER, COFFEE SHOP & CANTEEN 59, 296 0 59, 296 0.00 IPONO RESEARCH 9, 119 0 7, 905, 423 7, 9						76	
99 07699 LI THOTRI PSY 0 0 0UTPATI ENT SERVICE COST CENTERS 0 0 0 00 09000 CLI NI C 7, 455, 688 0 7, 455, 688 00 09100 EMERGENCY 10, 852, 690 0 10, 852, 690 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 10, 852, 690 0 0100 BURSABLE COST CENTERS 0 3, 960, 319 0 3, 960, 319 010100 HOME HEALTH AGENCY 3, 960, 319 0 3, 960, 319 SPECI AL PURPOSE COST CENTERS 59, 296 0 211, 619, 871 01000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 59, 296 0 59, 296 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 59, 296 0 59, 296 1.00 19100 RESEARCH 9, 119 0 9, 119 2.00 19200 PHYSI CI ANS' PRI VATE OFFICES 7, 905, 423 0 7, 905, 423 1.00 19200 PHYSI CI ANS' PRI VATE OFFICES 7, 905, 423 0 7, 905, 423 1.00 079			1	,		76	
00 09000 CLINIC 7,455,688 0 7,455,688 00 09100 EMERGENCY 10,852,690 0 10,852,690 0 00 09200 DBSERVATION BEDS (NON-DISTINCT PART 0 3,960,319 0 01 01000 HOME HEALTH AGENCY 3,960,319 0 3,960,319 0 010100 HOME HEALTH AGENCY 3,960,319 0 3,960,319 SPECIAL PURPOSE COST CENTERS 59,296 0 211,619,871 0 211,619,871 NONREI MBURSABLE COST CENTERS 59,296 0 59,296 9,119 9,119 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 59,296 9,119 9,119 2.00 19200 PHYSI CI ANS' PRI VATE OFFICES 7,905,423 0 7,905,423 0.00 0 0 0 0 0 0 0.00 0 0 0 0 0 0 0		0	0		0	76	
00 09100 EMERGENCY 10,852,690 0 10,852,690 0 00 09200 0BSERVATI ON_BEDS (NON-DI STI NCT_PART 0 0 0 0100 OTHER_REI MBURSABLE_COST_CENTERS 0 3,960,319 0 3,960,319 10100 HOME HEALTH_AGENCY 3,960,319 0 3,960,319 0 SPECIAL_PURPOSE_COST_CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 211,619,871 0 211,619,871 NONREI MBURSABLE_COST_CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 211,619,871 0 59,296 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 59,296 0 59,296 1.00 19100 RESEARCH 9,119 0 9,119 2.00 19200 PHYSI CI ANS' PRI VATE OFFICES 7,905,423 0 7,905,423 4.00 07950 OTHER NON-REI MBURSABLE COST CENTER 2,013,992 0 2,013,992 0.01 07951 OTHER NON-REI MBURSABLE 0 0 0 0 0.00 <td></td> <td></td> <td></td> <td></td> <td><u>.</u></td> <td></td>					<u>.</u>		
00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0THER REI MBURSABLE COST CENTERS 0 3,960,319 0 3,960,319 1.00 10100 HOME HEALTH AGENCY 3,960,319 0 3,960,319 SPECI AL PURPOSE COST CENTERS SPECI AL PURPOSE COST CENTERS NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 211,619,871 0 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 59,296 0 59,296 1.00 19100 RESEARCH 9,119 0 9,119 2.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 7,905,423 0 7,905,423 2.00 019200 OHYSI CI ANS' PRI VATE OFFI CES 7,905,423 0 7,905,423 2.00 07950 OTHER NON-REI MBURSABLE COST CENTER 2,013,992 2,013,992 4.01 07951 OTHER NONREI MBURSABLE 0 0 0 0.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>90</td></t<>						90	
OTHER REI MBURSABLE COST CENTERS 1. 00 10100 HOME HEALTH AGENCY 3, 960, 319 0 3, 960, 319 SPECIAL PURPOSE COST CENTERS 5 5 5 5 5 5 5 7 1 0 211, 619, 871 0 211, 619, 871 1				10, 852, 69	90	91	
I. 00 10100 HOME HEALTH AGENCY 3, 960, 319 0 3, 960, 319 SPECIAL PURPOSE COST CENTERS 5 0 211, 619, 871 0 211, 619, 871 NONREI MBURSABLE COST CENTERS 59, 296 0 59, 296 0.00 19100 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9, 119 0 9, 119 0.01 19200 PHYSI CI ANS' PRI VATE OFFICES 7, 905, 423 0 7, 905, 423 0.00 07950 OTHER NONREI MBURSABLE 0 0 2, 013, 992 0.01 07951 OTHER NON-REI MBURSABLE 0 0 0 0 0.00 VORSE Foot Adj ustments 0 0 0 0 0		r	0			92	
SPECIAL PURPOSE COST CENTERS 3. 00 SUBTOTALS (SUM OF LINES 1 through 117) 211, 619, 871 0 211, 619, 871 NONREI MBURSABLE COST CENTERS 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 59, 296 0 59, 296 0. 00 19000 RESEARCH 9, 119 0 9, 119 2. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 7, 905, 423 0 7, 905, 423 0. 00 07950 OTHER NON-REI MBURSABLE COST CENTER 2, 013, 992 0 2, 013, 992 0. 01 07951 OTHER NONREI MBURSABLE 0 0 0 0. 00 Cross Foot Adj ustments 0 0 0 0			1	_	1		
SUBTOTALS (SUM OF LINES 1 through 117) 211,619,871 0 211,619,871 NONREI MBURSABLE COST CENTERS 59,296 0 59,296 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 59,296 0 1.00 19100 RESEARCH 9,119 0 9,119 2.00 19200 PHYSI CI ANS' PRI VATE OFFICES 7,905,423 0 7,905,423 4.00 07950 OTHER NON-REI MBURSEABLE COST CENTER 2,013,992 0 2,013,992 4.01 07951 OTHER NONREI MBURSABLE 0 0 0 0.00 Cross Foot Adj ustments 0 0 0 0		3, 960, 319	0	3, 960, 3	19	101	
NONREI MBURSABLE COST CENTERS 0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 59, 296 0 59, 296 1. 00 19100 RESEARCH 9, 119 0 9, 119 2. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 7, 905, 423 0 7, 905, 423 4. 00 07950 OTHER NON-REI MBURSEABLE COST CENTER 2, 013, 992 0 2, 013, 992 4. 01 07951 OTHER NONREI MBURSABLE 0 0 0 0.00 Cross Foot Adj ustments 0 0 0				011 (10 0	71	4.60	
D. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 59, 296 0 59, 296 1. 00 19100 RESEARCH 9, 119 0 9, 119 2. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 7, 905, 423 0 7, 905, 423 4. 00 07950 OTHER NON-REI MBURSEABLE COST CENTER 2, 013, 992 0 2, 013, 992 4. 01 07951 OTHER NONREI MBURSABLE 0 0 0 0. 00 Cross Foot Adj ustments 0 0 0 0		117) 211, 619, 871	0	211, 619, 8	/	118	
1. 00 19100 RESEARCH 9, 119 0 9, 119 2. 00 19200 PHYSI CLANS' PRI VATE OFFICES 7, 905, 423 0 7, 905, 423 4. 00 07950 OTHER NON-REI MBURSEABLE COST CENTER 2, 013, 992 0 2, 013, 992 4. 01 07951 OTHER NONREI MBURSABLE 0 0 0 0.00 Cross Foot Adj ustments 0 0 0		E0.00/		E0. 20	24	100	
22.00 19200 PHYSI CLANS' PRI VATE OFFICES 7,905,423 0 7,905,423 4.00 07950 OTHER NON-REI MBURSEABLE COST CENTER 2,013,992 0 2,013,992 4.01 07951 OTHER NONREI MBURSABLE 0 0 0 0.00 Cross Foot Adj ustments 0 0 0						190	
4. 00 07950 0THER NON-REI MBURSEABLE COST CENTER 2, 013, 992 0 2, 013, 992 4. 01 07951 0THER NONREI MBURSABLE 0 0 0 0. 00 Cross Foot Adj ustments 0 0 0 0						191	
4. 01 07951 OTHER NONREI MBURSABLE 0 0 0 0. 00 Cross Foot Adjustments 0 0 0						192	
0.00 Cross Foot Adjustments 0 0 0		x 2,013,992	0	2, 013, 99		194.	
		0	0			194.	
I DUE INPOSITIVE LOST LEPTERS DE DUE DUE DUE DUE		0	0			200.	
2.00 TOTAL (sum Lines 118 through 201) 221,607,701 0 221,607,701		0	0	004 (07 -	0	201. 202.	

LOCATI ON	anci al Systems S OF CAPI TAL RELATED COSTS	T. MARY MEDICAL	Provider C	F	Period: From 07/01/2019 To 06/30/2020	Worksheet B Part II Date/Time Pre 11/25/2020 2:	pareo
			CAPI TAL REI	ATED COSTS		11/25/2020 2.	56 pi
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
GENE	RAL SERVICE COST CENTERS	<u> </u>		2100	2.11		
	00 CAP REL COSTS-BLDG & FIXT						1.
	00 CAP REL COSTS-MVBLE EQUIP 00 EMPLOYEE BENEFITS DEPARTMENT	0	7, 211	7, 068	3 14, 279	14, 279	2. 4.
	1 MAINTENANCE OF PERSONNEL	0	62, 358			14, 279	4.
	IO NONPATI ENT TELEPHONES	0	35, 096			0	5.
	0 PURCHASING RECEIVING AND STORES	0	76, 831	75, 299	9 152, 130	78	5.
	70 PATIENT REGISTRATION	0	49, 688			322	5.
	30 PATIENT ACCOUNTING	0	11, 912			0	5. 5.
	20 ADMINISTRATIVE & GENERAL DO MAINTENANCE & REPAIRS	0	477, 786 881, 049			857 369	5. 6.
	OO OPERATION OF PLANT	0	392, 985			211	7.
00 0080	DO LAUNDRY & LINEN SERVICE	0	16, 428	16, 100	32, 528	20	8.
-	00 HOUSEKEEPI NG	0	72, 130			404	9.
-	DO DI ETARY DO CAFETERI A	0	121, 144 81, 600			232	10.
	DO MAINTENANCE OF PERSONNEL	0	81,600	19,912	2 101, 572	147 0	11. 12.
	DO NURSI NG ADMI NI STRATI ON	0	69, 435	68, 050	5	539	13.
. 00 0140	00 CENTRAL SERVICES & SUPPLY	0	67, 227	65, 886		94	14.
	DO PHARMACY	0	74, 321	72, 838			
	00 MEDICAL RECORDS & LIBRARY	0	35, 602			0	16.
	00 SOCIAL SERVICE 00 NONPHYSICIAN ANESTHETISTS	0	0			0	17. 19.
	DO PARAMEDICAL EDUCATION PROGRAM EMS	0	7, 481	7, 332	-	46	
	TIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS	0	1, 535, 412			2, 943	30.
		0	221, 378			720	31.
	00 SUBPROVI DER – I RF 00 NURSERY	0	184, 344 82, 728			345 185	41. 43.
	LLARY SERVICE COST CENTERS		02,720	01,070	100,000	100	10.
	OO OPERATING ROOM	0	549, 141	538, 188	3 1, 087, 329	910	50.
	DO RECOVERY ROOM	0	107, 075			348	
	00 DELIVERY ROOM & LABOR ROOM 00 ANESTHESI OLOGY	0	77, 269			173 0	52. 53.
	00 RADI OLOGY - DI AGNOSTI C	0	5, 594 299, 642			624	53. 54.
	BO ULTRA SOUND	0	47, 750				
	DO RADI OI SOTOPE	0	98, 516	96, 551	1 195, 067	103	
	00 CT SCAN	0	54, 961	53, 865		182	
	00 CARDI AC CATHETERI ZATI ON 00 LABORATORY	0	177, 133 189, 652				59. 60.
	DO WHOLE BLOOD & PACKED RED BLOOD CELL	0	15, 029			39	
	50 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0 0	0	62.
	00 RESPI RATORY THERAPY	0	61, 600			402	
	00 PHYSI CAL THERAPY	0	290, 661	284, 864		0	66.
	00 OCCUPATI ONAL THERAPY 00 SPEECH PATHOLOGY	0	13, 361 3, 976	13, 095 3, 897		0	67. 68.
	00 ELECTROENCEPHALOGRAPHY	0	56, 225			114	
00 0710	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0 0	0	71.
	DO IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.
	DO DRUGS CHARGED TO PATIENTS	0	0			0	73.
	00 RENAL DIALYSIS 07 CARDIAC REHABILITATION	0	0 132, 045	129, 412	2 261, 457	0 104	74. 76.
	28 HYPERBARI C OXYGEN THERAPY	0	02,010	(0 0	0	76.
	99 LI THOTRI PSY	0	0		0 0	0	76.
	PATIENT SERVICE COST CENTERS		447 400	420 (0)	1 004 000	E 47	00
	DO CLINIC DO EMERGENCY	0	447, 609 313, 778			547 784	90. 91.
	00 OBSERVATION BEDS (NON-DISTINCT PART		515,770		0	,04	92.
OTHE	R REIMBURSABLE COST CENTERS			-			
	DO HOME HEALTH AGENCY	0	0		0 0	464	101.
<u>SPEC</u> 8. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	7, 505, 163	7, 355, 47	1 14, 860, 634	14, 278	118
	REIMBURSABLE COST CENTERS	U	7, 505, 105	1,555,47	14,000,034	14, 270	110.
0. 00 1900	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 996	11, 75	7 23, 753	0	190.
	00 RESEARCH	0	0	(0 0		191.
	00 PHYSICIANS' PRIVATE OFFICES	0	1, 598, 196				192.
	0 OTHER NON-REI MBURSEABLE COST CENTER	0	184, 850 0	181, 163	3 366, 013		194. 194.
4. 01 0795 0. 00	Cross Foot Adjustments	0	0				200.
		1		1	0	0	

Health Financial Systems	S	T. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COS	TS		Provider CO		Period: From 07/01/2019	Worksheet B Part II	
						Date/Time Pre 11/25/2020 2:	
			CAPI TAL REL	ATED COSTS			
Cost Center Descripti		Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs	1.00	2.00	2A	4.00	
202.00 TOTAL (sum lines 118	through 201)	0	9, 300, 205				202.00

ALLOCATI ON	ancial Systems S I OF CAPITAL RELATED COSTS		CENTER, INC.	CN: 15-0034 P	eri od:	u of Form CMS-2 Worksheet B	2002-
					rom 07/01/2019	Part II Date/Time Pre	parec
	Cast Contan Description	MALNTENANCE OF			PATIENT	11/25/2020 2:	58 pm
	Cost Center Description	MAINTENANCE OF PERSONNEL	NONPATI ENT TELEPHONES	PURCHASING RECEIVING AND	REGI STRATI ON	PATI ENT ACCOUNTI NG	
		1 Entoonniee	TELETHONED	STORES		///////////////////////////////////////	
		4.01	5.01	5.02	5.03	5.04	
	ERAL SERVICE COST CENTERS DO CAP REL COSTS-BLDG & FIXT			1			1 1
	00 CAP REL COSTS-BEDG & FIXT						1.0
	OO EMPLOYEE BENEFITS DEPARTMENT						4.
	01 MAINTENANCE OF PERSONNEL	123, 659					4.
	40 NONPATIENT TELEPHONES	0	69, 492				5.0
	60 PURCHASING RECEIVING AND STORES	1, 251	0		101.111		5.
	70 PATI ENT REGI STRATI ON 80 PATI ENT ACCOUNTI NG	4, 249	1, 313 0		104, 464 0	23, 587	5. 5.
	90 ADMI NI STRATI VE & GENERAL	6,097	14, 191		0	23, 387	5.
	00 MAI NTENANCE & REPAI RS	2, 881	1, 263		0	0	6.1
. 00 0070	00 OPERATION OF PLANT	2, 759	606		0	0	7.
	00 LAUNDRY & LINEN SERVICE	355	51		0	0	8.
	00 HOUSEKEEPI NG 00 DI ETARY	6, 913 3, 592	1, 061 758		0	0	9.0
	DO CAFETERI A	2, 288	/30		0	0	11.
	00 MAINTENANCE OF PERSONNEL	0	0		0	0	12.
	00 NURSI NG ADMI NI STRATI ON	3, 815	404	41	0	0	13.
	00 CENTRAL SERVICES & SUPPLY	1,024	556		0	0	14.
	00 PHARMACY 00 MEDI CAL RECORDS & LI BRARY	2, 921	1, 010		0	0	15.
	00 SOCIAL SERVICE	0	0		0	0	16. 17.
	DO NONPHYSI CI AN ANESTHETI STS	0	0		0	0	19.
	DO PARAMEDICAL EDUCATION PROGRAM EMS	408	101		0	0	23.
	ATLENT ROUTINE SERVICE COST CENTERS	,					
	00 ADULTS & PEDIATRICS	26, 408	17, 972		7,442	1,654	30.
	00 I NTENSI VE CARE UNI T 00 SUBPROVI DER – I RF	5, 228 3, 183	2, 273 1, 970		1, 310 752	291 167	31.
	00 NURSERY	1, 436	1, 970		400	89	
	I LLARY SERVICE COST CENTERS	1,100		, <u> </u>	100		
	OO OPERATING ROOM	7, 537	3, 737	64, 316	11, 986	2, 664	50.
	OO RECOVERY ROOM	2, 496	455		1, 475	328	
	DO DELIVERY ROOM & LABOR ROOM DO ANESTHESIOLOGY	1, 342	0		374	83	
	00 RADI OLOGY-DI AGNOSTI C	5, 324	101 2, 273		2, 400 8, 640	533 1, 920	
	30 ULTRA SOUND	1,067	556		2,075	461	54.
	DO RADI OI SOTOPE	601	1, 111	218	1, 784	396	56.
	DO CT SCAN	1, 374	606		7, 517	1, 670	
	00 CARDI AC CATHETERI ZATI ON 00 LABORATORY	3, 250	1, 616		9,070	2,016	
	00 WHOLE BLOOD & PACKED RED BLOOD CELL	7, 102 323	1, 465 202		12, 758 555	3, 209 123	
	50 BLOOD CLOTTING FOR HEMOPHILIACS	0_0	0		0	0	
	00 RESPI RATORY THERAPY	3, 233	202	2, 483	2, 031	451	65.
	00 PHYSI CAL THERAPY	0	1, 263			361	66.
	00 OCCUPATI ONAL THERAPY 00 SPEECH PATHOLOGY	0	455 152			157 30	67. 68.
1	00 ELECTROENCEPHALOGRAPHY	905	758		2, 187	486	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		2, 628	584	
	00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3, 534	785	72.
	DO DRUGS CHARGED TO PATIENTS	0	0		10, 914	2, 425	
	00 RENAL DI ALYSI S 97 CARDI AC REHABI LI TATI ON	0	0		395	88	
	97 CARDIAC REHABILITATION 98 HYPERBARIC OXYGEN THERAPY	779	859 0		204 0	45 0	76. 76.
	99 LI THOTRI PSY	0	0		0	0	76.
	PATIENT SERVICE COST CENTERS						1
	DO CLINIC	4, 243	4, 899			364	90.
	DO EMERGENCY	6, 341	3, 030	8, 985	9, 458	2, 102	
	00 0BSERVATION_BEDS_(NON-DISTINCT_PART ER_REIMBURSABLE_COST_CENTERS						92.
	00 HOME HEALTH AGENCY	2,920	1, 364	23	473	105	101.
	CIAL PURPOSE COST CENTERS	2,720	1,001	20		100	101.
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	123, 645	68, 633	153, 394	104, 464	23, 587	118.
	REIMBURSABLE COST CENTERS			1			
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.
	00 RESEARCH 00 PHYSI CI ANS' PRI VATE OFFI CES	14 0	0		0		191. 192.
	50 OTHER NON-REIMBURSEABLE COST CENTER	0	859		0		192.
	51 OTHER NONELIMBURSABLE	0	037		0		194.
00.00	Cross Foot Adjustments		-				200.
01.00	Negative Cost Centers	0	0	0	0		201.
02.00	TOTAL (sum lines 118 through 201)	123, 659	69, 492	153, 459	104, 464	23, 587	1202

	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATI ON OF	Com 07/01/2019 06/30/2020 LAUNDRY &	Part II Date/Time Pre 11/25/2020 2: HOUSEKEEPING	
		& GENERAL 5.05	REPAI RS 6.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	
	GENERAL SERVICE COST CENTERS	5.05	0.00	7.00	0.00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01 5. 01	00401 MAI NTENANCE OF PERSONNEL 00540 NONPATI ENT TELEPHONES						4. 01 5. 01
5.02	00560 PURCHASING RECEIVING AND STORES						5.02
5.03	00570 PATI ENT REGI STRATI ON						5.03
5.04	00580 PATIENT ACCOUNTING						5.04
5.05	00590 ADMINISTRATIVE & GENERAL	967, 496					5.05
6.00	00600 MAINTENANCE & REPAIRS	37, 693	1, 786, 854				6.00
7.00	00700 OPERATION OF PLANT	30, 304	91, 216	903, 255	10 111		7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	4, 340 17, 074	3, 813 16, 742	2, 031 8, 918	43, 144 0	194, 389	8.00 9.00
10.00	01000 DI ETARY	13, 138	28, 119	14, 979	0	3, 263	1
11.00	01100 CAFETERI A	7,032	18, 940	10, 089	0	2, 198	
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	18, 699	16, 117	8, 585	0	1, 870	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 123	15, 604	8, 312	0	1, 811	
15.00	01500 PHARMACY	21, 153	17, 251	9, 189	0	2,002	
16.00		13, 451	8, 264	4, 402	0	959	
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
23.00		1,633	1, 736	925	0	202	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1,000	1,700	720		202	20.00
30.00	03000 ADULTS & PEDI ATRI CS	122, 236	356, 386	189, 845	15, 633	41, 358	30.00
31.00	03100 INTENSIVE CARE UNIT	29, 984	51, 384	27, 372	2, 090	5, 963	31.00
41.00		17, 053	42, 788		1, 928	4, 965	
43.00		8, 331	19, 202	10, 229	344	2, 228	43.00
	ANCI LLARY SERVI CE COST CENTERS	95, 310	107 440	47.000	6 090	14, 792	50.00
50.00 51.00		14, 177	127, 462 24, 853	67, 898 13, 239	6, 080 0	2, 884	
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 781	17, 935	9, 554	403	2,081	52.00
53.00	05300 ANESTHESI OLOGY	2,869	1, 298		0	151	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	38, 377	69, 550	37, 049	2, 826	8, 071	54.00
54.01	03630 ULTRA SOUND	8, 268	11, 083	5, 904	800	1, 286	54.01
56.00	05600 RADI OI SOTOPE	9, 729	22, 867	12, 181	360	2,654	
57.00	05700 CT SCAN	13, 185	12, 757	6, 796	863	1, 480	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	26, 227 51, 691	41, 115 44, 020	21, 901 23, 449	1, 474 266	4, 771 5, 108	59.00 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	7, 275	3, 488	1, 858	200	405	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	1
65.00	06500 RESPI RATORY THERAPY	16, 219	14, 298	7, 616	0	1, 659	65.00
66.00	06600 PHYSI CAL THERAPY	17, 693	67, 466		815	7, 829	66.00
67.00		5, 370	3, 101	1, 652	270	360	
68.00 70.00		2, 311	923	492	62	107	
70.00		8, 697 43, 985	13, 050	6, 952 0	0	1, 514 0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	72, 407	0	0	0	0	
73.00		64, 921	0	0	0	0	1
74.00		4, 440	0	0	0	0	74.00
76.97	07697 CARDI AC REHABI LI TATI ON	4, 966	30, 649	16, 327	40	3, 557	76.97
76. 98		0	0	0	0	0	
76.99		0	0	0	0	0	76.99
00.00		24 545	102.005	EF 2/4	1 222	12 057	00.00
90.00 91.00		26, 565 37, 334	103, 895 72, 831	55, 344 38, 797	1, 322 7, 501	12, 057 8, 452	90.00
92.00		57, 554	72,031	30,777	7, 301	0, 432	92.00
/2:00	OTHER REIMBURSABLE COST CENTERS						/2.00
101.00	0 10100 HOME HEALTH AGENCY	16, 978	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00		945, 019	1, 370, 203	681, 309	43, 077	146, 037	118.00
100 0	NONREI MBURSABLE COST CENTERS		0.305	4 400			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	118 39	2, 785	1, 483	0		190.00 191.00
	0 19100 RESEARCH 0 19200 PHYSI CLANS' PRI VATE OFFI CES	39 15, 702	0 370, 960	197, 607	67		191.00
	07950 OTHER NON-REIMBURSEABLE COST CENTER	6, 618	42, 906	22, 856	0		192.00
	1 07951 OTHER NON-RELIMBURSABLE	0,010	τ <u>2</u> , 300	22, 850	0		194.00
200.00			0	Ĭ	Ŭ		200.00
	3	0	0	0	0		201.00
201.00				903, 255		194, 389	

	Financial Systems STION OF CAPITAL RELATED COSTS	T. MARY MEDICAL	Provider C	CN: 15-0034	Period: From 07/01/2019		
					To 06/30/2020	Date/Time Pre 11/25/2020 2:	
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE PERSONNEL		CENTRAL SERVI CES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401 MAI NTENANCE OF PERSONNEL						4.01
5.01	00540 NONPATI ENT TELEPHONES						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES						5.02
5.03 5.04	00570 PATIENT REGISTRATION 00580 PATIENT ACCOUNTING						5.03 5.04
5.05	00590 ADMINI STRATI VE & GENERAL						5.04
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
9.00 10.00	01000 DI ETARY	305, 083					10.00
11.00	01100 CAFETERI A	0	202, 266				11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0		12.00
13.00	01300 NURSING ADMINISTRATION	0	8, 273		0 195, 828		13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	2, 220 6, 334		0 0	170, 429 0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0, 334		0 0	0	
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0		0 0	0	
23.00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	885		0 0	0	23.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	248, 931	57, 264		0 94, 452	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	17,602	11, 338		0 18, 700		
41.00	04100 SUBPROVI DER – I RF	32, 329	6, 903		0 11, 386	0	41.00
43.00	04300 NURSERY	0	3, 114		0 5, 136	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	16, 344		0 26, 959	0	50.00
51.00	05100 RECOVERY ROOM	0	5, 413		0 20, 939		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 909		0 4, 797	0	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	11, 545		0 0	0	
54.01 56.00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	2, 314 1, 304		0 0	0	
57.00	05700 CT SCAN	0	2, 980		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	7,047		0 0	0	59.00
60.00	06000 LABORATORY	0	15, 400		0 0	0	
62.00 62.30	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	701		0 0	0	
	06500 RESPI RATORY THERAPY	0	7, 012		0 0		
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	01.00
68.00 70.00		0	0		0 0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 963 0		0 0	64, 283	70.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	106, 146	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	1, 690		0 2, 788	0	
	07699 LI THOTRI PSY	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS					· · · · · · · · · · · · · · · · · · ·	
90.00	09000 CLINIC	0	9, 201		0 0	0	
	09100 EMERGENCY	6, 221	13, 750		0 22, 680	0	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	6, 331		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS					1	1
118.00		305, 083	202, 235		0 195, 828	170, 429	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	1	0 0		190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 31		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
194.00	07950 OTHER NON-REIMBURSEABLE COST CENTER	0	0		0 0	0	194.00
	07951 OTHER NONREI MBURSABLE	0	0		0 0	0	194.01
200.00		~	~		0	_	200.00 201.00
201.00 202.00		0 305, 083	0 202, 266		0 195, 828		
202.00		303, 063	202,200	1	J 175, 020	1 170,429	1202.00

LLUCATIO	N OF CAPITAL RELATED COSTS		Provider CC	F	eriod: rom 07/01/2019	Worksheet B Part II	
				T	o 06/30/2020	Date/Time Pre 11/25/2020 2:	
	Cost Center Description	PHARMACY	RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	PARAMEDI CAL EDUCATI ON PROGRAM EMS	
		15.00	LI BRARY 16. 00	17.00	19.00	23.00	
	IERAL SERVICE COST CENTERS						
	00 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP						1.00
	100 EMPLOYEE BENEFITS DEPARTMENT						2.00
	101 MAINTENANCE OF PERSONNEL						4.0
	540 NONPATI ENT TELEPHONES						5.0
	560 PURCHASING RECEIVING AND STORES						5.0
	570 PATIENT REGISTRATION						5.0
1	580 PATIENT ACCOUNTING						5.0
	590 ADMINISTRATIVE & GENERAL 500 MAINTENANCE & REPAIRS						5.0 6.0
	00 OPERATION OF PLANT						7.0
	300 LAUNDRY & LINEN SERVICE						8.0
0.00 009	POO HOUSEKEEPI NG						9.0
	DOO DI ETARY						10.0
							11.0
	200 MAINTENANCE OF PERSONNEL						12.0
	300 NURSI NG ADMI NI STRATI ON 100 CENTRAL SERVI CES & SUPPLY						13.00
	500 PHARMACY	210, 089					14.0
	500 MEDICAL RECORDS & LIBRARY	210,007	97, 570				16.0
	700 SOCIAL SERVICE	0	0	0			17.0
9.00 019	200 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
	BOO PARAMEDICAL EDUCATION PROGRAM EMS	0	0	0		21, 020	23.0
	PATIENT ROUTINE SERVICE COST CENTERS		(001	0			1 20 0
	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT	0	6, 991 1, 231	0			30.0 31.0
	100 SUBPROVI DER – I RF	0	706	0			41.0
	BOO NURSERY	0	376	0			43.00
ANC	LILARY SERVICE COST CENTERS						
	DOO OPERATING ROOM	0	11, 260	0			50.0
	OO RECOVERY ROOM	0	1, 385	0			51.0
	200 DELIVERY ROOM & LABOR ROOM 300 ANESTHESIOLOGY	0	352	0			52.0 53.0
	100 RADI OLOGY-DI AGNOSTI C	0	2, 255 8, 116	0			54.0
	530 ULTRA SOUND	o	1, 949	0			54.0
	500 RADI OI SOTOPE	0	1, 676	0			56.0
7.00 057	700 CT SCAN	0	7, 061	0			57.0
	200 CARDI AC CATHETERI ZATI ON	0	8, 520	0			59.0
1		0	11, 421	0			60.0
	200 WHOLE BLOOD & PACKED RED BLOOD CELL 250 BLOOD CLOTTING FOR HEMOPHILIACS	0	521 0	0			62.0 62.3
	500 RESPIRATORY THERAPY	0	1, 908	0			65.0
	500 PHYSI CAL THERAPY	0	1, 526	0			66.0
	00 OCCUPATI ONAL THERAPY	0	664	0			67.0
	300 SPEECH PATHOLOGY	0	125	0			68.0
	DOO ELECTROENCEPHALOGRAPHY	0	2, 055	0			70.0
	100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	2,469	0			71.0
	200 I MPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	210, 089	3, 320 10, 253	0			72.0
	100 RENAL DIALYSIS	210,007	371	0			74.0
	597 CARDI AC REHABI LI TATI ON	0	191	0			76.9
	98 HYPERBARI C OXYGEN THERAPY	0	0	0			76.98
6.99 076	599 LI THOTRI PSY	0	0	0			76.9
	PATIENT SERVICE COST CENTERS						
		0	1, 539	0			90.00
	OO EMERGENCY	0	8, 885	0			91.0
	200 OBSERVATI ON BEDS (NON-DI STI NCT PART				l		92.0
	100 HOME HEALTH AGENCY	0	444	0			101.00
	CIAL PURPOSE COST CENTERS	-1					
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	210, 089	97, 570	0	0	0]118. 00
	IREI MBURSABLE COST CENTERS						
	DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.0
	100 RESEARCH	0	0	0			191.0
	200 PHYSICIANS' PRIVATE OFFICES 250 OTHER NON-REIMBURSEABLE COST CENTER	0	0	0			192. 0 194. 0
	251 OTHER NON-REIMBURSABLE COST CENTER	0	0	0			194.0
00.00	Cross Foot Adjustments	0	0	0	0	21, 020	
	Negative Cost Centers	0	0	0	0		201.0
201.00	negative cost centers		01	0		0	

LOCATION OF CAPITAL RELATED COSTS		Provi der CCI		Period: From 07/01/2019	Worksheet B Part II
				To 06/30/2020	
Cost Center Description	Subtotal	Intern &	Total		<u></u>
		Residents Cost & Post			
		Stepdown			
	24.00	Adjustments	24.00	_	
GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
00 00100 CAP REL COSTS-BLDG & FIXT					1.
00 00200 CAP REL COSTS-MVBLE EQUIP					2.
00 00400 EMPLOYEE BENEFITS DEPARTM 01 00401 MAINTENANCE OF PERSONNEL	ENI				4.
01 00540 NONPATI ENT TELEPHONES					5.
02 00560 PURCHASING RECEIVING AND	STORES				5.
03 00570 PATIENT REGISTRATION					5.
04 00580 PATIENT ACCOUNTING 05 00590 ADMINISTRATIVE & GENERAL					5.
00 00600 MAI NTENANCE & REPAI RS					6.
00 00700 OPERATION OF PLANT					7.
00 00800 LAUNDRY & LINEN SERVICE					8.
00 00900 HOUSEKEEPI NG . 00 01000 DI ETARY					9. 10.
. 00 01100 CAFETERIA					11.
. 00 01200 MAINTENANCE OF PERSONNEL					12.
. 00 01300 NURSI NG ADMI NI STRATI ON					13.
. 00 01400 CENTRAL SERVICES & SUPPLY . 00 01500 PHARMACY					14.
. 00 01600 MEDICAL RECORDS & LIBRARY					16.
. 00 01700 SOCIAL SERVICE					17.
. 00 01900 NONPHYSI CI AN ANESTHETI STS					19.
. 00 02300 PARAMEDICAL EDUCATION PRO I NPATIENT ROUTINE SERVICE COST					23.
. 00 03000 ADULTS & PEDI ATRI CS	4, 242, 41	1 0	4, 242, 41	1	30.
. 00 03100 INTENSIVE CARE UNIT	618, 79		618, 798		31.
. 00 04100 SUBPROVIDER - IRF	513, 25		513, 250		41.
. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	214, 87	6 0	214, 870	5	43.
. 00 05000 OPERATING ROOM	1, 544, 58	4 0	1, 544, 584	4	50.
. 00 05100 RECOVERY ROOM	289, 84		289, 84		51.
. 00 05200 DELIVERY ROOM & LABOR ROOM			200, 78		52.
. 00 05300 ANESTHESI OLOGY . 00 05400 RADI OLOGY-DI AGNOSTI C	24, 22 790, 33		24, 22 ⁻ 790, 332		53. 54.
. 01 03630 ULTRA SOUND	132, 35		132, 350		54.
. 00 05600 RADI OI SOTOPE	250, 05		250, 05		56.
. 00 05700 CT SCAN	167, 07		167, 070		57.
. 00 05900 CARDI AC CATHETERI ZATI ON . 00 06000 LABORATORY	483, 85 576, 02		483, 85 ⁻ 576, 026		59. 60.
. 00 06200 WHOLE BLOOD & PACKED RED			46, 763		62.
. 30 06250 BLOOD CLOTTING FOR HEMOPH	I LI ACS	0 0	(C	62.
. 00 06500 RESPIRATORY THERAPY	179, 48		179, 48		65.
. 00 06600 PHYSI CAL THERAPY . 00 06700 OCCUPATI ONAL THERAPY	710, 56 39, 26		710, 568 39, 266		66. 67.
. 00 06800 SPEECH PATHOLOGY	12, 22		12, 22		68.
. 00 07000 ELECTROENCEPHALOGRAPHY	155, 90	0 0	155, 900	C	70.
. 00 07100 MEDI CAL SUPPLI ES CHARGED			113, 949		71.
.00 07200 IMPL. DEV. CHARGED TO PAT .00 07300 DRUGS CHARGED TO PATIENTS	I ENTS 186, 19 298, 60		186, 192 298, 602		72.
. 00 07400 RENAL DI ALYSI S	5, 29		5, 29		74.
. 97 07697 CARDIAC REHABILITATION	323, 73	1 0	323, 73	1	76.
. 98 07698 HYPERBARI C OXYGEN THERAPY		0 0			76.
. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS		0 0	()	
. 00 09000 CLINIC	1, 111, 16	3 0	1, 111, 163	3	90.
00 09100 EMERGENCY	868, 44	1	868, 449		91.
. 00 09200 OBSERVATI ON BEDS (NON-DI S		0			92.
OTHER REIMBURSABLE COST CENTERS 1. 00 10100 HOME HEALTH AGENCY	29, 10	2 0	29, 102	2	101.
SPECIAL PURPOSE COST CENTERS					
B. 00 SUBTOTALS (SUM OF LINES 1	through 117) 14, 129, 15	1 0	14, 129, 15	1	118.
NONREI MBURSABLE COST CENTERS	& CANTEEN 20.44	2	20 44		100
0. 00 19000 GLFT, FLOWER, COFFEE SHOP 1. 00 19100 RESEARCH	& CANTEEN 28, 46 8		28, 462 8!		190. 191.
2. 00 19200 PHYSI CLANS' PRI VATE OFFI C		1	3, 791, 893		192.
4. 00 07950 OTHER NON-REIMBURSEABLE C	OST CENTER 444, 29	6 0	444, 296	5	194.
4. 01 07951 OTHER NONREI MBURSABLE		0 0			194.
0.00Cross Foot Adjustments1.00Negative Cost Centers	21, 02		21, 020		200. 201.
nogative oust centers		~ V	18, 414, 90		201. 202.

Heal th	Fi nanci al	Systems	
COST A			R

	LLOCATION - STATISTICAL BASIS	I. MARY MEDICAL	Provider C	°N· 15-0034	Peri od:	Worksheet B-1	
JJ1 F	LEUGATION - STATISTICAL DASIS			F	From 07/01/2019 To 06/30/2020		pared:
		CAPI TAL REI	ATED COSTS				-
			MVBLE EQUIP				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	(SQUARE FEET)	EMPLOYEE BENEFITS	MAINTENANCE OF PERSONNEL	NONPATI ENT TELEPHONES	
		(SEGARE TEET)		DEPARTMENT	(NUMBER OF	(NUMBER OF	
				(GROSS	FTES)	PHONES)	
				SALARI ES)	,	· ·	
	L	1.00	2.00	4.00	4.01	5. 01	
~~	GENERAL SERVICE COST CENTERS	FF1 075			1		1 1 0
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	551, 975	551, 975				1.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT	428			5		4.0
01	00401 MAINTENANCE OF PERSONNEL	3, 701	3, 701	957, 959			4.0
01	00540 NONPATI ENT TELEPHONES	2,083	2, 083	(0 0	1, 376	5.0
02	00560 PURCHASING RECEIVING AND STORES	4, 560					
03	00570 PATIENT REGISTRATION	2,949					
04 05	00580 PATIENT ACCOUNTING 00590 ADMINISTRATIVE & GENERAL	707 28, 357	707 28, 357	4, 392, 469	-	-	
00	00600 MAINTENANCE & REPAIRS	52, 291	52, 291	1, 890, 098			
00	00700 OPERATION OF PLANT	23, 324					
00	00800 LAUNDRY & LINEN SERVICE	975	975	101, 542	2 327		
00	00900 HOUSEKEEPI NG	4, 281	4, 281	2, 070, 586			
0.00		7, 190					
1.00 2.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	4,843					
3.00	01300 NURSI NG ADMI NI STRATI ON	4, 121	4, 121	2, 763, 078	-	-	
1.00	01400 CENTRAL SERVICES & SUPPLY	3, 990					
5.00	01500 PHARMACY	4, 411	4, 411	2, 299, 11	2, 691	20	
5.00	01600 MEDI CAL RECORDS & LI BRARY	2, 113		0	-	-	1
7.00	01700 SOCIAL SERVICE	0	-	(-	-	
9.00 3.00	01900 NONPHYSICIAN ANESTHETISTS	444	0	224 015	0 0 5 376	-	
5. 00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	444	444	234, 915	5/0	2	23.0
). 00	03000 ADULTS & PEDIATRICS	91, 128	91, 128	15, 025, 57	7 24, 330	356	30.0
. 00	03100 I NTENSI VE CARE UNI T	13, 139					
I. 00	04100 SUBPROVI DER – I RF	10, 941	10, 941	1, 768, 424			
3.00	04300 NURSERY	4, 910	4, 910	950, 143	3 1, 323	0	43.0
0. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	32, 592	32, 592	4, 669, 120	6, 944	74	50. 0
1.00	05100 RECOVERY ROOM	6, 355					
2.00	05200 DELIVERY ROOM & LABOR ROOM	4, 586					
8.00	05300 ANESTHESI OLOGY	332	332	(-	_	53.0
1.00	05400 RADI OLOGY-DI AGNOSTI C	17, 784					
1.01	03630 ULTRA SOUND 05600 RADI OI SOTOPE	2,834					
o. 00 7. 00	05700 CT SCAN	5, 847 3, 262	5, 847 3, 262				
. 00	05900 CARDI AC CATHETERI ZATI ON	10, 513					
. 00	06000 LABORATORY	11, 256					
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	892	892	200, 559	9 298	4	
. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	-		0 0	-	
. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 656 17, 251		2, 062, 17	2,979	4 25	
. 00	06700 OCCUPATIONAL THERAPY	793	17, 251 793				
. 00	06800 SPEECH PATHOLOGY	236				3	
. 00	07000 ELECTROENCEPHALOGRAPHY	3, 337		584, 065	5 834	15	
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0 0	0	
. 00	07200 I MPL. DEV. CHARGED TO PATI ENTS	0	0	(0 0	0	
. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
. 00 . 97	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON	7,837	7, 837	534, 127	7 718	0 17	
. 98	07698 HYPERBARI C OXYGEN THERAPY	, 037	, 037	004, 12			
. 99	07699 LI THOTRI PSY	0	0		-	-	
	OUTPATIENT SERVICE COST CENTERS				1		
. 00	09000 CLI NI C	26, 566					
. 00	09100 EMERGENCY	18, 623	18, 623	4, 021, 851	5, 842	60	
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					<u>i</u>	92.0
1 00	10100 HOME HEALTH AGENCY	0	0	2, 378, 084	1 2, 690	27	101.
	SPECIAL PURPOSE COST CENTERS	0	0	2, 570, 004	<u>'</u> 2, 090	21	1'''''
8.00		445, 438	445, 438	73, 154, 556	5 113, 917	1, 359	118.
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	712	712		0		190.
	19100 RESEARCH			5, 799			191.
0 0 -	19200 PHYSI CLANS' PRI VATE OFFI CES	94, 854	94, 854	(0 0	0	192.
				/		17	101 1
4.00	07950 OTHER NON-REIMBURSEABLE COST CENTER 07951 OTHER NONREIMBURSABLE	10, 971 0	10, 971				194. (194. (

COST ALLC	CATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					rom 07/01/2019 o 06/30/2020		
		CAPI TAL REI	_ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER OF FTES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	
		1.00	2.00	4.00	4. 01	5. 01	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	9, 300, 205	9, 114, 702	11, 945, 153	1, 539, 457	596, 782	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16. 848961	16. 512889	0. 163274	13. 512306	433. 707849	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			14, 279	123, 659	69, 492	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0. 000195	1. 085395	50. 502907	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

alth Financial Systems ST ALLOCATION - STATISTICAL BASIS	ST. WART MEDICA	L CENTER, INC. Provider C	CN: 15-0034	Period:	u of Form CMS- Worksheet B-1	
				From 07/01/2019		
				To 06/30/2020	Date/Time Pre 11/25/2020 2:	par 58
Cost Center Description	PURCHASI NG	PATI ENT	PATI ENT	Reconciliation	ADMI NI STRATI VE	
	RECEIVING AND	REGI STRATI ON	ACCOUNTI NG		& GENERAL	
	STORES	(GROSS REVE	(GROSS REVE		(ACCUM. COST)	
	(SUPPLY EXP ENSE)	NUE)	NUE)			
	5.02	5.03	5.04	5A. 05	5.05	
GENERAL SERVICE COST CENTERS		1				
00 00100 CAP REL COSTS-BLDG & FIXT						1
00 00200 CAP REL COSTS-MVBLE EQUIP 00 00400 EMPLOYEE BENEFITS DEPARTMENT						2
00400 EMPLOYEE BENEFITS DEPARTMENT 00401 MAINTENANCE OF PERSONNEL						4
00540 NONPATI ENT TELEPHONES						5
00560 PURCHASING RECEIVING AND STORES	800, 284					5
00570 PATIENT REGISTRATION	1, 017					5
04 00580 PATIENT ACCOUNTING	0	-	1			5
05 00590 ADMINI STRATI VE & GENERAL	1,610			0 -26, 383, 309		
00 00600 MAI NTENANCE & REPAI RS 00 00700 OPERATI ON OF PLANT	649 140			0 0 0 0	7, 605, 517 6, 114, 618	
00 00800 LAUNDRY & LINEN SERVICE	29			0 0	875, 646	
00 00900 HOUSEKEEPING	2, 371	0		0 0	3, 445, 193	
00 01000 DI ETARY	5, 891	0		0 0	2, 650, 971	10
00 01100 CAFETERIA	0			0 0	1, 418, 818	
00 01200 MAINTENANCE OF PERSONNEL	0	0		0 0	C	
00 01300 NURSI NG ADMI NI STRATI ON	214			0 0	3, 772, 926	
00 01400 CENTRAL SERVICES & SUPPLY 00 01500 PHARMACY	8, 196 13, 675			0 0 0 0	1, 235, 401 4, 268, 215	
00 01600 MEDICAL RECORDS & LIBRARY	0			0 0	2, 714, 068	
00 01700 SOCIAL SERVICE	0	-		0 0	C	
00 01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	C	19
00 02300 PARAMEDICAL EDUCATION PROGRAM EMS	1, 412	0		0 0	329, 526	23
INPATIENT ROUTINE SERVICE COST CENTERS		75 4 4 9 9 9 9	75 4 4 9 9 9		04 (70 40)	
00 03000 ADULTS & PEDIATRICS 00 03100 INTENSIVE CARE UNIT	66, 215					
00 03100 I NTENSI VE CARE UNI T 00 04100 SUBPROVI DER – I RF	25, 925 5, 058				6, 050, 067 3, 440, 907	
00 04300 NURSERY	0,000					
ANCILLARY SERVICE COST CENTERS				-		
00 05000 OPERATING ROOM	335, 397					
00 05100 RECOVERY ROOM	9, 649				2, 860, 515	
00 05200 DELIVERY ROOM & LABOR ROOM 00 05300 ANESTHESI OLOGY	0				1, 569, 984 578, 960	
00 05400 RADI OLOGY-DI AGNOSTI C	14, 841				7, 743, 537	
01 03630 ULTRA SOUND	9, 831				1, 668, 223	
00 05600 RADI 0I SOTOPE	1, 139				1, 963, 061	
00 05700 CT SCAN	9, 279				2, 660, 373	
00 05900 CARDI AC CATHETERI ZATI ON	29, 409				5, 292, 035	
	124, 696				10, 429, 998	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	7,902		5, 603, 10	4 0 0 0	1, 467, 953 C	
00 06500 RESPIRATORY THERAPY	12, 948	-	20, 514, 07		3, 272, 530	
00 06600 PHYSI CAL THERAPY	2,743				3, 570, 075	
00 06700 OCCUPATIONAL THERAPY	393				1, 083, 564	
00 06800 SPEECH PATHOLOGY	99				466, 291	68
00 07000 ELECTROENCEPHALOGRAPHY	30, 718				1, 754, 760	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	26, 545, 380			8, 875, 001	
00 07200 I MPL. DEV. CHARGED TO PATIENTS 00 07300 DRUGS CHARGED TO PATIENTS	0	35, 695, 354 110, 242, 958			14, 609, 921 13, 099, 418	
00 07400 RENAL DIALYSIS	0	3, 988, 736			895, 935	
97 07697 CARDI AC REHABI LI TATI ON	389				1, 001, 977	
98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	C	
99 07699 LI THOTRI PSY	0	0		0 0	C	76
OUTPATIENT SERVICE COST CENTERS		41 515 5			E 9/5 5	
00 09000 CLINIC 00 09100 EMERGENCY	16, 998					
00 09200 OBSERVATION BEDS (NON-DISTINCT PART	46, 854	95, 539, 169	95, 539, 16	9 0	7, 533, 143	91
OTHER REIMBURSABLE COST CENTERS		1	1	<u> </u>	L	1 74
. 00 10100 HOME HEALTH AGENCY	122	4, 777, 469	4, 777, 46	9 0	3, 425, 663	101
SPECIAL PURPOSE COST CENTERS						
3.00 SUBTOTALS (SUM OF LINES 1 through 117) 799,943	1,054,011,441	1,054,011,44	1 -26, 383, 309	190, 689, 229	118
NONREI MBURSABLE COST CENTERS						1
0.0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-		0 0	23, 753	
I. 00 19100 RESEARCH 2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			0 0	7, 789 3, 168, 287	
4. 00 07950 0THER NON-REIMBURSEABLE COST CENTER	341				1, 335, 334	
4. 01 07951 OTHER NON-REIMBURSABLE COST CENTER	0	0		o o		194
D. 00 Cross Foot Adjustments						200
I.00 Negative Cost Centers	1	1	1	1		201

COST ALLO	CATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 2:	
	Cost Center Description	PURCHASI NG	PATI ENT	PATI ENT	Reconci I i ati on	ADMI NI STRATI VE	
		RECEIVING AND	REGI STRATI ON	ACCOUNTI NG		& GENERAL	
		STORES	(GROSS REVE	(GROSS REVE		(ACCUM. COST)	
		(SUPPLY EXP	NUE)	NUE)			
		ENSE)					
		5.02	5.03	5.04	5A. 05	5.05	
202.00	Cost to be allocated (per Wkst. B, Part I)	768, 272	2, 372, 555	3, 411, 33	8	26, 383, 309	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 959999	0. 002251	0.00323	7	0. 135144	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	153, 459	104, 464	23, 58	7	967, 496	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 191756	0. 000099	0.00002	2	0. 004956	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

ST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 07/01/2019	Worksheet B-1	
				06/30/2020	Date/Time Pre 11/25/2020 2:	
Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS 00 00100 CAP REL COSTS-BLDG & FIXT			1			1 1
00 00200 CAP REL COSTS-MVBLE EQUIP 00 00400 EMPLOYEE BENEFITS DEPARTMENT 01 00401 MAINTENANCE OF PERSONNEL 01 00540 NONPATIENT TELEPHONES 02 00560 PURCHASING RECEIVING AND 03 00570 PATIENT REGISTRATION 04 00580 PATIENT ACCOUNTING 05 00590 ADMINISTRATIVE & GENERAL 00 00600 MAINTENANCE & REPAIRS 00 00700 OPERATION OF PLANT 00 00700 DETARY GO 00 00800 LAUNDRY & LINEN SERVICE GO 00 01000 DIETARY GO GO 00 01000 DIETARY GO GO 00 01200 MAINTENANCE OF PERSONNEL 00 01300 NURSING ADMINISTRATION 00 01	456, 899 23, 324 975 4, 281 7, 190 4, 843 0 4, 121 3, 990 4, 411 2, 113 0 0	433, 575 975 4, 281 7, 190 4, 843 0 4, 121 3, 990 4, 411 2, 113 0 0	1, 491, 526 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	428, 319 7, 190 4, 843 0 4, 121 3, 990 4, 411 2, 113 0 0	171, 741 0 0 0 0 0 0 0 0 0 0 0 0 0	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
00 02300 PARAMEDICAL EDUCATION PROGRAM EMS	444	444	0	444	0	23
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 00 03000 ADULTS & PEDI ATRI CS	91, 128	91, 128	540, 427	91, 128	140, 131	30
00 03100 I NTENSI VE CARE UNI T	13, 139			13, 139	9, 909	31
00 04100 SUBPROVIDER - IRF 00 04300 NURSERY	10, 941 4, 910	10, 941 4, 910		10, 941 4, 910	18, 199 0	
ANCI LLARY SERVICE COST CENTERS	4, 910	4,910	<u> </u>	4, 910	0	4
00 05000 OPERATING ROOM	32, 592			32, 592	0	50
00 05100 RECOVERY ROOM	6, 355			6, 355	0	
00 05200 DELIVERY ROOM & LABOR ROOM 00 05300 ANESTHESIOLOGY	4, 586	4, 586 332		4, 586 332	0	5
00 05400 RADI OLOGY - DI AGNOSTI C	17, 784	17, 784		17, 784	0	5
01 03630 ULTRA SOUND	2, 834	2, 834	27, 652	2, 834	0	54
00 05600 RADI OI SOTOPE	5,847	5, 847		5, 847	0	5
00 05700 CT SCAN 00 05900 CARDIAC CATHETERIZATION	3, 262				0	5
00 06000 LABORATORY	10, 513 11, 256			10, 513 11, 256	0	6
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	892			892	0	
30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			-		-
00 06500 RESPI RATORY THERAPY 00 06600 PHYSI CAL THERAPY	3, 656 17, 251	3, 656 17, 251		3, 656 17, 251	0	6
00 06700 OCCUPATIONAL THERAPY	793			793	0	6
00 06800 SPEECH PATHOLOGY	236			236	0	6
00 07000 ELECTROENCEPHALOGRAPHY	3, 337	3, 337	0	3, 337	0	7
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	7
00 07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	
00 07400 RENAL DIALYSIS	0	C	0	0	0	7
97 07697 CARDIAC REHABILITATION	7,837	7, 837	1, 370	7, 837	0	7
98 07698 HYPERBARI C OXYGEN THERAPY 99 07699 LI THOTRI PSY	0		0	0	0	7
OUTPATIENT SERVICE COST CENTERS	0		ν <u>ι</u> υ	0	0	1
00 09000 CLINIC	26, 566	26, 566	45, 715	26, 566	0	9
00 09100 EMERGENCY	18, 623	18, 623	259, 304	18, 623	3, 502	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						9
00 10100 HOME HEALTH AGENCY	0	C	0	0	0	10
SPECIAL PURPOSE COST CENTERS						1.0
3.00 SUBTOTALS (SUM OF LINES 1 through 117)	350, 362	327, 038	1, 489, 195	321, 782	171, 741	11
NONREI MBURSABLE COST CENTERS 0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	710	710		710		10
. 00/19000/GFFT, FLOWER, COFFEE SHOP & CANTEEN	712	712 0		712		190 19
2. 00 19200 PHYSICIANS' PRIVATE OFFICES 4. 00 07950 OTHER NON-REIMBURSEABLE COST CENTER 4. 01 07951 OTHER NONREIMBURSABLE 5. 00 Cross Foot Adjustments	94, 854 10, 971 0	94, 854 10, 971 C		94, 854 10, 971 0	0 0	19: 19: 19: 19: 20:
0.00 Negative Cost Centers 2.00 Cost to be allocated (per Wkst. B, Part I)	8, 633, 357	7, 381, 692	1, 029, 007	4, 064, 567	3, 335, 734	20

Health Fi	nancial Systems S	T. MARY MEDICAL	_ CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLO	OCATION - STATISTICAL BASIS		Provider CO		Period: From 07/01/2019	Worksheet B-1	
					Го 06/30/2020	Date/Time Pre 11/25/2020 2:	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
				LAUNDRY)			
		6.00	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	18. 895548	17. 025179	0. 68990	9. 489579	19. 423050	203.00
204.00	Cost to be allocated (per Wkst. B,	1, 786, 854	903, 255	43, 14	4 194, 389	305, 083	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	3. 910829	2. 083273	0. 02892	6 0. 453842	1. 776413	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

ST ALLOGATION	STATI STI CAL BASI S				eriod: rom 07/01/2019 o 06/30/2020	Worksheet B-1 Date/Time Pre	
Cost C	enter Description	CAFETERIA (NUMBER OF FTES)	MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)		CENTRAL	11/25/2020 2: PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
	/ICE COST CENTERS						1 1.
00 00400 EMPLOY 01 00401 MAI NTE 01 00540 NONPAT 02 00560 PURCHA 03 00570 PATI EN 04 00580 PATI EN 05 00590 ADMI NI 00 00600 MAI NTE 00 00600 MAI NTE 00 00700 OPERAT 00 00900 HOUSEK 0.00 01000 DI ETAR 1.00 01200 MAI NTE 2.00 01200 MAI NTE 3.00 01300 NURSI N 4.00 01400 CENTRA 5.00 01500 PHARMA	Y RIA NANCE OF PERSONNEL G ADMINISTRATION L SERVICES & SUPPLY	85, 936 0 3, 515 943 2, 691 0		1, 049, 231 0 0 0 0	23, 143, 345 0 0	10, 000 0	
7. 00 01700 SOCI AL		0	(-	0	0	
	SICIAN ANESTHETISTS	0	(0	0	
	DICAL EDUCATION PROGRAM EMS	376	(0 0	0	0	23.
	& PEDIATRICS	24, 330	(506, 065	0	0	30.
	IVE CARE UNIT	4, 817	(0	
I. 00 04100 SUBPRC		2, 933	(0	0	
3. 00 04300 NURSER		1, 323	(27, 520	0	0	43
0. 00 05000 OPERAT	RVICE COST CENTERS	6, 944	(144, 442	0	0	50
. 00 05100 RECOVE		2, 300	(0	0	
	RY ROOM & LABOR ROOM	1, 236	(0	0	
3. 00 05300 ANESTH	ESI OLOGY	0	(0 0	0	0	53
	OGY-DI AGNOSTI C	4, 905	(0	0	
. 01 03630 ULTRA		983 554	(-	0	0	
. 00 05600 RADI 01 . 00 05700 CT SCA		1, 266			0	0	
	C CATHETERI ZATI ON	2, 994	(-	0	0	
. 00 06000 LABORA		6, 543	(0 0	0	0	
	BLOOD & PACKED RED BLOOD CELL	298	(0 0	0	0	
	CLOTTING FOR HEMOPHILIACS	0	(0	0	0	
. 00 06500 RESPI R . 00 06600 PHYSI 0	ATORY THERAPY	2,979			0	0	
	TI ONAL THERAPY	0	(0	0	
. 00 06800 SPEECH		0	(0 0	0	0	
	OENCEPHALOGRAPHY	834	(0 0	0	0	
	L SUPPLIES CHARGED TO PATIENT	0	(0 0	8, 729, 320	0	
	DEV. CHARGED TO PATIENTS CHARGED TO PATIENTS	0			14, 414, 025	0 10, 000	
. 00 07400 RENAL		0	(0	10, 000	
	C REHABILITATION	718	(14, 937	0	0	
	ARIC OXYGEN THERAPY	0	(0 0	0	0	
. 99 07699 LI THOT		0	(00	0	0	76
	SERVICE COST CENTERS	2,000			0		
. 00 09000 CLINIC . 00 09100 EMERGE		3, 909 5, 842	(0	0	
	ATION BEDS (NON-DISTINCT PART	5, 042		121, 317	U	0	92
	IRSABLE COST CENTERS						1 -
1.00 10100 HOME H	EALTH AGENCY	2, 690	(0 0	0	0	101
	POSE COST CENTERS			-			
	ALS (SUM OF LINES 1 through 117)	85, 923	(1, 049, 231	23, 143, 345	10, 000	118
	BLE COST CENTERS		· · · · · · · · · · · · · · · · · · ·				100
0. 00 19000 GFFT, 1. 00 19100 RESEAR	FLOWER, COFFEE SHOP & CANTEEN	0 13	(0		190 191
	IANS' PRIVATE OFFICES	13			0		191
	NON-REIMBURSEABLE COST CENTER	0	(0 0	0		194
		Ű			0		
4.01079510THER	NONREIMBURSABLE	0	(0	0	0	194

Heal th Fi	nancial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-:	2552-10
COST ALLC	CATION - STATISTICAL BASIS		Provider C		Period: From 07/01/2019	Worksheet B-1	
		_			To 06/30/2020	Date/Time Pre 11/25/2020 2:	
	Cost Center Description	CAFETERI A	MAINTENANCE OF		CENTRAL	PHARMACY	
		(NUMBER OF		ADMI NI STRATI OI		(COSTED	
		FTES)	(NUMBER		SUPPLY	REQUIS.)	
			HOUSED)	(NURSING HO	(SUPPLY EXP		
				URS)	ENSE)		
		11.00	12.00	13.00	14.00	15.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 830, 485	0	4, 544, 822	2 1, 603, 630	5, 102, 664	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	21. 300561	0. 000000	4. 331574	0. 069291	510. 266400	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	202, 266	0	195, 828	3 170, 429	210, 089	204. 00
205.00	Unit cost multiplier (Wkst. B, Part II)	2. 353682	0. 000000	0. 186640	0. 007364	21.008900	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

ST AI	Financial Systems S LOCATION - STATISTICAL BASIS		Provider CC		eri od:	Worksheet B-1
					rom 07/01/2019 0 06/30/2020	Date/Time Prepar
						11/25/2020 2:58
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	ANESTHETI STS	PARAMEDI CAL EDUCATI ON	
		LI BRARY	(TIME SPENT)	(ASSI GNED	PROGRAM EMS	
		(GROSS REVE		TIME)	(ASSI GNED	
		NUE)	17.00	10.00	TIME)	
	GENERAL SERVICE COST CENTERS	16.00	17.00	19.00	23.00	
	00100 CAP REL COSTS-BLDG & FIXT					
	00200 CAP REL COSTS-MVBLE EQUIP					
	00400 EMPLOYEE BENEFITS DEPARTMENT					
	00401 MAI NTENANCE OF PERSONNEL					
	00540 NONPATIENT TELEPHONES					
	00560 PURCHASING RECEIVING AND STORES 00570 PATIENT REGISTRATION					
	00580 PATIENT ACCOUNTING					
	00590 ADMI NI STRATI VE & GENERAL					
	00600 MAINTENANCE & REPAIRS					
00	00700 OPERATION OF PLANT					
	00800 LAUNDRY & LINEN SERVICE					
	00900 HOUSEKEEPING					
						10
						1
	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON					1
	01400 CENTRAL SERVICES & SUPPLY					1
	01500 PHARMACY					1
	01600 MEDICAL RECORDS & LIBRARY	1, 054, 011, 441				1
00	01700 SOCIAL SERVICE	0	0			1
00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	C		1
	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	0		1, 352	23
	INPATIENT ROUTINE SERVICE COST CENTERS	75 4 (0, 000			1.10	
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	75, 168, 380 13, 231, 282				30
	04100 SUBPROVI DER – I RF	7, 595, 715				4
	04300 NURSERY	4, 038, 816		C		4
	ANCI LLARY SERVICE COST CENTERS		1			
	05000 OPERATING ROOM	121, 072, 178		C		50
	05100 RECOVERY ROOM	14, 895, 166		C	-	5
	05200 DELIVERY ROOM & LABOR ROOM	3, 782, 209		C	0	5:
		24, 243, 755			0	5
	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	87, 269, 983 20, 956, 930	-		0	5
	05600 RADI OI SOTOPE	18, 018, 157			0	5
	05700 CT SCAN	75, 928, 829		C	0	5
	05900 CARDI AC CATHETERI ZATI ON	91, 616, 864		C	0	5
	06000 LABORATORY	127, 698, 865		C	0	61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	5, 603, 104		C	0	63
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	-	6
	06500 RESPI RATORY THERAPY	20, 514, 071		C	80	6
		16, 409, 705			0	6
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	7, 134, 946 1, 344, 715				6
	07000 ELECTROENCEPHALOGRAPHY	22, 095, 722				70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 545, 380			o	7
	07200 IMPL. DEV. CHARGED TO PATIENTS	35, 695, 354		C	0	7:
	07300 DRUGS CHARGED TO PATIENTS	110, 242, 958		C	0	7
	07400 RENAL DI ALYSI S	3, 988, 736		C	0	7
	07697 CARDI AC REHABI LI TATI ON	2, 059, 117		0	0	70
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0		-	70
	OT699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	I 0			
	09000 CLINIC	16, 543, 866	0	C	0	90
	09100 EMERGENCY	95, 539, 169		C		9
00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92
	OTHER REIMBURSABLE COST CENTERS					
	10100 HOME HEALTH AGENCY	4, 777, 469	0	C	0	10
. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	1.054 011 441	0	C	1, 352	11:
	NONREIMBURSABLE COST CENTERS	1, 034, 011, 441	0		1, 302	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	190
I. 00	19100 RESEARCH	0	0	C	0	19
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0	19:
	07950 OTHER NON-REIMBURSEABLE COST CENTER	0	0	C	0	19
	07951 OTHER NONREI MBURSABLE	0	0	0	0	194
4. 01 0. 00	Cross Foot Adjustments				1	200

Health Fir	nancial Systems S	T. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 2:	
	Cost Center Description		SOCI AL SERVI CE				
		RECORDS &		ANESTHETI STS			
		LI BRARY	(TIME SPENT)	(ASSI GNED	PROGRAM EMS		
		(GROSS REVE		TIME)	(ASSI GNED		
		NUE)			TIME)		
		16.00	17.00	19.00	23.00		
202.00	Cost to be allocated (per Wkst. B, Part I)	3, 176, 809	0		0 402, 230		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.003014	0. 000000	0.00000	0 297.507396		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	97, 570	0		0 21, 020		204.00
205.00	Unit cost multiplier (Wkst. B, Part)	0. 000093	0. 000000	0. 00000	0 15.547337		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000		207.00

COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Pre 11/25/2020 2:	pared 58 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
I	NPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00 0	03000 ADULTS & PEDIATRICS	38, 219, 952		38, 219, 95	20, 542	38, 240, 494] 30. C
31.00 0	03100 INTENSIVE CARE UNIT	8, 304, 562		8, 304, 56	9, 029	8, 313, 591	31.0
41.00 0	04100 SUBPROVIDER - IRF	5, 151, 834		5, 151, 83	34 0	5, 151, 834	41. C
43.00 0	04300 NURSERY	2, 298, 802		2, 298, 80	02 0	2, 298, 802	43. C
	NCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	24, 636, 490		24, 636, 49	4, 138	24, 640, 628	50.0
	05100 RECOVERY ROOM	3, 836, 811		3, 836, 81	1 0	3, 836, 811	51.0
	05200 DELIVERY ROOM & LABOR ROOM	2, 149, 089		2, 149, 08	39 0	2, 149, 089	52.0
	05300 ANESTHESI OLOGY	745, 350		745, 35		745, 350	
	05400 RADI OLOGY-DI AGNOSTI C	10, 032, 515		10, 032, 51		10, 043, 789	
	03630 ULTRA SOUND	2, 125, 544		2, 125, 54		2, 125, 544	
	05600 RADI OI SOTOPE	2, 568, 573		2, 568, 57		2, 568, 573	
	05700 CT SCAN	3, 444, 431		3, 444, 43		3, 444, 431	
	05900 CARDI AC CATHETERI ZATI ON	6, 859, 690		6, 859, 69		6, 866, 177	
	06000 LABORATORY	12, 881, 314		12, 881, 31		12, 916, 151	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 730, 080		1, 730, 08		1, 730, 080	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	_		0 0	0	
	06500 RESPI RATORY THERAPY	4, 029, 897	0	4, 029, 89		4, 030, 381	
	06600 PHYSI CAL THERAPY	4, 904, 830		.,		4, 904, 830	
	06700 OCCUPATI ONAL THERAPY	1, 293, 953	0	1, 293, 95		1, 293, 953	
	06800 SPEECH PATHOLOGY	545, 551	0	545, 55		545, 551	
	07000 ELECTROENCEPHALOGRAPHY	2, 227, 801		2, 227, 80		2, 230, 599	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	10, 759, 275		10, 759, 27		10, 759, 275	
	07200 IMPL. DEV. CHARGED TO PATIENTS	17, 690, 717		17, 690, 7		17, 690, 717	
	7300 DRUGS CHARGED TO PATIENTS	20, 304, 662		20, 304, 66		20, 304, 662	
	07400 RENAL DIALYSIS	1, 029, 037		1, 029, 03		1,029,037	
)7697 CARDI AC REHABI LI TATI ON)7698 HYPERBARI C OXYGEN THERAPY	1, 580, 414		1, 580, 41		1, 580, 414	
	07699 LI THOTRI PSY	0			0 0	0	
	DUTPATIENT SERVICE COST CENTERS	0		l	0 0	0	1 /0.9
	09000 CLINIC	7, 455, 688		7, 455, 68	38 37, 993	7, 493, 681	90.0
	09100 EMERGENCY	10, 852, 690		10, 852, 69		10, 852, 690	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 746, 563		4, 746, 56		4, 746, 563	
	THER REIMBURSABLE COST CENTERS	-, 740, 303	<u> </u>	-, 740, 50		+, /40, 303	, 2. (
	0100 HOME HEALTH AGENCY	3, 960, 319		3, 960, 3	9	3, 960, 319	101 (
00.00	Subtotal (see instructions)	216, 366, 434	0			216, 494, 016	
201.00	Less Observation Beds	4, 746, 563	-	4, 746, 56		4, 746, 563	
202.00	Total (see instructions)	211, 619, 871	0			211, 747, 453	

In Lieu of Form CMS-2552-10

Health Financial Systems	SI. MARY MEDICAL	_ CENTER, INC.		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0034	Peri od:	Worksheet C	
				From 07/01/2019	Part I	
				To 06/30/2020	Date/Time Pre 11/25/2020 2:	pared:
						<u>58 pm</u>
			XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	60, 944, 567		60, 944, 56	57		30.00
31.00 03100 I NTENSI VE CARE UNI T	13, 231, 282		13, 231, 28			31.00
41. 00 04100 SUBPROVIDER - IRF	7, 595, 715		7, 595, 71			41.00
43. 00 04300 NURSERY	4, 038, 816		4, 038, 81			43.00
	4,030,010		4, 030, 01	0		43.00
ANCI LLARY SERVI CE COST CENTERS	40, 700, 070	00 2/2 100	101 070 17	0 202404	0,00000	
50. 00 05000 OPERATING ROOM	40, 709, 070	80, 363, 108				
51.00 05100 RECOVERY ROOM	4, 784, 466	10, 110, 700			0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 823, 209	959, 000			0.000000	
53. 00 05300 ANESTHESI OLOGY	8, 130, 154	16, 113, 601	24, 243, 75	0. 030744	0.00000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	12, 408, 566	74, 861, 417	87, 269, 98	0. 114960	0.00000	54.00
54.01 03630 ULTRA SOUND	3, 459, 481	17, 497, 449	20, 956, 93	0. 101424	0.00000	54.01
56. 00 05600 RADI 0I SOTOPE	2, 796, 812	15, 221, 345		0. 142555	0.000000	56.00
57. 00 05700 CT SCAN	21, 503, 978	54, 424, 851			0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	30, 596, 949	61, 019, 915			0. 000000	
60. 00 06000 LABORATORY	39, 466, 545	88, 232, 320			0.000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	3, 508, 059	2, 095, 045			0.00000	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	18, 678, 345	1, 835, 726			0.000000	
66. 00 06600 PHYSI CAL THERAPY	6, 269, 243	10, 140, 462			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	4, 909, 231	2, 225, 715			0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	963, 782	380, 933	1, 344, 71	5 0.405700	0.00000	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	4, 207, 224	17, 888, 498			0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 694, 793	14, 850, 587	26, 545, 38	0. 405316	0.000000	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	19, 394, 383	16, 300, 971			0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	52, 238, 494	58,004,464			0. 000000	
74. 00 07400 RENAL DI ALYSI S	3, 790, 508	198, 228			0. 000000	
74. 00 107400 REINAL DIALISIS 76. 97 107697 CARDIAC REHABILITATION						
	370, 636	1, 688, 481			0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0. 000000	0.00000	
76. 99 07699 LI THOTRI PSY	0	0		0 0.000000	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS			1	1		
90. 00 09000 CLINIC	807, 119				0.000000	
91. 00 09100 EMERGENCY	29, 878, 918	65, 660, 251			0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 479, 772	11, 744, 041	14, 223, 81	3 0. 333705	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	4, 777, 469	4, 777, 46	.9		101.00
200.00 Subtotal (see instructions)	411, 680, 117	642, 331, 324	1,054,011,44	1		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	411, 680, 117	642, 331, 324	1, 054, 011, 44	1		202.00
	1 11,000,117	512,001,024	1 ., 00 ., 0, 4-		1	1-02.00

	ATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0034	Peri od: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prep 11/25/2020 2:55	ared:
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
41.00	04100 SUBPROVIDER - IRF					41.00
43.00	04300 NURSERY					43.00
	ANCI LLARY SERVICE COST CENTERS	· · · · · ·				
50.00	05000 OPERATING ROOM	0. 203520				50.00
51.00	05100 RECOVERY ROOM	0. 257588				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 568210				52.00
53.00	05300 ANESTHESI OLOGY	0. 030744				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 115089				54.00
54.01	03630 ULTRA SOUND	0. 101424				54.01
56.00	05600 RADI OI SOTOPE	0. 142555				56.00
57.00	05700 CT SCAN	0.045364				57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0.074944				59.00
60.00	06000 LABORATORY	0. 101145				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 308772				62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.30
65.00	06500 RESPI RATORY THERAPY	0. 196469				65.00
66.00	06600 PHYSI CAL THERAPY	0. 298898				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0, 181354				67.00
68.00	06800 SPEECH PATHOLOGY	0. 405700				68.00
	07000 ELECTROENCEPHALOGRAPHY	0. 100952				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 405316				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 495603				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 184181				73.00
	07400 RENAL DI ALYSI S	0. 257986				74.00
	07697 CARDI AC REHABI LI TATI ON	0. 767520				76.97
	07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76.98
	07699 LI THOTRI PSY	0. 000000				76.99
/0. //	OUTPATIENT SERVICE COST CENTERS	0.000000				/0. //
90, 00	09000 CLINIC	0. 452958				90.00
	09100 EMERGENCY	0. 113594				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 333705				92.00
72.00	OTHER REIMBURSABLE COST CENTERS	0.000700				72.00
101 00	10100 HOME HEALTH AGENCY				1	101.00
200.00						200.00
200.00						200.00
201.00						202.00
202.00		1			2	.02.00

OMPUTATION OF RATIO OF COSTS TO CHARGES			Provider C	CN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Pre 11/25/2020 2:	pared 58 pm
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
IN	IPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDI ATRI CS	38, 219, 952		38, 219, 95	20, 542	38, 240, 494	1 30. C
	100 I NTENSI VE CARE UNI T	8, 304, 562		8, 304, 56		8, 313, 591	
1.00 04	100 SUBPROVI DER – I RF	5, 151, 834		5, 151, 83		5, 151, 834	
	300 NURSERY	2, 298, 802		2, 298, 80		2, 298, 802	
AN	ICI LLARY SERVI CE COST CENTERS						1
	000 OPERATING ROOM	24, 636, 490		24, 636, 49	4, 138	24, 640, 628	50.0
	100 RECOVERY ROOM	3, 836, 811		3, 836, 81	1 0	3, 836, 811	51.0
2.00 05	200 DELIVERY ROOM & LABOR ROOM	2, 149, 089		2, 149, 08	9 0	2, 149, 089	52.0
3.00 05	300 ANESTHESI OLOGY	745, 350		745, 35	0 0	745, 350	53.0
4.00 05	400 RADI OLOGY-DI AGNOSTI C	10, 032, 515		10, 032, 51	5 11, 274	10, 043, 789	54.0
4.01 03	630 ULTRA SOUND	2, 125, 544		2, 125, 54	4 0	2, 125, 544	54.0
	600 RADI OI SOTOPE	2, 568, 573		2, 568, 57	3 0	2, 568, 573	56. (
	5700 CT SCAN	3, 444, 431		3, 444, 43	1 0	3, 444, 431	57.0
	900 CARDI AC CATHETERI ZATI ON	6, 859, 690		6, 859, 69	6, 487	6, 866, 177	59.0
	000 LABORATORY	12, 881, 314		12, 881, 31		12, 916, 151	
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 730, 080		1, 730, 08		1, 730, 080	
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	62.
	500 RESPI RATORY THERAPY	4, 029, 897	0	4, 029, 89		4, 030, 381	
	600 PHYSI CAL THERAPY	4, 904, 830	0	4, 904, 83		4, 904, 830	
	700 OCCUPATI ONAL THERAPY	1, 293, 953	0	1, 293, 95		1, 293, 953	
	800 SPEECH PATHOLOGY	545, 551	0	545, 55		545, 551	
	000 ELECTROENCEPHALOGRAPHY	2, 227, 801		2, 227, 80		2, 230, 599	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 759, 275		10, 759, 27		10, 759, 275	
	200 IMPL. DEV. CHARGED TO PATIENTS	17, 690, 717		17, 690, 71		17, 690, 717	
	300 DRUGS CHARGED TO PATIENTS	20, 304, 662		20, 304, 66		20, 304, 662	
	400 RENAL DIALYSIS	1, 029, 037		1, 029, 03		1, 029, 037	
	697 CARDIAC REHABILITATION	1, 580, 414		1, 580, 41		1, 580, 414	
	698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	
		0			0 0	0	76. 9
	ITPATIENT SERVICE COST CENTERS	7 455 400		7 455 46	0 07 000	7 400 404	0.0
		7, 455, 688		7, 455, 68		7, 493, 681	
	2100 EMERGENCY	10, 852, 690		10, 852, 69		10, 852, 690	
	0200 OBSERVATION BEDS (NON-DISTINCT PART	4, 746, 563		4, 746, 56	03	4, 746, 563	92. (
	HER REIMBURSABLE COST CENTERS	2 0/0 210		2 040 21	0	2 0/0 210	101
		3, 960, 319	0	3, 960, 31		3, 960, 319	
00. 00 01. 00	Subtotal (see instructions) Less Observation Beds	216, 366, 434 4, 746, 563	0	216, 366, 43 4, 746, 56		216, 494, 016 4, 746, 563	

In Lieu of Form CMS-2552-10

	ATION OF RATIO OF COSTS TO CHARGES	ST. WART MEDICAL	Provider C		Period: From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 2:	pared:
				e XIX	Hospi tal	PPS	
	Cost Center Description	I npati ent	<u>Charges</u> Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					-	
	03000 ADULTS & PEDIATRICS	60, 944, 567		60, 944, 56	57		30.00
	03100 INTENSIVE CARE UNIT	13, 231, 282		13, 231, 28	32		31.00
41.00	04100 SUBPROVI DER – I RF	7, 595, 715		7, 595, 71			41.00
43.00	04300 NURSERY	4, 038, 816		4, 038, 81	6		43.00
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			_		
	05000 OPERATING ROOM	40, 709, 070	80, 363, 108				•
	05100 RECOVERY ROOM	4, 784, 466	10, 110, 700				•
	05200 DELIVERY ROOM & LABOR ROOM	2, 823, 209	959, 000				•
53.00	05300 ANESTHESI OLOGY	8, 130, 154	16, 113, 601				•
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 408, 566	74, 861, 417				•
	03630 ULTRA SOUND	3, 459, 481	17, 497, 449				
	05600 RADI OI SOTOPE	2, 796, 812	15, 221, 345		0. 142555	0. 000000	•
57.00	05700 CT SCAN	21, 503, 978	54, 424, 851			0. 000000	•
59.00	05900 CARDI AC CATHETERI ZATI ON	30, 596, 949	61, 019, 915	91, 616, 86	0. 074874	0. 000000	59.00
60.00	06000 LABORATORY	39, 466, 545	88, 232, 320	127, 698, 86	0. 100873	0. 000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	3, 508, 059	2, 095, 045	5, 603, 10		0. 000000	•
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0. 000000		
	06500 RESPI RATORY THERAPY	18, 678, 345	1, 835, 726				•
66.00	06600 PHYSI CAL THERAPY	6, 269, 243	10, 140, 462				•
67.00	06700 OCCUPATI ONAL THERAPY	4, 909, 231	2, 225, 715			0. 000000	67.00
68.00	06800 SPEECH PATHOLOGY	963, 782	380, 933			0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	4, 207, 224	17, 888, 498				
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 694, 793	14, 850, 587				
	07200 IMPL. DEV. CHARGED TO PATIENTS	19, 394, 383	16, 300, 971				
	07300 DRUGS CHARGED TO PATIENTS	52, 238, 494	58,004,464			0.000000	•
	07400 RENAL DI ALYSI S	3, 790, 508	198, 228				
	07697 CARDI AC REHABI LI TATI ON	370, 636	1, 688, 481	2, 059, 11			•
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.000000		•
76.99	07699 LI THOTRI PSY	0	0		0 0.00000	0.00000	76.99
	OUTPATIENT SERVICE COST CENTERS	I		1	-		
	09000 CLI NI C	807, 119	15, 736, 747				
	09100 EMERGENCY	29, 878, 918	65, 660, 251	95, 539, 16			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 479, 772	11, 744, 041	14, 223, 81	3 0. 333705	0.000000	92.00
404 65	OTHER REIMBURSABLE COST CENTERS		4 777 440	4 777 4			101 02
	10100 HOME HEALTH AGENCY	0	4, 777, 469				101.00
200.00		411, 680, 117	042, 331, 324	1, 054, 011, 44	1		200.00
201.00		411 600 117	(10 001 004	1 054 011 4	1		201.00
202.00	Total (see instructions)	411, 680, 117	042, 331, 324	1, 054, 011, 44	+1	I	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Dravidar CCN, 1E 0024			
		Provider CCN: 15-0034	Period: From 07/01/2019	Worksheet C Part I	
			To 06/30/2020	Date/Time Pre 11/25/2020 2:	epared:
		Title XIX	Hospi tal	PPS	Jo pill
Cost Center Description	PPS Inpatient	Писили	nospi tui	110	
	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. 203520				50.00
51.00 05100 RECOVERY ROOM	0. 257588				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 568210				52.00
53. 00 05300 ANESTHESI OLOGY	0. 030744				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 115089				54.00
54. 01 03630 ULTRA SOUND	0. 101424				54.01
56. 00 05600 RADI 0I SOTOPE	0. 142555				56.00
57.00 05700 CT SCAN	0. 045364				57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 074944				59.00
50. 00 06000 LABORATORY	0. 101145				60.00
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 308772				62.00
52. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.30
55. 00 06500 RESPI RATORY THERAPY	0. 196469				65.00
56. 00 06600 PHYSI CAL THERAPY	0. 298898				66.00
57.00 06700 OCCUPATI ONAL THERAPY	0. 181354				67.00
58. 00 06800 SPEECH PATHOLOGY	0. 405700				68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 100952				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 405316				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 495603				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 184181				73.00
74. 00 07400 RENAL DI ALYSI S	0. 257986				74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 767520				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76.98
76. 99 07699 LI THOTRI PSY	0. 000000				76.99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 452958				90.00
91. 00 09100 EMERGENCY	0. 113594				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 333705				92.00
OTHER REIMBURSABLE COST CENTERS					1
101.00 10100 HOME HEALTH AGENCY					101.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C	CN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part II Date/Time Pre 11/25/2020 2:	pared: 58 pm
		Ti tl	e XIX	Hospi tal	PPS	•
Cost Center Description	Total Cost	Capital Cost	Operating Co	st Capital	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capit	al Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	24, 636, 490	1, 544, 584	23, 091, 9	0 0	0	50.0
1. 00 05100 RECOVERY ROOM	3, 836, 811	289, 847	3, 546, 9	64 0	0	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	2, 149, 089	200, 781	1, 948, 3	0 80	0	52.0
3. 00 05300 ANESTHESI OLOGY	745, 350	24, 221	721, 1	29 0	0	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 032, 515	790, 332	9, 242, 1	83 0	0	54.0
4. 01 03630 ULTRA SOUND	2, 125, 544	132, 356	1, 993, 1	88 0	0	54.0
6. 00 05600 RADI 0I SOTOPE	2, 568, 573	250, 051	2, 318, 5	22 0	0	56.0
7. 00 05700 CT SCAN	3, 444, 431	167,076	3, 277, 3	55 0	0	57.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	6, 859, 690				0	59.0
0. 00 06000 LABORATORY	12, 881, 314				0	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 730, 080				0	
2. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	62.3
5. 00 06500 RESPI RATORY THERAPY	4, 029, 897	179, 485	3, 850, 4	-	0	
6. 00 06600 PHYSI CAL THERAPY	4, 904, 830				0	66.0
57. 00 06700 OCCUPATI ONAL THERAPY	1, 293, 953				0	67.0
8. 00 06800 SPEECH PATHOLOGY	545, 551				0	68.0
0. 00 07000 ELECTROENCEPHALOGRAPHY	2, 227, 801				0	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 759, 275				0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 690, 717				0	
3. 00 07300 DRUGS CHARGED TO PATIENTS					0	73.0
	20, 304, 662				0	
4. 00 07400 RENAL DIALYSIS	1,029,037				0	
6. 97 07697 CARDI AC REHABI LI TATI ON	1, 580, 414				0	
6. 98 07698 HYPERBARI C OXYGEN THERAPY	0	-		0 0	0	76.9
6. 99 07699 LI THOTRI PSY	0	C)	0 0	0	76.9
OUTPATIENT SERVICE COST CENTERS	7 155 100			a.=a		
0.00 09000 CLINIC	7, 455, 688				0	
1.00 09100 EMERGENCY	10, 852, 690				0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 746, 563	526, 584	4, 219, 9	79 0	0	92.0
OTHER REIMBURSABLE COST CENTERS				1		
01.00 10100 HOME HEALTH AGENCY	3, 960, 319					101.0
00.00 Subtotal (sum of lines 50 thru 199)	162, 391, 284					200. 0
201.00 Less Observation Beds	4, 746, 563					201.0
202.00 Total (line 200 minus line 201)	157, 644, 721	8, 539, 816	149, 104, 9	05 0	0	202.0

leal th Financial Systems CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE I	ST. MARY MEDICAL RATIOS NET OF		CN: 15-0034	Peri od:	u of Form CMS- Worksheet C	2002
REDUCTIONS FOR MEDICAID ONLY				From 07/01/2019	Part II	
				To 06/30/2020	Date/Time Pre 11/25/2020 2:	<pre>>pared: 58 nm</pre>
		Titl	e XIX	Hospi tal	PPS	<u>50 pii</u>
Cost Center Description	Cost Net of	Total Charges				
·		(Worksheet C,				
	Operating Cost	Part I, columr	Ratio (col.	6		
	Reducti on	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	24, 636, 490	121, 072, 178	0. 2034	86		50.0
51.00 05100 RECOVERY ROOM	3, 836, 811	14, 895, 166	0. 2575	88		51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 149, 089	3, 782, 209	0. 5682	10		52.0
53. 00 05300 ANESTHESI OLOGY	745, 350	24, 243, 755	0. 0307	44		53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 032, 515	87, 269, 983	0. 1149	60		54.0
54. 01 03630 ULTRA SOUND	2, 125, 544	20, 956, 930	0. 1014	24		54.0
56. 00 05600 RADI OI SOTOPE	2, 568, 573	18, 018, 157	0. 1425	55		56.0
57.00 05700 CT SCAN	3, 444, 431	75, 928, 829				57.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	6, 859, 690	91, 616, 864				59.0
0. 00 06000 LABORATORY	12, 881, 314					60.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 730, 080	5, 603, 104				62.0
2. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0,000,101				62.3
5. 00 06500 RESPIRATORY THERAPY	4, 029, 897	20, 514, 071				65.0
66.00 06600 PHYSI CAL THERAPY	4, 904, 830					66.
57. 00 06700 OCCUPATI ONAL THERAPY	1, 293, 953	7, 134, 946				67.0
58. 00 06800 SPEECH PATHOLOGY	545, 551	1, 344, 715				68.
0.00 07000 ELECTROENCEPHALOGRAPHY	2, 227, 801	22, 095, 722				70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 759, 275					71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 690, 717	35, 695, 354				72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	20, 304, 662	110, 242, 958				73.0
						74. (
	1,029,037	3, 988, 736				
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 580, 414	2, 059, 117				76.
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C				76.
76. 99 07699 LI THOTRI PSY	0	0	0.0000	00		76.
	7 455 (00	1/ 540 0//	0.450(()		
00.00 09000 CLINIC	7, 455, 688					90.0
11.00 09100 EMERGENCY	10, 852, 690					91.0
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 746, 563	14, 223, 813	0. 3337	05		92. (
OTHER REIMBURSABLE COST CENTERS	2.0(0.210		0.0000	50		101
01.00 10100 HOME HEALTH AGENCY	3, 960, 319			50		101.
200.00 Subtotal (sum of lines 50 thru 199)	162, 391, 284					200.
201.00 Less Observation Beds	4, 746, 563	0				201. (
202.00 Total (line 200 minus line 201)	157, 644, 721	968, 201, 061				202.

Health Financial Systems	ST. MARY MEDICA	CENTER, INC.		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPITAL COSTS	Provider C		Period: From 07/01/2019 Fo 06/30/2020		epared:
·		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost (from Wkst. B,	Adjustment	Capital Related Cost	Days	3 / col. 4)	
	Part II, col.		(col, 1 - col)			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTER	RS		-			
30. 00 ADULTS & PEDI ATRI CS	4, 242, 411		4, 242, 41			30.00
31.00 INTENSIVE CARE UNIT	618, 798		618, 798			
41.00 SUBPROVIDER – IRF	513, 250		513, 250			
43.00 NURSERY	214, 876		214, 876			43.00
200.00 Total (lines 30 through 199)	5, 589, 335		5, 589, 33	5 56, 372		200.00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col. 6)				
	6.00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTER		7.00	1			
30. 00 ADULTS & PEDI ATRI CS	16, 879	1, 633, 887	1			30.00
31.00 INTENSIVE CARE UNIT	1, 707					31.00
41.00 SUBPROVIDER - IRF	3, 787					41.00
43.00 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	22, 373	2, 163, 944	t			200.00

Health Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0034	Peri od:	Worksheet D	
				From 07/01/2019	Part II	norod.
				To 06/30/2020	Date/Time Pre 11/25/2020 2:	
·		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		1	1			
50. 00 05000 OPERATING ROOM	1, 544, 584					
51.00 05100 RECOVERY ROOM	289, 847					
52.00 05200 DELIVERY ROOM & LABOR ROOM	200, 781					
53. 00 05300 ANESTHESI OLOGY	24, 221					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	790, 332					
54. 01 03630 ULTRA SOUND	132, 356					
56. 00 05600 RADI OI SOTOPE	250, 051					
57. 00 05700 CT SCAN	167,076					
59. 00 05900 CARDI AC CATHETERI ZATI ON	483, 851					
	576, 026					
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	46, 763					
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	-	010000		0	
65. 00 06500 RESPI RATORY THERAPY	179, 485					
66.00 06600 PHYSI CAL THERAPY	710, 568					
67. 00 06700 OCCUPATI ONAL THERAPY	39, 266					
68. 00 06800 SPEECH PATHOLOGY	12, 227					
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	155, 900					
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	113, 949 186, 192					
72.00 07200 TMPL. DEV. CHARGED TO PATTENTS 73.00 07300 DRUGS CHARGED TO PATTENTS	298, 602					
73. 00 07300 DR0GS CHARGED TO PATTENTS 74. 00 07400 RENAL DIALYSIS	298, 602					
76. 97 07697 CARDI AC REHABI LI TATI ON	323, 731				2, 173	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	323, 731					1
76. 99 07699 LI THOTRI PSY					0	76.99
OUTPATIENT SERVICE COST CENTERS	0	1 0	0.0000		0	10.77
90. 00 09000 CLINIC	1, 111, 163	16, 543, 866	0.0671	232, 069	15, 587	90.00
91. 00 09100 EMERGENCY	868, 449					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	526, 584					
200.00 Total (lines 50 through 199)	9, 037, 298			132, 338, 689		
	1 7,007,270	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I			1_200.00

Health Financial Systems	ST. MARY MEDICAL	_ CENTER, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT	HER PASS THROUGH COST	S Provider C	1	Period: From 07/01/2019 Fo 06/30/2020		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	14	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF	0	0		44, 031 21, 421	0 0 0	31.00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0		0 0 0 0 65, 452	0	
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	0	44, 031 21, 421 0	5, 13 5, 99	7 4. 17 1 0. 00	1, 707 3, 787	31.00 41.00
43. 00 04300 NURSERY		0	1, 41			
200.00 Total (Lines 30 through 199) Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	65, 452	56, 37	2	22, 313	200.00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	16, 879 7, 118 0 23, 997					30. 00 31. 00 41. 00 43. 00 200. 00

Health Financial Systems	ST. MARY MEDICA	_ CENTER, INC.		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS				Period: From 07/01/2019 To 06/30/2020		pared: 58 pm
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS			_			
50.00 05000 OPERATING ROOM	0	C		0 0	42, 841	50.00
51.00 05100 RECOVERY ROOM	0	C		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
54.01 03630 ULTRA SOUND	0	C		0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0	C		0 0	0	56.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	l o	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60,00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	23, 801	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
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 I MPL. 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 DI ALYSI S	0	0		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS		<u> </u>	1	<u> </u>	. <u> </u>	
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	270, 136	
92. 00 09200 OBSERVATION BEDS (NON-DI STINCT PART	0	Ŭ		0		92.00
200.00 Total (lines 50 through 199)	0	0		0 0		
			1	-1 0	0.2,211	

Health Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2019 To 06/30/2020		narod
				10 06/30/2020	11/25/2020 2:	
		Title	XVIII	Hospi tal	PPS	<u>oo piii</u>
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	(00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		42, 841	42, 84	1 121, 072, 178	0. 000354	50.00
51. 00 05100 RECOVERY ROOM	0	42,841	42,84	0 14, 895, 166		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 14, 895, 186		
53. 00 05300 ANESTHESI OLOGY	0	0		0 24, 243, 755		
54. 00 05400 RADI OLOGY DI AGNOSTI C	0	0		0 24, 243, 755		
54. 01 03630 ULTRA SOUND	0	0		0 20, 956, 930		
56. 00 05600 RADI OI SOTOPE	0	0		0 18, 018, 157		
57. 00 05700 CT SCAN	0	0		0 75, 928, 829		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 91, 616, 864		
60. 00 06000 LABORATORY	0			0 127, 698, 865		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 5, 603, 104		
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0,000,101	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	23, 801	23, 80	20, 514, 071	0.001160	
66. 00 06600 PHYSI CAL THERAPY	0	0	,	0 16, 409, 705	0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 7, 134, 946	0.000000	
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 344, 715	0.000000	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 22, 095, 722	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0 26, 545, 380	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 35, 695, 354	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 110, 242, 958	0.00000	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 3, 988, 736	0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 2, 059, 117	0.00000	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0.00000	
76. 99 07699 LI THOTRI PSY	0	0		0 0	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0			0 16, 543, 866		
91.00 09100 EMERGENCY	0	270, 136				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 463				
200.00 Total (lines 50 through 199)	0	342, 241	342, 24	963, 423, 592		200.00

Health Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PASS	Provider CO		Period: From 07/01/2019 To 06/30/2020	11/25/2020 2:	
		Title XVIII		Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000354	15, 784, 356			7, 190	50.00
51.00 05100 RECOVERY ROOM	0. 000000	1, 948, 288		0 2, 405, 036	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	8, 938		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	3, 368, 739		0 4, 297, 055	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	4, 932, 467		0 20, 077, 010	0	54.00
54.01 03630 ULTRA SOUND	0. 000000	1, 419, 535		0 4, 278, 434	0	54.01
56. 00 05600 RADI 0I SOTOPE	0. 000000	1, 262, 339		0 5, 396, 703	0	56.00
57.00 05700 CT SCAN	0. 000000	9, 051, 739		0 15, 205, 316	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	13, 577, 621		0 23, 718, 177	0	59.00
60. 00 06000 LABORATORY	0. 000000	16, 165, 533		0 8, 838, 359	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	1, 369, 753		0 605, 827	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 001160	8, 139, 093	9, 44	41 506, 910	588	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 672, 665		0 13, 029	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 000000	944, 775		0 2, 574	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	256, 980		0 4, 475	0	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	2, 195, 919		0 5, 822, 496	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	4, 956, 486		0 4, 705, 487	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	9, 339, 590		0 5, 364, 106	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	19, 859, 912		0 22, 406, 127	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	1, 637, 620		0 177, 974	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	162, 777		0 733, 602	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0. 000000	232, 069		0 6, 032, 802	0	90.00
91. 00 09100 EMERGENCY	0. 002827	12, 666, 373	35, 80	11, 351, 398	32, 090	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000384	1, 385, 122		32 2, 669, 646		
						200.00

Health Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0034	Period: From 07/01/2019 To 06/30/2020		pared: 58 pm
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	-					
50. 00 05000 OPERATI NG ROOM	0. 203486			0 267, 368		
51.00 05100 RECOVERY ROOM	0. 257588			0 0	619, 508	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 568210			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 030744	4, 297, 055		0 0	132, 109	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 114960			0 0	2, 308, 053	54.00
54.01 03630 ULTRA SOUND	0. 101424	4, 278, 434		0 0	433, 936	54.01
56. 00 05600 RADI 0I SOTOPE	0. 142555	5, 396, 703		0 0	769, 327	56.00
57.00 05700 CT SCAN	0. 045364	15, 205, 316		0 0	689, 774	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 074874	23, 718, 177		0 0	1, 775, 875	59.00
60. 00 06000 LABORATORY	0. 100873	8, 838, 359		0 0	891, 552	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 308772	605, 827		0 0	187, 062	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 196446	506, 910		0 0	99, 580	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 298898	13, 029		0 0	3, 894	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 181354	2, 574		0 0	467	67.00
68.00 06800 SPEECH PATHOLOGY	0. 405700	4, 475		0 0	1, 816	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 100825	5, 822, 496		0 0	587, 053	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 405316	4, 705, 487		0 0	1, 907, 209	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 495603	5, 364, 106		0 0	2, 658, 467	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 184181			0 123, 222	4, 126, 783	73.00
74.00 07400 RENAL DIALYSIS	0. 257986			0 0	45, 915	•
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 767520			0 0	563,054	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0.000000			0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0.000000			0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS		-			-	
90. 00 09000 CLINIC	0. 450662	6, 032, 802		0 0	2, 718, 755	90.00
91.00 09100 EMERGENCY	0. 113594			0 0	1, 289, 451	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 333705			0 0	890, 874	
200.00 Subtotal (see instructions)		164, 922, 930		0 390, 590		
201.00 Less PBP Clinic Lab. Services-Program		,		0 0		201.00
Only Charges				-		
202.00 Net Charges (line 200 - line 201)		164, 922, 930		0 390, 590	26, 833, 393	202.00

		ST. MARY MEDICAL CENTER, INC.			In Lieu of Form CMS-2552		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Peri od: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Pr 11/25/2020 2	epared: :58 pm	
		Title	XVIII	Hospi tal	PPS	_	
	Cos	sts					
Cost Center Description	Cost	Cost					
	Reimbursed	Reimbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
	Ded. & Coins.	Ded. & Coins.					
	(see inst.)	(see inst.)	-				
	6.00	7.00				-	
ANCI LLARY SERVI CE COST CENTERS	-		1				
50. 00 05000 OPERATING ROOM	0					50.00	
51.00 05100 RECOVERY ROOM	0	0				51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00	
53. 00 05300 ANESTHESI OLOGY	0	0				53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00	
54.01 03630 ULTRA SOUND	0	0				54. O	
56. 00 05600 RADI 0I SOTOPE	0	0				56.00	
57.00 05700 CT SCAN	0	0				57.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00	
60. 00 06000 LABORATORY	0	0				60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30	
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0				66.0	
67.00 06700 OCCUPATI ONAL THERAPY	0	0)			67.0	
68.00 06800 SPEECH PATHOLOGY	0	0				68.00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)			71.0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1			72.0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	22, 695				73.0	
74. 00 07400 RENAL DIALYSIS	0	0	1			74.00	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	Ö	1			76.9	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	Ö				76.98	
76. 99 07699 LI THOTRI PSY	0	0				76.99	
OUTPATIENT SERVICE COST CENTERS			1			- /0. //	
90. 00 09000 CLINIC	0	0				90.00	
91. 00 09100 EMERGENCY	0					91.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92.00	
200.00 Subtotal (see instructions)	0	-				200.00	
201.00 Less PBP Clinic Lab. Services-Program		//, 101				200.00	
Only Charges	0					201.00	
202.00 Net Charges (line 200 - line 201)	0	77, 101				202.00	
202.00 [Net charges (The 200 - The 201)	1 0	//, 101	I			1202.00	

ealth Financial Systems S PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		_ CENTER, INC. Provider CCN: 15-0034		In Lieu of Form CMS- Period: Worksheet D		
THORTONIMENT OF THEATTENT ANOTELART SERVICE OATTA	E 00010		511. 15 0054	From 07/01/2019	Part II	
		Component	CCN: 15-T034	To 06/30/2020	Date/Time Pre 11/25/2020 2:	pared: 58 pm
		Title	XVIII	Subprovider -	PPS	00 pm
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,			(column 3 x	
	(from Wkst. B,	Part I, col.		I. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				-		
0.00 05000 OPERATING ROOM	1, 544, 584					
1.00 05100 RECOVERY ROOM	289, 847					
2.00 05200 DELIVERY ROOM & LABOR ROOM	200, 781				-	52.0
3. 00 05300 ANESTHESI OLOGY	24, 221				21	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	790, 332					54.0
4.01 03630 ULTRA SOUND	132, 356					
6. 00 05600 RADI OI SOTOPE	250, 051	18, 018, 157	0. 0138	78 19, 774	274	56. C
7.00 05700 CT SCAN	167, 076	75, 928, 829	0.00220	00 169, 246	372	57.C
9. 00 05900 CARDI AC CATHETERI ZATI ON	483, 851	91, 616, 864	0.0052	81 66, 311	350	59. C
0. 00 06000 LABORATORY	576, 026	127, 698, 865	0.0045	11 748, 676	3, 377	60. C
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	46, 763	5, 603, 104	0.0083	46 50, 794	424	62. C
2.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000	00 00	0	62.3
5. 00 06500 RESPI RATORY THERAPY	179, 485	20, 514, 071	0.00874	49 597, 600	5, 228	65. C
6. 00 06600 PHYSI CAL THERAPY	710, 568	16, 409, 705	0. 04330	02 1, 801, 318	78, 001	66.0
7.00 06700 OCCUPATI ONAL THERAPY	39, 266	7, 134, 946	0.00550	03 1, 843, 481	10, 145	67.0
8.00 06800 SPEECH PATHOLOGY	12, 227	1, 344, 715	0.0090	93 252, 328	2, 294	68.0
0. 00 07000 ELECTROENCEPHALOGRAPHY	155, 900	22, 095, 722	0.0070	56 0	0	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	113, 949	26, 545, 380	0.0042	93 409, 641	1, 759	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	186, 192	35, 695, 354	0.0052	16 7,447	39	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	298, 602	110, 242, 958	0.00270	09 1, 975, 250	5, 351	73.0
4. 00 07400 RENAL DIALYSIS	5, 294					74. (
6. 97 07697 CARDI AC REHABI LI TATI ON	323, 731					76.9
6. 98 07698 HYPERBARI C OXYGEN THERAPY	0			00 00	0	76.9
6. 99 07699 LI THOTRI PSY	0	0	0.0000	00 00	0	76.9
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	1, 111, 163	16, 543, 866	0.0671	65 19,042	1, 279	90.0
1.00 09100 EMERGENCY	868, 449					
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
00.00 Total (lines 50 through 199)	8, 510, 714			8, 721, 042		

Health Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	CN: 15-0034	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T034	From 07/01/2019 To 06/30/2020		narod
		component	CCN. 15-1054	10 00/30/2020	11/25/2020 2:	58 pm
		Title	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments	0.00	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS					40.044	50.00
50. 00 05000 OPERATING ROOM	0	0		0 0	42, 841	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
54. 01 03630 ULTRA SOUND	0	0		0 0	0	0.1.01
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	
57.00 05700 CT SCAN	0	C		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	07100
60. 00 06000 LABORATORY	0	C		0 0	0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	23, 801	•
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	1 2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C		0 0	0	101.70
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	1				1	
90. 00 09000 CLINIC	0	C		0 0	-	
91. 00 09100 EMERGENCY	0	C		0 0	270, 136	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
200.00 Total (lines 50 through 199)	0	0		0 0	336, 778	200.00

All Other Total Cost (sum of cols. 4) Total Cost (sum of cols. 4) Total Cost (sum of cols. 4) Total Charges Outpatient Cost (sum of cols. 2, 3, and 4) Ratio of Cols. (from Wkst. C, Part I, col. 8) Ratio of Cols. (see instruction 7) ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 0PERATI NG ROOM 0 42,841 42,841 121,072,178 0.000 51.00 05000 05000 0 0 0 0 14,895,166 0.000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 3,782,209 0.000	Prepared: 0 2:58 pm PS ost es col .
All Other Component CCN: 15-T034 To 06/30/2020 Date/Time 11/25/202 Title XVIII Subprovider - IRF P Cost Center Description All Other Medical Education Cost Total Cost (sum of cols. 4) Total Outpatient Cost (sum of cols. 2, 3, and 4) Total Charges (from Wkst. C, 8) Ratio of C to Charges (col. 5 ÷ cols. 2, 3, and 4) Ratio of C cols. 2, 3, and 4) ANCI LLARY SERVICE COST CENTERS 0 4.00 5.00 6.00 7.00 8.00 ANCI LLARY SERVICE COST CENTERS 0 42, 841 42, 841 121, 072, 178 0.00 0.00 0 0 14, 895, 166 0.00 51. 00 05200 DELIVERY ROOM 0 0 0 3, 782, 209 0.00	0 2:58 pm PS ost es col.
Cost Center Description All Other Medical Education Cost Total Cost (sum of cols. 4) Total Charges Outpatient Cost (sum of cols. 2, 3, and 4) Ratio of Cost (from Wkst. C, Part I, col. 8) Ratio of Cost (col. 5 ÷ 7) ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 0 0 42,841 121,072,178 0.000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 3,782,209 0.000	0 2:58 pm PS ost es col.
All Other Total Cost (sum of cols. 4) Total Cost (sum of cols. 4) Total Charges Outpatient Cost (sum of cols. 2, 3, and 4) Ratio of Cols. (from Wkst. C, Part I, col. 8) Ratio of Cols. (see instruction 7) ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 Subprovider - IRF 4.00 5.00 6.00 7.00 8.00 ANCI LLARY SERVICE COST CENTERS 0 42,841 42,841 121,072,178 0.000 51.00 05100 RECOVERY ROOM 52.00 0 0 0 0 0 3,782,209 0.000	ost es col.
Cost Center Description All Other Medical Education Cost Total Cost (sum of cols. 4) Total Cost Outpatient Cost (sum of cols. 2, 3, and 4) Total Charges (from Wkst. C, Part I, col. 8) Ratio of Cols. to Charge (col. 5 + 7) ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATI NG ROOM 51.00 0 42,841 42,841 121,072,178 0.000 51.00 05100 RECOVERY ROOM 0 0 0 0 0 3,782,209 0.000	es col.
Medical Education Cost (sum of cols. 1, 2, 3, and 4) Outpatient Cost (sum of cols. 2, 3, and 4) (from Wkst. C, Part I, col. 8) to Charg (col. 5 ÷ 7) 4.00 5.00 6.00 7.00 8.00 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATI NG ROOM 0 42,841 121,072,178 0.000 51.00 05100 RECOVERY ROOM 0 0 0 14,895,166 0.000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 3,782,209 0.000	es col.
Education Cost 1, 2, 3, and 4 Cost (sum of cols. 2, 3, and 4) Part I, col. 8 (col. 5 + 7) (see instruction ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATI NG ROOM 0 42,841 121,072,178 0.00 51.00 05100 RECOVERY ROOM 0 0 0 14,895,166 0.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 3,782,209 0.00	col .
ANCI LLARY SERVICE COST CENTERS 0 4.00 5.00 6.00 7.00 8.00 1.00 1.00 5.00 0.00 7.00 8.00 0.00 1.00 0.00 7.00 8.00 0.00 0.00 7.00 8.00 0.00 <	
ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATING ROOM 0 42,841 121,072,178 0.00 51.00 05100 RECOVERY ROOM 0 0 14,895,166 0.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 3,782,209 0.00	ns)
ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATI NG ROOM 0 42,841 42,841 121,072,178 0.00 51.00 05100 RECOVERY ROOM 0 0 0 14,895,166 0.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 3,782,209 0.00	ns)
ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATI NG ROOM 0 42,841 42,841 121,072,178 0.000 51.00 05100 RECOVERY ROOM 0 0 0 14,895,166 0.000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 3,782,209 0.000	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0 42, 841 121, 072, 178 0. 00 51. 00 05100 RECOVERY ROOM 0 0 0 14, 895, 166 0. 00 52. 00 05200 DELI VERY ROOM & LABOR 0 0 0 3, 782, 209 0. 00	
50.00 05000 OPERATI NG ROOM 0 42,841 42,841 121,072,178 0.00 51.00 05100 RECOVERY ROOM 0 0 0 14,895,166 0.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 3,782,209 0.00	
51.00 05100 RECOVERY ROOM 0 0 14, 895, 166 0.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 3, 782, 209 0.00	0354 50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 3, 782, 209 0. 00	
53. 00 05300 ANESTHESI OLOGY 0 0 24, 243, 755 0. 00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 87, 269, 983 0. 00	0000 54.00
54. 01 03630 ULTRA SOUND 0 0 20, 956, 930 0. 00	0000 54.01
56. 00 05600 RADI 0I SOTOPE 0 0 0 18, 018, 157 0. 00	0000 56.00
57. 00 05700 CT SCAN 0 0 0 75, 928, 829 0. 00	
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 91, 616, 864 0. 00	
60. 00 06000 LABORATORY 0 0 0 127, 698, 865 0. 00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 5,603,104 0.00	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0.00	
65. 00 06500 RESPI RATORY THERAPY 0 23, 801 23, 801 20, 514, 071 0. 00	
66. 00 06600 PHYSI CAL THERAPY 0 0 16, 409, 705 0. 00	
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 7, 134, 946 0. 00	
68. 00 06800 SPEECH PATHOLOGY 0 0 1, 344, 715 0. 00 70. 00 0 07000 ELECTROENCEPHALOGRAPHY 0 0 0 22, 095, 722 0. 00	
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 22, 095, 722 0. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 26, 545, 380 0. 00	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 35, 695, 354 0. 00	
72. 00 07200 TMPE. DEV. CHARGED TO PATIENTS 0 0 0 33, 053, 054, 0.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 110, 242, 958 0.00	
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 3, 988, 736 0. 00	
74. 00 07400 REIARE DIALISIS	
76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 0	
76. 99 076991LTHOTRIPSY 0 0 0 0 0 0	
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 0 0 16, 543, 866 0. 00	90.00
91. 00 09100 EMERGENCY 0 270, 136 270, 136 95, 539, 169 0. 00	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 14, 223, 813 0.00	0000 92.00
200.00 Total (Lines 50 through 199) 0 336, 778 336, 778 963, 423, 592	200.00

Health Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-0034	Peri od:	Worksheet D	
THROUGH COSTS		Composit	20N 15 T024	From 07/01/2019		
		Component (CCN: 15-T034	To 06/30/2020	Date/Time Pre 11/25/2020 2:	
		Title	XVIII	Subprovider -	PPS	<u>oo piii</u>
				I RF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0,000054	404,000		40	0	50.00
50. 00 05000 OPERATING ROOM	0.000354	136, 308		48 0		50.00
51.00 05100 RECOVERY ROOM	0. 000000	11, 954		0 0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	20, 614		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	194, 300		0 0	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000	43, 623		0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0. 000000	19, 774		0 0	0	56.00
57. 00 05700 CT SCAN	0. 000000	169, 246		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	66, 311		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	748, 676		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	50, 794		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 001160	597, 600		93 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 801, 318		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 843, 481		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	252, 328		0 0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	409, 641		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	7,447		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 975, 250		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	353, 335		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00 09000 CLI NI C	0. 000000	19, 042		0 0	-	90.00
91.00 09100 EMERGENCY	0. 002827	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)		8, 721, 042	7	41 0	0	200. 00

Health Financial Systems	ST. MARY MEDICAL	_ CENTER, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	TAL COSTS			Period: From 07/01/2019 Fo 06/30/2020	Date/Time Pre 11/25/2020 2:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 242, 411	0	4, 242, 41	1 43, 827	96.80	30.00
31.00 INTENSIVE CARE UNIT	618, 798		618, 79	5, 137	120.46	31.00
41.00 SUBPROVIDER - IRF	513, 250	0	513, 25	5, 991	85.67	41.00
43.00 NURSERY	214, 876		214, 87	5 1, 417	151.64	43.00
200.00 Total (lines 30 through 199)	5, 589, 335		5, 589, 33	5 56, 372		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 331	128, 841				30.00
31.00 INTENSIVE CARE UNIT	38	4, 577	7			31.00
41.00 SUBPROVIDER - IRF	0	c c				41.00
43.00 NURSERY	227	34, 422				43.00
200.00 Total (lines 30 through 199)	1, 596					200.00

Health Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0034	Peri od:	Worksheet D	
				From 07/01/2019		
				To 06/30/2020		pared:
		T: +1	e XIX	llooni tol	11/25/2020 2: PPS	58 pm
Cost Conton Deporintion	Capi tal	Total Charges		Hospital t Inpatient	Capital Costs	
Cost Center Description		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.		2)	. Charges		
	26)	0)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50. 00 05000 OPERATING ROOM	1, 544, 584	121, 072, 178	0. 01275	288, 828	3, 685	50.00
51. 00 05100 RECOVERY ROOM	289, 847					•
52.00 05200 DELIVERY ROOM & LABOR ROOM	200, 781					
53. 00 05300 ANESTHESI OLOGY	24, 221					•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	790, 332					
54. 01 03630 ULTRA SOUND	132, 356					
56. 00 05600 RADI OI SOTOPE	250, 051					
57. 00 05700 CT SCAN	167,076					
59. 00 05900 CARDI AC CATHETERI ZATI ON	483, 851					
60. 00 06000 LABORATORY	576, 026					
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	46, 763					
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0					•
65. 00 06500 RESPI RATORY THERAPY	179, 485	20, 514, 071			1, 690	•
66. 00 06600 PHYSI CAL THERAPY	710, 568	16, 409, 705	0. 04330			66,00
67.00 06700 OCCUPATI ONAL THERAPY	39, 266					
68.00 06800 SPEECH PATHOLOGY	12, 227					•
70.00 07000 ELECTROENCEPHALOGRAPHY	155, 900					•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	113, 949			157, 431	676	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	186, 192	35, 695, 354	0. 00521	6 52, 574	274	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	298, 602			1, 130, 139	3, 062	73.00
74.00 07400 RENAL DI ALYSI S	5, 294	3, 988, 736	0. 00132	31,639		
76. 97 07697 CARDI AC REHABILI TATI ON	323, 731	2,059,117	0. 15721	8 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0				0	76.98
76. 99 07699 LI THOTRI PSY	0	c	0.00000		0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	1, 111, 163	16, 543, 866	0.06716	5 1, 204	81	90.00
91. 00 09100 EMERGENCY	868, 449					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	526, 584					92.00
200.00 Total (lines 50 through 199)	9, 037, 298	963, 423, 592		3, 469, 622		200.00
						-

Health Financial Systems	ST. MARY MEDICAL	_ CENTER, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE (OTHER PASS THROUGH COS		-	Period: From 07/01/2019 Fo 06/30/2020		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTER	S		1			
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	000000000000000000000000000000000000000	0 0 0) 44, 031) 21, 421	0 0 0	31.00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	C		0 0 0 65, 452	0	
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY	0	44, 031 21, 421 0 0		7 4. 17 1 0. 00	38 0	31.00 41.00
200.00 Total (lines 30 through 199)		65, 452	56, 372	2	1, 596	200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
1NPATIENT ROUTINE SERVICE COST CENTER 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	5 1, 331 158 0 0 1, 489					30. 00 31. 00 41. 00 43. 00 200. 00

Health Financial Systems S	ST. MARY MEDICA	_ CENTER, INC.		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS				Period: From 07/01/2019 To 06/30/2020		pared: 58 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			_			
50.00 05000 OPERATING ROOM	0	C		0 0	42, 841	50.00
51.00 05100 RECOVERY ROOM	0	C		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
54.01 03630 ULTRA SOUND	0	C		0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0	C		0 0	0	56.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	l o	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	23, 801	
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	
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 CARDI AC REHABILI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	0 0	<u> </u>	/0. //
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	270, 136	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	Ŭ		õ		92.00
200.00 Total (lines 50 through 199)	0	0		0 0		
	1 0		Т	- -	1 012,241	200.00

Health Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2019		
				To 06/30/2020	Date/Time Pre 11/25/2020 2:	
			e XIX	Hospi tal	PPS	<u>50 piii</u>
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	- 1	1				
50.00 O5000 OPERATING ROOM	0	42, 841	42, 84			
51.00 05100 RECOVERY ROOM	0	0		0 14, 895, 166		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 782, 209		1
53. 00 05300 ANESTHESI OLOGY	0	0		0 24, 243, 755		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 87, 269, 983		1
54.01 03630 ULTRA SOUND	0	0		0 20, 956, 930		
56. 00 05600 RADI 0I SOTOPE	0	0		0 18, 018, 157		
57.00 05700 CT SCAN	0	0		0 75, 928, 829		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 91, 616, 864		
60. 00 06000 LABORATORY	0	0		0 127, 698, 865		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 5, 603, 104		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	23, 801	23, 80		0. 001160	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 16, 409, 705	0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 7, 134, 946	0.00000	
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 344, 715	0.00000	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 22, 095, 722	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 26, 545, 380	0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 35, 695, 354		1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 110, 242, 958		
74.00 07400 RENAL DI ALYSI S	0	0		0 3, 988, 736		1
76. 97 07697 CARDIAC REHABILITATION	0	0		0 2, 059, 117	0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0.00000	
76. 99 07699 LI THOTRI PSY	0	0		0 0	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS	1			a		
90. 00 09000 CLINIC	0			0 16, 543, 866		
91. 00 09100 EMERGENCY	0	270, 136				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 463				1
200.00 Total (lines 50 through 199)	0	342, 241	342, 24	963, 423, 592		200. 00

Health Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-0034	Period: From 07/01/2019 To 06/30/2020		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS					1	
50. 00 05000 OPERATI NG ROOM	0.000354	288, 828		02 0		
51.00 05100 RECOVERY ROOM	0. 000000	32, 486		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	91, 396		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	60, 446		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	80, 630		0 0	0	54.00
54.01 03630 ULTRA SOUND	0. 000000	40, 782		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	24, 937		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	187, 928		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	119, 072		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	563, 637		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	13, 995		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 001160	193, 187	2	24 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	39, 451		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	14, 639		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	29, 341		0 0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	7, 717		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	157, 431		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	52, 574		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 130, 139		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	31, 639		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	· ·			· ·	•	1
90. 00 09000 CLI NI C	0.000000	1, 204		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 002827	277, 662	7	85 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000384	30, 501		12 0	0	92.00
200.00 Total (lines 50 through 199)		3, 469, 622	1, 1:	23 0	0	200.00

Health Financial Systems ST. MARY MEDICAL CENTER, INC. In Lieu c						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Conception	CN: 15-0034 CCN: 15-T034	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part II Date/Time Pre	pared:
		Titl	e XIX	Subprovider - IRF	11/25/2020 2: PPS	<u>58 pili</u>
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ co	I. Charges	column 4)	
	Part II, col.	8)	2)	Ŭ		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	1, 544, 584	121, 072, 178	0. 0127	58 0	0	50.00
51.00 05100 RECOVERY ROOM	289, 847	14, 895, 166	0. 0194	59 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	200, 781	3, 782, 209	0. 0530	86 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	24, 221			99 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	790, 332	87, 269, 983	0.0090	56 0	0	54.00
54.01 03630 ULTRA SOUND	132, 356	20, 956, 930	0.0063	16 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	250, 051				0	56.00
57.00 05700 CT SCAN	167,076	75, 928, 829	0.0022	00 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	483, 851			81 0	0	59.00
60. 00 06000 LABORATORY	576,026			11 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	46, 763	5, 603, 104	0.0083	46 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			00 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	179, 485	20, 514, 071	0.0087	49 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	710, 568	16, 409, 705	0.0433	02 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	39, 266				0	67.00
68.00 06800 SPEECH PATHOLOGY	12, 227				0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	155, 900			56 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	113, 949	26, 545, 380	0.0042	93 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	186, 192			16 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	298, 602			09 0	0	73.00
74.00 07400 RENAL DIALYSIS	5, 294	3, 988, 736	0.0013	27 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	323, 731	2, 059, 117		18 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		1		0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0.0000	00 0	0	76.99
OUTPATIENT SERVICE COST CENTERS				1		1
90. 00 09000 CLINIC	1, 111, 163	16, 543, 866	0.0671	65 0	0	90.00
91.00 09100 EMERGENCY	868, 449				0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00 Total (lines 50 through 199)	8, 510, 714			0	0	200.00
				1		

Health Financial Systems ST. MARY MEDICAL CENTER, INC. In Lie						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	S Provider C	CN: 15-0034	Period: From 07/01/2019	Worksheet D Part IV	
		Component	CCN: 15-T034	To 06/30/2020	Date/Time Pre 11/25/2020 2:	
		Ti tl	e XIX	Subprovider - IRF	PPS	
Cost Center Description			Nursing Scho	ol Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	0	C		0 0	42, 841	50.00
51.00 05100 RECOVERY ROOM	0	C		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
54.01 03630 ULTRA SOUND	0	C		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	23, 801	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	C		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	C		0 0	0	90.00
91.00 09100 EMERGENCY	0	C		0 0	270, 136	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
200.00 Total (lines 50 through 199)	0	C		0 0	336, 778	200.00

Health Financial Systems	ST. MARY MEDICA	_ CENTER, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider CO		Period:	Worksheet D	
THROUGH COSTS		Component		From 07/01/2019 To 06/30/2020		norod.
		component (JUN. 15-1054	10 00/ 30/ 2020	11/25/2020 2:	
		Titl	e XIX	Subprovider -	PPS	
				I RF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	5.00	6.00	7.00	instructions) 8.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATI NG ROOM	0	42, 841	42, 84	1 121, 072, 178	0. 000354	50.00
51. 00 05100 RECOVERY ROOM	0	42, 041		14, 895, 166		1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		3, 782, 209		
53. 00 05300 ANESTHESI OLOGY	0	0				1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		87, 269, 983		
54. 01 03630 ULTRA SOUND	0	0		20, 956, 930		
56. 00 05600 RADI OI SOTOPE	0	0		18, 018, 157		
57. 00 05700 CT SCAN	0	0		75, 928, 829		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(91, 616, 864		
60. 00 06000 LABORATORY	0	0	(127, 698, 865	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(5, 603, 104	0.000000	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0 0	0. 000000	62.30
65. 00 06500 RESPI RATORY THERAPY	0	23, 801	23, 80	1 20, 514, 071	0. 001160	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(16, 409, 705	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	(7, 134, 946		
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 344, 715		1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(22, 095, 722		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		26, 545, 380	0.00000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		35, 695, 354		1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(110, 242, 958		
74.00 07400 RENAL DIALYSIS	0	0	(3, 988, 736		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(2, 059, 117	0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0.00000	1
76. 99 07699 LI THOTRI PSY	0	0	(0 0	0.00000	76.99
00000 CLINIC	0	0			0,000000	00.00
90. 00 109000 CLINIC 91. 00 109100 EMERGENCY	0	0		16, 543, 866		
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	270, 136 0		6 95, 539, 169 14, 223, 813		
200.00 Total (lines 50 through 199)		336, 778				200.00
	1 0	1 330,770	1 550,770	705, 425, 572	I	200.00

Health Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-0034	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2019		
		Component	CCN: 15-T034	To 06/30/2020	Date/Time Pre 11/25/2020 2:	pared: 58 nm
		Titl	e XIX	Subprovider -	PPS	<u>50 piii</u>
				I RF		
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			-		•	
50.00 O5000 OPERATI NG ROOM	0. 000354	0		0 0		50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0)	0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0)	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0)	0 0	0	54.00
54.01 03630 ULTRA SOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0)	0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0)	0 0	0	59.00
60.00 06000 LABORATORY	0. 000000	0		0 0	0	60,00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0)	0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0.001160	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0, 000000	0		0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0	0 0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	0			0 0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0			0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	-	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0				76.99
OUTPATIENT SERVICE COST CENTERS	0.000000	0	1	<u> </u>	<u>'</u>	70.77
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.00 09100 EMERGENCY	0. 000000	0				90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 002827	0				91.00
	0.000000	0			-	
200.00 Total (lines 50 through 199)	1	0	1	u u	'I U	200. 00

Health Financial Systems

ST.	MARY	MEDI CAL	CENTER,	INC.	

In Lieu of Form CMS-2552-10

	Financial Systems ST. MARY MEDICAL C		In Lie	u of Form CMS-2	
COMPUTA	TION OF INPATIENT OPERATING COST	Provider CCN: 15-0034	Period:	Worksheet D-1	
			From 07/01/2019 To 06/30/2020	Date/Time Pre	pared:
				11/25/2020 2:	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
P	PART I - ALL PROVIDER COMPONENTS			1.00	
	NPATIENT DAYS				1
	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		43, 827	1.00
	Inpatient days (including private room days, excluding swing-			43, 827	2.0
3.00 F	Private room days (excluding swing-bed and observation bed day	ys). If you have only p	rivate room days,	0	3.00
	do not complete this line.				
	Semi-private room days (excluding swing-bed and observation b			38, 387	4.00
	Total swing-bed SNF type inpatient days (including private roo	om days) through Decemb	er 31 of the cost	0	5.0
. 00	reporting period Total swing-bed SNF type inpatient days (including private row	om days) after December	31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)	on days) at ter becenber	ST OF THE COST	0	0.00
	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	0	7.0
l I	reporting period	5			
	Total swing-bed NF type inpatient days (including private room	m days) after December	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	16, 879	9.00
	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	room davs)	0	10.00
0.00	through December 31 of the cost reporting period (see instruc	tions)	room days)	0	10.0
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, end		<i>,</i>		
2.00	Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including priva	te room days)	0	12.0
	through December 31 of the cost reporting period				
	Swing-bed NF type inpatient days applicable to titles V or XI.			0	13.0
4.00	after December 31 of the cost reporting period (if calendar yo Medically necessary private room days applicable to the Progra	am (excluding swing-bed	davs)	0	14.0
	Total nursery days (title V or XIX only)	am (exer during swring bed	uuysy	0	
	Nursery days (title V or XIX only)			Ő	
	SWING BED ADJUSTMENT				1
17.00 🛽	Medicare rate for swing-bed SNF services applicable to service	es through December 31	of the cost	0.00	17.00
	reporting period				
	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.0
1	reporting period Medicaid rate for swing-bed NF services applicable to service:	s through December 21 o	f the cost	0.00	19.00
	reporting period	s through becember 31 0	i the cost	0.00	19.00
	Medicaid rate for swing-bed NF services applicable to service:	s after December 31 of	the cost	0.00	20.0
r	reporting period				
	Total general inpatient routine service cost (see instruction			38, 240, 494	
	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22.0
	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporti	ng pariod (line 4	0	23.0
	x line 18)	ST OF THE COST TEPOLT	ng period (inne o	0	23.0
	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24.0
	7 x line 19)			-	
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reportin	g period (line 8	0	25.0
>	x line 20)				
	Total swing-bed cost (see instructions)	(1.1. 0.1. 1.1. 0.()		0	
	General inpatient routine service cost net of swing-bed cost	(The 21 minus The 26)		38, 240, 494	27.0
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-beilder)	d and observation bed c	harges)	0	28.0
	Private room charges (excluding swing-bed charges)		nai ges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
1.00 0	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	31.0
32.00 A	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.0
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mil		ctions)	0.00	
	Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 2 x line 25)	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost d	ifferential (line	0 38, 240, 494	
	27 minus line 36)	ana private room cost a		30, 240, 494	37.0
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	USTMENTS			1
	Adjusted general inpatient routine service cost per diem (see			872.53	38.0
8.00 /					1 20 0
39.00 F	Program general inpatient routine service cost (line 9 x line			14, 727, 434	
39.00 F 40.00 N	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	am (line 14 x line 35)		14, 727, 434 0 14, 727, 434	40.00

OMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Peri od:	Worksheet D-1	1
					From 07/01/2019 To 06/30/2020		enare
					10 00/ 30/ 2020	11/25/2020 2:	
				XVIII	Hospi tal	PPS	_
	Cost Center Description	Total Inpatient Cost	Total Innatient Days	Average Per	Program Days	Program Cost (col. 3 x col.	
		inputiont obot	inpationt bajo	col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0	C	0.0	0 0	C	42
. 00	Intensive Care Type Inpatient Hospital UNIT	8, 313, 591	5, 137	1, 618. 3	7 1, 707	2, 762, 558	3 43
I. 00	CORONARY CARE UNIT	0, 515, 571	5, 157	1,010.0	1,707	2,702,000	44
5.00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00							47
	Cost Center Description					1.00	_
. 00	Program inpatient ancillary service cost	(Wkst. D-3, col. 3	, line 200)			23, 646, 110	48
. 00	Total Program inpatient costs (sum of li	•		ons)		41, 136, 102	
	PASS THROUGH COST ADJUSTMENTS					1	
0. 00	Pass through costs applicable to Program	inpatient routine	services (from	n Wkst. D, sum	of Parts I and	1, 863, 509	9 50
1.00	<pre>III) Pass through costs applicable to Program</pre>	inpatient ancillar	v services (fr	om Wkst D s	um of Parts II	1, 041, 852	51
	and IV)		, (11			.,	
2.00	Total Program excludable cost (sum of li					2, 905, 361	
3. 00	Total Program inpatient operating cost e		lated, non-phy	/sician anesth	etist, and	38, 230, 741	53
	medical education costs (line 49 minus I TARGET AMOUNT AND LIMIT COMPUTATION	111e 52)					
1.00	Program di scharges					C	54
. 00	Target amount per discharge					0.00	55
5.00	Target amount (line 54 x line 55)					C	
7.00	Difference between adjusted inpatient op	erating cost and ta	rget amount (I	ine 56 minus	line 53)	C	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cos	t reporting period	ending 1006 i	indated and co	mounded by the	0.00	
. 00	market basket	t reporting period	churng 1770, c		inpounded by the	0.00	/ <i>[,]</i>
0. 00	Lesser of lines 53/54 or 55 from prior y					0.00	60 60
I. 00	If line 53/54 is less than the lower of				2	C) 61
	which operating costs (line 53) are less amount (line 56), otherwise enter zero (s (lines 54 x	60), or 1% or	the target		
2.00	Relief payment (see instructions)					c c	62
8.00	Allowable Inpatient cost plus incentive	payment (see instru	ctions)			C	63
	PROGRAM INPATIENT ROUTINE SWING BED COST					I	
1.00	Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs through Dece	mber 31 of the	e cost reporti	ng period (See	C	64
5.00	Medicare swing-bed SNF inpatient routine	costs after Decemb	er 31 of the c	cost reporting	period (See	c	65
	instructions)(title XVIII only)					_	
5.00	Total Medicare swing-bed SNF inpatient r	outine costs (line	64 plus line 6	5)(title XVII	l only). For	C) 66
1 00	CAH (see instructions)	utina aaata thraugh	December 21	f the east re	nonting noried	0	
7.00	Title V or XIX swing-bed NF inpatient ro (line 12 x line 19)	utine costs through	December 31 C	on the cost re	porting period		67
3. 00	Title V or XIX swing-bed NF inpatient ro	utine costs after D	ecember 31 of	the cost repo	rting period	C	68
	(line 13 x line 20)						
9.00	Total title V or XIX swing-bed NF inpati					C	0 69
). 00	PART III - SKILLED NURSING FACILITY, OTH Skilled nursing facility/other nursing f						70
. 00	Adjusted general inpatient routine servi						71
. 00	Program routine service cost (line 9 x l	ine 71)		,			72
. 00	Medically necessary private room cost ap						73
. 00 5. 00	Total Program general inpatient routine	•			art II column		74
. 00	Capital-related cost allocated to inpati 26, line 45)	ent routine Service	CUSIS (ITUM V	IN NOR AND A STREET B, P	artir, corunn		75
. 00	Per diem capital-related costs (line 75	÷line 2)					76
. 00	Program capital-related costs (line 9 x	,					77
. 00	Inpatient routine service cost (line 74						78
. 00 . 00	Aggregate charges to beneficiaries for e Total Program routine service costs for			· · ·	us line 70)		79
. 00	Inpatient routine service cost per diem	•			us i i i c / /)		81
. 00	Inpatient routine service cost limitatio)				82
. 00	Reasonable inpatient routine service cos	•	s)				83
1.00	Program inpatient ancillary services (se		>				84
5.00 00	Utilization review - physician compensat						85
o. 00	Total Program inpatient operating costs PART IV - COMPUTATION OF OBSERVATION BED		rouyir 65)				86
7.00	Total observation bed days (see instruct					5, 440	87
	Adjusted general inpatient routine cost		line 2)			872.53	
3.00 9.00	Observation bed cost (line 87 x line 88)					4, 746, 563	

Health Financial Systems S	T. MARY MEDICAL	_ CENTER, INC.		In Lieu of Form CMS-2552		
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2019	Worksheet D-1	
				To 06/30/2020	Date/Time Pre 11/25/2020 2:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	4, 242, 411	38, 240, 494	0. 110940	4, 746, 563	526, 584	90.00
91.00 Nursing School cost	0	38, 240, 494	0.00000	4, 746, 563	0	91.00
92.00 Allied health cost	44,031	38, 240, 494	0.00115	4, 746, 563	5, 463	92.00
93.00 All other Medical Education	0	38, 240, 494	0.00000	4, 746, 563	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Pre			
		Title XVIII	Subprovi der -	11/25/2020 2: PPS			
	Cost Center Description		IRF				
	PART I - ALL PROVIDER COMPONENTS			1.00			
	INPATIENT DAYS						
00	Inpatient days (including private room days and swing-bed da			5, 991	1		
00	Inpatient days (including private room days, excluding swing			5, 991	2		
00	Private room days (excluding swing-bed and observation bed o	days). If you have only pr	ivate room days,	0	3		
00	do not complete this line. Semi-private room days (excluding swing-bed and observation	bed days)		5, 991	4		
00	Total swing-bed SNF type inpatient days (including private r		r 31 of the cost	0, 771			
	reporting period						
00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6		
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	oom days) through December	31 of the cost	0	5		
00	reporting period	Join days) thi bugh becember	ST OF THE COST	0	'		
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	1 of the cost	0	8		
	reporting period (if calendar year, enter 0 on this line)						
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the program (excluding	swing-bed and	3, 787	9		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	oom davs)	0	10		
	through December 31 of the cost reporting period (see instru						
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11		
00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or >		e room dave)	0	12		
. 00	through December 31 of the cost reporting period	(including privat	e room days)	0	12		
8.00	Swing-bed NF type inpatient days applicable to titles V or >	KIX only (including privat	e room days)	0	13		
	after December 31 of the cost reporting period (if calendar			0	14		
	00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 00 Total nursery days (title V or XIX only)						
	Nursery days (title V or XIX only)			0	15		
	SWING BED ADJUSTMENT		1				
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31 o	f the cost	0.00	17		
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18		
	reporting period						
9.00	Medicaid rate for swing-bed NF services applicable to service	ces through December 31 of	the cost	0.00	19		
	reporting period Medicaid rate for swing-bed NF services applicable to servic	res after December 31 of t	he cost	0.00	20		
. 00	reporting period			0.00	20		
	Total general inpatient routine service cost (see instruction			5, 151, 834			
. 00	Swing-bed cost applicable to SNF type services through Decen	mber 31 of the cost report	ing period (line	0	22		
8. 00	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	ar 31 of the cost reportin	a period (line 6	0	23		
. 00	x line 18)		g per lou (i i i e e	0			
. 00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost reporti	ng period (line	0	24		
. 00	7 x line 19) Swing had east applicable to NE type convices after December	- 21 of the cost reporting	ported (line 9	0	25		
. 00	Swing-bed cost applicable to NF type services after December x line 20)	ST OF THE COST TEPOLETING	period (inte o	0	20		
. 00	Total swing-bed cost (see instructions)			0	26		
. 00	General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		5, 151, 834	27		
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	and and observation had a	argac)	0	1 20		
	General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges)	bed and observation bed ch	arges)	0			
	Semi-private room charges (excluding swing bed charges)			0			
. 00	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0. 000000			
	Average private room per diem charge (line 29 ÷ line 3)	<u>,</u>		0.00			
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m		tions)	0.00 0.00			
	Average per diem private room cost differential (line 32 m	, ,		0.00			
	Private room cost differential adjustment (line 3 x line 35)			0	36		
. 00	General inpatient routine service cost net of swing-bed cost	t and private room cost di	fferential (line	5, 151, 834	37		
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY						
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	DJUSTMENTS					
. 00	Adjusted general inpatient routine service cost per diem (se			859. 93	38		
	Program general inpatient routine service cost (line 9 x lir			3, 256, 555			
	Medically necessary private room cost applicable to the Prog			0			
	Total Program general inpatient routine service cost (line 3	37 + 1110 40)		3, 256, 555	14		

IPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0034	Period: From 07/01/2019	Worksheet D-1	1
		Component	CCN: 15-T034	To 06/30/2020		
		Title	e XVIII	Subprovider -	PPS	
Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	Inpatient Costl	npatient Days			(col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital U	0 Jni ts	0	0.0	0 0	1	24
00 INTENSIVE CARE UNIT	0	C	0. (0 00	C	
00 CORONARY CARE UNIT 00 BURN INTENSIVE CARE UNIT						4
00 BURN INTENSIVE CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT						4
00 OTHER SPECIAL CARE (SPECIFY)						4
Cost Center Description					1.00	
00 Program inpatient ancillary service cos	t (Wkst. D-3, col. 3,	line 200)			1, 890, 937	7 4
00 Total Program inpatient costs (sum of I	nes 41 through 48)(s	ee instructio	ns)		5, 147, 492	2 4
PASS THROUGH COST ADJUSTMENTS 00 Pass through costs applicable to Program	n inpatient routine s	ervices (from	Wkst. D, sur	n of Parts I and	324, 432	2 5
00 Pass through costs applicable to Program and IV)	n inpatient ancillary	services (fr	om wkst. D, s	sum or Parts II	114, 132	2 5
00 Total Program excludable cost (sum of I	-				438, 564	
00 Total Program inpatient operating cost medical education costs (line 49 minus		ated, non-phy	sician anesth	netist, and	4, 708, 928	3 5
TARGET AMOUNT AND LIMIT COMPUTATION					1	
00 Program di scharges					0	
00 Target amount per discharge 00 Target amount (line 54 x line 55)					0.00	
00 Difference between adjusted inpatient of	perating cost and tar	aet amount (I	ine 56 minus	line 53)		
00 Bonus payment (see instructions)	5	5		,	0) 5
00 Lesser of lines 53/54 or 55 from the cos	st reporting period e	nding 1996, ι	pdated and co	ompounded by the	0.00) 5
market basket 00 Lesser of lines 53/54 or 55 from prior	vear cost report upd	lated by the m	arket basket		0.00	0 6
00 If line 53/54 is less than the lower of				the amount by	0.00	
which operating costs (line 53) are less		6 (lines 54 x	60), or 1% of	the target		
amount (line 56), otherwise enter zero 00 Relief payment (see instructions)	(see instructions)				0) 6
00 Allowable Inpatient cost plus incentive	payment (see instruc	tions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST	-		++:			
00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	e costs through Decem	iber 31 of the	cost reporti	ng period (See	C) 6
00 Medicare swing-bed SNF inpatient routing	e costs after Decembe	er 31 of the c	ost reporting	g period (See	0) 6
instructions)(title XVIII only) 00 Total Medicare swing-bed SNF inpatient	routine costs (line 6	4 plus line 6	5)(title XVII	l onlv). For	0	0 6
CAH (see instructions)			, ,	3,		
00 Title V or XIX swing-bed NF inpatient re (line 12 x line 19)	outine costs through	December 31 c	of the cost re	eporting period	C	0 6
00 Title V or XIX swing-bed NF inpatient re	outine costs after De	cember 31 of	the cost repo	orting period	0	0 6
(line 13 x line 20)	ant routing goats (1	ing (7 , ling	(0)			
00 Total title V or XIX swing-bed NF inpat PART III - SKILLED NURSING FACILITY, OTH					0) 6
00 Skilled nursing facility/other nursing	facility/ICF/IID rout	ine service c	ost (line 37)			7
00 Adjusted general inpatient routine serv		ne 70 ÷ line	2)			7
00 Program routine service cost (line 9 x 00 Medically necessary private room cost a		(line 14 x li	ne 35)			7
00 Total Program general inpatient routine						7
00 Capital-related cost allocated to inpat 26, line 45)	ent routine service	costs (from W	lorksheet B, F	Part II, column		7
00 Per diem capital-related costs (line 75	÷line 2)					7
00 Program capital -related costs (line 9 x						7
00 Inpatient routine service cost (line 74 00 Aggregate charges to beneficiaries for		ovider rocord	le)			7
00 Aggregate charges to beneficiaries for 00 Total Program routine service costs for				nus line 79)		8
00 Inpatient routine service cost per diem	•		(8
00 Inpatient routine service cost limitation						8
00 Reasonable inpatient routine service co	•	5)				8
00 Program inpatient ancillary services (so 00 Utilization review - physician compensation		e)				8
00 Total Program inpatient operating costs						8
PART IV - COMPUTATION OF OBSERVATION BEI	PASS THROUGH COST	~ /			1	
00 Total observation bed days (see instruct	tions)				0	
00 Adjusted general inpatient routine cost	nor diam (liz- 07	Line 2			0.00) 8

Health Financial Systems S	ST. MARY MEDICA	L CENTER, INC.		In Lieu of Form CMS-2552-		
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2019	Worksheet D-1	
		Component (CCN: 15-T034	To 06/30/2020	Date/Time Pre 11/25/2020 2:	pared: 58 pm
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	513, 250	5, 151, 834	0. 09962	.5 0	0	90.00
91.00 Nursing School cost	0	5, 151, 834	0.00000	0 0	0	91.00
92.00 Allied health cost	0	5, 151, 834	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	5, 151, 834	0.00000	0 0	0	93.00

ST.	MARY	MEDI CAL	CENTER,	INC.	

In Lieu of Form CMS-2552-10

	Financial Systems ST. MARY MEDICAL C	CENTER, INC.	In Lie	u of Form CMS-2	<u>2552-10</u>
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0034	Peri od:	Worksheet D-1	
			From 07/01/2019 To 06/30/2020	Date/Time Pre	pared.
			10 00/00/2020	11/25/2020 2:	
		Title XIX	Hospi tal	PPS	
	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 day	rs, excluding newborn)		43, 827	1.00
2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		43, 827	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
1 00	do not complete this line.			00.007	1 00
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		r 21 of the cost	38, 387 0	4.00
3.00	reporting period	ioni days) thi ough becembe	a si ui the cust	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7.00
0 00	reporting period				0.00
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	I OF THE COST	0	8.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	1, 331	9.00
	newborn days) (see instructions)		oming bou and	1,001	// 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
12.00	through December 31 of the cost reporting period	x only (mer daring privat	days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 417 227	
10.00	SWING BED ADJUSTMENT			221	10.00
17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0.00	17.00
	reporting period	5			
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.00
10.00	reporting period	- the second Desembles 21 of		0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	is through becember 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			38, 240, 494	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22.00
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a poriod (line 6	0	23.00
23.00	x line 18)	ST OF the cost reportin	ig period (Time o	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)		0 1 1		
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
26.00	x line 20) Total swing-bed cost (see instructions)			0	26.00
20.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		38, 240, 494	•
27.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			00,210,171	27.00
28.00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0.000000	
32.00 33.00	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	1
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li		,	0.00	
36.00	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 di	fferential (line	38, 240, 494	37.00
	27 minus line 36)				
	PART II – HOSPITAL AND SUBPROVIDERS ONLY				-
	DDOCDAM INDATIENT ODEDATING COST REFORE DASS THROUGH COST AD H	HEIMENIE			
38 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			872 53	38 00
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	instructions)		872. 53 1, 161, 337	38.00 39.00
39.00	Adjusted general inpatient routine service cost per diem (see	e instructions) e 38)			39.00 40.00

OMPUT	Financial Systems	ST. MARY MEDICAL	Provider C	CN: 15-0034	Period:	eu of Form CMS- Worksheet D-1	
					From 07/01/2019		
					To 06/30/2020	Date/Time Pre 11/25/2020 2:	
			Titl	e XIX	Hospi tal	PPS	00 1
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	0.00	col . 2)	4.00	4)	-
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00 1,622.3	4.00	5.00	2 42
. 00	Intensive Care Type Inpatient Hospital Un		1,417	1,022.3	221	368, 262	42
. 00	INTENSIVE CARE UNIT	8, 313, 591	5, 137	1, 618. 3	7 38	61, 498	3 43
. 00	CORONARY CARE UNIT	0,010,071	0, 10,	., 0.0.0			44
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
						1.00	
. 00	Program inpatient ancillary service cost	•		``		630, 216	
. 00	Total Program inpatient costs (sum of lin	es 41 through 48)(see instructio	ns)		2, 221, 313	3 49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program	innationt routing	sorvicos (from	Wkst D sum	of Parts L and	169, 329	0 50
. 00			Services (ITOI	WKSt. D, Sum		107, 327	
I. 00	Pass through costs applicable to Program	inpatient ancillar	y services (fr	om Wkst. D, s	um of Parts II	26, 976	51
	and IV)						
2.00	Total Program excludable cost (sum of lin					196, 305	
3.00	Total Program inpatient operating cost ex	5 1	lated, non-phy	sician anesth	etist, and	2, 025, 008	3 53
	medical education costs (line 49 minus li	ne 52)					-
00	TARGET AMOUNT AND LIMIT COMPUTATION					с с	54
. 00	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient ope	rating cost and ta	rget amount (I	ine 56 minus	line 53)		
. 00	Bonus payment (see instructions)						
. 00	Lesser of lines 53/54 or 55 from the cost	reporting period	ending 1996, u	pdated and co	mpounded by the	0.00	59
	market basket						
). 00	Lesser of lines 53/54 or 55 from prior ye					0.00	
. 00	If line 53/54 is less than the lower of l				2	C	61
	which operating costs (line 53) are less amount (line 56), otherwise enter zero (s		s (lines 54 x	60), or 1% or	the target		
2. 00	Relief payment (see instructions)					c	62
. 00	Allowable Inpatient cost plus incentive p	avment (see instru	ictions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				
. 00	Medicare swing-bed SNF inpatient routine	costs through Dece	mber 31 of the	cost reporti	ng period (See	C	64
	instructions)(title XVIII only)						
5.00	Medicare swing-bed SNF inpatient routine	costs after Decemb	er 31 of the c	ost reporting	period (See	C	65
b. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient ro	utino coste (lino	64 plus lipo 6	5) (+i +l o XV/11		C	66
5. 00	CAH (see instructions)		o4 prus rifie o	s)(title xvii	i oniy). Foi		00
7.00	Title V or XIX swing-bed NF inpatient rou	tine costs through	December 31 o	f the cost re	porting period	0	67
. 00	(line 12 x line 19)	tine costs through	becchiber of o		por tring period		
3.00		tine costs after D	ecember 31 of	the cost repo	rting period	C	68
	(line 13 x line 20)						
9.00	Total title V or XIX swing-bed NF inpatie					C) 69
	PART III - SKILLED NURSING FACILITY, OTHE						1 70
0. 00	Skilled nursing facility/other nursing fa	2		• • •			70
. 00	Adjusted general inpatient routine servic Program routine service cost (line 9 x li		ine /U ÷ IIne	Z)			71
. 00	Medically necessary private room cost app	,	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine s						74
. 00	Capital -related cost allocated to inpatie	•	,		art II, column		75
	26, line 45)						
. 00	Per diem capital-related costs (line 75 ÷						76
. 00	Program capital-related costs (line 9 x l	,					77
. 00	Inpatient routine service cost (line 74 m	,	nould				78
. 00	Aggregate charges to beneficiaries for ex	· ·		· .	us lino 70)		80
. 00 . 00	Total Program routine service costs for c Inpatient routine service cost per diem I	•	ost i i mitati on	(IIIE /8 MIN	us IIIe /9)		81
. 00	Inpatient routine service cost per drem r)				82
. 00	Reasonable inpatient routine service cost	•					83
. 00	Program inpatient ancillary services (see	•	- /				84
. 00	Utilization review - physician compensati		ins)				85
6. 00	Total Program inpatient operating costs (86
	PART IV - COMPUTATION OF OBSERVATION BED						
7.00	Total observation bed days (see instructi					5, 440	
	Adjusted general inpatient routine cost p	er diem (line 27 ÷				872.53	
. 00 . 00	Observation bed cost (line 87 x line 88)	(ooo in-t '' ``				4, 746, 563	

Health Financial Systems	ST. MARY MEDICAL	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2019	Worksheet D-1	
				To 06/30/2020		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	4, 242, 411	38, 240, 494	0. 110940	4, 746, 563	526, 584	90.00
91.00 Nursing School cost	0	38, 240, 494	0.00000	4, 746, 563	0	91.00
92.00 Allied health cost	44,031	38, 240, 494	0.001151	4, 746, 563	5, 463	92.00
93.00 All other Medical Education	0	38, 240, 494	0.00000	4, 746, 563	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0034	Peri od:	Worksheet D-1	
		Component CCN: 15-T034	From 07/01/2019 To 06/30/2020	Date/Time Prep 11/25/2020 2:	
		Title XIX	Subprovider - IRF	PPS	_
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		1		
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days			5, 991 5, 991	1.
00 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed o		ivate room dave	5, 991	3.
00	do not complete this line.	aays). Ti you have only pr	rvate room days,	0	
00	Semi-private room days (excluding swing-bed and observation	bed days)		5, 991	4
00	Total swing-bed SNF type inpatient days (including private r	room days) through Decembe	r 31 of the cost	0	5
00	reporting period	com dava) often December	21 of the east	0	
00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	"oom days) after December	31 OF THE COST	0	6
00	Total swing-bed NF type inpatient days (including private ro	oom days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)		and any local and	0	
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excluding	swing-bed and	0	9
). 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instru			-	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11
00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or >		a raam daya)	0	1.
2.00	through December 31 of the cost reporting period	a chi y (including privat	e room days)	0	12
8. 00	Swing-bed NF type inpatient days applicable to titles V or >	<pre>(IX only (including privat)</pre>	e room days)	0	13
	after December 31 of the cost reporting period (if calendar	year, enter 0 on this lin	e)		
	Medically necessary private room days applicable to the Prog	gram (excluding swing-bed	days)		14
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 417 227	
. 00	SWING BED ADJUSTMENT		I	221	
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 o	f the cost	0.00	17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost	0.00	11
. 00	Medicaid rate for swing-bed NF services applicable to servic	ces through December 31 of	the cost	0.00	19
	reporting period	-			
0. 00	Medicaid rate for swing-bed NF services applicable to servic	ces after December 31 of t	he cost	0.00	20
00	reporting period			E 1E1 024	21
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		ing period (line	5, 151, 834 0	22
. 00	5 x line 17)	iber 51 61 the cost report		0	
8.00	Swing-bed cost applicable to SNF type services after December	er 31 of the cost reportin	g period (line 6	0	23
~~	x line 18)				
. 00	Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	per 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	- 31 of the cost reporting	period (line 8	0	25
	x line 20)			-	
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		5, 151, 834	27
8. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ed and observation hed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)	bed and observation bed en	ai ges)	0	29
	Semi-private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m		tions)	0.00	
	Average per diem private room cost differential (line 34 x l	, ,	(10115)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
	General inpatient routine service cost net of swing-bed cost		fferential (line	5, 151, 834	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AL Adjusted general inpatient routine service cost per diem (se			859.93	38
	Program general inpatient routine service cost per drem (se			037.73	39
				0	40
. 00	Medically necessary private room cost applicable to the Prog		1	0	

OMPUTATION C	F INPATIENT OPERATING COST		Provider C	CN: 15-0034	Period: From 07/01/2019	Worksheet D-	1
			Component	CCN: 15-T034	To 06/30/2020	Date/Time Pre	
			Titl	e XIX	Subprovider -	11/25/2020 2: PPS	: 58
(Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient Costl	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
	Y (title V & XIX only)	1.00	2.00 0	3.00	4.00	5.00) 4
	ve Care Type Inpatient Hospital Units	0		0.0	0		
	I VE CARE UNIT	0	C	0.0	0 00	0) 4
4	RY CARE UNIT NTENSIVE CARE UNIT						4
	AL INTENSIVE CARE UNIT						4
	SPECIAL CARE (SPECIFY)						4
(Cost Center Description					1.00	_
00 Progra	m inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)) 4
	Program inpatient costs (sum of lines	41 through 48)(s	see instructio	ns)			2 4
	HROUGH COST ADJUSTMENTS hrough costs applicable to Program inp	atient routine s	services (from	Wkst D sun	of Parts L and		5
				intot. D, Sui			
	hrough costs applicable to Program inp	atient ancillary	/ services (fr	om Wkst. D, s	sum of Parts II	0) 5
and IV .00 Total) Program excludable cost (sum of lines -	50 and 51)				(5 5
	Program inpatient operating cost exclu		ated, non-phy	sician anesth	netist, and	C	5 5
	I education costs (line 49 minus line AMOUNT AND LIMIT COMPUTATION	52)				I	_
	m discharges					(5 5
	amount per discharge					0.00	
0	amount (line 54 x line 55)					(
	ence between adjusted inpatient operat payment (see instructions)	ing cost and tar	get amount (I	ine 56 minus	line 53)) 5) 5
	of lines 53/54 or 55 from the cost re	porting period e	endina 1996. u	pdated and co	mpounded by the		
market	basket		Ū I				
	of lines 53/54 or 55 from prior year				the emount by	0.00	
	e 53/54 is less than the lower of line operating costs (line 53) are less tha					0) 6
	(line 56), otherwise enter zero (see				the turget		
	payment (see instructions)) 6
	ble Inpatient cost plus incentive paym / INPATIENT ROUTINE SWING BED COST	ent (see instruc	ctions)			[(<u> </u>
	re swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	5 6
	ctions)(title XVIII only)						
	re swing-bed SNF inpatient routine cos ctions)(title XVIII only)	ts atter Decembe	er 31 of the c	ost reporting	period (See) 6
	Medicare swing-bed SNF inpatient routi	ne costs (line 6	54 plus line 6	5)(title XVII	l only). For	0	0 6
	ee instructions)			C 11 1			
	V or XIX swing-bed NF inpatient routin 12 x line 19)	e costs through	December 31 c	T THE COST RE	eporting period) 6
1 *	V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	orting period	0) 6
	13 x line 20)		ine (7 line	(0)			
	title V or XIX swing-bed NF inpatient I - SKILLED NURSING FACILITY, OTHER NU					[(<u> </u>
	d nursing facility/other nursing facil						7
	ed general inpatient routine service c		ne 70 ÷ line	2)			7
0	m routine service cost (line 9 x line Ily necessary private room cost applic.		(line 14 v li	ne 35)			7
	Program general inpatient routine serv						7
. 00 Capita	I-related cost allocated to inpatient	•			Part II, column		7
26, li .00 Per di	ne 45) em capital-related costs (line 75 ÷ li	ne 2)					7
	m capital-related costs (line 9 x line						7
	ent routine service cost (line 74 minu			- >			7
	ate charges to beneficiaries for exces Program routine service costs for comp				us line 70)		8
	ent routine service costs for comp.		St TIMI LALI UI		103 TTHE /7)		8
00 Inpati	ent routine service cost limitation (I	ine 9 x line 81)					8
	able inpatient routine service costs (5)				8
	m inpatient ancillary services (see in ation review - physician compensation))				8
	ation review - physician compensation Program inpatient operating costs (sum						8
PART I	/ - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	/			н 1	
1	observation bed days (see instructions		Line 2				8 0
	ed general inpatient routine cost per 🛛		1111E Z)			0.00) 8

Health Financial Systems S	ST. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2019	Worksheet D-1	
		Component (CCN: 15-T034	To 06/30/2020	Date/Time Pre 11/25/2020 2:	
		Ti tl	e XIX	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	•				
90.00 Capital-related cost	513, 250	5, 151, 834	0. 09962	5 0	0	90.00
91.00 Nursing School cost	0	5, 151, 834	0.00000	0 0	0	91.00
92.00 Allied health cost	0	5, 151, 834	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 151, 834	0.00000	0 0	0	93.00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0034		riod: om 07/01/2019	Worksheet D-3	3
				To		Date/Time Pre 11/25/2020 2:	
		Title	e XVIII		Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	st	Inpati ent	I npati ent	
			To Charges	;	Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
			1.00		2.00	3.00	-
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	-	<u> </u>		
	03000 ADULTS & PEDIATRICS				26, 400, 986		30.0
	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF				5, 032, 595		31.0
	04300 NURSERY				0		41.0
43.00	ANCI LLARY SERVICE COST CENTERS		1				43.0
0. 00	05000 OPERATI NG ROOM		0. 2035	20	15, 784, 356	3, 212, 432	50.0
	05100 RECOVERY ROOM		0. 2575		1, 948, 288	501, 856	
	05200 DELIVERY ROOM & LABOR ROOM		0. 5682		8, 938	5, 079	
	05300 ANESTHESI OLOGY		0.0307		3, 368, 739	103, 569	
	05400 RADI OLOGY-DI AGNOSTI C		0. 1150		4, 932, 467	567, 673	
	03630 ULTRA SOUND		0. 1014		1, 419, 535	143, 975	
	05600 RADI OI SOTOPE		0. 1425		1, 262, 339	179, 953	
	05700 CT SCAN		0.0453		9,051,739	410, 623	
	05900 CARDI AC CATHETERI ZATI ON		0.0749		13, 577, 621	1, 017, 561	
0.00	06000 LABORATORY		0. 1011		16, 165, 533	1, 635, 063	60. (
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 3087	72	1, 369, 753	422, 941	62.0
2.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000	000	0	0	62.3
	06500 RESPI RATORY THERAPY		0. 1964	69	8, 139, 093	1, 599, 079	65.0
6.00	06600 PHYSI CAL THERAPY		0. 2988	98	1, 672, 665	499, 956	66.
7.00	06700 OCCUPATI ONAL THERAPY		0. 1813	54	944, 775	171, 339	67.0
8.00	06800 SPEECH PATHOLOGY		0. 4057	00	256, 980	104, 257	68.
0.00	07000 ELECTROENCEPHALOGRAPHY		0. 1009	52	2, 195, 919	221, 682	2 70. (
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4053	16	4, 956, 486	2, 008, 943	71. (
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4956	03	9, 339, 590	4, 628, 729	72.0
	07300 DRUGS CHARGED TO PATIENTS		0. 1841		19, 859, 912	3, 657, 818	
	07400 RENAL DIALYSIS		0. 2579		1, 637, 620	422, 483	
	07697 CARDI AC REHABI LI TATI ON		0. 7675		162, 777	124, 935	
	07698 HYPERBARI C OXYGEN THERAPY		0.0000		0	0	
6.99	07699 LI THOTRI PSY		0.0000	000	0	0	76.
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC		0. 4529		232, 069	105, 118	
	09100 EMERGENCY		0. 1135		12, 666, 373	1, 438, 824	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3337	05	1, 385, 122	462, 222	
00.00		() · · · · · · · · · · · · · · · · · · ·			132, 338, 689	23, 646, 110	
201.00		es (line 61)			0		201.0
202.00	Net charges (line 200 minus line 201)				132, 338, 689		202.

Health Financial Systems ST. MARY MEDICAL CI	ENTER, INC.		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0034	Peri od:	Worksheet D-3	
	Component (From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 2:	
	Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INDATIENT DOUTINE CEDVICE COST CENTERS		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	0		20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T			0		30.00
41. 00 04100 SUBPROVI DER – I RF			4, 709, 754		41.00
43. 00 04300 NURSERY			4, 709, 754		41.00
ANCI LLARY SERVI CE COST CENTERS		I		<u> </u>	43.00
50. 00 05000 OPERATI NG ROOM		0. 20352	136, 308	27, 741	50.00
51. 00 05100 RECOVERY ROOM		0. 20352			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 56821		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 03074			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11508			
54. 01 03630 ULTRA SOUND		0. 10142			
56. 00 05600 RADI OI SOTOPE		0. 14255			
57. 00 05700 CT SCAN		0. 04536			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 07494		4, 970	
60. 00 06000 LABORATORY		0. 10114			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 30877			
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 19646			1
66. 00 06600 PHYSI CAL THERAPY		0. 29889			
67.00 06700 OCCUPATI ONAL THERAPY		0. 18135		334, 323	
68.00 06800 SPEECH PATHOLOGY		0. 40570		102, 369	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 10095	2 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 40531	6 409, 641	166, 034	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 49560	3 7, 447	3, 691	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 18418		363, 804	73.00
74. 00 07400 RENAL DI ALYSI S		0. 25798	6 353, 335	91, 155	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 76752		0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.00000	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY		0.00000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS		1	_		
90. 00 09000 CLINIC		0. 45295			
91.00 09100 EMERGENCY		0. 11359		-	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 33370		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			8, 721, 042	1, 890, 937	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	8, 721, 042		202.00

	MARY MEDICAL CENTER, INC.			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Pre 11/25/2020 2:	epared:
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	1.00	2.00	3.00	-
30. 00 03000 ADULTS & PEDIATRICS		1	786, 978		30, 00
31. 00 03100 I NTENSI VE CARE UNI T			289, 093		31.00
41. 00 04100 SUBPROVI DER – I RF			0		41.00
43. 00 04300 NURSERY			217, 430		43.00
ANCI LLARY SERVI CE COST CENTERS		1			1
50. 00 05000 OPERATI NG ROOM		0. 2035	20 288, 828	58, 782	50.00
51.00 05100 RECOVERY ROOM		0. 2575	88 32, 486	8, 368	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 5682	10 91, 396	51, 932	52.00
53. 00 05300 ANESTHESI OLOGY		0.0307	44 60, 446	1, 858	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1150			
54.01 03630 ULTRA SOUND		0. 1014			
56. 00 05600 RADI OI SOTOPE		0. 1425		3, 555	
57.00 05700 CT SCAN		0.0453			1
59.00 05900 CARDI AC CATHETERI ZATI ON		0.0749		8, 924	
60. 00 06000 LABORATORY		0. 1011		57, 009	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.3087			
62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS		0.0000		0	
		0.1964		37, 955	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY		0. 2988		11, 792 2, 655	
68. 00 06800 SPEECH PATHOLOGY		0. 1813		11, 904	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 4037			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4053		63, 809	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4055		26, 056	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1841			
74. 00 07400 RENAL DIALYSIS		0. 2579			
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 7675			
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000			
76. 99 07699 LI THOTRI PSY		0.0000			
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLINIC		0. 4529	58 1, 204	545	90.00
91.00 09100 EMERGENCY		0. 1135	94 277, 662	31, 541	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3337	05 30, 501	10, 178	
200.00 Total (sum of lines 50 through 94 and 96			3, 469, 622	630, 216	200.00
201.00 Less PBP Clinic Laboratory Services-Prog	ram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			3, 469, 622		202.00

ALCUL	Financial Systems ST. MARY MEDICAL CE	ENTER, INC. Provider CCN: 15-0034	In Lie Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Pre	pare
		Title XVIII	Hospi tal	11/25/2020 2: PPS	<u>58 p</u>
				1.00	-
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
00 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (see	0 10, 230, 693	1
02	instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (see	26, 983, 884	1.
03	instructions) DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	prior to October	0	1
04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for Database 1 (see instructions)	or discharges occurring	on or after	0	1
00 01	October 1 (see instructions) Outlier payments for discharges. (see instructions) Outlier recordination amount			0	2
01	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	
02	Outlier payments for discharges occurring prior to October 1 (24, 710	
04	Outlier payments for discharges occurring on or after October			253, 924	
00	Managed Care Simulated Payments	()		0	
00	Bed days available divided by number of days in the cost repor	ting period (see instru	ictions)	165.00	4
00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cost reporting	period ending on	0.00	5
00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet th	ne criteria for an add-c	on to the cap for	0.00	6
00	new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified u	under 42 CER 8412 105(f)	(1)(iv)(B)(1)	0.00	-
01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.			0.00	
00	Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.7 1998), and 67 FR 50069 (August 1, 2002).			0.00	8
01	The amount of increase if the hospital was awarded FTE cap slo report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8
02	The amount of increase if the hospital was awarded FTE cap slounder § 5506 of ACA. (see instructions)			0.00	
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)			0.00	
	FTE count for allopathic and osteopathic programs in the curre	ent year from your recor	as	0.00 0.00	
. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00	
. 00	Total allowable FTE count for the prior year.			0.00	
	Total allowable FTE count for the penultimate year if that yea otherwise enter zero.	ar ended on or after Sep	tember 30, 1997,	0.00	
. 00	Sum of lines 12 through 14 divided by 3.			0.00	1!
	Adjustment for residents in initial years of the program			0.00	
. 00	Adjustment for residents displaced by program or hospital clos	sure		0.00	1
	Adjusted rolling average FTE count			0.00	
. 00	Current year resident to bed ratio (line 18 divided by line 4)			0.00000	10
	Prior year resident to bed ratio (see instructions)			0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0	
. 01	IME payment adjustment - Managed Care (see instructions)			0	22
. 00	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE reside		FR 412.105	0.00	23
. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24
	If the amount on line 24 is greater than -0-, then enter the linstructions)	ower of line 23 or line	e 24 (see	0.00	
. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26
. 00	IME payments adjustment factor. (see instructions)			0.00000	27
	IME add-on adjustment amount (see instructions)			0	
	IME add-on adjustment amount - Managed Care (see instructions)			0	
	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	
. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pa	tient days (see instruc	tions)	3. 43	30
	Percentage of Medicaid patient days (see instructions)			3. 43 15. 10	
. 00	Sum of lines 30 and 31			18.53	
00					1 02
2.00 3.00	Allowable disproportionate share percentage (see instructions)			4.79	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0034	Period: From 07/01/2019 To 06/30/2020		pared: 58 pm
		Title XVIII	Hospi tal	PPS	00 pm
			Prior to 10/1	0n/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
	Total uncompensated care amount (see instructions)		8, 272, 872, 447		
	Factor 3 (see instructions)		0.000222432	0.000167267	
5. 02	Hospital uncompensated care payment (If line 34 is zero, enter	zero on this line) (se	e 1, 840, 149	1, 396, 784	35. C
- 02	instructions)	nt (and instructions)	44.2 010	1 045 (00	35. C
	Pro rata share of the hospital uncompensated care payment amou Total uncompensated care (sum of columns 1 and 2 on line 35.03		463, 819 1, 509, 499	1, 045, 680	35.0
5. 00	Additional payment for high percentage of ESRD beneficiary dis				30.0
). 00	Total Medicare discharges on Worksheet S-3, Part I excluding d		0		40. (
	652, 682, 683, 684 and 685 (see instructions)	5			
			Before 1/1	On/After 1/1	
			1.00	1.01	
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	3, 684 an 685. (see	0	0	41. C
	instructions)				
I. 01	Total ESRD Medicare covered and paid discharges excluding MS-D	105 052, 682, 683, 684	0	0	41.0
2.00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qualif	v for adjustment)	0.00		42.0
	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682		0.00		43.
	instructions)	,,	-		
1.00	Ratio of average length of stay to one week (line 43 divided b	y line 41 divided by 7	0. 000000		44. (
	days)				
5.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	
	Total additional payment (line 45 times line 44 times line 41.	01)	0		46.
	Subtotal (see instructions)		39, 448, 355		47.
3. 00	Hospital specific payments (to be completed by SCH and MDH, sm	iaii rurai nospitais	0		48.
	only. (see instructions)			Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instructions)			39, 448, 355	49. (
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and			3, 111, 954	
I. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.
2.00	Direct graduate medical education payment (from Wkst. E-4, lin	e 49 see instructions).		0	52.
3.00	Nursing and Allied Health Managed Care payment			18, 441	53.
	Special add-on payments for new technologies			8, 316	
4.01	Islet isolation add-on payment			0	54.
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69			0	55.
5.00 7.00	Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II		brough 2E)	23, 997	56. 57.
	Ancillary service other pass through costs from Wkst. D, Pt. I		ni ougir 55).	51, 369	
	Total (sum of amounts on lines 49 through 58)	v, cor. If fine 200)		42, 662, 432	
	Primary payer payments			5, 990	
	Total amount payable for program beneficiaries (line 59 minus	line 60)		42, 656, 442	
. 00	Deductibles billed to program beneficiaries			3, 714, 612	
. 00	Coinsurance billed to program beneficiaries			249, 370	63.
1.00	Allowable bad debts (see instructions)			450, 112	64.
	Adjusted reimbursable bad debts (see instructions)			292, 573	
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		59, 274	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)	ppliable to NC DDC (a inctruction >	38, 985, 033	
. 00	Credits received from manufacturers for replaced devices for a			5, 157	
. 00 . 00		I UL SUN SEE LINSTRUCTION	5)	0	
. 00 . 00 . 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(
. 00 . 00 . 00 . 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(ADD BACK GME REIMBURSEMENT			()	
. 00 . 00 . 00 . 00 . 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(0	70.
. 00 . 00 . 00 . 00 . 01 . 02	Outlier payments reconciliation (sum of lines 93, 95 and 96).(ADD BACK GME REIMBURSEMENT OTHER ADJ (NO DESC ENTERED)		instructions)		
 00 00 00 00 00 01 02 50 	Outlier payments reconciliation (sum of lines 93, 95 and 96).(ADD BACK GME REIMBURSEMENT OTHER ADJ (NO DESC ENTERED) OTHER ADJUSTMENTS PER PSR		instructions)	0	70.
2.00 3.00 0.00 0.00 0.01 0.02 0.50 0.87	Outlier payments reconciliation (sum of lines 93, 95 and 96).(ADD BACK GME REIMBURSEMENT OTHER ADJ (NO DESC ENTERED) OTHER ADJUSTMENTS PER PSR Rural Community Hospital Demonstration Project (§410A Demonstr		instructions)	0	70. 70.
7.00 3.00 9.00 9.00 9.00 9.00 9.01 9.02 9.50 9.87 9.88	Outlier payments reconciliation (sum of lines 93, 95 and 96).(ADD BACK GME REIMBURSEMENT OTHER ADJ (NO DESC ENTERED) OTHER ADJUSTMENTS PER PSR Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration	ation) adjustment (see	instructions)	0 0 0	70. 70. 70.
7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.87 9.88 9.89 9.90	Outlier payments reconciliation (sum of lines 93, 95 and 96).(ADD BACK GME REIMBURSEMENT OTHER ADJ (NO DESC ENTERED) OTHER ADJUSTMENTS PER PSR Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instr HSP bonus payment HVBP adjustment amount (see instructions)	ation) adjustment (see	instructions)	0 0 0	70. 70. 70. 70. 70.
. 00 . 00 . 00 . 01 . 02 . 50 . 87 . 88 . 89 . 90 . 91	Outlier payments reconciliation (sum of lines 93, 95 and 96).(ADD BACK GME REIMBURSEMENT OTHER ADJ (NO DESC ENTERED) OTHER ADJUSTMENTS PER PSR Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instr HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	ation) adjustment (see	instructions)	0 0 0 0 0	70.
7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 9. 01 9. 02 9. 50 9. 87 9. 88 9. 89 9. 90 9. 91 9. 92	Outlier payments reconciliation (sum of lines 93, 95 and 96).(ADD BACK GME REIMBURSEMENT OTHER ADJ (NO DESC ENTERED) OTHER ADJUSTMENTS PER PSR Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instr HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ation) adjustment (see	instructions)	0 0 0 0 0 0 0	70. 70. 70. 70. 70. 70. 70.
7.00 3.00 0.00 0.00 0.01 0.02 0.50 0.87 0.88 0.89 0.90 0.91 0.91	Outlier payments reconciliation (sum of lines 93, 95 and 96).(ADD BACK GME REIMBURSEMENT OTHER ADJ (NO DESC ENTERED) OTHER ADJUSTMENTS PER PSR Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instr HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	ation) adjustment (see	instructions)	0 0 0 0 0	70. 70. 70. 70. 70. 70. 70. 70.

	ATION OF REIMBURSEMENT SETTLEMENT	Provider C		Period: From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 2:	
		litle	XVIII	Hospi tal	PPS	
			FFY	<u>(yyyy)</u> 0	Amount 1.00	
), 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O		0		70.9
	the corresponding federal year for the period prior to 10/1)			0	Ū	
). 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O		0	0	70.9
	the corresponding federal year for the period ending on or af					
). 98	Low Volume Payment-3					70.9
	HAC adjustment amount (see instructions)				0	
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	69 & 70)			38, 091, 661	
	Sequestration adjustment (see instructions)				636, 131	
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs				0	71.0 71.0
	Interim payments				37, 292, 695	
	Interim payments-PARHM				57, 272, 075	72.0
	Tentative settlement (for contractor use only)				0	
3. 01	Tentative settlement-PARHM (for contractor use only)					73.0
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			162, 835	74.0
	73)					
4. 01	Balance due provider/program-PARHM (see instructions)					74.C
5.00	Protested amounts (nonallowable cost report items) in accordan	nce with			529, 174	75. C
	CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum (of 2 03			0	90.0
	plus 2.04 (see instructions)	01 2.00			Ŭ	/0.0
. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. (
. 00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92.0
. 00	Capital outlier reconciliation adjustment amount (see instruct	tions)			0	93. (
	The rate used to calculate the time value of money (see instru	ucti ons)				94. (
5.00	Time value of money for operating expenses (see instructions)				0	
5.00	Time value of money for capital related expenses (see instruct	tions)		Prior to 10/1	0 0 (After 10/1	96. C
				11101 10 10/1	UNALLEI TO/T	
				1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	
0. 00	HSP bonus amount (see instructions)			1.00		100. 0
0. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	
0. 00 1. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 000000000	0. 000000000	101. (
0. 00 1. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	s)		0	0. 000000000	
0. 00 1. 00 2. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment	s)		0.000000000	0.0000000000000000000000000000000000000	101. (102. (
0. 00 1. 00 2. 00 3. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0.0000000000000000000000000000000000000	0. 0000000000 0	101. 102. 103.
0.00 1.00 2.00 3.00 4.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions))	stment	0.000000000	0. 0000000000 0	101. (102. (
0.00 1.00 2.00 3.00 4.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see 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) ration) Adju		0.0000000000000000000000000000000000000	0. 0000000000 0	101. (102. (103. (104. (
0.00 1.00 2.00 3.00 4.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see 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) ration) Adju		0.0000000000000000000000000000000000000	0. 0000000000 0	101. (102. (103. (
0. 00 1. 00 2. 00 3. 00 4. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see 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) ration) Adju		0.0000000000000000000000000000000000000	0. 0000000000 0	101. 102. 103. 104.
0.00 1.00 2.00 3.00 4.00 0.00 1.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see 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. 11, line) ration) Adju riod under t		0.0000000000000000000000000000000000000	0. 0000000000 0	101. (102. (103. (104. (200. (201. (
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see 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. 11, line Medicare discharges (see instructions)) ration) Adju riod under t		0.0000000000000000000000000000000000000	0. 0000000000 0	101. (102. (103. (104. (200. (201. (202. (
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see 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)) ration) Adju riod under t e 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. (102. (103. (104. (200. (201. (202. (
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see 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) ration) Adju riod under t e 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. (102. (103. (104. (200. (201. (202. (
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see 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 e 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. (102. (103. (104. (200. (201. (202. (203. (
 00 0	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) 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 e 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. 102. 103. 200. 201. 202. 203.
 00 0	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) 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 e 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 203. 204. 205.
 00 0	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) 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 e 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 203. 204. 205.
 00 0	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) 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)) ration) Adju riod under t e 49) first year	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 203. 204. 205. 206.
 00 0	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) 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) ration) Adju riod under t e 49) first year ructions)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. 1 102. 1 103. 1 200. 1 201. 1 202. 1 203. 1 204. 1 205. 1 206. 1
 00 0	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) 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) 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 IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
 00 0	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) 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) Adju riod under t e 49) first year ructions)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 208. 209. 210.
 00 0	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) 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) 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) Adju riod under t e 49) first year ructions)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 208. 209. 210.
0.00 1.00 2.00 3.00 4.00 0.00 1.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) 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) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement) ration) Adju riod under t e 49) first year ructions) line 59)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 205. 206. 205. 206. 207. 208. 209. 201. 201. 201. 201. 201. 201. 201. 201
 0.00 <li< td=""><td>HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see 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) 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 203) Comparision of PPS versus Cost Reimbursement</td><td>) ration) Adju riod under t e 49) first year ructions) line 59)</td><td>he 21st</td><td>0. 0000000000 0 0. 0000000000 0 0. 00000 0</td><td>0. 0000000000 0 0. 0000 0 0. 0000 0</td><td>101. 103. 104. 200. 201. 202. 203. 204. 204. 205. 206. 206. 206. 206. 207. 208. 209. 201. 208. 209. 201. 201. 202. 203. 201. 202. 203. 203. 201. 202. 203. 203. 204. 205.</td></li<>	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) 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) 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 203) Comparision of PPS versus Cost Reimbursement) ration) Adju riod under t e 49) first year ructions) line 59)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. 103. 104. 200. 201. 202. 203. 204. 204. 205. 206. 206. 206. 206. 207. 208. 209. 201. 208. 209. 201. 201. 202. 203. 201. 202. 203. 203. 201. 202. 203. 203. 204. 205.
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) 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) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement) ration) Adju riod under t e 49) first year ructions) line 59) 211)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211.

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0034	Period: From 07/01/2019					
			To 06/30/2020	Date/Time Pre 11/25/2020 2:				
		Title XVIII	Hospi tal	PPS				
				1.00				
~~	PART B - MEDI CAL AND OTHER HEALTH SERVICES			77.404				
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instr	77, 101 26, 792, 500						
00	OPPS payments			27, 058, 115				
00	Outlier payment (see instructions)		32, 571					
01	Outlier reconciliation amount (see instructions)							
00								
00	Line 2 times line 5			0				
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00				
00 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt	t IV col 12 line 200		0 40, 893				
00	Organ acquisitions	L. TV, COL. 13, THE 200		40, 893				
. 00	Total cost (sum of lines 1 and 10) (see instructions)	77, 101						
	COMPUTATION OF LESSER OF COST OR CHARGES	11111	1					
	Reasonabl e charges				1			
. 00	Ancillary service charges	390, 590						
. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,		0					
. 00	Total reasonable charges (sum of lines 12 and 13)			390, 590	114			
5. 00	Customary charges Aggregate amount actually collected from patients liable for	or navment for services on	a charge basis	0	15			
b. 00	Amounts that would have been realized from patients liable			0				
. 00	had such payment been made in accordance with 42 CFR §413.	, o	''					
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17					
8.00	Total customary charges (see instructions)	390, 590	18					
0. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 313, 48							
	instructions)							
0. 00	Excess of reasonable cost over customary charges (complete instructions)	0	20					
I. 00	Lesser of cost or charges (see instructions)	77, 101	21					
	Interns and residents (see instructions)	0						
	Cost of physicians' services in a teaching hospital (see in	0						
1.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 21							
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	I			
	Deductibles and coinsurance amounts (for CAH, see instructi			0 5, 103, 869				
. 00	eductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) ubtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see							
. 00	instructions)	b) prus the sum of thes 22		22, 104, 811	21			
8. 00	Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28			
	ESRD direct medical education costs (from Wkst. E-4, line 3							
0. 00	Subtotal (sum of lines 27 through 29)	22, 104, 811	30					
	Primary payer payments	14, 208						
2.00	Subtotal (line 30 minus line 31)			22, 090, 603	32			
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SEF	RVICES)			1 ~~			
3.00 .00	Composite rate ESRD (from Wkst. I-5, line 11)			0 599, 125				
	Adjusted reimbursable bad debts (see instructions)	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)						
	Allowable bad debts for dual eligible beneficiaries (see in	389, 431 325, 416						
	Subtotal (see instructions)		22, 480, 034					
	MSP-LCC reconciliation amount from PS&R	-54						
	FDO LOSS			0				
. 50	Pioneer ACO demonstration payment adjustment (see instructi				39			
. 97	Demonstration payment adjustment amount before sequestration	0						
. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)							
. 99	RECOVERY OF ACCELERATED DEPRECIATION							
. 00	Subtotal (see instructions) Sequestration adjustment (see instructions)			22, 480, 088 375, 417				
	Demonstration payment adjustment amount after sequestration	n		0				
	Sequestration adjustment-PARHM pass-throughs				40			
	Interim payments			22, 306, 325				
	Interim payments-PARHM				41			
2. 00	Tentative settlement (for contractors use only)			0	42			
01	Tentative settlement_PARHM (for contractor use only)			1	42			

42.01

42.01

Tentative settlement-PARHM (for contractor use only)

Health Financial Systems ST. MARY MEDICA ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0034		Period: From 07/01/2019 To 06/30/2020		
			Title XVIII		PPS	
		Inpatien	t Part A	Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		36, 783, 239 483, 656		21, 680, 421 625, 904	1.00 2.00
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) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER	01/15/2020	25, 80	00	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	0	3. 05
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.5
3.53				0	0	3.53
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		25, 80	0	0	3.54 3.99
3.99	3, 50-3, 98)		25, 60	00	U	3.9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		37, 292, 69	95	22, 306, 325	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
5.01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.01
5.01				0	0	5.02
5.03				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.5 5.5
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
-	5. 50-5. 98)				Ĵ	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
6.01	SETTLEMENT TO PROVIDER		162, 83	35	0	6.0
6.02 7.00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		37, 455, 53	30	201, 654 22, 104, 671	6.02 7.00
,			57,400,00	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent	CN: 15-0034 CCN: 15-T034	Period: From 07/01, To 06/30,	/2019 Part I /2020 Date/T	eet E-1 ime Pre 2020 2:	
		Title	XVIII	Subprovi de I RF	er -	PPS	•
		Inpatien	t Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/y			
		1.00	2.00	3.00	4. (
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment 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)		7, 158, 2	20 0		0	1. (2. (3. (
	Program to Provider			1	1		
01 02 03 04 05	ADJUSTMENTS TO PROVIDER			0 0 0 0		0 0 0 0	3. 3. 3. 3.
	Provider to Program		•		ł		
50 51 52 53 54 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 0 0 0 0		0 0 0 0 0	3. 3. 3. 3. 3. 3. 3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		7, 158, 2	20		0	4.
0	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						5
01	TENTATI VE TO PROVI DER			0		0	5.
)2)3				0 0		0 0	5. 5.
	Provider to Program			-1			
50 51 52 99	TENTATIVE TO PROGRAM Subtotal (sum of lines 5.01-5.49 minus sum of lines			0 0 0		0 0 0	5 5 5 5
)0	5. 50-5. 98) Determined net settlement amount (balance due) based on the cost report. (1)			-		5	6
)1)2)0	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		79, 2 7, 237, 4	0 61		0 0 0	6. 6. 7.
				Contrac Numbe			
		()	1.00			

Heal th	Financial Systems ST. MARY MEDICAL C	CENTER, INC.	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0034	Period: From 07/01/2019	Worksheet E- Part II	1
			To 06/30/2020	Date/Time Pre 11/25/2020 2:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	1-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0034	Peri od:	Worksheet E-3	255
		Component CCN: 15-T034	From 07/01/2019 To 06/30/2020	Part III Date/Time Prep 11/25/2020 2:5	
		Title XVIII	Subprovider -	PPS	<u></u>
		I		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
00	Net Federal PPS Payment (see instructions)			7, 189, 856	
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0284	2
00	Inpatient Rehabilitation LIP Payments (see instructions))		227, 918	
00	Outlier Payments	cont cost consting poriod or	ding on or prior	37, 466	
00	Unweighted intern and resident FTE count in the most red to November 15, 2004 (see instructions)	1 3 1	5 1	0.00	
01	Cap increases for the unweighted intern and resident FTE program or hospital closure, that would not be counted w CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	without a temporary cap adjust		0.00	!
00	New Teaching program adjustment. (see instructions)			0.00	
00	Current year's unweighted FTE count of I&R excluding FTE	Es in the new program growth p	eriod of a "new	0.00	
	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents wi teaching program" (see instructions)			0.00	
00	Intern and resident count for IRF PPS medical education	adjustment (see instructions)		0.00	
. 00	Average Daily Census (see instructions)			16. 368852	
. 00 . 00	Teaching Adjustment Factor (see instructions) Teaching Adjustment (see instructions)			0. 000000 0	1
. 00	Total PPS Payment (see instructions)			7, 455, 240	
. 00	Nursing and Allied Health Managed Care payments (see ins	struction)		7, 433, 240	
. 00	Organ acquisition (DO NOT USE THIS LINE)				1
. 00	Cost of physicians' services in a teaching hospital (see	e instructions)		0	1
. 00	Subtotal (see instructions)	,		7, 455, 240	1
. 00	Primary payer payments			0	1
. 00	Subtotal (line 17 less line 18).			7, 455, 240	
. 00	Deductibles			35, 904	
. 00	Subtotal (line 19 minus line 20)			7, 419, 336	
. 00				65, 527	
. 00	Subtotal (line 21 minus line 22)			7, 353, 809	
. 00	Allowable bad debts (exclude bad debts for professional Adjusted reimbursable bad debts (see instructions)	services) (see instructions)		8, 967 5, 829	
. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		2, 387	
. 00	Subtotal (sum of lines 23 and 25)			7, 359, 638	
. 00	Direct graduate medical education payments (from Wkst. E	F-4 line 49)		0007,000	2
. 00	Other pass through costs (see instructions)	,,		741	
. 00	Outlier payments reconciliation			0	3
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
. 50	Pioneer ACO demonstration payment adjustment (see instru	uctions)		0	3
. 99	Demonstration payment adjustment amount before sequestra	ation		0	3
. 00	Total amount payable to the provider (see instructions)			7, 360, 379	
. 01	Sequestration adjustment (see instructions)			122, 918	
. 02	Demonstration payment adjustment amount after sequestrat	ti on			3
. 00 . 00	Interim payments Tentative settlement (for contractor use only)			7, 158, 220	3.
. 00	Balance due provider/program (line 32 minus lines 32.01,	32 02 33 and 34		0 79, 241	
. 00	Protested amounts (nonallowable cost report items) in ac §115.2		chapter 1,	79, 241 0	3
	TO BE COMPLETED BY CONTRACTOR				
0. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			37, 466	50
. 00	Outlier reconciliation adjustment amount (see instruction	ons)		0	5
					5

	Financial Systems ST. MARY MEDICAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0034	Peri od:	u of Form CMS-2 Worksheet E-3	
LCUL	ATTON OF REFMIDURSEMENT SETTLEMENT		From 07/01/2019 To 06/30/2020	Part VII Date/Time Pre	pare
		Title XIX	Hospi tal	11/25/2020 2: PPS	50 k
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SI	ERVICES FOR TITLES V OR X	I X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		0	0	1
00 00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	2
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0	0	5
00	Outpatient primary payer payments		Ū	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				
00	Routine service charges		786, 978		8
00	Ancillary service charges		3, 469, 622	0	
	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11)		4, 256, 600	0	11
. 00	CUSTOMARY CHARGES		4, 230, 000	0	1 12
. 00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	1 13
	basi s				
. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with		n 0	0	14
00	Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CIN 3413. 15(6)	0. 000000	0.000000	15
	Total customary charges (see instructions)		4, 256, 600	0	
	Excess of customary charges over reasonable cost (complete o	nlyifline 16 exceeds	4, 256, 600	0	
	line 4) (see instructions)	5			
. 00	Excess of reasonable cost over customary charges (complete o	nly if line 4 exceeds lin	е 0	0	18
	16) (see instructions)			_	
	Interns and Residents (see instructions)	+	0	0	
	Cost of physicians' services in a teaching hospital (see ins Cost of covered services (enter the lesser of line 4 or line		0	0	20
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	2
. 00	Other than outlier payments		0	0	22
	Outlier payments		0	0	
	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		2, 612	0	
	Subtotal (sum of lines 22 through 26)		2, 612	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		2, 612	0	29
00	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	2, 612	0	
	Deducti bl es		2, 012	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	nd 33)	2, 612	0	
	TO ZERO OUT SETTLEMENT, SINCE NO ADD		-2, 612	0	
	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4)	N	0	0	39
	Total amount payable to the provider (sum of lines 38 and 39))	0	0	
	Interim payments Balance due provider/program (line 40 minus line 41)		0	0	
	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub 15-2	0	0	
	chapter 1, §115.2		0	0	1 '

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0034	Period: From 07/01/2019	Worksheet E-3 Part VII	
		Component CCN: 15-T034	To 06/30/2020	Date/Time Pre 11/25/2020 2:	
		Title XIX	Subprovider - IRF	PPS	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		0		1 .
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0	0	
00	Outpatient primary payer payments		0	0	
00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		0	0	
	Reasonable Charges				
00	Routine service charges		0		1
00	Ancillary service charges		0	0	
00	Organ acquisition charges, net of revenue		0	0	1(
	Incentive from target amount computation		0		1
00	Total reasonable charges (sum of lines 8 through 11)		0	0	1
	CUSTOMARY CHARGES				
00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	1
	basi s				
00	Amounts that would have been realized from patients liable fo	n 0	0	1	
~~	a charge basis had such payment been made in accordance with	0,000000	0 00000		
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	ly if lips 14 avecade	0	0	
00	line 4) (see instructions)	il y 11 11he 16 exceeds	0	0	1
00	Excess of reasonable cost over customary charges (complete on	lvifline 4 exceeds lin		0	1
00	16) (see instructions)		° °	0	1
00	Interns and Residents (see instructions)		0	0	10
00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	20
00	Cost of covered services (enter the lesser of line 4 or line		0	0	2'
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi	ders.		
00	Other than outlier payments		0	0	
00	Outlier payments		0	0	1 -
00	Program capital payments		0		2
00	Capital exception payments (see instructions)		1 490	0	2
00 00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		1, 489 1, 489	0	
00	Customary charges (title V or XIX PPS covered services only)		1, 409	0	
	Titles V or XIX (sum of lines 21 and 27)		1, 489	0	
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1,407	0	12
00	Excess of reasonable cost (from line 18)		0	0	3
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1, 489	0	
	Deducti bl es		0	0	
00	Coinsurance		0	0	3
00	Allowable bad debts (see instructions)		0	0	
	Utilization review		0		3
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	1, 489	0		
00	TO ZERO OUT SETTLEMENT	-1, 489	0		
00	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0	0	3
00 00	Interim payments		0	0	
00	Balance due provider/program (line 40 minus line 41)		0	0	
00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	0	0	
00	chapter 1, §115.2		0	0	1 1

	inancial Systems ST. MARY MEDICAL SHEET (If you are nonproprietary and do not maintain be accounting records, complete the General Fund column	Provider C		Period: From 07/01/2019	u of Form CMS-: Worksheet G	
ly)		_		To 06/30/2020	Date/Time Pre 11/25/2020 2:	pare 58 p
		General Fund	Specific Purpose Fund		Plant Fund	
CL	JRRENT ASSETS	1.00	2.00	3.00	4.00	
	ash on hand in banks	2, 898		0 0	0	1 1
	emporary investments	C		0 0	0	
00 No	otes recei vabl e	C		o o	0	3
	ccounts receivable	32, 204, 618		0 C	0	
	ther receivable	0		0 0	0	
	llowances for uncollectible notes and accounts receivable	0 004 400		0	0	
	nventory repaid expenses	8, 084, 403 29, 333			0	
	ther current assets	27, 333			0	-
	ue from other funds	1, 709, 780		0 0	0	
	otal current assets (sum of lines 1-10)	42,031,032		0 0	0	
	XED ASSETS					
	and	C		0 C	0	
	and improvements	C		0 0	0	
	ccumulated depreciation	0		0 0	0	
	uildings coumulated depressiation	124, 414, 977			0	
	ccumulated depreciation easehold improvements				0	
	ccumulated depreciation				0	
	i xed equipment				0	
	ccumulated depreciation	0		0 0	0	
. 00 Ai	utomobiles and trucks	0		o c	0	21
. 00 🛛 Ad	ccumul ated depreciation	0		0 0	0	22
	ajor movable equipment	0		0 C	0	
	ccumulated depreciation	0		0 0	0	
	inor equipment depreciable			0 0	0	
	ccumulated depreciation IT designated Assets				0	
	ccumul ated depreciation				0	
	i nor equi pment-nondepreci abl e			0 0	0	
	otal fixed assets (sum of lines 12-29)	124, 414, 977		0 0	0	
ТО	THER ASSETS					
	nvestments	0		0 C	0	
	eposits on leases	0		0 0	0	
	ue from owners/officers			0 0	0	
	ther assets otal other assets (sum of lines 31-34)	11, 001, 637 11, 001, 637			0	
	otal assets (sum of lines 11, 30, and 35)	177, 447, 646			0	
	JRRENT LI ABI LI TI ES	177,447,040			0	1
	ccounts payable	1, 769, 940		0 0	0	37
	al ari es, wages, and fees payabl e	8, 661, 974		o o	0	38
	ayroll taxes payable	0		0 0	0	
	otes and loans payable (short term)	C		0 0	0	
	eferred income	0		0 0	0	
	ccelerated payments				0	42
	ue to other funds ther current liabilities	41, 475, 744			0	
	otal current liabilities (sum of lines 37 thru 44)	51, 907, 658			0	
	DNG TERM LIABILITIES	01,707,000				1
00 M	ortgage payable	C		0 0	0	46
	otes payable	0		o c	0	
	nsecured Loans	0		0 0	0	
	ther long term liabilities	6, 893, 398		0 0	0	
	otal long term liabilities (sum of lines 46 thru 49)	6, 893, 398			0	
	otal liabilities (sum of lines 45 and 50) APITAL ACCOUNTS	58, 801, 056	1	0 0	0	51
	eneral fund balance	118, 646, 590				52
	pecific purpose fund			b		53
	onor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - unrestricted			0		55
	overning body created - endowment fund balance			0		56
	lant fund balance - invested in plant				0	
	lant fund balance - reserve for plant improvement,				0	58
	eplacement, and expansion stal fund balances (sum of Lines 52 thru 58)	110 444 500			0	6
	otal fund balances (sum of lines 52 thru 58) otal liabilities and fund balances (sum of lines 51 and	118, 646, 590			0	
	Utar Franciscues and fund natalices (Sum OF FILES 3) and	177, 447, 646	1	J U	0	1 00

	Financial Systems S IENT OF CHANGES IN FUND BALANCES	T. MARY MEDICAL	Provi der C	N. 15 0024	Peri od:	eu of Form CMS-2 Worksheet G-1	1002 1
	IENT OF CHANGES IN FUND BALANCES				From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 2:	
		General	Fund	Special I	Purpose Fund	Endowment Fund	
		1.00	2.00	3,00	4.00	5, 00	
1.00	Fund balances at beginning of period	1.00	160, 392, 766		4.00		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		28, 499, 912				2.00
3.00	Total (sum of line 1 and line 2)		188, 892, 678		0		3.00
4.00	Additions (credit adjustments) (specify)	0	100,072,070		0	0	4.00
5.00	TRANSFER OF FUNDS	0			0	0	5.00
6.00	CONTRIBUTIONS	147,000			0	0	6.00
7.00	RELEASE RESTRICTED ASSETS	186,000			0	0	7.00
8.00	OTHER	2,000			0	0	8.00
9.00		0			0	0	9.00
10.00	Total additions (sum of line 4-9)		335,000		C		10.00
11.00	Subtotal (line 3 plus line 10)		189, 227, 678		C		11.00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00	TRANSFER FUNDS	69, 793, 000			0	0	13.00
14.00	ASSETS RELEASED	259,000			0	0	14.00
15.00	OTHER	529,000			0	0	15.00
16.00	ROUNDING	88			0	0	16.00
17.00		0			0	0	17.00
18.00	Total deductions (sum of lines 12-17)		70, 581, 088		C		18.00
19.00	Fund balance at end of period per balance		118, 646, 590		C		19.00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund	_		
		6.00	7.00	8.00			
	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7.00	8.00			2.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		7.00	8.00	0		2.00 3.00
2.00 3.00 4.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)		7.00	8.00			2.00 3.00 4.00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS		7.00	8.00			2.00 3.00 4.00 5.00
2.00 3.00 4.00 5.00 6.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS		7.00	8.00			2.00 3.00 4.00 5.00 6.00
2.00 3.00 4.00 5.00 6.00 7.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS RELEASE RESTRICTED ASSETS		7.00	8.00			2.00 3.00 4.00 5.00 6.00 7.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS		7.00 0 0 0 0	8.00			2.00 3.00 4.00 5.00 6.00 7.00 8.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS RELEASE RESTRICTED ASSETS OTHER		7.00 0 0 0 0 0 0 0	8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS RELEASE RESTRICTED ASSETS OTHER Total additions (sum of line 4-9)		7.00 0 0 0 0 0 0	8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS RELEASE RESTRICTED ASSETS OTHER Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		7.00 0 0 0 0 0	8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSEER OF FUNDS CONTRIBUTIONS RELEASE RESTRICTED ASSETS OTHER Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		7.00 0 0 0 0 0 0	8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS RELEASE RESTRICTED ASSETS OTHER Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFER FUNDS		7.00 0 0 0 0 0 0 0 0 0 0 0	8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS RELEASE RESTRICTED ASSETS OTHER Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFER FUNDS ASSETS RELEASED		7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS RELEASE RESTRICTED ASSETS OTHER Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFER FUNDS ASSETS RELEASED OTHER		7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS RELEASE RESTRICTED ASSETS OTHER Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFER FUNDS ASSETS RELEASED		7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00	0		$\begin{array}{c} 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS RELEASE RESTRICTED ASSETS OTHER Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFER FUNDS ASSETS RELEASED OTHER ROUNDING		7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 13.00 14.00 15.00 16.00 17.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) TRANSFER OF FUNDS CONTRIBUTIONS RELEASE RESTRICTED ASSETS OTHER Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFER FUNDS ASSETS RELEASED OTHER		7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00	0		$\begin{array}{c} 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\end{array}$

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet G-2 Parts I & II Date/Time Pre 11/25/2020 2:	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1.00	General Inpatient Routine Services Hospital		62, 652, 4	07	62, 652, 497	1.00
2.00	SUBPROVIDER - IPF		02,052,4	77	02,052,477	2.00
3.00	SUBPROVIDER - IRF		7, 455, 3	88	7, 455, 388	•
1.00	SUBPROVIDER		.,, .		.,,	4.00
5.00	Swing bed - SNF			0	0	5.00
5.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
3.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		70, 107, 8	85	70, 107, 885	10.00
	Intensive Care Type Inpatient Hospital Services			[
11.00	INTENSIVE CARE UNIT		13, 728, 4	82	13, 728, 482	•
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT					13.00 14.00
14.00 15.00	OTHER SPECIAL CARE (SPECIFY)					14.00
16.00	Total intensive care type inpatient hospital services (sum of		13, 728, 4	01	13, 728, 482	
10.00	111-15)	TTHES	13, 720, 4	02	13, 720, 402	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16		83, 836, 3	67	83, 836, 367	17.00
18.00	Ancillary services		327, 843, 7		327, 843, 750	
19.00	Outpatient services			0 637, 568, 368	637, 568, 368	
20.00	RURAL HEALTH CLINIC			0 0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY			4, 778, 403	4, 778, 403	22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE				1 9/9 195	26.00
27.00	PHYSICIAN OFFICES		1, 9		1, 068, 405	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	5 to WKST.	411, 682, 0	20 643, 413, 273	1, 055, 095, 293	28.00
	G-3, Line 1) PART II - OPERATING EXPENSES					-
29.00	Operating expenses (per Wkst. A, column 3, line 200)	1		248, 807, 382		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00	BAD DEBTS			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 (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
11.00	Total deductions (sum of lines 27 41)			0		41.00
12.00 13.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 4	2) (transfor		0 248, 807, 382		42.00
+3.00	to Wkst. G-3, line 4)			∠40, 8U7, 382		43.00

DIAIEM	ENT OF REVENUES AND EXPENSES Pr	rovider CCN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet G-3 Date/Time Prep 11/25/2020 2:5	pared: 58 pm
			-	1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 2	8)		1,055,095,293	1.0
2.00	Less contractual allowances and discounts on patients' accounts			786, 409, 850	2.0
3.00	Net patient revenues (line 1 minus line 2)			268, 685, 443	3.0
1.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			248, 807, 382	4.0
5.00	Net income from service to patients (line 3 minus line 4)			19, 878, 061	5.0
	OTHER INCOME		I	· · ·	
5.00	Contributions, donations, bequests, etc			1, 556	6.0
7.00	Income from investments			142, 444	7.0
3. 00	Revenues from telephone and other miscellaneous communication se	ervi ces		0	8.0
9.00	Revenue from television and radio service			0	9.0
0.00	Purchase di scounts			0	10. 0
1.00	Rebates and refunds of expenses			0	11.0
2.00	Parking lot receipts			0	12.C
3.00	Revenue from Laundry and Linen service			0	13. C
4.00	Revenue from meals sold to employees and guests			988, 867	14. C
5.00	Revenue from rental of living quarters			0	15. C
	Revenue from sale of medical and surgical supplies to other than	patients		0	16. C
	Revenue from sale of drugs to other than patients			0	17. C
8.00	Revenue from sale of medical records and abstracts			0	18. C
9.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. C
0.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.0
1.00	Rental of vending machines			3, 127	21.0
2.00	Rental of hospital space			1, 038, 234	
3.00	Governmental appropriations			0	23.0
4.00	OTHER OPERATING INCOME			407, 711	24. C
4.01	CARDIO INCOME			46, 590	
4.02	RELEASED TEMP ASSETS			67, 708	
4.03	LAB INCOME THERAPY INCOME			163, 028 263	24. C 24. C
4.04	CLASSES			40, 300	
4.05	PHOTOGRAPHI C FEES			40, 300	24. C 24. C
4.00	GAIN ON SALE OF ASSETS			0	24.0
4.07	ROUNDI NG			0	24. C
4.50	COVID-19 PHE Funding			5, 722, 023	24.0
5.00	Total other income (sum of lines 6-24)			8, 621, 851	
6.00	Total (line 5 plus line 25)			28, 499, 912	
7.00	ROUNDING			20, 477, 712	27.0
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.0
	Net income (or loss) for the period (line 26 minus line 28)			28, 499, 912	

	Financial Systems IS OF HOSPITAL-BASED HOME HEALT		T. MARY MEDICAI	CENTER, INC.	NV 15 0024	In Lie Period:	u of Form CMS-2 Worksheet H	2552-10
ANALIS	IS OF HUSPITAL-BASED HUME HEALT	H AGENCY CUSTS				From 07/01/2019		
				HHA CCN:	15-7313	To 06/30/2020	Date/Time Prep 11/25/2020 2:	pared: 58 pm
						Home Health Agency I	PPS	
		Sal ari es	Empl oyee	Transportati on	Contracted/Pu		Total (sum of	
			Benefits	(see	chased		cols. 1 thru	
		1.00	2.00	instructions) 3.00	Services 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable			0		0	0	2.00
	Equi pment							
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3.00 4.00
4.00 5.00	Administrative and General	775, 498	243, 385	0		0 54, 239	1, 073, 122	
	HHA REIMBURSABLE SERVICES		,					
6.00	Skilled Nursing Care	761,068	0			0 0	867, 314	
7.00 8.00	Physical Therapy Occupational Therapy	615, 998 93, 961	0	0	26, 18 27, 96		642, 179 121, 924	
9.00	Speech Pathology	38, 942	0	0	27,70	0 0	38, 942	
10.00	Medical Social Services	12, 814	0	0		0 0	12, 814	10.00
11.00	Home Health Aide	79, 804	0	15, 456		0 0		11.00
12.00	Supplies (see instructions)	0	0	0		0 117, 907	117, 907	
13.00 14.00	Drugs DME	0	0			0 0	0	
1 11 00	HHA NONREI MBURSABLE SERVI CES							
15.00	Home Dialysis Aide Services	0	0			0 0	0	
	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	
	Clinic	0	0			0 0	0	
	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
	Homemaker Service All Others (specify)	0	0	0		0 0	0	22.00 23.00
23.50	Tel emedi ci ne	0	0	0		0 0	0	23.50
24.00	Total (sum of lines 1-23)	2, 378, 085	243, 385		54, 14		2, 969, 462	24.00
		Recl assi fi cati on	Reclassified Trial Balance	Adjustments	Net Expenses for Allocatic			
		UII	(col. 6 +		$(col \cdot 8 + col$			
			col . 7)		9)			
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00			
1.00	Capital Related - Bldg. &	0	0	0		0		1.00
	Fixtures		-	_				
2.00	Capital Related - Movable	0	0	0		0		2.00
3.00	Equipment Plant Operation & Maintenance	0	0			0		3.00
4.00	Transportation	0	0	0		0		4.00
5.00	Administrative and General	0	1, 073, 122		1, 066, 65	50		5.00
6.00	HHA REIMBURSABLE SERVICES		0/7 044		0/7.04			6.00
6.00 7.00	Skilled Nursing Care Physical Therapy	0	867, 314 642, 179		867, 31 642, 17			6.00 7.00
8.00	Occupational Therapy	0	121, 924		121, 92			8.00
	Speech Pathol ogy	0	38, 942		38, 94			9.00
10.00	Medical Social Services	0	12, 814		12, 81			10.00
	Home Health Aide	0	95, 260		95, 26			11.00
12.00 13.00	Supplies (see instructions) Drugs	0	117, 907 0		117, 90	0		12.00 13.00
	DME	0	0			0		14.00
	HHA NONREI MBURSABLE SERVI CES							
15.00	Home Dialysis Aide Services	0	0			0		15.00
	Respiratory Therapy Private Duty Nursing	0	0	0		0		16.00 17.00
17.00	Clinic	0	0	0 0		0		17.00
18,00		0	0	0		0		19.00
	Health Promotion Activities					0		20.00
19. 00 20. 00	Day Care Program	0	0	0		0		
19. 00 20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0		0		21.00
19.00 20.00 21.00 22.00	Day Care Program Home Delivered Meals Program Homemaker Service		0 0 0			0		21. 00 22. 00
19.00 20.00 21.00 22.00 23.00	Day Care Program Home Delivered Meals Program		0 0 0 0 0 0	0 0 0 0 0		0 0 0 0		21.00

	Financial Systems		T. MARY MEDICAL		N 15 0024	Developed		u of Form CMS-	
COSTA	LLOCATION - HHA GENERAL SERVICE	COST		Provider CO HHA CCN:	I5-7313	Period From O To O	: 07/01/2019 06/30/2020	Date/Time Pre	pared:
							Health	11/25/2020 2: PPS	58 pm
			Capital Rel	ated Costs		Age	ency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	&	portati on	Subtotal (col s. 0-4)	-
		0	1.00	2.00	3.00		4.00	4A. 00	-
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0					C	1.00
2.00	Fixtures Capital Related - Movable	0		0				C	2.00
	Equipment			0		0			
3.00 4.00	Plant Operation & Maintenance Transportation	0	0 0	0		0 0	0	C	3.00 4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	1, 066, 650	0	0		0	0	1, 066, 650	5.00
6.00	Skilled Nursing Care	867, 314	0	0		0	0	867, 314	6.00
7.00 8.00	Physical Therapy Occupational Therapy	642, 179 121, 924	0	0		0 0	0		
9.00	Speech Pathology	38, 942	0	0		0	0		
	Medical Social Services Home Health Aide	12, 814 95, 260	0	0		0 0	0 0		
12.00	Supplies (see instructions)	117, 907	0	0		0	0		
	Drugs DME	0	0	0		0 0	0		
	HHA NONREI MBURSABLE SERVI CES		0	0			0	0	14.00
	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0 0	0		
17.00	Private Duty Nursing	0	0	0		0	0	-	
	Clinic Health Promotion Activities	0	0	0		0 0	0		
20.00	Day Care Program	0	0	0		0	0	0	20.00
	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0		
23.00	All Others (specify)	0	0	0		0	0	0	
	Telemedicine Total (sum of lines 1–23)	0 2, 962, 990	0	0		0 0	0	-	23.50
21.00		Admi ni strati ve						2,702,770	21.00
		& General 5.00	<u>4A + 5)</u> 6.00						-
1 00	GENERAL SERVICE COST CENTERS	1							1.00
1.00	Capital Related - Bldg. & Fixtures								1.00
2.00	Capital Related – Movable Equipment								2.00
3.00	Plant Operation & Maintenance								3.00
4.00 5.00	Transportation Administrative and General	1, 066, 650							4.00
	HHA REIMBURSABLE SERVICES								
6.00 7.00	Skilled Nursing Care Physical Therapy	463, 265 329, 513	1, 330, 579 971, 692						6.00 7.00
8.00	Occupational Therapy	120, 795	242, 719						8.00
9.00 10.00	Speech Pathology Medical Social Services	25, 541 6, 603	64, 483 19, 417						9.00
11.00	Home Health Aide	60, 895	156, 155						11.00
	Supplies (see instructions) Drugs	60, 038 0	177, 945 0						12.00
	DME	0	0						14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0						15.00
16.00	Respiratory Therapy	0	0						16.00
	Private Duty Nursing Clinic	0	0 0						17.00
19.00	Health Promotion Activities	0	0						19.00
	Day Care Program Home Delivered Meals Program	0	0						20.00
	Homemaker Service	0	0						22.00
22.00		-	-						
22. 00 23. 00	Al I Others (specify) Tel emedicine	0	0						23.00 23.50

COST A	ALLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:	CN: 15-0034 15-7313	Period: From 07/01/2019 To 06/30/2020	Date/Time Pre	pared:
						Home Health	11/25/2020 2: PPS	<u>58 pm</u>
		Capital Re	lated Costs			Agency I		
		Bldgs & Fixtures	Movable Equipment	Plant Operation &	Transportati (MI LEAGE)	onReconciliation	Administrative & General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	C				0		1.00
0.00	Fixtures					0		0.00
2.00	Capital Related – Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	C	-	0		0		4.00
5.00	Administrative and General		0	0		0 -1,066,650	2,069,917	5.00
0.00	HHA REI MBURSABLE SERVI CES		0	0		0 1,000,000	2,007,717	0.00
6.00	Skilled Nursing Care	C	0	0		0 31, 691	899, 005	6.00
7.00	Physical Therapy	c	0	0		0 -2, 735	639, 444	7.00
8.00	Occupational Therapy	C	0	0		0 112, 487		
9.00	Speech Pathol ogy	C	0	0		0 10, 622		
10.00	Medical Social Services	C	0	0		0 0	12, 814	
11.00	Home Health Aide	C	0	0		0 22, 911	118, 171	11.00
12.00	Supplies (see instructions)	C		0		0 -1, 399	116, 508	
13.00	Drugs DME			0		0 0		13.00 14.00
14.00	HHA NONREI MBURSABLE SERVI CES		u U	0		0 0	0	14.00
15.00	Home Dialysis Aide Services	C	0	0		0 0	0	15.00
16.00	Respiratory Therapy		-	0		0 0	0	16.00
17.00	Private Duty Nursing	c	0	0		0 0	0	17.00
18.00	Clinic	c	0	0		0 0	0	18.00
19.00	Health Promotion Activities	C	0	0		0 0	0	19.00
20. 00	Day Care Program	C	0	0		0 0	0	20.00
21.00	Home Delivered Meals Program	C	0	0		0 0	0	21.00
22.00	Homemaker Service	C	0	0		0 0	0	22.00
23.00	All Others (specify)		0	0		U 0	0	23.00
23.50	Telemedicine		0	0		0 000 070		23.50
24.00 25.00	Total (sum of lines 1-23) Cost To Be Allocated (per		0	0		0 -893, 073 0	2, 069, 917 1, 066, 650	
	Worksheet H-1, Part I)		J J	0		-	., 000, 000	_0.00
26 00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0.0000	00	0. 515311	26.00

LLUU	ATION OF GENERAL SERVICE COSTS 1	O HHA COSI CEN	TERS	Provider CC		Period:	Worksheet H-2	
				HHA CCN:		rom 07/01/2019 o 06/30/2020	11/25/2020 2:	pared: 58 pm
						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS	I	Agency		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS	MAI NTENANCE OF PERSONNEL	NONPATI ENT TELEPHONES	
		0	1.00	2.00	DEPARTMENT 4.00	4. 01	5. 01	
00 00 00 00 00 00 00 00 00 00 00 00 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	0 1, 330, 579 971, 692 242, 719 64, 483 19, 417 156, 155 177, 945 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	388, 279 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		11, 710 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 0 3. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 17. 0 17. 0 18. 0 19. 0 19. 5
	Cost Center Description	PURCHASI NG RECEI VI NG AND STORES	PATI ENT REGI STRATI ON	PATI ENT ACCOUNTI NG	Subtotal	ADMI NI STRATI VE & GENERAL	MAI NTENANCE & REPAI RS	
_		5.02	5.03	5.04	5A. 04	5.05	6.00	
.00 .00	Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	117 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 754 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 465 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	462, 673 1, 330, 579 971, 692 242, 719 64, 483 19, 417 156, 155 177, 945 0 0 0 0 0 0 0 0 0 0 0 0 0	177, 430 126, 201 46, 264 9, 782 2, 624 23, 322 21, 373 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2. (3. (5. (6. (7. (8. (9. (10. (11. (12. (13. (14. (15. (15. (17. (17. (17. (19. (1

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

	Financial Systems TION OF GENERAL SERVICE COSTS 1		T. MARY MEDICAL	Provider CC	N: 15-0034	Period:	u of Form CMS-2 Worksheet H-2	
ALLOG		U HIN COST CEN	TERS	HHA CCN:	15-7313	From 07/01/2019 To 06/30/2020	Part I	pared:
						Home Health	PPS	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	Agency I CAFETERI A	MAINTENANCE OF PERSONNEL	
		7.00	8.00	9.00	10.00	11.00	12.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to			9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	0 57, 299 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
	6 decimal places. Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	
		13.00	14.00	15.00	16.00	17.00	19.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.				14, 39 14, 39	0 0 0 0		$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ \end{array}$

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

Heal th	Financial Systems	S	T. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider CO	CN: 15-0034 15-7313	Period: From 07/01/2019 To 06/30/2020		pared:
						Home Health	PPS	•
	Cost Center Description	PARAMEDI CAL	Subtotal	Intern &	Subtotal	Agency I Allocated HHA	Total HHA	
	cost center bescription	EDUCATION PROGRAM EMS		Residents Cost & Post Stepdown		A&G (see Part II)	Costs	
		22.00	24.00	Adjustments	24.00	07.00	20,00	
1 00	Administrative and General	23.00	24.00	25.00	26.00	27.00	28.00	1.00
1.00		0	590, 333	0	0,0,0		1 770 170	
2.00	Skilled Nursing Care	0	1, 508, 009	0	1, 508, 00			
3.00 4.00	Physical Therapy	0	1,097,893	0	1, 097, 8			
4.00 5.00	Occupational Therapy Speech Pathology	0	288, 983	0	288, 98 74, 20			
5.00 6.00	Medical Social Services	0	74, 265 22, 041	0	22, 04			
7.00	Home Heal th Aide	0	179, 477	0	179, 4			
8.00	Supplies (see instructions)	0	199, 318	0	199, 3			
9.00	Drugs	0	177, 310	0	177, 3	0 54, 915	234, 233	9.00
10.00	DME	0	0	0			0	10.00
11.00	Home Dialysis Aide Services	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	
15.00	Health Promotion Activities	0	0	0		0 0	0	
16.00	Day Care Program	0	0	0		0 0	0	
17.00	Home Delivered Meals Program	0	0	0		0 0	0	17.00
18.00	Homemaker Service	0	0	0		0 0	0	18.00
19.00	All Others (specify)	0	0	0		0 0	0	19.00
19.50	Tel emedi ci ne	0	0	0		0 0	0	19.50
20. 00 21. 00	Total (sum of lines 1–19) (2) Unit Cost Multiplier: column	0	3, 960, 319	0	3, 960, 3	19 590, 333 0. 175174		20. 00 21. 00
	26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							

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

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS TO		T. MARY MEDICAL TERS STATISTICAL		CN: 15-0034	Period:	u of Form CMS-2 Worksheet H-2	
BASI S			HHA CCN:	15-7313	From 07/01/2019 To 06/30/2020	Part II Date/Time Pre 11/25/2020 2:	pared:
					Home Health Agency I	PPS	
	CAPITAL REL	ATED COSTS			Agency		
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	MAI NTENANCE (PERSONNEL (NUMBER OF FTES)	DF NONPATIENT TELEPHONES (NUMBER OF PHONES)	PURCHASI NG RECEI VI NG AND STORES (SUPPLY EXP ENSE)	
1.00 Administrative and Conserve	1.00	2.00	4.00	4.01	5.01	5. 02	1.00
 Administrative and General Administrative and General Skilled Nursing Care O Skilled Nursing Care O Physical Therapy O Occupational Therapy O Speech Pathology O Medical Social Services O Home Health Aide So Supplies (see instructions) O Drugs O DME O Meme Dialysis Aide Services O Respiratory Therapy O Respiratory Therapy O Home Delivered Meals Program O Home Delivered Meals Program O Home Delivered Meals Program O All Others (specify) So Telemedicine O Total cost to be allocated O Unit cost multiplier 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 378, 084 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 66 36, 34 13. 51220	0 0 0 0	122 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\$
Cost Center Description	REGI STRATI ON (GROSS REVE NUE)	ACCOUNTI NG (GROSS REVE NUE)		& GENERAL (ACCUM. COST	REPAI RS) (SQUARE FEET)	PLANT (SQUARE FEET)	
1.00 Administrative and General 2.00 Skilled Nursing Care	5. 03 4, 777, 469	5. 04 4, 777, 469	5A. 05 -48, 644 -17, 888			7.00	1.00 2.00
 a.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Heal th Ai de 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Ai de Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Heal th Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Unit cost multiplier 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-38, 002 99, 558 7, 888 0 16, 393 -19, 816 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	933, 64 342, 2 72, 3 19, 4 172, 54 158, 12	20 0 77 0 77 0 71 0 17 0 18 0 19 0 0 0		$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 25.\ 00\\ 20.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$

Heal th	Financial Systems	S	T. MARY MEDICAI	CENTER INC		Inlie	eu of Form CMS-2	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS				CN: 15-0034	Peri od:	Worksheet H-2	
BASI S				HHA CCN:	15-7313	From 07/01/2019 To 06/30/2020	Part II Date/Time Pre 11/25/2020 2:	pared: 58 pm
						Home Health Agency I	PPS	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	
		LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(NUMBER OF FTES)	PERSONNEL (NUMBER	ADMI NI STRATI ON	
		LAUNDRY)			TTES)	HOUSED)	(NURSING HO	
		8.00	9.00	10.00	11.00	12.00	URS) 13.00	
1.00	Administrative and General	0.00	9.00		2, 6		0	1.00
2.00	Skilled Nursing Care	0	0	0		0 0	0	2.00
3.00	Physical Therapy	0	0	0		0 0	0	
4.00 5.00	Occupational Therapy Speech Pathology	0	0	0		0 0	0	4.00 5.00
6.00	Medical Social Services	0	0	0			0	6.00
7.00	Home Health Aide	0	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	0	9.00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0		0 0	0	10.00
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 16.00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	15.00 16.00
17.00	Home Delivered Meals Program	0	0	0		0 0	0	
18.00	Homemaker Service	0	0	0		0 0	0	18.00
19.00	All Others (specify)	0	0	0		0 0	0	
19. 50 20. 00	Telemedicine Total (sum of lines 1–19)	0	0	0	2, 6		0	19.50 20.00
20.00	Total cost to be allocated	0	0	0	57, 2		0	21.00
22.00	Unit cost multiplier	0. 000000			21. 3007	43 0. 000000		22.00
	Cost Center Description	CENTRAL	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCIAL SERVI	CE NONPHYSI CI AN ANESTHETI STS	PARAMEDI CAL	
		SERVICES & SUPPLY	REQUIS.)	LIBRARY	(TIME SPENT)		EDUCATION PROGRAM EMS	
		(SUPPLY EXP		(GROSS REVE	(· · ···- · · · · · · · · · · · · · · ·	TIME)	(ASSI GNED	
		ENSE)	15.00	NUE)	17.00	10.00	TIME)	
1.00	Administrative and General	14.00	15.00 0	16.00 4,777,469	17.00	19.00 0 0	23.00	1.00
2.00	Skilled Nursing Care	0	0	0		0 0	0	
3.00	Physical Therapy	0	0	0		0 0	0	3.00
4.00 5.00	Occupational Therapy Speech Pathology	0	0	0			0	4.00 5.00
6.00	Medical Social Services	0	0	0		0 0	0	6.00
7.00	Home Health Aide	0	0	0		0 0	0	7.00
8.00	Supplies (see instructions)	0	0	0		0 0	0	8.00
9.00	Drugs DME	0	0	0		0 0	0	
10. 00 11. 00	Home Dialysis Aide Services	0	0	0			0	10.00
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	
15. 00 16. 00	Health Promotion Activities Day Care Program		0				0	
17.00	Home Delivered Meals Program	0	0	0		0 0	0	17.00
18.00	Homemaker Service	0	0	0		0 0	0	
19.00	All Others (specify)	0	0	0		0 0	0	19.00
19. 50 20. 00	Telemedicine Total (sum of lines 1–19)	0	0	0 4, 777, 469		0 0	0	19.50 20.00
20.00		0	0	4, 777, 469 14, 399		0 0	0	20.00
22.00		0. 000000	0. 000000			0. 000000	0. 000000	

	FIONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-0034	Peri od:	Worksheet H-3	
				HHA CCN:	15-7313	From 07/01/2019 To 06/30/2020	Part I Date/Time Pre 11/25/2020 2:	pared 58 pm
				Titl€	e XVIII	Home Health	PPS	
	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.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
			1.00	Part II)	2.00	1.00	4)	
	PART I - COMPUTATION OF LESSER		1.00				5.00	
	BENEFICIARY COST LIMITATION	OF AGGREGATE P	-KUGKAW CUST, A	GOREGATE OF TH	IL FROGRAM LIN	TATION COST, OF	X	
	Cost Per Visit Computation					-		
00	Skilled Nursing Care	2.00			1, 772, 17			
00	Physi cal Therapy	3.00						
00	Occupational Therapy	4.00						
00	Speech Pathology	5.00		C	87, 27 25, 90			
00 00	Medical Social Services Home Health Aide	6.00 7.00			210, 9			
00	Total (sum of lines 1-6)	7.00	3, 726, 086					7.
00			0,720,000		Program Visit			7.1
						art B		1
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject †	to Subject to		
					Deducti bl es			
			1.00	2.00	Coi nsurance		F 00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
00	Skilled Nursing Care		23844	C	6, 82	24		8.0
00	Physical Therapy		23844	C C				9.1
0. 00	Occupational Therapy		23844	C				10.
I. 00	Speech Pathology		23844	C	30	06		11.
2.00	Medical Social Services		23844	C		23		12.0
3.00	Home Health Aide		23844	C				13. (
4.00		E 111 - 11 - 0		0				14.0
	Cost Center Description		Facility Costs		Total HHA		Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)	1 (from HHA Records)	÷ col. 4)	
		20, 11110	11 2, 101 (1)	Part II)	1 2)	Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput							
5.00	Cost of Medical Supplies	8.00						
5.00	Cost of Drugs	9.00		-		0 0	0. 000000	16. (
			Program Visits		Cost of Services			
			Par	† B	Jervices	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles &			Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LIN	ITATION COST, OF	< compared by the second secon	
	Cost Per Visit Computation							1
. 00	Skilled Nursing Care	0	6, 824			0 1,009,679		1.(
00	Physical Therapy	0				0 748, 881		2.
00	Occupational Therapy	0				0 211, 857		3.
00	Speech Pathology	0	306			0 50, 869		4.
00	Medical Social Services	0	-			0 18, 617		5.
00	Home Heal th Aide	0				0 151, 955		6.0
00	Total (sum of lines 1-6)	0	14, 939			0 2, 191, 858		7.
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation	0.00	7.00	0.00	9.00	10.00	11.00	
00	Skilled Nursing Care							8.
00	Physical Therapy							9.
0. 00	Occupational Therapy							10.
I. 00	Speech Pathol ogy							11.
	Medical Social Services							12.
2.00								
. 00 . 00 . 00	Home Health Aide Total (sum of lines 8-13)							13. 14.

Heal th	Financial Systems	S	T. MARY MEDICA	L CENTER. INC.		In Lie	u of Form CMS-2	2552-10
	FIONMENT OF PATIENT SERVICE COST	S		Provider CO	CN: 15-0034	Peri od:	Worksheet H-3	
						From 07/01/2019	Part I	
				HHA CCN:	15-7313	To 06/30/2020	Date/Time Pre 11/25/2020 2:	pared: 58 pm
				Title	XVIII	Home Health	PPS	<u> </u>
						Agency I		
		Prog	ram Covered Cha	arges	Cost of			
					Servi ces			
				t B		Part B		
	Cost Center Description	Part A	Not Subject to	Deductibles &	Part A	Not Subject to	Subject to Deductibles &	
			Coi nsurance	Coinsurance		Deductibles & Coinsurance	Coi nsurance	
		6.00	7.00	8.00	9,00	10,00	11.00	
	Supplies and Drugs Cost Compute		7.00	0.00	9.00	10.00	11.00	
15.00	Cost of Medical Supplies		224, 519	0		0 224, 343	0	15.00
	Cost of Drugs		0			0 224, 349		
10100	Cost Center Description	Total Program						10100
		Cost (sum of						
		col s. 9-10)						
		12.00						
-	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	1, 009, 679						1.00
2.00	Physical Therapy	748, 881						2.00
3.00	Occupational Therapy	211, 857						3.00
4.00	Speech Pathol ogy	50, 869						4.00
5.00	Medical Social Services	18, 617						5.00
6.00	Home Heal th Ai de	151, 955						6.00
7.00	Total (sum of lines 1-6) Cost Center Description	2, 191, 858						7.00
	Cost center Description	12.00	-					
	Limitation Cost Computation	12.00						
8.00	Skilled Nursing Care	1	1					8.00
9.00	Physical Therapy							9,00
10,00	Occupational Therapy							10.00
11.00	Speech Pathol ogy							11.00
12.00								12.00
13.00	Home Heal th Ai de							13.00
	Total (sum of lines 8-13)							14.00
11.00		I	I					

Health Financial Systems	S	T. MARY MEDICAL	CENTER, INC.		In Lieu of Form CMS-2552-1			
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0034	Period: From 07/01/2019	Worksheet H-3 Part		
			HHA CCN:	15-7313	To 06/30/2020	Date/Time Pre 11/25/2020 2:	pared: 58 pm	
			Title	e XVIII	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		provi der	Costs (col.	1 Indicated			
			records)	x col. 2)				
	0	1.00	2.00	3.00	4.00			
PART II - APPORTIONMENT OF COS	ST OF HHA SERVI	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS			
1.00 Physical Therapy	66.00	0. 298898	0	I	0 col. 2, line 2	. 00	1.00	
2.00 Occupational Therapy	67.00	0. 181354	0		Ocol. 2, line 3	. 00	2.00	
3.00 Speech Pathology	68.00	0. 405700	0		Ocol. 2, line 4	. 00	3.00	
4.00 Cost of Medical Supplies	71.00	0. 405316	0		0 col. 2, line 1	5. 00	4.00	
5.00 Cost of Drugs	73.00	0. 184181	0		Ocol. 2, line 1	6. 00	5.00	
					1		•	

	Financial Systems ST. MARY MEDICAL CE ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCM	N: 15-0034	Peri od:		u of Form CMS- Worksheet H-4	
		HHA CCN:	15-7313	From 07/01 To 06/30		Part I-II Date/Time Pre 11/25/2020 2:	pare
		Ti tl e	XVIII	Home Hea Agency		PPS	
					Par		
			Part A	Deductibl	es &	Subject to Deductibles &	
		-	1.00	Coi nsura 2. 00		Coi nsurance 3. 00	-
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGES		2.00		3.00	
00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0	0	0	1
0	Total charges			0	0	0	
	Customary Charges				0		
0	Amount actually collected from patients liable for payment for on a charge basis (from your records)	servi ces		0	0	0	3
00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a	payment ccordance		0	0	0	4
00	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00 0.0	00000	0. 000000	5
00	Total customary charges (see instructions)		0.0000	0	00000	0.000000	
00	Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1)			0	0	0	
00	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	y it line		0	0	0	8
00	Primary payer amounts			0	0	0	Ģ
				Part Servi c		Part B Services	
				1.00		2.00	
00	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)				0	0	10
00	Total PPS Reimbursement - Full Episodes without Outliers				0	1, 965, 265	
00	Total PPS Reimbursement - Full Episodes with Outliers				0	362, 380	
00	Total PPS Reimbursement - LUPA Episodes				0	32, 622	
00	Total PPS Reimbursement - PEP Episodes				0	23, 307	
00 00	Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes				0	106, 597 9, 984	
00	Total Other Payments				0	9, 984 0	
00	DME Payments				0	0	
00	Oxygen Payments				0	0	
00	Prosthetic and Orthotic Payments				Ő	0	
00	Part B deductibles billed to Medicare patients (exclude coinsu	rance)			0	0	-
00	Subtotal (sum of lines 10 thru 20 minus line 21)	r unoc)			0	2, 500, 155	
00	Excess reasonable cost (from line 8)				Ő	2,000,100	
00	Subtotal (line 22 minus line 23)				Ő	2, 500, 155	
00	Coinsurance billed to program patients (from your records)				-	_,,	
00	Net cost (line 24 minus line 25)				0	2, 500, 155	
00	Reimbursable bad debts (from your records)				-	, ,	2
00	Reimbursable bad debts for dual eligible beneficiaries (see in	structions)					28
00	Total costs - current cost reporting period (line 26 plus line				0	2, 500, 155	
00	OTHER ADJUSTMENT	,			0	882	
50	Pioneer ACO demonstration payment adjustment (see instructions)			0	0	
99	Demonstration payment adjustment amount before sequestration				0	0	
00	Subtotal (see instructions)				0	2, 501, 037	
01	Sequestration adjustment (see instructions)				0	44, 983	
	Demonstration payment adjustment amount after sequestration				Ő	0	
02	Interim payments (see instructions)				Ő	2, 456, 054	
02 00					0	2, 100, 001	
00	Tentative settlement (for contractor use only)						
00 00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32, a	nd 33)			0		
00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32, a Protested amounts (nonallowable cost report items) in accordan		Pub. 15-2		0	0	34

	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider CC	CN: 15-0034	Period: From 07/01/201	Worksheet H-5	
PR	JGRAM BENEFI CI ARI ES	HHA CCN:	15-7313	To 06/30/202		pare 58 p
				Home Health Agency I	PPS	<u>oo p</u>
		I npati en	t Part A		ırt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0 0	2, 456, 054 0	1. 2.
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
	Program to Provider					
01				0	0	3
)2				0	0	3
)3				0	0	
)4)5				0	0	
.0	Provider to Program			0		
0				0	0	3
51				0	0	3
52 53				0	0	
53 54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	2, 456, 054	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1)2				0	0	5
)2)3				0	0	5
-	Provider to Program					ĺÌ
0				0	0	5
51 52				0	0	5
12	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
0	5.50-5.98) Determined net settlement amount (balance due) based on				, i i i i i i i i i i i i i i i i i i i	6
	the cost report. (1)					
)1	SETTLEMENT TO PROVIDER			0	0	6
)2)0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)			0	0 2, 456, 054	
				Contractor	NPR Date	<u> </u>
				Number	(Mo/Day/Yr)	
		C)	1.00	2.00	

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

 CALCULATION OF CAPITAL PAYMENT
 Provider CCN: 15-0034
 Period: From 07/01/2019 To 06/30/2020
 Worksheet L Parts I-III Date/Time Prepared: 11/25/2020 2:58 pm

				11/25/2020 2.	Jo pili		
		Title XVIII	Hospi tal	PPS			
				1.00			
	PART I - FULLY PROSPECTIVE METHOD						
	CAPITAL FEDERAL AMOUNT			-			
1.00	Capital DRG other than outlier			2, 979, 224	1.00		
1.01	Model 4 BPCI Capital DRG other than outlier			0	1.01		
2.00	Capital DRG outlier payments			18, 924	2.00		
2.01	Model 4 BPCI Capital DRG outlier payments			0	2.01		
3.00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructions)	119.53	3.00		
4.00	Number of interns & residents (see instructions)			0.00	4.00		
5.00	Indirect medical education percentage (see instructions)			0.00	5.00		
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.01	, columns 1 and	0	6.00		
	1.01) (see instructions)						
7.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (Worksheet E	, part A line	3.43	7.00		
	30) (see instructions)	5	•				
8.00	Percentage of Medicaid patient days to total days (see instru		15.10	8.00			
9.00	Sum of lines 7 and 8			18.53	9.00		
10.00	Allowable disproportionate share percentage (see instructions)		3.82	10.00			
11.00	Disproportionate share adjustment (see instructions)			113, 806	11.00		
12.00	Total prospective capital payments (see instructions)			3, 111, 954	12.00		
				1.00			
	PART II - PAYMENT UNDER REASONABLE COST			1			
1.00	Program inpatient routine capital cost (see instructions)			0	1.00		
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00		
3.00	Total inpatient program capital cost (line 1 plus line 2)			0			
4.00	Capital cost payment factor (see instructions)			0	4.00		
4.00 5.00	Total inpatient program capital cost (line 3 x line 4)			0			
5.00				0	5.00		
				1.00			
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00			
1.00	Program inpatient capital costs (see instructions)			0	1.00		
2.00	Program inpatient capital costs for extraordinary circumstance	oc (coo instructions)		0	2.00		
		es (see mistructions)					
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00		
4.00	Applicable exception percentage (see instructions)			0.00			
5.00	Capital cost for comparison to payments (line 3 x line 4)			0			
6.00	Percentage adjustment for extraordinary circumstances (see in			0.00			
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	line 6)	0			
8.00	Capital minimum payment level (line 5 plus line 7)			0			
9.00	Current year capital payments (from Part I, line 12, as appli			0			
10.00	Current year comparison of capital minimum payment level to ca			0	10.00		
11.00	Carryover of accumulated capital minimum payment level over ca	apital payment (from pri-	or year	0	11.00		
	Worksheet L, Part III, line 14)						
12.00	Net comparison of capital minimum payment level to capital pay		0	12.00			
13.00	Current year exception payment (if line 12 is positive, enter	the amount on this line)	0	13.00		
14.00	Carryover of accumulated capital minimum payment level over ca	apital payment for the f	ollowing period	0	14.00		
	(if line 12 is negative, enter the amount on this line)						
15.00	Current year allowable operating and capital payment (see ins	tructions)		0	15.00		
16.00	Current year operating and capital costs (see instructions)			0	16.00		
17.00	Current year exception offset amount (see instructions)			0	17.00		