PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY MEDICAL CENTER, INC. (15-0034) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 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 (Si gned) Officer or Administrator of Provider(s)

VP OF FINANCE/CFO

Title

(Dated when report is electronically signed.)

number of times reopened = 0-9.

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	393, 775	11, 951	0	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	80, 115	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	o	0		0	9. 00
200.00	Total	0	473, 890	11, 951	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.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0034 Peri od: Worksheet S-2 From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:33 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1500 SOUTH LAKE AVENUE 1.00 PO Box: 1.00 State: IN 2.00 City: HOBART Zip Code: 46342 County: LAKE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST. MARY MEDICAL 150034 23844 07/01/1966 Ν 3.00 1 CENTER, INC. Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF SMMC REHABILITATION 15T034 23844 5 01/01/2001 Ν Р Р 5.00 6.00 Subprovi der - (Other) 6.00 Swi ng Beds - SNF Swi ng Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA SMMC HOME HEALTH AGENCY 157313 23844 02/08/1996 Ν Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital - Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2020 06/30/2021 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1 22 03 22.03 Did this hospital receive a geographic reclassification from urban to N N N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to N 22.04 rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 3 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

57.00 | If line 56 is yes, is this the first cost reporting period during which residents in approved

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

57 00

58 00

59.00

N

N

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider 0	CCN: 15-0034	Peri od: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Pre 11/23/2021 10	pared
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1. 00	2.00	3.00	
O.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in cois "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	.85? (se lumn 1. CR) NAHE umn 2.	ee If column 1 MA payment	Y	Y		60. (
 Of liftine 60 is yes, complete columns 2 and 3 for each instructions) 	program.	. (see	Direct GME	23. 00	1 Direct GME	60.
	1710	I IVIL	Direct GWL	I WIL	DITECT GWL	
	1. 00	2. 00	3. 00	4.00	5. 00	<u></u>
 .00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) .01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 	N			0.00	0.00	61.
 .02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) .03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for 						61.
determining compliance with the 75% test. (see instructions) .04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.
current cost reporting period. (see instructions). 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.
care or general surgery. (see instructions)	Dro	gram Name	Program Code	e Unweighted IME	Unweighted	
	PIO	graiii Naiile	Program cou		Direct GME FTE Count	
10 00 11 575 1 11 (4 05		1. 00	2. 00	3.00	4.00	
 .10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. .20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0. 00		
	•		•	·	1.00	
ACA Provisions Affecting the Health Resources and Se .00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru	trai ned			riod for which	0.00	62.
your inspiral received mask rock fulling (see fist) Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	a Teachiı			o your hospital	0.00	62.

Health Financial Systems	ST. MARY	MEDICAL CENTER, INC.		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL			F	eriod: from 07/01/2020 fo 06/30/2021	Worksheet S-2 Part I Date/Time Pre 11/23/2021 10	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	oo um
C 1' 5504 C 11 404 B V	ETE D ' I I ' N		1.00	2.00	3.00	
Section 5504 of the ACA Base Yea period that begins on or after J			inis base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTÉs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2.00	3. 00	4.00	5. 00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unwei ghted FTEs in	Ratio (col. 1/ (col. 1 + col.	65. 00
			Nonprovi der	Hospi tal	2))	
			Si te			
5504 6 44 404 0			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	sETTECTIVE T	or cost reporti	ng perioas	
66.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3 column 2)). (see ins	rovider settings. ry care resident 3 the ratio of structions)	0. 00			66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4.00	5. 00	
67.00 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)			0.00	0. 00	0. 000000	67. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	r CCN: 15-0034	Period: From 07/01, To 06/30,	/2021	Workshe Part I Date/Ti 11/23/2	me Pre	pared:
			1.00	2. 00	3. 00	-
Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it or	ontain an IDE su	hnrovi dor?	l N			70.00
Enter "Y" for yes or "N" for no.			Į IN			
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME tead recent cost report filed on or before November 15, 2004? Enter "Y" for					0	71. 00
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residen	nts in a new tea	chi ng				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for Column 3: If column 2 is Y, indicate which program year began during the						
(see instructions)						
Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does in	t contain an IRF		Υ			75. 00
subprovider? Enter "Y" for yes and "N" for no.					_	
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teach recent cost reporting period ending on or before November 15, 2004? En			N	N	0	76. 00
no. Column 2: Did this facility train residents in a new teaching progr	ram in accordanc	e with 42				
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: indicate which program year began during this cost reporting period. (
		,	<u> </u>		_	
Long Term Care Hospital PPS				1.0	0	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for				N		80.00
81.00 Is this a LTCH co-located within another hospital for part or all of the "Y" for yes and "N" for no.	he cost reportin	g period? E	nter	N		81.00
TEFRA Provi ders						1
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? En 86.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit) under 1.00 Did this facility establish a new Other subprovider (excluded unit)	-		no.	N		85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						00.00
87.00 Is this hospital an extended neoplastic disease care hospital classification [1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ed under section			N		87.00
Troco(d) (1) (B) (VI). Enter 1 101 yes of 11 101 inc.		V		XI X		
Title V and XIX Services		1. 00		2. 0	0	
90.00 Does this facility have title V and/or XIX inpatient hospital services	? Enter "Y" for	N		Υ		90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost re	nort either in	l N		Υ		91.00
full or in part? Enter "Y" for yes or "N" for no in the applicable colu	umn.					
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certific instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00
93.00 Does this facility operate an ICF/IID facility for purposes of title V		N		N		93.00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for	r no in the	N		N		94.00
applicable column.						
95.00 If line 94 is "Y", enter the reduction percentage in the applicable col 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for		0. 00 N		0. 0 N		95. 00 96. 00
applicable column.						
97.00 If line 96 is "Y", enter the reduction percentage in the applicable col 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and i		0. 00 N	'	0. 0 N		97.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or '						70.00
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of	charges on Wkst	. N		Υ		98. 0
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and						
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation (of observation	N		Υ		98. 02
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for I						
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access	s hospital (CAH)	N		N		98. 03
reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for	, ,					
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed	101% of	N		N		98. 04
outpatient services cost? Enter "Y" for yes or "N" for no in column 1						
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE	di sal I owance on	N		Υ		98. 05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for						
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed	for Wkst. D.	N		N		98. 06
Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for titl						
column 2 for title XIX. Rural Providers						1
105.00 Does this hospital qualify as a CAH?		N				105. 00
106.00 If this facility qualifies as a CAH, has it elected the all-inclusive r for outpatient services? (see instructions)	method of paymen	t				106. 00
		1				107. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimburs						107.00
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimburs training programs? Enter "Y" for yes or "N" for no in column 1. (see i	instructions)					107.00
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimburs	instructions) I&Rs in an					107.00

	Provi der Co		eri od:	Worksheet S-2	2
		F	rom 07/01/2020 o 06/30/2021	Date/Time Pro	
			V	XI X	0: 33
			1. 00	2.00	
8.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N		108
John Section 3412. 115(c). Effect 1 101 yes of 14 101 its.	Physi cal	Occupati onal	Speech	Respi ratory	
2 00 E this best tall such Sissers a CAN are a seat many idea.	1.00	2.00 N	3.00 N	4. 00 N	100
Or 0.00 or 1 f 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.		IN IN	IN	IN IN	109
				1.00	+
D. 00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. In	f yes,	N	110
			1.00	2.00	-
1.00 f this facility qualifies as a CAH, did it participate in t	the Frontier C	ommuni ty	1. 00 N	2.00	111
Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting of solumn 1 is Y, or ticipating in	period? Enter enter the column 2.	·		
		1.00	2. 00	3.00	1
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear	period? s "Y", enter ne	N			11:
participation in the demonstration, if applicable.					
Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N			011!
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	3, or E only) 93" percent (includes				
the definition in CMS Pub.15-1, chapter 22, §2208.1. 5.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			11
0.00 is this facility legally-required to carry malpractice insur	rance? Enter	Y			11
"Y" for yes or "N" for no. B.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr			1		11
	- G.1.0C.	Premi ums	Losses	Insurance	
	S.1.661				
		Premi ums	2.00	3.00	0 11
	<u> </u>	1.00	2.00	3.00	0 118
3.01 List amounts of malpractice premiums and paid losses:	center other	1.00 than the	2.00	3.00	
E.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 9.00 Is this a SCH or EACH that qualifies for the Outpatient Hold S3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that queloud Hold Harmless provision in ACA §3121 and applicable amendments?	center other dule listing c d Harmless pro n column 1, "Y ualifies for t	than the ost centers vision in ACA " for yes or he Outpatient	2.00	3.00	111
6.01 List amounts of malpractice premiums and paid losses: 6.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 7.00 DO NOT USE THIS LINE 7.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	center other dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst	than the ost centers vision in ACA " for yes or he Outpatient ructions)	2.00 1 00 1.00 N	3.00	118
Administrative and General? If yes, submit supporting schedand amounts contained therein. ODD NOT USE THIS LINE OD Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter ir "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in Column 2, "Y" for yes or "N" for no. OD Did this facility incur and report costs for high cost implayments? Enter "Y" for yes or "N" for no.	center other dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to	2.00 1 C 1.00 N	3.00	118
.01 List amounts of malpractice premiums and paid losses: .02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. .00 DO NOT USE THIS LINE .00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA \$3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost implated patients? Enter "Y" for yes or "N" for no. .00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	center other dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device	than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to (w)(3) of the	2.00 1.00 N	3.00	11111120
6.01 List amounts of malpractice premiums and paid losses: 6.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 7.00 DO NOT USE THIS LINE 7.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualled Hold Harmless provision in ACA \$3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 8.00 Did this facility incur and report costs for high cost implainable patients? Enter "Y" for yes or "N" for no. 8.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information	center other dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device fined in §1903 1 is "Y", ente	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the r in column 2	2.00 1 C 1.00 N	3.00	118
Administrative and General? If yes, submit supporting schedand amounts contained therein. ODD NOT USE THIS LINE ODIS this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA \$3121 and applicable amendment in column 2, "Y" for yes or "N" for no. ODD designation of the Column of the Worksheet A line number where these taxes are included. Transplant Center Information ODD Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	center other dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device fined in §1903 1 is "Y", ente	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to (w) (3) of the r in column 2	2.00 1 00 1.00 N	3.00	118 119 120 121 122
Are malpractice premiums and paid losses: Administrative and General? If yes, submit supporting schedand amounts contained therein. OUDDO NOT USE THIS LINE OUBSTAND IN THE STAND IN THE	center other dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device fined in \$1903 1 is "Y", ente	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to (w) (3) of the r in column 2	2.00 1 00 1.00 N	3.00	118 119 120 122 122
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 3.00 DO NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no. 3.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 3.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, enter of this is a Medicare certified heart transplant center, enter of the column 1 and termination date, if applicable, in column 2.	center other dule listing control disting control disting control disting control distinct	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the rin column 2 for no. If fication date	2.00 1 00 1.00 N	3.00	118 119 120 122 122 126
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 3.00 DO NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no. 4.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 5.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2.	center other dule listing control dule listing control dumn 1, "Y dualifies for the device fined in \$1903 1 is "Y", enter the certical control dumn 1, "Y dualifies for the certical dumn 1, "Y dumn 1	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the r in column 2 for no. If fication date	2.00 1 00 1.00 N	3.00	118 119 120 122 122 123 120
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 9.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for no. 10.00 Did tharmless provision in ACA \$3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 10.00 Did this facility incur and report costs for high cost implated patients? Enter "Y" for yes or "N" for no. 10.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 10.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 10.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 and termination date	center other dule listing content dule list and list of the certiful content dule list of th	than the ost centers vision in ACA "for yes or he Outpatient ructions) s charged to (w) (3) of the rin column 2 for no. If fication date ication date ication date	2.00 1.00 N N N N N	3.00	118 118 119 120 121 122 128 126 127
8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 9.00 DO NOT USE THIS LINE 9.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that quelled Hold Harmless provision in ACA \$3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in c	center other dule listing content dule list and list of the certiful content dule list of th	than the ost centers vision in ACA "for yes or he Outpatient ructions) s charged to (w) (3) of the rin column 2 for no. If fication date ication date ication date	2.00 1.00 N N N N N	3.00	118 119 120 122 122 126 126

Health Financial Systems	ST. MARY MEDICA	AL CENTER, INC.		In Lie	eu of Form CMS	S-2552-10
HOSPI TAL AND HOSPI TAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi der CC	CN: 15-0034	Peri od: From 07/01/2020	Worksheet S- Part I	-2
				To 06/30/2021		
					11/23/2021	10. 33 aiii
131.00 If this is a Medicare certified int	ostinal transplant cont	or ontor the co	orti fi cati on	1. 00	2.00	131. 00
date in column 1 and termination da	te, if applicable, in c	olumn 2.				
132.00 If this is a Medicare certified isl in column 1 and termination date, i			cation date			132. 00
133.00 Removed and reserved	•					133. 00
134.00 If this is an organ procurement organd termination date, if applicable		the OPO number i	n column 1			134. 00
All Providers		defined in OMC	D. b. 15 1		1511054	140.00
140.00 Are there any related organization chapter 10? Enter "Y" for yes or "N				Y Y	15H054	140. 00
are claimed, enter in column 2 the		<u>r. (see instruct</u> 00	tions)	3. 00		
If this facility is part of a chair	organization, enter on	lines 141 thro			of the	
home office and enter the home offi 141.00 Name: COMMUNITY FOUNDATION OF NW I				or's Number: 0800	01	141. 00
I NC.			Johntract	or a rumber. ooo	<i>.</i>	
142.00 Street: STREET: STREET: 10010 DONA	ALD PO Box: 2	201				142. 00
143.00 Ci ty: MUNSTER	State: I	N	Zi p Code	: 4632	21	143. 00
					1.00	
144.00 Are provider based physicians' cost	s included in Worksheet	A?			Y	144. 00
				1. 00	2.00	
145.00 If costs for renal services are cla				Y	N	145. 00
no, does the dialysis facility incl	ude Medicare utilization					
period? Enter "Y" for yes or "N" f 146.00 Has the cost allocation methodology		nusty filed cost	renort?	N		146. 00
Enter "Y" for yes or "N" for no in	column 1. (See CMS Pub.					140.00
yes, enter the approval date (mm/dd	/yyyy) in column 2.					
					1.00	
147.00 Was there a change in the statistic 148.00 Was there a change in the order of					Y N	147. 00 148. 00
149.00 Was there a change to the simplifie		Enter "Y" for ye	es or "N" for		N	149. 00
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX	
Does this facility contain a provio		n exemption from	n the applica	ation of the lowe	er of costs	
or charges? Enter "Y" for yes or "N 155.00 Hospi tal	" for no for each compo	nent for Part A	and Part B.	(See 42 CFR §413	3. 13) N	155. 00
156.00 Subprovi der - IPF		N	N	N	N	156. 00
157. 00 Subprovi der - I RF 158. 00 SUBPROVI DER		N	l N	N	N	157. 00 158. 00
159. 00 SNF		N	N	N	N	159. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	l N N	N N	N N	160. 00 161. 00
				'		
Multicampus					1.00	
165.00 s this hospital part of a Multicam	pus hospital that has o	ne or more campu	uses in diffe	erent CBSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State Zi	p Code CBSA	FTE/Campus	
1// 00/15 11 1/5 1	0	1. 00	2. 00	3.00 4.00	5.00	00111
166.00 If line 165 is yes, for each campus enter the name in column					0.0	00 166. 00
0, county in column 1, state in						
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	
Health Information Technology (HIT)				nt Act		
167.00 ls this provider a meaningful user 168.00 lf this provider is a CAH (line 105				, enter the	Y	167. 00 168. 00
reasonable cost incurred for the HI	T assets (see instruction	ons)	ŕ			
168.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?						168. 01
169.00 If this provider is a meaningful us transition factor. (see instruction	er (line 167 is "Y") and				9.	99169.00

Health Financial Systems	CENTER, INC.	In Lie	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0034				
			From 07/01/2020		
			To 06/30/2021	Date/Time Pre	
				11/23/2021 10	:33 am_
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider	nave any days for indiv	viduals enrolled in	N	0	171. 00
section 1876 Medicare cost plans report					
"Y" for yes and "N" for no in column 1.	If column 1 is ves. er	nter the number of section	n l		
1876 Medicare days in column 2. (see in					
11070 Medicare days in cordini 2. (see in	oti ucti onoj		1	1	I

Heal th	Financial Systems ST. MARY MEDICAL	CENTER, INC.		In Li∈	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0034	Peri od: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Pro 11/23/2021 10	epared:
				Y/N 1.00	Date	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	sponses. Ent		2.00 the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					_
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N)		1.00
		<u> </u>	Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare P	rogram2 lf	1.00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	ın 3, "V" for				
3. 00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)					3.00
	refute offships. (See Thisti dett offs)		Y/N	Туре	Date	
	Financial Data and Deports		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Y A Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.					4. 00
5. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5. 00
	those on the fired financial statements: If yes, submit fee	oner i rati on.		Y/N	Legal Oper.	
				1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider i	s N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		I during the	Y N		7. 00 8. 00
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medic	al education	N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	S.		N		10. 00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
					Y/N 1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	see instruct	ions		Y	12. 00
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		-		N	14. 00
15. 00	Did total beds available change from the prior cost reporti		<u>yes, see ins</u> t A		t B	15. 00
		Y/N	Date	Y/N	Date	
	DC4D D I	1. 00	2. 00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	09/28/2021	Y	09/28/2021	17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

10SPI T	Financial Systems ST. MARY MEDICAL FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-0034	Peri od: From 07/01/2020	worksheet S-2			
				To 06/30/2021	Part II Date/Time Pre 11/23/2021 10			
		Descri	ption	Y/N	Y/N). 33 all		
		C		1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00		
	report data for other. Beseribe the other day astments.	Y/N	Date	Y/N	Date			
1 00		1.00	2. 00	3. 00	4. 00	04.0		
1. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 0		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCER	PT CHILDRENS HO	OSPI TALS)					
2. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 0		
3. 00	Have changes occurred in the Medicare depreciation expense (reporting period? If yes, see instructions.		als made du	ring the cost		23. 0		
4. 00	Were new leases and/or amendments to existing leases entered of the second of the seco	d into during	this cost re	eporting period?		24.0		
5. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period′	? If yes, see		25. 0		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period?	If yes, see		26. 0		
27. 00								
8. 00								
9. 00	period? If yes, see instructions. Do Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)							
0. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled mature.	ructions rity with new o	debt? If yes	s, see		30.0		
1. 00	instructions. Has debt been recalled before scheduled maturity without issinstructions.	suance of new (debt? If yes	s, see		31.0		
2. 00	Purchased Services Have changes or new agreements occurred in patient care services		d through co	ontractual		32.0		
3. 00	arrangements with suppliers of services? If yes, see instruction and instructions are instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the section of Sec. 2135.2 applied to the section of Sec. 2135.2 applied to the sec. 2135.2 ap		g to competi	itive bidding? If		33. 0		
	Provi der-Based Physi ci ans					١		
4. 00	Are services furnished at the provider facility under an arr If yes, see instructions.	rangement with	provi der-ba	ased physicians?		34.0		
5. 00	If line 34 is yes, were there new agreements or amended eximply sicians during the cost reporting period? If yes, see in:		ts with the	provi der-based		35.0		
	This or the darring the book rope, tring porroas it. your book in			Y/N	Date			
	Home Office Costs			1. 00	2. 00	-		
36. 00	Were home office costs claimed on the cost report?					36. 0		
	If line 36 is yes, has a home office cost statement been proof of the line 36 is yes, see instructions.	epared by the	home office	?		37. 0		
8. 00				f		38. 0		
9. 00				S,		39.0		
0. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40.0		
		1. (00	2.	00	1		
	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,	CATHERI NE		WOERNER		41.0		
1. 00	respectively							
1. 00	respectively. Enter the employer/company name of the cost report preparer.	COMMUNITY HOSPI	I TAL			42.0		

Heal th	Health Financial Systems ST. MARY MEDI				In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provi der C	CN: 15-0034	Peri od: From 07/01/2020	Worksheet S-2 Part II		
					To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :33 am	
			3.	. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/positio	n	REIMBURSEMENT	SUPERVI SOR			41.00	
	held by the cost report preparer in columns 1, 2, and	13,						
	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 c	cost					43.00	
	report preparer in columns 1 and 2, respectively.							

| Peri od: | Worksheet S-3 | From 07/01/2020 | Part | | To 06/30/2021 | Date/Time Prepared:
 Heal th Financial
 Systems
 ST.
 MARY

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 15-0034

						o 06/30/2021	Date/Time Pre		
							I/P Days / O/P		
							Visits / Trips		
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V		
		Line Number			Avai I abl e				
		1. 00		2. 00	3. 00	4. 00	5. 00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		160	58, 400	0.00	0	1	. 00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
2 00	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2. 00
3.00	HMO I PF Subprovi der								3. 00
4.00	HMO IRF Subprovider						0		. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF								5. 00 5. 00
7. 00	, ,			160	E0 400	0.00			. 00 '. 00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)			100	58, 400	0.00	0	′	. 00
8. 00	INTENSIVE CARE UNIT	31. 00		20	7, 300	0.00	0	۾ ا	3. 00
9. 00	CORONARY CARE UNIT	31.00		20	7,300	0.00	Ĭ		0. 00
10. 00	BURN INTENSIVE CARE UNIT). 00
11. 00	SURGICAL INTENSIVE CARE UNIT								. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)								2. 00
13. 00	NURSERY	43. 00					0		3. 00
14. 00	Total (see instructions)	10.00		180	65, 700	0.00			. 00
15. 00	CAH visits						0		5. 00
16. 00	SUBPROVIDER - IPF						_		. 00
17. 00	SUBPROVIDER - IRF	41. 00		20	7, 300		l 0	17	. 00
18. 00	SUBPROVI DER				1			18	3. 00
19. 00	SKILLED NURSING FACILITY							19	0.00
20.00	NURSING FACILITY							20	0. 00
21.00	OTHER LONG TERM CARE							21	. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22	2. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23	3. 00
24.00	HOSPI CE							24	. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24	. 10
25. 00	CMHC - CMHC							25	5. 00
26. 00	RURAL HEALTH CLINIC								. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0		. 25
27. 00	Total (sum of lines 14-26)			200)				. 00
28. 00	Observation Bed Days						0		3. 00
29. 00	Ambul ance Tri ps								0. 00
30.00	Employee discount days (see instruction)								0. 00
31. 00	Employee discount days - IRF								. 00
32.00	Labor & delivery days (see instructions)			0)			2. 00
32. 01	Total ancillary labor & delivery room							32	2. 01
22 00	outpatient days (see instructions)							22	
33.00	LTCH non-covered days								3. 00
33. UI	LTCH site neutral days and discharges		l		I		l	33	3. 01

Provider CCN: 15-0034

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 07/01/2020 Part I
To 06/30/2021 Date/Time Prepared:
11/23/2021 10:33 am

						11/23/2021 10	: 33 am
		I/P Days	o/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	15, 204	933	36, 121			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)	11, 411	5, 706				2. 00
3.00	HMO IPF Subprovider	11, 411	3, 700				3.00
4.00	HMO IRF Subprovider	698	469				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0 70	409	,			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	o o	0				6.00
7. 00	Total Adults and Peds. (exclude observation	15, 204	933	36, 121			7.00
7.00	beds) (see instructions)	10, 201	700	00, 121			7.00
8.00	INTENSIVE CARE UNIT	1, 795	18	5, 136	,		8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		98	1, 434			13. 00
14.00		16, 999	1, 049	42, 691	0.00	1, 091. 87	14. 00
15. 00		0	0	C)		15. 00
16. 00							16. 00
17. 00	I .	3, 441	44	5, 437	0.00	27. 84	
18.00							18.00
19.00	I .						19.00
20.00	I .						20.00
21. 00 22. 00	I .	12, 274	0	24, 672	0.00	27. 34	21. 00 22. 00
23. 00		12, 214	U	24, 072	0.00	27.34	23. 00
24. 00							24. 00
24. 10				9			24. 10
25. 00							25. 00
26. 00	l .						26.00
26. 25		0	0	C	0.00	0.00	ł
27. 00	l .	_		_	0. 00	l	ł
28. 00	,		0	5, 096		,	28. 00
29. 00		o					29. 00
30.00				C)		30. 00
31.00	Employee discount days - IRF			C			31. 00
32.00	Labor & delivery days (see instructions)	0	110	229			32. 00
32. 01				C			32. 01
	outpatient days (see instructions)						
	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

| Period: | Worksheet S-3 | From 07/01/2020 | Part | To 06/30/2021 | Date/Time Prepared: Provider CCN: 15-0034

				To	06/30/2021	Date/Time Prep 11/23/2021 10	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	'	Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(3, 476	201	8, 567	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			1, 801	1, 153		2. 00
3. 00	HMO IPF Subprovider			1, 601	1, 155		3. 00
4.00	HMO IRF Subprovider				37		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				0.		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00 14. 00	NURSERY	0. 00	(2 474	201	8, 567	13. 00 14. 00
15. 00	Total (see instructions) CAH visits	0.00	(3, 476	201	0, 307	15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF	0. 00	(322	4	488	
18. 00	SUBPROVI DER	0.00	·	1		100	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00 26. 25	RURAL HEALTH CLINIC	0. 00					26. 00 26. 25
27. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0034

					Ť.	o 06/30/2021		
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.		Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	. 33 aiii
		1. 00	2. 00	A-6) 3.00	4.00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	76, 001, 850	0	76, 001, 850	2, 385, 864. 22	31. 86	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0.00	2. 00
3. 00	Non-physician anesthetist Part		0	0	0	0.00	0.00	3. 00
4.00	Physician-Part A -		0	О	0	0.00	0.00	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		0 171, 380	0	1	0. 00 3, 588. 00		4. 01 5. 00
	Physician-Part B							
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0.00	0.00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 4, 441, 177	0	_	0. 00 123, 297. 00	1	
10.00	instructions) OTHER WAGES & RELATED COSTS		4, 441, 177		4, 441, 177	123, 297. 00	36. 02	10.00
11. 00	Contract Labor: Direct Patient		4, 398, 009	0	4, 398, 009	86, 231. 14	51.00	11. 00
12. 00	Care Contract labor: Top level management and other		0	0	0	0.00	0. 00	12. 00
	management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		700, 247	0	700, 247	4, 435. 34	157. 88	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		10, 443, 308	О	10, 443, 308	290, 538. 00	35. 94	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0		1	
	- Administrative		O	١				
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		19, 870, 044	0	19, 870, 044			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 153, 780 0	0	1, 153, 780 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23.00	Physician Part B Wage-related costs (RHC/FQHC)		39, 087 0	0	39, 087 0			23. 00 24. 00
25. 00 25. 50	Interns & residents (in an approved program) Home office wage-related		2 455 502	0	2 455 502			25. 00
25. 50 25. 51	(core) Related organization		2, 655, 503	0	_, _, _,			25. 50 25. 51
	wage-related (core)		0					
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0				25. 52

Provider CCN: 15-0034

In Lieu of Form CMS-2552-10
Period: Worksheet S-3
From 07/01/2020 Part II

						rom 0//01/2020	Part II	
					To	06/30/2021	Date/Time Pre	
		1411 1 4 1 1	Δ 1	D 1 161 11		D ' 1 II	11/23/2021 10	
		Wkst. A Line		Reclassi fi cati	Adj usted		Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
		1.00		A-6)	3)	col . 4		
05.50	Tu 661 BI I I B 1 A	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	05.50
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
0/ 00	OVERHEAD COSTS - DIRECT SALARII		507 547		507 547	47,004,00	20.40	0, 00
26. 00	Employee Benefits Department	4. 00	537, 517	0	537, 517	·	l .	26. 00
27. 00	Administrative & General	5. 00	8, 864, 603	0	8, 864, 603	·	l e	
28. 00	Administrative & General under		1, 366, 297	0	1, 366, 297	11, 752. 10	116. 26	28. 00
	contract (see inst.)		_	_	_			
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	2, 228, 409	0	2, 228, 409	·	•	1
31. 00	Laundry & Linen Service	8. 00	88, 263	0	88, 263	·		31. 00
32.00	Housekeepi ng	9. 00	1, 981, 118	0	1, 981, 118	120, 574. 00	16. 43	32. 00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	1, 941, 302	-687, 749	1, 253, 553	70, 193. 00	17. 86	34. 00
35.00	Di etary under contract (see		0	0	0	0.00	0.00	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	687, 749	687, 749	38, 510. 00	17. 86	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38. 00	Nursing Administration	13. 00	3, 493, 889	0	3, 493, 889	93, 972. 00	37. 18	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41. 00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0.00	42. 00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

Health Financial Systems In Lieu of Form CMS-2552-10 ST. MARY MEDICAL CENTER, INC. HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0034 Peri od:

Worksheet S-3 Part III Date/Time Prepared: From 07/01/2020 To 06/30/2021 11/23/2021 10:33 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 77, 196, 767 77, 196, 767 2, 394, 028. 32 32. 25 1.00 instructions) 2.00 Excluded area salaries (see 4, 441, 177 ol 123, 297. 00 36. 02 2.00 4, 441, 177 instructions) 3.00 Subtotal salaries (line 1 72, 755, 590 0 72, 755, 590 2, 270, 731. 32 32.04 3.00 minus line 2) 4.00 Subtotal other wages & related 15, 541, 564 15, 541, 564 381, 204. 48 40.77 4.00 costs (see inst.) Subtotal wage-related costs 5.00 22, 525, 547 0 22, 525, 547 0.00 30. 96 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 110, 822, 701 0 110, 822, 701 2, 651, 935. 80 41. 79 7.00 Total overhead cost (see 20, 501, 398 20, 501, 398 705, 749. 10 29. 05 7.00

instructions)

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0034	Peri od:	Worksheet S-3
		From 07/01/2020	
		T- 0//20/2021	D-+- /T! D

	From 07/0° To 06/30	1/2020 0/2021	Part IV Date/Time Prep 11/23/2021 10:	
			Amount	
			Reported	
			1. 00	
	PART IV - WAGE RELATED COSTS			
	Part A - Core List			
	RETI REMENT COST			
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		2, 384, 880	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5. 00	401K/TSA Plan Administration fees		0	5. 00
6. 00	Legal/Accounting/Management Fees-Pension Plan		0	6. 00
7.00	Employee Managed Care Program Administration Fees		0	7. 00
	HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)		0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)		0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)		11, 313, 385	8. 02
8. 03	Health Insurance (Purchased)		0	8. 03
9.00	Prescription Drug Plan		0	9. 00
10. 00	Dental, Hearing and Vision Plan		669, 538	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)		58, 007	
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)		53, 753	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15. 00	'Workers' Compensation Insurance		888, 151	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 1	06.	0	16.00
	Non cumulative portion)			
	TAXES			
	FICA-Employers Portion Only		4, 449, 698	
	Medicare Taxes - Employers Portion Only		1, 052, 088	
	Unempl oyment Insurance		193, 411	
20. 00	State or Federal Unemployment Taxes		0	20. 00
	OTHER			
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. instructions))	(see	0	21. 00
22. 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)		21, 062, 911	24. 00
	Part B - Other than Core Related Cost			
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	ا		25. 00

Health Financial Systems S	T. MARY MEDICAL CENTER. INC.	In lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0034	Peri od: From 07/01/2020	Worksheet S-3	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identif	i cati on:			
1 00 Total facility's contract Labor and honofit of	cost	4 209 000	21 062 011	1 00

	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4, 398, 009	21, 062, 911	1.00
2.00	Hospi tal	4, 398, 009	19, 870, 044	2.00
3.00	Subprovi der - IPF			3.00
4.00	Subprovi der - I RF	0	451, 854	4.00
5.00	Subprovi der - (0ther)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA	0	627, 933	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis	0	0	17.00
18. 00	0ther	0	113, 080	18. 00

Heal th	Financial Systems S	T. MARY MEDICAL	CENTER, INC.			u of Form CMS-2	2552-10
HOME F	EALTH AGENCY STATISTICAL DATA		Provider Component	CN: 15-0034 CCN: 15-7313	Peri od: From 07/01/2020 To 06/30/2021	Worksheet S-4 Date/Time Pre 11/23/2021 10	pared:
					Home Health	PPS	. 00 4111
					Agency I		
0. 00	County	-			1.	00	0.00
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	l ol	1, 187	I	0 939	2, 126	1.00
2.00	Unduplicated Census Count (see instructions)	0. 00	595. 00	0.0	00 834.00	1, 429. 00	
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the number		Staff	Contract	Total	
		your normal	work week				
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0)	1.00	2. 00	3. 00	
3. 00	Administrator and Assistant Administrator(s)		40. 00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1. (1. 02	4.00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			10. d		10. 67 7. 10	5. 00 6. 00
7. 00	Nursi ng Supervi sor			0.0	0.00	0.00	7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			2. 0		2. 65 1. 09	8. 00 9. 00
10. 00	Occupational Therapy Service			1. (0. 12	1. 20	
11.00	Occupational Therapy Supervisor			0.4			
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0.0		0. 00 0. 30	1
14. 00	Medical Social Service			0.0	0.00	0.00	14. 00
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. 0 3. 0		0. 00 3. 06	
17. 00	Home Health Aide Supervisor			0.0			
18. 00	MONI TORI NG			0.0	0. 01	0. 01	18. 00
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				1		19. 00
17.00	you provided services during the cost						17.00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			23844			20. 00
20.00	during this cost reporting period (line 20 contains the first code).			23044			20.00
			<u>visodes</u> With Outliers	LUPA Episode	es PEP Only	Total (cols.	
		Outliers		·	Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2. 00	3. 00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	4, 181	1, 493		27 19	5, 820	1
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	840, 075 2, 255	302, 906 1, 218	1	71 3, 775 25 11	1, 172, 327 3, 509	
24. 00	Physical Therapy Visits Physical Therapy Visit Charges	529, 760	285, 740			823, 910	1
25. 00	Occupational Therapy Visits	636	900	-	10 5	1, 551	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	149, 470 82	211, 090 122	1	70 1, 160 3 0	364, 090 207	26. 00 27. 00
28. 00	Speech Pathology Visit Charges	19, 220	28, 810	1	90 0	48, 720	
29. 00 30. 00	Medical Social Service Visits	0	0	•	0 0	0	29. 00 30. 00
31. 00	Medical Social Service Visit Charges Home Health Aide Visits	596	584		3 4	1, 187	31.00
32. 00	Home Health Aide Visit Charges	89, 916	88, 088	45	57 588	179, 049	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7, 750	4, 317	16	68 39	12, 274	33.00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 1, 628, 441	916, 634	34, 92	0 28 8, 093	0 2, 588, 096	34. 00 35. 00
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	799		1	14 6	919	36. 00
37. 00	•	450.071	186		1	187	•
38. UU	Total Non-Routine Medical Supply Charges	153, 874	35, 875	4, 30	09 0	194, 058	J 38. 00

551 1 17	AL UNCOMPENSATED AND INDIGENT CARE DATA Provid	ler CCN: 15-0034	Peri od:	Worksheet S-10	0			
			From 07/01/2020	Doto/Time Dros				
			To 06/30/2021	Date/Time Prep 11/23/2021 10:				
				1. 00				
	Uncompensated and indigent care cost computation							
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	oy line 202 colu	mn 8)	0. 191914	1.			
	Medicaid (see instructions for each line)			44 505 500				
- 1	Net revenue from Medicaid			16, 585, 593 N	3			
	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental pa	uments from Medi	cai d?	į v	4			
1	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid							
	Medi cai d charges		0 150, 364, 460	5 6				
00	Medicaid cost (line 1 times line 6)			28, 857, 045	7			
00	Difference between net revenue and costs for Medicaid program (line	7 minus sum of I	ines 2 and 5; if	12, 271, 452	8			
	<pre>< zero then enter zero) Children Market Market </pre>	- 1:>						
	Children's Health Insurance Program (CHIP) (see instructions for eac Net revenue from stand-alone CHIP	n iine)		0	9			
	Stand-alone CHIP charges							
1	Stand-alone CHIP cost (line 1 times line 10)							
	Difference between net revenue and costs for stand-alone CHIP (line	11 minus line 9;	if < zero then	Ö	11 12			
	enter zero)							
	Other state or local government indigent care program (see instruction							
	Net revenue from state or local indigent care program (Not included Charges for patients covered under state or local indigent care prog	· ·	,	0	13 14			
00	10)	all (Not Include	u III IIIles o oi	U	14			
00	State or local indigent care program cost (line 1 times line 14)			0	15			
00	Difference between net revenue and costs for state or local indigent							
			1110 10 11111100 111110	ı "	1 ' '			
L	13; if < zero then enter zero)				'			
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)				10			
00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding	state/local ind		ns (see	17			
00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit	state/local ind charity care al operations	gent care program	ns (see	17 18			
00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding	state/local ind charity care al operations	gent care program	ns (see	17 18			
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi	state/local ind charity care al operations	gent care program	0 0 12,271,452 Total (col. 1	17 18			
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi	state/local ind charity care al operations gent care prograt Uninsured patients	ms (sum of lines I Insured patients	0 0 12,271,452 Total (col. 1 + col. 2)	17 18			
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16)	state/local ind charity care al operations gent care program Uninsured	gent care program ms (sum of lines	0 0 12,271,452 Total (col. 1	17 18			
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated Care (see instructions for each line)	state/local ind charity care al operations gent care prograi Uninsurec patients 1.00	ms (sum of lines I Insured patients 2.00	0 0 12,271,452 Total (col. 1 + col. 2) 3.00	17 18 19			
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16)	state/local ind charity care al operations gent care prograi Uninsurec patients 1.00	ms (sum of lines I Insured patients 2.00	0 0 12,271,452 Total (col. 1 + col. 2) 3.00	17 18 19			
00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (state/local ind charity care al operations gent care progra Uninsured patients 1.00 6,639,	ms (sum of lines I Insured patients 2.00 325 628,551	Total (col. 1 + col. 2) 3.00	17 18 19			
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00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prograff line 24 is yes, enter the charges for patient days beyond the indigent care.	state/local ind charity care all operations gent care prograi Uninsured patients 1.00 6,639, 1,274, s beyond a lengt	gent care program ms (sum of lines l Insured patients 2.00 325 628,551 0 0 179 628,551 h of stay limit	Total (col. 1 + col. 2) 3.00 7,267,876 1,902,730 0 1,902,730	177 188 199 200 211 222 233			
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00 00 00 00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prograff line 24 is yes, enter the charges for patient days beyond the indigent care.	state/local ind charity care al operations gent care progra Uninsured patients 1.00 6,639, see 1,274, s beyond a lengt am? igent care progra	gent care program ms (sum of lines l Insured patients 2.00 325 628,551 0 0 179 628,551 h of stay limit	Total (col. 1 + col. 2) 3.00 7,267,876 1,902,730 0 1,902,730 N	177 188 199 200 211 222 233 244 255 260			
00 00 00 00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progral line 24 is yes, enter the charges for patient days beyond the ind stay limit Total bad debt expense for the entire hospital complex (see instruct	state/local ind charity care al operations gent care progra Uninsured patients 1.00 6,639, see 1,274, s beyond a lengt am? gent care progra	gent care program ms (sum of lines l Insured patients 2.00 325 628,551 0 0 179 628,551 h of stay limit	Total (col. 1 + col. 2) 3.00 7,267,876 1,902,730 0,1,902,730 1.00 N 0 8,573,465	177 188 199 200 211 222 233 244 255 266 277			
00 00 00 00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prograff line 24 is yes, enter the charges for patient days beyond the ind stay limit Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see in Non-Medicare bad debt expense (see instructions)	state/local ind charity care all operations gent care prograt Uninsured patients 1.00 6,639, see 1,274, s beyond a lengt am? gent care prograt ions) instructions)	ms (sum of lines I Insured patients 2.00 325 628,551 0 0 179 628,551 h of stay limit am's length of	Total (col. 1 + col. 2) 3.00 7, 267, 876 1, 902, 730 0 1, 902, 730 N 0 8, 573, 465 628, 249	20 21 22 23 24 25 26 27 27			
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progralf line 24 is yes, enter the charges for patient days beyond the ind stay limit Total bad debt expense for the entire hospital complex (see instruct Medicare eimbursable bad debts for the entire hospital complex (see in Non-Medicare and non-reimbursable Medicare bad debt expense	state/local ind charity care all operations gent care prograt Uninsured patients 1.00 6,639, see 1,274, s beyond a lengt am? gent care prograt ions) instructions)	ms (sum of lines I Insured patients 2.00 325 628,551 0 0 179 628,551 h of stay limit am's length of	Total (col. 1 + col. 2) 3.00 7,267,876 1,902,730 0 1,902,730 1.00 N 0 8,573,465 628,249 966,536 7,606,929 1,798,163	20 21 22 23 24 25 26 27 27 28 29			
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Heal th	Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CO	CN: 15-0034	Peri od:	Worksheet A	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	pared.
						11/23/2021 10	
	Cost Center Description	Sal ari es	0ther		Reclassificati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		9, 548, 128	9, 548, 12	8 182, 087	9, 730, 215	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		8, 257, 207				1
3.00	00300 OTHER CAP REL COSTS		0		0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	537, 517	11, 980, 920			12, 518, 192	1
5. 01	00560 PURCHASING RECEIVING AND STORES	376, 299	99, 891			475, 923	1
5. 02 5. 03	OO570 ADMI TTI NG OO580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 300, 847	362, 946 10		3 -252 0 0	2, 663, 541 10	1
5. 04	00590 OTHER ADMINISTRATIVE & GENERAL	6, 187, 457	51, 820, 937	•			1
7. 00	00700 OPERATION OF PLANT	2, 228, 409	7, 206, 350				1
8.00	00800 LAUNDRY & LINEN SERVICE	88, 263	881, 998			970, 261	
9.00	00900 HOUSEKEEPI NG	1, 981, 118	769, 678	2, 750, 79	6 4, 974	2, 755, 770	9. 00
10.00	01000 DI ETARY	1, 941, 302	1, 380, 132	3, 321, 43		2, 144, 743	
11.00	01100 CAFETERI A	0	0		0 1, 176, 691	1, 176, 691	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	3, 493, 889	2, 887, 786	6, 381, 67	56, 379	6, 438, 054	1
15. 00	01500 PHARMACY		0		0 0	1 0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		0		0 0	0	16.00
17. 00	01700 SOCIAL SERVICE	o	0		o o	Ö	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	O	0		0 0	0	19. 00
23. 00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	273, 643	105, 683	379, 32	6 0	379, 326	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	13, 825, 535	3, 331, 745				
31. 00 41. 00	03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	3, 791, 721 1, 739, 296	1, 202, 756 1, 234, 312			4, 997, 902 2, 973, 585	1
43.00	04300 NURSERY	1, 739, 290	1, 234, 312		0 1, 507, 690		1
10.00	ANCILLARY SERVICE COST CENTERS	<u> </u>			1,007,070	1,007,070	10.00
50.00	05000 OPERATI NG ROOM	6, 598, 256	14, 955, 354	21, 553, 61	0 437, 319	21, 990, 929	50.00
51. 00	05100 RECOVERY ROOM	2, 811, 016	677, 131			3, 488, 147	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 332, 977	951, 648			1, 239, 408	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	0 3, 166, 351	4, 010, 655 1, 932, 447			4, 010, 655 5, 095, 772	
55. 00	05500 RADI OLOGY - THERAPEUTI C	527, 538	683, 749				1
56.00	05600 RADI 0I SOTOPE	519, 284	926, 038			1, 445, 322	1
57.00	05700 CT SCAN	1, 004, 382	1, 054, 503	2, 058, 88	5 0	2, 058, 885	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	527, 727	697, 287			1, 225, 014	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 575, 454	1, 411, 555				
60.00	06000 LABORATORY	3, 662, 627	7, 543, 728	11, 206, 35	5 84, 115		1
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING, & TRANS.	154, 004	1, 187, 786	1, 341, 79	0 0	0 1, 341, 790	
64. 00	06400 I NTRAVENOUS THERAPY	376, 045	144, 704			520, 749	1
	06500 RESPIRATORY THERAPY	2, 091, 965	638, 548				1
66.00	06600 PHYSI CAL THERAPY	8, 025	3, 291, 385	3, 299, 41	0	3, 299, 410	66. 00
	06700 OCCUPATI ONAL THERAPY	984	999, 388			1, 000, 372	
68. 00	06800 SPEECH PATHOLOGY	0	486, 323			486, 323	
69. 00		855, 385	334, 452			1, 189, 837	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	414, 480	157, 111	571, 59 9, 278, 90		571, 591	1
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS		9, 278, 904 12, 986, 172			8, 952, 312 12, 453, 228	
	07300 DRUGS CHARGED TO PATIENTS	2, 350, 808	15, 063, 211			17, 414, 084	1
74. 00	07400 RENAL DIALYSIS	0	834, 241			834, 241	1
76. 97	07697 CARDI AC REHABI LI TATI ON	478, 263	112, 241	590, 50	4 0	590, 504	76. 97
	OUTPATIENT SERVICE COST CENTERS			1			
90.00	09000 CLINIC	1, 132, 662	1, 006, 561			2, 138, 941	
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 220, 083	1, 765, 021	5, 985, 10	4, 627	5, 989, 731	91.00
72.00	OTHER REIMBURSABLE COST CENTERS			l			72.00
101.00	10100 HOME HEALTH AGENCY	2, 417, 067	554, 045	2, 971, 11	2 -135	2, 970, 977	101. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		75, 990, 679	184, 754, 667	260, 745, 34	6 -86, 441	260, 658, 905	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		ol o	^	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 171	1, 425	1			191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	8, 833				192. 00
194.00	07950 OTHER NON-REIMBURSABLE COST CENTER	0	718, 324	718, 32	4 0	718, 324	194. 00
	07952 ADVERTI SI NG	0	129, 810			216, 251	
200.00	TOTAL (SUM OF LINES 118 through 199)	76, 001, 850	185, 613, 059	261, 614, 90	9 0	261, 614, 909	200. 00

Provider CCN: 15-0034

Peri od: From 07/01/2020 To 06/30/2021 Date/Ti me Prepared: 11/23/2021 10:33 am

				11/23/2021 10	:33 am
	Cost Center Description		Net Expenses		
		(See A-8) F	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	-528, 928	9, 201, 287		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 108, 857	9, 387, 862		2. 00
3.00	00300 OTHER CAP REL COSTS	0	0	l .	3.00
4. 00 E. 01	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 505, 162	14, 023, 354		4.00
5. 01 5. 02	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	0 0	475, 923 2, 663, 541		5. 01 5. 02
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 988, 167	2, 988, 177		5. 03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	-29, 780, 681	27, 671, 769		5. 04
7.00	00700 OPERATION OF PLANT	0	9, 438, 684		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	970, 261		8. 00
9.00	00900 HOUSEKEEPI NG	0	2, 755, 770		9.00
10. 00 11. 00	1	-290 -865, 704	2, 144, 453 310, 987		10. 00 11. 00
13. 00	1 I	-2, 003, 534	4, 434, 520		13.00
14. 00		0	0		14. 00
15. 00	1 I	0	0		15. 00
16.00		2, 535, 834	2, 535, 834		16. 00
17. 00		0	0		17. 00
19.00		0	0		19.00
23. 00	02300 PARAMEDICAL EDUCATION PROGRAM EMS INPATIENT ROUTINE SERVICE COST CENTERS	-37, 474	341, 852		23. 00
30. 00		-16, 064	17, 764, 416		30.00
31. 00	1 1	-6, 711	4, 991, 191		31.00
41. 00	1	-11	2, 973, 574		41. 00
43.00	04300 NURSERY	0	1, 507, 690		43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	l i	-18, 137	21, 972, 792		50.00
51. 00 52. 00	l i	-2 -316, 268	3, 488, 145		51. 00 52. 00
53. 00	1 I	-3, 551, 473	923, 140 459, 182		53.00
54. 00	1	-16, 214	5, 079, 558		54.00
55. 00	l l	0	1, 210, 987		55. 00
56.00	05600 RADI OI SOTOPE	0	1, 445, 322		56. 00
57. 00	I I	-1, 350	2, 057, 535		57. 00
58. 00		0	1, 225, 014	l .	58. 00
59.00	1	-6, 912	3, 392, 425		59.00
60. 00 62. 00	1	-209, 238 0	11, 081, 232		60. 00 62. 00
63. 00	1 1	0	1, 341, 790		63.00
64. 00		0	520, 749		64. 00
65.00	06500 RESPI RATORY THERAPY	-13, 393	2, 753, 974		65.00
66. 00	1	0	3, 299, 410	·	66. 00
67. 00		0	1, 000, 372	·	67.00
68. 00		0	486, 323		68. 00
69. 00 70. 00	1 1	-2, 065 -3, 398	1, 187, 772 568, 193	l e e e e e e e e e e e e e e e e e e e	69. 00 70. 00
71.00	1	0,370	8, 952, 312	·	71.00
72. 00	1 1	0	12, 453, 228	l e e e e e e e e e e e e e e e e e e e	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-477, 200	16, 936, 884		73. 00
74. 00	l i	0	834, 241		74. 00
76. 97		-31, 375	559, 129		76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	-216, 258	1 022 402		90.00
	09100 EMERGENCY	-210, 256	1, 922, 683 5, 989, 420		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		3, 707, 420		92.00
	OTHER REIMBURSABLE COST CENTERS				1
101.00	0 10100 HOME HEALTH AGENCY	-485	2, 970, 492		101. 00
	SPECIAL PURPOSE COST CENTERS				
118. 00	, ,	-29, 965, 456	230, 693, 449		118. 00
100.0	NONREI MBURSABLE COST CENTERS				100 00
	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 12, 596	l .	190. 00 191. 00
	0 19100 RESEARCH 0 19200 PHYSLCIANS' PRIVATE OFFICES		12, 596 8, 833		191.00
	007950 OTHER NON-REIMBURSABLE COST CENTER	0	718, 324		194. 00
	1 07952 ADVERTI SI NG	O	216, 251		194. 01
200.00		-29, 965, 456	231, 649, 453		200. 00
		•			

| Peri od: | Worksheet A-6 | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared:

					10	Date/IIMe Prepared: 11/23/2021 10:33 am
		Increases				1172072021 10.00 4111
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3.00	4.00	5. 00		
	A - RECLASS PROPERTY INSURANCE	E				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182, 087		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	13, 193		2. 00
	TOTALS		0	195, 280		
	B - CAFETERIA EXPENSES RECLAS	S				
1.00	CAFETERI A	<u>11.</u> 00	687, 749	488, 942		1. 00
	TOTALS		687, 749	488, 942		
	C - RECLASS LDRP COSTS					
1.00	ADULTS & PEDIATRICS	30.00	381, 782	155, 733		1.00
2.00	NURSERY	4300	<u>1, 070, 870</u>	436, 820		2. 00
	TOTALS		1, 452, 652	592, 553		
	D - RECLASS COVID COSTS					
1. 00	OPERATION OF PLANT	7. 00	0	5, 161		1. 00
2.00	HOUSEKEEPI NG	9. 00	0	4, 974		2. 00
3.00	NURSING ADMINISTRATION	13. 00	0	56, 379		3. 00
4. 00	ADULTS & PEDIATRICS	30.00	0	87, 458		4. 00
5.00	INTENSIVE CARE UNIT	31.00	0	3, 425		5. 00
6.00	OPERATING ROOM	50.00	0	1, 041		6. 00
7. 00	LABORATORY	60.00	0	84, 115		7. 00
8.00	RESPI RATORY THERAPY	65.00	0	36, 854		8. 00
9. 00	EMERGENCY	91.00	0	4, 812		9. 00
10. 00	HOME HEALTH AGENCY	101.00	•	1, 056		10. 00
	TOTALS		0	285, 275		
	E - INTEREST EXPENSE RECLASS					
1. 00	CAP REL COSTS-MVBLE EQUIP		•	<u>8, 6</u> 05		1. 00
	TOTALS		0	8, 605		
	F - I NVENTORY ADJUSTMENT					
1.00	OPERATING ROOM	50. 00	0	447, 208		1.00
2. 00	CARDI AC CATHETERI ZATI ON	59.00		412, 328		2. 00
	TOTALS		0	859, 536		
4 00	G - ADVERTISING NONREIMBURSAB		ما	0/ 114		1.00
1.00	ADVERTISING	194. 01	0	86, 441		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	65		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0. 00 0. 00	0	0		5. 00
6. 00 7. 00		0.00	0	0		6. 00 7. 00
8.00		0.00	0	o		8.00
9. 00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		10.00
12.00		0.00	0	0		12.00
12.00		0.00	0	0		12.00
14. 00		0.00	0	0		14. 00
14.00	TOTALS — — — —		 	86, 506		14.00
500 00	Grand Total: Increases		2, 140, 401	2, 516, 697		500, 00
300.00	or and rotal. Thereases	I	2, 170, 401	2, 510, 071		1 300. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0034

Decreases Decr						'	21 10:33 am
A - RECLASS PROPERTY INSURANCE 1.00 10 10 10 10 10 10			Decreases				
A - RCCLASS PROPERTY INSURANCE 1.00 OTHER ADMIN ISTRATI VE		Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
1.00 OTHER ADMINISTRATIVE & 5.04 0 195, 280 12 2.00 TOTALS 0 105, 280 0 12 2.00 TOTALS 0 105, 280 0 105,				8. 00	9. 00	10. 00	
CHERRAL 0,00							
2,00	1.00		5. 04	0	195, 280	12	1. 00
TOTALS		GENERAL					
B - CAFETERIA EXPENSES RECLASS 10.00 687,749 488,942 0 1.00	2.00		0.00	•	0		2. 00
1.00				0	195, 280		
TOTALS							
C - RECLASS LORP COSTS 1. 00	1.00						1.00
1.00 DELLYERY ROOM & LABOR ROOM 52.00 1.452,652 592,553 0 2.00 2.00 0 2.00 0 0 0 0 0 0 0 0 0				687, 749	488, 942		
2. 00	4 00		F0.00	4 450 (50	F00 FF0		4 00
TOTALS		DELIVERY ROOM & LABOR ROOM		1, 452, 652	•		
D - RECLASS COVID COSTS	2.00						2.00
1.00				1, 452, 652	592, 553		
Color	1 00		F 04	٥	205 275		1 00
2.00 3.00 4.00 4.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6	1.00		5. 04	٥	285, 275	١	1.00
3.00	2 00	GENERAL	0 00	0	0	0	2.00
A . 00							
5.00 0.00 0.00 0 0 0 0 0				-			
0.00				0			
7. 00 0.				0	-	-	
8. 00 0. 0				0	-	9	
9,00				Ö			
10.00				0	-	-	
TOTALS				Ö	0	-	
1.00 OPERATING ROOM		TOTALS — — — —			285. 275		131.33
TOTALS		E - INTEREST EXPENSE RECLASS	<u>'</u>			·	
1.00 MEDI CAL SUPPLI ES CHARGED TO 71.00 0 326, 592 0 1.00	1.00	OPERATING ROOM	50.00	0	8, 605	11	1.00
1.00 MEDI CAL SUPPLIES CHARGED TO		TOTALS	T		8, 605		İ
PATI ENT IMPL. DEV. CHARGED TO 72.00 0 532,944 0 2.00 PATI ENTS		F - INVENTORY ADJUSTMENT	•				
MPL. DEV. CHARGED TO	1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	326, 592	0	1. 00
PATI ENTS 0 859, 536		PATI ENT					
TOTALS	2.00		72. 00	0	532, 944	0	2. 00
Color Colo							
1.00 EMPLOYEE BENEFITS DEPARTMENT				0	859, 536		
2.00 PURCHASI NG RECEI VI NG AND 5.01 0 267 0 3.00 3.00 ADMITTI NG 5.02 0 252 0 3.00 4.00 OTHER ADMINISTRATI VE & 5.04 0 75, 389 0 4.00 GENERAL 5.00 OPERATION OF PLANT 7.00 0 1, 236 0 5.00 6.00 ADULTS & PEDIATRICS 30.00 0 1,773 0 6.00 7.00 SUBPROVI DER - IRF 41.00 0 23 0 7.00 8.00 OPERATI NG ROOM 50.00 0 2, 325 0 8.00 9.00 DELI VERY ROOM & LABOR ROOM 52.00 0 12 0 10.00 RADI OLOGY-DI AGNOSTI C 54.00 0 300 0 11.00 RADI OLOGY - THERAPEUTI C 55.00 0 300 0 12.00 CLI NI C 90.00 0 282 0 13.00 EMERGENCY 91.00 0 185 0 14.00 HOME HEALTH AGENCY 101.00 0 1, 191 0 TOTALS 0 86, 506						T T	
STORES		•		•			
3. 00 ADMITTING 5. 02 0 252 0 3. 00 4. 00 OTHER ADMINISTRATIVE & 5. 04 0 75, 389 0 4. 00 GENERAL 5. 00 OPERATION OF PLANT 7. 00 0 1, 236 0 5. 00 7. 00 SUBPROVIDER - IRF 41.00 0 23 0 7. 00 8. 00 OPERATING ROOM 50. 00 0 23 0 8. 00 9. 00 DELIVERY ROOM & LABOR ROOM 52. 00 0 12 0 9. 00 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 30 0 0 11. 00 11. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 300 0 11. 00 12. 00 CLINIC 90. 00 185 0 11. 00 13. 00 EMERGENCY 91. 00 0 185 0 14. 00 14. 00 HOME HEALTH AGENCY 101. 00 14. 00 TOTALS	2.00		5. 01	0	267	0	2.00
4. 00 OTHER ADMINISTRATIVE & 5. 04 O 75, 389 O GENERAL 5. 00 OPERATION OF PLANT 7. 00 O 1, 236 O 5. 00 6. 00 ADULTS & PEDI ATRICS 30. 00 O 1, 773 O 6. 00 8. 00 OPERATING ROOM 50. 00 O 23 O 7. 00 9. 00 DELIVERY ROOM & LABOR ROOM 50. 00 O 12 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 O 3, 026 O 10. 00 11. 00 RADI OLOGY - THERAPEUTI C 55. 00 O 300 O 11. 00 12. 00 CLI NI C 90. 00 13. 00 EMERGENCY 91. 00 O 1, 191 14. 00 HOME HEALTH AGENCY 101. 00 14. 00 FAGE ADMINISTRATIVE & 5. 04. 00 O 1, 191 TOTALS O 1. 12 O 13. 00 14. 00 BAG, 506	2 00		F 02		252		2.00
SENERAL SENERAL SENERAL SENERATION OF PLANT SENERATION O		1		-			1
5. 00 OPERATION OF PLANT 7. 00 0 1, 236 0 5. 00 6. 00 ADULTS & PEDIATRICS 30. 00 0 1, 773 0 6. 00 7. 00 SUBPROVI DER - I RF 41. 00 0 23 0 7. 00 8. 00 OPERATI NG ROOM 50. 00 0 2, 325 0 8. 00 9. 00 DELI VERY ROOM & LABOR ROOM 52. 00 0 12 0 9. 00 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 3, 026 0 10. 00 11. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 300 0 11. 00 12. 00 CLI NI C 90. 00 0 282 0 12. 00 13. 00 EMERGENCY 91. 00 0 185 0 13. 00 14. 00 HOME HEALTH AGENCY 101. 00 0 86, 506 0 14. 00	4.00		5. 04	U	75, 389	0	4.00
6. 00 ADULTS & PEDI ATRI CS 30. 00 0 1,773 0 6. 00 7. 00 SUBPROVI DER - I RF 41. 00 0 23 0 7. 00 8. 00 OPERATI NG ROOM 50. 00 0 2,325 0 8. 00 9. 00 DELI VERY ROOM & LABOR ROOM 52. 00 0 12 0 9. 00 10. 00 RADI OLOGY - DI AGNOSTI C 54. 00 0 3,026 0 10. 00 11. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 300 0 11. 00 12. 00 CLI NI C 90. 00 282 0 12. 00 13. 00 EMERGENCY 91.00 0 185 0 13. 00 14. 00 HOME HEALTH AGENCY 101.00 0 1,191 0 14. 00 TOTALS	E 00		7 00		1 224		E 00
7. 00 SUBPROVI DER - I RF 41.00 0 23 0 7.00 8. 00 OPERATI NG ROOM 50.00 0 2,325 0 8.00 9. 00 DELI VERY ROOM & LABOR ROOM 52.00 0 12 0 9.00 10. 00 RADI OLOGY-DI AGNOSTI C 54.00 0 3,026 0 10.00 11. 00 RADI OLOGY - THERAPEUTI C 55.00 0 300 0 11.00 12. 00 CLI NI C 90.00 0 282 0 12.00 13. 00 EMERGENCY 91.00 0 185 0 13.00 14. 00 HOME HEALTH AGENCY 101.00 0 1, 191 0 14.00 TOTALS 0 86, 506 0 86, 506 14.00 14.00				0			•
8. 00 OPERATING ROOM 50. 00 0 2, 325 0 8. 00 9. 00 DELIVERY ROOM & LABOR ROOM 52. 00 0 12 0 9. 00 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 3, 026 0 10. 00 11. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 300 0 11. 00 12. 00 CLI NI C 90. 00 0 282 0 12. 00 13. 00 EMERGENCY 91. 00 0 185 0 13. 00 14. 00 HOME HEALTH AGENCY 101. 00 0 1, 191 0 14. 00 TOTALS 0 86, 506 0 86, 506 0 0 0				0			•
9. 00 DELI VERY ROOM & LABOR ROOM 52. 00 0 12 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 3, 026 0 10. 00 11. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 300 0 11. 00 12. 00 CLI NI C 90. 00 0 282 0 12. 00 13. 00 EMERGENCY 91. 00 0 185 0 13. 00 HOME HEALTH AGENCY 101.00 0 1, 191 0 14. 00 TOTALS 0 86, 506		•		0			
10. 00 RADI OLOGY - DI AGNOSTI C 54. 00 0 3, 026 0 10. 00 11. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 300 0 12. 00 CLI NI C 90. 00 282 0 12. 00 13. 00 EMERGENCY 91. 00 0 185 0 13. 00 14. 00 HOME HEALTH AGENCY 101. 00 0 1, 191 0 14. 00 TOTALS 0 86, 506				0			
11. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 300 0 11. 00 12. 00 CLI NI C 90. 00 0 282 0 12. 00 13. 00 EMERGENCY 91. 00 0 185 0 13. 00 14. 00 HOME HEALTH AGENCY 101. 00 0 1, 191 0 14. 00 TOTALS 0 86, 506				0		-	
12. 00 CLINIC 90. 00 0 282 0 12. 00 13. 00 14. 00 HOME HEALTH AGENCY 101. 00 0 1, 191 0 14. 00 14. 00 16. 50 16. 50 16. 50 17. 101. 101. 102 16. 50 17. 101. 102 16. 50 17. 101. 102 17.				0			
13. 00 EMERGENCY 91. 00 0 185 0 13. 00 14. 00 14. 00 15 15 15 15 15 15 15				O O			
14. 00 HOME HEALTH AGENCY 101. 00 0 1, 191 0 14. 00 14. 00				O O			
TOTALS 0 86, 506				O O			1
	55		· · · · · · · · · · · · · · · · · ·	— — ŏ			00
	500. 00			2, 140, 401			500. 00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0034

				į	To 06/30/2021	Date/Time Pre 11/23/2021 10		
				Acqui si ti ons				
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and		
		Bal ances				Retirements		
		1.00	2. 00	3. 00	4. 00	5. 00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	13, 037, 475	0	(0	0	1. 00	
2.00	Land Improvements	7, 863, 723	224, 702	(224, 702		2. 00	
3.00	Buildings and Fixtures	129, 138, 378	255, 383	(255, 383		3. 00	
4.00	Building Improvements	73, 902, 380	5, 780, 251	(5, 780, 251	443, 866	4. 00	
5.00	Fi xed Equipment	0	0	(0	0	5. 00	
6.00	Movable Equipment	78, 116, 159	6, 226, 610	(6, 226, 610	2, 346, 172	6. 00	
7.00	HIT designated Assets	0	0	(0	0	7. 00	
8.00	Subtotal (sum of lines 1-7)	302, 058, 115	12, 486, 946	(12, 486, 946	2, 970, 038	8. 00	
9.00	Reconciling Items	0	0	(0	0	9. 00	
10.00	Total (line 8 minus line 9)	302, 058, 115	12, 486, 946	(12, 486, 946	2, 970, 038	10.00	
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	13, 037, 475	0				1. 00	
2.00	Land Improvements	8, 088, 425	0				2. 00	
3.00	Buildings and Fixtures	129, 213, 761	0				3. 00	
4.00	Building Improvements	79, 238, 765	0				4. 00	
5.00	Fi xed Equipment	0	0				5. 00	
6.00	Movable Equipment	81, 996, 597	0				6. 00	
7.00	HIT designated Assets	0	0				7. 00	
8.00	Subtotal (sum of lines 1-7)	311, 575, 023	0				8. 00	
9.00	Reconciling Items	0	0				9. 00	
10.00	Total (line 8 minus line 9)	311, 575, 023	0				10. 00	

Hool +h	Financial Systems	ST. MARY MEDICAL	CENTED INC		Inlia	u of Form CMS-2	DEE2 10
		OI. WART WEDICAL	<u> </u>	ON 15 0004			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CC		Peri od: From 07/01/2020	Worksheet A-7 Part II	
					To 06/30/2021	Date/Time Pre	narod:
					10 00/30/2021	11/23/2021 10	
			SI	JMMARY OF CAP	ΤΔΙ	1172072021 10	00 4111
			30	JUNIARY OF CALL	IAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
						instructions)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	8, 197, 404			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5, 671, 240	2, 585, 967		0	0	2. 00
3.00	Total (sum of lines 1-2)	13, 868, 644	3, 936, 691		0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	y ,				
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	9, 548, 128				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	o	8, 257, 207	•			2. 00
2 00	Total (sum of Lines 1.2)	ا م	17 005 225				2 00

0 0 0

9, 548, 128 8, 257, 207 17, 805, 335

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems S	ST. MARY MEDICAL	L CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	F	Period: From 07/01/2020 To 06/30/2021	Worksheet A-7 Part III Date/Time Pre 11/23/2021 10	
		COMI	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	. 33 aiii
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
			Leases	(col. 1 - col. 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C				_		
1.00	CAP REL COSTS-BLDG & FLXT	229, 578, 426				0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	81, 996, 597					2. 00
3.00	Total (sum of lines 1-2)	311, 575, 023		011/070/020			3. 00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY O	OF CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		1			4 050 704	4 00
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(7, 668, 476		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		6, 788, 702		2.00
3.00	Total (sum of lines 1-2)	0		<u> </u>	14, 457, 178	3, 936, 691	3. 00
			51	JIMIMARY OF CAPI	IAL		
	Cost Center Description		Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLTAL COSTS O	11. 00	12.00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	ENTERS 0	182, 087	,		9, 201, 287	1. 00
2.00	CAP REL COSTS-BLDG & FIXT				0		2.00
3.00	Total (sum of lines 1-2)						
3.00	Total (Suil of Titles 1-2)	1	195, 200	1		10, 307, 147	3.00

| Period: | Worksheet A-8 | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared: Provider CCN: 15-0034

				T	06/30/2021	Date/Time Prep 11/23/2021 10:	
	,			Expense Classification on		1172372021 10.	33 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1. 00
0.00	COSTS-BLDG & FIXT (chapter 2)				0.00		0.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3.00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	O	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0.00	9	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	О	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-235, 210			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	О	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-21, 060, 133			0	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests	1	Ö		0.00	ō	14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A-0-3	O	RESPIRATORI IIIERAFI	03.00		23.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of		_				
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114.00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
20.00	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	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
	limitation (chapter 14)	[
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
	1-1-1 00. 41. 011 4114 THEOLOGE	, ,		ı	ı	'	

From 07/01/2020
To 06/30/2021 Date/Time Prepared:

						11/23/2021 10	:33 am
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33.00	ANESTHESIA - NON-SALARIES,	A	-3, 551, 473	ANESTHESI OLOGY	53.00	0	33. 00
	NON-BENEF						
33. 01	COVID DRUG DONATIONS	В	-477, 200	DRUGS CHARGED TO PATIENTS	73.00	0	33. 01
33. 07	NON-PATIENT CARE COST	A	-120	OTHER ADMINISTRATIVE &	5. 04	0	33. 07
				GENERAL			
34.00	PART B CONTRACTED SERVICES	A		NURSING ADMINISTRATION	13. 00		34.00
34. 01	PART B CONTRACTED SERVICES	A	-316, 250	DELIVERY ROOM & LABOR ROOM	52.00	0	34. 01
34. 03	PART B CONTRACTED SERVICES	A		RADI OLOGY-DI AGNOSTI C	54.00	0	34. 03
34.04	PART B CONTRACTED SERVICES	A	-1, 350	CT SCAN	57. 00	0	34.04
35.00	PART B CONTRACTED SERVICES	A	-31, 375	CARDIAC REHABILITATION	76. 97	0	35.00
35. 03	PART B SALARIES	A	-171, 380	CLINIC	90.00	0	35. 03
35.09	PRE-MERGER ASSETS DEPRECIATION	A	-413, 206	CAP REL COSTS-BLDG & FIXT	1.00	9	35. 09
35. 10	PATIENT TELEPHONES	A	-139, 823	OTHER ADMINISTRATIVE &	5. 04	O	35. 10
				GENERAL			
35. 12	TELEPHONE DEPRECIATION	A	-218	CAP REL COSTS-MVBLE EQUIP	2. 00	9	35. 12
37.00	TV DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	37.00
38.00	OTHER REVENUE	В	-248, 239	CAP REL COSTS-BLDG & FIXT	1.00	9	38. 00
39.00	OTHER REVENUE	В	-95	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	39.00
39. 01	OTHER REVENUE	В	-6, 942	OTHER ADMINISTRATIVE &	5. 04	0	39. 01
				GENERAL			
39. 02	OTHER REVENUE	В	-290	DI ETARY	10.00	0	39. 02
39. 03	OTHER REVENUE	В	-1, 870	NURSING ADMINISTRATION	13.00	0	39. 03
39.04	OTHER REVENUE	В	-37, 474	PARAMEDICAL EDUCATION	23. 00	0	39. 04
				PROGRAM EMS			
39. 05	OTHER REVENUE	В	-213	ADULTS & PEDIATRICS	30.00	0	39. 05
39.06	OTHER REVENUE	В	-24	INTENSIVE CARE UNIT	31.00	0	39.06
41.03	OTHER REVENUE	В	-11	SUBPROVI DER - I RF	41.00	0	41. 03
42.01	OTHER REVENUE	В	-2	RECOVERY ROOM	51.00	0	42. 01
42.03	OTHER REVENUE	В	-18	DELIVERY ROOM & LABOR ROOM	52.00	0	42. 03
42. 05	OTHER REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	O	42. 05
42.06	OTHER REVENUE	В		CARDIAC CATHETERIZATION	59.00	0	42.06
43.00	OTHER REVENUE	В		LABORATORY	60.00	0	43.00
43. 03	OTHER REVENUE	В		RESPIRATORY THERAPY	65. 00		43. 03
43. 04	OTHER REVENUE	В		CLINIC	90.00		43. 04
43. 05	OTHER REVENUE	В	·	EMERGENCY	91.00	o	43. 05
44. 00	OTHER REVENUE	В		HOME HEALTH AGENCY	101.00	· ·	44. 00
46. 00	OTHER REVENUE	В		CAFETERI A	11. 00		46. 00
46. 01	OTHER REVENUE	В	·	CAP REL COSTS-MVBLE EQUIP	2.00		46. 01
47. 00	PART B BENEFITS	A	-17, 005		90.00		47. 00
47. 01	PART B BENEFITS	Ä		EMPLOYEE BENEFITS DEPARTMENT	4.00		47. 01
50.00	TOTAL (sum of lines 1 thru 49)	1	-29, 965, 456	1	7. 00	Ĭ	50.00
55. 55	(Transfer to Worksheet A,		27, 700, 400				55.00
	column 6, line 200.)						
-	1001 dimit 0, 11110 200. j			I .			

⁽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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0034 OFFICE COSTS

Peri od: Worksheet A-8-1 From 07/01/2020 To 06/30/2021 Date/Time Prepared

				10 06/30/2021	11/23/2021 10				
	Li ne No.	Cost Center	Expense Items	Amount of	Amount				
			·	Allowable Cost	Included in				
					Wks. A, column				
					5				
	1. 00	2. 00	3. 00	4. 00	5. 00				
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								
	HOME OFFICE COSTS:								
1.00	5. 04	OTHER ADMINISTRATIVE & GENER	OTHER NONCAPITAL COSTS	8, 324, 323	30, 642, 421	1.00			
2.00	1.00	CAP REL COSTS-BLDG & FIXT	BLDG DEPR	132, 517	0	2.00			
3.00	2. 00	CAP REL COSTS-MVBLE EQUIP	EQ DEPR	1, 119, 680	0	3.00			
3.01	16. 00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	2, 535, 834	0	3. 01			
3.02	5. 03	CASHIERING/ACCOUNTS RECEIVAB	PATIENT ACCTING	2, 988, 167	0	3. 02			
3.03	13. 00	NURSING ADMINISTRATION	CANCER REGISTRY COSTS	153, 568	0	3. 03			
3.04	4. 00	EMPLOYEE BENEFITS DEPARTMENT	ALLOCATED FRINGE BENEFITS CO	1, 524, 424	0	3.04			
3.05	5. 04	OTHER ADMINISTRATIVE & GENER	ALLOCATED SALARY COSTS	7, 392, 542	0	3.05			
4.00	5. 04	OTHER ADMINISTRATIVE & GENER	PHYSICIAN ALLOCATION	0	14, 588, 767	4.00			
5.00	TOTALS (sum of lines 1-4).			24, 171, 055	45, 231, 188	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.

	as not been pested to werkeness A, cordinate a diagram and another arrestable ended a be manded in cordinate and the partition								
				Related Organization(s) and/					
						l			
	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.

. 01 111241 001	To mode comorte discor et el circi Attiti										
6.00	В	CFNI	100.00	0.0	00	6. 00					
7. 00			0.00	0.0	00	7.00					
8. 00			0.00	0.0	00	8.00					
9. 00			0.00	0.0	00	9.00					
10. 00			0.00	0.0	00	10.00					
100. 00 G.	Other (financial or					100.00					
no	n-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.

Heal th	Financial Syste	ems	ST. MARY MEDICAL CENTER, INC.			u of Form CMS-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0034	Peri od:	Worksheet A-8-1
OFFICE	COSTS				From 07/01/2020	
					To 06/30/2021	Date/Time Prepared: 11/23/2021 10:33 am
	Net	Wkst. A-7 Ref.				11/23/2021 10:33 am
		WKSt. A-7 Rei.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6. 00	7. 00				
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF T	RANSACTIONS WITH RELATED	ORGANIZATIONS OR (CLAI MED
	HOME OFFICE CO	STS:				
1.00	-22, 318, 098	0				1. 00
2.00	132, 517	9				2. 00
3.00	1, 119, 680	9				3.00
3.01	2, 535, 834	0				3. 01
3.02	2, 988, 167	0				3. 02
3.03	153, 568	0				3. 03
3.04	1, 524, 424	0				3. 04
3.05	7, 392, 542	0				3. 05
4.00	-14, 588, 767	0				4. 00
5.00	-21, 060, 133					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.

 	cordinate i dilator 2, the dimedite difference of chedia be find edited in cordinati for the parti-	
Related Organization(s)		
and/or Home Office		
Type of Business		
3.		
6. 00		
 B. INTERRELATIONSHIP TO RELAT	TED 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	6. 00
7.00	7.00
8. 00	8. 00 9. 00
9. 00	9.00
10. 00	10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- $\hbox{B. Corporation, partnership, or other organization has financial interest in provider}.$
- 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
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0034

						10 06/30/2021	Date/lime Pre 11/23/2021 10	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	5. 04	AGGREGATE-OTHER	357, 411	0	357, 411	211, 500	2, 340	1. 00
2. 00	13. 00	ADMINISTRATIVE & GEN AGGREGATE-NURSING ADMINISTRATION	18, 225	0	18, 225	211, 500	122	2. 00
3. 00	30.00	AGGREGATE-ADULTS & PEDIATRICS	26, 223	0	26, 223	211, 500	102	3. 00
4. 00	31.00	AGGREGATE-INTENSIVE CARE	27, 939	0	27, 939	211, 500	209	4. 00
5. 00 6. 00	1	AGGREGATE-OPERATING ROOM AGGREGATE-RADIOLOGY-DIAGNOST	46, 449 18, 634		46, 449 18, 634	246, 400 271, 900		5. 00 6. 00
7. 00	59.00	I C AGGREGATE - CARDI AC	9, 550	0	9, 550	211, 500	48	7. 00
8. 00	60.00	CATHETERI ZATI ON AGGREGATE-LABORATORY	66, 600	0	66, 600	260, 300	333	8. 00
9. 00		AGGREGATE - RESPI RATORY THERAPY	3, 132		3, 132	211, 500		
10.00		AGGREGATE-ELECTROCARDI OLOGY	4, 200		4, 200	211, 500		10. 00
11. 00		AGGREGATE-ELECTROENCEPHALOGR APHY	25, 565		25, 565			
12. 00 200. 00		AGGREGATE-CLINIC	86, 470 690, 398	0	86, 470 690, 398		4, 338	
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit		Cost of Memberships &	Provider Component	Physician Cost of Malpractice	
		ruentimei	LI IIII C	Li mi t	Continuing Education	Share of col.	Insurance	
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	
1.00	5. 04	AGGREGATE-OTHER	237, 938	11, 897	0	0	0	1. 00
2. 00	13.00	ADMINISTRATIVE & GEN AGGREGATE-NURSING	12, 405	620	0	0	0	2. 00
3. 00	30.00	ADMINISTRATION AGGREGATE-ADULTS & PEDIATRICS	10, 372	519	0	0	0	3. 00
4. 00	31.00	AGGREGATE-INTENSIVE CARE	21, 252	1, 063	0	0	0	4. 00
5. 00 6. 00		AGGREGATE-OPERATING ROOM AGGREGATE-RADIOLOGY-DIAGNOST	28, 312 10, 196			0	0	
7. 00	59. 00	I C AGGREGATE-CARDI AC CATHETERI ZATI ON	4, 881	244	0	0	O	7. 00
8. 00 9. 00		AGGREGATE-LABORATORY AGGREGATE-RESPI RATORY	41, 673 2, 949		0	0	0	
10. 00		THERAPY AGGREGATE-ELECTROCARDI OLOGY	2, 135		0	0	0	
11. 00		AGGREGATE-ELECTROENCEPHALOGR APHY	22, 167	1, 108	0	0	0	11. 00
12. 00 200. 00		AGGREGATE-CLINIC	60, 908 455, 188	22, 760	0	0	0	12. 00 200. 00
	Wkst. A Line #	Cost Center/Physician I denti fi er	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		AGGREGATE - OTHER ADMINI STRATI VE & GEN	0	, , , , , , , , , , , , , , , , , , , ,				1.00
2. 00 3. 00		AGGREGATE-NURSING ADMINISTRATION AGGREGATE-ADULTS &	0	,		5, 820 15, 851		2. 00 3. 00
4. 00		PEDIATRICS AGGREGATE-INTENSIVE CARE	0	·		6, 687		4. 00
5. 00		UNIT AGGREGATE-OPERATING ROOM	0			18, 137		5. 00
6. 00	1	AGGREGATE-RADI OLOGY-DI AGNOST I C	0					6. 00
7. 00		AGGREGATE - CARDI AC CATHETERI ZATI ON	0	,	4, 669			7. 00
8. 00 9. 00	1	AGGREGATE-LABORATORY AGGREGATE-RESPI RATORY THERAPY	0			24, 927 183		8. 00 9. 00
10. 00 11. 00	1	AGGREGATE-ELECTROCARDI OLOGY AGGREGATE-ELECTROENCEPHALOGR	0			1		10. 00 11. 00
12. 00 200. 00	1	APHY AGGREGATE-CLI NI C 	0			25, 562 235, 210		12. 00 200. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST. MARY MEDICAL CENTER, INC. In Lieu of Form CMS-2552-10 Worksheet B Part I Date/Time Prepared: 11/23/2021 10: 33 am Provider CCN: 15-0034 Peri od: From 07/01/2020 To 06/30/2021 CAPITAL RELATED COSTS

Cost Center Description		Net Expenses for Cost Allocation	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	
		(from Wkst A col. 7)					
	CENEDAL SERVICE COST CENTERS	0	1.00	2.00	4. 00	5. 01	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	9, 201, 287	9, 201, 287				1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	9, 387, 862		9, 387, 862			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	14, 023, 354			14, 065, 515		4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES	475, 923			70, 137		5. 01
5. 02 5. 03	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 663, 541 2, 988, 177			428, 846 0		5. 02 5. 03
5. 04	00590 OTHER ADMINISTRATIVE & GENERAL	27, 671, 769			1, 153, 255		5. 04
7. 00	00700 OPERATION OF PLANT	9, 438, 684			415, 344		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	970, 261	15, 615		16, 451		8. 00
9.00	00900 HOUSEKEEPI NG	2, 755, 770			369, 253		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 144, 453 310, 987			233, 645 128, 187		10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	4, 434, 520			651, 212		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0		14. 00
15. 00	01500 PHARMACY	0	0		0	-	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 535, 834			0	0	16. 00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	_	0	1	17. 00 19. 00
23. 00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	341, 852		- 1	51, 003		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,	,	
30.00	03000 ADULTS & PEDIATRICS	17, 764, 416			2, 648, 065		
31.00	03100 I NTENSI VE CARE UNI T	4, 991, 191	210, 426		706, 724		
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	2, 973, 574 1, 507, 690			324, 180 199, 595		41. 00 43. 00
43.00	ANCI LLARY SERVICE COST CENTERS	1, 307, 070	04, 727	<u> </u>	177, 373		45.00
50. 00	05000 OPERATING ROOM	21, 972, 792	705, 460	3, 491, 130	1, 229, 823	290, 949	50. 00
51. 00	05100 RECOVERY ROOM	3, 488, 145			523, 934		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	923, 140			164, 080		52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	459, 182 5, 079, 558			0 590, 163		53. 00 54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	1, 210, 987			98, 326		55. 00
56. 00	05600 RADI OI SOTOPE	1, 445, 322			96, 787		56. 00
57. 00	05700 CT SCAN	2, 057, 535			187, 203		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 225, 014			98, 361		58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	3, 392, 425 11, 081, 232			293, 643 682, 662		59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	11,001,232	180, 440		082, 002		62.00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 341, 790		- 1	28, 704		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	520, 749			70, 090		64. 00
65. 00	06500 RESPI RATORY THERAPY	2, 753, 974			389, 913		
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 299, 410 1, 000, 372			1, 496 183		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	486, 323			0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 187, 772	60, 842	275, 455	159, 432		69. 00
	07000 ELECTROENCEPHALOGRAPHY	568, 193			77, 253		70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 952, 312		0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	12, 453, 228 16, 936, 884		- 1	438, 158		73. 00
74. 00	07400 RENAL DIALYSIS	834, 241	0 0	0	0	1	74. 00
76. 97	07697 CARDIAC REHABILITATION	559, 129	125, 512	3, 771	89, 142	253	76. 97
	OUTPATIENT SERVICE COST CENTERS	1 000 (00	100.000	55.070	011 110		
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	1, 922, 683 5, 989, 420			211, 112 786, 564		90. 00 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 909, 420	290, 991	120, 733	760, 304	32, 020	91.00
72.00	OTHER REIMBURSABLE COST CENTERS	I.		J			72.00
101.00	10100 HOME HEALTH AGENCY	2, 970, 492	0	2, 878	450, 507	59	101. 00
110 0	SPECIAL PURPOSE COST CENTERS	220 (02 440	7 202 0/0	0 224 214	14.0/2.422	/20.000	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	230, 693, 449	7, 293, 969	9, 324, 214	14, 063, 433	628, 900	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 11, 403 0 0				0	190. 00		
191.00	19100 RESEARCH	12, 596	0		2, 082	0	191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	8, 833			0		192. 00
	0/07950 OTHER NON-REIMBURSABLE COST CENTER	718, 324		62, 927	0		194. 00
200.00	· ·	216, 251	14, 206	721	0	3	194. 01 200. 00
201.00			0	О	0	0	201. 00
202.00		231, 649, 453	9, 201, 287	9, 387, 862	14, 065, 515		

Provider CCN: 15-0034

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2020 | Part |
| To 06/30/2021 | Date/Time Prepared: | 11/23/2021 | 10:33 am

					'	0 00/30/2021	11/23/2021 10	
		Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	OPERATION OF	
				OUNTS RECEI VABLE		ADMINISTRATIVE & GENERAL	PLANT	
			5. 02	5. 03	5A. 03	5. 04	7. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT					I	1. 00
2.00		CAP REL COSTS-MVBLE EQUIP					I	2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					l	4. 00
5. 01	1	PURCHASING RECEIVING AND STORES	2 105 0/1				I	5. 01
5. 02 5. 03	1	ADMITTING CASHIERING/ACCOUNTS RECEIVABLE	3, 195, 961 0	2, 999, 500				5. 02 5. 03
5. 04		OTHER ADMINISTRATIVE & GENERAL	0	2, 999, 500	29, 574, 055	29, 574, 055	I	5. 04
7. 00	1	OPERATION OF PLANT	0	0	11, 452, 182		13, 128, 232	1
8. 00	1	LAUNDRY & LINEN SERVICE	0	O	1, 002, 334		28, 584	
9.00	00900	HOUSEKEEPI NG	0	0	3, 196, 246	467, 777	115, 539	9. 00
10.00		DI ETARY	0	0	2, 556, 700		211, 757	
11. 00		CAFETERI A	0	0	516, 736		141, 983	
13.00		NURSI NG ADMI NI STRATI ON	0	0	5, 165, 019		125, 243	
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	0	0 0	0	0	0 0	14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	0	2, 569, 674	376, 077	61, 947	
17. 00		SOCIAL SERVICE	0	Ö	2, 307, 074	0,077	01, 747	1
19. 00		NONPHYSI CI AN ANESTHETI STS	0	o	0	0	Ō	ı
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	0	408, 040	59, 717	13, 017	23. 00
		ENT ROUTINE SERVICE COST CENTERS						
30. 00		ADULTS & PEDI ATRI CS	214, 559		22, 588, 920		2, 574, 981	30.00
31.00		INTENSIVE CARE UNIT	39, 687		6, 326, 048		385, 198	
41. 00 43. 00		SUBPROVI DER - I RF NURSERY	20, 786 13, 387	19, 512 12, 567	3, 548, 120		321, 462 155, 469	
43.00		LARY SERVICE COST CENTERS	13, 307	12, 307	1, 818, 168	200, 093	155, 469	43.00
50. 00		OPERATING ROOM	427, 901	401, 099	28, 519, 154	4, 173, 750	1, 291, 389	50.00
51. 00		RECOVERY ROOM	54, 441	51, 105	4, 511, 184		452, 099	
52.00	05200	DELIVERY ROOM & LABOR ROOM	10, 858	10, 193	1, 474, 883		128, 438	52. 00
53.00	05300	ANESTHESI OLOGY	82, 802	77, 727	633, 702	92, 744	7, 095	53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	167, 745	157, 464	6, 840, 995		420, 613	1
55. 00		RADI OLOGY - THERAPEUTI C	51, 571	48, 410	1, 628, 804		88, 479	1
56. 00		RADI OI SOTOPE	51, 800		1, 846, 146		172, 795	
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	228, 090 98, 157	214, 110 92, 141	2, 854, 173 2, 124, 186		95, 632 106, 480	
59. 00		CARDI AC CATHETERI ZATI ON	230, 477	216, 350	5, 823, 572		251, 951	59.00
60.00		LABORATORY	411, 505		12, 970, 174		331, 313	
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00		BLOOD STORING, PROCESSING, & TRANS.	16, 618	15, 599	1, 451, 018	212, 359	26, 151	63. 00
64. 00		INTRAVENOUS THERAPY	10, 703	10, 047	673, 334		69, 657	
65. 00		RESPI RATORY THERAPY	40, 324	37, 852	3, 373, 186		107, 183	
66.00		PHYSI CAL THERAPY	51, 235	48, 094	3, 721, 887		510, 645	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	18, 834 4, 000	17, 679 3, 755	1, 055, 050 499, 394		30, 021 8, 209	1
69. 00		ELECTROCARDI OLOGY	89, 710	84, 212	1, 858, 482		111, 376	
70. 00		ELECTROENCEPHALOGRAPHY	26, 664	25, 030	783, 763			
		MEDICAL SUPPLIES CHARGED TO PATIENT	95, 490		9, 137, 439			
		IMPL. DEV. CHARGED TO PATIENTS	98, 647	92, 601	12, 644, 476		0	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	326, 558		18, 324, 574	2, 681, 838	102, 874	73. 00
74. 00	07400	RENAL DI ALYSI S	10, 771	10, 111	855, 124			
76. 97		CARDI AC REHABI LI TATI ON	5, 594	5, 251	788, 652	115, 421	229, 758	76. 97
00 00		TIENT SERVICE COST CENTERS CLINIC	10 444	17, 314	2 /12 100	353, 029	222 E00	90.00
90. 00 91. 00		EMERGENCY	18, 444 265, 988		2, 412, 188 7, 744, 207		333, 599 547, 321	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	203, 700	247,003	7, 744, 207		347,321	92.00
72.00		REI MBURSABLE COST CENTERS						72.00
101.00		HOME HEALTH AGENCY	12, 615	11, 842	3, 448, 393	504, 679	0	101. 00
	SPECI	AL PURPOSE COST CENTERS						
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	3, 195, 961	2, 999, 500	228, 720, 382	29, 145, 379	9, 636, 769	118. 00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	11, 403		20, 874	190. 00
		RESEARCH	0	0	14, 678			191. 00
		PHYSICIANS' PRIVATE OFFICES	0	0	1, 890, 542			
		OTHER NON-REIMBURSABLE COST CENTER	0	0	781, 267			194. 00
194. 01 200. 00		ADVERTISING Cross Foot Adjustments	0	0	231, 181	33, 834	26, 004	194. 01 200. 00
200.00		Negative Cost Centers	0		0	0		200.00
201.00	1	TOTAL (sum lines 118 through 201)	3, 195, 961	2, 999, 500	231, 649, 453	-		
,	1							

Provider CCN: 15-0034

						11/23/2021 10	33 am
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE				ADMI NI STRATI ON	
	OFNEDAL CEDIU OF COST OFNITEDS	8.00	9. 00	10.00	11. 00	13. 00	
1 00	GENERAL SERVICE COST CENTERS					I	1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES						5. 01
5.02	00570 ADMI TTI NG						5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5. 04
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 177, 612					8. 00
9.00	00900 HOUSEKEEPI NG	0	3, 779, 562				9. 00
10.00	01000 DI ETARY	0	61, 641	3, 204, 276			10.00
11.00	01100 CAFETERI A	0	41, 330	0	775, 674		11. 00
13.00	01300 NURSING ADMINISTRATION	0	36, 457	0	40, 817		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	. 0	l o	14.00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	18, 032	0	0	Ö	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	1	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	· -	0	Ö	19.00
23. 00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	3, 789		3, 578		23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	U	3, 707	U	3, 370		23.00
20.00		002 021	740 555	2 400 450	100.044	2 504 1/5	20.00
30.00	03000 ADULTS & PEDIATRICS	883, 821	749, 555		198, 046		
31.00	03100 I NTENSI VE CARE UNI T	125, 669	112, 128		42, 687		
41.00	04100 SUBPROVI DER - I RF	133, 034	93, 575		25, 152		41. 00
43. 00	04300 NURSERY	35, 088	45, 256	0	12, 738	166, 264	43. 00
	ANCILLARY SERVICE COST CENTERS	_					
50. 00	05000 OPERATING ROOM	0	375, 912		88, 654		50. 00
51. 00	05100 RECOVERY ROOM	0	131, 602		32, 081		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	37, 387		10, 471	136, 675	
53.00	05300 ANESTHESI OLOGY	0	2, 065	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	122, 437	0	42, 209	0	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0	25, 755	0	5, 773	0	55. 00
56.00	05600 RADI OI SOTOPE	0	50, 299	0	4, 870	0	56.00
57.00	05700 CT SCAN	0	27, 838	0	12, 178	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	30, 995	0	6, 306	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	73, 341	0	18, 240		59. 00
60.00	06000 LABORATORY	0	96, 442	0	59, 491		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	0		62. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	7, 612		1, 924		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	20, 277		5, 375		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	31, 200		26, 407		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	148, 644		54		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	8, 739		9		67. 00
	06800 SPEECH PATHOLOGY	0	2, 390		7	0	68. 00
68. 00		0			10 471		69.00
69.00	06900 ELECTROCARDI OLOGY	0	32, 421	0	10, 471		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	22, 854		6, 071	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	29, 946		24, 068		
74. 00	07400 RENAL DI ALYSI S	0	0		0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	66, 881	0	5, 746	75, 021	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	97, 108		13, 777		
91. 00	09100 EMERGENCY	0	159, 320	104, 089	53, 664	700, 314	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	24, 700	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 177, 612	2, 763, 228	3, 204, 276	775, 557	6, 123, 447	118. 00
	NONREI MBURSABLE COST CENTERS				·		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 076	0	0	0	190. 00
	19100 RESEARCH	n	n -, 3, 0	0	117		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	١	1, 002, 688	· ·	 		192. 00
	07950 OTHER NON-REIMBURSABLE COST CENTER		1, 002, 000 n		0		194. 00
	07952 ADVERTI SI NG		7, 570		0		194. 00
200.00			7,370		U	I	200. 00
200.00	1 1		^	_	^	_	200.00
	1 1 0	1 177 413	2 770 542	2 204 274	77E 474		
202.00	I TOTAL (Sum TITIES TTO THE OUGH ZOT)	1, 177, 612	3, 779, 562	3, 204, 276	775, 674	J 0, 123, 44/	₁ 202. UU

Provider CCN: 15-0034

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2020 Part I
To 06/30/2021 Date/Time Prepared: 11/23/2021 10:33 am

			'	0 00/30/2021	11/23/2021 10	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	
	SERVICES &		RECORDS &		ANESTHETI STS	
	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	17. 00	19. 00	
GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	17.00	19.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01 00560 PURCHASING RECEIVING AND STORES						5. 01
5. 02 00570 ADMI TTI NG						5. 02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5. 04 00590 OTHER ADMINISTRATIVE & GENERAL						5. 04
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0				1	14. 00
15. 00 01500 PHARMACY	o o	0				15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	o	0	3, 025, 730			16. 00
17. 00 01700 SOCI AL SERVI CE	o	0	C C	_		17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	C	o	0	19. 00
23.00 02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	0	C	0		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	203, 130			1
31. 00 03100 INTENSI VE CARE UNI T	0	0	37, 573			
41. 00 04100 SUBPROVI DER - RF	0	0				1
43. 00 04300 NURSERY	0	0	12, 674	0	0	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 OPERATING ROOM	0	0	405, 111	0	0	50.00
51. 00 05100 RECOVERY ROOM		0	51, 542			
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	10, 280		0	
53. 00 05300 ANESTHESI OLOGY	0	0	78, 391		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	0	158, 810		1	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	48, 824	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	49, 040	0	0	56. 00
57. 00 05700 CT SCAN	0	0	215, 940	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	92, 929	0		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	218, 200		0	
60. 00 06000 LABORATORY	0	0	389, 586	0	0	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0	0	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	15, 733	1	0	
64. 00 06400 I NTRAVENOUS THERAPY	0	0	10, 133		0	1
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0	38, 176 48, 506		0	
67. 00 06700 OCCUPATI ONAL THERAPY		0	17, 831		0	1
68. 00 06800 SPEECH PATHOLOGY		0	3, 787		Ö	
69. 00 06900 ELECTROCARDI OLOGY	o	0	84, 932		Ö	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0	25, 244		Ō	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	93, 392	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	309, 164		0	
74. 00 07400 RENAL DI ALYSI S	0	0	10, 198			
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	5, 296	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS		٥	17.4/2			1 00 00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0	0			l .	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		U	251, 620		l	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101. 00 10100 HOME HEALTH AGENCY	0	0	11, 943	0	0	101. 00
SPECIAL PURPOSE COST CENTERS		-				
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 0	0	3, 025, 730	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	-		190. 00
191. 00 19100 RESEARCH	0	0	C	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
194.00 07950 OTHER NON-REIMBURSABLE COST CENTER		0			l	194.00
194.01 07952 ADVERTISING 200.00 Cross Foot Adjustments		U		ή		194. 01 200. 00
201.00 Negative Cost Centers		0	_)		201.00
202.00 TOTAL (sum lines 118 through 201)		0	3, 025, 730			202. 00
	1 -1	-,		,	_	

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0034 Peri od: Worksheet B From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:33 am Cost Center Description PARAMEDI CAL Total Subtotal Intern & **EDUCATION** Residents Cost PROGRAM EMS & Post Stepdown Adjustments 23.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00560 PURCHASING RECEIVING AND STORES 5.01 5.01 00570 ADMITTING 5.02 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02300 PARAMEDICAL EDUCATION PROGRAM EMS 488, 141 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 35, 498, 010 0 35, 498, 010 30.00 03100 INTENSIVE CARE UNIT 0 8, 672, 023 0 8, 672, 023 31.00 31.00 41.00 04100 SUBPROVIDER - IRF 0 5, 313, 387 0 5, 313, 387 41.00 <u>2, 5</u>11, 750 04300 NURSERY 0 2, 511, 750 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 36, 047, 305 0 36, 047, 305 50.00 05000 OPERATING ROOM 36.327 05100 RECOVERY ROOM 6, 386, 821 0 6, 386, 821 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 090, 642 0 2, 090, 642 0 52.00 0 53.00 05300 ANESTHESI OLOGY 813, 997 0 813, 997 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 8, 586, 257 8, 586, 257 54.00 2, 036, 014 2, 036, 014 55.00 05500 RADI OLOGY - THERAPEUTI C 00000 0 55.00 05600 RADI OI SOTOPE 0 56.00 2, 393, 337 2, 393, 337 56 00 57.00 05700 CT SCAN 3, 623, 475 3, 623, 475 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 2, 671, 775 2, 671, 775 58.00 05900 CARDIAC CATHETERIZATION 0 7, 237, 595 7, 237, 595 59.00 59.00 60.00 06000 LABORATORY 15, 745, 217 15, 745, 217 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 000000000000 0 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 1, 714, 797 0 1, 714, 797 63.00 63.00 06400 I NTRAVENOUS THERAPY 0 877, 320 877, 320 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 4, 069, 825 4, 069, 825 65.00 66.00 06600 PHYSI CAL THERAPY 4, 974, 442 4, 974, 442 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 1, 266, 059 1, 266, 059 67.00 06800 SPEECH PATHOLOGY 0 68.00 586, 867 586, 867 68.00 69.00 06900 ELECTROCARDI OLOGY 2, 369, 675 2, 369, 675 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 031, 148 1, 031, 148 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 10, 565, 125 71 00 10, 565, 125 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 14, 588, 412 0 14, 588, 412 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 21, 472, 464 73.00 21, 472, 464 73.00 07400 RENAL DIALYSIS 0 990. 471 0 990, 471 74.00 74.00 07697 CARDIAC REHABILITATION 76. 97 1, 286, 775 0 1, 286, 775 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3, 227, 163 0 3, 227, 163 90.00 09100 EMERGENCY 437.057 0 91 00 91 00 11, 131, 172 11, 131, 172 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 3, 989, 715 0 3, 989, 715 101.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 473, 384 223, 769, 035 0 223, 769, 035 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 40. 022 40, 022 190.00 191. 00 19100 RESEARCH 0 16, 943 191. 00 0 16, 943 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 6, 614, 500 0 6, 614, 500 192.00 194. 00 07950 OTHER NON-REIMBURSABLE COST CENTER 12, 487 908, 094 0 908, 094 194.00 194. 01 07952 ADVERTI SI NG 2, 270 300, 859 0 300, 859 194. 01 200.00 Cross Foot Adjustments 0 200.00 0 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 488, 141 231, 649, 453 231, 649, 453 202. 00

| Peri od: | Worksheet B | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: | 10 06/30/2021 | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0034

				To	06/30/2021	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		1172372021 10	. 55 dili
	Cook Cooks Decoristics	D:+1	DIDC & FLVT	MVDLE FOULD	C	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs	1.00	2.00	2.4	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2. 00	2A	4. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	40, 455		42, 161	42, 161	4. 00
5. 01 5. 02	OO560 PURCHASING RECEIVING AND STORES OO570 ADMITTING	0	73, 030 89, 334	1	82, 859 102, 698		5. 01 5. 02
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	11, 323	1	11, 323	0	5. 02
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	0	497, 837	239, 816	737, 653	3, 459	5. 04
7.00	00700 OPERATION OF PLANT	0	1, 317, 615	1	1, 597, 603	1, 246	7. 00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	0	15, 615 63, 117		15, 615 68, 982	49 1, 107	8. 00 9. 00
10. 00	01000 DI ETARY	0	115, 679	1	175, 803	701	10.00
11. 00	01100 CAFETERI A	0	77, 562	1 1	77, 562	384	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	68, 418	· _	74, 796	1, 953	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	0	0	0	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	33, 840		33, 840	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	7 111		12 125	0	19.00
23. 00	02300 PARAMEDICAL EDUCATION PROGRAM EMS INPATIENT ROUTINE SERVICE COST CENTERS	0	7, 111	6, 014	13, 125	153	23. 00
30.00	03000 ADULTS & PEDIATRICS	0	1, 406, 661	307, 782	1, 714, 443	7, 922	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	210, 426		531, 672	2, 120	1
41. 00	04100 SUBPROVI DER - I RF	0	175, 608	1	206, 128	972 599	41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	84, 929	0	84, 929	599	43. 00
50.00	05000 OPERATING ROOM	0	705, 460	3, 491, 130	4, 196, 590	3, 688	50.00
51. 00	05100 RECOVERY ROOM	0	246, 973	1	384, 477	1, 571	51. 00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	70, 163		359, 294	492 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 876 229, 772	1 1	3, 876 833, 750	1, 770	•
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	48, 334	1	218, 979	295	55. 00
56. 00	05600 RADI OI SOTOPE	0	94, 395		202, 851	290	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	52, 242	1	160, 651 609, 294	561 295	57. 00 58. 00
59.00	05900 CARDIAC CATHETERIZATION	0	58, 168 137, 636	1	1, 658, 807	881	59.00
60.00	06000 LABORATORY	0	180, 990		306, 334	2, 047	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62. 00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	14, 286 38, 052	1	43, 410 59, 633	86 210	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	58, 552	1	142, 750	1, 169	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	278, 955	1	319, 694	4	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	16, 400		17, 877	1	67. 00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	4, 484 60, 842		5, 224 336, 297	0	68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	42, 889		84, 301		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	56, 198	256, 602	312, 800	1, 314 0	73. 00 74. 00
	07697 CARDI AC REHABI LI TATI ON	0	125, 512	3, 771	129, 283	267	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0		1	238, 217	633	1
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	298, 991	120, 733	419, 724 0	2, 359	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	l.		1			72.00
101.00	10100 HOME HEALTH AGENCY	0	0	2, 878	2, 878	1, 351	101. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	7, 293, 969	9, 324, 214	16 610 102	42, 155	119 00
118.00	NONREIMBURSABLE COST CENTERS	0	1, 293, 909	9, 324, 214	16, 618, 183	42, 155]118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 403	0	11, 403	0	190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NON-REIMBURSABLE COST CENTER	0	1, 881, 709	0 62, 927	1, 881, 709 62, 927		192. 00 194. 00
	07950 OTHER NON-REIMBURSABLE COST CENTER	0	14, 206		62, 927 14, 927		194. 00
200.00	Cross Foot Adjustments				0		200. 00
201.00		_	0 224 5	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	9, 201, 287	9, 387, 862	18, 589, 149	42, 161	1202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0034

						11/23/2021 10	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC		OPERATION OF	
		RECEIVING AND		OUNTS	ADMI NI STRATI VE	PLANT	
		STORES 5. 01	5. 02	RECEI VABLE 5. 03	& GENERAL 5.04	7. 00	
	GENERAL SERVICE COST CENTERS	5.01	5. 02	5.03	5.04	7.00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES	83, 069					5. 01
5.02	00570 ADMITTING	116	104, 100				5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	O	0	11, 323			5. 03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	1, 503	0	0	742, 615		5. 04
7.00	00700 OPERATION OF PLANT	73	0	0	42, 087	1, 641, 009	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1	0	0	3, 684	3, 573	8. 00
9. 00	00900 HOUSEKEEPI NG	296	0		11, 746	14, 442	1
10. 00	01000 DI ETARY	370	0	0	9, 396	26, 469	1
11. 00	01100 CAFETERI A	0	0			17, 748	1
13.00	01300 NURSI NG ADMI NI STRATI ON	593	0	0		15, 655	1
14.00	01400 CENTRAL SERVI CES & SUPPLY	0	0	0	0	0	1
15. 00	01500 PHARMACY	0	0	0	0 444	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	9, 444	7, 743	1
17. 00 19. 00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
23. 00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	272	0	1	1, 500	1, 627	1
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	212	0	0	1, 500	1, 027	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	6, 080	6, 967	783	83, 014	321, 869	30.00
31. 00	03100 NTENSI VE CARE UNI T	2, 578	1, 289		· · ·	48, 149	1
41. 00	04100 SUBPROVI DER – I RF	520	675			40, 182	1
43.00	04300 NURSERY	O	435			19, 433	1
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	38, 427	14, 214	1, 225	104, 795	161, 422	50. 00
51. 00	05100 RECOVERY ROOM	1, 200	1, 768		· · ·	56, 512	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	967	353		I	16, 055	1
53. 00	05300 ANESTHESI OLOGY	1, 336	2, 689		· · ·	887	1
54.00	05400 RADI OLOGY - DI AGNOSTI C	1, 627	5, 447	612		52, 576	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	70	1, 675			11, 060	1
56. 00	O5600 RADI OI SOTOPE	101	1, 682			21, 599	1
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	870 161	7, 406 3, 187			11, 954 13, 310	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 209	7, 484	•	21, 402	31, 494	1
60. 00	06000 LABORATORY	13, 493	13, 362		47, 665	41, 414	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	13, 473	13, 302	1, 301	l	0	1
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	647	540	1	5, 332	3, 269	
64. 00	06400 I NTRAVENOUS THERAPY	279	348	•	l	8, 707	1
65.00	06500 RESPI RATORY THERAPY	1, 106	1, 309	•	· · · · · · · · · · · · · · · · · · ·	13, 398	1
66.00	06600 PHYSI CAL THERAPY	259	1, 664	187	13, 678	63, 830	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	14	612	69	3, 877	3, 753	67. 00
68. 00	06800 SPEECH PATHOLOGY	12	130	15	1, 835	1, 026	68. 00
69. 00	06900 ELECTROCARDI OLOGY	140	2, 913		6, 830	13, 922	
70.00	07000 ELECTROENCEPHALOGRAPHY	307	866		,	9, 814	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 101		· · ·		1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	3, 203			0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	480	10, 603			12, 859	
74.00	07400 RENAL DIALYSIS	0	350			0	
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	33	182	20	2, 898	28, 719	76. 97
90. 00	09000 CLINIC	583	599	67	8, 865	41, 699	90.00
91. 00	09100 EMERGENCY	4, 336	8, 637			68, 414	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 330	0, 037	770	20, 400	00, 414	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	8	410	46	12, 673	0	101. 00
	SPECIAL PURPOSE COST CENTERS	·			,		
118.00	3 /	83, 067	104, 100	11, 323	731, 850	1, 204, 583	118. 00
400.00	NONREI MBURSABLE COST CENTERS	1				0.400	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
	19100 RESEARCH 19200 PHYSICIANS'PRIVATE OFFICES	0	0	1	_ · ·		191.00
	07950 OTHER NON-REIMBURSABLE COST CENTER		0	1	l		194. 00
	07952 ADVERTI SI NG	2 0	0	0	l		194. 00
200.00		"	U		650	3, 250	200. 00
201.00		0	Λ	0	n	Λ	201.00
202.00		83, 069	104, 100	11, 323	742, 615		
	, (1 1.0 till oagi. 201)	1 33,537	,	1, 525	, , , , , , , , , , , , , , , , , , , ,	., 5 , 50 /	,

Provider CCN: 15-0034

						11/23/2021 10	33 am
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE				ADMI NI STRATI ON	
		8. 00	9. 00	10.00	11. 00	13. 00	
	GENERAL SERVICE COST CENTERS	T					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00560 PURCHASING RECEIVING AND STORES						5. 01
5.02	00570 ADMI TTI NG						5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5. 04
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	22, 922					8. 00
9. 00	00900 HOUSEKEEPI NG	0	96, 573				9. 00
	1	1		214 214			ł
10.00	01000 DI ETARY	0	1, 575	214, 314	00 / 10		10.00
11.00	01100 CAFETERI A	0	1, 056	0	98, 649	l .	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	932	0	5, 191		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	461	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	o	0	0	0	19. 00
23.00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	97	0	455	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			-1		_	
30. 00	03000 ADULTS & PEDI ATRI CS	17, 204	19, 152	161, 154	25, 186	49, 840	30.00
31. 00	03100 I NTENSI VE CARE UNI T	2, 446		10, 688	5, 429		31.00
	04100 SUBPROVI DER – I RF					l .	1
41. 00		2, 589		21, 725	3, 199		41.00
43. 00	04300 NURSERY	683	1, 156	0	1, 620	3, 207	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0		0	11, 275		50. 00
51.00	05100 RECOVERY ROOM	0	3, 363	8, 658	4, 080	8, 074	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	955	5, 127	1, 332	2, 636	52.00
53.00	05300 ANESTHESI OLOGY	0	53	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 128	0	5, 368	0	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0	658	0	734		55. 00
56.00	05600 RADI OI SOTOPE	0	1, 285	0	619		56. 00
57. 00	05700 CT SCAN	0	711	0	1, 549		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	792	0	802		58. 00
59. 00		0	l .	-			•
	05900 CARDI AC CATHETERI ZATI ON	· -	1, 874	0	2, 320		59.00
60. 00	06000 LABORATORY	0	2, 464	0	7, 566	l .	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	195	0	245	1	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	518	0	684	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	797	0	3, 358	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	3, 798	0	7	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	223	0	1	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	61	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	828	0	1, 332		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	584	Ő	772		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,12	Ö	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	1			0	0 0/4		1
	07300 DRUGS CHARGED TO PATIENTS	0	1	0	3, 061		73. 00
	07400 RENAL DI ALYSI S	0		0	0	_	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	1, 709	0	731	1, 447	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	2, 481	0	1, 752	0	90.00
91.00	09100 EMERGENCY	0	4, 071	6, 962	6, 825	13, 507	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS			· · · · · · · · · · · · · · · · · · ·			
101 00	10100 HOME HEALTH AGENCY	0	0	0	3, 141	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS				0, 111		101.00
118. 00		22, 922	70, 603	214, 314	98, 634	118, 101	110 00
110.00	NONREI MBURSABLE COST CENTERS	22, 722	70,003	214, 314	70, 034	110, 101	1110.00
100.00		_	455		^		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190.00
	19100 RESEARCH	0		0	15		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	25, 622	0	0		192. 00
	07950 OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0		194. 00
194. 01	07952 ADVERTI SI NG	0	193	0	0	0	194. 01
200.00	Cross Foot Adjustments						200. 00
201.00	, ,	0	0	o	0	0	201.00
202.00		22, 922	96, 573	214, 314	98, 649		
	, , , , , , , , , , , , , , , , , , ,	1 22,722	1 ,5,5,6	2,511	,5,51,		,

| Peri od: | Worksheet B | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0034

				Ť	06/30/2021	Date/Time Pre	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		1. 33 aiii
	·	SERVICES &		RECORDS &		ANESTHETI STS	
		SUPPLY	15 00	LI BRARY	17.00	10.00	
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	19. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES						5. 01
5. 02 5. 03	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE						5. 02 5. 03
5. 04	00590 OTHER ADMINISTRATIVE & GENERAL						5. 04
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0					14. 00
15. 00	01500 PHARMACY	0	0				15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	51, 488			16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			17. 00 19. 00
23. 00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	0				23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					20.00
30. 00	03000 ADULTS & PEDI ATRI CS	0	0				30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	0		0		31. 00
41.00	04100 SUBPROVI DER - I RF	0	0				41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	U	0	215	0		43.00
50. 00	05000 OPERATING ROOM	0	0	7, 052	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	1, 329			53. 00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	0	0	2, 693 828			54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	0	0	832			56.00
57. 00	05700 CT SCAN	0	0	3, 661	0		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1, 576	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	-,			59. 00
60. 00 62. 00	06000 LABORATORY	0	0	6, 606 0			60.00
63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	267	0		62.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	172	ı .		64. 00
65.00	06500 RESPIRATORY THERAPY	0	0	647	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	822			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	302	0		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	64 1, 440			68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1, 533			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	5, 242			73.00
74. 00 76. 97	07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION	0	0	173 90			74. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>		70			70. 77
90.00	09000 CLI NI C	0	0	296	0		90.00
91. 00	09100 EMERGENCY	0	0	4, 270	0		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	203	0		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	U	0		0		1101.00
118.00		0	0	51, 488	0	0	118. 00
	NONREI MBURSABLE COST CENTERS			·			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	19100 RESEARCH	0	0	1			191. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NON-REIMBURSABLE COST CENTER		0	0	0		192. 00 194. 00
	07952 ADVERTI SI NG	0	0		0		194. 00
200.00	Cross Foot Adjustments		· ·			0	200. 00
201.00		0	0		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	0	51, 488	0	0	202. 00

	•	I. MARY MEDICAL		CN: 1E 0024 Do		u of Form CMS-2552-10
ALLOCATION	OF CAPITAL RELATED COSTS		Provider C		riod: om 07/01/2020 06/30/2021	Worksheet B Part II Date/Time Prepared: 11/23/2021 10:33 am
	Cost Center Description	PARAMEDICAL EDUCATION PROGRAM EMS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23. 00	24. 00	25. 00	26. 00	
	ERAL SERVICE COST CENTERS	T		1		
2. 00 0024 4. 00 0044 5. 01 0055 5. 02 0055 5. 03 0056 7. 00 0076 8. 00 0086 9. 00 0090 11. 00 0110 13. 00 0130 14. 00 0140 15. 00 0150 16. 00 0160 17. 00 0170 19. 00 0190 23. 00 0230	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP CEMPLOYEE BENEFITS DEPARTMENT CO PURCHASING RECEIVING AND STORES CO ADMITTING COCCUPATION OF PLANT COCCUPATION COCCUP	17, 229				1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00
	DO ADULTS & PEDIATRICS		2, 417, 058	0	2, 417, 058	30.00
31. 00 031	DO INTENSIVE CARE UNIT		642, 010	0	642, 010	31.00
	00 SUBPROVI DER – I RF		298, 161		298, 161	41.00
	DO NURSERY LLARY SERVICE COST CENTERS		119, 008	0	119, 008	43. 00
	OO OPERATING ROOM		4, 570, 608	8 0	4, 570, 608	50.00
51. 00 051	OO RECOVERY ROOM		487, 355		487, 355	51.00
	DO DELIVERY ROOM & LABOR ROOM DO ANESTHESIOLOGY		392, 845 12, 801		392, 845 12, 801	52. 00 53. 00
	DO RADI OLOGY-DI AGNOSTI C		932, 112		932, 112	54.00
	OO RADI OLOGY - THERAPEUTI C		240, 473		240, 473	55. 00
	DO RADI OI SOTOPE		236, 233	0	236, 233	56. 00
	OO CT SCAN		198, 684		198, 684	57. 00
	OO MAGNETIC RESONANCE IMAGING (MRI)		637, 581		637, 581	58.00
	OO CARDI AC CATHETERI ZATI ON OO LABORATORY		1, 733, 012 442, 452		1, 733, 012 442, 452	59. 00 60. 00
	OO WHOLE BLOOD & PACKED RED BLOOD CELL		0		0	62. 00
63. 00 063	DO BLOOD STORING, PROCESSING, & TRANS.		54, 052	2 0	54, 052	63. 00
1	OO I NTRAVENOUS THERAPY		73, 065		73, 065	64. 00
	OO RESPIRATORY THERAPY		177, 077		177, 077	65. 00
	DO PHYSI CAL THERAPY DO OCCUPATI ONAL THERAPY		403, 943 26, 729		403, 943 26, 729	66. 00 67. 00
	OO SPEECH PATHOLOGY		8, 367		8, 367	68. 00
69. 00 069	DO ELECTROCARDI OLOGY		364, 507	0	364, 507	69. 00
4	OO ELECTROENCEPHALOGRAPHY		100, 281		100, 281	70.00
	DO MEDICAL SUPPLIES CHARGED TO PATIENT DO IMPL. DEV. CHARGED TO PATIENTS		38, 562 51, 615		38, 562 51, 615	71. 00 72. 00
	DO DRUGS CHARGED TO PATTENTS		415, 658		415, 658	73.00
	00 RENAL DIALYSIS		3, 705		3, 705	74. 00
	97 CARDIAC REHABILITATION		165, 379	0	165, 379	76. 97
	PATIENT SERVICE COST CENTERS DO CLINIC	T T	295, 192	. 0	295, 192	90.00
	DO EMERGENCY		568, 535		568, 535	91.00
4	OO OBSERVATION BEDS (NON-DISTINCT PART		,	0	222, 222	92. 00
	ER REIMBURSABLE COST CENTERS					
	OO HOME HEALTH AGENCY		20, 710	0	20, 710	101. 00
118. 00	CIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	0	16, 127, 770	0	16, 127, 770	118. 00
190. 00 190	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN		14, 209		14, 209	190. 00
	DO RESEARCH		75		75	191. 00
	DO PHYSICIANS' PRIVATE OFFICES 50 OTHER NON-REIMBURSABLE COST CENTER		2, 344, 846 65, 800		2, 344, 846 65, 800	192. 00 194. 00
	52 ADVERTI SI NG		19, 220		19, 220	194. 00
200. 00	Cross Foot Adjustments	17, 229	17, 229		17, 229	200. 00
201. 00	Negative Cost Centers	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	17, 229	18, 589, 149	0	18, 589, 149	202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0034 Peri od: Worksheet B-1 From 07/01/2020 06/30/2021 Date/Time Prepared: 11/23/2021 10:33 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** PURCHASI NG ADMI TTI NG (SQUARE FEET) (DOLLAR VALUE) BENEFITS RECEIVING AND (GROSS REVE NUE) DEPARTMENT STORES (GROSS (COSTED REQ) SALARI ES) 1.00 2.00 5. 01 5. 02 GENERAL SERVICE COST CENTERS 1 00 574 529 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 21, 933, 735 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2,526 3, 987 75, 464, 333 4.00 00560 PURCHASING RECEIVING AND STORES 5 01 4 560 22, 965 376 299 5 01 856 466 5.02 00570 ADMITTING 5,578 31, 224 2, 300, 847 1, 193 1, 165, 984, 894 5.02 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 707 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 31,085 560, 305 6, 187, 457 15, 495 5.04 0 00700 OPERATION OF PLANT 7 00 2, 228, 409 7 00 82, 272 654, 162 751 0 8.00 00800 LAUNDRY & LINEN SERVICE 975 88, 263 10 0 8.00 00900 HOUSEKEEPI NG 3, 941 9.00 13, 704 1, 981, 118 3.052 9.00 01000 DI ETARY 7, 223 10.00 140, 473 1, 253, 553 3, 812 10.00 0 11.00 01100 CAFETERI A 4.843 687, 749 0 11.00 13.00 01300 NURSING ADMINISTRATION 4, 272 14, 901 3, 493, 889 0 13.00 6, 116 01400 CENTRAL SERVICES & SUPPLY 14.00 0 14.00 01500 PHARMACY 0 0 15.00 15.00 0 0 0 01600 MEDICAL RECORDS & LIBRARY 16.00 2.113 C 0 0 0 16.00 01700 SOCIAL SERVICE 0 0 17.00 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS C O 19.00 02300 PARAMEDICAL EDUCATION PROGRAM EMS 14, 051 444 273, 643 2,806 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 719, 099 14, 207, 317 30.00 03000 ADULTS & PEDIATRICS 87,832 62,683 78, 277, 528 30.00 03100 INTENSIVE CARE UNIT 3, 791, 721 14, 478, 897 31.00 13, 139 750, 558 26, 582 31.00 04100 SUBPROVIDER - IRF 41.00 10, 965 71, 306 1, 739, 296 7, 583, 246 41.00 5, 366 04300 NURSERY 43.00 5, 303 1,070,870 4, 884, 078 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 44, 049 8, 156, 646 6, 598, 256 396, 214 156, 113, 456 50.00 19, 861, 864 51.00 05100 RECOVERY ROOM 15, 421 321, 264 2, 811, 016 12, 368 51.00 05200 DELIVERY ROOM & LABOR ROOM 9, 966 3, 961, 432 52.00 4, 381 675, 525 880, 325 52.00 53.00 05300 ANESTHESI OLOGY 242 13, 774 30, 208, 580 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 411, 131 3, 166, 351 16, 770 61, 198, 624 54 00 14 347 54 00 55.00 05500 RADI OLOGY - THERAPEUTI C 3,018 398, 693 527, 538 723 18, 814, 637 55.00 05600 RADI OI SOTOPE 18, 898, 031 56, 00 5,894 253, 395 519, 284 1,037 56.00 05700 CT SCAN 253, 287 8, 966 83, 214, 033 57.00 3.262 1,004,382 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1, 287, 648 35, 810, 735 58.00 3,632 527, 727 1, 660 58.00 59.00 05900 CARDIAC CATHETERIZATION 8,594 3, 554, 054 1, 575, 454 43, 401 84, 084, 840 59.00 60.00 06000 LABORATORY 11, 301 292, 854 3, 662, 627 139, 120 150, 129, 358 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62 00 62 00 0 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 892 68, 044 154,004 6, 669 6, 062, 639 63.00 64.00 06400 I NTRAVENOUS THERAPY 2, 376 50, 422 376, 045 2,876 3, 904, 638 64.00 14, 711, 344 65.00 06500 RESPIRATORY THERAPY 3,656 196, 719 2,091,965 11, 402 65.00 06600 PHYSI CAL THERAPY 8, 025 18, 691, 954 17 418 95, 183 66 00 2.667 66 00 1, 024 67.00 06700 OCCUPATIONAL THERAPY 3, 452 984 143 6, 871, 114 67.00 06800 SPEECH PATHOLOGY 280 1, 728 1, 459, 228 68.00 125 68.00 69.00 06900 ELECTROCARDI OLOGY 3,799 643.572 855, 385 1.442 32, 729, 078 69.00 07000 ELECTROENCEPHALOGRAPHY 2, 678 70.00 96, 754 414, 480 3, 162 9, 727, 891 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 34, 837, 691 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 35, 989, 313 72.00 72.00 599, 524 07300 DRUGS CHARGED TO PATIENTS 3, 509 4, 945 73.00 2, 350, 808 119, 138, 311 73.00 07400 RENAL DIALYSIS 74.00 3, 929, 673 74 00 07697 CARDIAC REHABILITATION 7,837 8,810 478, 263 344 2, 040, 795 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 130.787 6.016 6, 729, 049 90.00 11, 379 1, 132, 662 91.00 09100 EMERGENCY 18, 669 282, 079 4, 220, 083 44, 702 97, 040, 446 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 4, 602, 391 101. 00 101.00 10100 HOME HEALTH AGENCY 0 6, 723 2, 417, 067 80 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 455, 436 21, 785, 029 75, 453, 162 856, 440 1, 165, 984, 894 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 712 0 190 00 191. 00 19100 RESEARCH 0 0 191.00 11, 171 192.00 19200 PHYSICIANS' PRIVATE OFFICES o 117, 494 0 0 192. 00 194. 00 07950 OTHER NON-REIMBURSABLE COST CENTER 147, 022 0 22 0 194, 00 194. 01 07952 ADVERTI SI NG 887 1,684 0 0 194.01 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 Cost to be allocated (per Wkst. B, 3, 195, 961 202.00 202.00 9, 201, 287 9, 387, 862 14, 065, 515 628, 919 Part I)

Heal th Fina	ncial Systems S	ST. MARY MEDICAL CENTER, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provider CO	F	Period: From 07/01/2020 To 06/30/2021	Worksheet B-1 Date/Time Pre	pared:	
		0481741 851	1750 00070			11/23/2021 10	:33 am	
		CAPITAL REL	_ATED COSTS					
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	PURCHASI NG	ADMI TTI NG		
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS	RECEIVING AND	(GROSS REVE		
				DEPARTMENT	STORES	NUE)		
				(GROSS	(COSTED REQ)			
				SALARI ES)				
		1. 00	2. 00	4. 00	5. 01	5. 02		
203. 00	Unit cost multiplier (Wkst. B, Part I)	16. 015357	0. 428010	0. 186386	0. 734319	0. 002741	203. 00	
204. 00	Cost to be allocated (per Wkst. B,			42, 161	83, 069	104, 100	204. 00	
	Part II)							
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000559	0. 096990	0. 000089	205. 00	
206. 00	NAHE adjustment amount to be allocated						206. 00	
	(per Wkst. B-2)							
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00	
	Parts III and IV)							

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0034 Peri od: Worksheet B-1 From 07/01/2020 06/30/2021 Date/Time Prepared: 11/23/2021 10:33 am Cost Center Description CASHIERING/ACC Reconciliation OPERATION OF LAUNDRY & **OTHER** ADMI NI STRATI VE LINEN SERVICE OUNTS **PLANT** RECEI VABLE & GENERAL (SQUARE FEET) (TOTAL PATIENT (GROSS REVE (ACCUM. COST) DAYS) NUE) 5.04 7. 00 8.00 5.03 5A. 04 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00560 PURCHASING RECEIVING AND STORES 5.01 5.01 00570 ADMITTING 5.02 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 1, 165, 984, 894 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL -29, 574, 055 202, 075, 398 5.04 7.00 00700 OPERATION OF PLANT 11, 452, 182 447, 801 7.00 0 48, 128 00800 LAUNDRY & LINEN SERVICE 1,002,334 8 00 0 0 975 8 00 00900 HOUSEKEEPI NG 9.00 0 3, 196, 246 3, 941 0 9.00 10.00 01000 DI ETARY 2, 556, 700 7, 223 0 10.00 11.00 01100 CAFETERI A 0 0 516, 736 4,843 11.00 0 01300 NURSING ADMINISTRATION 13 00 5, 165, 019 13 00 4.272 0 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 14.00 01500 PHARMACY 15.00 0 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 0 2, 569, 674 2 113 0 16 00 17.00 01700 SOCIAL SERVICE 0 \cap 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 19.00 0 02300 PARAMEDICAL EDUCATION PROGRAM EMS 408, 040 444 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 78, 277, 528 0 22, 588, 920 87,832 36, 121 30.00 03100 INTENSIVE CARE UNIT 14, 478, 897 6, 326, 048 5, 136 31.00 13, 139 31.00 5, 437 41.00 04100 SUBPROVIDER - IRF 7, 583, 246 0 3, 548, 120 10, 965 41.00 04300 NURSERY 4, 884, 078 1, 818, 168 5.303 1, 434 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 156, 113, 456 28, 519, 154 44, 049 50.00 05000 OPERATING ROOM 0 05100 RECOVERY ROOM 19, 861, 864 4, 511, 184 15, 421 51.00 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 474, 883 3, 961, 432 0 4.381 0 52.00 53.00 05300 ANESTHESI OLOGY 30, 208, 580 0 633, 702 242 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 6, 840, 995 54.00 61, 198, 624 14, 347 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 18, 814, 637 0 1, 628, 804 3.018 55.00 0 18, 898, 031 56.00 05600 RADI OI SOTOPE 1, 846, 146 5.894 0 56.00 05700 CT SCAN 83, 214, 033 2, 854, 173 57.00 57.00 3, 262 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 35, 810, 735 2, 124, 186 3, 632 0 58.00 05900 CARDIAC CATHETERIZATION 84.084.840 5, 823, 572 59.00 0 8.594 59.00 0 60.00 06000 LABORATORY 150, 129, 358 12, 970, 174 11, 301 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 6,062,639 1, 451, 018 892 63.00 63.00 06400 I NTRAVENOUS THERAPY 3, 904, 638 0 673, 334 64.00 2, 376 Λ 64.00 65.00 06500 RESPIRATORY THERAPY 14, 711, 344 3, 373, 186 3,656 0 65.00 66.00 06600 PHYSI CAL THERAPY 18, 691, 954 3, 721, 887 17, 418 66.00 06700 OCCUPATIONAL THERAPY 1, 024 6, 871, 114 1, 055, 050 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 1, 459, 228 499, 394 280 0 68.00 69.00 06900 ELECTROCARDI OLOGY 32, 729, 078 1, 858, 482 3, 799 69.00 07000 ELECTROENCEPHALOGRAPHY 9, 727, 891 0 783, 763 70.00 70.00 2.678 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 9, 137, 439 34, 837, 691 0 71 00 0 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 35, 989, 313 0 12, 644, 476 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 18, 324, 574 73.00 119, 138, 311 3, 509 0 73.00 07400 RENAL DIALYSIS 3, 929, 673 0 74.00 855.124 0 74.00 07697 CARDIAC REHABILITATION 76. 97 2,040,795 0 788, 652 7,837 0 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 6, 729, 049 2, 412, 188 11, 379 0 90.00 09100 EMERGENCY 97, 040, 446 r 7, 744, 207 0 91 00 91 00 18.669 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 3, 448, 393 0 101. 00 4, 602, 391 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) | 1,165,984,894 -29, 574, 055 199, 146, 327 328, 708 48, 128 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 11, 403 712 0 190. 00 191. 00 19100 RESEARCH 0 191.00 0 Ω 14,678 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 1, 890, 542 117, 494 0 192.00 0 194.00 194. 00 07950 OTHER NON-REIMBURSABLE COST CENTER 0 781, 267 194. 01 07952 ADVERTI SI NG 0 231, 181 887 0 194. 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 999, 500 29, 574, 055 13, 128, 232 1, 177, 612 202. 00 Part I) 24. 468334 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002573 0.146352 29. 317112

Health Financial Systems		ST. MARY MEDICAL CENTER, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS				Peri od:	Worksheet B-1		
					From 07/01/2020 Fo 06/30/2021	Date/Time Pre 11/23/2021 10		
	Cost Center Description	CASHI ERI NG/ACC			OPERATION OF	LAUNDRY &		
		OUNTS		ADMI NI STRATI VI		LINEN SERVICE		
		RECEI VABLE		& GENERAL	(SQUARE FEET)	(TOTAL PATIENT		
		(GROSS REVE		(ACCUM. COST)		DAYS)		
		NUE)						
		5. 03	5A. 04	5. 04	7. 00	8. 00		
204. 00	Cost to be allocated (per Wkst. B, Part II)	11, 323		742, 61	1, 641, 009	22, 922	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000010		0. 00367	3. 664594	0. 476272	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Health Financial Systems ST. MARY MEDICAL CENTER, INC. In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0034 Peri od: Worksheet B-1 From 07/01/2020 06/30/2021 Date/Time Prepared: 11/23/2021 10:33 am Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL (SQUARE FEET) (MEALS SERVED) (NUMBER OF ADMI NI STRATI ON SERVICES & FTES) **SUPPLY** (NURSING HO (COSTED URS) REQUIS. 1 9.00 10.00 11.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00560 PURCHASING RECEIVING AND STORES 5.01 5.01 00570 ADMITTING 5.02 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 442,885 9.00 10.00 01000 DI ETARY 7, 223 162, 355 10.00 01100 CAFETERI A 4,843 85, 858 11.00 11.00 01300 NURSING ADMINISTRATION 1, 080, 286 13 00 4, 518 13 00 4 272 14.00 01400 CENTRAL SERVICES & SUPPLY C C 0 14.00 01500 PHARMACY 15.00 C 0 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 2 113 Ω 0 0 16 00 0 17.00 01700 SOCIAL SERVICE C 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 19.00 0 02300 PARAMEDICAL EDUCATION PROGRAM EMS 444 396 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 87,832 122,083 21, 921 455, 893 0 30.00 8, 097 03100 INTENSIVE CARE UNIT 4, 725 98, 280 0 31.00 31.00 13, 139 16, 458 41.00 04100 SUBPROVIDER - IRF 10, 965 2, 784 57, 913 0 41.00 04300 NURSERY 5.303 29, 332 43.00 1.410 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 44, 049 9, 813 50.00 05000 OPERATING ROOM 204, 117 0 05100 RECOVERY ROOM 6, 559 51.00 15. 421 3.551 73.856 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 4.381 3.884 1, 159 24, 112 0 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 242 05400 RADI OLOGY-DI AGNOSTI C 54 00 14, 347 4,672 0 0 54.00 0 55.00 05500 RADI OLOGY - THERAPEUTI C 3.018 0 639 0 55.00 56.00 05600 RADI OI SOTOPE 5.894 C 539 0 56.00 05700 CT SCAN 0 0 0 57.00 57.00 3, 262 1, 348 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3,632 698 0 58.00 05900 CARDIAC CATHETERIZATION 8.594 2.019 59.00 59.00 0 0 60.00 06000 LABORATORY 11, 301 0 6,585 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 892 213 63.00 0 63.00 06400 INTRAVENOUS THERAPY 0 64.00 2,376 595 Λ 64.00 65.00 06500 RESPIRATORY THERAPY 3,656 2, 923 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 17, 418 0 66.00 06700 OCCUPATIONAL THERAPY 1, 024 67.00 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 280 0 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 799 1, 159 0 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 2.678 0 672 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 0 C C 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 3,509 0 2,664 0 73.00 07400 RENAL DIALYSIS 74.00 74.00 C 0 0 76. 97 07697 CARDIAC REHABILITATION 7,837 636 13, 235 0 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 11, 379 1, 525 0 90.00 09100 EMERGENCY 5, 274 5, 940 123, 548 0 91 00 91 00 18,669 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 101.00 10100 HOME HEALTH AGENCY 2, 734 0 101. 00 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 323, 792 162, 355 85, 845 1, 080, 286 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 712 0 190. 00 0 191.00 191. 00 19100 RESEARCH 13 0 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 117, 494 0 0 0 0 192.00 0 194.00 194. 00 07950 OTHER NON-REIMBURSABLE COST CENTER 0 0 194, 01 07952 ADVERTI SI NG 887 C 0 0 0 194. 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 3, 779, 562 3, 204, 276 775.674 6. 123. 447 0 202.00 Part I) 0. 000000 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 8.533958 19. 736232 9. 034382 5. 668357

Heal th	Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS			Peri od:	Worksheet B-1		
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(SQUARE FEET)	(MEALS SERVED)	(NUMBER OF	ADMI NI STRATI ON	SERVICES &	
				FTES)		SUPPLY	
					(NURSING HO	(COSTED	
					URS)	REQUIS.)	
		9.00	10.00	11. 00	13.00	14.00	
204.00	Cost to be allocated (per Wkst. B,	96, 573	214, 314	98, 64	9 118, 101	0	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 218054	1. 320033	1. 14897	9 0. 109324	0.000000	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated	1					206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	nancial Systems ST CATION - STATISTICAL BASIS	Γ. MARY MEDICAL	Provider C	CN: 15_0034 D		u of Form CMS- Worksheet B-1	
COST ALLO	CATTUN - STATISTICAL BASIS		Provider Co		eriod: rom 07/01/2020 o 06/30/2021	Date/Time Pre	pared:
	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS REVE NUE)	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	PARAMEDI CAL EDUCATI ON PROGRAM EMS (ASSI GNED TI ME)	. 33 dill
		15. 00	16. 00	17. 00	19. 00	23. 00	
	ERAL SERVICE COST CENTERS				I I		
2. 00 002 4. 00 004 5. 01 005 5. 02 005 5. 03 005 5. 04 005 7. 00 007 8. 00 008 9. 00 009 10. 00 010 11. 00 011 13. 00 013 14. 00 014 15. 00 015 16. 00 016 17. 00 017 19. 00 019	OO CAP REL COSTS-BLDG & FIXT OO CAP REL COSTS-MYBLE EQUIP OO EMPLOYEE BENEFITS DEPARTMENT OF OO PURCHASING RECEIVING AND STORES OF OO ADMITTING OF OO OTHER ADMINISTRATIVE & GENERAL OO OPERATION OF PLANT OO LAUNDRY & LINEN SERVICE OO OF OO O	0 0 0 0	1, 165, 984, 894 0 0 0	0 0	0	860	1.00 2.00 4.00 5.01 5.01 5.02 5.03 5.04 7.00 8.00 9.00 11.00 13.00 14.00 15.00 16.00 17.00 19.00 23.00
INP	ATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	0	78, 277, 528			0	
1	00 INTENSIVE CARE UNIT 00 SUBPROVIDER - IRF	0	14, 478, 897 7, 583, 246	1		0	
	NURSERY	o	4, 884, 078	•		0	1
	ILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0	156, 113, 456	1		64	
	OO RECOVERY ROOM	0	19, 861, 864 3, 961, 432	1		0	
	OO ANESTHESI OLOGY	o	30, 208, 580			0	1
1	OO RADI OLOGY-DI AGNOSTI C	О	61, 198, 624		0	0	54.00
1	600 RADI OLOGY - THERAPEUTI C	0	18, 814, 637		_	0	
	000 RADI OI SOTOPE 100 CT SCAN	0	18, 898, 031 83, 214, 033			0	
	MAGNETIC RESONANCE IMAGING (MRI)	o	35, 810, 735			0	1
	OOO CARDI AC CATHETERI ZATI ON	Ō	84, 084, 840			0	1
	000 LABORATORY	0	150, 129, 358			0	
	200 WHOLE BLOOD & PACKED RED BLOOD CELL 300 BLOOD STORING, PROCESSING, & TRANS.	0	0 6, 062, 639	0		0	
	100 INTRAVENOUS THERAPY	o	3, 904, 638			0	1
	000 RESPI RATORY THERAPY	o	14, 711, 344		0	0	1
	OO PHYSI CAL THERAPY	0	18, 691, 954	1		0	
	OO OCCUPATIONAL THERAPY OO SPEECH PATHOLOGY	0	6, 871, 114 1, 459, 228			0	
	OO ELECTROCARDI OLOGY	o	32, 729, 078			0	
	000 ELECTROENCEPHALOGRAPHY	o	9, 727, 891			0	1
	OO MEDICAL SUPPLIES CHARGED TO PATIENT	0	34, 837, 691	1	-	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	0	35, 989, 313 119, 138, 311		-	0	
	00 RENAL DIALYSIS	ō	3, 929, 673		_	0	1
	97 CARDI AC REHABI LI TATI ON	0	2, 040, 795	0	0	0	76. 97
	PATIENT SERVICE COST CENTERS	O	6, 729, 049	0	O	0	90.00
	OO EMERGENCY	o	97, 040, 446	1			91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART		, ,				92. 00
	ER REIMBURSABLE COST CENTERS	_1		_			
	OO HOME HEALTH AGENCY CLAL PURPOSE COST CENTERS	0	4, 602, 391	0	0	0	101. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 165, 984, 894	. 0	0	834	118. 00
	REIMBURSABLE COST CENTERS OOGGIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0	ol	0	190. 00
191. 00 191	00 RESEARCH	0	0	0		0	191. 00
	PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	_		192. 00
	PSO OTHER NON-REIMBURSABLE COST CENTER PS2 ADVERTISING	0	0	0	0		194. 00 194. 01
200.00	Cross Foot Adjustments	Ĭ	0	ĺ		7	200. 00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	0	3, 025, 730	0	0	488, 141	202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 002595	0. 000000	0. 000000	567. 605814	203. 00
1							

Health Fir	nancial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der C		eri od:	Worksheet B-1	
					rom 07/01/2020 o 06/30/2021	Date/Time Pre 11/23/2021 10	
	Cost Center Description	PHARMACY		SOCIAL SERVICE		PARAMEDI CAL	
		(COSTED	RECORDS &		ANESTHETI STS	EDUCATI ON	
		REQUIS.)	LI BRARY	(TIME SPENT)	(ASSI GNED	PROGRAM EMS	
			(GROSS REVE		TIME)	(ASSI GNED	
			NUE)			TIME)	
		15. 00	16.00	17. 00	19. 00	23. 00	
204.00	Cost to be allocated (per Wkst. B,	0	51, 488	C	0	17, 229	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000044	0.000000	0.000000	20. 033721	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated					0	206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,					0.000000	207. 00
	Parts III and IV)						

| Period: | Worksheet C | From 07/01/2020 | Part | To 06/30/2021 | Date/Time Prepared:

				Т	o 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :33 am
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDI ATRI CS	35, 498, 010		35, 498, 010	15, 851	35, 513, 861	30. 00
31.00	03100 INTENSIVE CARE UNIT	8, 672, 023		8, 672, 023	6, 687	8, 678, 710	31. 00
41.00	04100 SUBPROVI DER - I RF	5, 313, 387		5, 313, 387	0	5, 313, 387	41. 00
43.00	04300 NURSERY	2, 511, 750		2, 511, 750	0	2, 511, 750	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	36, 047, 305		36, 047, 305	18, 137	36, 065, 442	50. 00
	05100 RECOVERY ROOM	6, 386, 821		6, 386, 821	0	6, 386, 821	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 090, 642		2, 090, 642	0	2, 090, 642	52. 00
53.00	05300 ANESTHESI OLOGY	813, 997		813, 997	0	813, 997	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 586, 257		8, 586, 257	8, 438	8, 594, 695	54. 00
55.00	05500 RADI OLOGY - THERAPEUTI C	2, 036, 014		2, 036, 014	0	2, 036, 014	55. 00
56.00	05600 RADI 0I SOTOPE	2, 393, 337		2, 393, 337	0	2, 393, 337	56. 00
57.00	05700 CT SCAN	3, 623, 475		3, 623, 475	0	3, 623, 475	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 671, 775		2, 671, 775		2, 671, 775	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	7, 237, 595		7, 237, 595	4, 669	7, 242, 264	59. 00
60.00	06000 LABORATORY	15, 745, 217		15, 745, 217	24, 927	15, 770, 144	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 714, 797		1, 714, 797	0	1, 714, 797	63. 00
64.00	06400 I NTRAVENOUS THERAPY	877, 320		877, 320	0	877, 320	64. 00
65.00	06500 RESPI RATORY THERAPY	4, 069, 825	0	4, 069, 825	183	4, 070, 008	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 974, 442	0	4, 974, 442	0	4, 974, 442	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 266, 059	0	1, 266, 059	0	1, 266, 059	67.00
68.00	06800 SPEECH PATHOLOGY	586, 867	0	586, 867	0	586, 867	68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 369, 675		2, 369, 675	2, 065	2, 371, 740	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 031, 148		1, 031, 148	3, 398	1, 034, 546	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 565, 125		10, 565, 125	0	10, 565, 125	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 588, 412		14, 588, 412	0	14, 588, 412	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21, 472, 464		21, 472, 464	0	21, 472, 464	73.00
	07400 RENAL DIALYSIS	990, 471		990, 471	0	990, 471	74. 00
76. 97	07697 CARDIAC REHABILITATION	1, 286, 775		1, 286, 775	0	1, 286, 775	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	3, 227, 163		3, 227, 163	25, 562	3, 252, 725	90. 00
91.00	09100 EMERGENCY	11, 131, 172		11, 131, 172	0	11, 131, 172	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 390, 866		4, 390, 866		4, 390, 866	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	3, 989, 715		3, 989, 715		3, 989, 715	1
200.00	, , , , , , , , , , , , , , , , , , , ,	228, 159, 901	0			228, 269, 818	
201.00		4, 390, 866		4, 390, 866		4, 390, 866	
202.00	Total (see instructions)	223, 769, 035	0	223, 769, 035	109, 917	223, 878, 952	202. 00

Provider CCN: 15-0034 From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:33 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 63, 462, 005 63, 462, 005 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 14, 478, 897 14, 478, 897 31.00 04100 SUBPROVI DER - I RF 41.00 7, 583, 246 7, 583, 246 41.00 43.00 04300 NURSERY 4, 884, 078 4, 884, 078 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 46, 183, 088 109, 930, 368 156, 113, 456 0. 230905 0.000000 50.00 51.00 05100 RECOVERY ROOM 4, 851, 380 15, 010, 484 19, 861, 864 0.321562 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.527749 2, 892, 616 1,068,816 3, 961, 432 0.000000 52.00 52.00 05300 ANESTHESI OLOGY 21, 895, 549 0.026946 0.000000 53.00 8, 313, 031 30, 208, 580 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 563, 149 52, 635, 475 61, 198, 624 0.140301 0.000000 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 543, 865 18, 270, 772 18, 814, 637 0.108214 0.000000 55.00 16, 301, 164 05600 RADI 0I SOTOPE 18, 898, 031 0.000000 56.00 56,00 2, 596, 867 0.126645 57.00 05700 CT SCAN 22, 298, 071 60, 915, 962 83, 214, 033 0.043544 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 6, 091, 707 29, 719, 028 35, 810, 735 0.074608 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 22, 905, 292 61, 179, 548 84, 084, 840 0.086075 0.000000 59.00 06000 LABORATORY 43, 292, 107 150, 129, 358 0.104878 60.00 106, 837, 251 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0.000000 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 3, 728, 693 2, 333, 946 0. 282847 0.000000 63.00 6, 062, 639 63.00 06400 I NTRAVENOUS THERAPY 3, 880, 089 3, 904, 638 0. 224687 0.000000 64.00 24.549 64.00 06500 RESPIRATORY THERAPY 65.00 13, 047, 811 1, 663, 533 14, 711, 344 0.276645 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 5, 482, 840 13, 209, 114 18, 691, 954 0.266127 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 2, 473, 325 6, 871, 114 67.00 4, 397, 789 0.184258 0.000000 67.00 68 00 06800 SPEECH PATHOLOGY 895.092 564, 136 1, 459, 228 0 402176 0 000000 68 00 32, 729, 078 69.00 06900 ELECTROCARDI OLOGY 7, 651, 969 25, 077, 109 0.072403 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 432, 431 9, 295, 460 9, 727, 891 0. 105999 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 17, 754, 427 17, 083, 264 34, 837, 691 0.303267 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 35, 989, 313 72.00 18,000,482 17, 988, 831 0.405354 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 61, 403, 214 57, 735, 097 119, 138, 311 0.180231 0.000000 73.00 74.00 07400 RENAL DIALYSIS 3, 735, 249 194, 424 3, 929, 673 0.252049 0.000000 74.00 1, 741, 712 2, 040, 795 76 97 07697 CARDIAC REHABILITATION 299.083 0.630526 0.000000 76 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 286, 726 6, 442, 323 6, 729, 049 0. 479587 0.000000 90.00 91.00 09100 EMERGENCY 31, 049, 326 65, 991, 120 97, 040, 446 0.114707 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 14, 815, 523 0. 296369 0.000000 92.00 92 00 2, 192, 843 12, 622, 680 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 4, 602, 391 4, 602, 391 101.00 200.00 Subtotal (see instructions) 429, 321, 923 736, 662, 971 1, 165, 984, 894 200.00

429, 321, 923

736, 662, 971 1, 165, 984, 894

201 00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	ST. MARY MEDICAL CE	NTER, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0034	Peri od: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared:

			10 06/30/2021	11/23/2021 10:33	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient		<u> </u>		
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					0. 00
31.00 03100 INTENSIVE CARE UNIT				31	1.00
41. 00 04100 SUBPROVI DER - I RF				41	1.00
43. 00 04300 NURSERY				43	3. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 231021			50	0. 00
51.00 05100 RECOVERY ROOM	0. 321562			51	1.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 527749				2. 00
53. 00 05300 ANESTHESI OLOGY	0. 026946			53	3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 140439			54	1. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 108214			55	5. 00
56. 00 05600 RADI 0I SOTOPE	0. 126645			56	5. 00
57. 00 05700 CT SCAN	0. 043544			57	7. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 074608			58	3. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 086130			59	9. 00
60. 00 06000 LABORATORY	0. 105044			60	0. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62	2. 00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 282847			63	3. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 224687			64	1. 00
65. 00 06500 RESPIRATORY THERAPY	0. 276658			65	5. 00
66. 00 06600 PHYSI CAL THERAPY	0. 266127			66	5. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 184258			67	7. 00
68.00 06800 SPEECH PATHOLOGY	0. 402176			68	3. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 072466			69	9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 106348			70	0. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 303267			71	1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 405354			72	2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 180231			73	3. 00
74. 00 07400 RENAL DI ALYSI S	0. 252049				1. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 630526			76	5. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 483386				0. 00
91. 00 09100 EMERGENCY	0. 114707			91	1.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 296369			92	2. 00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					1.00
200.00 Subtotal (see instructions)					0. 00
201.00 Less Observation Beds					1.00
202.00 Total (see instructions)				202	2. 00

	ATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/23/2021 10	pared:
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	0.00				
	LAIDATI ENT. DOUTLAIE CEDIU OF COCT. CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	25 400 040	ı	05 400 04	45.054	05 540 0/4	00.00
30.00		35, 498, 010	ł	35, 498, 01		35, 513, 861	
31.00	03100 NTENSI VE CARE UNI T	8, 672, 023		8, 672, 02	6, 687	8, 678, 710	
41.00	04100 SUBPROVI DER – I RF	5, 313, 387	l e	5, 313, 38		5, 313, 387	
43.00	04300 NURSERY	2, 511, 750		2, 511, 75	0	2, 511, 750	43. 00
F0 00	ANCI LLARY SERVI CE COST CENTERS	0/ 047 005	Γ	04 047 04	10 407	0/ 0/5 440	F0 00
50.00	05000 OPERATI NG ROOM	36, 047, 305		36, 047, 30		36, 065, 442	
51.00	05100 RECOVERY ROOM	6, 386, 821		6, 386, 82		6, 386, 821	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 090, 642		2, 090, 64		2, 090, 642	
53.00	05300 ANESTHESI OLOGY	813, 997	l e	813, 99		813, 997	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	8, 586, 257	l e	8, 586, 25			
55. 00	05500 RADI OLOGY - THERAPEUTI C	2, 036, 014	l e	2, 036, 01		2, 036, 014	
56. 00	05600 RADI OI SOTOPE	2, 393, 337	l e	2, 393, 33		2, 393, 337	
57. 00	05700 CT SCAN	3, 623, 475		3, 623, 47		3, 623, 475	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 671, 775		2, 671, 77	75 0	2, 671, 775	
59. 00	05900 CARDI AC CATHETERI ZATI ON	7, 237, 595		7, 237, 59			
60.00	06000 LABORATORY	15, 745, 217	l	15, 745, 21		15, 770, 144	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	l		0 0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 714, 797		1, 714, 79		1, 714, 797	63.00
64.00	06400 I NTRAVENOUS THERAPY	877, 320	l .	877, 32		877, 320	64. 00
65. 00	06500 RESPI RATORY THERAPY	4, 069, 825	l .			4, 070, 008	65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 974, 442				4, 974, 442	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 266, 059	l e			1, 266, 059	67. 00
68. 00	06800 SPEECH PATHOLOGY	586, 867	l e	586, 86		586, 867	
69. 00	06900 ELECTROCARDI OLOGY	2, 369, 675	ł	2, 369, 67			
70.00	1 1	1, 031, 148	ł	1, 031, 14		1, 034, 546	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 565, 125		10, 565, 12		10, 565, 125	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	14, 588, 412	ł	14, 588, 41		14, 588, 412	
73. 00	07300 DRUGS CHARGED TO PATIENTS	21, 472, 464		21, 472, 46		21, 472, 464	
74. 00	07400 RENAL DIALYSIS	990, 471		990, 47		990, 471	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 286, 775		1, 286, 77	'5 0	1, 286, 775	76. 97
	OUTPATIENT SERVICE COST CENTERS	0.007.440	Γ		0 05 5 6	0.050.705	
90.00	09000 CLI NI C	3, 227, 163		3, 227, 16		3, 252, 725	
91.00	09100 EMERGENCY	11, 131, 172		11, 131, 17		11, 131, 172	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 390, 866		4, 390, 86	06	4, 390, 866	92.00
101 00	OTHER REIMBURSABLE COST CENTERS	2 000 745	I	2 000 7	F	2 000 745	101 00
	10100 HOME HEALTH AGENCY	3, 989, 715		3, 989, 71		3, 989, 715	
200.00	, ,	228, 159, 901	l e				
201.00	1 1	4, 390, 866		4, 390, 86		4, 390, 866	
202.00	Total (see instructions)	223, 769, 035	0	223, 769, 03	109, 917	223, 878, 952	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0034 Peri od: Worksheet C From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:33 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 63, 462, 005 63, 462, 005 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 14, 478, 897 14, 478, 897 31.00 04100 SUBPROVI DER - I RF 41.00 7, 583, 246 7, 583, 246 41.00 43.00 04300 NURSERY 4, 884, 078 4, 884, 078 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 46, 183, 088 109, 930, 368 156, 113, 456 0. 230905 0.000000 50.00 51.00 05100 RECOVERY ROOM 4, 851, 380 15, 010, 484 19, 861, 864 0.321562 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.527749 2, 892, 616 1,068,816 3, 961, 432 0.000000 52.00 52.00 05300 ANESTHESI OLOGY 21, 895, 549 0.026946 0.000000 53.00 8, 313, 031 30, 208, 580 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 563, 149 52, 635, 475 61, 198, 624 0.140301 0.000000 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 543, 865 18, 270, 772 18, 814, 637 0.108214 0.000000 55.00 16, 301, 164 05600 RADI 0I SOTOPE 18, 898, 031 0.000000 56.00 56,00 2, 596, 867 0.126645 57.00 05700 CT SCAN 22, 298, 071 60, 915, 962 83, 214, 033 0.043544 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 6, 091, 707 29, 719, 028 35, 810, 735 0.074608 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 22, 905, 292 61, 179, 548 84, 084, 840 0.086075 0.000000 59.00 06000 LABORATORY 43, 292, 107 150, 129, 358 0.104878 60.00 106, 837, 251 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0.000000 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 3, 728, 693 2, 333, 946 0. 282847 0.000000 63.00 6, 062, 639 63.00 06400 I NTRAVENOUS THERAPY 3, 880, 089 3, 904, 638 0. 224687 0.000000 64.00 24.549 64.00 06500 RESPIRATORY THERAPY 65.00 13, 047, 811 1, 663, 533 14, 711, 344 0.276645 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 5, 482, 840 13, 209, 114 18, 691, 954 0.266127 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 2, 473, 325 6, 871, 114 67.00 4, 397, 789 0.184258 0.000000 67.00 68 00 06800 SPEECH PATHOLOGY 895.092 564, 136 1, 459, 228 0 402176 0 000000 68 00 32, 729, 078 69.00 06900 ELECTROCARDI OLOGY 7, 651, 969 25, 077, 109 0.072403 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 432, 431 9, 295, 460 9, 727, 891 0. 105999 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 17, 754, 427 17, 083, 264 34, 837, 691 0.303267 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 35, 989, 313 72.00 18,000,482 17, 988, 831 0.405354 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 61, 403, 214 57, 735, 097 119, 138, 311 0.180231 0.000000 73.00 74.00 07400 RENAL DIALYSIS 3, 735, 249 194, 424 3, 929, 673 0.252049 0.000000 74.00 1, 741, 712 2, 040, 795 76 97 07697 CARDIAC REHABILITATION 299.083 0.630526 0.000000 76 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 286, 726 6, 442, 323 6, 729, 049 0. 479587 0.000000 90.00 91.00 09100 EMERGENCY 31, 049, 326 65, 991, 120 97, 040, 446 0.114707 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 14, 815, 523 0.296369 0.000000 92.00 92 00 2, 192, 843 12, 622, 680 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 4, 602, 391 4, 602, 391 101.00

429, 321, 923

429, 321, 923

736, 662, 971

1, 165, 984, 894

736, 662, 971 1, 165, 984, 894

200.00 201 00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	ST. MARY MEDICAL CE	NTER, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0034	Peri od: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared:

				10 00/30/2021	11/23/2021 10	
			Title XIX	Hospi tal	PPS	. 30 4111
	Cost Center Description	PPS Inpatient				
	'	Ratio				
		11.00				
1.1	NPATIENT ROUTINE SERVICE COST CENTERS					
30.00 0	3000 ADULTS & PEDI ATRI CS					30.00
31.00 0	3100 INTENSIVE CARE UNIT					31.00
41.00 0	4100 SUBPROVI DER - I RF					41.00
43.00 0	14300 NURSERY					43.00
A	NCILLARY SERVICE COST CENTERS					1
50.00 0	5000 OPERATING ROOM	0. 231021				50.00
51.00 0	5100 RECOVERY ROOM	0. 321562				51.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	0. 527749				52.00
53.00 0	5300 ANESTHESI OLOGY	0. 026946				53.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	0. 140439				54.00
55.00 0	5500 RADI OLOGY - THERAPEUTI C	0. 108214				55.00
56.00 0	5600 RADI OI SOTOPE	0. 126645				56.00
57.00 0	5700 CT SCAN	0. 043544				57.00
58.00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 074608				58.00
	5900 CARDI AC CATHETERI ZATI ON	0. 086130				59.00
60.00 0	6000 LABORATORY	0. 105044				60.00
62.00 0	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
63.00 0	6300 BLOOD STORING, PROCESSING, & TRANS.	0. 282847				63.00
64.00 0	16400 INTRAVENOUS THERAPY	0. 224687				64.00
65.00 0	6500 RESPI RATORY THERAPY	0. 276658				65.00
66.00 0	6600 PHYSI CAL THERAPY	0. 266127				66.00
67.00 0	6700 OCCUPATI ONAL THERAPY	0. 184258				67.00
68.00 0	6800 SPEECH PATHOLOGY	0. 402176				68.00
69.00 0	6900 ELECTROCARDI OLOGY	0. 072466				69.00
	7000 ELECTROENCEPHALOGRAPHY	0. 106348				70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 303267				71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 405354				72. 00
	7300 DRUGS CHARGED TO PATIENTS	0. 180231				73.00
	7400 RENAL DIALYSIS	0. 252049				74.00
	7697 CARDIAC REHABILITATION	0. 630526				76. 97
	UTPATIENT SERVICE COST CENTERS					4
	9000 CLI NI C	0. 483386				90.00
	9100 EMERGENCY	0. 114707				91.00
_	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 296369				92.00
	THER REIMBURSABLE COST CENTERS					4
4	0100 HOME HEALTH AGENCY					101. 00
200.00	Subtotal (see instructions)					200. 00
201.00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00

REDUCT	TONS FOR MEDICALD UNLY			T	o 06/30/2021		
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	'	(Wkst. B, Part			Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
			·	col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	36, 047, 305	4, 570, 608	31, 476, 697	0	0	00.00
51.00	05100 RECOVERY ROOM	6, 386, 821	487, 355	5, 899, 466	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 090, 642	392, 845	1, 697, 797	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	813, 997	12, 801	801, 196	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 586, 257	932, 112	7, 654, 145	0	0	54. 00
55.00	05500 RADI OLOGY - THERAPEUTI C	2, 036, 014	240, 473	1, 795, 541	0	0	55. 00
56.00	05600 RADI 0I SOTOPE	2, 393, 337	236, 233	2, 157, 104	0	0	56. 00
57.00	05700 CT SCAN	3, 623, 475	198, 684	3, 424, 791	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 671, 775	637, 581	2, 034, 194	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	7, 237, 595	1, 733, 012	5, 504, 583	0	0	59. 00
60.00	06000 LABORATORY	15, 745, 217	442, 452	15, 302, 765	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 714, 797	54, 052	1, 660, 745	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	877, 320	73, 065	804, 255	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	4, 069, 825	177, 077	3, 892, 748	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 974, 442	403, 943	4, 570, 499	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 266, 059	26, 729	1, 239, 330	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	586, 867	8, 367	578, 500	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 369, 675	364, 507	2, 005, 168	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 031, 148	100, 281	930, 867	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 565, 125	38, 562	10, 526, 563	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 588, 412	51, 615	14, 536, 797	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	21, 472, 464	415, 658	21, 056, 806	0	0	73. 00
74.00	07400 RENAL DIALYSIS	990, 471	3, 705	986, 766	0	0	74.00
76. 97	07697 CARDIAC REHABILITATION	1, 286, 775	165, 379	1, 121, 396	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	3, 227, 163	295, 192	2, 931, 971	0	0	90. 00
91.00	09100 EMERGENCY	11, 131, 172	568, 535	10, 562, 637	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 390, 866	298, 842	4, 092, 024	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	3, 989, 715	20, 710	3, 969, 005	0	0	101. 00
200.00	Subtotal (sum of lines 50 thru 199)	176, 164, 731	12, 950, 375	163, 214, 356	0	0	200. 00
201.00	Less Observation Beds	4, 390, 866	298, 842	4, 092, 024	0	0	201. 00
202.00	Total (line 200 minus line 201)	171, 773, 865	12, 651, 533	159, 122, 332	0	0	202. 00

Health Financial Systems	ST. MARY MEDICAL CE	ENTER, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO REDUCTIONS FOR MEDICAID ONLY	CHARGE RATIOS NET OF	Provider CCN: 15-0034	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part II Date/Time Prepared:

						00/ 30/ 2021	11/23/2021 10	
			Titl	e XIX		Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges					
		Capital and	(Worksheet C,	Cost to Charg	ge			
		Operating Cost	Part I, column		6			
		Reducti on	8)	/ col. 7)				
		6.00	7. 00	8. 00				
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	36, 047, 305						50.00
51. 00	05100 RECOVERY ROOM	6, 386, 821						51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 090, 642	3, 961, 432	0. 52774	19			52. 00
53.00	05300 ANESTHESI OLOGY	813, 997	30, 208, 580					53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 586, 257	61, 198, 624	0. 14030	01			54.00
55. 00	05500 RADI OLOGY - THERAPEUTI C	2, 036, 014	18, 814, 637	0. 10821	14			55. 00
56.00	05600 RADI OI SOTOPE	2, 393, 337	18, 898, 031	0. 12664	15			56. 00
57.00	05700 CT SCAN	3, 623, 475	83, 214, 033					57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 671, 775	35, 810, 735	0. 07460	80			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	7, 237, 595	84, 084, 840	0. 08607	75			59. 00
60.00	06000 LABORATORY	15, 745, 217	150, 129, 358	0. 10487	78			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000	00			62. 00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 714, 797	6, 062, 639	0. 28284	17			63.00
64.00	06400 I NTRAVENOUS THERAPY	877, 320	3, 904, 638	0. 22468	37			64. 00
65.00	06500 RESPI RATORY THERAPY	4, 069, 825	14, 711, 344	0. 27664	15			65. 00
66.00	06600 PHYSI CAL THERAPY	4, 974, 442	18, 691, 954	0. 26612	27			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 266, 059	6, 871, 114	0. 18425	58			67. 00
68. 00	06800 SPEECH PATHOLOGY	586, 867	1, 459, 228	0. 40217	76			68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 369, 675	32, 729, 078	0. 07240	03			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 031, 148	9, 727, 891	0. 10599	99			70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 565, 125	34, 837, 691	0. 30326	57			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 588, 412	35, 989, 313	0. 40535	54			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	21, 472, 464	119, 138, 311	0. 18023	31			73. 00
74.00	07400 RENAL DIALYSIS	990, 471	3, 929, 673	0. 25204	19			74. 00
76. 97	07697 CARDIAC REHABILITATION	1, 286, 775	2, 040, 795	0. 63052	26			76. 97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	3, 227, 163	6, 729, 049	0. 47958	37			90. 00
91.00	09100 EMERGENCY	11, 131, 172	97, 040, 446	0. 11470)7			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 390, 866	14, 815, 523	0. 29636	59			92. 00
	OTHER REIMBURSABLE COST CENTERS							
	10100 HOME HEALTH AGENCY	3, 989, 715			79			101. 00
200.00			1, 075, 576, 668					200. 00
201.00	Less Observation Beds	4, 390, 866	0					201. 00
202.00	Total (line 200 minus line 201)	171, 773, 865	1, 075, 576, 668					202. 00

Health Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C	<u> </u>	Period: From 07/01/2020 Fo 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :33 am
			XVIII	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 & PEDI ATRI CS	2, 417, 058	3 C	2, 417, 058	41, 217	58. 64	30.00
31.00 INTENSIVE CARE UNIT	642, 010		642, 010	5, 136	125.00	31.00
41. 00 SUBPROVI DER - I RF	298, 161	0	298, 16°	1 5, 437	54.84	41.00
43. 00 NURSERY	119, 008	3	119, 008	1, 434	82. 99	43.00
200.00 Total (lines 30 through 199)	3, 476, 237	·	3, 476, 23	7 53, 224		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	15, 204	891, 563				30. 00
31.00 INTENSIVE CARE UNIT	1, 795	224, 375				31. 00
41. 00 SUBPROVI DER - I RF	3, 441	188, 704				41. 00
43. 00 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	20, 440	1, 304, 642				200. 00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provider CCN: 15-0034	Period: From 07/01/2020	Worksheet D Part II

06/30/2021 Date/Time Prepared: 11/23/2021 10:33 am Title XVIII Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent (from Wkst. C. to Charges (column 3 x Related Cost Program (from Wkst. B. column 4) Part I, col. (col. 1 ÷ col Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 4, 570, 608 50.00 05000 OPERATING ROOM 156, 113, 456 0.029277 16, 722, 426 489, 582 50.00 51.00 05100 RECOVERY ROOM 487, 355 19, 861, 864 0.024537 1, 847, 635 45, 335 51.00 05200 DELIVERY ROOM & LABOR ROOM 392, 845 3, 961, 432 0.099167 52.00 52.00 05300 ANESTHESI OLOGY 12, 801 30, 208, 580 0.000424 3, 185, 479 53.00 1.351 53.00 3, 499, 931 05400 RADI OLOGY-DI AGNOSTI C 932, 112 61, 198, 624 0.015231 53, 307 54.00 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 240, 473 18, 814, 637 0.012781 88, 266 1, 128 55.00 56.00 05600 RADI OI SOTOPE 236, 233 18, 898, 031 0.012500 1, 137, 421 14, 218 56.00 21, 795 05700 CT SCAN 198.684 83, 214, 033 0.002388 9, 127, 027 57 00 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 210, 399 58.00 637, 581 35, 810, 735 0.017804 39, 354 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 1, 733, 012 84, 084, 840 0.020610 9, 892, 473 203, 884 59.00 60.00 06000 LABORATORY 442, 452 150, 129, 358 0.002947 16, 923, 053 49,872 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62 00 62 00 0 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 54,052 6,062,639 0.008916 1, 328, 948 11, 849 63.00 06400 INTRAVENOUS THERAPY 64.00 73,065 3, 904, 638 0.018712 0 64.00 06500 RESPIRATORY THERAPY 177.077 14.711.344 5, 166, 665 65 00 0.012037 62, 191 65 00 66.00 06600 PHYSI CAL THERAPY 403, 943 18, 691, 954 0.021611 1, 352, 055 29, 219 66.00 06700 OCCUPATIONAL THERAPY 26, 729 6, 871, 114 0.003890 868, 691 3, 379 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 8, 367 1, 459, 228 0.005734 205, 286 1, 177 68.00 06900 ELECTROCARDI OLOGY 364 507 32, 729, 078 0.011137 69 00 3, 342, 772 37, 228 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 100, 281 9, 727, 891 0.010309 175, 478 1,809 70.00 38, 562 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 34, 837, 691 0.001107 6, 825, 062 7, 555 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 51, 615 35, 989, 313 0.001434 8, 786, 918 12,600 72.00 07300 DRUGS CHARGED TO PATIENTS 0.003489 22, 482, 092 73.00 415, 658 119, 138, 311 78, 440 73.00 74.00 07400 RENAL DIALYSIS 3,705 3, 929, 673 0.000943 1, 590, 857 1, 500 74.00 07697 CARDIAC REHABILITATION 165, 379 9, 149 76. 97 76.97 2,040,795 0.081037 112, 898 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 295, 192 6, 729, 049 0.043868 83.686 3.671 90.00 91.00 09100 EMERGENCY 568, 535 97, 040, 446 0.005859 13, 127, 160 76, 912 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 105, 047 22, 290 92. 00 298, 842 14, 815, 523 0.020171 200.00 Total (lines 50 through 199) 12, 929, 665 1, 070, 974, 277 131, 187, 725 1, 278, 795 200. 00

	ST. MARY MEDICA			In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				From 07/01/2020 To 06/30/2021	Part III	nanad.
			'	0 06/30/2021	Date/Time Pre 11/23/2021 10	pareu: :33 am
		Title	· XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
·	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0	C	0	0	31. 00
41. 00 04100 SUBPROVI DER - RF	0	0	C	0	0	41.00
43. 00 04300 NURSERY	0	0	C	0	0	43.00
200.00 Total (lines 30 through 199)	0	0	C	0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	41, 217			30. 00
31.00 03100 I NTENSI VE CARE UNIT		0	5, 136	0.00	1, 795	31. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	5, 437	0.00	3, 441	41. 00
43. 00 04300 NURSERY		0	1, 434	0.00	0	43.00
200.00 Total (lines 30 through 199)		0	53, 224	1	20, 440	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
INDATIENT DOUTINE CEDVICE COST CENTERS	9. 00					

30. 00 31. 00

41. 00 43. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 04300 000 000 NURSERY Total (lines 30 through 199)

| In Lieu of Form CMS-2552-10 | Period: Worksheet D | From 07/01/2020 Part IV | To 06/30/2021 Date/Time Prepared: 11/23/2021 10: 33 am | PPS | P THROUGH COSTS Title XVIII

Cost Center	Description			Nursing School	Allied Health Post-Stepdown	Allied Health	
		Cost	Adjustments		Adjustments		
		1, 00	2A	2, 00	3A	3. 00	
ANCI LLARY SERVI CE	COST CENTERS						
50. 00 05000 OPERATING RO	OOM	0	O	0	0	36, 327	50.00
51.00 05100 RECOVERY RO	DM	0	0	0	0	0	51.00
52.00 05200 DELIVERY RO	OM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLO	OGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI	AGNOSTI C	0	0	0	0	0	54.00
55. 00 05500 RADI OLOGY -	THERAPEUTI C	0	0	0	0	0	55.00
56. 00 05600 RADI 0I S0T0PI	_	0	0	0	0	0	56.00
57.00 05700 CT SCAN		0	0	0	0	0	57.00
58.00 05800 MAGNETIC RES	SONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATI	HETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY		0	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD	& PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00 06300 BL00D STORII	NG, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64. 00 06400 I NTRAVENOUS	THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPIRATORY	THERAPY	0	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THI	ERAPY	0	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAI	_ THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATH	DLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI	OLOGY	0	0	0	0	0	69.00
70. 00 07000 ELECTROENCE	PHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPI	PLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGI	ED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYS	SIS	0	0	0	0	0	74.00
76. 97 07697 CARDI AC REHA	ABI LI TATI ON	0	0	0	0	0	76. 97
OUTPATIENT SERVIC	E COST CENTERS						
90. 00 09000 CLINIC		0	0	0	0	0	90.00
91.00 09100 EMERGENCY		0	0	0	0	437, 057	91.00
92. 00 09200 OBSERVATI ON	BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00 Total (lines	s 50 through 199)	0	0	0	0	473, 384	200. 00

Heal t	h Financial Systems	ST. MARY MEDICAL	L CENTER, INC.		In Li∈	eu of Form CMS-2	2552-10
APPOF	RTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROU	IGH COSTS				From 07/01/2020 Fo 06/30/2021		aanad.
					Го 06/30/2021	Date/Time Prep 11/23/2021 10	oareu: :33 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	ANOLLI ADV. CEDVI OF COCT. CENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
F0 00	ANCILLARY SERVICE COST CENTERS		0, 007	1 0/ 00-	45/ 440 45/	0.00000	F0 00
50.00		0	36, 327	36, 327			
51. 00 52. 00		0	0		19, 861, 864 3, 961, 432		
52.00		0	0		3, 961, 432		
54. 00		0	0		61, 198, 624		
55. 00		0			18, 814, 637		
56. 00		0			18, 898, 031		56. 00
57. 00		0			83, 214, 033		
58. 00		0			35, 810, 735		
59. 00	, ,	0	0		84, 084, 840		
60.00		0	0		150, 129, 358		
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0.000000	62.00
63.00	1	0	O		6, 062, 639	0. 000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		3, 904, 638	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0		14, 711, 344	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(18, 691, 954	0.000000	66.00
67.00		0	0	(6, 871, 114	0.000000	67.00
	LOCAL ORFECUL BATUOLOGY	1	۱ .	1	4 450 000		

Health Financial Systems S	T. MARY MEDICAL	CENTER INC		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS			1	Period: From 07/01/2020 Fo 06/30/2021	Worksheet D Part IV	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati 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	1	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	,					
50. 00 05000 OPERATING ROOM	0. 000233	16, 722, 426				50.00
51.00 05100 RECOVERY ROOM	0. 000000	1, 847, 635		3, 921, 700	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	(0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	3, 185, 479	(5, 488, 682	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 499, 931		12, 722, 958	0	54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	88, 266	(7, 269, 147	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000	1, 137, 421		5, 386, 740	0	56. 00
57. 00 05700 CT SCAN	0. 000000	9, 127, 027		15, 760, 538	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	2, 210, 399		6, 843, 077	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	9, 892, 473		23, 656, 069	0	59. 00
60. 00 06000 LABORATORY	0. 000000	16, 923, 053		10, 133, 082	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	(0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	1, 328, 948	(697, 570	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0	(1, 608, 482	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	5, 166, 665		415, 927	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 352, 055		22, 434	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	868, 691		2, 038	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	205, 286		4, 045	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 342, 772		8, 140, 588	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	175, 478		2, 104, 067	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	6, 825, 062	•		l .	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	8, 786, 918	•		l .	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	22, 482, 092	•		l .	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	1, 590, 857	•		0	74.00
74 07 07407 0400 40 051401 1747101	0 000000	440.000	1 .	740 400		7, 07

0.000000

0.000000

0. 004504

0.000000

13, 127, 160

1, 105, 047

131, 187, 725

112, 898

83, 686

90.00

91.00

0 76.97

0

0 92.00

57, 289 200. 00

50, 640

712, 490

2, 566, 833

11, 243, 346

2, 695, 434

183, 625, 204

59, 125

63, 021

0

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

07697 CARDIAC REHABILITATION

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

76. 97

200.00

Health Financial Systems	ST. MARY MEDICAL CE	ENTER, INC.	In Li	eu of Form CMS-2552-10
ADDODTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Drovi don CCN: 15 0024	Dori od:	Workshoot D

Heal th	Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
					From 07/01/2020	Part V	
					To 06/30/2021		
			Ti +l o	XVIII	Hospi tal	11/23/2021 10 PPS	: 33 am
			T TITLE	Charges	поѕрі таі	Costs	
	Cost Center Description	Coot to Charge	PPS Reimbursed		Cost	PPS Services	
	Cost Center Description	Ratio From		Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	Services (see inst.)	Servi ces	Services Not	(see mst.)	
		Part I, col. 9		Subject To	Subject To		
		Part I, Cor. 9		Ded. & Coins.	,		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATING ROOM	0. 230905	28, 537, 580		0 37, 180	6, 589, 470	50.00
	05100 RECOVERY ROOM	0. 230403			0 37, 180		1
	05200 DELIVERY ROOM & LABOR ROOM	0. 527749			0 0	1, 201, 070	1
			1		٥	1	
53. 00	05300 ANESTHESI OLOGY	0. 026946			0	147, 898	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 140301			0	1, 785, 044	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	0. 108214			0	786, 623	1
56.00	05600 RADI OI SOTOPE	0. 126645			0	682, 204	1
	05700 CT SCAN	0. 043544			0	686, 277	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 074608	1 ' '		0		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 086075	1 ' '		0	2,000,170	
	06000 LABORATORY	0. 104878			0	1, 062, 737	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			0	0	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 282847			0	197, 306	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 224687	1, 608, 482		0	361, 405	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 276645	415, 927		0 0	115, 064	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 266127	22, 434		0	5, 970	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 184258	2, 038		0	376	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 402176	4, 045		0	1, 627	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 072403	8, 140, 588		0	589, 403	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 105999	2, 104, 067		0	223, 029	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 303267	5, 441, 772		0 400	1, 650, 310	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 405354	5, 381, 232		0 0	2, 181, 304	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 180231			0 79, 410		1
	07400 RENAL DIALYSIS	0. 252049			ol o		1
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 630526			o o	449, 243	76. 97
	OUTPATIENT SERVICE COST CENTERS		, , , , ,				
90.00	09000 CLI NI C	0. 479587	2, 566, 833		0 0	1, 231, 020	90.00
	09100 EMERGENCY	0. 114707			o o	1, 289, 690	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 296369			0	798, 843	1
200.00			183, 625, 204		0 116, 990		
201.00	,		.55, 525, 201		0, ,,0	20,, , , , 0	201.00
201.00	Only Charges				٦		
202.00			183, 625, 204		0 116, 990	28, 770, 770	202. 00
50	, , , , , , , , , , , , , , , , , , , ,	T	,, 525, 201	ı	,	,,	,

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER	R HEALTH SERVICES AND VACCINE COST Provider CCN: 15	F-0034 Peri od: Worksheet D From 07/01/2020 Part V To 06/30/2021 Date/Time Prepared:

				From 07/01/2020 To 06/30/2021	Part V Date/Time Pre	pared:
					11/23/2021 10): 33 am_
			XVIII	Hospi tal	PPS	
		sts	-			
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCILLARY SERVICE COST CENTERS	0.00	7.00	l			
50. 00 05000 OPERATING ROOM	0	8, 585				50.00
51. 00 05100 RECOVERY ROOM	0	0, 555				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	· -				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	,			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	,			54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	,			55. 00
56. 00 05600 RADI 0I SOTOPE	0	Ö	,			56. 00
57. 00 05700 CT SCAN	0	0)			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)			59.00
60. 00 06000 LABORATORY	0	0)			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0)			62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0				63.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1			67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	121	1			71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		1			73.00
74. 00 07400 RENAL DI ALYSI S	0					74.00
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	0	1			76. 97
90. 00 09000 CLINIC	0	0	ı			90.00
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	23, 018	:			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	23, 018				202. 00

	ST. MARY MEDICA		ON 45 0004		eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	IL COSTS	Provi der C	CN: 15-0034	Peri od: From 07/01/2020	Worksheet D Part II	
		Component	CCN: 15-T034	To 06/30/2021	Date/Time Pre	pared:
		'			11/23/2021 10	:33 am
		Ti tl e	× XVIII	Subprovider -	PPS	
Cook Comban Doorwindian	C: +-1	T-+-L Ch	D-+:£ C	IRF	C: +-1	
Cost Center Description	Capi tal	Total Charges (from Wkst. C,		t Inpatient Program	Capital Costs (column 3 x	
	(from Wkst. B.				column 4)	
	Part II, col.	8)	2)	. Charges	COLUMN 4)	
	26))	2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS					0.00	
50. 00 05000 OPERATING ROOM	4, 570, 608	156, 113, 456	0. 02927	77 69, 928	2, 047	50.00
51.00 05100 RECOVERY ROOM	487, 355	19, 861, 864	0. 02453	5, 684	139	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	392, 845	3, 961, 432	0. 09916	57 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	12, 801	30, 208, 580	0. 00042	7, 069	3	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	932, 112	61, 198, 624	0. 01523	147, 109	2, 241	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	240, 473	18, 814, 637	0. 01278	56, 059	716	55. 00
56. 00 05600 RADI 0I SOTOPE	236, 233					
57. 00 05700 CT SCAN	198, 684					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	637, 581					
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 733, 012		1			
60. 00 06000 LABORATORY	442, 452					60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0.0000		1	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	54, 052					63. 00
64. 00 06400 I NTRAVENOUS THERAPY	73, 065				0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	177, 077		1			
67. 00 06700 OCCUPATI ONAL THERAPY	403, 943 26, 729					1
68. 00 06800 SPEECH PATHOLOGY	8, 367					1
69. 00 06900 ELECTROCARDI OLOGY	364, 507					1
70. 00 07000 ELECTROENCEPHALOGRAPHY	100, 281					1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	38, 562					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	51, 615					72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	415, 658		1			
74. 00 07400 RENAL DIALYSIS	3, 705				145	
76. 97 07697 CARDI AC REHABI LI TATI ON	165, 379				0	76. 97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	295, 192	6, 729, 049			_	90.00
91. 00 09100 EMERGENCY	568, 535					1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	, ,			0	
200.00 Total (lines 50 through 199)	12, 630, 823	1, 070, 974, 277	1	7, 584, 224	65, 312	200. 00

Health Financial Systems	ST. MARY MEDICAL C	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0034	Period: From 07/01/2020	Worksheet D
THROUGH COSTS		Component CCN: 15-T034		Date/Time Prepared:
		Title XVIII	Subprovi der -	11/23/2021 10:33 am PPS
			IRF	

			litle	e XVIII	I RF	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	oost denter beecht per en	Anesthetist	Post-Stepdown	lar or ng concor	Post-Stepdown	/ odod. til	
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
P	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	C	0	36, 327	50.00
51.00	D5100 RECOVERY ROOM	0	0) c	0	0	51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0	0) c	0	0	52.00
53.00	D5300 ANESTHESI OLOGY	0	0) c	0	0	53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0	0) c	0	0	54.00
	D5500 RADI OLOGY - THERAPEUTI C	0	0) c	0	0	55. 00
56.00	D5600 RADI OI SOTOPE	0	0	C	0	0	56. 00
57.00	D5700 CT SCAN	0	0) c	0	0	57. 00
58.00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0) c	0	0	58. 00
59.00	D5900 CARDI AC CATHETERI ZATI ON	0	0) c	0	0	59. 00
60.00	D6000 LABORATORY	0	0) c	0	0	60.00
62.00	D6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0) c	0	0	62.00
63.00	D6300 BLOOD STORING, PROCESSING, & TRANS.	0	0) c	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0) c	0	0	64. 00
65.00	06500 RESPIRATORY THERAPY	0	0) c	0	0	65.00
66.00	D6600 PHYSI CAL THERAPY	0	0) c	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0) c	0	0	67.00
68.00	D6800 SPEECH PATHOLOGY	0	0) c	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0) c	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0) c	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0) c	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) c	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	ol c	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	ol c	0	0	74.00
76. 97	07697 CARDIAC REHABILITATION	0	0	ol c	0	0	76. 97
C	DUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	0	0	90.00
91.00	09100 EMERGENCY	0	0) c	0	437, 057	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		[C		0	92.00
200.00	Total (lines 50 through 199)	0	0	(c	0	473, 384	200. 00

Health Financial Systems	ST. MARY MEDICAL	CENTER INC		ln li <i>e</i>	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI			CN: 15-0034	Peri od:	Worksheet D	2332 10
THROUGH COSTS			201 45 7004	From 07/01/2020	Part IV	
		Component	CCN: 15-T034	To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :33 am
		Title	XVIII	Subprovi der -	PPS	
Cost Contan Decemintion	All Other	Total Cost	Total	I RF	Ratio of Cost	
Cost Center Description	Medical	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col . 5 ÷ col .	
	Eddodti on oost	4)	col s. 2, 3,	8)	7)	
		,,	and 4)		(see	
					instructions)	
	4.00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0		36, 32			•
51. 00 05100 RECOVERY ROOM	0	· ·		0 19, 861, 864		ł
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0		0 3, 961, 432	l .	•
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 30, 208, 580 0 61 198 624		
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 61, 198, 624 0 18, 814, 637		•
56. 00 05600 RADI 0I SOTOPE	0	0		0 18, 898, 031		
57. 00 05700 CT SCAN	0	0		0 83, 214, 033		1
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 35, 810, 735	l .	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	o o		0 84, 084, 840		
60. 00 06000 LABORATORY	0	0		0 150, 129, 358		•
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0.000000	62. 00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 6, 062, 639	0.000000	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 3, 904, 638	0.000000	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 14, 711, 344		•
66. 00 06600 PHYSI CAL THERAPY	0	0		0 18, 691, 954		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 6, 871, 114		l
68. 00 06800 SPEECH PATHOLOGY	0	0		0 1, 459, 228		l
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 32, 729, 078		
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 9, 727, 891 0 34, 837, 691		
72. 00 07700 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 35, 989, 313		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 119, 138, 311		
74. 00 07400 RENAL DIALYSIS	0	0		0 3, 929, 673		•
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 2, 040, 795		ł
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0			0 6, 729, 049		90. 00
91. 00 09100 EMERGENCY	0	437, 057	437, 05		l .	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	· ·		0 14, 815, 523		1
200.00 Total (lines 50 through 199)	0	473, 384	473, 38	4 1, 070, 974, 277	l	200. 00

Health Financial Systems	ST. MARY MEDICAL	CENTED INC		In Lie	eu of Form CMS-2	DEE2 10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provider C	^N: 15_0034	Peri od:	Worksheet D	2332-10
THROUGH COSTS	KVI CE OTHEK TASS		CCN: 15-T034	From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre 11/23/2021 10	pared: :33 am
		Title	: XVIII	Subprovi der - I RF	PPS	_
Cost Center Description	Outpati ent	I npati ent	Inpatient	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			1		_	
50. 00 05000 OPERATI NG ROOM	0. 000233	69, 928		16 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	5, 684		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	7, 069	l .	0 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	147, 109		0 911	0	54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	56, 059	1	0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000	11, 663	•	0 0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	193, 462		0 0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	46, 362	•	0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	23, 053	l .	0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	685, 816		0 0	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	10.075		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	18, 365		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	410.040		0 0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	412, 869		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000 0. 000000	1, 658, 733		0 0	0	66.00
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000	1, 637, 071		0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 000000	233, 688 57, 585		9	1	68. 00 69. 00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	6, 965		0 696	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	358, 112		0 1, 402		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	650	•	0 1, 402	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 793, 709		0 877	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	1, 743, 704		0 0		
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000	154, 267		0 0		
OUTPATIENT SERVICE COST CENTERS	0.000000			0 0	0	70.77
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 004504	5, 985		27 0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3, 703		0 0	0	
200.00 Total (lines 50 through 199)	3. 555566	7, 584, 224		43 3, 886		200. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		== .	'	.,		

Health Financial Systems	ST MADY MEDICAL	CENTED INC		ln lio	eu of Form CMS-2	2552 10
	ancial Systems ST. MARY MEDICAL CENTER, INC. MENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0034				Worksheet D	2332-10
ALLONITONIMENT OF MEDICAL, OTHER HEALTH SERVICE	LES AND VACCINE COST	Trovider C		Peri od: From 07/01/2020		
		Component	CCN: 15-T034	To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :33 am
		Title	XVIII	Subprovi der – I RF	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 230905	0		0 0	0	50.00
51 OO OS1OO RECOVERY ROOM	0 321562	0			0	51 00

				char gcs		00313	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0. 230905	l e	0	0	0	
	5100 RECOVERY ROOM	0. 321562		0	0	0	
	5200 DELIVERY ROOM & LABOR ROOM	0. 527749		0	0	0	
53.00 05	5300 ANESTHESI OLOGY	0. 026946	0	0	0	0	53.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	0. 140301	911	0	0	128	54.00
55.00 05	5500 RADIOLOGY - THERAPEUTIC	0. 108214	0	0	0	0	55. 00
56.00 05	5600 RADI OI SOTOPE	0. 126645	0	0	0	0	56. 00
57.00 05	5700 CT SCAN	0. 043544	0	0	0	0	57. 00
58. 00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 074608	0	0	0	0	58. 00
59.00 05	5900 CARDI AC CATHETERI ZATI ON	0. 086075	0	0	0	0	59. 00
60.00 06	6000 LABORATORY	0. 104878	0	0	0	0	60. 00
62.00 06	3200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	0	0	0	62.00
	6300 BLOOD STORING, PROCESSING, & TRANS.	0. 282847		0	0	0	63. 00
64.00 06	5400 INTRAVENOUS THERAPY	0. 224687	0	0	0	0	64. 00
	5500 RESPIRATORY THERAPY	0. 276645		0	0	0	65. 00
	6600 PHYSI CAL THERAPY	0. 266127	l .	0	0	0	66. 00
	5700 OCCUPATIONAL THERAPY	0. 184258	l .	0	0	0	
	5800 SPEECH PATHOLOGY	0. 402176	l	0	0	0	1
	5900 ELECTROCARDI OLOGY	0. 072403	l	0	0	50	69. 00
	7000 ELECTROENCEPHALOGRAPHY	0. 105999		0	0	0	1
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 303267	l .	0	0	425	1
	7200 I MPL. DEV. CHARGED TO PATIENTS	0. 405354		0	0	0	1
	7300 DRUGS CHARGED TO PATIENTS	0. 180231	877	0	0	158	
	7400 RENAL DIALYSIS	0. 252049	l e	0	0	0	1
	7697 CARDI AC REHABI LI TATI ON	0. 630526		Ö	0	0	1
	JTPATIENT SERVICE COST CENTERS	0.000020	<u> </u>				70.77
	9000 CLINIC	0. 479587	0	0	0	0	90. 00
	9100 EMERGENCY	0. 114707		ĺ	0	ő	
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 296369		ĺ	0	Ö	
200. 00	Subtotal (see instructions)	0.270307	3, 886		0	-	200. 00
201.00	Less PBP Clinic Lab. Services-Program		3,000		0	/01	201. 00
201.00	Only Charges			١			201.00
202. 00	Net Charges (line 200 - line 201)		3, 886	o	0	761	202. 00
202.00	inct onarges (Trice 200 Trice 201)	I	3,000	٥	1	701	1202.00

	ST. MARY MEDICAL		ON 45 0004		u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0034	Peri od: From 07/01/2020	Worksheet D Part V	
		Component	CCN: 15-T034	To 06/30/2021	Date/Time Pre	pared:
		Ti tl e	e XVIII	Subprovi der -	PPS	. 33 alli
	_			IRF		
0 1 0 1 0 1 1	Cost		_			
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
		Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C)			50.00
51.00 05100 RECOVERY ROOM	0	C)			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C)			52. 00
53. 00 05300 ANESTHESI OLOGY	0	C				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)			54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	C	2			55. 00
56. 00 05600 RADI 01 SOTOPE	0	C	2			56. 00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C				57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON						59.00
60. 00 06000 LABORATORY						60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL						62. 00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0				63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	C				64. 00
65. 00 06500 RESPIRATORY THERAPY	o	C				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	C				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C)			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C)			73. 00
74. 00 07400 RENAL DIALYSIS	0	C	•			74. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	C)			76. 97
OUTPATIENT SERVICE COST CENTERS	0		N.			00.00
90 00 1090001 CLINIC	1 ()	C)i			90 00

0 0 0

90. 00 91. 00 92. 00 200. 00

201.00 202. 00

90. 00 | 09000 | CLI NI C 91. 00 | 09100 | EMERGENCY

200.00 201.00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

Health Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C		Period: From 07/01/2020		
				Го 06/30/2021	Date/Time Prep 11/23/2021 10	pared: :33 am_
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 417, 058		2, 417, 058			1
31.00 INTENSIVE CARE UNIT	642, 010		642, 010			1
41. 00 SUBPROVI DER - I RF	298, 161		298, 16°			
43. 00 NURSERY	119, 008		119, 008			1
200.00 Total (lines 30 through 199)	3, 476, 237		3, 476, 23	53, 224		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	933				l	30. 00
31.00 INTENSIVE CARE UNIT	18				ļ	31. 00
41. 00 SUBPROVI DER - I RF	44				l	41. 00
43. 00 NURSERY	98				ļ	43. 00
200.00 Total (lines 30 through 199)	1, 093	67, 507				200. 00

Heal th	Financial Systems	ST. MARY MEDICAL	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co		Peri od:	Worksheet D	
					From 07/01/2020	Part II	
					To 06/30/2021	Date/Time Pre 11/23/2021 10	
			Ti tl	e XIX	Hospi tal	PPS	. 55 diii
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(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)	Ŭ	·	
		26)	ŕ	ĺ			
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	4, 570, 608				9, 306	
	05100 RECOVERY ROOM	487, 355				832	1
	05200 DELIVERY ROOM & LABOR ROOM	392, 845				2, 347	
53.00	05300 ANESTHESI OLOGY	12, 801	30, 208, 580	0. 00042	4 64, 757	27	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	932, 112	61, 198, 624	0. 01523	1 79, 922	1, 217	54. 00
	05500 RADI OLOGY - THERAPEUTI C	240, 473	18, 814, 637			0	55. 00
56.00	05600 RADI 0I SOTOPE	236, 233		0. 01250	0 47, 209	590	56. 00
57.00	05700 CT SCAN	198, 684	83, 214, 033	0. 00238	8 361, 368	863	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	637, 581	35, 810, 735	0. 01780	4 55, 368	986	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 733, 012	84, 084, 840	0. 02061	0 89, 164	1, 838	59. 00
60.00	06000 LABORATORY	442, 452	150, 129, 358	0. 00294	7 671, 739	1, 980	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 00000	0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	54, 052	6, 062, 639	0. 00891	6 16, 300	145	63.00
64.00	06400 I NTRAVENOUS THERAPY	73, 065	3, 904, 638	0. 01871	2 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	177, 077	14, 711, 344	0. 01203	7 141, 092	1, 698	65. 00
66. 00	06600 PHYSI CAL THERAPY	403, 943	18, 691, 954	0. 02161	1 23, 163	501	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	26, 729	6, 871, 114	0. 00389	0 15, 393	60	67. 00
68. 00	06800 SPEECH PATHOLOGY	8, 367	1, 459, 228	0. 00573	4 17, 078	98	68. 00
69. 00	06900 ELECTROCARDI OLOGY	364, 507	32, 729, 078	0. 01113	7 126, 511	1, 409	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	100, 281	9, 727, 891	0. 01030	9 17, 591	181	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	38, 562	34, 837, 691	0. 00110	7 172, 267	191	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	51, 615	35, 989, 313	0. 00143	4 41, 519	60	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	415, 658	119, 138, 311	0. 00348	9 787, 837	2, 749	73. 00
74.00	07400 RENAL DIALYSIS	3, 705	3, 929, 673	0. 00094	3 68, 978	65	74. 00
76. 97	07697 CARDIAC REHABILITATION	165, 379	2, 040, 795	0. 08103	7 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	295, 192			8 0	0	90. 00
	09100 EMERGENCY	568, 535	97, 040, 446	0. 00585	9 332, 221	1, 946	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	298, 842			1 34, 198	690	92. 00
200.00	Total (lines 50 through 199)	12, 929, 665	1, 070, 974, 277		3, 539, 101	29, 779	200. 00

Health Financial Systems	ST. MARY MEDICA				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				From 07/01/2020	Part III	
				To 06/30/2021	Date/Time Pre 11/23/2021 10	parea:
		Ti +I	e XIX	Hospi tal	PPS	. 33 aiii
Cost Center Description	Nursing School	Nursing School		Allied Health		
oost center bescriptron	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C	0	(0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	C	0)	0	0	31.00
41. 00 04100 SUBPROVI DER - RF		ol o		0	0	41.00
43. 00 04300 NURSERY		ol o		0	0	43.00
200.00 Total (lines 30 through 199)	l c	ol o)	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
·	Adj ustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	·			
	instructions)	minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	C	0	41, 21	7 0.00	933	30.00
31.00 03100 INTENSIVE CARE UNIT		0	5, 13	0.00	18	31.00
41. 00 04100 SUBPROVI DER - I RF	C	0	5, 43	7 0.00	44	41.00
43. 00 04300 NURSERY		0	1, 43	0.00	98	43.00
200.00 Total (lines 30 through 199)		0	53, 22	4	1, 093	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
INDATIENT DOUTINE SERVICE COST CENTERS	9. 00					

30. 00 31. 00

41. 00 43. 00 200. 00

30. 00 | 03000 | ADULTS & PEDIATRICS | 03100 | INTENSIVE CARE UNIT | 41. 00 | 04100 | SUBPROVI DER - I RF | 04300 | NURSERY | Total (lines 30 through 199)

THROUGH COSTS				To 06/30/2021	Date/Time Pre 11/23/2021 10	
		Ti tI	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	C	0)	0	36, 327	50. 00
51.00 05100 RECOVERY ROOM	C	0)	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	0)	0 (0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	C	0)	0 (0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0)	0 (0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	C	0)	0 (0	0	55. 00
56. 00 05600 RADI OI SOTOPE	C	0)	0 0	0	56. 00
57. 00 05700 CT SCAN	C	0)	0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	0)	0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	0)	0 0	0	59. 00
60. 00 06000 LABORATORY	C	0)	0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	0		0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	C	0		0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	C	0		0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	C	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	C	0		0	0	66.00
67. 00 06700 OCCUPATIONAL THERAPY	C	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	C	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	C	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0)	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0)	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0)	0	0	73. 00
74.00 07400 RENAL DIALYSIS	C	0		0	0	74.00
76. 97 07697 CARDIAC REHABILITATION	C	0)	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	C	0)	0 0	0	90. 00
91. 00 09100 EMERGENCY	C	0		0 (C	437, 057	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C)		O	0	92.00
200.00 Total (lines 50 through 199)	C) o)	0	473, 384	200. 00

Health Financial Systems	ST. MARY MEDICAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provi der CC		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020		
			-	To 06/30/2021		
					11/23/2021 10	:33 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medical (sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	

Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	36, 327	36, 327	156, 113, 456		
51.00 05100 RECOVERY ROOM	0	0	0	19, 861, 864		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	3, 961, 432		52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	30, 208, 580		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	61, 198, 624		54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	0	18, 814, 637	0.000000	55.00
56. 00 05600 RADI 01 SOTOPE	0	0	0	18, 898, 031	0.000000	56.00
57. 00 05700 CT SCAN	0	0	0	83, 214, 033	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	35, 810, 735	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	84, 084, 840	0.000000	59.00
60. 00 06000 LABORATORY	0	0	0	150, 129, 358	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	6, 062, 639	0.000000	63.00
64. 00 06400 INTRAVENOUS THERAPY	0	0	0	3, 904, 638	0.000000	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	14, 711, 344	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	18, 691, 954	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	6, 871, 114	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	1, 459, 228	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	32, 729, 078		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	9, 727, 891	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34, 837, 691	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35, 989, 313	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	119, 138, 311	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	3, 929, 673		74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	2, 040, 795		76. 97
OUTPATIENT SERVICE COST CENTERS	,	•	•			
90. 00 09000 CLI NI C	0	0	0	6, 729, 049	0.000000	90.00
91. 00 09100 EMERGENCY	0	437, 057	437, 057	97, 040, 446	0. 004504	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14, 815, 523		
200.00 Total (lines 50 through 199)	0	473, 384	473, 384	1, 070, 974, 277		200. 00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0034	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/23/2021 10:33 am

THROUGH COS	TS				o 06/30/2021	Part IV Date/Time Pre	
			T: 41	e XIX	Hospi tal	11/23/2021 10 PPS	:33 am
	Cook Cook on Donor in this or	0					
	Cost Center Description	Outpatient Ratio of Cost	Inpati ent	Inpatient Program	Outpati ent	Outpati ent	
		to Charges	Program Charges	Pass-Through	Program Charges	Program Pass-Through	
		(col. 6 ÷ col.	criai ges	Costs (col. 8	criai ges	Costs (col. 9	
		7)		x col. 10)		x col . 12)	
		9.00	10.00	11.00	12.00	13. 00	
ANCLL	LARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
	OPERATING ROOM	0. 000233	317, 856	74	0	0	50.00
	RECOVERY ROOM	0. 000000	33, 898		_	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0. 000000	23, 672		0	0	52. 00
	ANESTHESI OLOGY	0. 000000	64, 757		0	0	53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0. 000000	79, 922		0	0	54.00
55. 00 05500	RADIOLOGY - THERAPEUTIC	0. 000000	0	l c	0	0	55. 00
56. 00 05600	RADI OI SOTOPE	0. 000000	47, 209	l c	0	0	56.00
57.00 05700	CT SCAN	0. 000000	361, 368	C	0	0	57.00
58. 00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	55, 368	l c	0	0	58. 00
59.00 05900	CARDI AC CATHETERI ZATI ON	0. 000000	89, 164	l c	0	0	59. 00
60.00 06000	LABORATORY	0. 000000	671, 739	l c	0	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	C	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	0. 000000	16, 300	C	0	0	63.00
64.00 06400	I NTRAVENOUS THERAPY	0. 000000	0	C	0	0	64.00
65. 00 06500	RESPI RATORY THERAPY	0. 000000	141, 092	l c	0	0	65. 00
66. 00 06600	PHYSI CAL THERAPY	0. 000000	23, 163	C	0	0	66.00
67. 00 06700	OCCUPATIONAL THERAPY	0. 000000	15, 393	C	0	0	67.00
68. 00 06800	SPEECH PATHOLOGY	0. 000000	17, 078	C	0	0	68. 00
69. 00 06900	ELECTROCARDI OLOGY	0. 000000	126, 511	C	0	0	69. 00
70.00 07000	ELECTROENCEPHALOGRAPHY	0. 000000	17, 591	C	0	0	70.00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	172, 267	C	0	0	71. 00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 000000	41, 519	C	0	0	72. 00
73. 00 07300	DRUGS CHARGED TO PATIENTS	0. 000000	787, 837	C	0	0	73. 00
74. 00 07400	RENAL DIALYSIS	0. 000000	68, 978	l c	0	0	74.00
76. 97 07697	CARDIAC REHABILITATION	0. 000000	0	l c	0	0	76. 97
OUTPA	ATIENT SERVICE COST CENTERS						
90.00 09000	CLI NI C	0. 000000	0	C	0	0	90.00
91.00 09100	EMERGENCY	0. 004504	332, 221	1, 496	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	34, 198	C	0	0	92. 00
200.00	Total (lines 50 through 199)		3, 539, 101	1, 570	0	0	200. 00

	ST. MARY MEDICAL		CN 15 0024		eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	IL CUSIS	Provi der C	CN: 15-0034	Peri od: From 07/01/2020	Worksheet D Part II	
		Component	CCN: 15-T034	To 06/30/2021	Date/Time Pre	pared:
					11/23/2021 10	: 33 am
		litl	e XIX	Subprovi der - I RF	PPS	
Cost Center Description	Capi tal	Total Charges	Patio of Cos		Capital Costs	
cost center bescription		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	. Griai ges	COT GIIIIT 1)	
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				<u> </u>		
50. 00 05000 OPERATING ROOM	4, 570, 608	156, 113, 456	0. 02927	7 0	0	50. 00
51.00 05100 RECOVERY ROOM	487, 355	19, 861, 864	0. 02453	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	392, 845	3, 961, 432	0. 09916	0 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	12, 801	30, 208, 580	0. 00042	24 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	932, 112		1		17	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	240, 473				0	
56. 00 05600 RADI 01 SOTOPE	236, 233				0	56. 00
57. 00 05700 CT SCAN	198, 684				8	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	637, 581				0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 733, 012				0	59. 00
60. 00 06000 LABORATORY	442, 452				12	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0.0000		0	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	54, 052				0	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	73, 065 177, 077				0 18	
66. 00 06600 PHYSI CAL THERAPY	403, 943					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	26, 729					
68. 00 06800 SPEECH PATHOLOGY	8, 367				0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	364, 507		1		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	100, 281				Ö	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	38, 562					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	51, 615				Ō	1
73.00 07300 DRUGS CHARGED TO PATIENTS	415, 658				89	73. 00
74.00 07400 RENAL DIALYSIS	3, 705			3 0	0	74. 00
76. 97 07697 CARDIAC REHABILITATION	165, 379	2, 040, 795	0. 08103	0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	295, 192					
91. 00 09100 EMERGENCY	568, 535				0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	, ,	1		0	
200.00 Total (lines 50 through 199)	12, 630, 823	1, 070, 974, 277	I	63, 267	474	200. 00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0034	Peri od: From 07/01/2020	Worksheet D Part IV
TIIKOBOTI COSTS		Component CCN: 15-T034		
		Title XIX	Subprovi der -	PPS

			Titl	e XIX	Subprovi der -	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	5051 5011tol 20501 pt oli	Anesthetist	Post-Stepdown	lar or rig correct	Post-Stepdown	7.1. T. Ou T. Out E.T.	
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	C	0	36, 327	50.00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54. 00
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0	C	0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	0	C	0	0	56. 00
57.00	05700 CT SCAN	0	0	C	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	C	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	o	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	C	o	0	74.00
76. 97	07697 CARDIAC REHABILITATION	0	0	C	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	0	0	90. 00
91.00	09100 EMERGENCY	0	0	C	0	437, 057	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		[C		0	92. 00
200.00	Total (lines 50 through 199)	0	0	c	0	473, 384	200. 00

	ST. MARY MEDICA			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV	norod.
		Component	JCN: 15-1034	To 06/30/2021	Date/Time Pre 11/23/2021 10	
		Ti tl	e XIX	Subprovider - IRF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	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	
ANCILLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATING ROOM	0	36, 327	36, 32	7 156, 113, 456	0. 000233	50. 00
51. 00 05100 RECOVERY ROOM	0			0 19, 861, 864		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 961, 432	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0	•	0 30, 208, 580	0. 000000	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 61, 198, 624		
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	Ö		0 18, 814, 637	0. 000000	1
56. 00 05600 RADI 0I SOTOPE	0	o		0 18, 898, 031	0.000000	
57. 00 05700 CT SCAN	0	0		0 83, 214, 033	0.000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 35, 810, 735	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 84, 084, 840	0. 000000	59. 00
60. 00 06000 LABORATORY	0	0		0 150, 129, 358	0. 000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0. 000000	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 6, 062, 639	0. 000000	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 3, 904, 638	0. 000000	1
65. 00 06500 RESPI RATORY THERAPY	0	0		0 14, 711, 344	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	•	0 18, 691, 954		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 6, 871, 114		1
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0		0 1, 459, 228 0 32, 729, 078		
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	-,,	0. 000000 0. 000000	
71. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 9, 727, 891 0 34, 837, 691	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 35, 989, 313		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 119, 138, 311	0.000000	1
74. 00 07400 RENAL DIALYSIS	0	0		0 3, 929, 673		1
76. 97 07697 CARDI AC REHABI LI TATI ON	0	1		0 2, 040, 795	0. 000000	
OUTPATIENT SERVICE COST CENTERS				2,010,170	0.000000	70.77
90. 00 09000 CLI NI C	0	0		0 6, 729, 049	0.000000	90.00
91. 00 09100 EMERGENCY	0					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1		0 14, 815, 523		92.00
200.00 Total (lines 50 through 199)	0	473, 384	473, 38	4 1, 070, 974, 277		200. 00

Health Financial S	Systems	ST. MARY MEDICAL	CENTER INC		In lie	eu of Form CMS-2	2552-10
	INPATIENT/OUTPATIENT ANCILLARY SE		Provi der Co	CN: 15-0034	Peri od:	Worksheet D	2332 10
THROUGH COSTS					From 07/01/2020 To 06/30/2021	Part IV	pared: :33 am
			Ti tl	e XIX	Subprovi der - I RF	PPS	
Cost	Center Description	Outpati ent	I npati 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	
	SERVI CE COST CENTERS					_	
50. 00 05000 OPERA		0. 000233	0		0		
51. 00 05100 RECOV		0. 000000	0		0	_	
	ERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53. 00 05300 ANEST		0. 000000	0		0	0	53. 00
	LOGY-DI AGNOSTI C	0. 000000	1, 088		0	0	54. 00
	LOGY - THERAPEUTI C	0. 000000	0		0	0	55. 00
56. 00 05600 RADI 0		0. 000000	0		0	0	56. 00
57. 00 05700 CT SC		0. 000000	3, 169		0	0	57. 00
	TIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58. 00
1 1	AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60. 00 06000 LABOR		0. 000000	4, 057		0	0	60. 00
	BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62. 00
	STORING, PROCESSING, & TRANS.	0. 000000	0		0 0	0	63. 00
1 1	VENOUS THERAPY	0. 000000	0		0 0	0	64. 00
	RATORY THERAPY	0. 000000	1, 475		0 0	0	65. 00
1 1	CAL THERAPY	0. 000000	12, 998		0 0	0	66. 00
	ATI ONAL THERAPY	0. 000000	11, 886		0	0	67. 00
	H PATHOLOGY	0. 000000	0		0 0	0	68. 00
	ROCARDI OLOGY	0. 000000	0		0 0	0	69. 00
	ROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
	AL SUPPLIES CHARGED TO PATIENT	0. 000000	3, 136		0	0	71. 00
	DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
	CHARGED TO PATIENTS	0. 000000	25, 458		0	0	73. 00
74. 00 07400 RENAL		0. 000000	0		0		74.00
	AC REHABILITATION	0. 000000	0		0 0	0	76. 97
	SERVICE COST CENTERS	0.000000					
90. 00 09000 CLI NI		0. 000000	0		0		
91. 00 09100 EMERG		0. 004504	0		0	_	
	VATION BEDS (NON-DISTINCT PART (lines 50 through 199)	0. 000000	63, 267		0 0	_	92. 00 200. 00
200.00 10181	(Titles 50 till ough 199)	1	03, 207	I	o _l	1	J≥00. 00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034	Peri od: From 07/01/2020	Worksheet D-1	
			To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :33 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description					

		Title XVIII	Hospi tal	11/23/2021 10 PPS	:33 am
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed days)	ped and newborn days)	ivate room days,	41, 217 41, 217 0	1.00 2.00 3.00
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	36, 121 0	4. 00 5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8.00	reporting period Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	o the Program (excluding	swi ng-bed and	15, 204	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private r	oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19. 00
20. 00					20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	35, 513, 861 0	21. 00 22. 00
23. 00	$5\ x$ line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	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
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			35, 513, 861	
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	1
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0. 000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		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 a 27 minus line 36)	and private room cost di	fferential (line	35, 513, 861	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			061 49	38 00
38. 00 39. 00	Program general inpatient routine service cost per diem (see			861. 63 13, 100, 223	
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		13, 100, 223	41. 00

Heal th	Financial Systems S	T. MARY MEDICAL	CENTER, INC.		In Li∈	eu of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1		
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10		
			_	XVIII	Hospi tal	PPS		
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost		
		Impatrent costi	inpatrent bays	col. 2)	-	4)		
		1.00	2. 00	3. 00	4. 00	5. 00		
42.00	NURSERY (title V & XIX only)	0	0	0.0	0	0	42. 00	
42.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0 (70 710	F 12/	1 (00 7	1 705	2 022 155	1 42 00	
43. 00 44. 00	CORONARY CARE UNIT	8, 678, 710	5, 136	1, 689. 7	1, 795	3, 033, 155	43. 00 44. 00	
45. 00	BURN INTENSIVE CARE UNIT	1					45. 00	
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00	
	OTHER SPECIAL CARE (SPECIFY)						47. 00	
	Cost Center Description					1. 00		
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			23, 078, 487	48. 00	
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ns)		39, 211, 865	•	
50. 00	Pass through costs applicable to Program inp	atient routine :	services (from	Wkst. D, sum	of Parts I and	1, 115, 938	50. 00	
51. 00	<pre> </pre>	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	1, 341, 816	51. 00	
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				2, 457, 754	52. 00	
53. 00	Total Program inpatient operating cost exclu		lated non-phy	sician anesth	etist and	36, 754, 111	1	
00.00	medical education costs (line 49 minus line	J 1	ratea, non phy	or er arr arrestri	oti ot, una	00, 701, 111	00.00	
	TARGET AMOUNT AND LIMIT COMPUTATION							
	Program di scharges					0		
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00	
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (li	ine 56 minus	ine 53)	0	•	
58. 00								
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period (endi ng 1996, u	pdated and co	mpounded by the	0.00	59. 00	
60. 00	market basket .00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							
	1.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						60. 00 61. 00	
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
	amount (line 56), otherwise enter zero (see	instructions)					,,,,,,,	
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0		
PROGRAM I NPATIENT ROUTINE SWING BED COST							05.00	
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00	
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	na costs (lina d	64 nlus lina 6	5)/+i+l_ YVII	only) For	0	66. 00	
00.00	CAH (see instructions)						00.00	
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 o	f the cost re	porting period	0	67. 00	
68. 00	08.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70. 00	
71. 00	Adjusted general inpatient routine service c	-					71.00	
72. 00	Program routine service cost (line 9 x line	71)					72. 00	
73.00	Medically necessary private room cost applic			ne 35)			73.00	
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			orksheet B, Pa	art II, column		74. 00 75. 00	
74 00	26, line 45)	no 2)					74 00	
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00	
78. 00	Inpatient routine service cost (line 74 minu	•					78. 00	
79. 00	Aggregate charges to beneficiaries for exces		79. 00					
80.00	Total Program routine service costs for comp		ost limitation	(line 78 min	us line 79)		80.00	
81.00							81. 00 82. 00	
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00	
84. 00	Program inpatient ancillary services (see in		•				84. 00	
85. 00	Utilization review - physician compensation	(see instruction					85. 00	
86. 00			rough 85)				86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					5, 096	87. 00	
88. 00	Adjusted general inpatient routine cost per		line 2)			861.63	1	
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				4, 390, 866	89. 00	

Health Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021		
		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	2, 417, 058	35, 513, 861	0.06806	0 4, 390, 866	298, 842	90. 00
91.00 Nursing School cost	0	35, 513, 861	0.00000	0 4, 390, 866	0	91.00
92.00 Allied health cost	0	35, 513, 861	0.00000	0 4, 390, 866	0	92.00
93 00 All other Medical Education	0	35 513 861	0 00000	0 4 390 866	0	93 00

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN:	15-0034 Peri od: From 07/01/2020	Worksheet D-1
	Component CCN:	To 06/30/2021	
	Title XV	/III Subprovider -	PPS

		litie XVIII	Supprovider -	PPS	
	Cost Center Description		TIM		
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)	T	5, 437	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			5, 437	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation by		. 21 -6 -1	5, 437	4. 00
5.00	Total swing-bed SNF type inpatient days (including private round reporting period	om days) through becembe	1 31 01 the cost	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 room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	i oi the cost	O	8.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	3, 441	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	nly (including private r	oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o	ulv (including private r	oom days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, en		days, ares.	· ·	
12.00	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	/!·· (!! ·! · ·! · ·		0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar year)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	3 - 3 - 3	,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT		£ 111	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				19. 00
19. 00					
20. 00	reporting period O Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost				
20.00	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			5, 313, 387	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	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	31 of the cost reportin	a period (line 6	0	23. 00
23.00	x line 18)	31 of the cost reportin	g perrod (Trile o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December : x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 313, 387	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)		28. 00
29. 00 30. 00	Semi - pri vate room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min		tions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	5, 313, 387	37.00
	27 minus line 36)	,			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			077.07	20 00
38. 00 39. 00	Program general inpatient routine service cost per diem (see			977. 26 3, 362, 752	
40. 00	Medically necessary private room cost applicable to the Progra			0,002,702	
	Total Program general inpatient routine service cost (line 39			3, 362, 752	

Comparent COX: 15-7034 From 17/17/2020 But 17/17 in Proported 1/2020 But 17/17 in Prop			T. MARY MEDICAL		ON 15 0024		eu of Form CMS-2		
Coast Center Description	COMPUT	ATION OF INPATIENT OPERATING COST							
Initial Oral Number Program Days Program				·			11/23/2021 10		
Input Inpu		Cost Center Description	Total	Total	Average Per		Program Cost		
MUNESERY (LISTER VS. AVX. enly)		5551 55115. 5553. pt. 51.			Diem (col. 1		(col. 3 x col.		
Intensive Care Type Impatient Hospital Britis 0 0 0 0 0 0 0 0 0	42.00	MIDSEDV (title V & YIY only)						42.00	
44.00 CORONNEW CARE UNIT	42.00		ı o		ų 0. t	0	0	42.00	
			0	C	0. (00	0		
17.00 OTHER SPECIAL CARE (SPECIFY)								45. 00	
28.00 Program Inpatient ancillary service cost (Wist. D-3, col. 3, line 2000) 1,000 49,000 1,505,403 49,00 lotal Program Inpatient ancillary service (Sum of lines 41 through 48) (see Instructions) 4,928, 155,400 49,00 10,000 1,505,403 49,00 10,000 1,505,403 49,00 10,000 1,505,403 49,00 10,000 10								46. 00	
1.00	47. 00							47. 00	
49.00 Total Program inpatient costs (sum of Flines 41 through 48)(see instructions) 49.00 Pass through costs applicable to Program inpatient routine services (from Wkst. 0, sum of Parts I and 188,704 So. 00 Total Program excludable cost (sum of Flines 50 and 51) 50.00 Total Program excludable cost (sum of Flines 50 and 51) 50.00 Total Program excludable cost (sum of Flines 50 and 51) 50.00 Total Program excludable cost (sum of Flines 50 and 51) 50.00 Total Program excludable cost (sum of Flines 52) FARSET MADIAT AND LITHIT COMPUTATION 50.00 Program and scharges 50.00 Total Program excludable cost (sum of Flines 52) FARSET MADIAT AND LITHIT COMPUTATION 50.00 Program of scharges 50.00 Program of scharges 50.00 Program of scharges 50.00 Program of St. VII.on 59) 50.00 Register of Flines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket of Flines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket of Flines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket of Flines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket of Flines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket of Flines 53/54 or 55 from the cost reporting 1996, updated by the market basket of Flines 53/54 or 55 from the cost reporting 1996, updated period 1996, updated 199		·					1.00		
PARS THROUGH COST ADJUSTMENTS					unc)				
111 111	49.00		41 through 48)(see mstructio	0115)		4, 928, 155	49.00	
51.00 Pass through costs applicable to Program inpatient and ill ary services (from Wkst. D. sum of Parts II 65, 355 51.0 and IV) 25.00 Total Program excludable cost (sum of lines 50 and 51) 25.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 4, 674, 995 32.0 April 1970 April 19	50. 00	, , , , , , , , , , , , , , , , , , , ,	atient routine	services (from	n Wkst. D, sur	n of Parts I and	188, 704	50.00	
	51, 00		atient ancillar	v services (fr	om Wkst. D. <	sum of Parts II	65, 355	51.00	
10 10 10 10 10 10 10 10		and IV)		<i>y</i> 33. 1. 333 (o m.o.c. 5, c	Ja 01 1 a. 10 11			
medical education costs (line 49 annus line 52)				lated non nh	ksician anos+b	netist and		1	
54.00 Program discharges 0.05 5.00 55.00 Target amount per discharge 0.00 55.00 55.00 Target amount per discharge 0.00 55.00	55.00	medical education costs (line 49 minus line !		. a teu, Holl-phi	or or arr driestl	ictist, and	4, 074, 090] 33.00	
55.00 Target amount per discharge 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Cost of otherwise enter zero (see instructions) 60.00 Medicare swing-bed SNF inpatient routine costs (lines 54 x 60), or 1% of the target 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 65.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 66.00 Total Medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 67.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total Program engered inpatient routine service cost (line 70 + line 2) 79.00 Program routine service cost (line 75 + line 71) 79.00 Aggretar barges to beneficiaries for excess cost	E4 00						1 0	1 54 00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 \$7.00 \$80.00 Bonus payment (see instructions) 0 \$80.00 Bonus payment (see instructions) (litle XVIII only) 5 \$80.00 Bonus payment (see instructions) (litle XVIII only) 5 \$80.00 Bonus payment (see instructions) (litle XVIII only) 5 \$80.00 Bonus payment (see payment paymen									
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 is 15 from the cost report, updated by the market basket 61.00 Lesser of lines 53/54 is 1ess than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Relief payment (see instructions) 65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only). 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PARTILI - SKILLED NURSING FACILITY. OMIPER NURSING FACILITY. AND ICYIID NURY 70.00 Skilled nursing facility/other nursing facility/ICY/ID routine service cost (line 37) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program routine service cost (line 9 x line 71) 73.00 Program and provide the cost period militation (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from provider records) 75.00 Capital - related costs (line 74 + line 76) 77.00 Program capital - related costs (line 97 + line 76) 78.00 Program and provide service costs (line 97 + line 77) 79.		Target amount (line 54 x line 55)							
Source S		, , , , , , , , , , , , , , , , , , , ,	ing cost and ta	rget amount (I	ine 56 minus	line 53)			
60.00 Lesser of lines \$3/54 or 55 from prior year cost report. Updated by the market basket 0.00 60.00 folions 51, 59 or 60 enter the lesser 50% of the amount by 0.01.00 folions 51, 59 or 60 enter the lesser 50% of the amount by 0.01.00 folions 51, 59 or 60 enter the lesser 50% of the amount by 0.01.00 folions 51, 50 or 60 enter the lesser 50% of the amount by 0.01.00 folions 52 or 60 or 60% of the amount by 0.01.00 folions 52 or 60% of the amount folions 52 or 60% of the amount by 0.01.00 folions 52 or 60% of the amount by 0.01.00 folions 52 or 60% of the amount by 0.01.00 folions 52 or 60% of the amount by 0.01.00 folions 52 or 60% of the amount by 0.01.00 folions 52 or 60% of the amount by 0.01.00 folions 52 or 60% of the amount by 0.01.00 folions 52 or 60% of the amount by 0.01.00 folions 52 or 60% of the amount by 0.01.00 folions 52 or 60% of the amount by 0.01.00 folions 52 or 60% of the amount by 0.01.00 fol									
61.00 If Iline 53/54 is less than the lower of Ilines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (Iline 53) are less than expected costs (Ilines 54 x 60), or 1% of the target amount (Iline 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (Itile XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (Itile XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (Iline 64 plus Iline 65) (Itile XVIII only). For CAH (See instructions) (Itile XVIII only) 67.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Iline 12 x Iline 19) 68.00 Total Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Iline 12 x Iline 19) 69.00 Total Itile V or XIX swing-bed NF inpatient routine costs (Iline 67 + Iline 68) 69.00 Total Itile V or XIX swing-bed NF inpatient routine costs (Iline 67 + Iline 68) 69.00 Total Itile V or XIX swing-bed NF inpatient routine costs (Iline 67 + Iline 68) 69.00 Total Itile V or XIX swing-bed NF inpatient routine costs (Iline 67 + Iline 68) 70.00 Skilled nursing facility/other nursing facility/ICIP Toutine service cost (Iline 73 x Iline 70) 71.00 Medically necessary private room cost applicable to Program (Iline 14 x Iline 35) 72.00 Total Program general inpatient routine service costs (Iline 72 + Iline 73) 73.00 Medically necessary private room cost applicable to Program (Iline 14 x Iline 35) 74.00 Per diem capital-related costs (Iline 75 + Iline 2) 75.00 Program routine service cost (Iline 74 minus Iline 77) 77.00 Program capital related costs (Iline 75 + Iline 2) 77.00 Program capital related costs (Iline 75 + Iline 2) 77.00 Program inpa	(0.00								
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 82.00 Relief payment (see instructions) 83.00 All wable Inpatient cost plus incentive payment (see instructions) 84.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (it it e XVII in only) 85.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (it it e XVII in only) 86.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (it it e XVIII only). For CAH (see instructions) (it it e XVII in only) 86.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (it it e XVIII only). For CAH (see instructions) 87.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 88.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 89.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 90.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 90.01 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 90.02 Adjusted general inpatient routine service cost (line 70 + line 2) 91.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 91.00 Adjusted general inpatient routine service costs (line 72 + line 73) 91.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 91.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 91.00 Inpatient routine service cost (line 75 + line 2) 92.00 Program capital -related costs (line 75 + line 2) 93.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 93.00 Reasonable inpatient poutine service costs (from provid								1	
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80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 89.00 Reasonable inpatient routine service costs (see instructions) 89.00 Reasonable inpatient routine service costs (see instructions) 89.00 Reasonable inpatient routine service costs limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 81 limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reasonable inpatient routine service cost (line 9 x line 81) 89.00 Reasonable inpatient routine service cost (line 9 x line 81) 89.00 Reasonable inpa									
82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Reasonable inpatient operating costs (sue instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable		Total Program routine service costs for compa	arison to the c			nus line 79)		80.00	
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Reasonable inpatient routine service costs (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine services (se)				81. 00 82. 00	
85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 88.00 Representation review - physician compensation (see instructions) 88.00 88.00 Representation review - physician compensation (see instructions) 88.00 Representation review - physician compensation review - physician review - physici	83. 00	Reasonable inpatient routine service costs (see instruction	* .				83. 00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 88.00 Representation of the cost per diem (line 27 + line 2) 88.00 Representation of the cost per diem (line 27 + line 2) 88.00 Representation of the cost per diem (line 27 + line 2)				ns)				84.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 98.00 88.00								86.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00	07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					1	
		,		line 2)					
		, , , , , , , , , , , , , , , , , , , ,	•	,				1	

Health Financial Systems S	T. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 07/01/2020 To 06/30/2021		
		Title	XVIII	Subprovi der -	PPS	
				IRF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	298, 161	5, 313, 387	0. 05611	5 0	0	90. 00
91.00 Nursing School cost	0	5, 313, 387	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	5, 313, 387	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 313, 387	0. 00000	0 0	0	93. 00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034	Peri od: From 07/01/2020	Worksheet D-1	
				Date/Time Prep	pared:
		Title XIX	Hospi tal	PPS	. 00 am
Cost Center Description					
				1 00	

		Title XIX	Hospi tal	PPS	. JJ alli
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	,		41, 217	1. 00 2. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-t Private room days (excluding swing-bed and observation bed day		vate room days	41, 217 0	3. 00
0.00	do not complete this line.	, , , , , , , , , , , , , , , , , , ,	rate reem daye,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation be			36, 121	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	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 room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3°	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swi ng-bed and	933	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private ro	oom davs)	0	10. 00
	through December 31 of the cost reporting period (see instruct	i ons)	,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
.2.00	through December 31 of the cost reporting period	(y (, com dayo,	· ·	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	iii (exer darrig swrrig bed t	lays)	1, 434	
16.00	Nursery days (title V or XIX only)			98	16. 00
17.00	SWING BED ADJUSTMENT	- th	T	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 of	the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
21 00	reporting period			25 512 0/1	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	35, 513, 861 0	21. 00 22. 00
22.00	5 x line 17)	0. 0 0001 . 000	ng por ou (i i i o	· ·	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportin	na period (line	0	24. 00
21.00	7 x line 19)	or or the cost reporter.	.g po ou (· ·	21.00
25. 00	Swing-bed cost applicable to NF type services after December 3	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
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		35, 513, 861	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		, 1		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0	28. 00 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 ÷	· line 28)		0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir		tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0. 00	35. 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 a 27 minus line 36)	and private room cost dit	ferential (line	35, 513, 861	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			861. 63	
39. 00	Program general inpatient routine service cost (line 9 x line	•		803, 901	39. 00
40.00	Medically necessary private room cost applicable to the Progra	,		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ II ne 40)	I	803, 901	41.00

Heal th	Financial Systems S	T. MARY MEDICAL	CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der CC	CN: 15-0034	Peri od:	Worksheet D-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Average Per		Program Cost (col. 3 x col.	
		Impatront costi	iipati ciit bays	col . 2)	•	4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	2, 511, 750	1, 434	1, 751. 5	57 98	171, 654	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0 (70 710	E 12/	1 (00	70 10	20.417	12.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	8, 678, 710	5, 136	1, 689.	78 18	30, 416	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	lino 200)			1. 00 561, 126	48. 00
	Total Program inpatient costs (sum of lines			ns)		1, 567, 097	1
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inp	atient routine s	services (from	Wkst. D, sun	n of Parts I and	65, 094	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	31, 349	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				96, 443	52.00
52.00	Total Program excludable cost (sum of fines) Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	netist, and	1, 470, 654	1
	medical education costs (line 49 minus line					.,,	
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	, 3						54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	1
58.00	Bonus payment (see instructions)	9	3 • • • • • • •		,	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	endi ng 1996, u	pdated and co	ompounded by the	0.00	59. 00
40.00	market basket	cost report une	lated by the m	arkat backat		0.00	60.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	61.00
011.00	which operating costs (line 53) are less tha				•		01100
	amount (line 56), otherwise enter zero (see	instructions)				0	
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)							62. 00 63. 00
63. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstruc	ti ons)			0	03.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	nber 31 of the	cost reporti	ng period (See	0	64. 00
<i>,</i> = 00	instructions)(title XVIII only)		0.1				/= 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts arter Decembe	er 31 of the c	ost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVII	I only). For	0	66. 00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 o	f the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
(0.00	(line 13 x line 20)		! /7 !!	(0)			
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil)		70. 00
71. 00	Adjusted general inpatient routine service c		ne 70 ÷ line .	2)			71. 00
72. 00	Program routine service cost (line 9 x line		/!!== 14 !!	25)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv			ne 35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	,		orksheet B. F	Part II. column		75. 00
	26, line 45)		,		,		
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi den record	s)			78. 00 79. 00
80.00	Total Program routine service costs for comp				nus line 79)		80.00
81. 00	•						81. 00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		·)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00	Total Program inpatient operating costs (sum						86. 00
07	PART IV - COMPUTATION OF OBSERVATION BED PASS						07
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2\			5, 096 861. 63	1
	Observation bed cost (line 87 x line 88) (se		TITIE ZJ			4, 390, 866	1
	(30)					., .,	

Health Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Prep 11/23/2021 10	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 417, 058	35, 513, 861	0.06806	0 4, 390, 866	298, 842	90.00
91.00 Nursing School cost	0	35, 513, 861	0.00000	0 4, 390, 866	0	91.00
92.00 Allied health cost	0	35, 513, 861	0.00000	0 4, 390, 866	0	92.00
93 00 All other Medical Education		35 513 861	0 00000	0 4 390 866	0	93 00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034	Peri od: From 07/01/2020	Worksheet D-1
		Component CCN: 15-T034	To 06/30/2021	Date/Time Prepared: 11/23/2021 10:33 am
		Title XIX	Subprovi der -	PPS

		II the XIX	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	, excluding newborn)		5, 437	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			5, 437	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		5, 437	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period		4 6 11		, 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December 3	or the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	44	9. 00
	newborn days) (see instructions)	0 . 0			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		om days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er	iter 0 on this line)	om days) area	G	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI>		room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ve			U	13.00
14.00	Medically necessary private room days applicable to the Progra		,	0	14. 00
15. 00	Total nursery days (title V or XIX only)				15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			98	16. 00
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	9			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period	em aug.: Bassinger et et		0.00	.,
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	e cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	3)		5, 313, 387	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0, 515, 557	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	a period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5, 313, 387	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		,		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	l and observation bed cha	rges)	0	28. 00 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 =	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	us line 22) (see instruct	i onc)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x lir		1 0113)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	nd private room cost dif	ferential (line	5, 313, 387	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			977. 26	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		42, 999	
40.00	Medically necessary private room cost applicable to the Program	•		0 42, 999	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ 11110 40)		42, 999	41.00

	<u> </u>	ST. MARY MEDICAL			In Lie	u of Form CMS-2	2552-10		
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN	F	Period: From 07/01/2020	Worksheet D-1	norod.		
			Component CC		To 06/30/2021	Date/Time Pre 11/23/2021 10			
			Title		Subprovi der - I RF	PPS			
	Cost Center Description	Total Inpatient CostIr		Average Per em (col. 1 - col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00		
	Intensive Care Type Inpatient Hospital Units								
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43. 00 44. 00		
45.00	BURN INTENSIVE CARE UNIT						45. 00		
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00		
	Cost Center Description		<u> </u>			1. 00			
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			12, 313	48. 00		
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(se	ee instructions	s)		55, 312	49. 00		
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from W	Vkst. D, sum	of Parts I and	2, 413	50. 00		
51. 00	<pre> Pass through costs applicable to Program inp</pre>	atient ancillary	services (from	n Wkst. D, su	um of Parts II	474	51. 00		
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				2, 887	52. 00		
53. 00	Total Program inpatient operating cost exclu	ding capital rela	ated, non-physi	cian anesthe	etist, and	52, 425			
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)							
	Program di scharges					0			
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	56.00		
57.00	Difference between adjusted inpatient operat	ing cost and tar	get amount (lin	ne 56 minus I	ine 53)	0	57. 00 58. 00		
59. 00	00 Bonus payment (see instructions) 00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the								
60. 00	market basket								
	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by								
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)								
62. 00 63. 00	2.00 Relief payment (see instructions)								
	PROGRAM INPATIENT ROUTINE SWING BED COST					0			
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decemb	per 31 of the c	cost reportir	ng period (See	0	64. 00		
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	r 31 of the cos	st reporting	period (See	0	65. 00		
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 65)	(title XVIII	only). For	0	66. 00		
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through [December 31 of	the cost rep	porting period	0	67. 00		
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after Dec	cember 31 of th	ne cost repor	rtina period	0	68. 00		
60.00	(line 13 x line 20)			•	3 1	0			
09.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID ON	ILY		0	09.00		
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70. 00 71. 00		
72. 00	Program routine service cost (line 9 x line	71)	,				72. 00		
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv			9 35)			73. 00 74. 00		
75. 00	Capital-related cost allocated to inpatient	•	,	ksheet B, Pa	art II, column		75. 00		
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00		
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00		
79. 00	Aggregate charges to beneficiaries for exces	s costs (from pro					79. 00		
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitation (line 78 minu	ıs line 79)		80. 00 81. 00		
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00		
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in)				83. 00 84. 00		
85. 00	Utilization review - physician compensation	(see instructions					85. 00		
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86. 00		
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	ine 2)			0 00	87. 00 88. 00		
	Observation bed cost (line 87 x line 88) (se		2)				89. 00		

Health Financial Systems S	T. MARY MEDICAL	_ CENTER, INC.	In Lie	2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 07/01/2020 To 06/30/2021	Date/Time Prep 11/23/2021 10	
		Ti tl	e XIX	Subprovi der - I RF	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (OST					
90.00 Capital-related cost	298, 161	5, 313, 387	0. 05611	5 0	0	90. 00
91.00 Nursing School cost	0	5, 313, 387			0	91. 00
92.00 Allied health cost	0	5, 313, 387			0	92. 00
93.00 All other Medical Education	0	5, 313, 387	0. 00000	0 0	0	93. 00

Near Financial Systems ST. MARY MEDICAL CENTER, INC. In Lieu of Form INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-0034 Period: From 07/01/2020 To 06/30/2021 To 06/30/2021 To 06/30/2021 To 06/30/2021 To 06/30/2021 To 06/30/2021 Inpatient Inpatient Program Charges Charges Cost Center Description Inpatient Program Charges Cost Center Center Cost Center	
Ratio of Cost Inpatient Program Charges Charge	
To Charges Program Charges	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 25, 887, 400 31. 00 03000 ADULTS & PEDI ATRI CS 25, 887, 400 31. 00 03100 INTENSI VE CARE UNI T 5, 203, 405 41. 00 04100 SUBPROVI DER - I RF 0 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0. 231021 16, 722, 426 3, 863 51. 00 05100 RECOVERY ROOM 0. 321562 1, 847, 635 594	
30. 00 03000 ADULTS & PEDIATRICS 25, 887, 400 31. 00 03100 INTENSIVE CARE UNIT 5, 203, 405 41. 00 04100 SUBPROVI DER - I RF 0 04300 NURSERY ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0. 231021 16, 722, 426 3, 863 51. 00 05100 RECOVERY ROOM 0. 321562 1, 847, 635 594	
50. 00 05000 OPERATI NG ROOM 0. 231021 16, 722, 426 3, 863 51. 00 05100 RECOVERY ROOM 0. 321562 1, 847, 635 594	30. 00 31. 00 41. 00 43. 00
51. 00 05100 RECOVERY ROOM 0. 321562 1, 847, 635 594	32 50.00
	•
	0 52.00
	36 53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	•
	552 55.00
56. 00 05600 RADI 0I SOTOPE 0. 126645 1, 137, 421 144	•
57. 00 05700 CT SCAN 0. 043544 9, 127, 027 397	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0. 074608 2, 210, 399 164	•
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 086130 9, 892, 473 852	39 59.00
60. 00 06000 LABORATORY 0. 105044 16, 923, 053 1, 777	65 60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0	0 62.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 0. 282847 1, 328, 948 375	89 63.00
64. 00 06400 I NTRAVENOUS THERAPY 0. 224687 0	0 64.00
65. 00 06500 RESPI RATORY THERAPY 0. 276658 5, 166, 665 1, 429	65.00
66. 00 06600 PHYSI CAL THERAPY 0. 266127 1, 352, 055 359	18 66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 184258 868, 691 160	•
	61 68. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 072466 3, 342, 772 242	•
	62 70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 303267 6, 825, 062 2, 069	•
72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0.405354 8, 786, 918 3, 561	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 180231 22, 482, 092 4, 051	70 73.00
74. 00 07400 RENAL DI ALYSI S 0. 252049 1, 590, 857 400	•

83, 686 13, 127, 160

1, 105, 047

131, 187, 725

131, 187, 725

112, 898

71, 185

40, 453

1, 505, 777

327, 502

23, 078, 487 200. 00

76. 97

90.00

91.00

92.00

201. 00

202. 00

0.630526

0. 483386

0.114707

0. 296369

07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

76. 97

201.00

202.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ST. MARY MEDICAL CENTER, INC.	CN: 15-0034	Period:	wof Form CMS-3 Worksheet D-3	
TWI ATTENT ANGIELANT SERVICE COST ATTORTIONWENT	Trovider c	CN. 13-0034	From 07/01/2020	WOLKSHEET D-3	'
	Component	CCN: 15-T034	To 06/30/2021	Date/Time Pre 11/23/2021 10	
	Ti tl e	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
41. 00 04100 SUBPROVI DER - RF			4, 888, 647		41.00
43. 00 04300 NURSERY			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		43.00
ANCILLARY SERVICE COST CENTERS				•	
50. 00 05000 OPERATING ROOM		0. 23102	21 69, 928	16, 155	50.00
51.00 05100 RECOVERY ROOM		0. 32156	5, 684	1, 828	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 52774	49 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 02694	7, 069	190	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14043	39 147, 109	20, 660	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 1082	14 56, 059	6, 066	55. 00
56. 00 05600 RADI 0I SOTOPE		0. 12664		1, 477	56. 00
57. 00 05700 CT SCAN		0. 04354	· ·	8, 424	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 07460		3, 459	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 08613		1, 986	
60. 00 06000 LABORATORY		0. 10504	· ·	72, 041	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 28284		5, 194	
64. 00 06400 I NTRAVENOUS THERAPY		0. 22468		0	
65. 00 06500 RESPIRATORY THERAPY		0. 2766		114, 224	
66. 00 06600 PHYSI CAL THERAPY		0. 26612		441, 434	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		0. 18425 0. 4021		301, 643 93, 984	
69. 00 06900 SPEECH PATHOLOGY		0. 4021	· ·	4, 173	
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 07240	· ·	741	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 30320		108, 604	
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATTENT		0. 4053!		263	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 18023		323, 282	
74. 00 07400 RENAL DI ALYSI S		0. 25204		38, 888	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 63052	· ·	0	
OUTPATIENT SERVICE COST CENTERS		0.0000	,	·	1 . 5. ,,
90. 00 09000 CLINI C		0. 48338	36 0	0	90. 00
91. 00 09100 EMERGENCY		0. 11470		687	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 29636		0	
200.00 Total (sum of lines 50 through 94 and	96 through 98)		7, 584, 224	1, 565, 403	
201.00 Less PBP Clinic Laboratory Services-P			0		201. 00
Net charges (line 200 minus line 201)	- , , , , ,	1	7, 584, 224	I	202.00

Health Financial Systems	ST. MAF	RY MEDICAL	CENTER	R, INC.		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Pro	vider CC	N: 15-0034	Peri od:	Worksheet D-3	
						From 07/01/2020		
						To 06/30/2021	Date/Time Pre 11/23/2021 10	pared:
							11/23/2021 10	:33 am
				Title	e XIX	Hospi tal	PPS	
Cost Center Description					Ratio of Cos	t Inpatient	Inpati ent	
					To Charges	Program	Program Costs	
						Charges	(col. 1 x col.	
							2)	
					1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS								
00 00 00000 ABUU TO A DEBU ATBUOD						1 051 000		1

		litle XI	X	Hospi tal	L PPS	
	Cost Center Description		io of Cost	I npati ent	Inpati ent	
		To	Charges	Program	Program Costs	
			•	Charges	(col. 1 x col.	
				,	2)	
			1.00	2. 00	3. 00	
IN	IPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03	3000 ADULTS & PEDIATRICS			1, 051, 300		30.00
31. 00 03	3100 INTENSIVE CARE UNIT			174, 460		31.00
41. 00 04	1100 SUBPROVI DER – I RF			0		41.00
43. 00 04	1300 NURSERY			312, 906		43.00
AN	ICILLARY SERVICE COST CENTERS	<u> </u>				
50.00 05	5000 OPERATING ROOM		0. 231021	317, 856	73, 431	50.00
51.00 05	5100 RECOVERY ROOM		0. 321562	33, 898	10, 900	51.00
52. 00 05	5200 DELIVERY ROOM & LABOR ROOM		0. 527749	23, 672	12, 493	52.00
53. 00 05	5300 ANESTHESI OLOGY		0. 026946	64, 757	1, 745	53.00
54. 00 05	5400 RADI OLOGY-DI AGNOSTI C		0. 140439	79, 922	11, 224	54.00
55. 00 05	5500 RADI OLOGY - THERAPEUTI C		0. 108214	0	0	55. 00
56. 00 05	5600 RADI OI SOTOPE		0. 126645	47, 209	5, 979	56.00
57.00 05	5700 CT SCAN		0.043544	361, 368	15, 735	57. 00
58. 00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)		0. 074608	55, 368	4, 131	58. 00
	5900 CARDI AC CATHETERI ZATI ON		0. 086130	89, 164	7, 680	59. 00
60.00 06	5000 LABORATORY		0. 105044	671, 739	70, 562	60.00
62.00 06	5200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	0	0	62. 00
63.00 06	5300 BLOOD STORING, PROCESSING, & TRANS.		0. 282847	16, 300	4, 610	63.00
64.00 06	5400 INTRAVENOUS THERAPY		0. 224687	0	0	64. 00
65. 00 06	5500 RESPI RATORY THERAPY		0. 276658	141, 092	39, 034	65. 00
66. 00 06	6600 PHYSI CAL THERAPY		0. 266127	23, 163	6, 164	66. 00
	5700 OCCUPATI ONAL THERAPY		0. 184258	15, 393	2, 836	
68. 00 06	5800 SPEECH PATHOLOGY		0. 402176	17, 078	6, 868	68. 00
69. 00 06	5900 ELECTROCARDI OLOGY		0. 072466	126, 511	9, 168	69. 00
70. 00 07	7000 ELECTROENCEPHALOGRAPHY		0. 106348	17, 591	1, 871	70. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 303267	172, 267	52, 243	71. 00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 405354	41, 519	16, 830	
	7300 DRUGS CHARGED TO PATIENTS		0. 180231	787, 837	141, 993	
74. 00 07	7400 RENAL DIALYSIS		0. 252049	68, 978	17, 386	74. 00
76. 97 07	7697 CARDIAC REHABILITATION		0. 630526	0	0	1
OU	ITPATIENT SERVICE COST CENTERS	<u>'</u>				
	9000 CLI NI C		0. 483386	0	0	90.00
91. 00 09	P100 EMERGENCY		0. 114707	332, 221	38, 108	91.00
	2200 OBSERVATION BEDS (NON-DISTINCT PART		0. 296369	34, 198	10, 135	1
200.00	Total (sum of lines 50 through 94 and 96 through 98)			3, 539, 101	561, 126	1
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			3, 539, 101		202. 00

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	P	Provi der CO	CN: 15-0034	Peri od: From 07/01/2020	Worksheet D-3	
		C	Component (CCN: 15-T034	To 06/30/2021	Date/Time Prep 11/23/2021 10:	
			Ti tl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description			Ratio of Cos		I npati ent	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
				1.00	2.00	2) 3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1.00	2. 00	3.00	
30. 00	03000 ADULTS & PEDIATRICS						30.00
1. 00	03100 NTENSIVE CARE UNIT						31.00
1. 00	04100 SUBPROVI DER – I RF				34, 773		41.0
	04300 NURSERY				01,770		43. 0
	ANCILLARY SERVICE COST CENTERS						
0.00	05000 OPERATI NG ROOM			0. 2310	21 0	0	50.00
1. 00	05100 RECOVERY ROOM			0. 3215	62 0	0	51.0
2. 00	05200 DELIVERY ROOM & LABOR ROOM			0. 5277	49 0	0	52.00
3.00	05300 ANESTHESI OLOGY			0. 02694	46 0	0	53.0
4. 00	05400 RADI OLOGY-DI AGNOSTI C			0. 1404:	1, 088	153	54.00
5. 00	05500 RADI OLOGY - THERAPEUTI C			0. 1082 ⁻	14 0	0	55. 0
6. 00	05600 RADI 0I SOTOPE			0. 1266		0	56.0
7. 00	05700 CT SCAN			0. 0435		138	57.0
8. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)			0. 07460		0	58. 0
9. 00	05900 CARDI AC CATHETERI ZATI ON			0. 0861		0	59.0
0.00	06000 LABORATORY			0. 1050		426	60.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0.0000		0	62.0
3. 00	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY			0. 2828 0. 2246		0	63. 0 64. 0
5. 00	06500 RESPIRATORY THERAPY			0. 22466			65.0
6. 00	06600 PHYSI CAL THERAPY			0. 2661	· ·		66.0
7. 00	06700 OCCUPATI ONAL THERAPY			0. 1842!		2, 190	67.0
8. 00	06800 SPEECH PATHOLOGY			0. 4021		2, 170	68. 0
9. 00	06900 ELECTROCARDI OLOGY			0. 0724		0	69.0
0.00	07000 ELECTROENCEPHALOGRAPHY			0. 1063		Ö	70.0
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 3032		951	71.0
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS			0. 4053		0	72. 0
3. 00	07300 DRUGS CHARGED TO PATIENTS			0. 1802:		4, 588	
4. 00	07400 RENAL DIALYSIS			0. 2520		0	74.0
6. 97	07697 CARDIAC REHABILITATION			0. 63052	26 0	0	76. 9 ⁻
	OUTPATIENT SERVICE COST CENTERS						
0.00				0. 4833	36 0	0	90.0
	20400 EMEDOENOV						

0. 114707 0. 296369

63, 267 0 63, 267

201. 00 202. 00

0 91.00

0 92.00 12, 313 200.00

91. 00 09100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 Net charges (line 200 minus line 201)

Health Financial Systems	ST. MARY MEDICAL CE	ENTER, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 10:33 am

				11/23/2021 10	:33 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring payments	orior to October 1 (s	see	0 9, 361, 977	1. 00 1. 01
1. 02	<pre>instructions) DRG amounts other than outlier payments for discharges occurring c instructions)</pre>	26, 901, 856	1. 02		
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October				1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for di October 1 (see instructions)	scharges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions))		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see			107, 925	2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (s			224, 508	2. 04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting Indirect Medical Education Adjustment	g period (see instruc	ctions)	166. 03	4. 00
5.00	FTE count for allopathic and osteopathic programs for the most recor before 12/31/1996. (see instructions)			0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the cr new programs in accordance with 42 CFR 413.79(e)		·	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under ACA § 5503 reduction amount to the IME cap as specified under 42 C cost report straddles July 1, 2011 then see instructions.			0. 00 0. 00	7. 00 7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) 1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots ureport straddles July 1, 2011, see instructions.	under § 5503 of the A	NCA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots funder § 5506 of ACA. (see instructions)	from a closed teachin	ng hospi tal	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8 instructions)	3, 8,01 and 8,02) (s	see	0.00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current y	ear from your record	ls	0.00	ı
11. 00	FTE count for residents in dental and podiatric programs.				11. 00
12.00	Current year allowable FTE (see instructions)				12.00
13.00	Total allowable FTE count for the prior year.	adad on an aften Cont	-amban 20 1007	0.00	1
14. 00	Total allowable FTE count for the penultimate year if that year er otherwise enter zero.	ided on or arter Sept	.elliber 30, 1997,	0. 00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital closure			0.00	17. 00
18. 00	Adjusted rolling average FTE count				18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
20. 00	Prior year resident to bed ratio (see instructions)			0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of	the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE resident of (f)(1)(iv)(C).		R 412. 105	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the lower instructions)	of line 23 or line	24 (see	0. 00	1
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26. 00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 00 29. 01
30 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patier	nt days (see instruct	ione)	3. 43	30 00
30. 00 31. 00	Percentage of Medicaid patient days (see instructions)	it days (see Ilistitudi	.1 0113)	3. 43 15. 99	30.00
32. 00	Sum of Lines 30 and 31			19. 42	32.00
33. 00	Allowable disproportionate share percentage (see instructions)			5. 37	1
	Disproportionate share adjustment (see instructions)			486, 843	1

.CUL	ATION OF REIMBURSEMENT SETTLEMENT	NTER, INC. Provider CCN: 15-0034	Peri od:	Worksheet E	2552-
			From 07/01/2020 To 06/30/2021	Part A Date/Time Pre	
		T: +1 - \/\/\ \ \	11: 4-1	11/23/2021 10	: 33 a
		Title XVIII	Hospi tal Pri or to 10/1	PPS On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment				
00	Total uncompensated care amount (see instructions)			8, 290, 014, 521	
01 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter	zero on this line) (se	0. 000167267 ee 1, 396, 784	0. 000197202 1, 634, 811	1
02	instructions)	2010 011 (1113 11110) (30	1, 370, 704	1, 054, 011	55. (
	Pro rata share of the hospital uncompensated care payment amoun	•	351, 104		1
00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1, 573, 853		36.
00	Additional payment for high percentage of ESRD beneficiary disc Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684		0		40.
	instructions)				10.
			Before 1/1	On/After 1/1	
00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683	8 684 an 685 (see	1. 00	1. 01	41.
00	instructions)	o, 004 an 005. (3cc			- 1.
01	Total ESRD Medicare covered and paid discharges excluding MS-DR	RGs 652, 682, 683, 684	4 0	0	41.
00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qualify	/ for adjustment)	0.00		42.
00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682,				43.
	instructions)	•			
00	Ratio of average length of stay to one week (line 43 divided by days)	/line 41 divided by 7	0. 000000		44.
00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.
	Total additional payment (line 45 times line 44 times line 41.0	01)	0		46.
00	Subtotal (see instructions)		38, 656, 962		47.
00	Hospital specific payments (to be completed by SCH and MDH, sma only. (see instructions)	ali rurai nospitais	0		48
	only. (See That detroils)			Amount	
				1. 00	
00	Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I and	Dt II as applicable	\	38, 656, 962 2, 937, 178	1
00	Exception payment for inpatient program capital (Wkst. L, Pt. I)	2, 437, 178	1
00	Direct graduate medical education payment (from Wkst. E-4, line			0	52
00	Nursing and Allied Health Managed Care payment			39, 320	
00 01	Special add-on payments for new technologies Islet isolation add-on payment			130, 331 0	1
00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69))		0	
00	Cost of physicians' services in a teaching hospital (see intruc	ctions)		0	1
00	Routine service other pass through costs (from Wkst. D, Pt. III		through 35).	0	57
00	Ancillary service other pass through costs from Wkst. D, Pt. IV Total (sum of amounts on lines 49 through 58)	7, col. 11 line 200)		63, 021 41, 826, 812	1
00	Primary payer payments			3, 358	
00	Total amount payable for program beneficiaries (line 59 minus l	ine 60)		41, 823, 454	1
00	Deductibles billed to program beneficiaries			3, 448, 420	
	Coinsurance billed to program beneficiaries			179, 731	1
00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			374, 821 243, 634	
00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		65, 281	
00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			38, 438, 937	67
00	Credits received from manufacturers for replaced devices for ap			0	1
00 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (F ADD BACK GME REIMBURSEMENT	or sch see instruction	ns)	0	
01	OTHER ADJ (NO DESC ENTERED)			0	1
02	OTHER ADJUSTMENTS PER PSR			0	70
50	Rural Community Hospital Demonstration Project (§410A Demonstra	ation) adjustment (see	instructions)	0	
87 88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0	1
89	Pioneer ACO demonstration payment adjustment amount (see instru	uctions)			70
90	HSP bonus payment HVBP adjustment amount (see instructions)	/		0	
91	HSP bonus payment HRR adjustment amount (see instructions)			0	
	Bundled Model 1 discount amount (see instructions)			0	
92	· · · · · · · · · · · · · · · · · · ·			00 000	
	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			82, 009 -994, 168	

Health Financial Systems	ST.	MARY	MEDI CAL	L CENT	TER, INC.		In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				Pi	rovider CC	N: 15-0034	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Pre 11/23/2021 10	
					Title	XVIII	Hospi tal	PPS	
						FFY	(yyyy)	Amount	
							0	1. 00	
70.96 Low volume adjustment for federal fiscal					olumn 0		0	0	70. 96

			'	o 06/30/2021	Date/Time Prep 11/23/2021 10:	
-		Title	e XVIII	Hospi tal	PPS	. 55 am
				уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or aft			0	0	70. 97
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			37, 526, 778	71. 00
71. 01	Sequestration adjustment (see instructions)				0	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72. 00	Interim payments				37, 133, 003	
72. 01	Interim payments-PARHM				_	72. 01
73. 00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)) 70 and			202 775	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02 73)	z, 72, and			393, 775	74. 00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordan	ice with			862, 378	•
73.00	CMS Pub. 15-2, chapter 1, §115.2	ice wi tii			002, 370	73.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	f 2.03			0	90.00
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92.00	Operating outlier reconciliation adjustment amount (see instru	ıcti ons)			0	92. 00
93. 00	Capital outlier reconciliation adjustment amount (see instruct				0	93. 00
94. 00	The rate used to calculate the time value of money (see instru	ıcti ons)			0. 00	94. 00
95. 00	Time value of money for operating expenses (see instructions)				0	95. 00
96. 00	Time value of money for capital related expenses (see instruct	ions)		15 1 1 10/1	0	96. 00
				Prior to 10/1 1.00	2. 00	
	HSP Ronus Payment Amount				2.00	
100.00	HSP Bonus Payment Amount HSP bonus amount (see instructions)					100. 00
100.00	HSP bonus amount (see instructions)			0		100. 00
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment	s)		0	0. 0000000000	
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	5)		0. 0000000000	0. 0000000000	101. 00
101. 00 102. 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	3)		0. 0000000000	0. 0000000000 0 0. 00000	101. 00 102. 00 103. 00
101. 00 102. 00 103. 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)			0. 0000000000	0. 0000000000 0 0. 00000	101. 00 102. 00
101. 00 102. 00 103. 00 104. 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	ation) Adju		0. 00000000000	0. 0000000000 0 0. 0000 0 0. 0000	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 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) RURA adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adju		0. 00000000000	0. 0000000000 0 0. 0000 0 0. 0000	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 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 Century Cures Act? Enter "Y" for yes or "N" for no.	ation) Adju		0. 00000000000	0. 0000000000 0 0. 0000 0 0. 0000	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 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) RRR 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	ration) Adju iod under t		0. 00000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 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 Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	ration) Adju iod under t		0. 00000000000	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 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) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA COMMUNITY (See instructions) RURA Adjustment amount for HSP bonus payment (see instructions) RURA Adjustment factor (see instructions)	ration) Adju iod under t		0. 00000000000	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 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 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	he 21st	0.0000000000000000000000000000000000000	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 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) HVBP 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	ration) Adju riod under t	he 21st	0.0000000000000000000000000000000000000	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 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 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)	ration) Adju riod under t	he 21st	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 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) HVBP 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	ration) Adju riod under t	he 21st	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 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 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	ration) Adju riod under t	he 21st	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 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 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	he 21st	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 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) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ration) Adjuriod under to 49) first year	he 21st	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	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 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 instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ration) Adjuriod under to 49) first year	he 21st	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	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) HRBR 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) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	ration) Adjuriod under to 49) first year	he 21st	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	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) HRBR 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) 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	ration) Adjuriod under to 49) first year	he 21st	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	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) HRBR 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) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ration) Adjuriod under to 49) first year	he 21st	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00	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) HRBR 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) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ration) Adjuriod under te 49) first year fuctions)	he 21st	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	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) HRBR 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) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	ration) Adjuriod under te 49) first year fuctions)	he 21st	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00 213. 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) HRBR 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) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	ration) Adjuriod under to 49) first year fuctions) line 59)	of the current	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 212. 00 213. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00 213. 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) HRBR 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) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	ration) Adjuriod under to 49) first year fuctions) line 59)	of the current	0.0000000000000000000000000000000000000	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0034	From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 10:33 am

	Title Will	11/23/2021 10:	33 am
	Title XVIII Hospital	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	23, 018	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	28, 713, 481	2. 00
3.00	OPPS payments	29, 751, 140	3. 00
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)	28, 146 0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5. 00
6. 00	Line 2 times line 5	0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7. 00
8.00	Transitional corridor payment (see instructions)	0	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	57, 289	9. 00
10.00	Organ acqui si ti ons	0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	23, 018	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
12. 00	Reasonable charges Ancillary service charges	116, 990	12 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	116, 990	14. 00
	Customary charges		
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)		47.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	116, 990 93, 972	18. 00 19. 00
19.00	instructions)	93, 972	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	o	20. 00
	instructions)		
21. 00	Lesser of cost or charges (see instructions)	23, 018	21. 00
22. 00	Interns and residents (see instructions)	0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	29, 836, 575	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	0	25. 00
26. 00	Deductibles and Coinsurance amounts (for CAH, see instructions)	5, 452, 469	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	24, 407, 124	
	instructions)	,,	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)	24, 407, 124	30. 00
31.00	Primary payer payments	14, 193	31.00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	24, 392, 931	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
34. 00	Allowable bad debts (see instructions)	591, 715	
35. 00	Adjusted reimbursable bad debts (see instructions)	384, 615	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	274, 165	36.00
37.00	Subtotal (see instructions)	24, 777, 546	
38. 00	MSP-LCC reconciliation amount from PS&R	57	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)	_	39. 50
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98 39. 99	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	24, 777, 489	39. 99 40. 00
40. 00	Sequestration adjustment (see instructions)	24, 777, 489	40. 00
40. 02	Demonstration payment adjustment amount after sequestration	l ől	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs		40. 03
41.00	Interim payments	24, 765, 538	41.00
41. 01	Interim payments-PARHM		41. 01
42.00	Tentative settlement (for contractors use only)	0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)		42. 01
43.00	Balance due provi der/program (see instructions)	11, 951	43.00
43. 01	Balance due provider/program-PARHM (see instructions)	0	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44. 00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)	Ö	91. 00
92.00	The rate used to calculate the Time Value of Money	0.00	92. 00
93. 00	Time Value of Money (see instructions)	0	93. 00
94. 00	Total (sum of lines 91 and 93)	0	94. 00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Peri od:	Worksheet E
		Component CCN: 15-T034	From 07/01/2020 To 06/30/2021	Date/Time Prepared:
				11/23/2021 10:33 am
		Title XVIII	Subprovi der -	PPS

		litle XVIII	Subprovi der -	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
00	Medical and other services (see instructions)			0	1.0
00	Medical and other services reimbursed under OPPS (see instruction	ns)		761	1
00	OPPS payments Outlier payment (see instructions)			155 0	
01	Outlier reconciliation amount (see instructions)			0	
00	Enter the hospital specific payment to cost ratio (see instruction	ons)		0. 000	
00	Line 2 times line 5			0	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV,	col 12 lino 200		0	1
00	Organ acquisitions	cor. 13, True 200		0	1
. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	1
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges			0	12.
2. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	
	Total reasonable charges (sum of lines 12 and 13)	07)		0	1
	Customary charges				
. 00	Aggregate amount actually collected from patients liable for payr		9	0	
. 00	Amounts that would have been realized from patients liable for partial had such payment been made in accordance with 42 CFR §413.13(e)	ayment for services o	n a chargebasis	0	16.
00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.
. 00	Total customary charges (see instructions)			0	1
. 00	Excess of customary charges over reasonable cost (complete only i	if line 18 exceeds li	ne 11) (see	0	19.
00	instructions)	if line 11 everede li	no 10) (coo	0	20.
00	Excess of reasonable cost over customary charges (complete only instructions)	II TITIE IT EXCEEUS IT	11e 16) (See	U	20.
. 00	Lesser of cost or charges (see instructions)			0	21.
	Interns and residents (see instructions)			0	1
	Cost of physicians' services in a teaching hospital (see instruc-	tions)		0	
00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			155	24.
00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.
00	Deductibles and Coinsurance amounts relating to amount on line 24	4 (for CAH, see instr	uctions)	31	26.
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	s the sum of lines 22	and 23] (see	124	27.
00	instructions) Direct graduate medical education payments (from Wkst. E-4, line	50)		0	28.
00	ESRD direct medical education costs (from Wkst. E-4, line 36)	30)		0	1
	Subtotal (sum of lines 27 through 29)			124	1
. 00	Primary payer payments			0	
. 00	Subtotal (line 30 minus line 31)	\		124	32.
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11))		0	33.
	Allowable bad debts (see instructions)			Ö	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see instruc-	tions)		0	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			124 0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50	Pioneer ACO demonstration payment adjustment (see instructions)			_	39.
97	Demonstration payment adjustment amount before sequestration			0	1
98	Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	0	
99 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 124	
	Sequestration adjustment (see instructions)			0	1
02	Demonstration payment adjustment amount after sequestration			0	1
	Sequestration adjustment-PARHM pass-throughs				40.
	Interim payments			124	1
00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 42.
01	Tentative settlement-PARHM (for contractor use only)			o l	42.
00	Balance due provider/program (see instructions)			0	1
01	Balance due provider/program-PARHM (see instructions)				43.
00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	44.
	§115.2 TO BE COMPLETED BY CONTRACTOR				1
00	Original outlier amount (see instructions)			0	90.
	Outlier reconciliation adjustment amount (see instructions)			Ö	
00	The mate wood to calculate the Time Value of Meney			0.00	92.
	The rate used to calculate the Time Value of Money				
00 00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0034 Peri od: Worksheet E-1 From 07/01/2020 Part I 06/30/2021 Date/Time Prepared: 11/23/2021 10:33 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 36, 745, 587 24, 334, 077 1. 00 2.00 Interim payments payable on individual bills, either 387, 416 431, 461 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 3.02 0 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3. 52 3.52 3.53 0 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 Ω 3.99 3.50-3.98) 37, 133, 003 24, 765, 538 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1)

393, 775

Contractor

Number

1 00

37, 526, 778

0

11, 951

24, 777, 489

NPR Date (Mo/Day/Yr)

2 00

0

6.01

6.02

7.00

8.00

SETTLEMENT TO PROVIDER

Total Medicare program liability (see instructions)

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

6.01

6 02

7.00

Component CCN: 15-T034

Subprovi der -Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		6, 501, 775		124	1.00
2.00	Interim payments payable on individual bills, either		C		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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			ı		
3. 01 3. 02	ADJUSTMENTS TO PROVIDER		C		0 0	3. 01 3. 02
3. 02			0		0	3. 02
3. 04			0		0	3. 04
3. 05			O			3. 05
0.00	Provider to Program				0	0.00
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3.52			C		0	3. 52
3.53			C		0	3. 53
3. 54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		6, 501, 775		124	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		0, 501, 775		124	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR			"	•	
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider TENTATIVE TO PROVIDER			1		F 01
5. 01 5. 02	TENTATIVE TO PROVIDER		0		0 0	5. 01 5. 02
5. 02			0			5. 02
0.00	Provider to Program			1	0	0.00
5. 50	TENTATI VE TO PROGRAM		C)	0	5. 50
5. 51			C)	0	5. 51
5. 52			C)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
/ 00	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		80, 115		o	6. 01
6. 02	SETTLEMENT TO PROGRAM		00, 113			6. 02
7. 00	Total Medicare program liability (see instructions)		6, 581, 890		124	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00		()	1. 00	2.00	0.00
8. 00	Name of Contractor			1		8. 00

Heal th	Financial Systems ST. MARY MEDICAL (CENTER, INC.	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0034	Peri od: From 07/01/2020 To 06/30/2021		epared:	
	Title XVIII Hospital					
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			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	3-12			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 I				6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I		7. 00	
8. 00	line 168				8. 00	
	Calculation of the HIT incentive payment (see instructions)				9. 00	
9. 00 10. 00	Sequestration adjustment amount (see instructions)	(ass i not must lone)			10.00	
10.00	Calculation of the HIT incentive payment after sequestration	(See Thistructions)			10.00	
20.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				30.00	
	Initial/interim HIT payment adjustment (see instructions) Other Adjustment (specify)				30.00	
31.00	, , , , , , , , , , , , , , , , , , , ,	ino 21) (coo instruction	26)		31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	The 31) (See Instruction	15)		j 32.00	

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Peri od:	Worksheet E-3	
			From 07/01/2020	Part III	
		Component CCN: 15-T034	To 06/30/2021		
				11/23/2021 10	:33 am_
		Title XVIII	Subprovi der -	PPS	
			I RF		

	IRF		
		1.00	
	DADT LLL MEDICADE DADT A SEDVICES LDE DOS	1.00	
1. 00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)	6, 414, 382	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0, 414, 382	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	240, 539	3.00
4. 00	Outlier Payments	48, 270	
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or price		5.00
3.00	to November 15, 2004 (see instructions)	0.00	3.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6. 00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	1	7. 00
7.00	teaching program" (see instructions)	0.00	7.00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	8. 00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	14. 895890	10.00
11. 00	Teaching Adjustment Factor (see instructions)	0.000000	11. 00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	6, 703, 191	13.00
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15. 00	Organ acquisition (DO NOT USE THIS LINE)		15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	6, 703, 191	17. 00
18. 00	Primary payer payments	35, 393	
19. 00	Subtotal (line 17 less line 18).	6, 667, 798	
20. 00	Deducti bl es	39, 004	
21. 00	Subtotal (line 19 minus line 20)	6, 628, 794	
22. 00	Coinsurance	46, 947	
23. 00		6, 581, 847	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	0	25. 00
26. 00	, ,	0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	6, 581, 847	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	43	
30. 00	Outlier payments reconciliation	0	30. 00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	l ol	
31. 99	Demonstration payment adjustment amount before sequestration	l ol	
32. 00	Total amount payable to the provider (see instructions)	6, 581, 890	
32. 01	Sequestration adjustment (see instructions)	0	
32. 02	Demonstration payment adjustment amount after sequestration	l ol	32. 02
33. 00	Interim payments	6, 501, 775	
34. 00	Tentative settlement (for contractor use only)	0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	80, 115	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36. 00
00.00	§115. 2	١	00.00
	TO BE COMPLETED BY CONTRACTOR		
50. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4	48, 270	50. 00
	Outlier reconciliation adjustment amount (see instructions)	0	51. 00
52. 00	The rate used to calculate the Time Value of Money	0.00	
	Time Value of Money (see instructions)	0	
			•

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0034	Peri od: Worksheet E-3 From 07/01/2020 Part VII To 06/30/2021 Date/Time Prepared:

			06/30/2021	Date/lime Pre 11/23/2021 10	
		Title XIX	Hospi tal	PPS	. 00 am
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		1, 538, 666		8. 00
9.00	Ancillary service charges		3, 539, 101	0	9. 00
10. 00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		5, 077, 767	0	12. 00
40.00	CUSTOMARY CHARGES	<u>-</u>			40.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14. 00	basis Amounts that would have been realized from nationts liable for	normant for carriage on	0	0	14. 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 4		٩	Ü	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		5, 077, 767	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	5, 077, 767	0	17. 00
17.00	line 4) (see instructions)	y IT TITLE TO EXCECUS	0,077,707	· ·	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	v if line 4 exceeds line	o	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		o	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	o	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1	(6)	0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	
	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
	The second section is the second seco		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		1, 570	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		1, 570	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		1, 570	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1 0	0	20.00
30. 00 31. 00	Excess of reasonable cost (from line 18)		0 1, 570	0	30. 00 31. 00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		1,570	0	31.00
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
			0	O	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	1, 570	0	36. 00
	TO ZERO OUT SETTLEMENT, SINCE NO ADD	. 33)	-1, 570	0	37. 00
	Subtotal (line 36 ± line 37)		1, 3, 0	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		o	Ü	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		o	0	40. 00
41. 00	Interim payments		o	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		O	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				
			·		

Health Financial Systems	ST. MARY MEDICAL C	CENTER, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Peri od: From 07/01/2020	Worksheet E-3
		Component CCN: 15-T034		Date/Time Prepared: 11/23/2021 10:33 am
		Title XIX	Subprovi der -	PPS

		TI LI E XIX	I RF	PPS	
			Inpati ent	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	/ICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		. 02.111.020		
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0	_	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		o	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		'		
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		0		8. 00
9.00	Ancillary service charges		63, 267	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		63, 267	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis				
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16. 00	Total customary charges (see instructions)		63, 267	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	63, 267	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds line	0	0	18. 00
40.00	16) (see instructions)				40.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	21. 00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide		0	22.00
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00 24. 00
24. 00 25. 00	Program capital payments Capital exception payments (see instructions)				25. 00
26. 00	1		0	0	26. 00
27. 00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)			0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		ı o	U	29.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31. 00
32. 00	Deductibles		l o	Ö	32. 00
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		l o	0	34. 00
35. 00	Utilization review		o	Ŭ.	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	o	0	36. 00
37. 00	TO ZERO OUT SETTLEMENT	,	o	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		o	-	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		o	0	40. 00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Health Financial Systems ST. MARY MEDI BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provi der CCN: 15-0034

Peri od: Worksheet G From 07/01/2020 To 06/30/2021 Date/Ti me Prepared: 11/23/2021 10: 33 am

oni y)					11/23/2021 10	0: 33 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4.00	
	CURRENT ASSETS		I	J .	Γ	
1. 00 2. 00	Cash on hand in banks Temporary investments	2, 898		0 0	0	
3.00	Notes receivable					
4. 00	Accounts receivable	34, 966, 257		0	Ö	
5.00	Other recei vable	0	(0	O	
6.00	Allowances for uncollectible notes and accounts receivable	0	(0	0	1
7.00	Inventory	9, 253, 981	(0	0	
8. 00 9. 00	Prepaid expenses Other current assets	0			0 1 0	
10.00	Due from other funds	2, 308, 704	1			
11. 00	Total current assets (sum of lines 1-10)	46, 531, 840	1	o o	1	
	FIXED ASSETS					
12.00	Land	0		0		•
13.00	Land improvements	0	1	0	1	
14. 00 15. 00	Accumulated depreciation Buildings	122, 930, 218		0 0		
16. 00	Accumulated depreciation	122, 930, 210	1			
17. 00	Leasehold improvements	Ö		-	Ö	
18.00	Accumul ated depreciation	0	(0	0	18. 00
19. 00	Fi xed equipment	0	(0	0	
20.00	Accumulated depreciation	0	(0	0	
21. 00 22. 00	Automobiles and trucks	0	1	0 0		
23. 00	Accumulated depreciation Major movable equipment	0	1			
24. 00	Accumulated depreciation	ا			ĺ	
25. 00	Mi nor equipment depreciable	Ō		0	Ö	
26.00	Accumulated depreciation	0		0	0	
27. 00	HIT designated Assets	0	(0	0	
28. 00	Accumulated depreciation	0		0	0	
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	122, 930, 218	1	0 0		
30.00	OTHER ASSETS	122, 730, 210	1	5 0		30.00
31.00	Investments	0	(0 0	С	31.00
32.00	Deposits on Leases	0		0		
33. 00	Due from owners/officers	0	(٦	0	1
34. 00	Other assets	10, 234, 844	1	٥	0	
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	10, 234, 844 179, 696, 902				
30. 00	CURRENT LIABILITIES	177,070,702		51 0		30.00
37. 00	Accounts payable	1, 567, 261	(0 0	0	37. 00
38. 00	Salaries, wages, and fees payable	10, 355, 032	(0	0	
39. 00	Payroll taxes payable	0	(0	0	•
40.00	Notes and Loans payable (short term)	0		0		
41. 00 42. 00	Deferred income Accel erated payments	0		J		41. 00
43. 00	Due to other funds	0		0	O	
44.00	Other current liabilities	38, 344, 507		0	l	
45. 00	Total current liabilities (sum of lines 37 thru 44)	50, 266, 800	(0	0	45. 00
	LONG TERM LIABILITIES	ı .	T.	J .	Г	
46. 00	Mortgage payable	0		9	0	
47. 00 48. 00	Notes payable Unsecured Loans	0	•	0 0		1
49. 00	Other long term liabilities	15, 116, 622				
50.00	Total long term liabilities (sum of lines 46 thru 49)	15, 116, 622	ı		l	
51.00	Total liabilities (sum of lines 45 and 50)	65, 383, 422		0	0	51.00
	CAPI TAL ACCOUNTS	,		_		
52. 00	General fund balance	114, 313, 480	1			52. 00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		(53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				o	
58.00	Plant fund balance - reserve for plant improvement,				O	
==	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	114, 313, 480	1	0	0	
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	179, 696, 902		0 ا	O	60.00
	1 - 7	ı	1	ı	ı	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0034

					To 06/30/2021		
		Genera	I Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		118, 646, 590 53, 140, 791		(1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		171, 787, 381				3. 00
4. 00	Additions (credit adjustments) (specify)	0	.,,,,,,,,,,		0	o	4. 00
5.00	NET ASSETS RELASED	6, 000			0	0	5. 00
6.00	CONTRI BUTI ONS	41, 000			0	0	6. 00
7. 00 8. 00	ROUNDI NG	99			0	0	7. 00 8. 00
9. 00		0			0		9. 00
10.00	Total additions (sum of line 4-9)		47, 099		(10.00
11. 00	Subtotal (line 3 plus line 10)		171, 834, 480		`		11. 00
12. 00 13. 00	Deductions (debit adjustments) (specify) TRANSFER FUNDS	57, 487, 000			0	0	12. 00 13. 00
14. 00	ASSETS RELEASED	34, 000			0		14. 00
15. 00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00	Total deductions (our of lines 12 17)	0	F7 F21 000		0	0	17. 00 18. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		57, 521, 000 114, 313, 480				19. 00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00	_		
1. 00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0		3. 00 4. 00
5. 00	NET ASSETS RELASED		0				5. 00
6.00	CONTRI BUTI ONS		0				6.00
7.00	ROUNDI NG		0				7. 00
8. 00 9. 00			0				8. 00 9. 00
10. 00	Total additions (sum of line 4-9)	0	0		0		10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13. 00 14. 00	TRANSFER FUNDS		0				13. 00 14. 00
15. 00	ASSETS RELEASED		0				14. 00 15. 00
16. 00			o				16. 00
17. 00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	0			0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00
	Tenede (Time II minus Time 10)	1		ı	1	ı	

Health Financial Systems ST. STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0034

			10	00/30/2021	11/23/2021 10:	
	Cost Center Description	Inpatier	nt	Outpati ent	Total	
	·	1.00		2. 00	3.00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	66, 884	, 485		66, 884, 485	1. 00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF	7, 510	, 355		7, 510, 355	3. 00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	74, 394	, 840		74, 394, 840	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	14, 980	, 273		14, 980, 273	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines 14, 980	, 273		14, 980, 273	16.00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	89, 375	, 113		89, 375, 113	17.00
18.00	Ancillary services	339, 946	, 810	0	339, 946, 810	18.00
19. 00	Outpati ent servi ces		0	732, 080, 253	732, 080, 253	19. 00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22.00	HOME HEALTH AGENCY			4, 603, 231	4, 603, 231	22. 00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25. 00	AMBULATORY SURGI CAL CENTER (D. P.)					25. 00
26.00	HOSPI CE					26.00
27.00	PHYSICIAN OFFICES		557	1, 226, 934	1, 227, 491	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst. 429, 322	, 480	737, 910, 418	1, 167, 232, 898	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			261, 614, 909		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 (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40.00		1	0			40. 00
41. 00			0			41. 00
42.00	Total deductions (sum of lines 37-41)	1		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		261, 614, 909		43.00
	to Wkst. G-3, line 4)	1				

	Financial Systems ST. MARY MEDICAL		In Lie	u of Form CMS-2	
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0034	Peri od:	Worksheet G-3	
			From 07/01/2020	Doto/Time Drop	aanad.
			To 06/30/2021	Date/Time Prep 11/23/2021 10	
	<u> </u>			1172372021 10	JJ dili
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		1, 167, 232, 898	1. 00
2.00	Less contractual allowances and discounts on patients' accou	•		861, 961, 707	2. 00
3.00	Net patient revenues (line 1 minus line 2)			305, 271, 191	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	2 43)		261, 614, 909	4. 00
5.00	Net income from service to patients (line 3 minus line 4)	,		43, 656, 282	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			477, 495	6. 00
7.00	Income from investments			132, 794	7. 00
8.00	Revenues from telephone and other miscellaneous communicatio	n services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10. 00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			864, 021	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			6, 017	21.00
22. 00	Rental of hospital space			1, 053, 349	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER OPERATING INCOME			94, 457	24.00
24. 02	RELEASED TEMP ASSETS			28, 486	24. 02
24. 03	UBI INCOME			184, 311	24. 03
24. 05	CLASSES			37, 774	24. 05
24. 07	GAIN ON SALE OF ASSETS			57, 376	
24. 08	ROUNDI NG			0	24. 08
24. 50	COVI D-19 PHE Fundi ng			6, 548, 429	
25. 00	Total other income (sum of lines 6-24)			9, 484, 509	25. 00
26 00	Total (line 5 plus line 25)			53 140 791	26 00

9, 484, 509 25. 00 53, 140, 791 26. 00 0 27. 00 0 28. 00

53, 140, 791 29. 00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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

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

0

0

0

2, 970, 977

Ω

-485

O

0

2, 970, 492

23 00

23.50

24.00

All Others (specify)

24.00 Total (sum of lines 1-23)

Tel emedi ci ne

23.00

23. 50

Heal th	Financial Systems	57	Γ. MARY MEDICAL	CENTER INC		Inlie	u of Form CMS-2	2552_10
	LLOCATION - HHA GENERAL SERVICE		. WATER MEDITORIE	Provider C	CN: 15-0034 15-7313	Peri od: From 07/01/2020 To 06/30/2021	Worksheet H-1 Part I Date/Time Pre	pared:
						Home Health	11/23/2021 10 PPS	:33 am
					1	Agency I		
			Capital Rela	ated Costs				
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fixtures	Movable Equipment	PI ant Operation & Maintenance		Subtotal (cols. 0-4)	
		0	1.00	2. 00	3.00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	O		I		0	1.00
2. 00	Fixtures Capital Related - Movable Equipment	0		C			0	
3. 00 4. 00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3. 00 4. 00
5.00	Administrative and General	930, 896	Ö	0	1	0 0	930, 896	1
	HHA REIMBURSABLE SERVICES	0/4 450	ما		ı		0/4 152	
6. 00 7. 00	Skilled Nursing Care Physical Therapy	864, 153 723, 962	0	0	1	0 0	864, 153 723, 962	
8. 00	Occupati onal Therapy	165, 483	Ö	0		0 0	165, 483	
9.00	Speech Pathology	45, 286	0	0		0 0	45, 286	
10. 00 11. 00	Medical Social Services Home Health Aide	0 127, 545	0	0		0 0	0 127, 545	
12. 00	Supplies (see instructions)	113, 167	Ö	0		0 0	113, 167	1
13.00	Drugs	0	0	0	1	0		13.00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	1	0 0	0	14. 00
15. 00	Home Dialysis Aide Services	0	0	C		0 0	0	15. 00
16. 00	Respi ratory Therapy	0	0	0		0 0	0	
17. 00 18. 00	Private Duty Nursing Clinic	0	0	0		0 0	0	
19. 00	Health Promotion Activities	0	0	0		0 0	0	1
20. 00	Day Care Program	О	0	0		0 0	0	
21. 00	Home Delivered Meals Program	0	0	0		0 0	0	
22. 00 23. 00	Homemaker Service All Others (specify)		0	0		0 0	0	
23. 50	Tel emedi ci ne	Ö	Ö	0		0 0	Ö	
24. 00	Total (sum of lines 1-23)	2, 970, 492	0	0		0 0	2, 970, 492	24. 00
		Administrative & General	Iotal (cols. 4A + 5)					
		5. 00	6.00					
1 00	GENERAL SERVICE COST CENTERS	I						1 00
1. 00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2. 00
3. 00	Equipment Plant Operation & Maintenance							3. 00
4.00	Transportation							4. 00
5.00	Administrative and General	930, 896						5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	394, 410	1, 258, 563					6. 00
7. 00	Physical Therapy	330, 425	1, 054, 387					7. 00
8.00	Occupational Therapy	75, 528	241, 011					8. 00
9. 00 10. 00	Speech Pathology Medical Social Services	20, 669	65, 955 0					9. 00 10. 00
11. 00	Home Heal th Ai de	58, 213	185, 758					11. 00
12.00	Supplies (see instructions)	51, 651	164, 818					12. 00
13.00	Drugs	0	0					13.00
14. 00	HHA NONREI MBURSABLE SERVI CES	0	0					14. 00
15. 00	Home Dialysis Aide Services	0	0					15. 00
16.00	Respiratory Therapy	0	0					16.00
17. 00 18. 00	Private Duty Nursing Clinic	0	0					17. 00 18. 00
19. 00	Health Promotion Activities	o o	Ö					19. 00
20.00	Day Care Program	0	0					20.00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0					21. 00 22. 00
	All Others (specify)		0					23. 00
23. 50	Tel emedi ci ne	0	О					23. 50
24. 00	Total (sum of lines 1-23)	l l	2, 970, 492					24. 00

	<u>Financial Systems</u> LLOCATION - HHA STATISTICAL BAS		T. MARY MEDICAL	Provi der C		Peri od:	u of Form CMS-2 Worksheet H-1	
				HHA CCN:		From 07/01/2020 To 06/30/2021	Part II Date/Time Prep 11/23/2021 10	
						Home Health	PPS	. 00 a
		Canital Bol	ated Costs			Agency I		
		Capital Rei	ateu costs					
		BI dgs &	Movabl e	PI ant		nReconciliation		
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& 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		
1. 00	Capital Related - Bldg. & Fixtures	0				0		1. 00
2. 00	Capital Related - Movable		0			0		2. 00
2.00	Equi pment		0					2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3. 00
4.00	Transportation (see	0	0	0		0		4. 00
	instructions)							
5. 00	Administrative and General	0	0	0		0 -930, 896	2, 039, 596	5. 00
	HHA REIMBURSABLE SERVICES	0	0	0		0 0	0(4 152	/ 00
6. 00 7. 00	Skilled Nursing Care Physical Therapy		0			0 0	864, 153 723, 962	
8. 00	Occupati onal Therapy	0	0	0		0 0	165, 483	
9. 00	Speech Pathology	0	0	0		0 0	45, 286	
10.00	Medical Social Services	Ö	0	0		0 0	0	10.00
11.00	Home Health Aide	0	0	0		0 0	127, 545	11. 00
12.00	Supplies (see instructions)	0	0	0		0 0	113, 167	12. 00
13.00	Drugs	0	0	0		0	0	
14. 00	DME	0	0	0		0 0	0	14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		ol o	0	15. 00
16. 00	Respiratory Therapy		0			0 0	0	16. 00
17. 00	Private Duty Nursing	0	0	0		0 0	0	
18. 00	Clinic	Ö	0	Ö		o o	Ö	18. 00
19. 00	Health Promotion Activities	Ō	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	21. 00
22.00	Homemaker Service	0	0	0		0	0	22. 00
23. 00	All Others (specify)	0	0	0		0	0	23. 00
23. 50	Telemedicine	0	0	0	•	0 030 004	0 000 504	23. 50
24. 00 25. 00	Total (sum of lines 1-23) Cost To Be Allocated (per	0	0	0		0 -930, 896	2, 039, 596	
23.00	Worksheet H-1, Part I)					ا	930, 896	25. 00
	mor Konock II I, Turk I)		l	l	I	1		

From 07/01/2020 To 06/30/2021 HHA CCN: 15-7313

Home Health

						Agency I	113	
			CAPI TAL REI	LATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	ADMI TTI NG	
		0	1.00	2.00	4. 00	5. 01	5. 02	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 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 20 minus	0 1, 258, 563 1, 054, 387 241, 011 65, 955 0 185, 758 164, 818 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, 878 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	147, 232 135, 446 118, 229 27, 559 4, 389 0 17, 652 0 0 0 0 0 0	59 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12, 615 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 50 20. 00 21. 00
	column 26, line 1, rounded to 6 decimal places. Cost Center Description	CASHI ERI NG/ACC	Subtotal	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		OUNTS RECEI VABLE		ADMINISTRATIVE & GENERAL	PLANT	LINEN SERVICE		
	1	5. 03	5A. 03	5. 04	7. 00	8. 00	9. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 17. 00 18. 00 17. 00 19. 00 20. 00 21. 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 20 minus column 26, line 1, rounded to 6 decimal places.	11, 842 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	174, 626 1, 394, 009 1, 172, 616 268, 570 70, 344 0 203, 410 164, 818 0 0 0 0 0 0 0 0 0 0 3, 448, 393 0. 0000000	204, 016 171, 615 39, 306 10, 295 0 29, 769 24, 121 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		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00

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

Worksheet H-2 Part I Date/Time Prepared: 11/23/2021 10:33 am Provider CCN: 15-0034 Peri od: From 07/01/2020 To 06/30/2021 HHA CCN: 15-7313

						Home Health	PPS	. 33 aiii
						Agency I	FF3	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		10. 00	11.00	13. 00	14.00	15. 00	16. 00	
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	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)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 498 6, 414 3, 361 1, 391 271 2, 765 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				11, 943 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	6 decimal places.							
	Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	PARAMEDICAL EDUCATION PROGRAM EMS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		17. 00	19. 00	23. 00	24.00	25.00	26. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 50 20. 00 21. 00	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)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			222, 624 1, 604, 439 1, 347, 592 309, 267 80, 910 235, 944 188, 939 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		222, 624 1, 604, 439 1, 347, 592 309, 267 80, 910 0 235, 944 188, 939 0 0 0 0 0 0 0 0 0 0 3, 989, 715	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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

Home Heal th Agency All ocated HHA A&G (see Part III) 27.00 28.00						11/23/2021 10.33	alli
A&6 (see Part 11)					Home Health Agency I	PPS	
110		Cost Center Description	Allocated HHA	Total HHA			
27.00 28.00		·	A&G (see Part	Costs			
1.00			11)				
2.00 Skilled Nursing Care 94,816 1,699,255 3.00 Physical Therapy 79,639 1,427,231 3.00 5.00 Speech Pathology 4,782 85,692 5.00 6.00 Medical Social Services 0 0 6.00 7.00 Home Health Aide 13,944 249,888 7.00 8.00 Supplies (see instructions) 11,166 200,105 8.00 9.00 Drugs 0 0 9.00 11.00 Home Dialysis Aide Services 0 0 10.00 12.00 Respiratory Therapy 0 0 11.00 12.00 Respiratory Therapy 0 0 12.00 14.00 Clinic 0 0 13.00 15.00 Health Promotion Activities 0 0 15.00 15.00 Home Delivered Meals Program 0 0 15.00 17.00 Home Delivered Meals Program 0 0 19.00 18.00 Home Delivered Meals Program 0 0 19.00 19.00 H			27. 00	28. 00			
3.00 Physical Therapy 79, 639 1, 427, 231 3.00 4.00 Occupati onal Therapy 18, 277 327, 544 4.00 5.00 Speech Pathology 4, 782 85, 692 5.00 6.00 Medical Social Services 0 0 6.00 7.00 Home Heal th Aide 13, 944 249, 888 7.00 8.00 Supplies (see instructions) 11, 166 200, 105 8.00 9.00 Drugs 0 0 9.00 10.00 DME 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 11.00 12.00 Respiratory Therapy 0 0 11.00 13.00 Private Duty Nursing 0 0 12.00 15.00 Health Promotion Activities 0 0 14.00 15.00 Health Promotion Activities 0 0 15.00 16.00 Day Care Program 0 0 0 17.00	1.00	Administrative and General				1.	. 00
4.00 Occupational Therapy 5.00 Speech Pathology 4,782 85,692 5.00 6.00 Medical Social Services 0 0 0 7.00 Home Heal th Aide 13,944 249,888 7.00 8.00 Supplies (see instructions) 11,166 200,105 8.00 9.00 Drugs 0 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 0 11.00 12.00 Respiratory Therapy 0 0 0 11.00 13.00 Private Duty Nursing 0 0 12.00 14.00 Clinic 0 0 0 13.00 15.00 Health Promotion Activities 0 0 0 15.00 16.00 Day Care Program 0 0 0 15.00 17.00 Home Delivered Meals Program 0 0 0 17.00 18.00 Home Delivered Meals Program 0 0 0 17.00 19.00 Ithers (specify) 0 0 17.00 19.50 Telemedicine 0 0 0 19.50 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to	2.00	Skilled Nursing Care	94, 816	1, 699, 255		2.	. 00
4.00 Occupational Therapy 5.00 Speech Pathology 4,782 85,692 5.00 6.00 Medical Social Services 0 0 0 5.00 7.00 Home Heal th Aide 13,944 249,888 7.00 8.00 Supplies (see instructions) 11,166 200,105 8.00 9.00 Drugs 0 0 0 9.00 11.00 Home Dialysis Aide Services 0 0 0 10.00 12.00 Respiratory Therapy 0 0 0 11.00 13.00 Private Duty Nursing 0 0 12.00 14.00 Clinic 0 0 0 13.00 15.00 Health Promotion Activities 0 0 0 15.00 16.00 Day Care Program 0 0 0 15.00 17.00 Home Delivered Meals Program 0 0 0 15.00 18.00 Homemaker Service 0 0 0 19.00 19.00 Total (sum of lines 1-19) (2) 222, 624 3, 989, 715 20.00 Total (sum of lines 1-19) (2) 222, 624 0 0.05 21.00 Unit Cost Multiplier: column 26, line 1, rounded to	3.00	Physical Therapy	79, 639	1, 427, 231		3.	. 00
5.00 Speech Pathology 4,782 85,692 5.00 6.00 Medical Social Services 0 0 6.00 7.00 Home Heal th Aide 13,944 249,888 7.00 8.00 Supplies (see Instructions) 11,166 200,105 8.00 9.00 Drugs 0 0 9.00 10.00 DME 0 0 10.00 11.00 Home Dial ysis Aide Services 0 0 11.00 12.00 Respiratory Therapy 0 0 11.00 13.00 Private Duty Nursing 0 0 13.00 14.00 Clinic 0 0 14.00 15.00 Heal th Promotion Activities 0 0 15.00 16.00 Day Care Program 0 0 16.00 17.00 Home Deli vered Meals Program 0 0 17.00 18.00 Homemaker Service 0 0 19.50 19.50 Tel emedicine	4.00		18, 277	327, 544		4.	. 00
6.00 Medical Social Services 0 0 0 0 0 0 0 0 0	5.00		4, 782			5.	. 00
8. 00 Supplies (see instructions) 11,166 200,105 8.00 9. 00 Drugs 0 0 9.00 10. 00 DME 0 0 10.00 11. 00 Home Dialysis Aide Services 0 0 11.00 12. 00 Respiratory Therapy 0 0 12.00 13. 00 Private Duty Nursing 0 0 13.00 14. 00 Clinic 0 0 14.00 15. 00 Health Promotion Activities 0 0 15.00 16. 00 Day Care Program 0 0 16.00 17. 00 Home Delivered Meals Program 0 0 17.00 18. 00 Homemaker Service 0 0 18.00 19. 50 Tel emedicine 0 0 19.50 20. 00 Total (sum of lines 1-19) (2) 222,624 3,989,715 20.00 21. 00 Unit Cost Multiplier: column of column 26, line 1, rounded to 0.059097 21.00			1			6.	. 00
8. 00 Supplies (see instructions) 11,166 200,105 8.00 9. 00 Drugs 0 0 9.00 10. 00 DME 0 0 10.00 11. 00 Home Dialysis Aide Services 0 0 11.00 12. 00 Respiratory Therapy 0 0 12.00 13. 00 Private Duty Nursing 0 0 13.00 14. 00 Clinic 0 0 14.00 15. 00 Health Promotion Activities 0 0 15.00 16. 00 Day Care Program 0 0 16.00 17. 00 Home Delivered Meals Program 0 0 17.00 18. 00 Homemaker Service 0 0 18.00 19. 50 Tel emedicine 0 0 19.50 20. 00 Total (sum of lines 1-19) (2) 222,624 3,989,715 20.00 21. 00 Unit Cost Multiplier: column of column 26, line 1, rounded to 0.059097 21.00	7. 00	Home Health Aide	13, 944	249, 888		7.	. 00
9.00 Drugs 0 0 10.00 DME 0 0 11.00 Home Dialysis Aide Services 0 0 12.00 Respiratory Therapy 0 0 13.00 Private Duty Nursing 0 0 14.00 Clinic 0 0 15.00 Health Promotion Activities 0 0 16.00 Day Care Program 0 0 18.00 Home Delivered Meals Program 0 0 18.00 Homemaker Service 0 0 19.00 All Others (specify) 0 0 19.50 Telemedicine 0 0 20.00 Total (sum of lines 1-19) (2) 222,624 3,989,715 21.00 Unit Cost Multiplier: column of column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 20 minus column 26, line 20 minus column 26, line 1, rounded to 0	8. 00	Supplies (see instructions)				8.	. 00
10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Home Delivered Meals Program 19.00 Home Delivered Meals Program 19.00 All Others (specify) 19.50 Telemedicine 19.50 Total (sum of lines 1-19) (2) 11.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to			0	0			
11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health 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 10.00 Unit Cost Multiplier: column of column 26, line 1, rounded to			o	0			
12.00 Respiratory Therapy 0 0 0 12.00 13.00 Private Duty Nursing 0 0 13.00 14.00 Clinic 0 0 0 14.00 15.00 Heal th Promotion Activities 0 0 0 15.00 16.00 Day Care Program 0 0 16.00 17.00 Home Delivered Meals Program 0 0 16.00 18.00 Homemaker Service 0 0 0 18.00 19.00 All Others (specify) 0 0 0 19.50 19.50 Telemedicine 0 0 0 19.50 20.00 Total (sum of lines 1-19) (2) 222,624 3,989,715 21.00 Unit Cost Multiplier: column of column 26, line 1 divided by the sum of column 26, line 1, rounded to			o	0			
13.00			o	0			
14.00 Clinic 0 0 15.00 Health Promotion Activities 0 0 16.00 Day Care Program 0 0 17.00 Home Delivered Meals Program 0 0 18.00 Homemaker Service 0 0 19.00 All Others (specify) 0 0 19.50 Tel emedicine 0 0 20.00 Total (sum of lines 1-19) (2) 222,624 3,989,715 21.00 Unit Cost Multiplier: column of column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 2, line 1, rounded to 0 0			o	0			
15.00 Health Promotion Activities 0 0 0 15.00 16.00 Day Care Program 0 0 0 17.00 Home Delivered Meals Program 0 0 0 18.00 Homemaker Service 0 0 0 19.00 All Others (specify) 0 0 19.00 19.50 Telemedicine 0 0 19.50 20.00 Total (sum of lines 1-19) (2) 222,624 21.00 Unit Cost Multiplier: column of column 26, line 1 divided by the sum of column 26, line 1, rounded to 15.00 15.00 0 16.00 17.00 17.00 0 17.00 18.00 18.00 19.00 19.00 19.50 20.00 21.00 21.00 22.00 22.00 22.00 22.00 22.00 23.00 23.00 24.00 24.00 25.00 25.00 25.00 26.00 26.00 26.00 27.00 27.00 27.00 28.00 27.00 29			0	0			
16.00 Day Care Program 0 0 17.00 Home Delivered Meals Program 0 0 18.00 Homemaker Service 0 0 19.00 All Others (specify) 0 0 19.50 Tel emedicine 0 0 20.00 Total (sum of lines 1-19) (2) 222,624 3,989,715 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 0.059097 21.00		1 -	0	0			
17. 00 Home Delivered Meals Program 0 0 17. 00 18. 00 Homemaker Service 0 0 18. 00 19. 00 All Others (specify) 0 0 19. 00 19. 50 Tel emedicine 0 0 19. 50 20. 00 Total (sum of lines 1-19) (2) 222, 624 3, 989, 715 20. 00 21. 00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 0. 059097 21. 00		II .		0			
18.00 Homemaker Service 0 0 19.00 All Others (specify) 0 0 19.50 Telemedicine 0 0 20.00 Total (sum of lines 1-19) (2) 222,624 3,989,715 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 0.059097				0			
19.00 All Others (specify)				0			
19.50 Telemedicine 0 0 19.50 20.00 Total (sum of lines 1-19) (2) 222,624 3,989,715 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 19.50 0 0 19.50 0 20.00 21.00		II .		0			
20.00 Total (sum of lines 1-19) (2) 222,624 3,989,715 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to				0			
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to			222 624	3 989 715			
26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to				0, 707, 710			
of column 26, line 20 minus column 26, line 1, rounded to	21.00					21.	. 00
column 26, line 1, rounded to							
		*					
1 1							
		1 p. 4000.	1	1		ı	

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

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HI	HA COST CENTERS STATISTICAL Provider CCN: 15-0034	Peri od: Worksheet H-2
BASIS		From 07/01/2020 Part II

HHA CCN:

15-7313 To

06/30/2021 Date/Time Prepared:

11/23/2021 10:33 am Home Health PPS Agency I CAPITAL RELATED COSTS MVBLE EQUIP **EMPLOYEE** PURCHASI NG ADMI TTI NG CASHI ERI NG/ACC Cost Center Description BLDG & FIXT RECEIVING AND (SQUARE FEET) (DOLLAR VALUE) **BENEFITS** (GROSS REVE OUNTS **DEPARTMENT STORES** NUE) RECEI VABLE (GROSS (COSTED REQ) (GROSS REVE SALARI ES) NUE) 1.00 2.00 5. 01 5. 02 4.00 5.03 Administrative and General 0 6, 723 4, 602, 391 1.00 789, 935 80 4, 602, 391 1.00 2.00 Skilled Nursing Care 726, 698 2.00 3.00 Physical Therapy 0 0 634, 322 0 0 3.00 Occupational Therapy 0 0 0 147, 860 4.00 0 4.00 0 0 5.00 Speech Pathology 23, 547 5.00 6.00 Medical Social Services 0 0 6.00 0000000 0 0 0 0 7.00 Home Health Aide 94, 705 0 7.00 0 0 8.00 8.00 Supplies (see instructions) C 0 9.00 Drugs C 0 9.00 10.00 DMF 0 0 0 10.00 0 0 11.00 Home Dialysis Aide Services 0 11.00 0 0 12.00 Respiratory Therapy C 12.00 13.00 Private Duty Nursing 13.00 0 0 14.00 Clinic 0 0 0 0 14.00 0 Health Promotion Activities 0 15.00 15.00 16.00 Day Care Program 16.00 0 17.00 Home Delivered Meals Program 0 0 0 0 17.00 0 0 Homemaker Service 18.00 18.00 0 0 0 19.00 All Others (specify) 19.00 0 19.50 Tel emedi ci ne 0 0 0 19.50 Total (sum of lines 1-19) 20.00 6,723 2, 417, 067 80 4, 602, 391 4, 602, 391 20.00 21.00 Total cost to be allocated 2.878 450, 507 59 12, 615 11. 842 21.00 0. 186386 22.00 Unit cost multiplier 0.000000 0. 428083 0.737500 0.002741 0.002573 22.00 Cost Center Description Reconciliation OTHER OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY ADMI NI STRATI VE PLANT LINEN SERVICE (SQUARE FEET) (MEALS SERVED) & GENERAL (SQUARE FEET) (TOTAL PATIENT (ACCUM. COST) DAYS) 9. 00 10.00 5A. 04 7.00 5.04 8.00 1.00 Administrative and General 174, 626 0 0 1.00 2.00 Skilled Nursing Care 0 1, 394, 009 0 0 0 0 0 0 0 0 0 0 2.00 Physical Therapy 0 0 1, 172, 616 0 3.00 3.00 0 0 Occupational Therapy 268, 570 4.00 0 0 4.00 5.00 Speech Pathology 0 70, 344 0 0 5.00 0 0 6.00 Medical Social Services 6.00 0 0 7.00 Home Health Aide 203.410 0 O 7 00 0 0 8.00 Supplies (see instructions) 164, 818 0 8.00 9.00 0 9.00 Drugs 0 0 10.00 DME 0 0 10.00 0 0 0 Home Dialysis Aide Services 11 00 Ω 11 00 0 12.00 Respiratory Therapy 0 12.00 0 0 13.00 Private Duty Nursing 0 0 0 13.00 0 Ω 0 14 00 14 00 Clinic 0 0 15.00 Health Promotion Activities 15.00 0 0 0 0 0 0 0 16.00 16.00 Day Care Program 0 17.00 Home Delivered Meals Program 0 0 17.00 0 0 18 00 Homemaker Service Ω 18 00 19.00 All Others (specify) 0 0 0 0 0 19.00 Tel emedi ci ne 0 0 19.50 19.50 Total (sum of lines 1-19) 3, 448, 393 0 0 0 20.00 20.00 0 504, 679 Total cost to be allocated 0 21 00 0 21 00

0. 146352

0.000000

0.000000

0.000000

0. 000000

22.00

22.00 Unit cost multiplier

Heal th	Financial Systems	S	T. MARY MEDICAL	CENTER, INC.		In Lie	eu of Form CMS-	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTICAL	. Provider CC HHA CCN:	N: 15-0034 15-7313	Period: From 07/01/2020 To 06/30/2021	Worksheet H-2 Part II Date/Time Pre 11/23/2021 10	pared:
						Home Health Agency I	PPS	
	Cost Center Description	CAFETERIA (NUMBER OF FTES)	NURSI NG ADMI NI STRATI ON (NURSI NG HO	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS REVE	SOCIAL SERVICE (TIME SPENT)	
		11.00	URS)	REQUIS.)	45.00	NUE)	17.00	
1. 00	Administrative and General	11. 00 1, 162	13.00	14.00	15. 00	16. 00 0 4, 602, 391	17. 00	1.00
2. 00	Skilled Nursing Care	710	l l	Ö		0 0		1
3.00	Physical Therapy	372	l l	0		0 0	1	
4. 00 5. 00	Occupational Therapy Speech Pathology	154	l l	0		0 0	1	
6. 00	Medical Social Services	0		Ö		0 0	1	
7.00	Home Heal th Ai de	306	1	0		0 0	1	1
8. 00 9. 00	Supplies (see instructions) Drugs		- 1	0		0 0	1	
10. 00	DME		Ö	o		0 0	1	
11.00	Home Dialysis Aide Services	0	0	0		0 0	1	
12. 00 13. 00	Respiratory Therapy Private Duty Nursing			0		0 0	1	
14. 00	Clinic		Ö	o		o c	1	1
15.00	Health Promotion Activities	0	0	0		0 0	1	
16. 00 17. 00	Day Care Program Home Delivered Meals Program			0		0 0	1	1
18. 00	Homemaker Service		Ö	Ö		0 0		1
19.00	All Others (specify)	0	0	0		0 0	1	
19. 50 20. 00	Telemedicine Total (sum of lines 1-19)	2, 734		0		0 0 4, 602, 391	1	
21. 00	Total cost to be allocated	24, 700		Ö		0 11, 943	1	1
22. 00		9. 034382		0. 000000	0.0000	0. 002595	0. 000000	22.00
	Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION PROGRAM EMS (ASSIGNED TIME)					
1. 00	Administrative and General	19. 00	23. 00					1. 00
2.00	Skilled Nursing Care							2.00
3. 00	Physical Therapy	0	o					3. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	0						4. 00 5. 00
6. 00	Medical Social Services		Ö					6. 00
7.00	Home Heal th Aide	0	0					7. 00
8. 00 9. 00	Supplies (see instructions) Drugs		0					8. 00 9. 00
10. 00	DME		1					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12. 00 13. 00	Respiratory Therapy Private Duty Nursing							12. 00 13. 00
14. 00	Clinic		Ö					14. 00
15.00	Health Promotion Activities	0	0					15. 00
16. 00 17. 00	Day Care Program Home Delivered Meals Program							16. 00 17. 00
18. 00	Homemaker Service		o o					18. 00
19.00	All Others (specify)	0	0					19.00
19. 50 20. 00	Telemedicine Total (sum of lines 1-19)							19. 50 20. 00
21. 00	Total cost to be allocated Unit cost multiplier	0. 000000	0. 000000					21. 00

40000	ı Financial Systems	S	T. MARY MEDICAL	. CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
APPOR	TIONMENT OF PATIENT SERVICE COST	S		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:		From 07/01/2020 To 06/30/2021	Part I Date/Time Pre 11/23/2021 10	pared: :33 am
				Ti tl e	: XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs	Shared	Total HHA	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.	
		0	1.00	Part II)	2.00	4.00	4)	
	PART I - COMPUTATION OF LESSER		1.00	2.00	3. 00	4.00	5. 00	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	-ROGRAM COST, AI	JUREUATE OF TH	E PROGRAW LIW	TIATION COST, OF	,	
1.00	Skilled Nursing Care	2.00	1, 699, 255		1, 699, 25	5 11, 312	150. 22	1.00
2. 00	Physical Therapy	3. 00		0				
3.00	Occupational Therapy	4. 00		0				•
4. 00	Speech Pathology	5. 00		0				
5. 00	Medical Social Services	6. 00		_		0 0		
6. 00	Home Heal th Ai de	7. 00			249, 88		l	1
7. 00	Total (sum of lines 1-6)		3, 789, 610	0				7. 00
					Program Visit			
						rt B		1
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t	o Subject to		
	·				Deductibles & Coinsurance	Deductibles		
		0	1.00	2. 00	3.00	4. 00	5. 00	
	Limitation Cost Computation					_		
8.00	Skilled Nursing Care		23844	0				8. 00
9. 00	Physi cal Therapy		23844	0				9. 00
10.00	Occupational Therapy		23844	0	,			10. 00
11. 00	Speech Pathology		23844	0				11. 00
12. 00	Medical Social Services		23844	0		0		12. 00
13.00	Home Heal th Ai de		23844	0	,			13. 00
14. 00	Total (sum of lines 8-13)	- "		0			D 11 (1 0	14. 00
	Cost Center Description		Facility Costs	Shared	Total HHA	Total Charges	Ratio (col. 3	
		Part I, col.	(from Wkst.		Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput			2.00	0.00	11.00	0.00	
15. 00	Cost of Medical Supplies	8. 00	200, 105	0	200, 10	5 214, 576	0. 932560	15. 00
	Cost of Drugs	9. 00		0		o o		16. 00
			Program Visits		Cost of			
					Servi ces			
			Part			Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to	Subject to	
			D 1 + ! - 0					l
				Deductibles &		Deductibles &		
			Coi nsurance	Coi nsurance	_	Coi nsurance	Coi nsurance	
		6. 00	Coi nsurance 7.00	Coi nsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER		Coi nsurance 7.00	Coi nsurance 8.00		Coi nsurance 10.00	Coi nsurance 11.00	
	BENEFICIARY COST LIMITATION		Coi nsurance 7.00	Coi nsurance 8.00		Coi nsurance 10.00	Coi nsurance 11.00	
1 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	Coinsurance 7.00 PROGRAM COST, AG	Coi nsurance 8.00	E PROGRAM LIM	Coinsurance 10.00 ITATION COST, OF	Coi nsurance 11.00	1 00
	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, AG 5,820	Coi nsurance 8.00	E PROGRAM LIM	Coi nsurance 10.00 I TATI ON COST, OI	Coi nsurance 11.00	1. 00
2.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, AG 5, 820 3, 509	Coi nsurance 8.00	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481	Coi nsurance 11.00	2. 00
2. 00 3. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, AG 5,820 3,509 1,551	Coi nsurance 8.00	E PROGRAM LIM	Coi nsurance 10.00 I TATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551	Coi nsurance 11.00	2. 00 3. 00
4.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	OF AGGREGATE F	Coinsurance 7.00 PROGRAM COST, AG 5,820 3,509 1,551 207	Coi nsurance 8.00	E PROGRAM LIM	Coi nsurance 10.00 I TATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 0 40, 965	Coi nsurance 11.00	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	OF AGGREGATE F	Coinsurance 7.00 PROGRAM COST, AG 5,820 3,509 1,551 207 0	Coi nsurance 8.00	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 0 40, 965 0 0	Coi nsurance 11.00	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	OF AGGREGATE F	Coinsurance 7.00 PROGRAM COST, AG 5,820 3,509 1,551 207 0 1,187	Coi nsurance 8.00	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 0 40, 965 0 0 139, 520	Coi nsurance 11.00	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	OF AGGREGATE F	Coinsurance 7.00 PROGRAM COST, AG 5,820 3,509 1,551 207 0 1,187	Coi nsurance 8.00	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 0 40, 965 0 0	Coi nsurance 11.00	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	OF AGGREGATE F	Coinsurance 7.00 PROGRAM COST, AG 5,820 3,509 1,551 207 0 1,187	Coi nsurance 8.00	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 0 40, 965 0 0 139, 520	Coi nsurance 11.00	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, AG 5, 820 3, 509 1, 551 207 0 1, 187 12, 274	Coinsurance 8.00 GGREGATE OF TH	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 40, 965 0 0 139, 520 0 1, 871, 797	Coi nsurance 11.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, AG 5, 820 3, 509 1, 551 207 0 1, 187 12, 274	Coinsurance 8.00 GGREGATE OF TH	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 40, 965 0 0 139, 520 0 1, 871, 797	Coi nsurance 11.00	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 9. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, AG 5, 820 3, 509 1, 551 207 0 1, 187 12, 274	Coinsurance 8.00 GGREGATE OF TH	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 40, 965 0 0 139, 520 0 1, 871, 797	Coi nsurance 11.00	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	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, AG 5, 820 3, 509 1, 551 207 0 1, 187 12, 274	Coinsurance 8.00 GGREGATE OF TH	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 40, 965 0 0 139, 520 0 1, 871, 797	Coi nsurance 11.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, AG 5, 820 3, 509 1, 551 207 0 1, 187 12, 274	Coinsurance 8.00 GGREGATE OF TH	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 40, 965 0 0 139, 520 0 1, 871, 797	Coi nsurance 11.00	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	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, AG 5, 820 3, 509 1, 551 207 0 1, 187 12, 274	Coinsurance 8.00 GGREGATE OF TH	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 40, 965 0 0 139, 520 0 1, 871, 797	Coi nsurance 11.00	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	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, AG 5, 820 3, 509 1, 551 207 0 1, 187 12, 274	Coinsurance 8.00 GGREGATE OF TH	E PROGRAM LIM	Coi nsurance 10.00 ITATI ON COST, OI 0 874, 280 0 657, 481 0 159, 551 40, 965 0 0 139, 520 0 1, 871, 797	Coi nsurance 11.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00

APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provider CO	CN: 15-0034 15-7313	Peri od: From 07/01/2020 To 06/30/2021	Worksheet H-3 Part I Date/Time Pre 11/23/2021 10	pared:
				Title	XVIII	Home Health	PPS	
		Prog	ram Covered Cha	raes	Cost of	Agency I		
		9	. a 5575. 54 51.5	. goo	Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to Deductibles &		Part A	Not Subject to Deductibles &	Subject to Deductibles &	
			Coinsurance	Coinsurance		Coi nsurance	Coinsurance	
		6, 00	7.00	8. 00	9, 00	10.00	11. 00	
	Supplies and Drugs Cost Computa							
	Cost of Medical Supplies	C	194, 058	0		0 180, 971	0	
16. 00	Cost of Drugs		0	0		0	0	16. 00
	Cost Center Description	Total Program						
		Cost (sum of						
		col s. 9-10) 12.00	-					+
	PART I - COMPUTATION OF LESSER		PROGRAM COST A	GGREGATE OF TH	F PROGRAM II	MITATION COST OF)	
	BENEFICIARY COST LIMITATION	or mooneome i	ROGIUM GGGT, 71	CONEONIE OF TH	E TROOM ET	17111011 0001, 01	-	
	Cost Per Visit Computation							1
1.00	Skilled Nursing Care	874, 280						1.00
2.00	Physi cal Therapy	657, 481						2. 00
3.00	Occupational Therapy	159, 551						3.00
4.00	Speech Pathology	40, 965						4.00
5.00	Medical Social Services	C						5.00
6.00	Home Heal th Aide	139, 520						6.00
7.00	Total (sum of lines 1-6) Cost Center Description	1, 871, 797						7. 00
	cost center bescription	12. 00						1
	Limitation Cost Computation	12.00						
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9. 0
10. 00	Occupational Therapy							10.00
11. 00	Speech Pathology							11.0
12.00	Medical Social Services							12. 0
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

Health Financial Systems	S	T. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE CO	STS		Provi der C	CN: 15-0034	Peri od:	Worksheet H-3	
			HHA CCN:	15-7313	From 07/01/2020 To 06/30/2021	Part II Date/Time Pre	narod:
			TITA CON.	13-7313	10 00/30/2021	11/23/2021 10	
			Ti tl e	XVIII	Home Health	PPS	
					Agency I		
Cost Center Descriptio	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 C	OST OF HHA SERVI	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00 Physical Therapy	66. 00	0. 266127	C		0 col. 2, line 2	. 00	1. 00
2.00 Occupational Therapy	67. 00	0. 184258	C)	0 col. 2, line 3	. 00	2. 00
3.00 Speech Pathology	68. 00	0. 402176	C		0 col. 2, line 4	. 00	3. 00
4.00 Cost of Medical Supplies	71. 00	0. 303267	C		0 col. 2, line 1	5. 00	4. 00
5.00 Cost of Drugs	73. 00	0. 180231	C		0 col. 2, line 1	6. 00	5. 00

CULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-0034	Peri od:	Worksheet H-4	255
	HHA CCN:	15-7313	From 07/01/2020 To 06/30/2021	Date/Time Pre	
	Title	XVIII	Home Health Agency I	11/23/2021 10 PPS	: 33
				t B	
		Part A	Not Subject to Deductibles &		
	-		Coi nsurance	Coi nsurance	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MADV CHADGES	1.00	2. 00	3. 00	
Reasonable Cost of Part A & Part B Services	WART CHARGES	,			1
Reasonable cost of services (see instructions)			0 0	0	
Total charges			0 0	0	1
Customary Charges					4
Amount actually collected from patients liable for payment for on a charge basis (from your records)	services		0 0	0	
Amount that would have been realized from patients liable for	payment		o o	0	
for services on a charge basis had such payment been made in a				I	
with 42 CFR §413.13(b)					
Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0. 0000	0.000000	0. 000000 0	1
Excess of total customary charges over total reasonable cost (complete			0	
only if line 6 exceeds line 1)	p. 010			l	
Excess of reasonable cost over customary charges (complete onl	yifline		0 0	0	
1 exceeds line 6)			0 7, 856	0	
Primary payer amounts			0 7,856 Part A	Part B	
			Servi ces	Servi ces	
			1. 00	2. 00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT 10 Total reasonable cost (see instructions)			O	-7, 856	1
0 Total PPS Reimbursement - Full Episodes without Outliers			0	1, 553, 635	
10 Total PPS Reimbursement - Full Episodes with Outliers			0	425, 901	
Total PPS Reimbursement - LUPA Episodes			0	29, 073	1
Total PPS Reimbursement - PEP Episodes			0	3, 516	
10 Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	127, 637	
10 Total PPS Outlier Reimbursement - PEP Episodes 10 Total Other Payments			0	46	1
DME Payments			0	ő	1
Oxygen Payments			0	0	1
Prosthetic and Orthotic Payments			0	0	
Part B deductibles billed to Medicare patients (exclude coinsu	rance)			0	
O Subtotal (sum of lines 10 thru 20 minus line 21) O Excess reasonable cost (from line 8)			0	2, 131, 952 0	
O Subtotal (line 22 minus line 23)			0	2, 131, 952	
O Coinsurance billed to program patients (from your records)				0	
Net cost (line 24 minus line 25)			0	2, 131, 952	2
Reimbursable bad debts (from your records)				I	2
NO Reimbursable bad debts for dual eligible beneficiaries (see in NO Total costs - current cost reporting period (line 26 plus line	,		0	2, 131, 952	2
NO OTHER ADJUSTMENT	: 21)		0	2, 131, 932	
0 Pioneer ACO demonstration payment adjustment (see instructions)		0	0	
Demonstration payment adjustment amount before sequestration	•		0	0	3
O Subtotal (see instructions)			0		
Sequestration adjustment (see instructions)			0	0	1 .
Demonstration payment adjustment amount after sequestration Interim payments (see instructions)			0	0 2, 131, 952	
10 Threfilm payments (see Instructions) 10 Tentative settlement (for contractor use only)			0	2, 131, 952	
o prometative sectionness (not sentillactor asc only)					
Balance due provider/program (line 31 minus lines 31.01, 32, a	nd 33)		0	0	3

In Lieu of Form CMS-2552-10
Worksheet H-5

Heal th Financial Systems ST. MARY MEDICAL CENTER, INC.
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES

Provider C Provider CCN: 15-0034 Peri od: From 07/01/2020 To 06/30/2021 HHA CCN: Date/Time Prepared: 11/23/2021 10:33 am 15-7313

				Home Health Agency I	PPS	<u>00 am</u>
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider			0	2, 131, 952	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	Program to Provider			ol	0	3. 01
3. 02				o	l ol	3. 02
3. 03				O	0	3. 03
3.04				0	0	3. 04
3. 05				0	0	3. 05
2 50	Provider to Program		Γ	ol	0	2 50
3. 50 3. 51				0		3. 50 3. 51
3. 52				Ö	Ö	3. 52
3. 53				O	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4. 00	3.50-3.98)			0	2, 131, 952	4. 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate,			U .	2, 131, 952	4.00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	i rogram to rrovidor			o	0	5. 01
5.02				О	0	5. 02
5.03				0	0	5. 03
F F0	Provider to Program					F F0
5. 50 5. 51				0	0	5. 50 5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			Ö	o o	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER			o	0	6. 01
6. 02	SETTLEMENT TO PROVIDER			0	0	6. 01
7.00	Total Medicare program liability (see instructions)			Ö	2, 131, 952	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	8. 00
0.00	INAME OF COTTLEACTOR			1	ı	0.00

PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT 1.00 Capital DRG other than outlier 1.01 Model 4 BPCI Capital DRG other than outlier 2.802 2.01 Model 4 BPCI Capital DRG other than outlier 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 1.01 Model 4 BPCI Capital DRG outlier payments 3.02 Indirect medical education percentage (see instructions) 1.03 Indirect medical education percentage (see instructions) 1.04 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions) 1.09 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) 8.00 Percentage of Medical patient days to total days (see instructions) 8.00 Allowable disproportionate share adjustment (see instructions) 1.00 Allowable disproportionate share adjustment (see instructions) 1.00 Disproportionate share adjustment (see instructions) 1.00 Total prospective capital payments (see instructions) PRART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) 1.00 Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Program inpatient capital costs (see instructions) An output the cost for	t L	
Title XVIII Hospital P		arod:
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT 1.00 Capital DRG other than outlier 2.00 Capital DRG other than outlier 3.00 Capital DRG outlier payments 3.01 Capital DRG outlier payments 3.07 Capital DRG outlier payments 3.07 Capital Inpatient days divided by number of days in the cost reporting period (see instructions) 3.07 Capital Inpatient days divided by number of days in the cost reporting period (see instructions) 3.07 Capital Inpatient days divided by number of days in the cost reporting period (see instructions) 3.07 Capital Inpatient days divided by number of days in the cost reporting period (see instructions) 3.07 Capital Inpatient days divided by number of days in the cost reporting period (see instructions) 3.07 Capital Inpatient days divided by number of days in the cost reporting period (see instructions) 3.07 Capital Inpatient days divided by number of days in the cost reporting period (see instructions) 3.07 Capital Inpatient days divided by number of days in the cost reporting period (see instructions) 3.07 Capital Inpatient Days divided by number of days in the cost reporting period (see instructions) 3.07 Capital Inpatient days divided by number of days in the cost reporting period (see instructions) 3.07 Capital Inpatient Days divided by number of days in the cost reporting period (see instructions) 3.08 Capital Inpatient Days divided by number of days in the cost reporting period (see instructions) 3.09 Capital Inpatient Days divided by number days to deal days (see instructions) 3.00 Capital Inpatient Days divided by number days to deal days (see instructions) 3.00 Capital Inpatient Capital costs (see instructions) 3.00 Capital Inpatient Capital Costs (see instructions) 3.00 Capital Inpatient Capital Capital Cost (see instructions) 3.00 Capital Inpatient Capital Capital Capital Capital Days divided by number days divi		
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT	PPS	
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT		
CAPITAL FEDERAL AMOUNT CAPITAL FEDERAL CAPITAL FEDERAL CAPITAL FEDERAL CAPITAL CAPIT		
1.00 Capit all DRG other than outlier 2.802 101 Model 4 BPCL Capit all DRG other than outlier 2.01 Capit all DRG outlier payments 22 201 Model 4 BPCL Capit all DRG outlier payments 22 201 Model 4 BPCL Capit all DRG outlier payments 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 11 101		
2 20 Capit all DRG outilier payments 22 21 Model 4 BPCI Capit all DRG outlier payments 70 10 10 10 10 10 10 10	, 465	1.00
Model 4 BPCI Capital DRG outlier payments	0	1. 01
Total inpatient days divided by number of days in the cost reporting period (see instructions) 11	2, 334	2.00
Number of Interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see Instructions)	0	2. 01
Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3. 66	3.00
Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 1 10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see instructions) 11.00 Total prospective capital payments (see instructions) 10.00 Total prospective capital payments (see instructions) 10.00 Part II - Payment under reasonable Cost Program inpatient ancillary capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) 1.00 Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) Part III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) A.00 Applicable exception percentage (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) A.00 Applicable exception percentage (see instructions) A.00 Percentage adjustment for extraordinary circumstances (see instructions) A.00 Capital cost for comparison to payments (line 3 x line 4) A.00 Percentage adjustment for extraordinary circumstances (see instructions) A.00 Capital minimum payment level (line 5 plus line 7) A.00 Current year capital payments (from Part I, line 12, as applicable) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level or capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level or capital payments (line 10 plus line 11)	0.00	4. 00
1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 10.00 More of lines 7 and 8 11.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see instructions) 11.00 Disproportionate share adjustment (see instructions) 11.00 Total prospective capital payments (see instructions) 11.00 PART II - PAYMENT UNDER REASONABLE COST 1.00 Porgam inpatient routine capital cost (see instructions) 1.00 Capital cost payment factor (see instructions) 1.00 Total inpatient program capital cost (line 1 plus line 2) 1.00 Capital cost payment factor (see instructions) 1.00 Porgam inpatient capital costs (see instructions) 1.00 Porgam inpatient capital costs (see instructions) 1.00 Porgam inpatient capital costs (line 1 minus line 2) 1.00 Porgam inpatient capital costs (line 1 minus line 2) 1.00 Porgam inpatient capital costs (line 1 minus line 2) 1.00 Porgam inpatient capital costs (line 1 minus line 2) 1.00 Porgam inpatient capital costs (line 1 minus line 2) 1.00 Porgam inpatient capital costs (line 1 minus line 2) 1.00 Porgam inpatient capital costs (line 1 minus line 2) 1.00 Porgam inpatient capital costs (line 1 minus line 2) 1.00 Porgam inpatient capital costs (line 1 minus line 2) 1.00 Porgam inpatient capital cost (line 3 x line 4) 1.00 Porgam inpatient capital cost (line 3 x line 4) 1.00 Porgam inpatient capital minum payment level (line 3 x line 4) 1.00 Carrover capital payments (from Part I, line 12, as applicable) 1.00 Current year capital payments (from Part I, line 12, as applicable) 1.00 Current year capital payments (from Part I, line 12, as applicable) 1.00 Current year capital payments (from Part I, line 12, as applicable) 1.00 Carrover of accumulated capital minimum payment level or capital payments (line 8 less line 9) 1.00 Carrover of accumulated capital minimum paymen	0.00	5. 00
30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Percentage of Medicaid patient days to total days (see instructions) 10.00 Allowable disproportionate share percentage (see instructions) 112 12.00 Total prospective capital payments (see instructions) 112 12.00 Total prospective capital payments (see instructions) 112 12.00 Total prospective capital payments (see instructions) PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions) Program inpatient program capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 1 plus line 2) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) 1.00 Porgram inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level over capital payments (from prior year Worksheet L, Part III, line 14) Part III (line 10 plus line 10 plus line 11)	0	6. 00
Percentage of Medicaid patient days to total days (see instructions) 1 2 3 3 3 1 3 3 1 3 3 3	3. 43	7. 00
10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see instructions) 112.00 Total prospective capital payments (see instructions) PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions) 2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 1 null plus line 2) 4.00 Program inpatient capital costs (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Capital ininimum payment level for extraordinary circumstances (line 2 x line 6) 6.00 Capital minimum payment level for extraordinary circumstances (line 2 x line 6) 6.00 Carryover of accumulated capital minimum payment level to capital payments (line 8 less line 9) 6.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 6.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	5. 99	8.00
11. 00 Disproportionate share adjustment (see instructions) 12. 00 Total prospective capital payments (see instructions) 2, 937 PART II - PAYMENT UNDER REASONABLE COST	9. 42	9.00
2,937	4. 01	10.00
PART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient routine capital cost (see instructions) 2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		11.00
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1.00 2.00 Program inpatient routine capital cost (see instructions) 2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level over capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		
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4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) Program inpatient capital costs (for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	2.00
Total inpatient program capital cost (line 3 x line 4) DART III - COMPUTATION OF EXCEPTION PAYMENTS	0	3. 00
PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level over capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	4. 00 5. 00
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6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	4. 00
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9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0 0 0.00 0 0.00	8. 00
10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0 0 0.00 0 0.00	
11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0 0 0.00 0 0.00 0	
Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0 0 0.00 0 0.00 0 0	9. 00
12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0 0 0.00 0 0.00 0 0 0	9. 00 10. 00
	0 0 0.00 0 0.00 0 0 0	9. 00
13.00 Journaint year exception payment (if fine 12 is positive, enter the amount on this fille)	0 0.00 0.00 0.00 0 0	9. 00 10. 00
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0 0 0.00 0 0.00 0 0 0	9. 00 10. 00 11. 00

15.00 0 16.00 0 17.00

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

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)