This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0034 Worksheet S Peri od: From 07/01/2021 Parts I-III AND SETTLEMENT SUMMARY 06/30/2022 Date/Time Prepared: 11/22/2022 9:31 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/22/2022 9:31 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low.

[1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[19] 19. NPR Date:
[10] 19. NPR Date:
[10] 19. NPR Date:
[10] 19. NPR Date:
[10] 19. NPR Date:
[11] 19. NPR Date:
[12] 19. NPR Date:
[13] 19. NPR Date:
[14] 19. NPR Date:
[15] 19. NPR Date:
[16] 19. NPR Date:
[17] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19.

number of times reopened = 0-9.

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

(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 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 07/01/2021 and ending 06/30/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	Cost Center Description		Title	XVIII			
			Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY							
1.00	Hospi tal	0	547, 353	19, 797	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	27, 972	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200. 00 Total		0	575, 325	19, 797	0	0	200. 00
The al	pove amounts represent "due to" or "due from"	the applicable	program for th	a alament of t	he above comple	ev indicated	

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.

Contractor use only

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 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/22/2022 9:31 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1500 SOUTH LAKE PARK 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 Ρ 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 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) 07/01/2021 06/30/2022 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 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 Did this hospital receive a geographic reclassification from urban to N 22 03 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 Ν 22.04 rural as a result of the revised OMB delineations 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 23.00 3 Ν 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.

year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.

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

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.

alth Financial Systems ST. MARY N OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		Provi der C		Peri od: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Pre 11/22/2022 9:	pared
			NAHE 413.85 Y/N	Li ne #	Pass-Through Qualification Criterion Code	
			1. 00	2.00	3.00	
Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413.8 instructions) Enter "Y" for yes or "N" for no in coluis "Y", are you impacted by CR 11642 (or subsequent Cladjustement? Enter "Y" for yes or "N" for no in coluing is "Y", and in the subsequent Cladjustement? Enter "Y" for yes or "N" for no in coluing instructions.	35? (s umn 1. R) NAHE nn 2.	ee If column 1 MA payment	Y	Y 23. 00	1	60. (
i nstructi ons)	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4.00	5. 00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 1.02 Enter the current year total unweighted primary care	N			0. 00		61. (
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 determining compliance with the 75% test. (see instructions)						61.
.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)05 Enter the difference between the baseline primary						61. 61.
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) .06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
	Pro	gram Name	Program Cod		Unweighted Direct GME FTE Count	
		1. 00	2. 00	3.00	4. 00	
1.10 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. 1.20 Of the FTEs in line 61.05, specify each expanded				0. 00		61.
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.						
			(UDC:)		1.00	
ACA Provisions Affecting the Health Resources and Seron Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructions)	trai ned			eriod for which	0.00	62.
.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programment of the properties o	Teachi am. (s	ee instructio		o your hospital	0.00	62.

Health Financial Systems	ST. MARY	MEDICAL CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL			F	Period: From 07/01/2021 o 06/30/2022	Worksheet S-2 Part I Date/Time Pre	pared:
		L	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	11/22/2022 9: Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Yea			This base year	is your cost r	reporti ng	
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	ry trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0. 0	0.00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
	-	, and the second	FTEs 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)			0.00	0. 00 Unwei ghted	0.000000 Ratio (col. 1/	65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective f	or cost reporti	ng peri ods	
beginning on or after July 1, 20 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	rovider settings. Ty care resident B the ratio of	0.0	0.00	0. 000000	66. 00
(Coramir I divided by (Cordilli I +	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
	J	ŭ	FTEs Nonprovi der Si te	FTEs in Hospital	(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)			0.0	0. 00	0. 000000	67. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0034 Peri od: Worksheet S-2 From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/22/2022 9:31 am 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.

If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 75.00 Υ 75.00 0 Ν Ν 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 'Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 86.00 \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 87.00 N XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν 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 report either in Ν N 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see 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 and XIX? Enter Ν Ν 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 no in the N N 94.00 applicable column. 95 00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0 00 95 00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν N 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 98.00 N N stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in 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. Ν 98.01 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 Υ 98.02 Ν 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 hospital (CAH) Ν 98.03 reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 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 Ν 98.04 Ν outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Υ 98.05 Ν Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Ν 98.06 Ν Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Ν 105.00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

Health Financial Systems ST. MARY MEDICAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	F	In Lie eriod: rom 07/01/2021 o 06/30/2022	w of Form CMS- Worksheet S- Part I Date/Time Pro	epared:
			V	11/22/2022 9 XI X	31 am
108.00 s this a rural hospital qualifying for an exception to the	CRNA fee scher	dul e2 See 42	1. 00 N	2.00	108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					100.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	-
109.00 of this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109. 00
				1.00	
110.00 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 Worapplicable.	'Y" for yes or	"N" for no. It	ges,	N	110. 00
			1. 00	2, 00	_
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this country. The response to continuous term of the FCHIP demonstration properties and the FCHIP demonstration properties. The response to continuous term of the FCHIP demonstration properties and the response to continuous terms of the response terms of the	ost reporting polumn 1 is Y, erticipating in	period? Enter enter the column 2.	N	2.00	111.00
		1.00	2. 00	3.00	
112.00 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 ceaparticipation in the demonstration, if applicable.	period? s "Y", enter ne	N N	2.00	3.00	112. 00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care in psychiatric, rehabilitation and long term hospitals provider			0115.00		
the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116. 00
117.00 Is this facility legally-required to carry malpractice insurable "Y" for yes or "N" for no.	rance? Enter	Y	•		117. 00
118.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurrence.		1			118. 00
		Premiums	Losses	Insurance	
		1. 00	2.00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00		0 118. 01
			1. 00	2.00	
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.			N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 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 que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "Y' ualifies for th	' for yes or ne Outpatient	N	N	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost impla	antable devices	s charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 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.	N		122. 00		
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	N		125. 00		
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, en			126. 00		
in column 1 and termination date, if applicable, in column 2					
127.00 f this is a Medicare certified heart transplant center, enin column 1 and termination date, if applicable, in column 2			127. 00		
128.00 If this is a Medicare certified liver transplant center, entire in column 1 and termination date, if applicable, in column 2		cation date			128. 00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		cation date in			129. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col		ti fi cati on			130. 00

Health Financial Systems	ST. MARY MEDIC	AL CENTER, INC.		In Lie	eu of Form CM:	S-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CO	CN: 15-0034	Peri od: From 07/01/2021	Worksheet S Part I	-2		
				To 06/30/2022	Date/Time P			
					11/22/2022	9: 31 alli		
121 00 lf this is a Madisons contified in	ataati mal transplant cont	on onton the ex	antification	1. 00	2.00	131. 00		
131.00 If this is a Medicare certified in date in column 1 and termination			ertification			131.00		
132.00 If this is a Medicare certified is in column 1 and termination date,			cation date			132. 00		
133.00 Removed and reserved	тт арргтсавте, тт согиши	1 2.				133. 00		
134.00 If this is an organ procurement of and termination date, if applicable		the OPO number i	in column 1			134. 00		
All Providers	re, TH Corumit 2.							
140.00 Are there any related organization chapter 10? Enter "Y" for yes or				Y	15H054	140. 00		
are claimed, enter in column 2 the								
1.00 If this facility is part of a cha		00	ugh 142 thou	3. 00	of the			
home office and enter the home of				ialle and address	or the			
141.00 Name: COMMUNITY FOUNDATION OF NW INC.	IN, Contractor's Name: N	WPS	Contract	or's Number: 080	01	141. 00		
142.00 Street: 10010 DONALD S POWERS DRIV	E STE PO Box:					142. 00		
201	State:	l N	Zi p Code	e: 463:	21	143. 00		
143.00 Ci ty: MUNSTER	State.	I IV	ZI p code	:. 403.	21	143.00		
144.00 Are provider based physicians' co	sts included in Workshoot	. 42			1. 00 Y	144. 00		
144. OUNT e provider based physicians co.	sts ffici dued ffi worksheet	. A!			ı	144.00		
145 00 f agota for rand garding are a	laimed on Wkat A line 7	// are the cost	- for	1. 00 Y	2.00	145.00		
145.00 f costs for renal services are c inpatient services only? Enter "Y				Y		145. 00		
no, does the dialysis facility in		on for this cost	reporti ng					
period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog		ously filed cost	t report?	N		146. 00		
Enter "Y" for yes or "N" for no in		15-2, chapter	40, §4020) I f	=				
yes, enter the approval date (mm/	du/yyyy) iii corullii 2.							
147 00 Was there a shares in the statist	inal basis? Enter "V" for	on "N" for			1. 00 N	147. 00		
147.00 Was there a change in the statist 148.00 Was there a change in the order o					N N	148. 00		
149.00 Was there a change to the simplif	ed cost finding method?				N Titl VIV	149. 00		
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00			
Does this facility contain a prov			m the application		er of costs			
or charges? Enter "Y" for yes or 155.00 Hospi tal	"N" for no for each compo	onent for Part A N	and Part B. N	(See 42 CFR §41)	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	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	N N	N N	N N	160. 00 161. 00		
101. OOJOWING			Į IV	11	IV	101.00		
Multicampus					1.00			
165.00 Is this hospital part of a Multica	ampus hospital that has o	one or more campu	uses in diffe	erent CBSAs?	N	165. 00		
Enter "Y" for yes or "N" for no.	Nama	County	C+o+o 7:	n Codo CDCA	FTF /Compute			
	Name 0	County 1.00	State Zi	p Code CBSA 3.00 4.00	FTE/Campus 5.00	<u>-</u>		
166.00 If line 165 is yes, for each					0.	00 166. 00		
campus enter the name in column O, county in column 1, state in								
column 2, zip code in column 3,								
CBSA in column 4, FTE/Campus in column 5 (see instructions)						\perp		
					1.00			
Health Information Technology (HI	T) incentive in the Ameri	can Recovery and	d Reinvestme	nt Act	1.00			
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								
168.00 If this provider is a CAH (line 1) reasonable cost incurred for the			e 167 is "Y")	, enter the		168. 00		
168.01 If this provider is a CAH and is	not a meaningful user, do	es this provider				168. 01		
exception under §413.70(a)(6)(ii) 169.00 f this provider is a meaningful					9	99169.00		
transition factor. (see instruction			,	,,	1			

Health Financial Systems	CENTER, INC.	In Lieu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provi der CCN: 15-0034	Peri od:	Period: Worksheet S-2				
			From 07/01/2021	Part I				
			To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared:			
	1. 00	2.00						
170.00 Enter in columns 1 and 2 the EHR beging period respectively (mm/dd/yyyy)			170. 00					
			1. 00	2.00	1			
171.00 If line 167 is "Y", does this provider	N	0	171. 00					
section 1876 Medicare cost plans report								
"Y" for yes and "N" for no in column 1.	n							
1876 Medicare days in column 2. (see in								

)SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0034	In Lie Period: From 07/01/2021 To 06/30/2022		eparec
				Y/N	Date	
	0 11 1 1 5 1 1 1 5 1 1 1 1 5 1 1 1 1 1 1	6 11 110		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	TOT ALL NO TE	esponses. Ente	er all dates in t	tne 	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c		instructions)			1.
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in column		1. 00 N	2. 00	3.00	2.
00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the providual officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3.
			Y/N	Type	Date	
			1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
	Those on the fired financial statements: If yes, submit rec	oner i i ati on.		Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			T	T	
00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	s the provider	- N		6.
00 00	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing programs and/or allied health programs approve		wed during the	Y N		7. 8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		Ü	N		9.
. 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	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.
					Y/N 1. 00	
00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	soo instruct	tions		Υ	12.
	If line 12 is yes, did the provider's bad debt collection piperiod? If yes, submit copy.			ost reporting	N N	13.
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N N	14.
. 00	Did total beds available change from the prior cost reporti		yes, see inst t A		N N T B	15.
		Y/N	Date	Y/N	Date	
	DC4D, D-+-	1. 00	2.00	3. 00	4. 00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.
. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	09/27/2022	Y	09/27/2022	17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.

	Financial Systems ST. MARY MEDICAL AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	V: 15-0034	Peri od: From 07/01/2021	u of Form CMS- Worksheet S-2 Part II	2			
				To 06/30/2022	Date/Time Pre 11/22/2022 9:				
		Descri	oti on	Y/N	Y/N	J			
		0		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. 0			
	Report data for other? bescribe the other adjustments.	Y/N	Date	Y/N	Date				
		1.00	2.00	3. 00	4. 00				
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 0			
	records: IT yes, see Thistructions.								
	COMPLETED BY COST DELMBURGED AND TEEDA HOODITALC ONLY (EVOE	DT CHILDDENC HO	CDL TALC)		1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PI CHILDRENS HO	SPITALS)			-			
22. 00	Have assets been relifed for Medicare purposes? If yes, see	einstructions				22. 0			
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		Is made du	ring the cost		23. 0			
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during t	his cost re	eporting period?		24. 0			
25. 00	Have there been new capitalized leases entered into during instructions.	·	0.			25. 0			
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	•				26. 00 27. 00			
27. 00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. Interest Expense								
28. 00									
9. 00									
80. 00	Has existing debt been replaced prior to its scheduled matu instructions.		ebt? If yes	s, see		30.0			
31. 00									
2. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		through co	ontractual		32.0			
3. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		to competi	itive bidding? If		33. 0			
	Provi der-Based Physi ci ans					١			
	Are services furnished at the provider facility under an ar If yes, see instructions.	· ·	•	. ,		34.0			
5. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		s with the	provi der-based		35. 0			
	priysterans durring the cost reporting perrous in yes, see in	1311 4011 0113.		Y/N	Date				
				1. 00	2. 00				
	Home Office Costs					24.0			
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the h	ome office	?		36. 0 37. 0			
8. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off			f		38.0			
9. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other			S,		39.0			
0. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office? I	f yes, see			40. 0			
	Cost Report Preparer Contact Information	1.0	U	2.	00				
1.00	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			
	respecti vel y.			42.6					
12. 00	Enter the employer/company name of the cost report	COMMUNITY FOUND		42. U					
42. 00 43. 00	preparer.	IN, INC. 12197031267	ATTON OF IN	CATHERI NE. R. WOI	EDNED (OOM)	42. 0			

Heal th	Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-	2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	UESTI ONNAI RE	Provi der C		Peri od:	Worksheet S-2	
					From 07/01/2021 To 06/30/2022		nared·
					10 00/00/2022	11/22/2022 9:	
			3.	00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the tit	tle/position	REIMBURSEMENT	MANAGER			41.00
	held by the cost report preparer in columns	s 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost	t report					42.00
	preparer.						
43.00	Enter the telephone number and email address	ss of the cost					43.00
	report preparer in columns 1 and 2, respect	ti vel y.					
42. 00	Enter the first name, last name and the titheld by the cost report preparer in columns respectively. Enter the employer/company name of the cost preparer. Enter the telephone number and email address	s 1, 2, and 3, t report ss of the cost		00			31 am 41.00 42.00

| Peri od: | Worksheet S-3 | From 07/01/2021 | Part | To 06/30/2022 | Date/Time Prepared:
 Heal th Financial
 Systems
 ST.
 MARY

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

					7	To 06/30/2022	Date/Time Pre 11/22/2022 9:		
							I/P Days / 0/P		ı aiii
							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	T	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		160	58, 400	0.00	0)	1. 00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days)(see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2.00
3.00	HMO IPF Subprovider								3.00
4.00	HMO IRF Subprovider								4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0		6. 00
7. 00	Total Adults and Peds. (exclude observation			160	58, 400	0.00	0)	7. 00
	beds) (see instructions)						_		
8. 00	INTENSIVE CARE UNIT	31. 00		20	7, 300	0.00	0	1	8. 00
9. 00	CORONARY CARE UNIT								9. 00
10. 00	BURN INTENSIVE CARE UNIT								10. 00
11. 00	SURGI CAL INTENSI VE CARE UNI T								11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						_		12. 00
13.00	NURSERY	43. 00		400			0		13. 00
14.00	Total (see instructions)			180	65, 700	0.00			14. 00
15. 00	CAH visits						0		15. 00
16.00	SUBPROVIDER - I PF	44.00		0.0	7 00				16. 00
17. 00	SUBPROVI DER - I RF	41. 00		20	7, 300	7	0		17. 00
18.00	SUBPROVI DER								18.00
19. 00	SKILLED NURSING FACILITY								19. 00
20.00	NURSING FACILITY OTHER LONG TERM CARE								20. 00
21. 00	1	101 00					0		21. 00
22. 00 23. 00	HOME HEALTH AGENCY	101. 00					0		22. 00 23. 00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE								23. 00 24. 00
24. 00	HOSPICE (non-distinct part)	30. 00							24. 00 24. 10
25. 00	CMHC - CMHC	30.00							24. 10 25. 00
26. 00	RURAL HEALTH CLINIC								26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0		26. 00 26. 25
27. 00	Total (sum of lines 14-26)	07.00		200					20. 23 27. 00
28. 00	Observation Bed Days			200			0		28. 00
29. 00	Ambulance Trips						٥		29. 00
30. 00	Employee discount days (see instruction)								30. 00
31. 00	Employee discount days (see l'instruction)								31. 00
32. 00	Labor & delivery days (see instructions)			0					32. 00
32. 00	Total ancillary labor & delivery room			U		1			32. 00 32. 01
52.01	outpatient days (see instructions)							'	02.01
33. 00	LTCH non-covered days								33. 00
	LTCH site neutral days and discharges								33. 01
	1		•		•	1	•	1	-

Provider CCN: 15-0034

B exclude Swing Bed, Observation Bed and Hospice days (see instructions for col. 2 for the portion of LDP room available beds) 12, 192							11/22/2022 9:	31 am_
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed. Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LIDP room available beds) 12, 192 5, 575 2 2 3 3 3 5 5 5 2 2 5 3 3 3 5 5 5 2 2 5 3 3 3 5 5 5 2 2 5 3 5 5 5 5 5 5 5 5			I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
1.00		Component	Title XVIII	Title XIX				
1.00			6.00	7 00				
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1.00	Hospital Adults & Peds. (columns 5. 6. 7 and					10.00	1. 00
3. 00 HMO IPF Subprovider		8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	,	333	0.1, 0.70			
4.00	2.00	HMO and other (see instructions)	12, 192	5, 575				2. 00
5.00	3.00	HMO IPF Subprovider	0	0				3. 00
6.00 Hospital Adults & Peds. Swinğ Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 BURN INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 CAH visits 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 19.00 SWBROVIDER 10.00 OTHER LONG TERM CARE 10.00 OTHER LONG TERM	4.00	HMO IRF Subprovider	841	485				4. 00
7. 00 Total Adults and Peds. (exclude observation beds) (see instructions)			0	0	C			5. 00
BedS) (see instructions) 1,478 222 5,367 8.8 8.00 1NTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.11 12.00 OTHER SPECIAL CARE (SPECIFY) 11.12 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 91 1,498 13.40 Total (see instructions) 13,992 876 38,440 0.00 1,083.86 14.15 15.00 CAH visits 0 0 0 0 0 0 0 0 0	6.00	Hospital Adults & Peds. Swing Bed NF		0	C			6. 00
8. 00 INTENSIVE CARE UNIT 1,478 222 5,367 8,9 9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE (SPECIFY) 12. 00 OUTHER SPECIAL CARE (SPECIFY) 12. 00 OUTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 91 1,498 13. 00 OUTHER SPECIAL CARE (SPECIFY) 12. 00 OUTHER SPECIAL CARE (SPECIFY) 13. 00 OUTHER SPECIAL CARE (SPECIFY) 14. 00 Total (see instructions) 13,992 876 38,440 O. 00 1,083.86 14. 00 OUTHER SPECIAL CARE SUBPROVIDER - IPF 2,969 8 4,890 O. 00 25. 72 17. 16. 00 SUBPROVIDER - IRF 2,969 8 4,890 O. 00 25. 72 17. 18. 18. 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 OUTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 12,087 O 27,598 O. 00 27. 13 22. 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMIRC - CMHC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER O 0 O. 00 O. 00 O. 00 0.	7.00	· ·	12, 514	563	31, 575			7. 00
9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE (SPECIFY) 13.00 NURSERY 91 1,498 13.40 Total (see instructions) 13,992 876 38,440 0.00 1,083.86 14.15.00 CAH visits 0 0 0 0 0 0 1,083.86 14.15.00 SUBPROVIDER - IRF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00		4 470	000	F 0/7			0.00
10. 00 BURN INTENSIVE CARE UNIT 10. 11. 10. 11. 10. SURGICAL INTENSIVE CARE (UNIT 12. 12. 12. 13. 10. 11. 12. 10. 11. 12. 12. 13. 10. 11. 12. 13. 14. 13. 14. 14. 15. 14. 15. 14. 15. 14. 15. 16. 16. 15. 16. 16. 16. 15. 16			1,4/8	222	5, 367			8. 00
11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 13. 99 91 1, 498 15. 00 CAH visits 0 0 0 0 0 1, 083.86 14. 15. 00 CAH visits 0 0 0 0 0 0 1, 083.86 14. 16. 00 SUBPROVI DER - IPF 17. 00 SUBPROVI DER - IRF 18. 00 SUBPROVI DER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 SKILLED NURSING FACILITY 19. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room 32. 01 Total ancillary labor & delivery room 32. 01 Total ancillary labor & delivery room 31. 00 Employee & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room 31. 00 Employee discount days & delivery room 32. 01 Total ancillary labor & delivery room 31. 00 Employee discount days & delivery room 31. 00 Employee discount days & delivery room 31. 10. 11. 498 31. 12. 14. 498 31. 14. 498 31. 14. 498 31. 4890 0. 00 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0								9.00
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 17. 00 Total (see instructions) 18. 00 CAH visits 19. 00 CAH visits 10. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SUBLED NURSING FACILITY 19. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 OTHER LONG TERM CARE 24. 10 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 Observation Bed Days 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery groom 32. 01 Total ancillary labor & delivery room 31. 00 Total ancillary labor & delivery room 32. 01 Total ancillary labor & delivery room 32. 01 Total ancillary labor & delivery room 32. 01 Total ancillary labor & delivery room 33. 04 Total ancillary labor & delivery room 34. 05 Total ancillary labor & delivery room								10.00
13. 00 NURSERY 14. 00 Total (see instructions) 13. 992 876 38. 440 0. 00 1, 083. 86 14. 15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								11.00
14.00 Total (see instructions) 13,992 876 38,440 0.00 1,083.86 14. 15. 16. 00 00 00 00 00 00 00		, , ,		0.1	1 400			12.00
15. 00 CAH visits 0 0 0 0 15. 16. 00 SUBPROVI DER - IPF 16. 0 16. 00 SUBPROVI DER - IPF 17. 00 SUBPROVI DER - IRF 2, 969 8 4, 890 0. 00 25. 72 17. 18. 00 SUBPROVI DER 18. 00 SUBPROVI DER 18. 00 SUBPROVI DER 18. 00 SKILLED NURSING FACILITY 18. 00 SKILLED NURSING FACILITY 19. 00 OTHER LONG TERM CARE 20. 00 HOME HEALTH AGENCY 12. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 12. 087 0 27, 598 0. 00 27. 13 22. 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 23. 24. 10 HOSPI CE 18. 24. 10 HOSPI CE 18. 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 26. 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0. 00 0. 00 26. 27. 10 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trip S 0 30. 00 Empl oyee discount days (see instruction) 30. 00 Empl oyee discount days (see instructions) 30. 00 Labor & delivery days (see instructions) 0 159 277 32. 01 Total ancillary labor & delivery room 0 0 32. 01 Total ancillary labor & delivery room 0 32. 01 Total ancillary labor & delivery room 0 32. 01 Total ancillary labor & delivery room 0 32. 01 Total ancillary labor & delivery room 0 32. 01 Total ancillary labor & delivery room 0 32. 01 Total ancillary labor & delivery room 0 30. 00 25. 72 Total ancillary labor & delivery room 0 32. 01 Total ancillary labor & delivery room 0 32. 01 Total ancillary labor & delivery room 0 32. 01 Total ancillary labor & delivery room 18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			12 002		•		1 002 04	13.00
16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 18. 00 SUBPROVI DER 19. 00 SKI LLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HOSPI CE 24. 10 HOSPI CE 26. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Observation Bed Days 29. 00 Ambul ance Tri ps 30. 00 Empl oyee di scount days (see i nstruction) 31. 00 Empl oyee di scount days - IRF 32. 00 Labor & delivery days (see i nstructions) 32. 01 Total ancillary labor & delivery room 31. Total ancillary labor & delivery room 32. 01 Total ancillary labor & delivery room 31. Total ancillary labor & delivery room 32. 01 Total ancillary labor & delivery room 32. 01 Total ancillary labor & delivery room 33. 04. Total ancillary labor & delivery room 34. 06. Total ancillary labor & delivery room 35. 07. Total ancillary labor & delivery room 36. 07. Total ancillary labor & delivery room 37. Total ancillary labor & delivery room 38. 08. Total ancillary labor & delivery room 39. Total ancillary labor & delivery room 39. Total ancillary labor & delivery room		, ,	13, 992	8/0	38, 440	0.00	1,083.80	15. 00
17. 00 SUBPROVI DER - IRF 2,969 8 4,890 0.00 25.72 17. 18. 00 SUBPROVI DER 18. 00 SUBPROVI DER 18. 00 SUBPROVI DER 18. 00 SUBPROVI DER 18. 00 SILLED NURSI NG FACILITY 19. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 12,087 0 27,598 0.00 27. 13 22. 03. 00 AMBULATORY SURGI CAL CENTER (D. P.) 23. 00 CMHC - CMHC 24. 10 HOSPI CE (non-distinct part) 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 O		4	U	٩	U			16.00
18. 00 SUBPROVI DER 19. 00 SKI LLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Empl oyee discount days (see instruction) 31. 00 Empl oyee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room 18. 18. 19. 20 27. 598 27. 598 0. 00 27. 598 0. 00 27. 598 0. 00 27. 598 0. 00 27. 598 0. 00 27. 598 0. 00 27. 598 0. 00 0 27. 13 22. 23. 24. 10 HOSPI CE (non-distinct part) 24. 25. 26. 26. 26. 27. 28. 29. 27. 28. 29. 29. 29. 29. 29. 29. 29. 29. 29. 29		4	2 060	ρ	/ 800	0.00	25 72	
19. 00		4	2, 707	ď	4, 070	0.00	25.72	18. 00
20. 00		4						19.00
21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room 21. 087 12, 087 0 27, 598 0 0. 00 27, 598 0 0. 00 27, 598 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		4						20.00
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room 32. 01 Total ancillary labor & delivery room 33. 00 Total ancillary labor & delivery room 30. 00 Total ancillary labor & delivery room								21.00
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 24. 10 HOSPICE (non-distinct part) 0 24. 25. 00 CMHC - CMHC 25. 26. 20 RURAL HEALTH CLINIC 26. 27. 00 Total (sum of lines 14-26) 0 0 0 0.00 0.00 26. 27. 00 Observation Bed Days 0 3, 473 28. 29. 00 Ambulance Trips 0 29. 30. 00 Employee discount days (see instruction) 31. 31. 00 Employee discount days (see instructions) 31. 32. 01 Total ancillary labor & delivery room 0 159 277 32. 32. 01 Total ancillary labor & delivery room 0 32.		1	12 087	0	27 598	0.00	27 13	
24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room 32. 01 Total ancillary labor & delivery room 32. 02 CMHC - CMHC 24. 24. 24. 24. 24. 24. 24. 24. 24. 24.			12,007	Ĭ	27,070	0.00	27.10	23. 00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room 32. 02 Complex of the comp								24. 00
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 27. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room 25. 00 O O O O O O O O O O O O O O O O O O					C			24. 10
26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room 32. 03 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0. 00 0. 00 0. 00 0. 00 26. 27. 00 0 0. 0.								25. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26. 27. 00 Total (sum of lines 14-26) 0.00 1, 136. 71 27. 28. 00 Observation Bed Days 0 3, 473 28. 00 Ambul ance Trips 0 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 0 0 31. 00 Labor & delivery days (see instructions) 0 159 277 32. 01 Total ancillary labor & delivery room 0 32. 01 Total ancillary labor & delivery room 0 32. 01 32. 01 Total ancillary labor & delivery room 0 30. 00 0 0. 0.		1						26. 00
28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room 3 473 2 28. 29. 30			o	o	C	0.00	0.00	
28. 00 Observation Bed Days 0 3,473 28.	27.00	Total (sum of lines 14-26)				0.00	1, 136. 71	27. 00
29. 00 Ambulance Trips 0 29. 30. 00 Employee discount days (see instruction) 0 31. 00 Employee discount days - IRF 0 31. 32. 00 Labor & delivery days (see instructions) 0 159 277 32. 01 Total ancillary labor & delivery room 0 32.	28. 00			o	3, 473		·	28. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room 31.00 Employee discount days - IRF 0 159 277 32.01 Total ancillary labor & delivery room 0 32.01 Total ancillary labor & delivery room	29.00	1	o					29. 00
32.00 Labor & delivery days (see instructions) 0 159 277 32.01 Total ancillary labor & delivery room 0 32.	30.00	Employee discount days (see instruction)			Ö			30.00
32.01 Total ancillary labor & delivery room 0 32.	31.00	Employee discount days - IRF			C			31. 00
	32.00	Labor & delivery days (see instructions)	o	159	277			32. 00
					C			32. 01
outpatient days (see instructions)		outpatient days (see instructions)						
	33.00		0					33. 00
33.01 LTCH site neutral days and discharges 0 33.	33. 01	LTCH site neutral days and discharges	0					33. 01

| Period: | Worksheet S-3 | From 07/01/2021 | Part | To 06/30/2022 | Date/Time Prepared: Provi der CCN: 15-0034

					То	06/30/2022	Date/Time Pre 11/22/2022 9:	
		Full Time Equivalents	<u>'</u>		Di scha	irges		
	Component	Nonpai d Workers	Title V		Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00		13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and			0	2, 803	143	7, 708	1. 00
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)				2, 004	1, 108		2. 00
3.00	HMO IPF Subprovider					0		3. 00
4.00	HMO I RF Subprovi der					42		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF							5. 00
6.00	Hospital Adults & Peds. Swing Bed NF							6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)							7. 00
8. 00	INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13.00	NURSERY							13. 00
14.00	Total (see instructions)	0.00		0	2, 803	143	7, 708	14. 00
15.00	CAH visits							15. 00
16.00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF	0.00		0	290	1	459	17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							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
25. 00 26. 00	CMHC - CMHC RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00						26. 25
27. 00	Total (sum of lines 14-26)	0.00						27. 00
28. 00	Observation Bed Days	0.00						28.00
29. 00	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

Provider CCN: 15-0034

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 07/01/2021 Part II
To 06/30/2022 Date/Time Prepared:
11/22/2022 9:31 am

						06/30/2022	11/22/2022 9:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	,	
	DADT II WACE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see instructions)	200. 00	82, 306, 666	0	82, 306, 666	2, 364, 338. 42	34. 81	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0.00	0. 00	3. 00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0 174, 894		1	0. 00 3, 744. 00		1
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		0	0	O	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, 945, 233	0	- 1	0. 00 120, 181. 09	•	
	instructions) OTHER WAGES & RELATED COSTS		.,			-, -		Ī
11. 00	Contract Labor: Direct Patient Care		5, 731, 115	0	5, 731, 115	105, 101. 81	54. 53	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12. 00
13. 00	Contract Labor: Physician-Part A - Administrative		652, 010	0	652, 010	4, 110. 02	158. 64	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14. 00
14. 01	Home office salaries		10, 667, 430	0	10, 667, 430	293, 009. 00	36. 41	14. 01
14. 02	Related organization salaries		0		0	0.00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0.00	15. 00
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 instructions)		21, 198, 124	0	21, 198, 124			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 179, 789 0	0 0	1, 179, 789 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	О			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		37, 859	0	37, 859			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related (core)		2, 776, 317	0	2, 776, 317			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

						rom 0//01/2021	Part II	
					T	o 06/30/2022		
		WI+ A I :	A +-	D1: 6:+:	A -1: +1	Det al Harrisa	11/22/2022 9:	
		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	2.00	A-6)	3)	col . 4	/ 00	
05 50	LI CC: DI : : D : 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) OVERHEAD COSTS - DIRECT SALARII	I						
27 00			F00 /F0		F02 /F2	17 005 00	24.14	2/ 00
26. 00	Employee Benefits Department	4. 00	583, 653		583, 653		1	
27. 00	Administrative & General	5. 00	8, 487, 892		8, 487, 892		l	
28. 00	Administrative & General under		1, 578, 779	0	1, 578, 779	14, 955. 07	105. 57	28. 00
	contract (see inst.)		_	_	_			
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00	l e	29. 00
30. 00	Operation of Plant	7. 00	2, 428, 617		2, 428, 617			30. 00
31. 00	Laundry & Linen Service	8. 00	108, 028		108, 028			31. 00
32.00	Housekeepi ng	9. 00	2, 070, 222	0	2, 070, 222			32. 00
33. 00	Housekeeping under contract		0	0	0	0. 00	0.00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	2, 035, 649	-752, 887	1, 282, 762	66, 603. 00	19. 26	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	752, 887	752, 887	39, 091. 00	19. 26	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	4, 030, 736	0	4, 030, 736	106, 934. 00	37. 69	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	•	
	1			1				

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

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0034 Peri od: From 07/01/2021 To 06/30/2022 11/22/2022 9: 31 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 83, 710, 551 83, 710, 551 2, 375, 549. 49 1.00 35. 24 instructions) 2.00 4, 945, 233 ol 4, 945, 233 120, 181. 09 41. 15 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 78, 765, 318 0 78, 765, 318 2, 255, 368. 40 34. 92 3.00 minus line 2) 4.00 Subtotal other wages & related 17, 050, 555 17, 050, 555 402, 220. 83 42.39 4.00

0

0

23, 974, 441

119, 790, 314

21, 323, 576

0.00

2, 657, 589. 23

722, 671. 07

30.44

45 07

29.51

5.00

6.00

7.00

23, 974, 441

119, 790, 314

21, 323, 576

costs (see inst.)

(see inst.)

instructions)

5.00

6.00

7.00

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

Health Financial Systems	ST. MARY MEDICAL CENTER, INC.	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0034	Peri od: Worksheet S-3 From 07/01/2021 Part IV To 06/30/2022 Date/Time Prepared:

	To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		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, 514, 297	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)	•	ĺ
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)	12, 510, 372	8. 02
8. 03	Health Insurance (Purchased)	0	1
9. 00	Prescription Drug Plan	0	9.00
10. 00	Dental, Hearing and Vision Plan	668, 433	10.00
	Life Insurance (If employee is owner or beneficiary)	63, 723	1
	Accident Insurance (If employee is owner or beneficiary)	0	ı
	Disability Insurance (If employee is owner or beneficiary)	47, 828	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
	'Workers' Compensation Insurance	669, 335	15. 00
16. 00	·	0	ı
	Non cumulative portion)		
	TAXES	•	
17.00	FICA-Employers Portion Only	4, 872, 783	17. 00
18.00	Medicare Taxes - Employers Portion Only	1, 144, 435	18. 00
	Unemployment Insurance	-75, 435	19. 00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER	<u>'</u>	
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	22, 415, 771	24. 00
	Part B - Other than Core Related Cost	•	1
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
		•	

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0034	From 07/01/2021	Worksheet S-3 Part V Date/Time Prepared:

		To 06/30/2022	Date/Time Prep 11/22/2022 9:	
	Cost Center Description	Contract Labor		0 1 Gill
		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	5, 731, 115	22, 415, 771	1.00
2.00	Hospi tal	5, 731, 115	22, 415, 771	2. 00
3.00	SUBPROVI DER - I PF			3. 00
4.00	SUBPROVI DER - I RF	0	0	4.00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY			8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospi tal -Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18. 00	0ther	0	0	18. 00

Heal th	Financial Systems S	T. MARY MEDICA	L CENTER. INC.		In Lie	eu of Form CMS-2	2552-10
	EALTH AGENCY STATISTICAL DATA				eriod: rom 07/01/2021	Worksheet S-4	
			Component	CCN: 15-7313		Date/Time Prep 11/22/2022 9:	
					Home Health	PPS	<u> </u>
					Agency I		
0.00					1.	00	0.00
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	LIGHT HEALTH ACTION CTATLETICAL DATA	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	1, 707	60	1, 176	2, 943	1. 00
2.00	Unduplicated Census Count (see instructions)	0.00	637. 00	0.00 Number of Empl			2. 00
				Number of Empi	oyees (Full II	me Equivarent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
			 D	1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	1					
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	0. 00 0. 96	0. 00 0. 00		3. 00 4. 00
5.00	Other Administrative Personnel			9. 77	0.00	9. 77	5. 00
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			7. 57 0. 00	0. 00 0. 00		6. 00 7. 00
8.00	Physical Therapy Service			2. 51	0. 00		8. 00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			1. 09 1. 34	0. 00 0. 00		9. 00 10. 00
11. 00	Occupational Therapy Supervisor			0. 47	0.00	0. 47	11. 00
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 00 0. 39	0. 00 0. 00		•
14. 00	Medical Social Service			0. 39	0.00		•
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. 00 2. 58	0. 00 0. 00		•
17. 00	Home Health Aide Supervisor			0.00	0.00		•
18. 00	Other (specify)			0.00	0.00	0.00 CBSA Data	18. 00
						1. 00	
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where	vou provided se	arvices durina	the cost report	ting period	1	19. 00
20. 00	List those CBSA code(s) in column 1 serviced	, ,	J		9 1	23844	20. 00
	first code).	Full Fr	oi sodes				
		Wi thout		LUPA Epi sodes	PEP Only	Total (cols.	
		0utliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5. 00	
	PPS ACTIVITY DATA						
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	4, 352 911, 310					1
23. 00	Physical Therapy Visits	2, 471	921	53	92	3, 537	23. 00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	606, 132 867			23, 052 52		1
26. 00	Occupational Therapy Visit Charges	212, 940	158, 640	480	12, 948	385, 008	26. 00
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	62 15, 036			7 1, 764	151 36, 792	27. 00 28. 00
29. 00	Medical Social Service Visits	0	C	0	0	0	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	535			0 33		30. 00 31. 00
32.00	Home Health Aide Visit Charges	84, 997	74, 792	310	5, 347	165, 446	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8, 287	3, 269	189	342	12, 087	33. 00
34. 00	Other Charges	0	C		0		34. 00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1, 830, 415	719, 978	41, 023	76, 811	2, 668, 227	35. 00
36. 00	Total Number of Episodes (standard/non	843		107	25	975	36. 00
37. 00	outlier) Total Number of Outlier Episodes		147	,	11	158	37. 00
	Total Non-Routine Medical Supply Charges	122, 902	l e	•			

<u>alth Financial Systems</u> DSPITAL UNCOMPENSATED A		MEDICAL CENTER, INC. Provider CO	CN: 15-0034	Peri od:	u of Form CMS-2 Worksheet S-10		
				From 07/01/2021			
				To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared 31 ar	
					1. 00		
	indigent care cost computation						
	io (Worksheet C, Part I line 202 co	lumn 3 divided by li	ne 202 column	8)	0. 198906	1.	
	Medicaid (see instructions for each line)						
00 Net revenue from M 00 Did you receive DS		li cai d2			16, 007, 980	2. 3.	
1 3	H or supplemental payments from Med does line 2 include all DSH and/or:		s from Medica	i d2	N	4.	
1	hen enter DSH and/or supplemental pa			ı d:	0	•	
00 Medicaid charges	nen enter ben anarer eapprementar p	aymonto il om moai oai	-		156, 839, 667		
00 Medicaid cost (lir	e 1 times line 6)				31, 196, 351	•	
00 Difference between	net revenue and costs for Medicaid	program (line 7 min	us sum of lin	es 2 and 5; if	15, 188, 371	8.	
< zero then enter							
	Insurance Program (CHIP) (see instru	uctions for each lin	e)				
00 Net revenue from s					0		
0.00 Stand-alone CHIP o .00 Stand-alone CHIP o	cost (line 1 times line 10)				0		
	net revenue and costs for stand-al	one CHIP (line 11 mi	nus line 9· i	f < zero then	-	12.	
enter zero)	not revenue and easte for etaile and	(11110 11	,, .	2010 111011			
Other state or loc	al government indigent care program	(see instructions f	or each line)				
4	tate or local indigent care program	•		,		13.	
	ts covered under state or local ind	igent care program (Not included	in lines 6 or	0	14.	
10)		11 44				4.5	
	ligent care program cost (line 1 time pot revenue and costs for state or		nrogram (lin	o 1E minus Lino	0	15. 16.	
	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16 13; if < zero then enter zero)						
	and total unreimbursed cost for Medi	icaid, CHIP and stat	e/local indig	ent care program	ns (see		
instructions for e							
	nations, or endowment income restri					17.	
	appropriations or transfers for su			(£ 1!	0		
9.00 Total unreimbursed 8, 12 and 16)	cost for Medicaid , CHIP and state	and rocal rhurgent	care programs	(Sum of Titles	15, 188, 371	19.	
10, 12 and 10)			Uni nsured	Insured	Total (col. 1		
			pati ents	pati ents	+ col . 2)		
1			1. 00	2. 00	3. 00		
	(see instructions for each line) es and uninsured discounts for the	ontino fooilitu	(252 12	452.224	6, 804, 358	20	
(see instructions)		entire racifity	6, 352, 13	452, 224	0, 604, 336	20.	
1 '	pproved for charity care and uninsu	red discounts (see	1, 263, 47	8 452, 224	1, 715, 702	21.	
instructions)	77	()			, , ,		
	from patients for amounts previously	y written off as		0	0	22.	
charity care	(11 01 1 11 00)			450.004	4 745 700		
3.00 Cost of charity ca	re (line 21 minus line 22)		1, 263, 47	8 452, 224	1, 715, 702	23.	
					1. 00		
.00 Does the amount or	line 20 column 2, include charges	for patient days bey	ond a Length	of stay limit	N N	24.	
	s covered by Medicaid or other indi						
	enter the charges for patient days		care program	's length of	0	25.	
-							
stay limit							
stay limit Total bad debt exp .00 Medicare reimbursa	Medicare reimbursable bad debts for the entire hospital complex (see instructions) 670,950 27.						
stay limit 5.00 Total bad debt exp 7.00 Medicare reimbursa 7.01 Medicare allowable	ble bad debts for the entire hospital bad debts for the entire hospital		,		1, 032, 231	1	
stay limit Total bad debt exp OO Medicare reimbursa OO Medicare allowable Non-Medicare bad	ble bad debts for the entire hospital bad debts for the entire hospital bebt expense (see instructions)	complex (see instruc	tions)		7, 159, 129	28.	
stay limit Total bad debt exp 7.00 Medicare reimbursa 7.01 Medicare allowable 8.00 Non-Medicare bad 0.00 Cost of non-Medica	ble bad debts for the entire hospital bad debts for the entire hospital blebt expense (see instructions) are and non-reimbursable Medicare ba	complex (see instructed debt expense (see	tions)		7, 159, 129 1, 785, 275	28. 29.	
stay limit Total bad debt exp .00 Medicare reimbursa .01 Medicare allowable .00 Non-Medicare bad .00 Cost of non-Medica .00 Cost of uncompensa	ble bad debts for the entire hospital bad debts for the entire hospital bebt expense (see instructions)	complex (see instructed debt expense (see see 29)	tions)		7, 159, 129	28. 29. 30.	

		ST. MARY MEDICAL	CENTER, INC.		In Lie	eu of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der C		Period: From 07/01/2021	Worksheet A	
					To 06/30/2022		
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	11/22/2022 9: Recl assi fi ed	31 am
	cost denter bescription	Sararres	other	+ col . 2)	ons (See A-6)	Trial Balance	
				,		(col. 3 +-	
		1.00	2. 00	3.00	4. 00	col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		10, 221, 346	10, 221, 34	6 176, 205	10, 397, 551	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		9, 000, 136	1		9, 010, 191	2. 00
3. 00 4. 00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	E02 (E2	12 272 540		0		3. 00 4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES	583, 653 483, 219	12, 373, 569 190, 636			12, 957, 222 673, 855	
5. 02	00570 ADMI TTI NG	2, 649, 863	411, 134			3, 060, 997	
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		0 0	. 0	
5. 04 7. 00	00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	5, 354, 810 2, 428, 617	52, 809, 662 7, 945, 996			57, 978, 212 10, 374, 613	
8. 00	00800 LAUNDRY & LINEN SERVICE	108, 028	995, 850				
9.00	00900 HOUSEKEEPI NG	2, 070, 222	1, 090, 416			3, 160, 638	
10.00	01000 DI ETARY	2, 035, 649	1, 801, 786	3, 837, 43			
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	4, 030, 736	0 3, 091, 207	7, 121, 94	0 1, 419, 279 3 0		
14. 00	01400 CENTRAL SERVICES & SUPPLY	4, 030, 730	3, 071, 207	7, 121, 74	0 0	7, 121, 743	1
15.00	01500 PHARMACY	0	0		0	0	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0	0	16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	17. 00 19. 00
	02300 PARAMEDICAL EDUCATION PROGRAM EMS	305, 871	70, 118	375, 98	9 0	375, 989	
	INPATIENT ROUTINE SERVICE COST CENTERS		·				
30.00	03000 ADULTS & PEDIATRICS	14, 112, 209	4, 046, 875		· ·		
31. 00 41. 00	03100 NTENSI VE CARE UNI T 04100 SUBPROVI DER - RF	4, 537, 591 1, 996, 770	1, 295, 589 1, 308, 304			5, 833, 180 3, 305, 074	
43. 00	04300 NURSERY	1, 770, 770	1, 300, 304	1	1, 568, 037		
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7, 106, 300	16, 366, 859				
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	2, 993, 304 2, 858, 946	646, 545 988, 419			-,,	
53. 00	05300 ANESTHESI OLOGY	2, 030, 740	4, 448, 887			4, 448, 887	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 382, 734	2, 005, 679			5, 388, 413	54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	615, 880	731, 639			1, 347, 519	
56. 00 57. 00	05600 RADI 0I SOTOPE 05700 CT SCAN	578, 795 1, 140, 471	1, 034, 858 1, 327, 265			1, 613, 653 2, 467, 736	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	553, 524	765, 310				
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 646, 799	2, 107, 912				
60.00	O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELL	3, 903, 784	6, 568, 107	10, 471, 89	0	10, 471, 891 0	1
62. 00 63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	238, 424	1, 393, 567	1, 631, 99	1 0	1, 631, 991	
64.00	06400 I NTRAVENOUS THERAPY	403, 699	146, 454			550, 153	64. 00
65. 00		2, 442, 624	741, 090				65. 00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	20, 113 50	3, 748, 741 1, 038, 470			3, 768, 854 1, 038, 520	
	06800 SPEECH PATHOLOGY	8, 956	618, 372			627, 328	
69. 00	06900 ELECTROCARDI OLOGY	838, 657	453, 235			1, 291, 892	
	07000 ELECTROENCEPHALOGRAPHY	430, 649	223, 511			654, 160	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	0	10, 941, 195 15, 481, 498				
73.00		2, 585, 678	14, 759, 271		· ·		
74.00	07400 RENAL DIALYSIS	0	831, 862	831, 86	2 0	831, 862	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	476, 855	93, 718	570, 57	3 0	570, 573	76. 97
90 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	1, 292, 037	1, 133, 803	2, 425, 84	0 0	2, 425, 840	90.00
91. 00		5, 448, 557	1, 788, 161				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	2 (20 212	/15 072	2 24/ 00	4	2 24/ 004	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	2, 630, 212	615, 872	3, 246, 08	4 0	3, 246, 084	101.00
118.00		82, 294, 286	197, 652, 924	279, 947, 21	0 0	279, 947, 210	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1 502	1	0		190.00
	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES	12, 380	1, 592 9, 290				191. 00 192. 00
	07950 OTHER NON-REIMBURSABLE COST CENTER	0	495, 102			1	
194. 01	07952 ADVERTI SI NG	0	365, 001	365, 00	1 0	365, 001	194. 01
200.00	TOTAL (SUM OF LINES 118 through 199)	82, 306, 666	198, 523, 909	280, 830, 57	5 0	280, 830, 575	200. 00

near tn	Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-25	552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CCN	I: 15-0034	Peri od:	Worksheet A	
					From 07/01/2021 To 06/30/2022	Date/Time Prepa	ared:
		1			<u> </u>	11/22/2022 9: 3	
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	-152, 316	10, 245, 235				1.00
2. 00 3. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO300 OTHER CAP REL COSTS	1, 190, 704	10, 200, 895 0				2. 00 3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 609, 818	14, 567, 040				4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES	0	673, 855				5. 01
5.02	00570 ADMI TTI NG	0	3, 060, 997				5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	3, 054, 026	3, 054, 026				5. 03
5. 04	00590 OTHER ADMINISTRATIVE & GENERAL	-31, 002, 738	26, 975, 474				5. 04
7.00	00700 OPERATION OF PLANT	-925	10, 373, 688				7. 00
8. 00 9. 00	OO8OO LAUNDRY & LI NEN SERVI CE OO9OO HOUSEKEEPI NG	0	1, 103, 878 3, 160, 638				8. 00 9. 00
10.00	01000 DI ETARY	-3, 473	2, 414, 683				10.00
11.00	01100 CAFETERI A	-986, 654	432, 625			•	11.00
13.00	01300 NURSING ADMINISTRATION	-2, 057, 934	5, 064, 009				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0				14. 00
	01500 PHARMACY	0 272 171	0 272 171			1	15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2, 372, 171	2, 372, 171			1	16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0				19. 00
23. 00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	-7, 438	368, 551			•	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	-151	18, 801, 302			•	30.00
31.00	03100 I NTENSI VE CARE UNI T	-68	5, 833, 112				31.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	3, 305, 074 1, 568, 037			1	41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	1, 500, 037				43.00
50.00	05000 OPERATI NG ROOM	-30	23, 171, 386				50.00
51.00	05100 RECOVERY ROOM	0	3, 639, 849				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-517, 500	1, 119, 459				52.00
53.00	05300 ANESTHESI OLOGY	-4, 024, 076	424, 811				53.00
54. 00 55. 00	05400 RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	-2, 448 0	5, 385, 965 1, 347, 519				54. 00 55. 00
56. 00	05600 RADI OLOGI - THERAFEOTIC	0	1, 613, 653			1	56. 00
57. 00	05700 CT SCAN	-2, 900	2, 464, 836				57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 318, 834				58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-1, 363	3, 531, 895			1	59. 00
60.00	06000 LABORATORY	-610, 630	9, 861, 261			1	60.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING, & TRANS.	0 -106, 604	0 1, 525, 387			1	62. 00 63. 00
64. 00	06400 INTRAVENOUS THERAPY	- 100, 604	550, 153				64. 00
65. 00	06500 RESPI RATORY THERAPY	-3, 930	3, 179, 784				65. 00
66.00	06600 PHYSI CAL THERAPY	0	3, 768, 854			1	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 038, 520				67. 00
	06800 SPEECH PATHOLOGY	0	627, 328			•	68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	1, 291, 892 654, 160				69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		11, 141, 952				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	O	15, 803, 937				72. 00
	07300 DRUGS CHARGED TO PATIENTS	-1, 186, 872	16, 158, 077				73.00
	07400 RENAL DIALYSIS	0	831, 862				74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	-13, 313	557, 260				76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	-191, 841	2, 233, 999				90. 00
	09100 EMERGENCY	713	7, 237, 431				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	, 10	7,207,101				92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	3, 246, 084			1	101. 00
110 0-	SPECIAL PURPOSE COST CENTERS	00 / 15 ===-	247 204 125				110 25
118. 00	,	-32, 645, 772	247, 301, 438			1	118. 00
100 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0			1	190. 00
	19100 RESEARCH	0	13, 972			•	190. 00 191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	o o	9, 290				192. 00
	07950 OTHER NON-REIMBURSABLE COST CENTER	O	495, 102				194. 00
	07952 ADVERTI SI NG	ا ما	365, 001			1	194. 01
		-32, 645, 772	248, 184, 803			•	200. 00

Health Financial Systems

ST. MARY MEDICAL CENTER, INC.

RECLASSIFICATIONS

Provider CCN: 15-0034

Period: From 07/01/2021

Period: From 07/01/2021

					To 06/30/2022 Date/Time F 11/22/2022	repared: 9:31 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5. 00		
	A - RECLASS PROPERTY INSURANCE	E				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	176, 205		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP		0	1 <u>0, 0</u> 55		2. 00
	0		0	186, 260		
	B - CAFETERIA EXPENSES RECLAS	S				
1.00	CAFETERI A	11. 00	752, 887	666, 392		1. 00
	0		752, 887	666, 392		
	C - RECLASS LDRP COSTS					
1.00	ADULTS & PEDIATRICS	30.00	477, 339	165, 030		1. 00
2.00	NURSERY	43.00	<u>1, 165, 1</u> 96	402, 841		2. 00
	0		1, 642, 535	567, 871		
	D - INVENTORY ADJUSTMENT					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	200, 757		1. 00
	PATI ENT					
2.00	IMPL. DEV. CHARGED TO	72.00	0	322, 439		2. 00
	PATI ENTS	↓	↓			
	0		0	523, 196	1	
500.00	Grand Total: Increases		2, 395, 422	1, 943, 719		500.00

Health Financial Systems

ST. MARY MEDICAL CENTER, INC.

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-0034

Period: From 07/01/2021

Worksheet A-6

						To 06/30/2022	Date/Time Pro	epared: :31 am
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref			
	6. 00	7. 00	8. 00	9. 00	10. 00			
	A - RECLASS PROPERTY INSURANCE	E						
1.00	OTHER ADMINISTRATIVE &	5. 04	0	186, 260	1.	2		1. 00
	GENERAL							
2.00		0.00	0	0	1:	2		2. 00
	0		0	186, 260				
	B - CAFETERIA EXPENSES RECLAS							
1. 00	DI ETARY	1000	75 <u>2, 8</u> 87	66 <u>6, 3</u> 92	'	<u> </u>		1. 00
	0		752, 887	666, 392				
	C - RECLASS LDRP COSTS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 642, 535	567, 871		0		1. 00
2.00		0.00	0	0		<u> </u>		2. 00
	0		1, 642, 535	567, 871				
	D - INVENTORY ADJUSTMENT							
1.00	OPERATING ROOM	50.00	0	301, 743		0		1. 00
2.00	CARDI AC CATHETERI ZATI ON	<u>59.</u> 00	0	221, 453				2. 00
	0		0	523, 196				
500.00	Grand Total: Decreases		2, 395, 422	1, 943, 719				500.00

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

					To	06/30/2022	Date/Time Prep 11/22/2022 9:3	
				Acqui si ti ons	2		11/22/2022 9.	o i alli
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances	. u. c.iacco	2011411 011			Retirements	
		1.00	2. 00	3. 00		4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES						
1.00	Land	13, 037, 475	5, 800, 978		0	5, 800, 978	175, 202	1.00
2.00	Land Improvements	8, 088, 425	108, 214		0	108, 214	0	2.00
3.00	Buildings and Fixtures	129, 213, 761	22, 840, 256		0	22, 840, 256	-6, 266, 759	3.00
4.00	Building Improvements	79, 238, 765	12, 379, 131		0	12, 379, 131	3, 152, 047	4.00
5.00	Fi xed Equi pment	0	0		0	0	0	5.00
6.00	Movable Equipment	81, 996, 597	8, 372, 089		0	8, 372, 089	120, 059	6.00
7.00	HIT designated Assets	0	0		0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	311, 575, 023	49, 500, 668		0	49, 500, 668	-2, 819, 451	8.00
9.00	Reconciling Items	0	0		0	0	0	9. 00
10.00	Total (line 8 minus line 9)	311, 575, 023	49, 500, 668		0	49, 500, 668	-2, 819, 451	10.00
		Endi ng Bal ance	Ful I y					
			Depreci ated					
			Assets					
		6. 00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_					
1.00	Land	18, 663, 251	0					1. 00
2.00	Land Improvements	8, 196, 639	0					2. 00
3.00	Buildings and Fixtures	158, 320, 776	0					3. 00
4.00	Building Improvements	88, 465, 849	0					4. 00
5.00	Fi xed Equipment	0	0					5. 00
6.00	Movable Equipment	90, 248, 627	0					6. 00
7.00	HIT designated Assets	0	0					7. 00
8. 00	Subtotal (sum of lines 1-7)	363, 895, 142	0					8. 00
9.00	Reconciling Items	0	0					9. 00
10. 00	Total (line 8 minus line 9)	363, 895, 142	0				l	10. 00

Hool +k	Financial Customa	CT MADY MEDICAL	CENTED INC		ا ا ا ا	u of Form CMC	2552 10
	<u> </u>	ST. MARY MEDICAL		ON 45 0004		eu of Form CMS-2	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Peri od: From 07/01/2021	Worksheet A-7	
					To 06/30/2022		nared:
					10 00/30/2022	11/22/2022 9:	
			SU	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	'				instructions)	instructions)	
		9. 00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	7, 783, 502	2, 437, 844		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6, 231, 411	2, 768, 725		0	0	2. 00
3.00	Total (sum of lines 1-2)	14, 014, 913	5, 206, 569		0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	10, 221, 346				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9, 000, 136				2. 00
3.00	Total (sum of lines 1-2)	0	19, 221, 482				3.00

0 0 0

10, 221, 346 9, 000, 136 19, 221, 482

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	Financial Systems S	ST. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 07/01/2021 To 06/30/2022	Worksheet A-7 Part III Date/Time Prep 11/22/2022 9:3	nared.
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	PART III - RECONCILIATION OF CAPITAL COSTS C	1. 00	2.00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	273, 646, 515 90, 248, 627 363, 895, 142	0	273, 646, 51 90, 248, 62 363, 895, 14 CAPI TAL	7 0. 248007 2 1. 000000	O O O F CAPITAL	1. 00 2. 00 3. 00
	Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	T	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	ENTERS O	1 0		0 7, 950, 795	2, 118, 235	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0	0		0 7, 422, 115 0 15, 372, 910	2, 768, 725	2. 00
			Sl	JMMARY OF CAPI		., ,	
	Cost Center Description	Interest	Insurance (see instructions)	,	Other Capi tal -Rel ate d Costs (see i nstructions)	Total (2) (sum of cols. 9 through 14)	
	T	11. 00	12.00	13. 00	14. 00	15. 00	
1. 00 2. 00 3. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	ENTERS 0 0 0	10, 055		0 0 0	10, 245, 235 10, 200, 895 20, 446, 130	1. 00 2. 00 3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-0034

				T	o 06/30/2022	Date/Time Prep 11/22/2022 9:3	
				Expense Classification on	Worksheet A	11/22/2022 4.	o i aiii
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	T	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		0	CAL REE COSTS-WINDER EQUIT	2.00	Ĭ	2.00
3.00	Investment income - other		0		0.00	О	3.00
	(chapter 2)						
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
0.00	expenses (chapter 8)		0		0.00	Ĭ	0.00
6.00	Rental of provider space by		0		0.00	o	6.00
	suppliers (chapter 8)						
7. 00	Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0.00	0	8. 00
	(chapter 21)						
9. 00	Parking lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-6, 984, 375			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	o	11. 00
11.00	(chapter 23)		0		0.00	Ĭ	11.00
12.00	Related organization	A-8-1	-22, 298, 232			o	12.00
	transactions (chapter 10)						
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15. 00	Rental of quarters to employee and others		U		0. 00	٥	15. 00
16. 00	Sale of medical and surgical		0		0.00	o	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	o	18. 00
10.00	abstracts		0		0.00	Ĭ	10.00
19.00	Nursing and allied health		0		0.00	O	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of		0		0.00		21. 00
21100	interest, finance or penalty		· ·		0.00	Ĭ	200
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	N 0 3	O	KESI TRATORT THERAIT	05.00		23.00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization (chapter 14)		0	 *** Cost Center Deleted ***	114. 00		25. 00
_3.00	physicians' compensation		0				_3. 50
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	이	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		^	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
Z1. UU	COSTS-MVBLE EQUIP		U	IONI NEE COSTS-WYDLE EQUIP	2.00		Z1. UU
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	o	29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
55. //	instructions)		0		30.00		55. //
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
JZ. UU	Depreciation and Interest		U		0.00		J2. UU
33. 00	COVI D DRUG DONATI ONS	В	-1, 186, 850	DRUGS CHARGED TO PATIENTS	73. 00	o	33. 00

				11	0 06/30/2022	11/22/2022 9:	
				Expense Classification on	Worksheet A	1172272022 7.	J I dill
				To/From Which the Amount is			
				To Troil will ell the Allourt 13	to be haj astea		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	·	1.00	2.00	3.00	4. 00	5. 00	
33. 01	OTHER REVENUE	В	-319, 609	CAP REL COSTS-BLDG & FIXT	1.00	10	33. 01
33. 02	OTHER REVENUE	В	-705	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 02
33. 03	OTHER REVENUE	В	-36, 943	OTHER ADMINISTRATIVE &	5. 04	0	33. 03
				GENERAL			
33.04	OTHER REVENUE	В	-3, 473	DI ETARY	10.00	0	33. 04
33.05	OTHER REVENUE	В	-986, 654	CAFETERI A	11. 00	0	33. 05
33.06	OTHER REVENUE	В	-10	NURSING ADMINISTRATION	13.00	0	33. 06
33. 07	OTHER REVENUE	В	-7, 438	PARAMEDICAL EDUCATION	23. 00	0	33. 07
				PROGRAM EMS			
33. 08	OTHER REVENUE	В	-151	ADULTS & PEDIATRICS	30.00	0	33. 08
33.09	OTHER REVENUE	В	-68	INTENSIVE CARE UNIT	31.00	0	33. 09
33. 10	OTHER REVENUE	В	-30	OPERATING ROOM	50.00	0	33. 10
33. 11	OTHER REVENUE	В	-1, 188	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 11
33. 12	OTHER REVENUE	В	-1, 363	CARDIAC CATHETERIZATION	59. 00	0	33. 12
33. 13	OTHER REVENUE	В	-162, 605	LABORATORY	60.00	0	33. 13
33. 14	OTHER REVENUE	В	-3, 930	RESPIRATORY THERAPY	65.00	0	33. 14
33. 15	OTHER REVENUE	В	-22	DRUGS CHARGED TO PATIENTS	73.00	0	33. 15
33. 16	OTHER REVENUE	В	-2, 792	CLINIC	90.00	0	33. 16
33. 17	OTHER REVENUE	В	713	EMERGENCY	91.00	0	33. 17
33. 18	PRE-MERGER ASSETS DEPRECIATION	A	53, 714	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 18
33. 19	TAXABLE LABS	A	-448, 025	LABORATORY	60.00	0	33. 19
33. 20	TAXABLE LABS	A	-106, 604	BLOOD STORING, PROCESSING, &	63.00	0	33. 20
				TRANS.			
33. 21	PATIENT TELEPHONE SERVICE	A	-143, 442	OTHER ADMINISTRATIVE &	5. 04	0	33. 21
				GENERAL			
33. 22	PATIENT TELEPHONE PURCHASES	A	-2, 117	OTHER ADMINISTRATIVE &	5. 04	0	33. 22
				GENERAL			
33. 23	PATIENT TV DEPRECIATION	A	-2, 648	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 23
33. 24	PATIENT TV PURCHASES	A	-925	OPERATION OF PLANT	7. 00	0	33. 24
50.00	TOTAL (sum of lines 1 thru 49)		-32, 645, 772				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) D-	comintion all chanter referen			ONC DI 4E 4			

⁽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 Peri od: Worksheet A-8-1 From 07/01/2021 To 06/30/2022 Date/Time Prepared: OFFICE COSTS

				10 00/30/2022	11/22/2022 9:	
	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 ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
1.00		OTHER ADMINISTRATIVE & GENER	PHYSICIAN ALLOCATION PER GL	0	15, 511, 405	1. 00
2.00	5. 04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOCATION PER G	O	31, 421, 385	2. 00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOC-BLDG	113, 579	0	3.00
3.01	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOC-EQUIP	1, 193, 352	0	3. 01
3.02	5. 04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-SALARIES	7, 575, 944	0	3. 02
3.03	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOC-BENEFITS	1, 630, 963	0	3. 03
3.04	16. 00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOC-MEDICAL RE	2, 372, 171	0	3.04
3.05	5. 03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE ALLOC-PATIENT AC	3, 054, 026	0	3.05
3.06	5. 04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-OTHER NON	8, 883, 774	0	3.06
3.07	5. 04	OTHER ADMINISTRATIVE & GENER	CANCER CARE ALLOCATION PER G	0	587, 101	3. 07
3.08	5. 04	OTHER ADMINISTRATIVE & GENER	CANCER CARE ALLOC-ADMIN	71, 120	0	3. 08
3.09	13.00	NURSING ADMINISTRATION	CANCER CARE ALLOC-REGISTRY	152, 913	0	3.09
3. 10	5. 04	OTHER ADMINISTRATIVE & GENER	CANCER CARE ALLOC-NAVIGATORS	173, 817	0	3. 10
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			25, 221, 659	47, 519, 891	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
 B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	0. 00 CFNI 100. 00	6. 00
7.00		0.00	7.00
8.00		0.00	8. 00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

			11/22/2022 9:	.31 am
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	-15, 511, 405	0		1. 00
2.00	-31, 421, 385	0		2. 00
3.00	113, 579	9		3. 00
3. 01	1, 193, 352	9		3. 01
3.02	7, 575, 944	0		3. 02
3.03	1, 630, 963	0		3. 03
3.04	2, 372, 171	0		3. 04
3.05	3, 054, 026	0		3. 05
3.06	8, 883, 774	0		3. 06
3.07	-587, 101	0		3. 07
3.08	71, 120	0		3. 08
3.09	152, 913	0		3. 09
3. 10	173, 817	0		3. 10
4.00	0	0		4. 00
5.00	-22, 298, 232			5. 00
* Tho	amaunta an Lin	aa 1 4 (and aub	registeres and appropriate) are transferred in detail to Workshoot A. column 4. Lines as	

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

nas no	t been posted to worksheet A,	cordinas i and/or 2, the amount arrowable should be indicated in cordinar 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	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.

	. Comont under the Arrive	
6.00	HEALTHCARE	6.00
7. 00 8. 00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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 | Peri od: | Worksheet A-8-2 | From 07/01/2021 | To 06/30/2022 | Date/Ti me Prepared: Provider CCN: 15-0034

					-	Го 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		CLINIC	174, 894					
2.00		CLINIC	14, 155			0		2. 00
3.00		EMPLOYEE BENEFITS DEPARTMENT	20, 440			0	0	
4. 00	5. 04 OTHER ADMINISTRATIVE & GENERAL		5, 000	5, 000	0	0	0	4. 00
5.00	13. 00 NURSING ADMINISTRATION		2, 210, 837	2, 210, 837	0	0	0	5. 00
6. 00	52.00 DELIVERY ROOM & LABOR ROOM		517, 500			0	0	
7. 00	54. 00 RADI OLOGY-DI AGNOSTI C		1, 260			0	0	
8. 00	57.00 CT SCAN		2, 900			0	0	8. 00
9. 00	76. 97 CARDIAC REHABILITATION		13, 313			0	0	9. 00
10.00	53. 00	ANESTHESI OLOGY	4, 024, 076			0	0	10. 00
200.00			6, 984, 375				0	
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8. 00	9. 00	Education 12.00	12 13. 00	14. 00	
1. 00		CLINIC	0.00					1. 00
2. 00			0					
3.00	90. OO CLINIC 4. OO EMPLOYEE BENEFITS DEPARTMENT		0		_		0	3. 00
4. 00	5. 04 OTHER ADMINISTRATIVE &		0				0	
4.00		GENERAL	0	١	0			4.00
5.00		NURSI NG ADMI NI STRATI ON	0	0	0	0	0	5. 00
6. 00	52. 00 DELIVERY ROOM & LABOR ROOM		0	0	Ō	0	0	
7. 00	54. 00 RADI OLOGY-DI AGNOSTI C		0	0	0	0	0	1
8.00	57. 00 CT SCAN		0	0	0	l 0	0	8. 00
9.00	76. 97 CARDI AC REHABI LI TATI ON		0	0	0	0	0	9. 00
10.00	53. 00	ANESTHESI OLOGY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18.00		
1.00		CLINIC	0		_	,		1.00
2.00		CLINIC	0		_	14, 155		2.00
3.00	4. 00 EMPLOYEE BENEFITS DEPARTMENT		0		_	20, 440		3. 00
4.00		OTHER ADMINISTRATIVE &	0	0	0	5, 000		4. 00
5. 00		GENERAL NURSING ADMINISTRATION	0	0		2, 210, 837		5. 00
6. 00				1 0	_	517, 500		6. 00
7. 00	52. OO DELI VERY ROOM & LABOR ROOM 54. OO RADI OLOGY-DI AGNOSTI C		1			1, 260		7. 00
8. 00	54. OURADI OLOGY-DI AGNOSTI C 57. OO CT SCAN		0			2, 900		8.00
9. 00		CARDIAC REHABILITATION	1			13, 313		9. 00
10. 00		ANESTHESI OLOGY	1 0		n n	4, 024, 076		10.00
200.00			0		Ö			200.00
			· ·		1			

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0034 Peri od: Worksheet B From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/22/2022 9:31 am CAPITAL RELATED COSTS **PURCHASI NG** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** RECEIVING AND for Cost **BENEFITS** DEPARTMENT **STORES** Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 10, 245, 235 10, 245, 235 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 10, 200, 895 10, 200, 895 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 14, 567, 040 41, 151 1, 272 14, 609, 463 4.00 00560 PURCHASING RECEIVING AND STORES 86, 384 5 01 79, 143 7, 031 5 01 673 855 846 413 5.02 00570 ADMITTING 3,060,997 100,074 10, 155 473, 711 1, 492 5.02 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 3, 054, 026 12, 271 0 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 26, 975, 474 497, 019 1,096,340 957, 269 5.04 3.452 00700 OPERATION OF PLANT 7 00 10.373.688 1, 388, 363 279, 100 434, 159 1, 112 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 1, 103, 878 16, 922 19, 312 28 8.00 00900 HOUSEKEEPI NG 370, 089 3, 317 9.00 3, 160, 638 65, 761 28, 156 9.00 01000 DI ETARY 2, 414, 683 57, 713 229, 317 5, 480 10.00 125, 361 10.00 24, 734 134, 592 11.00 01100 CAFETERI A 432, 625 84, 054 2.348 11.00 13.00 01300 NURSING ADMINISTRATION 5,064,009 73, 554 80, 496 720, 567 5, 991 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 14.00 01500 PHARMACY 0 0 15.00 15.00 0 0 01600 MEDICAL RECORDS & LIBRARY 16.00 2, 372, 171 36, 673 0 0 0 16.00 01700 SOCIAL SERVICE 0 0 17.00 17.00 0 19.00 01900 NONPHYSICIAN ANESTHETISTS C 0 O 19.00 02300 PARAMEDICAL EDUCATION PROGRAM EMS 7, 706 368, 551 3,851 54, 680 1, 159 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 521, 013 273, 032 2, 608, 146 51, 954 30.00 18, 801, 302 30.00 03100 INTENSIVE CARE UNIT 5, 833, 112 203, 935 24, 612 31.00 31.00 228, 038 811, 176 04100 SUBPROVIDER - IRF 4, 179 41.00 3.305.074 190, 307 17, 031 356, 959 41.00 04300 NURSERY 43.00 1, 568, 037 81, 642 105, 953 208, 300 4, 517 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 23, 171, 386 842, 886 3, 363, 667 1, 270, 379 401, 614 50.00 51.00 05100 RECOVERY ROOM 3, 639, 849 267, 644 99, 858 535, 107 9, 945 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 119, 459 110, 368 52.00 85,044 217, 455 4,705 52.00 53.00 05300 ANESTHESI OLOGY 424, 811 4, 200 7, 641 12, 625 53.00 05400 RADI OLOGY-DI AGNOSTI C 5. 385. 965 251, 850 712.389 604, 725 54 00 17,684 54 00 55.00 05500 RADI OLOGY - THERAPEUTI C 1, 347, 519 52, 432 32, 508 110, 100 1, 071 55.00 05600 RADI OI SOTOPE 56, 00 1, 613, 653 102, 295 52, 933 103, 470 1,041 56.00 05700 CT SCAN 781, 719 203, 880 57.00 2, 464, 836 70.534 9.073 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 2, 157 1, 318, 834 63, 175 494, 460 98, 952 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 3, 531, 895 149, 156 1, 244, 669 294, 395 39, 429 59.00 60.00 06000 LABORATORY 9, 861, 261 196, 138 138, 384 697, 872 154, 487 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62 00 C Ω Ω 62 00 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 1, 525, 387 15, 481 16, 126 42, 623 6, 243 63.00 64.00 06400 I NTRAVENOUS THERAPY 550, 153 41, 237 14, 897 72, 168 2, 771 64.00 65.00 06500 RESPIRATORY THERAPY 3, 179, 784 63, 453 45, 488 436, 663 11,038 65.00 06600 PHYSI CAL THERAPY 358, 016 66 00 3.768.854 41, 484 3, 596 66 00 2, 561 67.00 06700 OCCUPATIONAL THERAPY 1,038,520 19, 751 977 135 67.00 06800 SPEECH PATHOLOGY 627, 328 5, 710 62, 838 1, 601 68.00 450 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 291, 892 64.807 302, 528 149, 925 1.683 69.00 5, 705 70.00 07000 ELECTROENCEPHALOGRAPHY 76, 986 654, 160 46, 479 28, 675 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 11, 141, 952 0 71.00 C 0 07200 IMPL. DEV. CHARGED TO PATIENTS 15, 803, 937 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 16, 158, 077 62, 429 462, 236 73.00 217, 841 3,859 73.00 07400 RENAL DIALYSIS 74.00 831, 862 74.00 07697 CARDIAC REHABILITATION 557, 260 136, 018 3, 109 85, 246 354 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2, 233, 999 64.926 230, 975 7.443 90.00 233, 800 91.00 09100 EMERGENCY 7, 237, 431 324, 016 104, 784 974, 028 40, 597 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 470, 198 58 101.00 3, 246, 084 Ol 2, 461 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 247, 301, 438 8,005,603 10, 133, 529 14, 607, 250 846, 372 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 12.357 191. 00 19100 RESEARCH 13, 972 0 2, 213 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 9, 290 2, 211, 863 0 0 3 192.00 194. 00 07950 OTHER NON-REIMBURSABLE COST CENTER 495, 102 66, 811 0 37 194, 00 194. 01 07952 ADVERTI SI NG 365,001 15, 412 555 0 1 194, 01 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 10, 245, 235 TOTAL (sum lines 118 through 201) 248, 184, 803 10, 200, 895 14, 609, 463 846, 413 202. 00 202.00

Provider CCN: 15-0034

Peri od: Worksheet B From 07/01/2021 Part I To 06/30/2022 Date/Time Prepared: 11/22/2022 9:31 am

						11/22/2022 9:	31 am
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	OPERATION OF	
			OUNTS		ADMI NI STRATI VE	PLANT	
		E 02	RECEI VABLE	EA 02	& GENERAL	7. 00	
	GENERAL SERVICE COST CENTERS	5. 02	5. 03	5A. 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						5. 01
5. 02	00570 ADMITTING	3, 646, 429					5. 02
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0,010,127	3, 066, 297				5. 03
5. 04	00590 OTHER ADMINISTRATIVE & GENERAL	0	0	29, 529, 554	29, 529, 554		5. 04
7. 00	00700 OPERATION OF PLANT	0	0	12, 476, 422		l e	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	o	1, 140, 140			
9.00	00900 HOUSEKEEPI NG	0	o	3, 627, 961	489, 960	114, 587	9. 00
10.00	01000 DI ETARY	0	0	2, 832, 554	382, 539	218, 437	10.00
11. 00	01100 CAFETERI A	0	0	678, 353	91, 612	146, 462	11. 00
13.00	01300 NURSING ADMINISTRATION	0	0	5, 944, 617	802, 826	128, 165	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	C	0	0	1
15. 00	01500 PHARMACY	0	0	C	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	2, 408, 844	_		
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	405.043	0	0	
23. 00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	0	435, 947	58, 875	13, 427	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	220 542	105 4/5	22 //1 /75	3, 195, 506	2 (50 200	30.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	220, 563	185, 465				
41. 00	04100 SUBPROVI DER – I RF	48, 836 23, 307	41, 065 19, 598			1	1
43.00	04300 NURSERY	23, 307 14, 534	19, 396	1, 995, 205		l	
43.00	ANCI LLARY SERVI CE COST CENTERS	14, 554	12, 222	1, 995, 205	207, 434	142, 230	43.00
50. 00	05000 OPERATING ROOM	498, 432	419, 235	29, 967, 599	4, 047, 099	1, 468, 698	50.00
51. 00	05100 RECOVERY ROOM	62, 905	52, 895			1	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	15, 164	12, 751	1, 564, 946			
53. 00	05300 ANESTHESI OLOGY	98, 523	82, 845	630, 645			1
54.00	05400 RADI OLOGY-DI AGNOSTI C	204, 611	172, 052			l	1
55.00	05500 RADI OLOGY - THERAPEUTI C	71, 811	60, 384	1, 675, 825			1
56.00	05600 RADI 0I SOTOPE	59, 089	49, 686	1, 982, 167	267, 694	178, 246	56. 00
57.00	05700 CT SCAN	257, 138	216, 220	4, 003, 400	540, 663	122, 903	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	115, 527	97, 144	2, 190, 249	295, 795	110, 081	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	283, 141	238, 085	5, 780, 770	780, 699	259, 899	59. 00
60.00	06000 LABORATORY	433, 101	364, 182	11, 845, 425	1, 599, 736	341, 764	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	_	-	
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	17, 578	14, 781	1, 638, 219			
64. 00	06400 I NTRAVENOUS THERAPY	12, 591	10, 588				
65. 00	06500 RESPI RATORY THERAPY	45, 817	38, 526	3, 820, 769		l	
66.00	06600 PHYSI CAL THERAPY	61, 361	51, 596			l	
67.00	06700 OCCUPATI ONAL THERAPY	20, 448				1	
68. 00	06800 SPEECH PATHOLOGY	5, 251	4, 415			1	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	108, 736	91, 433			1	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32, 543 101, 675		· ·			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	118, 652	99, 771			l	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	331, 988					
74. 00	07400 RENAL DIALYSIS	12, 503	10, 513	854, 881			74.00
	07697 CARDI AC REHABI LI TATI ON	7, 040				l	1
	OUTPATIENT SERVICE COST CENTERS	.,	57.1=0				
90.00	09000 CLI NI C	28, 436	23, 911	2, 823, 490	381, 315	407, 389	90.00
91.00		318, 291	267, 642				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			C			92. 00
	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	16, 837	14, 158	3, 749, 796	506, 414	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 646, 429	3, 066, 297	244, 992, 186	29, 098, 388	10, 258, 900	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12, 357			190. 00
	19100 RESEARCH	0	0	16, 185			191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	2, 221, 156			
	07950 OTHER NON-REIMBURSABLE COST CENTER	0	0	561, 950		l e	194. 00
	07952 ADVERTI SI NG	0	0	380, 969		26, 855 I	194. 01
200.00		_	_ ا	0		_	200. 00
201.00		2 444 420	2 044 207	240 104 003	20 520 554	l	201. 00
202.00	TOTAL (sum lines 118 through 201)	3, 646, 429	3, 066, 297	248, 184, 803	29, 529, 554	14, 101, 3/5	1202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0034

Peri od: Worksheet B From 07/01/2021 Part I To 06/30/2022 Date/Time Prepared:

11/22/2022 9:31 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG ADMI NI STRATI ON LINEN SERVICE 9.00 10.00 11.00 8.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 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 5.02 00570 ADMITTING 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.03 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 5.04 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 1, 323, 603 8.00 9.00 00900 HOUSEKEEPI NG 4, 232, 508 9 00 01000 DI ETARY 65, 957 10.00 3, 499, 487 10 00 0 11.00 01100 CAFETERI A 0 44, 224 960, 651 11.00 13.00 01300 NURSING ADMINISTRATION 0 38, 699 0 58, 815 6, 973, 122 13.00 0 01400 CENTRAL SERVICES & SUPPLY 14.00 0 0 14.00 01500 PHARMACY 0 15.00 0 0 15.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 19, 295 0 0 0 16.00 01700 SOCIAL SERVICE 0 17 00 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 19.00 0 02300 PARAMEDICAL EDUCATION PROGRAM EMS 23.00 4,054 0 5, 766 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 964, 523 800, 258 2, 477, 239 214, 503 2, 637, 469 30.00 03100 INTENSIVE CARE UNIT 31.00 163, 946 119, 979 206, 521 57,662 706, 441 31.00 41.00 04100 SUBPROVI DER - I RF 149, 375 100, 127 348, 624 29, 984 365, 358 41.00 43.00 04300 NURSERY 45, 759 42, 955 14, 992 179, 455 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 443.472 115, 324 1, 418, 701 50.00 51.00 05100 RECOVERY ROOM 0 140, 817 149, 907 41, 517 507, 074 51.00 05200 DELIVERY ROOM & LABOR ROOM 44, 744 52.00 0 0 0 96,036 14, 992 187, 345 52.00 05300 ANESTHESI OLOGY 2, 210 53.00 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 56, 509 54.00 132, 507 0 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 27, 586 0 8,073 0 55.00 000000000000000000 56.00 05600 RADI OI SOTOPE 53, 821 0 6, 919 0 56.00 57 00 05700 CT SCAN 37, 110 O 17, 299 57 00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 33, 239 8, 073 0 58.00 05900 CARDIAC CATHETERIZATION 78, 476 0 21, 912 0 59.00 59.00 60.00 06000 LABORATORY 103, 195 0 80.727 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 0 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 8, 145 0 3, 460 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 21, 696 6, 919 0 64.00 65 00 06500 RESPIRATORY THERAPY 33, 385 0 65 00 31, 138 0 06600 PHYSI CAL THERAPY 0 66.00 188, 365 0 0 66.00 06700 OCCUPATI ONAL THERAPY 10, 392 0 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 3, 004 0 0 0 68.00 06900 ELECTROCARDI OLOGY 0 34, 097 12 686 69 00 69 00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 24, 454 0 8,073 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 73 00 32, 846 33, 444 0 73 00 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 07697 CARDIAC REHABILITATION 76.97 71, 564 6.919 86, 708 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 123.011 O 20.758 0 90 00 09100 EMERGENCY 0 170, 476 221, 160 71, 501 884, 571 91.00 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 12, 686 0 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1, 323, 603 3, 054, 160 3, 499, 487 960, 651 6, 973, 122 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 6, 502 0 0 190, 00 191. 00 19100 RESEARCH 0 0 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 1, 163, 737 194.00 07950 OTHER NON-REIMBURSABLE COST CENTER 0 0 0 0 194.00 194. 01 07952 ADVERTI SI NG 0 0 0 0 194. 01 8, 109 200.00 Cross Foot Adjustments 200.00 201.00 0 201, 00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) 1, 323, 603 4, 232, 508 3, 499, 487 960, 651 6, 973, 122 202. 00

Provider CCN: 15-0034

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2021 | Part I | To 06/30/2022 | Date/Time Prepared: 11/22/2022 9: 31 am

						11/22/2022 9:	31 am
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	
		SERVICES &		RECORDS &		ANESTHETI STS	
		SUPPLY		LI BRARY			
		14. 00	15. 00	16. 00	17. 00	19. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					I	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4. 00
5. 01						I	5. 01
	00560 PURCHASING RECEIVING AND STORES					I	1
5. 02	00570 ADMI TTI NG					I	5. 02
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					I	5. 03
5. 04	00590 OTHER ADMINISTRATIVE & GENERAL					I	5. 04
7.00	00700 OPERATION OF PLANT					I	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					I	8.00
9. 00	00900 HOUSEKEEPI NG					I	9. 00
	01000 DI ETARY					I	10.00
	01100 CAFETERI A					I	11. 00
	l l					I	1
	01300 NURSI NG ADMINI STRATI ON					I	13. 00
	01400 CENTRAL SERVICES & SUPPLY	0				I	14. 00
15. 00	01500 PHARMACY	0	0			I	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	2, 817, 357		I	16. 00
17.00	01700 SOCIAL SERVICE	0	0	0	0	I	17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	l ol	0	0	o	0	19. 00
	02300 PARAMEDICAL EDUCATION PROGRAM EMS	o	0	0	0	I	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			U U		20.00
20.00	03000 ADULTS & PEDIATRICS		0	170 202	0	0	30.00
		0				0	
	03100 INTENSIVE CARE UNIT	0	0		0	0	
41. 00	04100 SUBPROVI DER – I RF	0	0		0	0	41.00
43.00	04300 NURSERY	0	0	11, 228	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						Ī
50.00	05000 OPERATING ROOM	0	0	385, 429	0	0	50. 00
	05100 RECOVERY ROOM	o	0	48, 596	0	0	1
	05200 DELIVERY ROOM & LABOR ROOM		0		0	Ö	1
		0	_		0		1
	05300 ANESTHESI OLOGY	0	0	76, 112	U	0	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	158, 069	0	0	
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	0	55, 476	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	45, 648	0	0	56.00
57.00	05700 CT SCAN	O	0	198, 647	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	l ol	0		0	0	1
	05900 CARDI AC CATHETERI ZATI ON	l ol	0		0	Ö	1
	l l		0		0	0	1
	06000 LABORATORY	0	-	334, 584	U	1	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62. 00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	13, 579	0	0	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	9, 727	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	35, 395	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	l ol	0	47, 403	0	0	66.00
	06700 OCCUPATI ONAL THERAPY	o	0		0	0	
	06800 SPEECH PATHOLOGY		0		0	Ö	1
	06900 ELECTROCARDI OLOGY		0	84, 002	0	-	1
		0	-		0	0	1
	07000 ELECTROENCEPHALOGRAPHY	0	0	25, 140	U	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	78, 548	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	91, 663	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	256, 472	0	0	73. 00
74.00	07400 RENAL DIALYSIS	o	0	9, 659	0	0	74.00
	07697 CARDIAC REHABILITATION	l ol	0	5, 439	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	-1		-,	-		1
90. 00	09000 CLI NI C	0	0	21, 968	0	0	90. 00
	09100 EMERGENCY	0	0	245, 890	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	0	0	13, 007	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						Ī
118.00		0	0	2, 817, 357	0	0	118. 00
	NONREI MBURSABLE COST CENTERS	<u> </u>		2/01//00/	9		1
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		^		٥	0	190. 00
		0	0]	0		
	19100 RESEARCH	0	0	1 0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	07950 OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0		194. 00
194. 01	07952 ADVERTI SI NG	o	0	0	0	0	194. 01
200.00						0	200. 00
201.00		ا	0	l n	n		201. 00
202.00		o	0		o		202.00
202.00	TIVIAL (Sum TITIES TTO LIMOUGH 201)	ı Y	U	1 2,017,337	۱	U	1202.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0034 Peri od: Worksheet B From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/22/2022 9:31 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 518,069 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 36, 771, 674 0 36, 771, 674 30.00 03100 INTENSIVE CARE UNIT 0 9, 851, 519 0 9, 851, 519 31.00 31.00 41.00 04100 SUBPROVIDER - IRF 0 5, 788, 451 0 5, 788, 451 41.00 04300 NURSERY 0 2, 701, 306 0 2, 701, 306 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 0 37, 846, 322 37, 846, 322 50.00 05000 OPERATING ROOM 0 05100 RECOVERY ROOM 00000000000000000000000 6, 652, 919 0 6, 652, 919 51.00 51.00 οĺ 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 279, 311 2, 279, 311 52.00 53.00 05300 ANESTHESI OLOGY 801, 455 0 801, 455 53.00 05400 RADI OLOGY-DI AGNOSTI C 9, 127, 728 54 00 9, 127, 728 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 2, 084, 643 0 2, 084, 643 55.00 05600 RADI OI SOTOPE 0 56.00 2, 534, 495 2, 534, 495 56 00 57.00 05700 CT SCAN 4, 920, 022 4, 920, 022 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 2, 726, 686 2, 726, 686 58.00 05900 CARDIAC CATHETERIZATION 0 7. 140. 491 7, 140, 491 59.00 59.00 14, 305, 431 60.00 06000 LABORATORY 14, 305, 431 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 1, 911, 622 0 1, 911, 622 63.00 63.00 06400 I NTRAVENOUS THERAPY 0 909, 733 909, 733 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 4, 547, 250 4, 547, 250 65.00 66.00 06600 PHYSI CAL THERAPY 5, 726, 093 5, 726, 093 66.00 06700 OCCUPATIONAL THERAPY 0 1, 305, 794 1, 305, 794 67.00 67.00 06800 SPEECH PATHOLOGY 0 68.00 820, 164 820, 164 68.00 69.00 06900 ELECTROCARDI OLOGY 2, 526, 300 2, 526, 300 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 128, 320 1, 128, 320 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 12, 937, 680 12, 937, 680 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 18, 277, 859 18, 277, 859 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 20, 312, 630 20, 312, 630 73.00 07400 RENAL DIALYSIS 0 979.993 0 979, 993 74.00 74.00 07697 CARDIAC REHABILITATION 76. 97 1, 309, 941 0 1, 309, 941 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3, 777, 931 3, 777, 931 90.00 09100 EMERGENCY 518.069 13, 194, 531 0 13, 194, 531 91 00 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 4, 281, 903 0 4, 281, 903 101.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 518, 069 239, 480, 197 0 239, 480, 197 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 42, 060 42, 060 190.00 191. 00 19100 RESEARCH 0 0 191. 00 18.371 18, 371 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 7, 538, 950 0 7, 538, 950 192.00 194. 00 07950 OTHER NON-REIMBURSABLE COST CENTER 0 0 194.00 637, 842 637, 842 0 194. 01 07952 ADVERTI SI NG 467, 383 0 467, 383 194. 01 200.00 Cross Foot Adjustments 0 0 200.00 0 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 518, 069 248, 184, 803 248, 184, 803 202. 00

| Peri od: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0034

			То	06/30/2022	Date/Time Pre 11/22/2022 9:	
		CAPI TAL REI	LATED COSTS		11/22/2022 /.	J I dill
Cook Cooker Dooreitsting	D:+1	DIDC & FLVT	M/DLE FOULD	C	EMDL OVEE	
Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs	1.00				
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			42, 423		4. 00
5.01 00560 PURCHASING RECEIVING AND STORES 5.02 00570 ADMITTING	0	79, 143 100, 074		86, 174 110, 229	251 1, 375	5. 01 5. 02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	12, 271		12, 271	0	5. 02
5.04 00590 OTHER ADMINISTRATIVE & GENERAL	0	497, 019		1, 593, 359	2, 779	5. 04
7. 00 00700 OPERATION OF PLANT	0	1, 388, 363		1, 667, 463	1, 260	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	0	16, 922 65, 761		16, 922 93, 917	56 1, 074	8. 00 9. 00
10. 00 01000 DI ETARY		125, 361		183, 074	666	10.00
11. 00 01100 CAFETERI A	0	84, 054		108, 788	391	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	73, 554		154, 050	2, 092	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	0	0	0	0	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	36, 673	-	36, 673	0	16. 00
17. 00 01700 SOCI AL SERVI CE	0	0		0	0	17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	-	0	0	19. 00
23. 00 O2300 PARAMEDI CAL EDUCATION PROGRAM EMS INPATIENT ROUTINE SERVICE COST CENTERS	0	7, 706	3, 851	11, 557	159	23. 00
30. 00 03000 ADULTS & PEDI ATRI CS	0	1, 521, 013	273, 032	1, 794, 045	7, 580	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	228, 038		431, 973	2, 355	31. 00
41. 00 04100 SUBPROVI DER - I RF	0	190, 307		207, 338		41. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	81, 642	105, 953	187, 595	605	43. 00
50. 00 05000 OPERATING ROOM	0	842, 886	3, 363, 667	4, 206, 553	3, 688	50. 00
51.00 05100 RECOVERY ROOM	0	267, 644		367, 502	1, 554	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	85, 044		195, 412	631	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	4, 200 251, 850		11, 841 964, 239	0 1, 756	53. 00 54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	Ö	52, 432		84, 940	320	55. 00
56. 00 05600 RADI OI SOTOPE	0	102, 295		155, 228	300	56. 00
57. 00 05700 CT SCAN	0	70, 534		852, 253	592	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	63, 175 149, 156		557, 635 1, 393, 825	287 855	58. 00 59. 00
60. 00 06000 LABORATORY	0	196, 138		334, 522	2, 026	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	-	0	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	15, 481		31, 607	124	63. 00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	41, 237 63, 453		56, 134 108, 941	210 1, 268	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	358, 016		399, 500	10	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	19, 751		20, 728	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	5, 710		68, 548	5	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	64, 807 46, 479		367, 335 75, 154		69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Ö	0		0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0	62, 429	217, 841	280, 270	1, 342 0	73. 00 74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		136, 018	3, 109	139, 127	247	76. 97
OUTPATIENT SERVICE COST CENTERS			,	,		
90. 00 09000 CLI NI C	0			298, 726	671	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	324, 016	104, 784	428, 800 0	2, 828	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS				0		72.00
101.00 10100 HOME HEALTH AGENCY	0	0	2, 461	2, 461	1, 365	101. 00
SPECIAL PURPOSE COST CENTERS		0.005.400	10 400 500	10 100 100	10 117	
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	8, 005, 603	10, 133, 529	18, 139, 132	42, 417	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 357	0	12, 357	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	6	191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	2, 211, 863		2, 211, 863		192. 00
194. 00 07950 OTHER NON-REIMBURSABLE COST CENTER 194. 01 07952 ADVERTISING	0	15, 412	66, 811 555	66, 811 15, 967		194. 00 194. 01
200.00 Cross Foot Adjustments		15, 412		13, 707		200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	10, 245, 235	10, 200, 895	20, 446, 130	42, 423	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0034

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2021 Part II
To 06/30/2022 Pate/Time Prepared:
11/22/2022 9: 31 am

						11/22/2022 9:	
	Cost Center Description	PURCHASI NG	ADMITTI NG	CASHI ERI NG/ACC		OPERATION OF	
		RECEIVING AND		OUNTS	ADMI NI STRATI VE	PLANT	
		STORES	F 02	RECEI VABLE	& GENERAL	7.00	
	GENERAL SERVICE COST CENTERS	5. 01	5. 02	5. 03	5. 04	7. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUI P	1					2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES	86, 425					5. 01
5. 02	00570 ADMITTING	152	111, 756				5. 02
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	12, 271			5. 03
5. 04	00590 OTHER ADMINISTRATIVE & GENERAL	352	0	0	1, 596, 490		5. 04
7.00	00700 OPERATION OF PLANT	114	0	0	91, 090	1, 759, 927	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	3	0	0	8, 324	3, 664	8. 00
9.00	00900 HOUSEKEEPI NG	339	0	0	26, 488	14, 240	9. 00
10.00	01000 DI ETARY	560	0	0	20, 680	27, 147	10. 00
11. 00	01100 CAFETERI A	240	0	0	4, 953	18, 202	11. 00
13. 00	01300 NURSI NG ADMINI STRATI ON	612	0	·		15, 928	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 MEDI CAL RECORDS & LI BRARY	0	0	0	17, 587	7, 941	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	2 102	0	19.00
23. 00	O2300 PARAMEDI CAL EDUCATI ON PROGRAM EMS	118	0	0	3, 183	1, 669	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	5, 305	6, 772	728	172, 752	329, 371	30.00
31. 00	03100 INTENSIVE CARE UNIT	2, 513	1, 499		52, 500	49, 381	31.00
41. 00	04100 SUBPROVI DER – I RF	427	716			41, 210	41. 00
43. 00	04300 NURSERY	461	446	48		17, 679	43. 00
10.00	ANCILLARY SERVICE COST CENTERS	10.1	110		1 17 007	177 077	10.00
50.00	05000 OPERATING ROOM	41, 010	15, 101	1, 877	218, 884	182, 525	50. 00
51.00	05100 RECOVERY ROOM	1, 015	1, 931	208		57, 958	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	480	466			18, 416	52. 00
53.00	05300 ANESTHESI OLOGY	1, 289	3, 025	325	4, 604	910	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 806	6, 282	676	53, 657	54, 538	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	109	2, 205	237	12, 235	11, 354	55. 00
56.00	05600 RADI OI SOTOPE	106	1, 814	195	14, 472	22, 152	56. 00
57.00	05700 CT SCAN	926	7, 895	849		15, 274	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	220	3, 547	381		13, 680	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 026	8, 693			32, 299	59. 00
60.00	06000 LABORATORY	15, 774	13, 298			42, 473	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	- 1	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	637	540	58		3, 352	63.00
64. 00	06400 I NTRAVENOUS THERAPY	283	387	42		8, 930	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 127 261	1, 407 1, 884	151 203		13, 741 77, 527	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	14	628	68		4, 277	67. 00
68. 00	06800 SPEECH PATHOLOGY	46	161	17		1, 237	68. 00
69. 00	06900 ELECTROCARDI OLOGY	172	3, 339			14, 034	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	583	999	107	6, 366	10, 065	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 122			0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	o	3, 643			0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	394	10, 193			13, 519	73. 00
74.00	07400 RENAL DIALYSIS	0	384	41	6, 241	0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	36	216	23	5, 804	29, 454	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	760	873	94	20, 614	50, 629	90. 00
91.00	09100 EMERGENCY	4, 145	9, 773	1, 051	67, 657	70, 165	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	6	517	56	27, 377	0	101. 00
440.00	SPECIAL PURPOSE COST CENTERS	0, 101	444 751	10.074	4 570 404	4 074 044	
118. 00	9 /	86, 421	111, 756	12, 271	1, 573, 181	1, 274, 941	118.00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		00	2 /7/	100 00
		0 0	0	0			190. 00 191. 00
	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES		0	·		478, 973	
	07950 OTHER NON-REIMBURSABLE COST CENTER		0	·			194. 00
	107950 OTHER NON-RETWINDURSABLE COST CENTER	0	0				194. 00
200.00		١	U		2, 701	5, 557	200. 00
201.00		n	n	n	n	n	201. 00
202.00		86, 425	111, 756	12, 271	1, 596, 490		
300	(3.2. (,	, -, .	, , - , - , - , - ,	, ,	

Provider CCN: 15-0034

						11/22/2022 9:	31 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						
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	28, 969					8. 00
9. 00	00900 HOUSEKEEPING	20,707	136, 058				9. 00
10. 00	01000 DI ETARY	0	2, 120				10.00
11. 00	01100 CAFETERI A	0	1, 422		133, 996		11. 00
		0		1			
13.00	01300 NURSI NG ADMI NI STRATI ON	0	1, 244		8, 204		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0	0	14. 00
15. 00	01500 PHARMACY	0	0		0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	620		0	0	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0		0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
23.00	02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	130	0	804	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	21, 110	25, 725	165, 821	29, 923	85, 305	30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 588	3, 857	13, 824	8, 043	22, 848	31. 00
41.00	04100 SUBPROVI DER - I RF	3, 269	3, 219		4, 182		41.00
43. 00	04300 NURSERY	1, 002	1, 381		2, 091		
10.00	ANCILLARY SERVICE COST CENTERS	1,002	1,001	<u> </u>	2,071	0,001	10.00
50. 00	05000 OPERATI NG ROOM	0	14, 256	0	16, 086	45, 885	50.00
51. 00	05100 RECOVERY ROOM	0	4, 527		5, 791		
	05200 DELIVERY ROOM & LABOR ROOM	0					
52. 00	1 1	0	1, 438		2, 091		52.00
53. 00	05300 ANESTHESI OLOGY	0	71			0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 260	0	7, 882		54.00
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	887	0	1, 126		55. 00
56. 00	05600 RADI 0I SOTOPE	0	1, 730	0	965	0	56. 00
57.00	05700 CT SCAN	0	1, 193	0	2, 413	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 068	0	1, 126	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	2, 523	0	3, 056		59. 00
60.00	06000 LABORATORY	0	3, 317		11, 260		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0,0.7		0		62. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	262		483		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	697		965		64. 00
		0					
65. 00	06500 RESPIRATORY THERAPY	0	1, 073		4, 343		65. 00
66.00	06600 PHYSI CAL THERAPY	0	6, 055		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	334		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	97		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 096	0	1, 769		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	786	0	1, 126	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 056	0	4, 665	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0		74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	2, 300	0	965	2, 804	76. 97
	OUTPATIENT SERVICE COST CENTERS		, , , , , ,	-1			
90.00	09000 CLI NI C	0	3, 954	0	2, 895	0	90. 00
91. 00	09100 EMERGENCY	0	5, 480		9, 973		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	J	3, 400	14,004	7, 773	20,010	92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
101 00			0		1 7/0		101 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	1, 769	0	101. 00
110.00	SPECIAL PURPOSE COST CENTERS	20.010	00.470	004 0:-	400.007	005 500	110 00
118. 00		28, 969	98, 178	234, 247	133, 996	225, 532	118.00
	NONREI MBURSABLE COST CENTERS			1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	209	0	0		190. 00
	19100 RESEARCH	0	0	0	0		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	37, 410	0	0	0	192. 00
	07950 OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0		194. 00
	07952 ADVERTI SI NG	o o	261	o	0		194. 01
200.00			231	l I	J	1	200. 00
201.00	1 1	n	0	n	Λ	0	201.00
202.00		28, 969	136, 058	234, 247	133, 996		
202.00	1.0me (sam iiilos iio tiiioagii 201)	20, 707	130, 030	257, 247	155, 770	, 225, 552	1202.00

| Peri od: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0034

				Ť	o 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		31 alli
	· ·	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 & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES						5. 01
5. 02 5. 03	00570 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	62, 821			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 & PEDIATRICS	0	0	3, 786			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	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	250	0		43.00
50. 00	05000 OPERATING ROOM	0	0	8, 779	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, 691			53. 00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	0	0	3, 513 1, 233			54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	0	0	1, 233			56.00
57. 00	05700 CT SCAN	0	0	4, 414			57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1, 983	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	.,			59. 00
60. 00 62. 00	06000 LABORATORY	0	0	7, 435 0			60. 00 62. 00
63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	302	-		63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	216			64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	787	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	1, 053			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	351	0		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	90 1, 867			68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1, 746			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	5, 699			73.00
74. 00 76. 97	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON	0	0	215 121			74. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>		121	0		70. 77
90.00	09000 CLI NI C	0	0	488	0		90.00
91. 00	09100 EMERGENCY	0	0	5, 464	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	289	0		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	U	0	209	U		1101.00
118.00		0	0	62, 821	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	62, 821	0	0	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0034 Peri od: Worksheet B From 07/01/2021 Part II Date/Time Prepared: 06/30/2022 11/22/2022 9:31 am Cost Center Description PARAMEDI CAL Subtotal Intern & Total **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 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 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 23.00 17,620 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 648, 223 0 2, 648, 223 30.00 03100 INTENSIVE CARE UNIT 593, 380 0 593, 380 31.00 31.00 41.00 04100 SUBPROVIDER - IRF 325, 621 0 325, 621 41.00 04300 NURSERY 231, 929 0 231, 929 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 4, 754, 644 0 4, 754, 644 50.00 05000 OPERATING ROOM 05100 RECOVERY ROOM 502, 083 0 502, 083 51.00 51.00 οĺ 52.00 05200 DELIVERY ROOM & LABOR ROOM 243, 157 243, 157 52.00 53.00 05300 ANESTHESI OLOGY 23, 756 0 23, 756 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 1, 098, 609 54 00 1,098,609 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 114, 646 0 114, 646 55.00 05600 RADI OI SOTOPE 197, 976 0 197, 976 56.00 56.00 57.00 05700 CT SCAN 915, 038 915, 038 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 595, 918 595, 918 58.00 05900 CARDIAC CATHETERIZATION 0 1, 493, 278 1. 493. 278 59.00 59.00 60.00 06000 LABORATORY 518, 018 518, 018 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 49, 326 0 49, 326 63.00 0 06400 I NTRAVENOUS THERAPY 73,007 73,007 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 160, 733 0 160, 733 65.00 66.00 06600 PHYSI CAL THERAPY 517, 796 0 517, 796 66.00 06700 OCCUPATIONAL THERAPY 34, 409 0 34, 409 67.00 67.00 06800 SPEECH PATHOLOGY 0 68.00 75, 367 75, 367 68.00 69.00 06900 ELECTROCARDI OLOGY 405, 088 405, 088 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 95, 969 95, 969 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 87, 918 0 87, 918 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 123, 051 0 123, 051 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 446, 115 446, 115 73.00 07400 RENAL DIALYSIS 0 74.00 6.881 6.881 74.00 07697 CARDIAC REHABILITATION 0 76. 97 181, 09₇ 181, 097 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 379, 704 0 379, 704 90.00 09100 EMERGENCY 0 91 00 91 00 648, 750 648.750 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 33, 840 0 33, 840 101.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 17, 575, 327 0 17, 575, 327 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 15, 332 15, 332 190.00 191. 00 19100 RESEARCH 0 191. 00 124 124 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 2, 744, 463 2, 744, 463 192.00 194. 00 07950 OTHER NON-REIMBURSABLE COST CENTER 70, 918 0 70, 918 194.00 194. 01 07952 ADVERTI SI NG 22.346 0 22, 346 194. 01 200.00 Cross Foot Adjustments 17,620 17, 620 0 17, 620 200.00 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118 through 201) 17.620 20, 446, 130 0 20, 446, 130 202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0034 Peri od: Worksheet B-1 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/22/2022 9:31 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 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 590 305 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 24, 931, 902 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 371 3, 108 81, 723, 013 4.00 00560 PURCHASING RECEIVING AND STORES 5 01 483 219 728 559 5 01 4 560 17, 185 5.02 00570 ADMITTING 5,766 24,820 2, 649, 863 1, 284 1, 203, 988, 103 5.02 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 707 5.03 2, 971 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 28, 637 2, 679, 556 5, 354, 810 5.04 0 00700 OPERATION OF PLANT 957 7 00 79,994 2, 428, 617 7 00 682, 145 0 8.00 00800 LAUNDRY & LINEN SERVICE 975 108, 028 24 0 8.00 00900 HOUSEKEEPI NG 3, 789 2, 070, 222 9.00 68, 817 2,855 0 9.00 01000 DI ETARY 1, 282, 762 4,717 10.00 7.223 141.056 10.00 0 2.021 11.00 01100 CAFETERI A 4.843 60, 452 752, 887 0 11.00 13.00 01300 NURSING ADMINISTRATION 4, 238 196, 739 4, 030, 736 5, 157 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 14.00 01500 PHARMACY 0 0 0 15.00 15.00 0 0 01600 MEDICAL RECORDS & LIBRARY 16.00 2.113 C 0 0 0 16.00 01700 SOCIAL SERVICE 0 0 0 17.00 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS C O 0 19.00 02300 PARAMEDICAL EDUCATION PROGRAM EMS 444 9.411 305, 871 998 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 667, 316 14, 589, 548 44, 720 72, 817, 107 30.00 03000 ADULTS & PEDIATRICS 87,637 30.00 03100 INTENSIVE CARE UNIT 4, 537, 591 21, 185 16, 122, 835 31.00 13.139 498, 435 31.00 04100 SUBPROVIDER - IRF 41.00 10.965 41, 626 1, 996, 770 3, 597 7, 694, 504 41.00 04300 NURSERY 43.00 4,704 258, 960 1, 165, 196 3,888 4, 798, 402 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 48, 565 8, 221, 084 7, 106, 300 345, 692 164, 702, 303 50.00 20, 767, 594 51.00 05100 RECOVERY ROOM 15.421 244, 063 2, 993, 304 8, 560 51.00 4, 900 05200 DELIVERY ROOM & LABOR ROOM 269, 750 4,050 5, 006, 274 52.00 1, 216, 411 52.00 53.00 05300 ANESTHESI OLOGY 242 18, 675 10, 867 32, 526, 675 53.00 1, 741, 145 3, 382, 734 05400 RADI OLOGY-DI AGNOSTI C 67, 550, 742 54 00 14.511 15, 222 54 00 55.00 05500 RADI OLOGY - THERAPEUTI C 3,021 79, 453 615, 880 922 23, 707, 796 55.00 05600 RADI OI SOTOPE 19, 507, 698 56, 00 5,894 129, 374 578, 795 896 56.00 1, 140, 471 7, 810 84, 891, 984 57.00 05700 CT SCAN 4.064 1, 910, 592 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3, 640 1, 208, 506 38, 140, 457 58.00 553, 524 1,857 58.00 59.00 05900 CARDIAC CATHETERIZATION 8,594 3, 042, 085 1, 646, 799 33, 939 93, 476, 708 59.00 60.00 06000 LABORATORY 11, 301 338, 222 3, 903, 784 132, 976 142, 984, 697 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62 00 Ω 62 00 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 892 39, 414 238, 424 5, 374 5, 803, 109 63.00 64.00 06400 I NTRAVENOUS THERAPY 2, 376 36, 409 403, 699 2, 385 4, 156, 914 64.00 65.00 06500 RESPIRATORY THERAPY 3,656 111, 178 2, 442, 624 9,501 15, 126, 050 65.00 06600 PHYSI CAL THERAPY 20, 257, 680 20.628 101.390 2.204 66 00 20, 113 66 00 67.00 06700 OCCUPATIONAL THERAPY 1, 138 2, 389 50 116 6, 750, 650 67.00 06800 SPEECH PATHOLOGY 329 153, 583 8, 956 387 1, 733, 450 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 3,734 739, 406 838, 657 1, 449 35, 898, 427 69.00 10, 743, 670 07000 ELECTROENCEPHALOGRAPHY 430, 649 70.00 2,678 70,085 4.911 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 33, 567, 325 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 39, 172, 134 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 597 73.00 2, 585, 678 3, 322 109, 603, 270 73.00 532, 423 07400 RENAL DIALYSIS 74.00 4, 127, 611 74 00 07697 CARDIAC REHABILITATION 7,837 7,599 476, 855 305 2, 324, 244 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 13.471 158, 685 1. 292, 037 6 407 9, 388, 066 90.00 91.00 09100 EMERGENCY 18, 669 5, 448, 557 34, 944 105, 081, 117 91.00 256, 102 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 5, 558, 610 101. 00 101.00 10100 HOME HEALTH AGENCY 0 6, 014 2, 630, 212 50 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 461, 263 24, 767, 252 81, 710, 633 728, 523 1, 203, 988, 103 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 712 0 190 00 191. 00 19100 RESEARCH 12, 380 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 3 127, 442 0 0 192. 00 194. 00 07950 OTHER NON-REIMBURSABLE COST CENTER 163, 293 0 0 32 0 194, 00 0 194. 01 07952 ADVERTI SI NG 888 1, 357 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, 646, 429 202. 00 202.00 10, 245, 235 10, 200, 895 14, 609, 463 846, 413 Part I)

Heal th Finar	ncial Systems S	T. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 07/01/2021 Fo 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 31 am
		CAPITAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		PURCHASING RECEIVING AND	ADMITTING (GROSS REVE	
				DEPARTMENT (GROSS	STORES (COSTED REQ)	NUE)	
				SALARI ES)	` ,		
		1. 00	2.00	4.00	5. 01	5. 02	
203.00	Unit cost multiplier (Wkst. B, Part I)	17. 355833	0. 409150	0. 178768	1. 161763	0. 003029	203. 00
204. 00	Cost to be allocated (per Wkst. B,			42, 423	86, 425	111, 756	204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part II)			0. 000519	0. 118625	0.000093	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0034 Peri od: Worksheet B-1 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/22/2022 9:31 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, 203, 988, 103 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL -29, 529, 554 218, 655, 249 5.04 7.00 00700 OPERATION OF PLANT 0 12, 476, 422 468, 270 7.00 43, 330 00800 LAUNDRY & LINEN SERVICE 1, 140, 140 8 00 0 Ω 975 8 00 00900 HOUSEKEEPI NG 9.00 0 3, 627, 961 3, 789 0 9.00 10.00 01000 DI ETARY 2, 832, 554 7, 223 0 10.00 11.00 01100 CAFETERI A 0 0 678, 353 4,843 11.00 0 01300 NURSING ADMINISTRATION 13 00 5, 944, 617 13 00 4.238 0 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 14.00 0 01500 PHARMACY 15.00 0 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 0 2, 408, 844 2 113 16 00 0 17.00 01700 SOCIAL SERVICE 0 \cap 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 0 02300 PARAMEDICAL EDUCATION PROGRAM EMS 435, 947 444 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 72, 817, 107 0 23, 661, 475 87,637 31, 575 30.00 16, 122, 835 03100 INTENSIVE CARE UNIT 7, 190, 774 5, 367 31.00 13, 139 31.00 41.00 04100 SUBPROVIDER - IRF 7, 694, 504 0 3, 916, 455 10, 965 4,890 41.00 <u>1, 995,</u> 205 04300 NURSERY 4, 798, 402 4.704 1, 498 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 164, 702, 303 29, 967, 599 48, 565 50.00 05000 OPERATING ROOM 0 05100 RECOVERY ROOM 20, 767, 594 51.00 0 4, 668, 203 15. 421 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 4, 900 5,006,274 1, 564, 946 Ω 0 52.00 53.00 05300 ANESTHESI OLOGY 32, 526, 675 0 630, 645 242 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 7, 349, 276 54.00 67, 550, 742 14, 511 54.00 23, 707, 796 1, 675, 825 55.00 05500 RADI OLOGY - THERAPEUTI C 0 3.021 55.00 0 19, 507, 698 56.00 05600 RADI OI SOTOPE 1, 982, 167 5.894 0 56.00 05700 CT SCAN 84, 891, 984 4,003,400 57.00 57.00 4,064 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 38, 140, 457 2, 190, 249 3,640 0 58.00 05900 CARDIAC CATHETERIZATION 93, 476, 708 59.00 0 5, 780, 770 8.594 59.00 0 0 60.00 06000 LABORATORY 142, 984, 697 11, 845, 425 11, 301 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 5, 803, 109 1, 638, 219 892 63.00 63.00 06400 INTRAVENOUS THERAPY 4, 156, 914 0 704, 405 64.00 2, 376 Λ 64.00 65.00 06500 RESPIRATORY THERAPY 15, 126, 050 3, 820, 769 3,656 0 65.00 66.00 06600 PHYSI CAL THERAPY 20, 257, 680 4, 287, 468 20, 628 66.00 06700 OCCUPATIONAL THERAPY 6, 750, 650 1, 097, 034 1, 138 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 1, 733, 450 707, 593 329 0 68.00 69.00 06900 ELECTROCARDI OLOGY 35, 898, 427 2, 011, 004 3, 734 69.00 07000 ELECTROENCEPHALOGRAPHY 10, 743, 670 0 871, 912 70.00 70.00 2.678 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT C 11, 329, 123 71 00 33, 567, 325 0 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 39, 172, 134 0 16, 022, 360 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 109, 603, 270 17, 515, 590 3, 597 0 73.00 07400 RENAL DIALYSIS 0 74.00 4, 127, 611 854.881 0 74.00 07697 CARDIAC REHABILITATION 76. 97 2, 324, 244 0 794, 947 7,837 0 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 9, 388, 066 2, 823, 490 13.471 0 90.00 105, 081, 117 09100 EMERGENCY 9, 266, 789 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 5, 558, 610 0 3, 749, 796 0 101. 00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) | 1,203,988,103 -29, 529, 554 215, 462, 632 339, 228 43, 330 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 12, 357 712 0 190. 00 191. 00 19100 RESEARCH 0 191.00 0 Ω 16, 185 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 2, 221, 156 127, 442 0 192.00 0 194.00 194. 00 07950 OTHER NON-REIMBURSABLE COST CENTER 0 561, 950 380, 969 194. 01 07952 ADVERTI SI NG 0 888 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, 3.066.297 29, 529, 554 14. 161. 375 1, 323, 603 202. 00 Part I) 30. 547034 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002547 0.135051 30. 241901

Heal th Fina	ncial Systems	ST. MARY MEDICAL	L CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der Co		Period: From 07/01/2021	Worksheet B-1	
					Го 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Cost Center Description	CASHI ERI NG/ACC	Reconciliation	OTHER	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,	12, 271		1, 596, 490	1, 759, 927	28, 969	204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000010		0. 00730	3. 758359	0. 668567	205 00
205.00	II)	0.000010		0.00730	3. 756359	0.000007	203.00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
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 07/01/2021 06/30/2022 Date/Time Prepared: 11/22/2022 9:31 am Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL (SQUARE FEET) (MEALS SERVED) (NUMBER OF ADMI NI STRATI ON SERVICES & **SUPPLY** FTES) (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 463, 506 9.00 10.00 01000 DI ETARY 7, 223 147, 980 10.00 01100 CAFETERI A 4,843 833 11.00 11.00 01300 NURSING ADMINISTRATION 1, 020, 856 13 00 4 238 13 00 51 14.00 01400 CENTRAL SERVICES & SUPPLY C C 0 14.00 01500 PHARMACY 15.00 0 0 0 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16 00 2 113 Ω 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 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 87,637 104, 753 186 386, 122 0 30.00 03100 INTENSIVE CARE UNIT 8, 733 50 103, 422 0 31.00 31.00 13, 139 14, 742 41.00 04100 SUBPROVIDER - IRF 10, 965 26 53, 488 0 41.00 04300 NURSERY 4.704 26, 272 43.00 13 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 48, 565 207, 696 50.00 05000 OPERATING ROOM 100 0 05100 RECOVERY ROOM 51.00 15. 421 6. 339 36 74. 235 0 51.00 4, 900 05200 DELIVERY ROOM & LABOR ROOM 52.00 4.061 13 27, 427 0 52.00 05300 ANESTHESI OLOGY 242 0 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 14, 511 49 0 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 3.021 0 0 7 0 55.00 0 56.00 05600 RADI OI SOTOPE 5.894 C 6 0 56.00 05700 CT SCAN 15 0 0 0 0 0 0 57.00 57.00 4,064 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3,640 0 58.00 05900 CARDIAC CATHETERIZATION 8.594 19 59.00 59.00 0 0 60.00 06000 LABORATORY 11, 301 0 70 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 892 3 63.00 0 63.00 06400 INTRAVENOUS THERAPY 6 64.00 2,376 0 Λ 64.00 65.00 06500 RESPIRATORY THERAPY 3,656 27 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 20, 628 C 0 66.00 06700 OCCUPATIONAL THERAPY 1, 138 0 67.00 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 329 0 Ω 68.00 69.00 06900 ELECTROCARDI OLOGY 3,734 11 0 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 2.678 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 0 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 3,597 0 29 0 73.00 07400 RENAL DIALYSIS 74.00 74.00 C 0 0 76. 97 07697 CARDIAC REHABILITATION 7,837 12, 694 0 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 13, 471 18 0 90.00 09100 EMERGENCY 9, 352 62 129, 500 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 11 0 101. 00 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 334, 464 147, 980 833 1, 020, 856 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 0 0 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 127, 442 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 888 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, 4, 232, 508 3, 499, 487 6. 973. 122 0 202.00 960, 651 Part I)

9. 131506

23. 648378 1, 153. 242497

0. 000000 203. 00

6.830662

Unit cost multiplier (Wkst. B, Part I)

203.00

Health Fin	ancial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der CO		Peri od: From 07/01/2021	Worksheet B-1	
					To 06/30/2022	Date/Time Pre 11/22/2022 9:	
	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, Part II)	136, 058	234, 247	133, 99	6 225, 532	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 293541	1. 582964	160. 85954	4 0. 220924	0. 000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	Financial Systems LLOCATION - STATISTICAL BASIS	ST. MARY MEDICAL	Provider C	CN: 15-0034 P	In Lie	u of Form CMS- Worksheet B-1	
0031 A	ELECTION - STATISTICAL BASIS		Trovider C	F	rom 07/01/2021 o 06/30/2022	Date/Time Pre	pared:
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	11/22/2022 9: PARAMEDI CAL	31 am
	·	(COSTED	RECORDS &		ANESTHETI STS	EDUCATION	
		REQUIS.)	LI BRARY (GROSS REVE	(TIME SPENT)	(ASSIGNED TIME)	PROGRAM EMS (ASSIGNED	
		15. 00	NUE) 16. 00	17. 00	19. 00	TIME) 23.00	
	GENERAL SERVICE COST CENTERS	15.00	16.00	17.00	19.00	23.00	
1	00100 CAP REL COSTS-BLDG & FIXT						1.00
1	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES						5. 01
	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE						5. 02 5. 03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5. 04
1	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
1	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						11.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	1, 203, 988, 103				15. 00 16. 00
	01700 SOCIAL SERVICE	Ö	0	o c			17. 00
1	01900 NONPHYSICIAN ANESTHETISTS 02300 PARAMEDICAL EDUCATION PROGRAM EMS	0	0			1, 000	19. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	i oi		,		1, 000	23.00
	03000 ADULTS & PEDIATRICS	0	72, 817, 107		I .	0	
4	03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	0	16, 122, 835 7, 694, 504	1	I .	0	
43. 00	04300 NURSERY	0	4, 798, 402	•	0	0	1
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	164, 702, 303	l c	ol	0	50.00
51. 00	05100 RECOVERY ROOM	O	20, 767, 594	C	o	0	51.00
1	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	5, 006, 274 32, 526, 675	1	1	0	
	05400 RADI OLOGY-DI AGNOSTI C	Ö	67, 550, 742			0	1
	05500 RADI OLOGY - THERAPEUTI C 05600 RADI OI SOTOPE	0	23, 707, 796 19, 507, 698		1	0	55. 00 56. 00
	05700 CT SCAN	0	84, 891, 984	1	- 1	0	1
1	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	38, 140, 457	1		0	
1	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	93, 476, 708 142, 984, 697			0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0) c		0	
	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	0	5, 803, 109 4, 156, 914		I I	0	
65. 00	06500 RESPI RATORY THERAPY	0	15, 126, 050) c	o	0	65. 00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	20, 257, 680 6, 750, 650	1	0	0	
68. 00	06800 SPEECH PATHOLOGY	Ö	1, 733, 450		Ö	0	
1	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	35, 898, 427	1	1	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10, 743, 670 33, 567, 325		1	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	39, 172, 134	1	- I	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	109, 603, 270 4, 127, 611		- 1	0	73.00
	07697 CARDI AC REHABI LI TATI ON	0	2, 324, 244		o	0	76. 97
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	9, 388, 066	ol c	ol	0	90.00
91. 00	09100 EMERGENCY	O	105, 081, 117	1		1, 000	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	5, 558, 610	C	0	0	101. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)) 0	1, 203, 988, 103	C	ol	1, 000	118. 00
İ	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0				190. 00 191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	O	0) c	o	0	192. 00
	07950 OTHER NON-REIMBURSABLE COST CENTER 07952 ADVERTISING	0	0		0		194. 00 194. 01
200.00	Cross Foot Adjustments		C			0	200.00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	0	0 017 057	,		518, 069	201. 00
	Part I)		2, 817, 357				
203. 00	Unit cost multiplier (Wkst. B, Part I	0. 000000	0. 002340	0.000000	0. 000000	518. 069000	203. 00

Heal th Fir	nancial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der C		eri od:	Worksheet B-1	
					from 07/01/2021 o 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 31 am
	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	62, 821	C	0	17, 620	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000052	0.000000	0.000000	17. 620000	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)						

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I	nared:
					10 00/30/2022	Date/Time Pre 11/22/2022 9:	31 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	1					
30. 00	03000 ADULTS & PEDIATRICS	36, 771, 674		36, 771, 67		36, 771, 674	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	9, 851, 519		9, 851, 51		9, 851, 519	31. 00
41. 00	04100 SUBPROVI DER - I RF	5, 788, 451		5, 788, 45		5, 788, 451	41. 00
43. 00	04300 NURSERY	2, 701, 306		2, 701, 30	0	2, 701, 306	43. 00
	ANCILLARY SERVICE COST CENTERS	1 07 04/ 000				07.044.000	
50. 00	05000 OPERATI NG ROOM	37, 846, 322		37, 846, 32		37, 846, 322	50.00
51. 00	05100 RECOVERY ROOM	6, 652, 919		6, 652, 91		6, 652, 919	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 279, 311		2, 279, 31		2, 279, 311	52. 00
53. 00	05300 ANESTHESI OLOGY	801, 455		801, 45		801, 455	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 127, 728		9, 127, 72		9, 127, 728	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	2, 084, 643		2, 084, 64		2, 084, 643	
56.00	05600 RADI OI SOTOPE	2, 534, 495		2, 534, 49		2, 534, 495	56. 00
57.00	05700 CT SCAN	4, 920, 022		4, 920, 02		4, 920, 022	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 726, 686		2, 726, 68		2, 726, 686	
59. 00	05900 CARDI AC CATHETERI ZATI ON	7, 140, 491		7, 140, 49		7, 140, 491	59. 00
60.00	06000 LABORATORY	14, 305, 431		14, 305, 43		14, 305, 431	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 911, 622		1, 911, 62		1, 911, 622	63.00
64. 00	06400 I NTRAVENOUS THERAPY	909, 733		909, 73	3 0	909, 733	64. 00
65.00	06500 RESPI RATORY THERAPY	4, 547, 250	0	4, 547, 25	0	4, 547, 250	65. 00
66.00	06600 PHYSI CAL THERAPY	5, 726, 093	0	5, 726, 09	3 0	5, 726, 093	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 305, 794	0	1, 305, 79	4 0	1, 305, 794	67. 00
68.00	06800 SPEECH PATHOLOGY	820, 164	0	820, 16	4 0	820, 164	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 526, 300		2, 526, 30	0 0	2, 526, 300	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 128, 320		1, 128, 32	0 0	1, 128, 320	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 937, 680		12, 937, 68	0 0	12, 937, 680	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	18, 277, 859		18, 277, 85	9 0	18, 277, 859	
73.00	07300 DRUGS CHARGED TO PATIENTS	20, 312, 630		20, 312, 63	0	20, 312, 630	73. 00
74.00	07400 RENAL DIALYSIS	979, 993		979, 99	3 0	979, 993	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 309, 941		1, 309, 94	1 0	1, 309, 941	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	3, 777, 931		3, 777, 93	1 0	3, 777, 931	90.00
91.00	09100 EMERGENCY	13, 194, 531		13, 194, 53	1 0	13, 194, 531	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 643, 802		3, 643, 80	2	3, 643, 802	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	4, 281, 903		4, 281, 90		4, 281, 903	
200.00	Subtotal (see instructions)	243, 123, 999	0	243, 123, 99	9 0	243, 123, 999	200. 00
201.00		3, 643, 802		3, 643, 80		3, 643, 802	
202.00	Total (see instructions)	239, 480, 197	0	239, 480, 19	7 0	239, 480, 197	202. 00

From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/22/2022 9:31 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 61, 260, 513 61, 260, 513 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 16, 122, 835 16, 122, 835 31.00 04100 SUBPROVI DER - I RF 41.00 7, 694, 504 7, 694, 504 41.00 43.00 04300 NURSERY 4, 798, 402 4, 798, 402 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 43, 407, 922 121, 294, 381 164, 702, 303 0. 229786 0.000000 50.00 51.00 05100 RECOVERY ROOM 4, 895, 900 15, 871, 694 20, 767, 594 0.320351 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 5, 006, 274 3, 550, 496 1, 455, 778 0.455291 0.000000 52.00 52.00 0.000000 53.00 05300 ANESTHESI OLOGY 8, 139, 528 24, 387, 147 32, 526, 675 0.024640 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 083, 904 59, 466, 838 67, 550, 742 0.135124 0.000000 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 587, 214 23, 120, 582 23, 707, 796 0.087931 0.000000 55.00 05600 RADI 0I SOTOPE 19, 507, 698 0.129923 0.000000 56,00 1, 977, 526 17, 530, 172 56.00 57.00 05700 CT SCAN 21, 034, 801 63, 857, 183 84, 891, 984 0.057956 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 5, 799, 953 32, 340, 504 38, 140, 457 0. 071491 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 23, 350, 240 70, 126, 468 93, 476, 708 0.076388 0.000000 59.00 06000 LABORATORY 142, 984, 697 0.100049 60.00 40, 168, 069 102, 816, 628 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, 727, 921 2, 075, 188 5, 803, 109 0. 329413 0.000000 63.00 63.00 06400 I NTRAVENOUS THERAPY 17, 214 4, 139, 700 4, 156, 914 0. 218848 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 1, 970, 262 65.00 13, 155, 788 15, 126, 050 0.300624 0.000000 65.00 66.00 66.00 06600 PHYSI CAL THERAPY 4, 925, 697 15, 331, 983 20, 257, 680 0.282663 0.000000 06700 OCCUPATIONAL THERAPY 2, 861, 069 6, 750, 650 67.00 3, 889, 581 0.193432 0.000000 67.00 68 00 06800 SPEECH PATHOLOGY 974 869 758 581 1 733 450 0 473140 0 000000 68 00 69.00 06900 ELECTROCARDI OLOGY 8, 992, 325 26, 906, 102 35, 898, 427 0.070374 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 320, 607 10, 423, 063 10, 743, 670 0.105022 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 15, 965, 990 17, 601, 335 33, 567, 325 0.385425 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 17, 440, 696 72.00 21, 731, 438 39, 172, 134 0.466604 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 55, 391, 130 54, 212, 140 109, 603, 270 0. 185329 0.000000 73.00 74.00 07400 RENAL DIALYSIS 3, 898, 869 228, 742 4, 127, 611 0.237424 0.000000 74.00 76 97 07697 CARDIAC REHABILITATION 272, 796 2.051.448 2, 324, 244 0.563599 0.000000 76 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 294, 521 9, 093, 545 9, 388, 066 0. 402418 0.000000 90.00 91.00 09100 EMERGENCY 32, 452, 897 72, 628, 220 105, 081, 117 0.125565 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 679, 958 11, 556, 594 0.315301 0.000000 92.00 92 00 9, 876, 636 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 5, 558, 610 5, 558, 610 101.00 414, 272, 666 200.00 Subtotal (see instructions) 789, 715, 437 1, 203, 988, 103 200.00 201 00 201.00 Less Observation Beds

414, 272, 666

789, 715, 437 1, 203, 988, 103

202.00

202.00

Total (see instructions)

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0034	From 07/01/2021	Worksheet C Part I Date/Time Prepared:

			10 00/00/2022	11/22/2022 9: 31 am
		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				30.00
31.00 03100 INTENSIVE CARE UNIT				31. 00
41. 00 04100 SUBPROVI DER - I RF				41. 00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 229786			50.00
51.00 05100 RECOVERY ROOM	0. 320351			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 455291			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 024640			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 135124			54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 087931			55. 00
56. 00 05600 RADI 0I SOTOPE	0. 129923			56.00
57. 00 05700 CT SCAN	0. 057956			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 071491			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 076388			59. 00
60. 00 06000 LABORATORY	0. 100049			60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CEL				62. 00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS				63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 218848			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 300624			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 282663			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 193432			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 473140			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 070374			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 105022			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 466604			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 185329			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 237424			74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 563599			76. 97
OUTPATIENT SERVICE COST CENTERS	0.000077			75.77
90. 00 09000 CLI NI C	0. 402418			90.00
91. 00 09100 EMERGENCY	0. 125565			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR				92.00
OTHER REIMBURSABLE COST CENTERS				
101. 00 10100 HOME HEALTH AGENCY				101. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00
	1			1232. 00

		SI. MARY MEDICA	L CENTER, INC.		In Lie	U OT FORM CMS	2552-10
COMPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-0034	Peri od:	Worksheet C	
					From 07/01/2021 To 06/30/2022	Part I Date/Time Pre	parod:
					10 06/30/2022	11/22/2022 9:	pareu:
			Ti +I	e XIX	Hospi tal	PPS	or am
			11 (1	C XIX	Costs	110	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oost contor bescription	(from Wkst. B,	Adj.	l rotal oosts	Di sal I owance	10141 00313	
		Part I, col.	7.69		Di Sai i Silanos		
		26)					
		1.00	2.00	3, 00	4. 00	5. 00	
П	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	36, 771, 674		36, 771, 67	4 0	36, 771, 674	30.00
	3100 INTENSIVE CARE UNIT	9, 851, 519	l .	9, 851, 51		9, 851, 519	
	4100 SUBPROVI DER - I RF	5, 788, 451		5, 788, 45		5, 788, 451	
	4300 NURSERY	2, 701, 306		2, 701, 30		2, 701, 306	
	NCILLARY SERVICE COST CENTERS		I	, , , , , , , , , , , , , , , , , , , ,	-	, , , , , , , , , , , , , , , , , , , ,	1
	5000 OPERATING ROOM	37, 846, 322		37, 846, 32	2 0	37, 846, 322	50.00
	5100 RECOVERY ROOM	6, 652, 919	l .	6, 652, 91		6, 652, 919	
4	5200 DELIVERY ROOM & LABOR ROOM	2, 279, 311		2, 279, 31		2, 279, 311	
	5300 ANESTHESI OLOGY	801, 455		801, 45		801, 455	1
	5400 RADI OLOGY-DI AGNOSTI C	9, 127, 728		9, 127, 72		9, 127, 728	
	5500 RADI OLOGY - THERAPEUTI C	2, 084, 643		2, 084, 64		2, 084, 643	
	5600 RADI OI SOTOPE	2, 534, 495		2, 534, 49		2, 534, 495	
	5700 CT SCAN	4, 920, 022		4, 920, 02		4, 920, 022	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	2, 726, 686		2, 726, 68	6 0	2, 726, 686	
	5900 CARDI AC CATHETERI ZATI ON	7, 140, 491		7, 140, 49		7, 140, 491	59.00
	6000 LABORATORY	14, 305, 431	l .	14, 305, 43		14, 305, 431	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	11,000,101		, 000, .0	o o	0	1
	6300 BLOOD STORING, PROCESSING, & TRANS.	1, 911, 622		1, 911, 62	-	1, 911, 622	
	6400 I NTRAVENOUS THERAPY	909, 733		909, 73		909, 733	
	6500 RESPIRATORY THERAPY	4, 547, 250		4, 547, 25		4, 547, 250	•
	6600 PHYSI CAL THERAPY	5, 726, 093		5, 726, 09		5, 726, 093	
	6700 OCCUPATI ONAL THERAPY	1, 305, 794		1, 305, 79		1, 305, 794	
4	6800 SPEECH PATHOLOGY	820, 164		820, 16		820, 164	
4	6900 ELECTROCARDI OLOGY	2, 526, 300		2, 526, 30		2, 526, 300	
4	7000 ELECTROENCEPHALOGRAPHY	1, 128, 320		1, 128, 32		1, 128, 320	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 937, 680		12, 937, 68		12, 937, 680	
	7200 IMPL. DEV. CHARGED TO PATIENTS	18, 277, 859	l .	18, 277, 85		18, 277, 859	
4	7300 DRUGS CHARGED TO PATIENTS	20, 312, 630		20, 312, 63		20, 312, 630	
	7400 RENAL DIALYSIS	979, 993		979, 99		979, 993	
	7697 CARDI AC REHABI LI TATI ON	1, 309, 941		1, 309, 94			
	UTPATIENT SERVICE COST CENTERS	1,007,711		1,007,71	· ·	1,007,711	1 70. 77
	9000 CLI NI C	3, 777, 931		3, 777, 93	1 0	3, 777, 931	90.00
	9100 EMERGENCY	13, 194, 531	l .	13, 194, 53		13, 194, 531	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	3, 643, 802		3, 643, 80		3, 643, 802	
	THER REIMBURSABLE COST CENTERS	3,010,002	1	3, 515, 66	-	3, 313, 002	1 /2.00
	0100 HOME HEALTH AGENCY	4, 281, 903		4, 281, 90	3	4, 281, 903	101 00
200.00	Subtotal (see instructions)	243, 123, 999	l .	243, 123, 99			
201.00	Less Observation Beds	3, 643, 802		3, 643, 80		3, 643, 802	
202.00	Total (see instructions)	239, 480, 197					
_02.00	1.222. (666 1.161 461 61.6)	1 207, 100, 177	'	207, 100, 17	. 1		1-32. 00

Provider CCN: 15-0034 From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/22/2022 9:31 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 61, 260, 513 61, 260, 513 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 16, 122, 835 16, 122, 835 31.00 04100 SUBPROVI DER - I RF 41.00 7, 694, 504 7, 694, 504 41.00 43.00 04300 NURSERY 4, 798, 402 4, 798, 402 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 43, 407, 922 121, 294, 381 164, 702, 303 0. 229786 0.000000 50.00 51.00 05100 RECOVERY ROOM 4, 895, 900 15, 871, 694 20, 767, 594 0.320351 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 5, 006, 274 3, 550, 496 1, 455, 778 0.455291 0.000000 52.00 52.00 0.000000 53.00 05300 ANESTHESI OLOGY 8, 139, 528 24, 387, 147 32, 526, 675 0.024640 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 083, 904 59, 466, 838 67, 550, 742 0.135124 0.000000 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 587, 214 23, 120, 582 23, 707, 796 0.087931 0.000000 55.00 05600 RADI 0I SOTOPE 19, 507, 698 0.129923 0.000000 56,00 1, 977, 526 17, 530, 172 56.00 57.00 05700 CT SCAN 21, 034, 801 63, 857, 183 84, 891, 984 0.057956 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 5, 799, 953 32, 340, 504 38, 140, 457 0. 071491 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 23, 350, 240 70, 126, 468 93, 476, 708 0.076388 0.000000 59.00 06000 LABORATORY 142, 984, 697 0.100049 60.00 40, 168, 069 102, 816, 628 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, 727, 921 2, 075, 188 5, 803, 109 0. 329413 0.000000 63.00 63.00 06400 I NTRAVENOUS THERAPY 17, 214 4, 139, 700 4, 156, 914 0. 218848 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 1, 970, 262 65.00 13, 155, 788 15, 126, 050 0.300624 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 4, 925, 697 15, 331, 983 20, 257, 680 0.282663 0.000000 66.00 06700 OCCUPATIONAL THERAPY 2, 861, 069 6, 750, 650 67.00 3, 889, 581 0.193432 0.000000 67.00 68 00 06800 SPEECH PATHOLOGY 974 869 758 581 1 733 450 0 473140 0 000000 68 00 69.00 06900 ELECTROCARDI OLOGY 8, 992, 325 26, 906, 102 35, 898, 427 0.070374 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 320, 607 10, 423, 063 10, 743, 670 0.105022 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 15, 965, 990 17, 601, 335 33, 567, 325 0.385425 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 17, 440, 696 72.00 21, 731, 438 39, 172, 134 0.466604 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 55, 391, 130 54, 212, 140 109, 603, 270 0. 185329 0.000000 73.00 74.00 07400 RENAL DIALYSIS 3, 898, 869 228, 742 4, 127, 611 0.237424 0.000000 74.00 76 97 07697 CARDIAC REHABILITATION 272, 796 2.051.448 2, 324, 244 0.563599 0.000000 76 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 294, 521 9, 093, 545 9, 388, 066 0.402418 0.000000 90.00 91.00 09100 EMERGENCY 32, 452, 897 72, 628, 220 105, 081, 117 0.125565 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 679, 958 11, 556, 594 0.315301 0.000000 92.00 92 00 9, 876, 636 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 5, 558, 610 5, 558, 610 101.00 414, 272, 666 200.00 Subtotal (see instructions) 789, 715, 437 1, 203, 988, 103 200.00 201 00 201.00 Less Observation Beds

414, 272, 666

789, 715, 437 1, 203, 988, 103

202.00

202.00

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	From 07/01/2021	Worksheet C Part I Date/Time Prepared:

	am
Ratio 11.00	
11. 00 I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 30	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 30	
30. 00 03000 ADULTS & PEDI ATRI CS 30	
31 00 103100LENTENSIVE CARE UNIT	0. 00
	. 00
	. 00
	3. 00
ANCILLARY SERVICE COST CENTERS	
	0.00
	. 00
	2. 00
	3. 00
	. 00
	5. 00
	5. 00
	7. 00
	3. 00
	9. 00
	0.00
	2. 00
	3. 00
	1. 00
	5. 00
	6. 00 7. 00
	3. 00
	9. 00
). 00
	. 00
	2. 00
	3. 00
	1. 00
	5. 97
OUTPATIENT SERVICE COST CENTERS	,. ,,
	0. 00
	. 00
	2. 00
OTHER REI MBURSABLE COST CENTERS	00
	. 00
). 00
	. 00
	2. 00

REDUCTIONS FOR MEDICALD ONLY			T	06/30/2022		pared:
		Ti tl	e XIX	Hospi tal	PPS	31 alli
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
· ·	(Wkst. B, Part)	Wkst. B, Part	Net of Capital	Reduction	Reduction	
			Cost (col. 1 -		Amount	
			col . 2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	37, 846, 322	4, 754, 644			1	00.00
51. 00 05100 RECOVERY ROOM	6, 652, 919	502, 083			1	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 279, 311	243, 157		0	0	1 02.00
53. 00 05300 ANESTHESI OLOGY	801, 455	23, 756	·	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 127, 728	1, 098, 609		0	0	
55. 00 05500 RADI OLOGY - THERAPEUTI C	2, 084, 643	114, 646		0	0	
56. 00 05600 RADI 0I SOTOPE	2, 534, 495	197, 976		0	0	56. 00
57. 00 05700 CT SCAN	4, 920, 022	915, 038		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MF		595, 918			0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	7, 140, 491	1, 493, 278	5, 647, 213	0	0	59. 00
60. 00 06000 LABORATORY	14, 305, 431	518, 018	13, 787, 413	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD		0	0	0	0	
63.00 06300 BLOOD STORING, PROCESSING, & 1	RANS. 1, 911, 622	49, 326	1, 862, 296	0	0	63. 00
64.00 06400 INTRAVENOUS THERAPY	909, 733	73, 007	836, 726	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	4, 547, 250	160, 733	4, 386, 517	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 726, 093	517, 796	5, 208, 297	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 305, 794	34, 409	1, 271, 385	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	820, 164	75, 367	744, 797	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 526, 300	405, 088	2, 121, 212	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 128, 320	95, 969	1, 032, 351	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PA	TI ENT 12, 937, 680	87, 918	12, 849, 762	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	18, 277, 859	123, 051	18, 154, 808	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	20, 312, 630	446, 115	19, 866, 515	0	0	73. 00
74.00 07400 RENAL DIALYSIS	979, 993	6, 881	973, 112	0	0	74.00
76. 97 07697 CARDIAC REHABILITATION	1, 309, 941	181, 097	1, 128, 844	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	3, 777, 931	379, 704	3, 398, 227	0	0	90.00
91. 00 09100 EMERGENCY	13, 194, 531	648, 750	12, 545, 781	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	PART 3, 643, 802	262, 419	3, 381, 383	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	4, 281, 903	33, 840	4, 248, 063	0	0	101. 00
200.00 Subtotal (sum of lines 50 thru	199) 188, 011, 049	14, 038, 593	173, 972, 456	0	0	200. 00
201.00 Less Observation Beds	3, 643, 802	262, 419	3, 381, 383	0	0	201. 00
202.00 Total (line 200 minus line 201) 184, 367, 247	13, 776, 174	170, 591, 073	0	0	202. 00
			•	•	•	

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

					10 06/30/2022	11/22/2022 9:	
			Ti tl	e XIX	Hospi tal	PPS	0
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Charge	е		
		Operating Cost	Part I, column	Ratio (col. 6			
		Reducti on	8)	/ col . 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	37, 846, 322					50.00
51. 00	05100 RECOVERY ROOM	6, 652, 919	20, 767, 594	0. 320351	1		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 279, 311					52. 00
53.00	05300 ANESTHESI OLOGY	801, 455	32, 526, 675				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 127, 728	67, 550, 742				54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	2, 084, 643	23, 707, 796				55. 00
56.00	05600 RADI OI SOTOPE	2, 534, 495					56. 00
57.00	05700 CT SCAN	4, 920, 022	84, 891, 984	0. 057956	5		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 726, 686	38, 140, 457	0. 071491	1		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	7, 140, 491	93, 476, 708	0. 076388	3		59. 00
60.00	06000 LABORATORY	14, 305, 431	142, 984, 697	0. 100049	9		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 000000			62. 00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 911, 622	5, 803, 109	0. 329413	3		63.00
64.00	06400 I NTRAVENOUS THERAPY	909, 733	4, 156, 914	0. 218848	3		64. 00
65.00	06500 RESPIRATORY THERAPY	4, 547, 250	15, 126, 050	0. 300624	1		65.00
66.00	06600 PHYSI CAL THERAPY	5, 726, 093	20, 257, 680	0. 282663	3		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 305, 794	6, 750, 650	0. 193432	2		67. 00
68.00	06800 SPEECH PATHOLOGY	820, 164	1, 733, 450	0. 473140			68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 526, 300	35, 898, 427	0. 070374	1		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 128, 320	10, 743, 670	0. 105022	2		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 937, 680	33, 567, 325	0. 385425	5		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 277, 859	39, 172, 134	0. 466604	1		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	20, 312, 630	109, 603, 270	0. 185329	9		73. 00
74.00	07400 RENAL DIALYSIS	979, 993	4, 127, 611	0. 237424	1		74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 309, 941	2, 324, 244	0. 563599	9		76. 97
	OUTPATIENT SERVICE COST CENTERS			<u>'</u>			
90.00	09000 CLI NI C	3, 777, 931	9, 388, 066	0. 402418	3		90.00
91.00	09100 EMERGENCY	13, 194, 531	105, 081, 117	0. 125565	5		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 643, 802					92. 00
	OTHER REIMBURSABLE COST CENTERS			<u>'</u>			
101.00	10100 HOME HEALTH AGENCY	4, 281, 903	5, 558, 610	0. 770319	9		101. 00
200.00	l l		1, 114, 111, 849				200.00
201.00		3, 643, 802					201.00
202.00	l l		1, 114, 111, 849				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 CAPITAL	COSTS	Provi der C		Period: From 07/01/2021	Worksheet D Part I	
				To 06/30/2022		pared: 31 am
		Ti tl e	e 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 & PEDIATRICS	2, 648, 223		_, _, _,			30.00
31. 00 I NTENSI VE CARE UNIT	593, 380)	593, 38	0 5, 367	110. 56	31.00
41. 00 SUBPROVI DER - I RF	325, 621	0	325, 62	1 4, 890	66. 59	41.00
43. 00 NURSERY	231, 929)	231, 92	9 1, 498	154. 83	43.00
200.00 Total (lines 30 through 199)	3, 799, 153		3, 799, 15	3 46, 803		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	12, 514	945, 558	8			30.00
31.00 INTENSIVE CARE UNIT	1, 478	163, 408	B			31.00
41. 00 SUBPROVI DER - I RF	2, 969	197, 706				41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	16, 961	1, 306, 672	2			200. 00

Health Financial Systems	ST. MARY MEDICAL	CENTER,	INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi	der CC		Peri od: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Pre 11/22/2022 9:	
			Title	XVIII	Hospi tal	PPS	
Cost Center Description				Ratio of Cos		Capital Costs	
	Related Cost	(from Wks	st. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,				. Charges	column 4)	

Cost Center Description					o 06/30/2022		
Capit tal Related Cost Center Description Related Cost Related Cost Center Description Related Cost Related Co			Title	XVIII	Hospi tal		31 alli
Related Cost (From Wisst. C)	Cost Center Description	Cani tal					
ANCILLARY SERVICE COST CENTERS	oost center bescription						
Part II. col. 26							
ANCILLARY SERVICE COST CENTERS						,	
ANCI LLARY SERVICE COST CENTERS							
50.00		1.00	2.00	3.00	4. 00	5. 00	
51.00 05.100 RECOVERY ROOM	ANCILLARY SERVICE COST CENTERS						
52. 00 05200 DELIVERY ROOM & LABOR ROOM 243,157 5,006,274 0,048570 0 0 52.00 53.00 05300 ANESTHESI OLOGY 23,756 32,526,675 0,000730 2,994,884 2,186 53.00 55.00 05400 RADIO LOGY - DI AGNOSTI C 1,098,609 67,550,742 0,016263 2,925,125 47,571 54.00 55.00 05500 RADIO LOGY - THERAPEUTI C 114,646 23,707,796 0,004836 286,318 1,385 55.00 57.00 05500 RADIO ID SOTOPE 197,976 19,507,698 0,010149 752,409 7,636 55.00 57.00 05700 CT SCAN 915,038 84,891,984 0,010779 7,984,749 86,068 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 595,918 38,140,457 0,015624 1,999,063 31,233 58.00 59.00 05800 CARDIA C CATHETERI ZATI ON 1,493,278 33,476,708 0,01575 9,291,513 148,432 59.00 60.00 06000 LABORATORY 518,018 142,984,697 0,003623 14,101,427 51,089 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0,000000 0 0 0 0,00000 63.00 06300 BLOOD STORI NG, PROCESSING, & TRANS. 49,326 5,803,109 0,008500 1,106,538 9,406 63.00 64.00 06400 INTRAVENOUS THERAPY 160,733 15,126,050 0,010626 4,896,565 52,031 65.00 65.00 06600 PHYSI CAL THERAPY 34,409 6,750,650 0,010626 4,896,565 52,031 66.00 66.00 06600 PHYSI CAL THERAPY 34,409 6,750,650 0,005097 693,484 3,535 67.00 69.00 06600 PHYSI CAL THERAPY 34,409 6,750,650 0,005097 693,484 3,535 67.00 69.00 06600 PHYSI CAL THERAPY 37,409 6,750,650 0,005097 693,484 3,535 67.00 69.00 06600 PHYSI CAL THERAPY 95,969 10,743,670 0,0025560 1,104,829 28,239 66.00 69.00 06600 PHYSI CAL THERAPY 95,969 10,743,670 0,0025560 1,104,829 28,239 66.00 69.00 06600 PHYSI CAL THERAPY 34,409 6,750,650 0,0000000 0,000000 0,0000000000	50. 00 05000 OPERATING ROOM	4, 754, 644	164, 702, 303	0. 028868	15, 455, 342	446, 165	50.00
53. 00 05300 ANESTHESI OLGY 23,756 32,526,675 0.000730 2,994,884 2,186 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1,998,609 67,550,742 0.016263 2,925,125 47,571 54. 00 55. 00 05500 RADI OLOGY - THERAPEUTI C 114,646 23,707,796 0.004836 286,318 1,385 55. 00 05500 RADI OLOGY - THERAPEUTI C 114,646 23,707,796 0.004836 286,318 1,385 55. 00 05500 RADI OLOGY - THERAPEUTI C 114,646 23,707,796 0.004836 286,318 1,385 55. 00 05500 RADI OLOGY - THERAPEUTI C 197,976 19,507,698 0.010149 752,409 7,636 56. 00 05500 RADI OLOGY - TSCAN 915,038 84,891,984 0.010779 7,984,749 86,068 57. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 595,918 38,140,457 0.015624 1,999,063 31,233 58. 00 05900 CARDI AC CATHETERI ZATI ON 1,493,278 93,476,708 0.015975 9,291,513 148,432 59. 00 06000 LABORATORY 518,018 142,984,697 0.003623 14,101,427 51,089 60. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0.000000 0 0 6200 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0.000000 0 0.000000 0 0 62. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 49,326 5,803,109 0.008500 1,106,538 9,406 63.00 64. 00 06500 RESPI RATIORY THERAPY 73,007 4,156,914 0.017563 0 0 0.00500 0.0	51.00 05100 RECOVERY ROOM	502, 083	20, 767, 594	0. 024176	1, 774, 191	42, 893	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 1,098,609 67,550,742 0.016263 2,925,125 47,571 54. 00 55. 00 05500 RADI OLOGY - THERAPEUTI C 114,646 23,707,796 0.004836 286,318 1,385 55. 00 05500 RADI OLOGY - THERAPEUTI C 117,976 19,507,698 0.010149 752,409 7,636 65. 00 05700 CT SCAN 915,038 84,891,984 0.010779 7,984,749 86,068 57. 00 05700 CT SCAN 915,038 84,891,984 0.010779 7,984,749 86,068 57. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 595,918 38,140,457 0.015624 1,999,063 31,233 58. 00 05900 CARDI AC CATHETERI ZATI ON 1,493,278 33,476,708 0.015975 9,291,513 148,432 59. 00 06000 LABORATORY 518,018 142,984,697 0.003623 14,101,427 51,089 60.00 62.00 06000 STORI NG , PROCESSI NG , TRANS. 49,326 5,803,109 0.008500 1,106,538 9,406 63. 00 63.00 0.0300 BLODO STORI NG , PROCESSI NG , TRANS. 49,326 5,803,109 0.008500 1,106,538 9,406 63. 00 65.00 0.0500 RESPI RATORY THERAPY 160,733 15,126,050 0.010626 4,896,565 52,031 65. 00 66.00 06600 PHYSI CAL THERAPY 517,796 20,257,680 0.025560 1,104,829 28,239 66.00 67.00 06700 0CCUPATI ONAL THERAPY 34,409 6,750,650 0.005097 693,484 3,535 67.00 68.00 06900 ELECTROCARDI OLOGY 75,367 1,733,450 0.043478 221,081 9,612 68.00 69.00 06900 ELECTROCARDI OLOGY 405,088 35,898,427 0.01284 3,656,957 41,265 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 87,918 33,567,325 0.002619 5,940,717 15,559 71.00 07400 RENAL DI ALYSI S 6,881 4,127,611 0.001667 1,339,970 2,234 74. 00 07400 RENAL DI ALYSI S 6,881 4,127,611 0.001667 1,339,970 2,234 74. 00 07400 RENAL DI ALYSI S 648,750 0.00200 085ERVATI ON BEDS (NON-DISTINCT PART 262,419 11,556,594 0.0022707 748,150 16,988 92.00 09000 00000 00000 000000 000000 000000	52.00 05200 DELIVERY ROOM & LABOR ROOM	243, 157	5, 006, 274	0. 048570	0	0	52.00
55. 00 05500 RADI OLOGY - THERAPEUTI C 114, 646 23, 707, 796 0.004836 286, 318 1, 385 55. 00 05600 RADI OLOGY - THERAPEUTI C 197, 976 197, 978 0.01049 752, 409 7, 636 56. 00 05700 CT SCAN 915, 038 84, 891, 984 0.010779 7, 984, 749 76, 636 56. 00 05700 CT SCAN 915, 038 84, 891, 984 0.010779 7, 984, 749 86, 068 57. 00 05700 CT SCAN 915, 038 84, 891, 984 0.010779 7, 984, 749 86, 068 57. 00 05700 CT SCAN 915, 038 84, 891, 984 0.010779 7, 984, 749 86, 068 57. 00 05700 CARDI AC CATHETERI ZATI ON 1, 493, 278 93, 476, 708 0.015975 9, 291, 513 148, 432 59. 00 0600 CARDI AC CATHETERI ZATI ON 1, 493, 278 93, 476, 708 0.015975 9, 291, 513 148, 432 59. 00 0600 CARDI AC CATHETERI ZATI ON 1, 493, 278 93, 476, 708 0.015975 9, 291, 513 148, 432 59. 00 0600 CARDI AC CATHETERI ZATI ON 1, 493, 278 93, 476, 708 0.015975 9, 291, 513 148, 432 59. 00 0600 CARDI AC CATHETERI ZATI ON 1, 493, 278 93, 476, 708 0.015975 9, 291, 513 148, 432 59. 00 0600 CARDI AC CATHETERI ZATI ON 1, 493, 278 93, 476, 708 0.015975 9, 291, 513 148, 432 59. 00 0600 CARDI AC CATHETERI ZATI ON 1, 493, 278 93, 476, 708 0.016975 9, 291, 513 148, 432 59. 00 0600 CARDI AC CATHETERI ZATI ON 1, 493, 278 93, 476, 708 0.016975 9, 291, 513 148, 432 59. 00 0600 CARDI AC CATHETERI ZATI ON 1, 493, 278 93, 476, 708 0.016970 0.00600 0.006							
56. 00 05600 RADI OI SOTOPE 197, 976 19, 507, 698 0. 0 10149 752, 409 7, 636 56. 00 5700 05700 CT SCAN 915, 038 84, 891, 984 0. 010779 7, 984, 749 86, 068 57. 00 0500 MARKETI C RESONANCE I MAGI NG (MRI) 595, 918 38, 140, 457 0. 015624 1, 999, 063 31, 233 58. 00 05900 CARDI AC CATHETERI ZATI ON 1, 493, 278 93, 476, 708 0. 015975 9, 291, 513 148, 432 59. 00 06000 LABORATORY 518, 018 142, 984, 697 0. 003623 14, 101, 427 51, 089 60. 00 06000 LABORATORY 518, 018 142, 984, 697 0. 003623 14, 101, 427 51, 089 60. 00 06000 LABORATORY 518, 018 142, 984, 697 0. 003623 14, 101, 427 51, 089 60. 00 06000 LABORATORY 7, 636 518, 018 142, 984, 697 0. 003623 14, 101, 427 51, 089 60. 00 06400 INTRAVENOUS THERAPY 73, 007 4, 156, 914 0. 017563 0 0 64. 00 06400 INTRAVENOUS THERAPY 160, 733 15, 126, 050 0. 010626 4, 896, 565 52, 031 65. 00 06500 RESPI RATORY THERAPY 160, 733 15, 126, 050 0. 010626 4, 896, 565 52, 031 65. 00 06600 PHYSI CAL THERAPY 517, 796 20, 257, 680 0. 025560 1, 104, 829 28, 239 66. 00 06700 OCCUPATI ONAL THERAPY 34, 409 6, 750, 650 0. 005097 693, 484 3, 535 67, 00 06900 ELECTROCARDI OLOGY 75, 367 1, 733, 450 0. 043478 221, 081 9, 612 68. 00 06900 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69, 00 06900 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69, 00 07000 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69, 00 07000 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69, 00 07000 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69, 00 07000 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69, 00 07000 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69, 00 07000 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69, 00 07000 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69, 00 07000 ELECTROCARDI OLOGY 405, 086 405, 080 405, 080 405, 080 405, 080 405, 080 405, 080 405, 080 405, 080 405, 080 405, 080 405, 080		1, 098, 609	67, 550, 742	0. 016263	2, 925, 125	47, 571	54.00
57. 00 05700 CT SCAN 915, 038 84, 891, 984 0. 010779 7, 984, 749 86, 068 57. 00 5800 MAGNETIC RESONANCE IMAGING (MRI) 595, 918 38, 140, 457 0. 015624 1, 999, 063 31, 233 58. 00 5900 CARDI AC CATHETERI ZATI ON 1, 493, 278 93, 476, 708 0. 015975 9, 291, 513 148, 432 59. 00 60. 00 6000 LABORATORY 518, 018 142, 984, 697 0. 003623 14, 101, 427 51, 089 60. 00 6200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0. 000000 0 0. 62. 00 63. 00 6300 BLOOD STORI NG, PROCESSING, & TRANS. 49, 326 5, 803, 109 0. 008500 1, 106, 538 9, 406 63. 00 64. 00 6600 PHYSI CAL THERAPY 160, 733 15, 126, 050 0. 010626 4, 896, 565 52, 031 65. 00 6600 PHYSI CAL THERAPY 517, 796 20, 257, 680 0. 025560 1, 104, 829 28, 239 66. 00 6600 PHYSI CAL THERAPY 34, 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69. 00 6900 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69. 00 6900 ELECTROCERCEPHALOGRAPHY 95, 969 10, 743, 670 0. 008933 121, 514 1, 085 70. 00 70. 00 C700 DRUGS CHARGED TO PATI ENTS 123, 051 39, 172, 134 0. 003141 7, 959, 275 25, 000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 123, 051 39, 172, 134 0. 003141 7, 959, 275 25, 000 72. 00 73. 00 07400 RENAL DI ALYSIS 6, 881 4, 127, 611 0. 001667 1, 339, 970 2, 234 74. 00 74. 00 7400 RENAL DI ALYSIS 6, 881 4, 127, 611 0. 001674 12, 365, 428 76, 344 91. 00 9100 EMERGENCY 648, 750 105, 081, 117 0. 006174 12, 365, 428 76, 344 91. 00 91. 00 9000 CLI NI C 9000 09000 CLI NI C 9000 09000 DRUGS CHARGED TO NOLTHINS 262, 419 11, 556, 594 0. 022707 748, 150 16, 988 22. 00 9000 09000 CLI NI C 9000 09000 CLI NI C 90000 CLI NI C 90000 CLI NI C 90000 CLI NI C 90000 CLI NI C 900000 CLI NI C 900000 CLI NI C 90000 CLI NI C 900000 CLI NI C 900000 CLI		· ·			1		
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 595, 918 38, 140, 457 0.015624 1, 999, 063 31, 233 58. 00 05900 CARDIAC CATHETERI ZATION 1, 493, 278 93, 476, 708 0.015975 9, 291, 513 148, 432 59. 00 06000 LABORATORY 518, 018 142, 984, 697 0.003623 14, 101, 427 51, 089 60. 00 0620 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0.000000 0 0 62. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 49, 326 5, 803, 109 0.008500 1, 106, 538 9, 406 63. 00 06500 RESPI RATORY 160, 733 15, 126, 050 0.010626 4, 896, 565 52, 031 65. 00 06500 PHYSI CAL THERAPY 160, 733 15, 126, 050 0.010626 4, 896, 565 52, 031 65. 00 06600 PHYSI CAL THERAPY 517, 796 20, 257, 680 0.025560 1, 104, 829 28, 239 66. 00 06700 OCCUPATI ONAL THERAPY 34, 409 6, 750, 650 0.005097 693, 484 3, 535 67. 00 06900 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0.011284 3, 656, 957 41, 265 69. 00 06900 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0.011284 3, 656, 957 41, 265 69. 00 07000 ELECTROCARDI OLOGY 405, 088 33, 898, 427 0.011284 3, 656, 957 41, 265 69. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 123, 051 39, 172, 134 0.003141 7, 959, 275 25, 000 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 123, 051 39, 172, 134 0.003141 7, 959, 275 25, 000 72. 00 07400 RENAL DI ALYSI S 6, 881 4, 127, 611 0.001667 1, 339, 970 2, 234 74. 00 07400 RENAL DI ALYSI S 6, 881 4, 127, 611 0.001674 17, 332, 079 70, 542 73. 00 07400 RENAL DI ALYSI S 6, 881 4, 127, 611 0.001674 12, 365, 428 76, 344 91. 00 97000 EMERGENCY 500 09200 (BMERGENCY 500 09200) BMERGENCY 648, 750 105, 081, 117 0.006174 12, 365, 428 76, 344 91. 00 99000 CLINIC 648, 750 105, 081, 117 0.006174 12, 365, 428 76, 344 91. 00 99000 CLINIC 99.00 09200 (BMERGENCY 500 09200) BMERGENCY 500 09200 (BMERGENCY 500 0920							
59. 00 05900 CARDIAC CATHETERIZATION 1,493,278 93,476,708 0.015975 9,291,513 148,432 59. 00 60. 00 06000 LABORATORY 518,018 142,984,697 0.003623 14,101,427 51,089 60. 00 62. 00 62.00 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0.000000 0 0.000000 0 0.000000 0 0.000000	57. 00 05700 CT SCAN	915, 038	84, 891, 984	0. 010779	7, 984, 749	86, 068	57. 00
60. 00							
62. 00		1, 493, 278	93, 476, 708				
63. 00	60. 00 06000 LABORATORY	518, 018	142, 984, 697	0. 003623	14, 101, 427	51, 089	60.00
64. 00		0	0				
65. 00		49, 326	5, 803, 109			9, 406	
66. 00 06600 PHYSI CAL THERAPY 517, 796 20, 257, 680 0. 025560 1, 104, 829 28, 239 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 34, 409 6, 750, 650 0. 005097 693, 484 3, 535 67. 00 68. 00 06800 SPEECH PATHOLOGY 75, 367 1, 733, 450 0. 043478 221, 081 9, 612 68. 00 69. 00 06900 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 87, 918 33, 567, 325 0. 002619 5, 940, 717 15, 559 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 123, 051 39, 172, 134 0. 003141 7, 959, 275 25, 000 72. 00 73. 00 07400 RENAL DI ALYSI S 6, 881 4, 127, 611 0. 001667 1, 339, 970 2, 234 74. 00 74. 00 07400 RENAL DI ALYSI S 6, 881 4, 127, 611 0. 001667 1, 339, 970 2, 234 74. 00 74. 00 07400 CARDI AC REHABI LI TATI ON 181, 097 2, 324, 244 0. 077917 115, 828 9, 025 76. 97 0000 00000 CLI NI C 000000						_	
67. 00		160, 733				52, 031	65. 00
68. 00 06800 SPEECH PATHOLOGY 75, 367 1, 733, 450 0. 043478 221, 081 9, 612 68. 00 69. 00 06900 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 95, 969 10, 743, 670 0. 008933 121, 514 1, 085 70. 00 71. 00							
69. 00 06900 ELECTROCARDI OLOGY 405, 088 35, 898, 427 0. 011284 3, 656, 957 41, 265 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 95, 969 10, 743, 670 0. 008933 121, 514 1, 085 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 87, 918 33, 567, 325 0. 002619 5, 940, 717 15, 559 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 123, 051 39, 172, 134 0. 003141 7, 959, 275 25, 000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 446, 115 109, 603, 270 0. 004070 17, 332, 079 70, 542 73. 00 74. 00 07400 RENAL DI ALYSI S 6, 881 4, 127, 611 0. 001667 1, 339, 970 2, 234 74. 00 70697 CARDI AC REHABI LI TATI ON 181, 097 2, 324, 244 0. 077917 115, 828 9, 025 76. 97 77. 00 77.		34, 409	6, 750, 650	0. 005097	693, 484	3, 535	
70. 00 07000 ELECTROENCEPHALOGRAPHY 95, 969 10, 743, 670 0.008933 121, 514 1, 085 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 87, 918 33, 567, 325 0.002619 5, 940, 717 15, 559 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 123, 051 39, 172, 134 0.003141 7, 959, 275 25, 000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 446, 115 109, 603, 270 0.004070 17, 332, 079 70, 542 73. 00 74. 00 07400 RENAL DI ALYSI S 6, 881 4, 127, 611 0.001667 1, 339, 970 2, 234 74. 00 70697 CARDI AC REHABI LI TATI ON 181, 097 2, 324, 244 0.077917 115, 828 9, 025 76. 97 09000 CLI NI C 379, 704 9, 388, 066 0.040445 70, 237 2, 841 90. 00 91. 00 09100 EMERGENCY 648, 750 105, 081, 117 0.006174 12, 365, 428 76, 344 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 262, 419 11, 556, 594 0.022707 748, 150 16, 988 92. 00					1		
71. 00							
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 123, 051 39, 172, 134 0.003141 7, 959, 275 25, 000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 446, 115 109, 603, 270 0.004070 17, 332, 079 70, 542 73. 00 74. 00 07400 RENAL DI ALYSIS 6, 881 4, 127, 611 0.001667 1, 339, 970 2, 234 74. 00 07697 CARDI AC REHABI LI TATI ON 181, 097 2, 324, 244 0.077917 115, 828 9, 025 76. 97 000000							
73. 00 07300 DRUGS CHARGED TO PATIENTS 446, 115 109, 603, 270 0.004070 17, 332, 079 70, 542 73. 00 74. 00 07400 RENAL DI ALYSI S 6, 881 4, 127, 611 0.001667 1, 339, 970 2, 234 74. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 181, 097 2, 324, 244 0.077917 115, 828 9, 025 76. 97 00000 00000 00000 00000 00000 00000 00000 0							
74. 00 07400 RENAL DI ALYSI S 6, 881 4, 127, 611 0. 001667 1, 339, 970 2, 234 74. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 181, 097 2, 324, 244 0. 077917 115, 828 9, 025 76. 97 000000							
76. 97 O7697 CARDI AC REHABI LI TATI ON 181, 097 2, 324, 244 0. 077917 115, 828 9, 025 76. 97 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 379, 704 9, 388, 066 0. 040445 70, 237 2, 841 90. 00 91. 00 09100 EMERGENCY 648, 750 105, 081, 117 0. 006174 12, 365, 428 76, 344 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 262, 419 11, 556, 594 0. 022707 748, 150 16, 988 92. 00				•	1 ' '		
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 379, 704 9, 388, 066 0. 040445 70, 237 2, 841 90. 00 91. 00 09100 EMERGENCY 648, 750 105, 081, 117 0. 006174 12, 365, 428 76, 344 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 262, 419 11, 556, 594 0. 022707 748, 150 16, 988 92. 00					1 ' '		
90. 00 09000 CLI NI C 379, 704 9, 388, 066 0. 040445 70, 237 2, 841 90. 00 91. 00 09100 EMERGENCY 648, 750 105, 081, 117 0. 006174 12, 365, 428 76, 344 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 262, 419 11, 556, 594 0. 022707 748, 150 16, 988 92. 00 09200		181, 097	2, 324, 244	0. 077917	115, 828	9, 025	76. 97
91. 00 09100 EMERGENCY 648, 750 105, 081, 117 0.006174 12, 365, 428 76, 344 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 262, 419 11, 556, 594 0.022707 748, 150 16, 988 92. 00							
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 262,419 11,556,594 0.022707 748,150 16,988 92.00							
					1 ' '		
200. 00 Total (Lines 50 through 199) 14, 004, 753 1, 108, 553, 239 115, 237, 673 1, 228, 364 200. 00							
	200.00 Total (lines 50 through 199)	14, 004, 753	1, 108, 553, 239	1	115, 237, 673	1, 228, 364	200. 00

Health Financial Systems S	T. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS		<u> </u>	Period: From 07/01/2021 Fo 06/30/2022	11/22/2022 9:	pared: 31 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	000000000000000000000000000000000000000	000000000000000000000000000000000000000		0 0 0	0 0 0 0	30. 00 31. 00 41. 00 43. 00 200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
obst control bescription	Adjustment Amount (see instructions)	(sum of cols. 1 through 3, minus col. 4)	Days	5 ÷ col . 6)	Program Days	
	4.00	5.00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	35, 048			
31. 00 03100 I NTENSI VE CARE UNIT		0	5, 36			
41. 00 04100 SUBPROVI DER - RF	0	0	4, 890			
43. 00 04300 NURSERY		0	1, 498			
200.00 Total (lines 30 through 199)		0	46, 803	3	16, 961	200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	0 0 0 0					30. 00 31. 00 41. 00 43. 00 200. 00

Health Financial Systems	ST. MARY MEDICAL C	CENTER, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0034	Peri od:	Worksheet D
THROUGH COSTS			From 07/01/2021	

TIROUGH COSTS				To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		Ti tl e	: XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCI LLARY SERVI CE COST CENTERS	_	_	1			
50. 00 05000 OPERATI NG ROOM	0	0	•	0	0	50. 00
51.00 05100 RECOVERY ROOM	0	0	1	0	0	51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	1	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	1	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	0	54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	1	0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0	0	1	0	0	56. 00
57. 00 05700 CT SCAN	0	0	1	0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0	1	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1	0	0	59. 00
60. 00 06000 LABORATORY	0	0	1	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	1	0	0	74. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	_	_	1			
90. 00 09000 CLI NI C	0	1	1	0	1	90. 00
91. 00 09100 EMERGENCY	0	0	1	0	518, 069	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_	(0	0	92.00
200.00 Total (lines 50 through 199)	0	0	1 (0	518, 069	[200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ST. MARY MEDICA RVICE OTHER PAS:			In Lie Period: From 07/01/2021 To 06/30/2022		pared:
		Ti tl e	: XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(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 OPERATING ROOM	0	0	1	0 164, 702, 303		
51.00 O5100 RECOVERY ROOM	0	0		0 20, 767, 594	0.000000	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0 5, 006, 274	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0)	0 32, 526, 675	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 67, 550, 742	0.000000	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0)	0 23, 707, 796	0.000000	55. 00
56. 00 05600 RADI OI SOTOPE	0	0)	0 19, 507, 698	0.000000	56. 00
57. 00 05700 CT SCAN	0	0	1	0 84, 891, 984	0.000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0 38, 140, 457	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1	0 93, 476, 708	0.000000	59. 00
60. 00 06000 LABORATORY	0	0	1	0 142, 984, 697	0.000000	60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0)	0 0	0.000000	62. 00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0)	0 5, 803, 109	0.000000	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	l o)	0 4, 156, 914	0.000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	l o)	0 15, 126, 050	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	l o)	0 20, 257, 680		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	l o)	0 6, 750, 650		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	,	0 1, 733, 450		
69. 00 06900 ELECTROCARDI OLOGY	0	0	,	0 35, 898, 427		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		,	0 10, 743, 670		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		,	0 33, 567, 325		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	l	1	0 39, 172, 134		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1	1	0 109, 603, 270		
74. 00 07400 RENAL DIALYSIS	0	1	1	0 4, 127, 611		
76. 97 07697 CARDI AC REHABI LI TATI ON	0		1	0 2, 324, 244		

0 0 0

518, 069

518, 069

518, 069

9, 388, 066

105, 081, 117

518, 069 1, 108, 553, 239

11, 556, 594

0.000000

0.004930

0.000000

90.00

91.00

92.00

200. 00

91. 00 09100 EMERGENCY

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

OUTPATIENT SERVICE COST CENTERS

90. 00 09000 CLINIC

Health Financial Systems S	ST. MARY MEDICAL	CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provi der Co		Period: From 07/01/2021 To 06/30/2022		pared: 31 am
			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	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS			T			
50.00 05000 OPERATING ROOM	0. 000000	15, 455, 342	•	0 30, 761, 188		00.00
51.00 05100 RECOVERY ROOM	0. 000000	1, 774, 191	•	0 4, 108, 654	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	2, 994, 884		0 6, 153, 423		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 925, 125		0 14, 300, 029		54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	286, 318		8, 644, 300		55. 00
56. 00 05600 RADI 01 SOTOPE	0. 000000	752, 409		5, 851, 026	0	56. 00
57. 00 05700 CT SCAN	0. 000000	7, 984, 749		0 16, 656, 951	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 999, 063		0 7, 831, 548		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	9, 291, 513		0 27, 403, 112		59. 00
60. 00 06000 LABORATORY	0. 000000	14, 101, 427		9, 765, 616	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, 106, 538		0 702, 296		63. 00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 1, 817, 042		64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	4, 896, 565		513, 324		65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 104, 829		0 24, 252		66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	0. 000000	693, 484		0 2, 228		67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	221, 081		0 16, 017		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 656, 957		0 8, 731, 364		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	121, 514	·	0 2, 288, 171		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	5, 940, 717	•	5, 533, 549		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	7, 959, 275	•	0 6, 029, 487		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	17, 332, 079	•	0 21, 943, 124		73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	1, 339, 970		0 118, 772	0	74. 00
7/ 07 07/07 04DDI 40 DELIADI I I TATI ON	0 000000	445 000		050 (04		1 7/ 07

0.000000

0.000000

0.004930

0. 000000

12, 365, 428 748, 150

115, 237, 673

115, 828

70, 237

90.00

0 92.00

0 76. 97

0

61, 161 91. 00

61, 161 200. 00

850, 601

3, 497, 573

12, 405, 962 1, 987, 272

197, 936, 881

60, 962

60, 962

0

90. 00 09000 CLI NI C

200.00

91. 00 09100 EMERGENCY

07697 CARDIAC REHABILITATION

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

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

Health Financial Systems	ST. MARY MEDICAL	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pre 11/22/2022 9:	
		Title	XVIII	Hospi tal	PPS	JI diii
			Charges	110061 101	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
'	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	,	
	Part I, col. 9	,	Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 229786			0 56, 610		1
51.00 05100 RECOVERY ROOM	0. 320351	4, 108, 654		0	1, 316, 211	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 455291	0		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 024640			0	151, 620	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 135124			0	1, 932, 277	54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 087931	8, 644, 300		0 0	760, 102	55. 00
56. 00 05600 RADI 0I SOTOPE	0. 129923			0 0	760, 183	56. 00
57.00 05700 CT SCAN	0. 057956	16, 656, 951		0 0	965, 370	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 071491	7, 831, 548		0 0	559, 885	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 076388			0 0	2, 093, 269	59. 00
60. 00 06000 LABORATORY	0. 100049			0 0	977, 040	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 329413	702, 296		0 0	231, 345	63. 00
64.00 06400 I NTRAVENOUS THERAPY	0. 218848	1, 817, 042		0 0	397, 656	
65. 00 06500 RESPIRATORY THERAPY	0. 300624			0 0	154, 318	
66. 00 06600 PHYSI CAL THERAPY	0. 282663			0 0	6, 855	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 193432			0 0	431	
68.00 06800 SPEECH PATHOLOGY	0. 473140			0 0	7, 578	
69. 00 06900 ELECTROCARDI OLOGY	0. 070374			0 0	614, 461	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 105022	2, 288, 171		0 0	240, 308	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 385425	5, 533, 549		0 0	2, 132, 768	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 466604	6, 029, 487		0 0	2, 813, 383	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 185329	21, 943, 124		0 39, 821	4, 066, 697	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 237424	118, 772		0 0	28, 199	74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 563599	850, 601		0 0	479, 398	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 402418			0 0	1, 407, 486	
91. 00 09100 EMERGENCY	0. 125565			0	1, 557, 755	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 315301			0	626, 589	
200.00 Subtotal (see instructions)		197, 936, 881		96, 431	31, 349, 674	
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201. 00
202.00 Net Charges (line 200 - line 201)		197, 936, 881		0 96, 431	31, 349, 674	202. 00

Health Financial Systems	ST. MARY MEDICAL CE	ENTER, INC.	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST		Peri od: From 07/01/2021	Worksheet D
				Date/Time Prepared:

				To 06/30/2022	Part V Date/Time Pro	epared:
-		Ti +Lo	e XVIII	Hospi tal	11/22/2022 9: PPS	:31 am_
	Co	sts	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Hospi tai	FF3	
Cost Center Description	Cost	Cost	1			
oost conten bescription	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	13, 008				50. 00
51.00 05100 RECOVERY ROOM	0	0				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0)			55. 00
56. 00 05600 RADI OI SOTOPE	0	0)			56. 00
57. 00 05700 CT SCAN	0	0)			57. 00
58.00 05800 MAGNETIC RESONANCE 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 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	7, 380				73. 00
74.00 07400 RENAL DI ALYSI S	0	_				74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90. 00
91. 00 09100 EMERGENCY	0	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1			92. 00
200.00 Subtotal (see instructions)	0	20, 388	1			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	20, 388				202. 00

Health Financial Systems	ST. MARY MEDICA	L CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part II	
		Component	CON. 13 1034	10 00/ 30/ 2022	Date/Time Pre 11/22/2022 9:	31 am
		Titl∈	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	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	4, 754, 644	164, 702, 303	0. 02886	8 49, 215	1, 421	50.00
51. 00 05100 RECOVERY ROOM	502, 083		II.	•		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	243, 157				0	52.00
53. 00 05300 ANESTHESI OLOGY	23, 756				0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 098, 609				1, 611	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	114, 646				1,011	55.00
56. 00 05600 RADI 01 SOTOPE	197, 976		•			56.00
57. 00 05700 CT SCAN	915, 038					
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	595, 918		•			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 493, 278				0	59.00
60. 00 06000 LABORATORY	518, 018					60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	010,010		0.00000		2, 101	62.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	49, 326	5, 803, 109	•		169	63.00
64. 00 06400 I NTRAVENOUS THERAPY	73, 007		•		0	64.00
65. 00 06500 RESPIRATORY THERAPY	160, 733				4, 221	65. 00
66. 00 06600 PHYSI CAL THERAPY	517, 796					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	34, 409					67.00
68. 00 06800 SPEECH PATHOLOGY	75, 367					68. 00
69. 00 06900 ELECTROCARDI OLOGY	405, 088	35, 898, 427	0. 01128	4 34, 482	389	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	95, 969	10, 743, 670	0. 00893	3 1, 023	9	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	87, 918	33, 567, 325	0. 00261	9 267, 206	700	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	123, 051	39, 172, 134	0. 00314	1 4, 222	13	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	446, 115		0. 00407	0 1, 396, 238	5, 683	73. 00
74. 00 07400 RENAL DI ALYSI S	6, 881				172	74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	181, 097	2, 324, 244	0. 07791	7 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	379, 704					70.00
91. 00 09100 EMERGENCY	648, 750				-	/ 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	, ,			0	92. 00
200.00 Total (lines 50 through 199)	13, 742, 334	1, 108, 553, 239	7	6, 117, 823	71, 616	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ST. MARY MEDICA		N. 15 0024	Peri o		u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	RVICE UTILER FAS.		CCN: 15-T034	From	07/01/2021 06/30/2022	Part IV Date/Time Pre 11/22/2022 9:	
		Title	XVIII	Subp	rovi der - I RF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Program Post-Stepdown Adjustments	Nursi ng Program	Post	t-Stepdown justments	Allied Health	
	1.00	2A	2.00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	0			0	0	0	
51. 00 05100 RECOVERY ROOM	0	0		0	0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C		0		0	0	0	54. 00 55. 00
56. 00 05600 RADI 01 SOTOPE				0	0	0	56.00
57. 00 05700 CT SCAN				0	0	0	
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)		0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON				0	0	0	59.00
60. 00 06000 LABORATORY		0		0	0	Ö	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		o o		0	0	ő	62.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		o o		0	0	Ö	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	o		Ö	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	О		0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0	0		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	
74. 00 07400 RENAL DI ALYSI S	0	0		0	0	0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	1					^	00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0			0	0	0 518, 069	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0	U	518,069	91.00
200.00 Total (lines 50 through 199)		0		0	0	_	
200.00 Total (Trios of through 177)	1	1	I	٥,	O	313,007	1200.00

Health Financial Systems	ST. MARY MEDICAL	CENTER INC		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN: 15-0034	Peri od:	Worksheet D	2002 10
THROUGH COSTS		Component	CCN: 15-T034	From 07/01/2021 To 06/30/2022		pared: 31 am
			: XVIII	Subprovi der – I RF	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	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 instructions)	
	4.00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 164, 702, 303	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 20, 767, 594		1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 5, 006, 274		
53. 00 05300 ANESTHESI OLOGY	0	0		0 32, 526, 675	l .	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 67, 550, 742		
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	Ö		0 23, 707, 796		1
56. 00 05600 RADI OI SOTOPE	0	Ö		0 19, 507, 698		
57. 00 05700 CT SCAN	0	0		0 84, 891, 984		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 38, 140, 457	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 93, 476, 708	0.000000	59. 00
60. 00 06000 LABORATORY	0	0		0 142, 984, 697	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 5, 803, 109	0.000000	63. 00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 4, 156, 914	0.000000	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 15, 126, 050		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 20, 257, 680		
67. 00 06700 OCCUPATIONAL THERAPY	0	0		0 6, 750, 650		1
68. 00 06800 SPEECH PATHOLOGY	0	0		0 1, 733, 450		1
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 35, 898, 427		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 10, 743, 670		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 33, 567, 325		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 39, 172, 134		1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 109, 603, 270		
74. 00 07400 RENAL DI ALYSI S	0	0		0 4, 127, 611		
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	1 0		1	0 2, 324, 244	0.000000	76. 97
90. 00 09000 CLINIC	0	0		0 9, 388, 066	0. 000000	90.00
91. 00 09100 EMERGENCY	0	518, 069	1	· · · · · ·		1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1 0	J 10, 009	310,00	0 11, 556, 594	l .	1
200.00 Total (lines 50 through 199)	0	518, 069	518 06	59 1, 108, 553, 239		200. 00
	1	0.0,007	0.5,00	,,, 200, 207	I	1=30.00

Health Financial Systems	ST. MARY MEDICAL	CENTED INC		In Lie	eu of Form CMS-2	2552 10
APPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS		Provi der CO		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre	pared:
		Title	: XVIII	Subprovi der -	11/22/2022 9: PPS	31 am _
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7) 9.00	Inpati ent Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	49, 215		0 0	0	50. 00
51. 00 05100 RECOVERY ROOM	0. 000000	2, 509		0 0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	5, 061		0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	99, 088		0	0	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0	0	
56. 00 05600 RADI OI SOTOPE	0. 000000	1, 762		0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	124, 898		0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	16, 418		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	
60. 00 06000 LABORATORY	0. 000000	594, 558		0	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELI		10.022		0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	19, 832		0 0	0	
64.00 06400 I NTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY	0. 000000 0. 000000	0 397, 251		0 0	0	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 415, 630		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	1, 347, 623			0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	237, 717			0	
69. 00 06900 ELECTROCARDI OLOGY	0.000000	34, 482		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 023		0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		267, 206		0	Ö	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 222		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 396, 238		0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	103, 090		0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	1
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0		1
91. 00 09100 EMERGENCY	0. 004930	0		0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0		
200.00 Total (lines 50 through 199)	1	6, 117, 823	1	0	1 0	200. 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	!	Period: From 07/01/2021 To 06/30/2022	11/22/2022 9:	pared: 31 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2, 648, 223	0	2, 648, 22	35, 048	75. 56	30.00
31.00 INTENSIVE CARE UNIT	593, 380)	593, 38	5, 367	110. 56	31.00
41. 00 SUBPROVI DER - I RF	325, 621	0	325, 62	1 4, 890	66. 59	41.00
43. 00 NURSERY	231, 929		231, 92	9 1, 498	154.83	43.00
200.00 Total (lines 30 through 199)	3, 799, 153		3, 799, 15	3 46, 803		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	563	42, 540)			30. 00
31.00 INTENSIVE CARE UNIT	222	24, 544				31. 00
41. 00 SUBPROVI DER - I RF	8	1				41. 00
43. 00 NURSERY	91	14, 090				43.00
200.00 Total (lines 30 through 199)	884		•			200. 00

Health Financial Systems ST.	ST. MARY MEDICAL CENTER, INC. In Lieu				u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	COSTS	Provider CCN:	15-0034	Peri od: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Prepared: 11/22/2022 9:31 am
		Title >	XIX	Hospi tal	PPS

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Period: From 07/01/2021 To 06/30/2022	11/22/2022 9:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	Г 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00 05000 OPERATING ROOM	4, 754, 644	164, 702, 303	0. 02886	8 628, 682	18, 149	50. 00
51. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	502, 083	20, 767, 594	•			50.00
52. 00 05100 RECOVERY ROOM	243, 157	5, 006, 274		· ·		51.00
53. 00 05300 ANESTHESI OLOGY	23, 756			· ·		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 098, 609					54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C						55. 00
56. 00 05600 RADI 01 SOTOPE	114, 646 197, 976				351	56. 00
57. 00 05700 CT SCAN	915, 038					57.00
58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	595, 918					58.00
59. 00 05900 CARDIAC CATHETERIZATION						59.00
60. 00 06000 LABORATORY	1, 493, 278			· ·		60.00
	518, 018 0	142, 984, 697 0		· ·		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1 "		0.0000		0	62.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	49, 326	5, 803, 109				63. 00
64. 00 06400 I NTRAVENOUS THERAPY	73, 007	4, 156, 914			_	64.00
65. 00 06500 RESPIRATORY THERAPY	160, 733	15, 126, 050		· ·		65. 00
66. 00 06600 PHYSI CAL THERAPY	517, 796					
67. 00 06700 OCCUPATI ONAL THERAPY	34, 409	6, 750, 650		· ·		67. 00
68. 00 06800 SPEECH PATHOLOGY	75, 367	1, 733, 450		· ·		68. 00
69. 00 06900 ELECTROCARDI OLOGY	405, 088					69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	95, 969	10, 743, 670				70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	87, 918	33, 567, 325				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	123, 051	39, 172, 134		· ·		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	446, 115	109, 603, 270				73. 00
74. 00 07400 RENAL DI ALYSI S	6, 881	4, 127, 611	•	· ·		74. 00
76. 97 O7697 CARDI AC REHABILITATION	181, 097	2, 324, 244	0. 07791	7 4, 561	355	76. 97
OUTPATIENT SERVICE COST CENTERS	070 704	0.000.044		-1 -		
90. 00 09000 CLI NI C	379, 704				_	90.00
91. 00 09100 EMERGENCY	648, 750					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	262, 419					92.00
200.00 Total (lines 50 through 199)	14, 004, 753	1, 108, 553, 239	1	4, 554, 098	46, 022	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	ER PASS THROUGH COST	TS Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part III Date/Time Pre 11/22/2022 9:	pared: 31 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	C)	0 (0	0	
31. 00 03100 I NTENSI VE CARE UNIT	0	(C)	0	0	
41. 00 04100 SUBPROVI DER - I RF	0	C)	0 (0	0	
43. 00 04300 NURSERY	0	C)	0 (0	0	
200.00 Total (lines 30 through 199)	0	C	(0		200.00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4.00	5.00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		ı	1		T .	
30. 00 03000 ADULTS & PEDIATRICS	0	C	35, 04			
31.00 03100 INTENSIVE CARE UNIT		C	5, 36			31.00
41. 00 04100 SUBPROVI DER - I RF	0	C	4, 890			41.00
43. 00 04300 NURSERY		C	1, 49			43.00
200.00 Total (lines 30 through 199)		C	46, 80	3	884	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
LABOT ENT DOUTLING DEDIVING COOT OFFITEDO	9. 00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	^					20.00
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
41. 00 04100 SUBPROVI DER - RF	0					41.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0	1				200.0

31. 00 41. 00 43. 00 200. 00

Total (lines 30 through 199)

200.00

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

THROUGH COSTS				From 07/01/2021 To 06/30/2022	Part IV Date/Time Pre 11/22/2022 9:	pared: 31 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown Adjustments		Adjustments		
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0		0	0	56. 00
57. 00 05700 CT SCAN	0	0		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60. 00 06000 LABORATORY	0	0		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	63. 00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0		0	0	74. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
90. 00 O9000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY		1 0	1		518, 069	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		١			510,00 9	92.00
200.00 Total (lines 50 through 199)		0		0 0	518, 069	
	'	1	1	-1		

Health Financial Systems	ST. MARY MEDICAL	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2021 Fo 06/30/2022	Part IV	aarad.
				10 06/30/2022	Date/Time Pre 11/22/2022 9:	pareu: 31 am
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
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	
ANCI LLARY SERVI CE COST CENTERS	_		1			
50. 00 05000 OPERATI NG ROOM	0	0		164, 702, 303	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	0		20, 767, 594		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		5, 006, 274		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		32, 526, 675		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		67, 550, 742		54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		23, 707, 796		55. 00
56. 00 05600 RADI OI SOTOPE	0	0		19, 507, 698		56.00
57. 00 05700 CT SCAN	0	0		84, 891, 984	0.000000	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		38, 140, 457	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		93, 476, 708		59.00
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		142, 984, 697	0. 000000 0. 000000	60. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		5, 803, 109	0. 000000	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		5, 803, 109 0 4, 156, 914	0. 000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		15, 126, 050		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		20, 257, 680		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY)	6, 750, 650		67. 00
68. 00 06800 SPEECH PATHOLOGY] }	1, 733, 450		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0			35, 898, 427	0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY				10, 743, 670		
. 5. 55 5. 555 ELEGINGENIOE INCOMM III	1	ı	1	10, , 10, 070	0.00000	. 0. 00

0 0 0 0

0

518, 069

518, 069

33, 567, 325

39, 172, 134

109, 603, 270

4, 127, 611

2, 324, 244

9, 388, 066

105, 081, 117

518, 069 1, 108, 553, 239

11, 556, 594

0

0

518, 069

0. 000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.004930

0.000000

71.00

72.00

73.00

74.00

76. 97

90.00

91.00

92.00

200. 00

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT

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

72.00 07200 IMPL. DEV. CHARGED TO PATIENTS
73.00 07300 DRUGS CHARGED TO PATIENTS

07697 CARDIAC REHABILITATION

OUTPATIENT SERVICE COST CENTERS

90. 00 OOOO CLINIC

07400 RENAL DIALYSIS

91. 00 09100 EMERGENCY

74.00

76. 97

Health Financial Systems	ST. MARY MEDICAL C	u of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0034	Peri od: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/22/2022 9:31 am
		Title XIX	Hospi tal	PPS

					To 06/30/2022	Date/Time Pre	
			Titl	e XIX	Hospi tal	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	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS	0.000000		ı			
50. 00	05000 OPERATING ROOM	0. 000000	628, 682	•	0	1	
51. 00	05100 RECOVERY ROOM	0. 000000	40, 774	l .	0 0	0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	10, 045	l .	0 0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	100, 304		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	157, 099	1	0 0	0	54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	34, 621		0 0	0	
57. 00	05700 CT SCAN	0. 000000	335, 573		0 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	60, 593		0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	89, 738		0 0) 0	59. 00
60.00	06000 LABORATORY	0. 000000	711, 933		0 0) 0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0) 0	62. 00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	17, 643		0 0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	198, 984		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	35, 927		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	25, 551		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	15, 254		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	178, 796		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	25, 454		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	216, 768		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	114, 708		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 088, 860		0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	88, 276		0 0	0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	4, 561		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0. 000000	0		0	0	1
91. 00	09100 EMERGENCY	0. 004930	346, 614	1, 70	19 C	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	27, 340		0	0	1
200.00	Total (lines 50 through 199)		4, 554, 098	1, 70	19 C	0	200. 00

Health Financial Systems	ST. MARY MEDICA	L CENTER. INC.		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0034	Peri od:	Worksheet D	
		Component	CCN: 15-T034	From 07/01/2021 To 06/30/2022	Part II Date/Time Pre 11/22/2022 9:	pared: 31 am
		Ti tI	e XIX	Subprovi der -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANGLI ARV OFRIGO OF SOUT OFFITERS	1. 00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	4.754.444	4/4 700 000	0.0000/			F0 00
50. 00 05000 OPERATING ROOM	4, 754, 644				0	
51. 00 05100 RECOVERY ROOM	502, 083				l	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	243, 157				0	
53. 00 05300 ANESTHESI OLOGY	23, 756				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 098, 609				0	
55. 00 05500 RADI OLOGY - THERAPEUTI C	114, 646				0	
56. 00 05600 RADI OI SOTOPE	197, 976				0	
57. 00 05700 CT SCAN	915, 038		1		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	595, 918				0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 493, 278		1		0	
60. 00 06000 LABORATORY	518, 018				4	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0.0000		0	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	49, 326				0	
64. 00 06400 I NTRAVENOUS THERAPY	73, 007				0	
65. 00 06500 RESPI RATORY THERAPY	160, 733				0	
66. 00 06600 PHYSI CAL THERAPY	517, 796				103	
67. 00 06700 OCCUPATI ONAL THERAPY	34, 409			•	20	1
68. 00 06800 SPEECH PATHOLOGY	75, 367				13	
69. 00 06900 ELECTROCARDI OLOGY	405, 088				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	95, 969		1		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	87, 918				0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	123, 051				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	446, 115				10	
74. 00 07400 RENAL DI ALYSI S	6, 881				0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	181, 097	2, 324, 244	0. 07791	7 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	379, 704					
91. 00 09100 EMERGENCY	648, 750				0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	,			0	
200.00 Total (lines 50 through 199)	13, 742, 334	1, 108, 553, 239	Ί	11, 637	150	200. 00

Health Financial Systems	ST. MARY MEDICA	CENTED INC		In Lie	eu of Form CMS	2552 10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF		S Provider Component	CCN: 15-T034	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/22/2022 9:	pared:
		Titl	e XIX	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS					1	
50. 00 05000 OPERATING ROOM	0	ľ		0 0	_	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	_	
53. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0				0	1
55. 00 05500 RADI OLOGY - THERAPEUTI C	0				0	55. 00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56. 00
57. 00 05700 CT SCAN	0	0		o c	0	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o		0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59. 00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0			0	
69. 00 06900 ELECTROCARDI OLOGY	0	0			0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	o o	Ö		o c	Ö	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	O		o c	0	1
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74. 00
76. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	_					
90. 00 09000 CLI NI C	0	-	•	0 0		
91. 00 09100 EMERGENCY	0	0		0 0	0.0,007	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	_		U	0	
200.00 Total (lines 50 through 199)	0	0	1	0 0	518, 069	J∠00. 00

Health Financial Systems	ST. MARY MEDICAL	_ CENTER, INC.		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider Co	CN: 15-0034	Peri od: From 07/01/2021	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15-T034	To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 31 am
		Ti tl	e XIX	Subprovi der - I RF	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, and 4)	8)	7) (see	
			and 4)		instructions)	
	4. 00	5. 00	6, 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 164, 702, 303	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 20, 767, 594		1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 5, 006, 274		52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		0 32, 526, 675	0.000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 67, 550, 742	0.000000	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 23, 707, 796		55. 00
56. 00 05600 RADI 0I SOTOPE	0	0		0 19, 507, 698		
57. 00 05700 CT SCAN	0	0		0 84, 891, 984		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 38, 140, 457	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 93, 476, 708		
60. 00 06000 LABORATORY	0	0		0 142, 984, 697	0. 000000	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0. 000000	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 5, 803, 109		
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 4, 156, 914		
65. 00 06500 RESPIRATORY THERAPY	0	0		0 15, 126, 050 0 20, 257, 680		
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0	0		0 20, 257, 680 0 6, 750, 650		
68. 00 06800 SPEECH PATHOLOGY		0		0 1, 733, 450		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 35, 898, 427		
70. 00 07000 ELECTROENCEPHALOGRAPHY		0		0 10, 743, 670		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 33, 567, 325		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 39, 172, 134		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	Ö		0 109, 603, 270		1
74. 00 07400 RENAL DIALYSIS	0	0		0 4, 127, 611		74. 00
76. 97 07697 CARDIAC REHABILITATION	0	0		0 2, 324, 244		76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0			0 9, 388, 066		90. 00
91. 00 09100 EMERGENCY	0	518, 069	518, 06			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 11, 556, 594		
200.00 Total (lines 50 through 199)	0	518, 069	j 518, 0 <i>6</i>	59 1, 108, 553, 239	l	200. 00

Health Financial Systems	ST. MARY MEDICAL	CENTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der Co	CN: 15-0034	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-T034	From 07/01/2021 To 06/30/2022	Part IV Date/Time Pre 11/22/2022 9:	pared: 31 am
		Ti tl	e XIX	Subprovi der -	PPS	
				I RF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)	10.00	x col . 10)	40.00	x col . 12)	
ANOLILIADY CEDITION OF COST OFNITEDS	9.00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000		1		0	F0 00
50. 00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	
51. 00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	0		0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	0		0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	1	0 0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	1, 082	•	0 0	0	60. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	•	0 0	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	0	i .	0 0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0	1	0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	4, 011		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	3, 847		0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	293	•	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	•	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 404		0	0	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0	0	74. 00
76. 97 O7697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	
91. 00 09100 EMERGENCY	0. 004930	0	1	0 0	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	
200.00 Total (lines 50 through 199)		11, 637	l	0 0	0	200. 00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-25	52-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0034	Peri od: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepa 11/22/2022 9:31	
		Title XVIII	Hospi tal	PPS	

		TI II 20011		11/22/2022 9:	31 am
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	cost center bescription			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS		,		
1.00	Inpatient days (including private room days and swing-bed days			35, 048	1.00
2.00	Inpatient days (including private room days, excluding swing-			35, 048	2.00
3. 00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ad days)		31, 575	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	31, 373	5. 00
0.00	reporting period	om days) trii odgir becembe	i or or the cost	١	0.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	<i>3</i> ,		 -	
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period			 	
8. 00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line)	the Dreamen (evaluding	owing had and	10 514	9. 00
9.00	Total inpatient days including private room days applicable to newborn days) (see instructions)	The Program (excruding	Swifig-bed and	12, 514	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instructions)			- I	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en			 -	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including privat	e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	/			12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			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)	(0	15. 00
16.00	Nursery days (title V or XIX only)			0	16. 00
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
40.00	reporting period	6. 5			40.00
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	s through December 31 of	the cost	0.00	19. 00
17.00	reporting period	o thi dagn becomber of or	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20.00
	reporting period			 -	
21. 00	Total general inpatient routine service cost (see instructions			36, 771, 674	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	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)	of the cost reportin	g perrou (Triic o	١	25.00
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)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
04.00	x line 20)				0, 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 24)		0 36, 771, 674	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Title 21 IIITius Title 26)		30, 771, 074	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		g/	0	
30.00	Semi -pri vate 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	1
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x line)	ne 31)		0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	and private mass asst di	fforontial (1)	0 24 771 474	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	rrerential (IINe	36, 771, 674	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 049. 18	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		13, 129, 439	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	+ line 40)		13, 129, 439	41.00

Heal th	Financial Systems S	T. MARY MEDICAL	CENTER, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0034	Peri od: From 07/01/2021	Worksheet D-1	
					To 06/30/2022	Date/Time Pre 11/22/2022 9:	
			_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total npati ent Days			Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00				42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9, 851, 519	5, 367	1, 835. !	57 1, 478	2, 712, 972	1
44. 00 45. 00	CORONARY CARE UNIT						44. 00 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)		,	21, 511, 638	48. 00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		37, 354, 049	1
50. 00	Pass through costs applicable to Program inp.	atient routine s	services (from	n Wkst. D, sur	n of Parts I and	1, 108, 966	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	/ services (fr	om Wkst. D, s	sum of Parts II	1, 289, 326	51. 00
52. 00	Total Program excludable cost (sum of lines					2, 398, 292	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	sician anesth	netist, and	34, 955, 757	53. 00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					_	E4 00
54. 00 55. 00	Target amount per discharge					l	54. 00 55. 00
56. 00						0	
57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)					0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period 6	ending 1996, u	ipdated and co	ompounaea by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	f the target		
62. 00	Relief payment (see instructions)	i iisti ucti olis)				0	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instruc	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	nber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	Ü		·		0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	·	•	, ,	3,	0	
67. 00	(line 12 x line 19)	3			. 31		67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
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	ost per diem (li					71. 00
72.00	Program routine service cost (line 9 x line		(1: 11 1:	25)			72.00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient 26, line 45)	•			Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					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	,	ovider rocord	le)			78. 00 79. 00
80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		80.00
			323.00		,		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		5)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00							86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						07.05
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			3, 473 1, 049. 18	
	Observation bed cost (line 87 x line 88) (se	•				3, 643, 802	
		,				•	

Health Financial Systems S	T. MARY MEDICAL	_ CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		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, 648, 223	36, 771, 674	0. 07201	8 3, 643, 802	262, 419	90.00
91.00 Nursing Program cost	0	36, 771, 674	0.00000	0 3, 643, 802	0	91.00
92.00 Allied health cost	0	36, 771, 674	0.00000	0 3, 643, 802	0	92.00
93.00 All other Medical Education	0	36, 771, 674	0. 00000	0 3, 643, 802	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 07/01/2021	Worksheet D-1
		Component CCN: 15-T034	To 06/30/2022	Date/Time Prepared: 11/22/2022 9:31 am
		Title XVIII	Subprovider -	PPS

16.00 Nursery days (title V or XIX only)			II the Aviii	I RF	FF3	
NAME		Cost Center Description				
MATLERT DAYS		DART I - ALL PROVINER COMPONENTS			1.00	
1. Inpatient days (including private room days, excluding saing-bed and nebborn days) 2. Op Private room days (sociuding saing-bed and observation bed days) 3. Op Private room days (sociuding saing-bed and observation bed days) 4. 00 4. 00 5. 00 6. 00 6. 00 7. 00		PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS Inpatient days (Including private room days and swing-bed days, excluding newborn) Inpatient days (Including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room day for the room days (excluding swing-bed and observation bed days). If you have only private room day for the room days (excluding swing-bed and observation bed days). If you have only private room day for last swing-bed SMF type inpatient days (including private room days) after December 31 of the corresporting period (if calendar year, enter 0 on this line) Total swing-bed SMF type inpatient days (including private room days) after December 31 of the corresporting period (if calendar year, enter 0 on this line) Total swing-bed SMF type inpatient days (including private room days) after December 31 of the corresporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed are newborn days) (see instructions) Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reoporting period (see instructions) Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Waing-bed SMF type inpatient days applicable to services after December 31 of the cost through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed Cost applicable to SMF type services applicable t				
Drivate room days (excluding swing-bed and observation bed days). If you have only private room days, do all on not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days). 5.01 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if call endar year, enter 0 on this line). 1.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). 1.01 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). 1.01 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). 1.02 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and resoluting period (if called year) and the cost reporting period (if called year) and the cost intrough December 31 of the cost reporting period (if it swill in only (including private room days) after becember 31 of the cost reporting period (if its WIII only (including private room days) after becember 31 or the cost reporting period (if its WIII only (including private room days) after becember 31 or the cost reporting period (if its WIII only (including private room days) after becember 31 or the cost reporting period (if its WIII only (including private room days) after becember 31 or the cost reporting period (if its WIII only (including private room days) after becember 31 or the cost reporting period (if its WIII only (including private room days) after becember 31 or the cost reporting period (if its WIII only (including private room days) after becember 31 or the cost reporting period (if its WIII only (including private room days) after becember 31 or the cost reporting period (if its WIII only (including private room days) after becember 31 or th						
do not complete this line. 4. 05 Sell-private room days (excluding saling-bed and observation bed days) 10 total saving-bed SWF type inpatient days (including private room days) after December 31 of the cost 7. 00 Total saving-bed SWF type inpatient days (including private room days) after December 31 of the cost 7. 00 Total sing-bed SWF type inpatient days (including private room days) after December 31 of the cost 8. 00 Total sing-bed SWF type inpatient days (including private room days) after December 31 of the cost 9. 00 Total sing-bed SWF type inpatient days (including private room days) after December 31 of the cost 10. 00 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and newbork) sell-provided saving bed SWF type inpatient days applicable to the Program (excluding swing-bed and newbork) sell-provided saving bed SWF type inpatient days applicable to the Program (excluding swing-bed and newbork) sell-provided saving-bed SWF type inpatient days applicable to the Program (excluding swing-bed and newbork) sell-provided saving-bed SWF type inpatient days applicable to the SWF type inpatient days applicable to SWF type inpatient day						
Semi-private room days (excluding swing-bed and observation bed days) through December 31 of the cost	3.00		/s). If you have only pri	vate room days,	U	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line) 7.00	4.00		ed days)		4, 890	4. 00
10 10 10 10 10 10 10 10		Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 1.00 Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost or reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SWF type inpatient days (including private room days) after December 31 of the cost own days) as a swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost (and in unservy days (title v or XIX only) december 31 of the cost (and in unservy days (title v or XIX only) december 31 of the cost (and in unservy days (title v or XIX only) december 31 of the cost (and in unservy days (title v or XIX only) december 31 of the cost (and in the cost (and in the cost period (in period year) december 31 of the cost (and in the cost (and in the cost period (in period year) december 31 of the cost (and in the cost period (in period year) december 31 of the cost reporting period			om dava) aftar Dagombar 3	11 of the cost		4 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal andar year, enter 0 on this line) Record of the cost reporting period (if cal andar year, enter 0 on this line) Record of the cost reporting period (if cal andar year, enter 0 on this line) Record of the cost reporting period (see instructions) Record of	6.00		om days) after becember 3	or the cost	U	6.00
1.00 Cotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 8.00 reporting period (if Cri calendar year, enter 0 on this line) 0 10 10 10 10 10 10 10	7. 00		n days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 10.00 10						
1.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1.10 1	8. 00		n days) after December 31	of the cost	0	8. 00
newborn days (see Instructions) 0 10.00	9 00		the Program (excluding	swing-bed and	2 969	9 00
through December' 31 of the cost reporting period (see Instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to to titles V or XIX only (including private room days) 1.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 1.00 Total nursery days (title V or XIX only) 1.00 No Nursery days (title V or XIX only) 1.00 Medicaler rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 1.00 Medicaler rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 1.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 1.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line Six I ine 17) 1.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Six I ine 17) 2.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Six I ine 18) 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Six I ine 18) 2.01 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Six I in	,, 00		the regram (exertaining	oming sou and	2,707	7.00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Nursery days (title V or XIX only) 18.00 SNIM BED ADUISMEND 18.00 SNIM BED ADUISMEND 18.00 Program general inpatient routine services applicable to services through December 31 of the cost reporting period cale d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period cale d rate for swing-bed NF services applicable to services after December 31 of the cost period period of a reporting period of the cost reporting period of a reporting period of the cost period period of the cost reporting period of the cost reporting period of the cost period period of the cost applicable to SNF type services after December 31 of the cost reporting period (line 6 X IIIne 18) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 X IIIne 18) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 X IIIne 18) 24.00 Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 X IIIne 18) 25.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 X IIIne 18) 26.00 For Inne 200 December 31 of the cost reporting period (line 6 X IIIne 32) 27.00 Comparison to the cost applicable to SNF type services	10. 00			oom days)	0	10. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)	11 00			om days) after		11 00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 17.00 Nursery days (title V or XIX only) 0 18.00 Nursery days (title V or XIX only) 0 18.00 Nursery days (title V or XIX only) 0 19.00 Nursery d	11.00	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	Joil days) arter	U	11.00
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) after December 31 of the cost reporting period (if called endary year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period of total general inpatient routine services (see instructions) 12.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 27.01 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 28.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 29.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line	12. 00			e room days)	o	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Norsery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (locare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (locare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (local drate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed NF services through December 31 of the cost reporting period (line 5 x line 17) 20.00 Medical drate for swing-bed NF services through December 31 of the cost reporting period (line 5 x line 18) 21.00 Total general inpatient routine services through December 31 of the cost reporting period (line 6 x line 18) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 24.00 Total swing-bed cost (see instructions) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 Compared in patient routine service cost period (line 21 minus line 26) 28.00 Compared in patient routine service cost period (line 27 + line 28) 39.00 Semi-private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Compared in patient routi	40.00				ا	40.00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 15.00 Nursery days (title V or XIX only) 0 15.00 15.00 Nursery days (title V or XIX only) 0 15.00 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 17.00 Nursery days (title V or XIX only) 0 17.00 Nursery days (title V or XIX only) 0 17.00 Nursery days (title V or XIX only) 0 18.00 18.00 18.00 19.00 Nursery days (title V or XIX only) 18.00 19.00 1	13. 00				0	13.00
15.00 Total nursery days (title V or XIX only) 0.16.00 0.	14. 00	1 91 1	•	, I	0	14. 00
SWING BED ADJUSTMENT 1.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period (line dare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line dare rate for swing-bed NF services applicable to services through December 31 of the cost (line dare) 20.00 Medical darate for swing-bed NF services applicable to services through December 31 of the cost (line dare) 20.00 Medical darate for swing-bed NF services applicable to services after December 31 of the cost (line dare) 20.00 Medical darate for swing-bed NF services applicable to services after December 31 of the cost (line dare) 20.00 Sing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line dare) 21.00 Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line dare) 22.00 Sing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line dare) 23.00 Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line dare) 24.00 Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line dare) 25.00 Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line dare) 26.00 Total swing-bed cost (see instructions) 27.00 Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line dare) 28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29.00 Fivitar ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service cost net of swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average peride mprivate room charged (line 29 + line 3) 30.00 Average peride mprivate			(gg	,		
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost (19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost (19. 00 Medicare for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Medicare for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Medicare for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Medicare for swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (19. 00 Medicare for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19. 00 Medicare for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19. 00 Medicare for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (19. 00 Medicare for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (19. 00 Medicare for swing-bed cost applicable for swing-bed	16. 00				0	16. 00
reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 p. 00 propring period 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost propring period	17 00		as through December 21 of	the east	0.00	17 00
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 20.00 20	17.00		es through December 31 of	the cost	0.00	17.00
19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 21.00 22.00 22.00 23.00 23.00 23.00 23.00 24.00 24.00 24.00 24.00 25	18. 00	' 3 '	es after December 31 of t	he cost	0. 00	18. 00
reporting period Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5, 788, 451 21.00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 17) 32.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 General inpatient routine service cost (line 29 + line 3) 30.00 Average private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room charge differential (line 32 minus line 31) 30.00 Average per diem private room cost differential (line 32 minus line 33) 30.00 Private room cost differential adjustment (line 32 minus line 31) 30.00 Average per diem private room cost differential (line 32 minus line 31) 30.00 Average per diem private room cost differential (line 32 minus line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 32						
20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 10tal general inpatient routine service cost (see instructions) 5,788,451 21.00 22.00 5 x line 17) 23.00 24.00 25.00 2	19. 00		s through December 31 of	the cost	0. 00	19. 00
reporting period Total general inpatient routine service cost (see instructions) 22.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Ceneral inpatient routine service cost net of swing-bed and observation bed charges) OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service cost/charges (excluding swing-bed and observation bed charges) OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service cost/charges (excluding swing-bed and observation bed charges) OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service cost/charges ratio (line 27 + line 28) OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service cost/charges ratio (line 27 + line 28) OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT ROVIDERS ONLY PROGRAM INPATIAL PROVIDERS ONLY PROGRAM INPATIAL PROVIDERS ONLY PROGRAM INPATIAL PROVIDERS ONLY PROGRAM INPATIAL AND SUBPROVIDER	20. 00	, , , , , , , , , , , , , , , , , , , ,	s after December 31 of th	ne cost	0.00	20.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 Feneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Feneral inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average per diem private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 3 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Average per diem private room per Application (see instructions) 30.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Average per diem private room cost diem per Application (see instructions) 30.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Average per diem per diem charge (line 30 + line 38) 30.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Average per diem private room cost diem per volument (see instructions) 30.00 Average p						
5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 6.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00						
23. 00	22. 00		er 31 of the cost reporti	ng period (line	0	22.00
x line 18) 24.00	23. 00	l	31 of the cost reporting	period (line 6	0	23. 00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 For vate room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 ÷ line 3) 31.00 Average perivate room per diem charge (line 30 + line 4) 32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 37.00 For vate room cost differential (line 3 x line 31) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 General inpatient routine service cost ret of swing-bed cost and private room cost differential (line 5, 788, 451) 38.00 Average per diem private room cost differential (line 3 x line 35) Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost differ				, , , , , , , , , , , , , , , , , , , ,		
25. 00	24. 00	, , , , , , , , , , , , , , , , , , , ,	31 of the cost reportin	ng period (line	0	24. 00
x line 20) Total swing-bed cost (see instructions) 26. 00 Total swing-bed cost (see instructions) 27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 788, 451) Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Average general inpatient routine service cost per diem (see instructions) 39. 00 Average general inpatient routine service cost per diem (see instructions) 39. 00 Average general inpatient routine service cost per diem (see instructions) 39. 00 Average general inpatient routine service cost per diem (see instructions) 39. 00 Average general inpatient routine service cost per diem (see instructions) 39. 00 Average general inpatient routine service cost per diem (see instructions) 39. 00 Average general inpatient routine service cost per diem (see instructions) 39. 00 Average general inpatient routine service cost per diem (see instructions) 39. 00 Average general inpatient routine service cost per diem (see instructions) 39. 00 Average per diem private room cost differential (line 3 x line 35) 39. 00 Average per diem private room cost differential (line 3 x line 35) Adjusted general inpatient routine service cost per diem charge (line 21 minus line 36)	25 00	l	21 of the cost reporting	period (line 8		25 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 5, 788, 451 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29. 00 29. 00 Frivate room charges (excluding swing-bed charges) 0 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 0 30. 00 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.0000000 31. 00 32. 00 Average private room per diem charge (line 29 ÷ line 3) 0.00 32. 00 33. 00 Average per diem private room charge differential (line 30 ÷ line 4) 0.00 33. 00 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34. 00 35. 00 Average per diem private room cost differential (line 34 x line 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 and private room cost differential (line 27 minus line 36) 0 40 used general inpatient routine service cost per diem (see instructions) 1, 183. 73 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 3, 514, 494 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	25.00		or the cost reporting	perrod (Trile 8	o l	25.00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average pri vate room per diem charge (line 29 + line 3) 32.00 Average semi-pri vate room per diem charge (line 30 + line 4) 32.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 33.00 Average per diem pri vate room cost differential (line 34 x line 31) 34.00 Average per diem pri vate room cost differential (line 34 x line 31) 35.00 Pri vate room cost differential adjustment (line 3 x line 35) 36.00 Pri vate room cost differential adjustment (line 3 x line 35) 36.00 Pri vate room cost differential adjustment (line 3 x line 35) 36.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 20.00 31.00 20.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 33.00 34.00 35.00 40.00	26.00	Total swing-bed cost (see instructions)				
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 5, 788, 451) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 5, 788, 451) 31.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 5, 788, 451) 31.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 5, 788, 451) 32.00 Average per diem	27. 00		(line 21 minus line 26)		5, 788, 451	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 788, 451) 30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Program general inpatient routine service cost applicable to the Program (line 14 x line 35)	28 00		d and observation had cha	rges)	0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 37 x line 31) 30.00 Average per diem private room cost differential (line 37 x line 31) 30.00 Average per diem private room cost differential (line 37 x line 31) 30.00 Average per diem private room cost differential (line 37 x line 31) 30.00 Average per diem private room cost differential (line 37 x line 31) 30.00 Average per diem private room cost differential (line 38 x line 31) 30.00 Average per diem private room cost differential (line 57 x 88, 451) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 57 x 88, 451) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 57 x 88, 451) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 58 x line 31) 30.00 Average per diem private room cost differential (line 38 x line 31) 30.00 Average per diem private room cost differential (line 38 x line 31) 30.00 Average per diem private room cost differential (line 38 x line 31) 30.00 Average per diem private room cost differential (line 38 x line 31) 30.00 Average per diem private room cost differential (line 38 x line 31) 30.00 Average per diem private room cost d			a and observation bed cha	ii ges)		
32.00 Average private room per diem charge (line 29 + line 3) 32.00 Average semi-private room per diem charge (line 30 + line 4) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 788, 451) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Average per diem charge (line 30 + line 4) 30.00 Jac. 00 32.00 Jac. 00 32.00 Jac. 00 33.00 34.00 35.00 36.00 37.00 40.00						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 788, 451) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 31.00 Average semi-private room per diem charge (line 30 ÷ line 31) 32.00 Average per diem private room cost differential (line 32 minus line 33) 33.00 Average per diem private room cost differential (line 32 minus line 31) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 32 minus line 33) 36.00 Average per diem private room cost differential (line 34 x line 31) 37.00 Average per diem private room cost differential (line 34 x line 31) 38.00 Average per diem private room cost differential (line 34 x line 31) 38.00 Average per diem private room cost differential (line 34 x line 31) 38.00 Average per diem private room cost differential (line 34 x line 31) 38.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost di		,	- line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 788, 451) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 35.00 36.00 37.00 37.00 37.00 38.00 37.00 38.00 37.00 40.00						
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 788, 451 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			nue lina 33)(saa instruct	i one)		
36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 5, 788, 451 5, 788, 451 5, 788, 451 5, 788, 451 5, 788, 451 7, 183. 73 8.00 9.00 1, 183. 73 9.00 40.00			, ,	.10113)		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 183.73 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 3, 514, 494 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						36. 00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,183.73 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 3,514,494 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	5, 788, 451	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,183.73 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 3,514,494 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,183.73 38.00 Program general inpatient routine service cost (line 9 x line 38) 3,514,494 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			ISTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 3,514,494 39.00 40.00	38. 00				1, 183. 73	38. 00
41.00 lotal Program general inpatient routine service cost (line 39 + line 40) 3,514,494 41.00		, , , , , , , , , , , , , , , , , , , ,	•			
	41.00	liotal Program general inpatient routine service cost (line 39	+ IIne 40)	I	3, 514, 494	41.00

	<u> </u>	T. MARY MEDICAL			In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN:	F	eriod: rom 07/01/2021	Worksheet D-1	
			Component CCN		0 06/30/2022	Date/Time Pre 11/22/2022 9:	
			Title X		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
47.00	Cost Center Description	L					47.00
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 1, 383, 733	48. 00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS)		4, 898, 227	
50. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from W	kst. D, sum	of Parts I and	197, 706	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (from	Wkst. D, su	m of Parts II	71, 616	51. 00
52. 00	Total Program excludable cost (sum of lines					269, 322	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-physi	cian anesthe	tist, and	4, 628, 905	53. 00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00						0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tare	rot amount (lin	o E4 minus l	ino E2)	0	56. 00 57. 00
58. 00	, , , , , , , , , , , , , , , , , , , ,	ing cost and targ	get amount (iin	e so illi flus i	THE 53)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period er	ndi ng 1996, upd	ated and com	pounded by the	0. 00	59. 00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, upda	ated by the mar	ket basket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					0	61. 00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)			_	0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruct	tions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the c	ost reportin	g period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the cos	t reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	1 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	orting 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	e cost repor	ting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line 6	8)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (lir		t (ITTIC 37)			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	(lina 14 v lina	35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv			33)			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service o	costs (from Wor	ksheet B, Pa	rt II, column		75. 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			l: 70:-	- 1: 70)		79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		scrimitation (ııne /σ Minu	S I I I I C / 7 / 7		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		ough 85)				86. 00
87. 00	Total observation bed days (see instructions)				0	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		ine 2)				88. 00 89. 00
	(30)				ļ	·	

COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 15-0034 Period: Worksheet D-1		ST. MARY MEDICAL	CLIVILK, TNC.		In Lie	u of Form CMS-2	2552-10
	OMPUTATION OF INPATIENT OPERATING COST		Provi der CC			Worksheet D-1	
Component CCN: 15-T034 From 07/01/2021 Date/Time Prepared: 11/22/2022 9:31 am			Component (From 07/01/2021 To 06/30/2022		
Title XVIII Subprovider - PPS			Title	XVIII	'	PPS	
IRF I					I RF		
Cost Center Description Cost Routine Cost column 1 ÷ Total Observation	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
(from line 21) column 2 Observation Bed Pass			(from line 21)	column 2	Observati on	Bed Pass	
Bed Cost (from Through Cost					Bed Cost (from	Through Cost	
line 89) (col. 3 x col.					line 89)	(col. 3 x col.	
4) (see						4) (see	
instructions)						instructions)	
1.00 2.00 3.00 4.00 5.00		1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST	COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90. 00 Capi tal -rel ated cost 325, 621 5, 788, 451 0. 056254 0 0 90. 00	0.00 Capital-related cost	325, 621	5, 788, 451	0. 05625	4 0	0	90.00
91.00 Nursing Program cost 0 5,788,451 0.000000 0 0 91.00	1.00 Nursing Program cost	0	5, 788, 451	0.00000	0 0	0	91.00
92.00 Allied health cost 0 5,788,451 0.000000 0 0 92.00	2.00 Allied health cost	0	5, 788, 451	0.00000	0 0	0	92.00
93.00 All other Medical Education 0 5,788,451 0.000000 0 0 93.00	3.00 All other Medical Education	0	5, 788, 451	0.00000	0	0	93. 00

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034	Peri od: From 07/01/2021	Worksheet D-1	
				Date/Time Pre 11/22/2022 9:	
		Title XIX	Hospi tal	PPS	
Cook Cooker Doored at the					

WRI 1 - ALL PROVIDER COMPONENTS MRI 1 - ALL PROVIDER COMPONENTS			Title XIX	Hospi tal	11/22/2022 9: PPS	31 am_
PART 1 - ALL PROVIDER CONFORMITS Impatient days (Including private room days, and saving-bed days, excluding newborn) Impatient days (Including private room days, excluding sering-bed and newborn days) Impatient days (Including private room days, excluding sering-bed and newborn days) Impatient days (Including private room days, excluding sering-bed and severation bed days). If you have only private room days, do not complete this time. Including sering		Cost Center Description	II LIE XIX	1103pi tai	113	
INPACT LINT PAYS 1.00 Impattient days (including private room days and swing-bed days, excluding newborn) 35,048 2.00 Impattient days (including private room days, excluding swing-bed and newborn days) 3,048 2.00 1 1 1 1 1 1 1 1 1					1. 00	
Inpatient days (Including private room days and swing-bed days, excluding newborn) 35,048 2,00						
Semi-private room days (excluding saring bed and observation bed days) through December 31 of the cost of preparing pariod (in claim pariot are now days) after December 31 of the cost of preparing pariod (in claim pariot are now days) after December 31 of the cost of preparing pariod (in claim pariot are now days) after December 31 of the cost of preparing pariod (in claim pariot days) (including private room days) after December 31 of the cost of preparing pariod (in claim pariot days) (including private room days) after December 31 of the cost of preparing pariod (in claim pariot days) (including private room days) after December 31 of the cost of preparing pariod (in claim pariot days) (including private room days) after December 31 of the cost of preparing pariod (in claim pariot days) (including private room days) after December 31 of the cost of preparing pariod (in claim pariot days) (including private room days) (including private room days) (including pariot days)	2.00	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,	35, 048	2. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost roporting period (if calendar year, enter 0 on 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		
7.00 Total swing-bed NF type inpatient days (including private room days) shrough December 31 of the cost reporting period of (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and total inpatient days including private room days applicable to title XVII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) after 10 on 30 on the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.00 Period Inverse (days) (title V or XIX only) 8.00 North Inverse (days) (title V or XIX only) 8.01 North Inverse (days) (title V or XIX only) 8.02 North Inverse (days) (title V or XIX only) 8.03 North Ed Augustian 7.00 North Inverse (days) (title V or XIX only) 8.01 North Inverse (days) (title V or XIX only) 8.02 North Inverse (days) (title V or XIX only) 8.03 North Inverse (days) (title V or XIX only) 8.04 North Inverse (days) (title V or XIX only) 8.05 North Inverse (days) (title V or XIX only) 8.06 North Inverse (days) (title V or XIX only) 8.07 North Inverse (days) (title V or XIX only) 8.08 North Inverse (days) (title V or XIX only) 8.09 North Inverse (days) (title V or XIX only) 8.00 North Inverse (days) (title V or XIX only) 8.01 North Inverse (days) (title V or XIX only) 8.02 North Inverse (days) (title V or X	6. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) of through December 31 of the cost reporting period (including private room days) after period of the private room days applicable to title SV or XIX only (including private room days) of the cost reporting period (including year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) of the cost reporting period (including year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) yii (including private room days) of the cost (including private room days) of the cost (including private room days) after visually applicable to services through December 31 of the cost (including private room days applicable to services after December 31 of the cost (including private room days applicable to services after December 31 of the cost (including private room days applicable to services after December 31 of the cost (including private room days applicable to services after December 31 of the cost (including private room days applicable to SNF type services through December 31 of the cost reporting period (line 6 or private room days) applicable to SNF type services after December 31 of the cost reporting period (line 6 or priv	7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Total nursery days (title V or XIX only) 17.00 Swing-BeD AUSINEMI 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including swing-bed SNF services) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed swing-bed SNF services) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed swing-bed SNF services) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 vices) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 vices) 19.00 Medicare rate for swing-bed SNF services after December 31 of the cost reporting period (line 6 vices) 20.00 Swing-bed cost applicable to SNF typ	8.00		n days) after December 3	1 of the cost	0	8. 00
through December 31 of the cost reporting period (see Instructions) 11.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 16.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 17.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Modicare rate for calendary (if the Vision of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (if the cost repor		newborn days) (see instructions)	9			
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Single-bal NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 13.00 Single-bal NF type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00 14.00 After December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 14.00 15.00 Total nursery days (title V or XIX only) 14.00 15.00 16.00 Norsery days (title V or XIX only) 9 16.00 17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17.00 Norsery days (title V or XIX only) 9 16.00 18.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 19.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Norser 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 19.00 0.0		through December 31 of the cost reporting period (see instruct	tions)			
through December 31 of the cost reporting period 13.00 Marg-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Arg-bed NT type inpatient days applicable to the Program (excluding swing-bed days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Mensery days (title V or XIX only) 18.00 Mold care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 20.00 Nama-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 20.00 Program general inpatient routine servi		December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,		
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 15.00 Total nursery days (title V or XIX only) 14.00 16.00 Total nursery days (title V or XIX only) 91 16.00		through December 31 of the cost reporting period	3 .	,	_	
15.00 Total nursery days (title V or XIX only) 15.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period swing-bed NF services applicable to services after December 31 of the cost reporting period swing-bed NF services applicable to services after December 31 of the cost reporting period swing-bed NF services applicable to services after December 31 of the cost reporting period swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19) 26.00 Total swing-bed cost (see instructions) 27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19) 26.00 Total swing-bed cost (see instructions) 27.00 Swing-bed cost (see instructions) 28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Privater room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average peridem private room cost differential (line 27 + line 28) 30.00 Average peridem private room charges (line 20 + line 30) 31.00 Average peridem privat		after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)	_	
SWING BED ADJUSTMENT 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18. 00 reporting period wedicare rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20. 00 No 19. 00 N	15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	1, 498	15. 00
reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 period on Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 period on Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 period on Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 28.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average per private room per diem charge (line 29 + line 3) 31.00 Average per private room per diem charge (line 29 + line 3) 32.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 38.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Average semi-private room cost differential (line 34 x line 35) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Average per diem private room cost differential (lin	16.00				91	16.00
reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost sapplicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 General inpatient routine service cost need of swing-bed cost (line 21 minus line 26) 28.00 Total swing-bed cost (see instructions) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 30.00 Average per lidem private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Average per lidem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Average per lidem private room cost differential (line 34 x line 31) 30.00 Average per lidem private room cost differential (line 35 x line 31) 30.00 Average seni-private room cost differential (line 30 x line 31) 30.00 Average seni-private room cost differential (line 35 x line 31) 30.00 Average seni-private room cost differential (line 35 x line 38) 30.00 Average seni-private room cost differential (line 35 x line 38) 30.00 Average manu	17. 00		es through December 31 o	f the cost	0. 00	17. 00
reporting period 20. 00 Medical air atte for swing-bed NF services applicable to services after December 31 of the cost reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average per diem private room per diem charge (line 29 + line 3) 33. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 34. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 32 minus line 33) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost (line 9 x line 35) 38. 00 Adjusted general inpatient routine service cost (line 9 x line 35) 38. 00 Adjusted general inpatient routine service cost (line 9 x line 35) 39. 00 Program general inpatient routine service cost (line 9 x line 35) 39. 00 Program general inpatient routine service cost (line 9 x line 35) 39. 00 Program general inpatient routine service cost (line 9 x line 35) 39. 00 Pr	18. 00		es after December 31 of	the cost	0.00	18. 00
reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 32 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 Average per diem private room cost differential (line 34 x line 31) 38.00 Adjusted general inpatient routine service cost reporting period (line 6 0 23.00 december 21.00 de	19. 00	reporting period	J		0.00	
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average perivate room per diem charge (line 29 + line 3) 31.00 Average perivate room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 x line 31) 30.00 Average per diem private room cost differential (line 32 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost		reporting period		he cost		
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 ÷ line 3) 30.00 Average perivate room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem		Swing-bed cost applicable to SNF type services through December		ing period (line		
7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 32. 00 Average semi-private room per diem charge (line 30 + line 4) 33. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36, 771, 674) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
x line 20) 26.00 27.00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 29.00 Private ROOM DIFFERENTIAL ADJUSTMENT 28.00 Semi-private room charges (excluding swing-bed and observation bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) O General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36, 771, 674) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Alusted general inpatient routine service cost (excluding swing-bed to the Program (line 14 x line 35) 0 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 0 26.00 26.00 27.00 28.00 28.00 29.0	24. 00		31 of the cost reporti	ng period (line	0	24. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) RIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 36, 771, 674) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions)		x line 20)	31 of the cost reporting	period (line 8	0	
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36, 771, 674) 30.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Adjusted general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Aocentral inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		-	
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36, 771, 674) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 30.00 30.00 30.00 30.00 30.00 31.00 32.00 3	28. 00		d and observation bed ch	arges)	0	28, 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36, 771, 674) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 00 00 00 00 00 00 00 00 00 00 00 00			and observation bod on	ai gooy		
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36, 771, 674) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 32.00 0.00 32.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 36.00 0.0	30. 00					
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36, 771, 674) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36, 771, 674) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 35.00 36		, , , , , , , , , , , , , , , , , , , ,				
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36, 771, 674) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 35.00 36.00	33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36, 771, 674) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 36.00 37.	34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 37	35.00	Average per diem private room cost differential (line 34 x lir	ne 31)		0.00	35. 00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 40.00		General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 36, 771, 674	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,049.18 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,049.18 38.00 39.00 40.00		PART II - HOSPITÁL AND SUBPROVIDERS ONLY	ICTUENTO -			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 590,688 39.00 0 40.00	00.00				4 0 40 15	00.05
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					·	
		5 5	•		•	
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 590,688 41.00		, , , , , , , , , , , , , , , , , , , ,	•			
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		590, 688	41.00

	Financial Systems S ATION OF INPATIENT OPERATING COST	ST. MARY MEDICAL	Provider C	CN: 15-0034	Peri od:	wof Form CMS-2 Worksheet D-1	
	THE STATE OF THE S				From 07/01/2021 To 06/30/2022		pare
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	2, 701, 306	1, 498	1, 803.	28 91	164, 098	42.
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	9, 851, 519	5, 367	1, 835.	57 222	407, 497	43.
4. 00	CORONARY CARE UNIT	7,031,317	5, 307	1, 635.	222	407, 497	44.
5. 00	BURN INTENSIVE CARE UNIT						45.
6. 00	SURGICAL INTENSIVE CARE UNIT						46.
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			809, 899	48
	Total Program inpatient costs (sum of lines			ons)		1, 972, 182	1
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sur	m of Parts I and	81, 174	50
. 00	<pre>III) Pass through costs applicable to Program inp.</pre>	atient ancillar	v services (fr	om Wkst D	sum of Parts II	47, 731	51
	and IV)		, 55 555 (11			'',','	
. 00	Total Program excludable cost (sum of lines					128, 905	
. 00	Total Program inpatient operating cost exclu	5 1	lated, non-phy	sician anestl	netist, and	1, 843, 277	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program discharges					0	54
. 00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	1
. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period	ending 1996 ı	indated and co	omnounded by the	0.00	
00	market basket	por tring perrou	charing 1770, c	ipaatea ana e	ompounded by the	0.00	"
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (Tines 54 x	60), or 1% o	r the target		
. 00	Relief payment (see instructions)	matractions)				0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST		1 04 6 11				١.,
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ing period (see	0	64
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	ost reporting	g period (See	0	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVI	ll only). For	0	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost re	enorting period	0	67
. 00	(line 12 x line 19)	o ooo to tiii ougi.	2000201		sportring porrod		"
3. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	orting period	0	68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs (lino 47 i lino	. 40)		_	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N					<u> </u>	1 09
0. 00	Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line		/I: 14 I:	25)			72
. 00 . 00	Medically necessary private room cost application. Total Program general inpatient routine serv						73
. 00	Capital -related cost allocated to inpatient	•			Part II, column		75
	26, line 45)		-	•			
. 00	Per diem capital related costs (line 75 ÷ li	,					76
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77
00	Aggregate charges to beneficiaries for exces		rovi der record	ls)			79
00	Total Program routine service costs for comp			*.	nus line 79)		80
. 00	Inpatient routine service cost per diem limi		`				81
. 00	Inpatient routine service cost limitation (I						82
. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		3)				84
. 00	Utilization review - physician compensation		ns)				85
	Total Program inpatient operating costs (sum	of lines 83 th					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS					2 472	
7. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			3, 473 1, 049. 18	
. 00						, .,	

Health Financial Systems S	T. MARY MEDICAL	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		Ti tl	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, 648, 223	36, 771, 674	0. 072018	3, 643, 802	262, 419	90. 00
91.00 Nursing Program cost	0	36, 771, 674	0.00000	3, 643, 802	0	91.00
92.00 Allied health cost	0	36, 771, 674	0.000000	3, 643, 802	0	92. 00
93.00 All other Medical Education	0	36, 771, 674	0.000000	3, 643, 802	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 07/01/2021	Worksheet D-1
		Component CCN: 15-T034	To 06/30/2022	Date/Time Prepared: 11/22/2022 9:31 am
		Title XIX	Subprovi der -	PPS

		TI LIE XIX	I RF	FF3	
	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			4, 890	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bell Private room days (excluding swing-bed and observation bed day		ivate room dave	4, 890 0	2. 00 3. 00
3.00	do not complete this line.	is). If you have only pri	i vate i oom days,	١	3.00
4.00	Semi-private room days (excluding swing-bed and observation be			4, 890	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room)	om davs) after December :	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	==9=, == ======		_	
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	n davs) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	r days) arter becomber 3	i or the cost	,	0.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	8	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	nom dave)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)		Join days)	١	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	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 XI)		o room days)	0	12. 00
12.00	through December 31 of the cost reporting period	t only (frictualing private	e room days)	١	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14.00	after December 31 of the cost reporting period (if calendar ye				14.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	im (excluding swing-bed o	uays)	0 1 498	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			91	16. 00
	SWING BED ADJUSTMENT				
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	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	he cost	0. 00	20. 00
20.00	reporting period	, arter becomber or er cr			20.00
21. 00	Total general inpatient routine service cost (see instructions			5, 788, 451	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	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
04.00	x line 18)	24 6 11			04.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportii	ng perioa (line	0	24. 00
25. 00	·	31 of the cost reporting	period (line 8	0	25. 00
0, 00	x line 20)				
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		0 5, 788, 451	26. 00 27. 00
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	THE 21 IIIIII 20)		3, 700, 431	27.00
	General inpatient routine service charges (excluding swing-bed	l and observation bed cha	arges)		28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0.00	
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 mir	, ,	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)	le 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	5, 788, 451	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			1, 183. 73	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		9, 470	39. 00
40.00	Medically necessary private room cost applicable to the Progra	•		0 470	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)	l	9, 4/0	41. 00

MPUT	Financial Systems S ATION OF INPATIENT OPERATING COST	T. MARY MEDICAL	Provider CC Component C	CN: 15-0034 CCN: 15-T034 e XIX	Peri od: From 07/01/2021 To 06/30/2022 Subprovi der -	worksheet D-1 Date/Time Pre 11/22/2022 9: PPS	pare
	Cost Center Description	Total Inpatient Costlr		col . 2)	÷	Program Cost (col. 3 x col. 4)	
00	NUDCEDY (+; +Lo V & VLV only)	1.00	2.00	3. 00	4. 00 00 C	5. 00	1 12
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	l d	0	0.	00 0	0	42.
. 00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	43.
. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						44. 45. 46. 47.
	Cost Center Description						
						1.00	
	Program inpatient ancillary service cost (Wk.			nc)		2, 571	1
. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 (111 Ough 40) (St	ee mstructro	115)		12, 041	49.
. 00	Pass through costs applicable to Program inpa	atient routine se	ervices (from	Wkst. D, sui	m of Parts I and	533	50.
	111)						
. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fr	om Wkst. D, :	sum of Parts II	150	51
. 00	Total Program excludable cost (sum of lines	50 and 51)				683	52
. 00	Total Program inpatient operating cost exclu	ding capital rela	ated, non-phy	sician anest	hetist, and	11, 358	53
	medical education costs (line 49 minus line	52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					Ι ο	54
	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient operations	ing cost and targ	get amount (I	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period er	ndina 1996 u	ndated and co	omnounded by the	0.00	
00	market basket	sortring period er	idi iig 1770, d	puareu anu ci	silipourided by the	0.00	
00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see	s 55, 59 or 60 er n expected costs	nter the less	er of 50% of	the amount by	0.00	
. 00	Relief payment (see instructions)	ilisti ucti olis)				0	62
	Allowable Inpatient cost plus incentive payme	ent (see instruct	tions)			0	
00	PROGRAM INPATIENT ROUTINE SWING BED COST		04 6 11			1	١.,
00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	is inrough beceili	ber 31 of the	cost report	ing period (see	0	64
00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reportin	g period (See	0	65
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino 4	Lalus lino 4	E) (+; + o V)/	II only) For		66
00	CAH (see instructions)	ie costs (Title 64	prus rine o	b)(title XVI	ii oniy). Foi	0	00
00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through [December 31 o	f the cost r	eporting period	0	67
00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Dec	cember 31 of	the cost rep	orting period	0	68
00	Total title V or XIX swing-bed NF inpatient					0	69
00	PART III - SKILLED NURSING FACILITY, OTHER NU				\		7,
00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of)		70
	Program routine service cost (line 9 x line	71)					72
00	Medically necessary private room cost application	9	•	ne 35)			73
00	Total Program general inpatient routine servicapital-related cost allocated to inpatient	•		orkshoot D	Part II column		74
00	26, line 45) Per diem capital-related costs (line 75 ÷ li		Joses (IIOII W	OINSHEEL D, I	rart II, COTUIIII		76
	Program capital -related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minus	s line 77)		_			78
	Aggregate charges to beneficiaries for excess				oue Line 70)		79
00	Total Program routine service costs for company inpatient routine service cost per diem limi		st iimitation	(IIIIe /8 MII	ius IIIle /9)		80
00	Inpatient routine service cost limitation (82
00	Reasonable inpatient routine service costs ()				83
. 00	Program inpatient ancillary services (see in:		:)				84
	Utilization review - physician compensation Total Program inpatient operating costs (sum						86
20	PART IV - COMPUTATION OF OBSERVATION BED PASS] ~
00	Total observation bed days (see instructions))			·	0	87
00	Adjusted general inpatient routine cost per					0.00	

Health Financial Systems S	T. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 07/01/2021 To 06/30/2022	Date/Time Prep 11/22/2022 9:	
		Ti tl	e XIX	Subprovider -	PPS	
				I RF		
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	325, 621	5, 788, 451	0. 05625	4 0	0	90.00
91.00 Nursing Program cost	0	5, 788, 451	0.00000	0	0	91.00
92.00 Allied health cost	0	5, 788, 451	0.00000	0	0	92.00
93.00 All other Medical Education	0	5, 788, 451	0.00000	0	0	93. 00
93.00 All other Medical Education	0	5, 788, 451	0. 00000	0 0	0	93. 00

I NPAT	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0034	Peri od:	Worksheet D-3	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 31 am
		Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					1
30.00	03000 ADULTS & PEDI ATRI CS			22, 296, 825		30.00
31. 00	03100 I NTENSI VE CARE UNI T			5, 346, 347		31.00
41. 00	04100 SUBPROVI DER - I RF			0		41.00
43.00						43.00
	ANCILLARY SERVICE COST CENTERS				T	
50.00	05000 OPERATING ROOM		0. 22978			
51.00	05100 RECOVERY ROOM		0. 32035		568, 364	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 45529		0	
53.00	05300 ANESTHESI OLOGY		0. 02464		73, 794	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 13512		395, 255	
55. 00	05500 RADI OLOGY - THERAPEUTI C		0. 08793			
56.00	05600 RADI OI SOTOPE		0. 12992			
57.00	05700 CT SCAN		0.05795			
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07149			
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 07638			
60.00	06000 LABORATORY		0. 10004		1, 410, 834	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	
63. 00 64. 00	06300 BLOOD STORING, PROCESSING, & TRANS.		0. 32941			63. 00 64. 00
65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		0. 21884		1 472 025	
			0. 30062		1, 472, 025	1
66.00	06600 PHYSI CAL THERAPY		0. 28266			
67.00	06700 OCCUPATIONAL THERAPY		0. 19343			
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0. 47314		104, 602	
70.00	07000 ELECTROCARDI OLOGY		0. 07037 0. 10502			
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1			
71.00			0. 38542			
73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0.46660			
74.00	07400 RENAL DIALYSIS		0. 18532 0. 23742			74.00
74.00	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON		0. 23742			
10.71	OUTDATIENT SERVICE COST CENTERS		1 0. 5035	77 113,020	00, 201	1 /0.7/

0. 402418 0. 125565

0. 315301

28, 265

1, 552, 665

235, 892

21, 511, 638 200. 00

70, 237

748, 150

12, 365, 428

115, 237, 673

115, 237, 673

90.00

91.00

92.00

201. 00

202. 00

OUTPATIENT SERVICE 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)

90.00

201.00

202.00

09000 CLI NI C

91. 00 09100 EMERGENCY

Health Financial Systems		CAL CENTER, INC.			eu of Form CMS-	
INPATIENT ANCILLARY SERV	CE COST APPORTIONMENT	Provi der C	CN: 15-0034	Peri od:	Worksheet D-3	1
		Component	CCN: 15-T034	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		Titl∈	: XVIII	Subprovi der – I RF	PPS	
Cost Center	Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE	SERVICE COST CENTERS		•			
30. 00 03000 ADULTS & PED	ATRI CS					30.00
31.00 03100 INTENSIVE CA	RE UNIT					31.00
41. 00 04100 SUBPROVI DER	- IRF			4, 660, 909		41.00
43. 00 04300 NURSERY						43.00
ANCI LLARY SERVI CE						
50. 00 05000 OPERATI NG RO			0. 22978		11, 309	
51. 00 05100 RECOVERY ROO			0. 32035		804	51.00
52. 00 05200 DELI VERY RO0			0. 45529		0	
53. 00 05300 ANESTHESI OLO			0. 02464		125	
54. 00 05400 RADI OLOGY-DI			0. 13512		13, 389	
55. 00 05500 RADI OLOGY -	THERAPEUTI C		0. 08793		0	
56. 00 05600 RADI 0I SOTOPE			0. 12992		229	
57. 00 05700 CT SCAN			0. 05795		7, 239	
	DNANCE IMAGING (MRI)		0. 07149		1, 174	
59. 00 05900 CARDI AC CATH	ETERI ZATI ON		0. 07638		0	1
60. 00 06000 LABORATORY			0. 10004			
	A PACKED RED BLOOD CELL		0.00000		0	
	G, PROCESSING, & TRANS.		0. 3294		6, 533	
64. 00 06400 I NTRAVENOUS			0. 21884		0	
65. 00 06500 RESPIRATORY			0. 30062		119, 423	
66. 00 06600 PHYSI CAL THE			0. 28266		400, 146	
67. 00 06700 0CCUPATI ONAL 68. 00 06800 SPEECH PATHO			0. 19343		260, 673	
69. 00 06900 ELECTROCARDI			0. 47314 0. 07037	· ·	112, 473 2, 427	1
70. 00 07000 ELECTROCARDI			1	· ·		
	IALOGRAPHY LIES CHARGED TO PATIENT		0. 10502 0. 38542		l	
72. 00 07100 MEDICAL SUPP			0. 38542	· ·	1, 970	
73. 00 07200 TMFE. BEV. C			0. 18532	· ·		
74. 00 07400 RENAL DIALYS			0. 18332		24, 476	1
76. 97 07697 CARDI AC REHA			0. 56359		24, 470	
OUTPATIENT SERVICE			0. 3033	, , ,	<u> </u>	1 ,0. ,,
90. 00 09000 CLI NI C	occ. center		0. 4024	18 0	0	90.00
91. 00 09100 EMERGENCY			0. 12556		Ö	
	BEDS (NON-DISTINCT PART		0. 31530		Ö	
	flines 50 through 94 and 96 through 98	3)		6, 117, 823		
	nic Laboratory Services-Program only ch		1	0	,, 555, , 66	201. 00
	(line 200 minus line 201)	. 3 - ()	1	6, 117, 823	l	202. 00

Health Financial Systems ST.	MARY MEDICAL CENTER, INC.		In lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN:		Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Pre 11/22/2022 9:	pared:
	Title		Hospi tal	PPS	
Cost Center Description	The state of the s	atio of Cost To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 320, 716		30.00
31. 00 03100 I NTENSI VE CARE UNI T			261, 830		31. 00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
43. 00 04300 NURSERY			332, 331		43. 00
ANCILLARY SERVICE COST CENTERS			.1		
50. 00 05000 OPERATI NG ROOM		0. 22978		144, 462	50. 00
51. 00 05100 RECOVERY ROOM		0. 32035		13, 062	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 45529		4, 573	
53. 00 05300 ANESTHESI OLOGY		0. 02464		2, 471	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13512		21, 228	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 08793		0	55. 00
56. 00 05600 RADI 0I SOTOPE		0. 12992		4, 498	56. 00
57. 00 05700 CT SCAN		0. 05795		19, 448	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07149		4, 332	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 07638		6, 855	
60. 00 06000 LABORATORY		0. 10004		71, 228	60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 32941		5, 812	63. 00
64. 00 06400 I NTRAVENOUS THERAPY		0. 21884		0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 30062		59, 819	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 28266		10, 155	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 19343		4, 942	67. 00
68.00 06800 SPEECH PATHOLOGY		0. 47314		7, 217	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 07037		12, 583	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 10502		2, 673	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 38542			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 46660		53, 523	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 18532		201, 797	
74 00 07400 PENAL DIALVSIS		0 23742	ام QQ 276	20 050	74 00

88, 276

4, 561

346, 614

27, 340

4, 554, 098

4, 554, 098

0. 237424

0. 563599

0. 402418

0.125565

0. 315301

20, 959

2, 571

43, 523

8, 620

809, 899 200. 00

74.00

76. 97

90.00

91.00

92.00

201. 00 202. 00

07400 RENAL DIALYSIS

09000 CLI NI C

91. 00 09100 EMERGENCY

76. 97 90.00

201.00 202.00

07697 CARDIAC REHABILITATION
OUTPATIENT SERVICE 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)

Health Financial Systems ST. MARY MEDICAL C	ENTER INC		In lie	eu of Form CMS-	2552_10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0034	Peri od:	Worksheet D-3	
	Component	CCN: 15-T034	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Titl	e XIX	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos To Charges	•	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
31. 00 03100 INTENSIVE CARE UNIT					31.00
41. 00 04100 SUBPROVI DER - I RF			12, 840		41.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS		0.0007	0/		
50. 00 05000 0PERATI NG ROOM		0. 2297			
51. 00 05100 RECOVERY ROOM		0. 3203			
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 4552			
53. 00 05300 ANESTHESI OLOGY		0. 0246			
54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 1351 0. 0879			
56. 00 05600 RADI OI SOTOPE		0. 0879		_	
57. 00 05700 CT SCAN		0. 1299			
58. 00 05800 MAGNETI C RESONANCE MAGING (MRI)		0.0374			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0714			
60. 00 06000 LABORATORY		0. 1000			
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000			1
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 3294			1
64. 00 06400 NTRAVENOUS THERAPY		0. 2188			
65. 00 06500 RESPI RATORY THERAPY		0. 3006			
66. 00 06600 PHYSI CAL THERAPY		0. 2826			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 1934			1
68. 00 06800 SPEECH PATHOLOGY		0. 4731	·		
69. 00 06900 ELECTROCARDI OLOGY		0.0703	74 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1050	22 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3854	25 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4666		0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1853	2, 404	446	73.00
74.00 07400 RENAL DIALYSIS		0. 2374	24 0	0	74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 5635	99 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 4024			
91. 00 09100 EMERGENCY		0. 1255			
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3153			
Total (sum of lines 50 through 94 and 96 through 98)			11, 637	2, 571	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			11, 637	I	202. 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 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/22/2022 9:31 am

			10 06/30/2022	Date/IIme Pre 11/22/2022 9:3	
		Title XVIII	Hospi tal	PPS	
			•	1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurri	ing prior to October 1 (see	7, 965, 679	1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ing on or after October	1 (see	23, 171, 270	1. 02
1.02	instructions)	ing on or arter betober	1 (300	23, 171, 270	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	prior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCL fo	or discharges occurring	on or after	0	1. 04
1.04	October 1 (see instructions)	or discharges occurring	on or arter	U	1.04
2.00	Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi			42, 204	2. 02
2. 03 2. 04	Outlier payments for discharges occurring prior to October 1 Outlier payments for discharges occurring on or after October			42, 384 184, 801	2. 03 2. 04
3.00	Managed Care Simulated Payments	(See Histractions)		184, 801	3.00
4. 00	Bed days available divided by number of days in the cost repo	rting period (see instru	ctions)	170. 48	4. 00
	Indirect Medical Education Adjustment	3 1	ĺ		
5.00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0. 00	5. 00
	or before 12/31/1996. (see instructions)			0.00	/ 00
6. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	ne criteria for an add-o	n to the cap for	0. 00	6. 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR §412.105(f)	(1)(iv)(B)(1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under			0.00	7. 01
	cost report straddles July 1, 2011 then see instructions.				
8.00	Adjustment (increase or decrease) to the FTE count for allopa			0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.7998), and 67 FR 50069 (August 1, 2002).	/9(c)(2)(IV), 64 FR 2634	0 (May 12,		
8. 01	The amount of increase if the hospital was awarded FTE cap slo	nts under 8 5503 of the	ACA If the cost	0. 00	8. 01
0.01	report straddles July 1, 2011, see instructions.	ors under 3 occor or the	1071. 11 110 0031	0.00	0.01
8.02	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospital	0. 00	8. 02
	under § 5506 of ACA. (see instructions)				
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (see	0. 00	9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the curre	ent vear from vour recor	ds	0.00	10. 00
	FTE count for residents in dental and podiatric programs.	one year from year recen	u3	0.00	
	Current year allowable FTE (see instructions)				12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that yea	ar ended on or after Sep	tember 30, 1997,	0.00	14. 00
45.00	otherwise enter zero.			0.00	45.00
	Sum of lines 12 through 14 divided by 3.				15. 00 16. 00
	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clos	sura			17. 00
	Adjusted rolling average FTE count	sui e			18.00
	Current year resident to bed ratio (line 18 divided by line 4)).		0. 000000	
	Prior year resident to bed ratio (see instructions)	•		0.000000	20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21. 00
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)) -6 +L- MMA		0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE reside		FD /12 105	0.00	23. 00
23.00	(f)(1)(iv)(C).	ent cap stots under 42 c	IK 412. 105	0.00	23.00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
	If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line	24 (see	0.00	
	instructions)				
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
	IME payments adjustment factor. (see instructions)			0. 000000	
	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28))		0	28. 01 29. 00
	Total IME payment - Managed Care (sum of lines 22.01 and 28.0)	1)		0	29. 01
_,. 01	Disproportionate Share Adjustment	·,		0	
30.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	2. 72	30. 00
31.00	Percentage of Medicaid patient days (see instructions)			17. 07	
	Sum of lines 30 and 31			19. 79	
	Allowable disproportionate share percentage (see instructions))		5. 61	
34. UU	Disproportionate share adjustment (see instructions)		l	436, 696	34.00

	Financial Systems ST. MARY MEDICAL			u of Form CMS-2	2552-10
CALCUI	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0034	Peri od: From 07/01/2021 To 06/30/2022		
		Title XVIII	Hospi tal	11/22/2022 9: PPS	31 am
		11 (1 6 70111		On/After 10/1	
			1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		8 290 014 521	7, 192, 008, 710	35. 00
35. 00	Factor 3 (see instructions)		0. 000197202		
35. 02		ter zero on this line) (se			1
35. 03 36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.	. 03)	412, 062 1, 301, 919		35. 03 36. 00
40.00	Additional payment for high percentage of ESRD beneficiary of	discharges (lines 40 throu	ugh 46)		40.00
40. 00	Total Medicare discharges (see instructions)		Before 1/1	On/After 1/1	40. 00
			1.00	1. 01	
41. 00	Total ESRD Medicare discharges (see instructions)		0		1
41. 01 42. 00	Total ESRD Medicare covered and paid discharges (see instruc		0.00	0	41. 01 42. 00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days (see instructions)	illy for adjustment)	0.00		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	d by line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instruction	•	0.00	0.00	1
46. 00 47. 00	Total additional payment (line 45 times line 44 times line 4	41. 01)	22 102 740		46. 00 47. 00
48.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	33, 102, 749 0		48.00
	only. (see instructions)	<u> </u>			
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruction	ns)		33, 102, 749	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a)	2, 479, 641	1
51.00	Exception payment for inpatient program capital (Wkst. L, Pi Direct graduate medical education payment (from Wkst. E-4, I			0	
52. 00 53. 00		Title 49 See Thistructions).		43, 511	
54.00	Special add-on payments for new technologies			356, 941	1
54. 01	Islet isolation add-on payment	(0)		0	
55. 00 56. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see integration)			0	55. 00 56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	Ö	1
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	. IV, col. 11 line 200)		60, 962	1
59.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			36, 043, 804	1
60. 00 61. 00		us line 60)		36, 043, 804	1
62. 00	Deductibles billed to program beneficiaries	uss ss,		3, 088, 196	
63.00	Coinsurance billed to program beneficiaries			73, 180	1
64. 00 65. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			449, 575 292, 224	1
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		43, 663	1
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	· · · · · · · · · · · · · · · · · · ·		33, 174, 652	1
68.00	Credits received from manufacturers for replaced devices for	11	,	659	1
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)).(For SCH see instruction	ns)	0	1
70. 50	Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	1
70. 87	Demonstration payment adjustment amount before sequestration	, ,	,	0	70. 87
	SCH or MDH volume decrease adjustment (contractor use only)	structions)		0	1
70. 88	Pioneer ACO demonstration payment adjustment amount (see instructions)	STEUCTEONS)		0	70. 89 70. 90
70. 88 70. 89	in a series paymone men adjacement amount (500 moth dott ons)			Ö	1
70. 88	HSP bonus payment HRR adjustment amount (see instructions)				
70. 88 70. 89 70. 90 70. 91 70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 92
70. 88 70. 89 70. 90 70. 91	Bundled Model 1 discount amount (see instructions)			l	70. 92 70. 93

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0034	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/22/2022 9:31 am

				From 07/01/2021 To 06/30/2022	Part A Date/Time Pre 11/22/2022 9:	pared: 31 am
		Titl∈	XVIII	Hospi tal	PPS	
			FF	Y (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0	0	70. 96
70.07	the corresponding federal year for the period prior to 10/1)					70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
70.00	the corresponding federal year for the period ending on or aft	ter 10/1)			0	70.00
70. 98	Low Volume Payment-3				0	70. 98 70. 99
	HAC adjustment amount (see instructions)	(۵ م م			22 240 500	
	Amount due provider (line 67 minus lines 68 plus/minus lines 6	39 α /0)			32, 340, 509	1
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration				80, 851 0	71.01
	Sequestration adjustment-PARHM pass-throughs				U	71.02
	Interim payments				31, 712, 305	
	Interim payments-PARHM				31, 712, 303	72. 00
	Tentative settlement (for contractor use only)				0	ı
73. 01	Tentative settlement-PARHM (for contractor use only)				· ·	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2. 72. and			547, 353	ł
	73)	_,,				
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			497, 149	•
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 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	uctions)			0	92. 00
	Capital outlier reconciliation adjustment amount (see instruct				0	93. 00
	The rate used to calculate the time value of money (see instru	uctions)			0.00	1
	Time value of money for operating expenses (see instructions)				0	
96.00	Time value of money for capital related expenses (see instruct	tions)		Dui +- 10 /1	0 // (45) - 10 //	96. 00
				Prior to 10/1 1.00	0n/After 10/1 2.00	
	HSP Bonus Payment Amount			1.00	2.00	
	noi bondo i dymont Amount					I
100 00	HSP honus amount (see instructions)			0	0	100 00
100. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
101. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	5)		0. 0000000000	0. 0000000000	101. 00
101. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	5)		0. 0000000000	0. 0000000000	
101. 00 102. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	5)		0. 0000000000	0. 0000000000	101. 00 102. 00
101. 00 102. 00 103. 00	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			0.0000000000	0. 0000000000 0	101. 00 102. 00
101. 00 102. 00 103. 00	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))	ıstment	0.0000000000	0. 0000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr) ration) Adju		0.0000000000	0. 0000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	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 Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.) ration) Adju		0.0000000000	0. 0000000000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	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	oration) Adju ration Adju riod under t		0.0000000000	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	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	oration) Adju ration Adju riod under t		0.0000000000	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	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)	oration) Adju ration Adju riod under t		0.0000000000	0. 0000000000 0 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	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) Adjuriod under t	he 21st	0. 0000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	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	ration) Adjuriod under t	he 21st	0. 0000000000 0 0. 0000 0	0. 000000000 0 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	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)	ration) Adjuriod under t	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 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	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) Adjuriod under t	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 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	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)	ration) Adjuriod under t	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 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	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)	ration) Adjuriod under t	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 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. 00 206. 00	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	ration) Adju riod under t e 49) first year	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	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) 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)	first year	he 21st	0. 0000000000 0 0. 0000 0	0.000000000 0 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	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	first year	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 00000 0 cration	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. 00 205. 00 206. 00 207. 00 208. 00 209. 00	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) 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)	first year	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 00000 0 cration	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. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 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	first year	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 cration	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
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	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 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)	first year	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 cration	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. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 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	first year ructions)	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 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. 00 211. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 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)	first year ructions)	he 21st	0. 0000000000 0 0. 0000 0	0.0000000000 0 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. 00 210. 00
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. 00 211. 00	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) 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 205)	ration) Adjuriod under to the 49) first year ructions) line 59)	of the curre	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 00000 0 cration	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. 00 211. 00
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. 00 211. 00	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) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	ration) Adjuriod under to the 49) first year ructions) line 59)	of the curre	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 00000 0 cration	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

Health Financial Systems	ST. MARY MEDICAL C	ENTER, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0034	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/22/2022 9:31 am
		T1 11 \000111		222

		11/22/2022 9:	31 am
	Title XVIII Hospital	PPS	
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	20, 388	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	31, 288, 513	2. 00
3.00	OPPS payments	31, 886, 687	3. 00
4.00	Outlier payment (see instructions)	22, 708	4. 00
4. 01	Outlier reconciliation amount (see instructions)	0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6	0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)	0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	61, 161	
10.00	Organ acqui si ti ons	0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	20, 388	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
40.00	Reasonable charges	1 0/ 101	
12.00	Ancillary service charges	96, 431	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)	96, 431	13.00
14.00	Customary charges	70, 431	14.00
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
	had such payment been made in accordance with 42 CFR §413.13(e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17. 00
	Total customary charges (see instructions)	96, 431	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	76, 043	19. 00
20. 00	instructions)	0	20. 00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		20.00
21. 00	Lesser of cost or charges (see instructions)	20, 388	21. 00
	Interns and residents (see instructions)	0	22. 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)	31, 970, 556	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5, 705, 658	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	26, 285, 286	27. 00
20 00	instructions)	0	20 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	28. 00 29. 00
30. 00	Subtotal (sum of lines 27 through 29)	26, 285, 286	
	Primary payer payments	11, 309	
	Subtotal (line 30 minus line 31)	26, 273, 977	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
	Allowable bad debts (see instructions)	582, 656	
	Adjusted reimbursable bad debts (see instructions)	378, 726	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	246, 227	
37. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	26, 652, 703 -162	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-102	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	11, 083	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40.00	Subtotal (see instructions)	26, 652, 865	40. 00
40. 01	Sequestration adjustment (see instructions)	66, 632	40. 01
40. 02	Demonstration payment adjustment amount after sequestration	0	
40. 03	Sequestration adjustment-PARHM pass-throughs		40. 03
	Interim payments	26, 566, 436	
	Interim payments-PARHM		41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)	0	42. 00 42. 01
42. 01	Balance due provider/program (see instructions)	19, 797	
43. 01	Balance due provider/program-PARHM (see instructions)	17, 777	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 00
00	\$115. 2		55
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90. 00
	Outlier reconciliation adjustment amount (see instructions)	0	91. 00
92. 00	The rate used to calculate the Time Value of Money	0.00	
93. 00		0	
94. 00	Total (sum of lines 91 and 93)	1 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	
			From 07/01/2021		
			To 06/30/2022		
				11/22/2022 9	: 31 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C		Period: From 07/01/2021 To 06/30/2022	Part I Date/Time Pre 11/22/2022 9:	pared: 31 am
		Titl∈	XVIII	Hospi tal	PPS	
		Inpatier	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		31, 349, 65	5	26, 140, 931	1. 00
2.00	Interim payments payable on individual bills, either		362, 65	0	425, 505	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			ol	0	3. 01
3. 02	ABSOSTMENTS TO TROVIDER			o	0	3. 02
3. 03				o	0	3. 03
3. 04				o	0	3. 04
3. 05				Ö	0	3. 05
	Provider to Program		1	<u>'</u>		ĺ
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51			1	0	0	3. 51
3.52			1	0	0	3. 52
3.53			1	0	0	3. 53
3.54			1	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) Total interim payments (sum of lines 1, 2, and 3.99)		31, 712, 30	_	26, 566, 436	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		31, /12, 30	5	20, 300, 430	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR		1			
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	T		_T	г	
5. 01	TENTATI VE TO PROVI DER			0	0	
5. 02 5. 03				0	0	5. 02 5. 03
5.03	Provider to Program	1		U	0	5.03
5. 50	TENTATI VE TO PROGRAM	1		ol	0	5. 50
5. 51	TENTATI VE TO TROGRAM		1	0	0	5. 51
5. 52				o	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			Ö	Ō	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		547, 35		19, 797	6. 01
6. 02	SETTLEMENT TO PROGRAM		1	0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		32, 259, 65		26, 586, 233	7. 00
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr) 2.00	
8 00	Name of Contractor		0	1.00	2.00	8 00

8. 00

8.00 Name of Contractor

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	
	T	1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		6, 157, 130 0		0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program			<u> </u>		
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54			0		0	3. 53
3. 54 3. 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines		0			3. 54 3. 99
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		6, 157, 130		0	4. 00
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5. 00
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTITIVE TO TROVIDER		0		0	5. 02
5. 03			Ö		o o	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5.51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)		07.070			6. 00
6. 01	SETTLEMENT TO PROVIDER		27, 972		0	6. 01
6. 02	SETTLEMENT TO PROGRAM Total Medicara program Liability (see instructions)		(0	6. 02
7.00	Total Medicare program liability (see instructions)		6, 185, 102	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems ST. MARY MEDICAL C	CENTER INC	Inlie	u of Form CMS-	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0034 Period: V From 07/01/2021 To 06/30/2022 EV From 07/01/2021 From 07/01/2021				
		Title XVIII	Hospi tal	PPS	
	TO DE COURT STEP BY CONTRACTOR FOR HONOTANDARD COOK REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
1. 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA §4102 from Wkst.		. 14		1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and				2.00
2.00	reporting periods beginning on or after 10/01/2013, line 32)	o through 12, and prus i	oi cost		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	plus for cost		4. 00
	reporting periods beginning on or after 10/01/2013, line 32)	3	'		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10. 00		(see instructions)			10. 00
20.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				20.00
	Initial/interim HIT payment adjustment (see instructions) Other Adjustment (specify)				30. 00 31. 00
	Balance due provider (line 8 (or line 10) minus line 30 and l	ino 21) (soo instruction	·c)		31.00
32.00	parance due provider (Title o (OFTTHE 10) IIII IIUS TITLE 30 and T	THE STATE (See THISTI UCTION) 		j 32.00

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 07/01/2021	Worksheet E-3
		Component CCN: 15-T034		Date/Time Prepared: 11/22/2022 9:31 am
		Title XVIII	Subprovi der -	PPS
			IRF	

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	11 00	
00	Net Federal PPS Payment (see instructions)	6, 039, 238	1.
00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0219	2.
00	Inpatient Rehabilitation LIP Payments (see instructions)	226, 471	3.
00	Outlier Payments	28, 768	4.
00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0. 00	5.
01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.
00	New Teaching program adjustment. (see instructions)	0.00	6.
00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7.
00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8.
00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.
0.00	Average Daily Census (see instructions)	13. 397260	
1. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
2. 00	Teaching Adjustment (see instructions)	0.000000	12.
3. 00	Total PPS Payment (see instructions)	6, 294, 477	13.
1. 00	Nursing and Allied Health Managed Care payments (see instruction)	0, 2, 4, 4, 7	14.
5. 00	Organ acquisition (DO NOT USE THIS LINE)	U	15.
. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.
. 00	Subtotal (see instructions)	6, 294, 477	17.
	· · · · · · · · · · · · · · · · · · ·	0, 294, 477	18
00	Primary payer payments	- 1	-
00	Subtotal (line 17 less line 18).	6, 294, 477	19
00	Deducti bl es	34, 564	
00	Subtotal (line 19 minus line 20)	6, 259, 913	
. 00	Coi nsurance	59, 309	
00	Subtotal (line 21 minus line 22)	6, 200, 604	23
00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24
00	Adjusted reimbursable bad debts (see instructions)	0	25
00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26
00	Subtotal (sum of lines 23 and 25)	6, 200, 604	27
00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28
00	Other pass through costs (see instructions)	0	29
00	Outlier payments reconciliation	0	30
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31
50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31
98	Recovery of accelerated depreciation.	0	31
99	Demonstration payment adjustment amount before sequestration	0	31
00	Total amount payable to the provider (see instructions)	6, 200, 604	32
01	Sequestration adjustment (see instructions)	15, 502	32
02	Demonstration payment adjustment amount after sequestration	0	32
00	Interim payments	6, 157, 130	33
00	Tentative settlement (for contractor use only)	0	34
00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	27, 972	35
00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36
	TO BE COMPLETED BY CONTRACTOR		
. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4	28, 768	50
	Outlier reconciliation adjustment amount (see instructions)	0	51
. 00	The rate used to calculate the Time Value of Money	0.00	
. 00	Time Value of Money (see instructions)	0	53
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19		33
. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	99
	1. I I I I I I I I I I I I I I I I I I I	5. 555566	

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)

Provider CCN: 15-0034

Peri od: Worksheet G From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: 11/22/2022 9: 31 am

		General Fund	Speci fi c	Endowment Fund	11/22/2022 9: Plant Fund	31 am
			Purpose Fund			
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	1, 883		ol ol	0	1.00
2.00	Temporary investments	0	d		0	
3.00	Notes recei vabl e	0	C	o	0	
4.00	Accounts receivable	36, 188, 758	C	0	0	
5.00	Other receivable	326, 911	(0	0	1
6.00	Allowances for uncollectible notes and accounts receivable	0 072 410			0	6. 00 7. 00
7. 00 8. 00	Inventory Prepai d expenses	8, 073, 618			0	8.00
9. 00	Other current assets	1, 688, 444		ol ol	0	9. 00
10.00	Due from other funds	0	d	o o	0	10.00
11. 00	Total current assets (sum of lines 1-10)	46, 279, 614	C	o	0	11. 00
	FIXED ASSETS					
12.00	Land	0	C	-1	0	1
13.00	Land improvements	0			0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	149, 893, 779			0	14. 00 15. 00
16. 00	Accumulated depreciation	147, 073, 777			0	16.00
17. 00	Leasehold improvements	0	d	o o	0	17. 00
18.00	Accumul ated depreciation	0	C	o	0	18. 00
19. 00	Fi xed equipment	0	C	0	0	19. 00
20. 00	Accumulated depreciation	0	C	0	0	20. 00
21. 00	Automobiles and trucks	0			0	21.00
22. 00 23. 00	Accumulated depreciation Major movable equipment	0			0	22. 00 23. 00
24. 00	Accumulated depreciation	0			0	24.00
25. 00	Mi nor equi pment depreci abl e	0		ol ol	0	25. 00
26.00	Accumulated depreciation	0	ď	o	0	26. 00
27. 00	HIT designated Assets	0	C	0	0	27. 00
28. 00	Accumulated depreciation	0	C	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0			0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	149, 893, 779		0	0	30.00
31. 00	Investments	1 0		ol ol	0	31. 00
32. 00	Deposits on Leases	0			0	32. 00
33.00	Due from owners/officers	0	C	o	0	33. 00
34.00	Other assets	12, 616, 111	C	o	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	12, 616, 111	C		0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	208, 789, 504		0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	1, 341, 056		ol	0	37.00
38. 00	Salaries, wages, and fees payable	10, 427, 437		-	0	38.00
39. 00	Payrol I taxes payable	0		ol ol	0	39. 00
40.00	Notes and Loans payable (short term)	0		o	0	40. 00
41.00	Deferred income	0	C	o	0	41. 00
42. 00	Accel erated payments	0				42. 00
43. 00	Due to other funds	0			0	
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	21, 133, 538			0	
45.00	LONG TERM LIABILITIES	32, 902, 031)		45.00
46. 00	Mortgage payable	0	(ol ol	0	46. 00
47. 00	Notes payable	0	Ċ	o	0	1
48.00	Unsecured Loans	0	C	o	0	48. 00
49. 00	Other long term liabilities	5, 411, 181	C		0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	5, 411, 181		-1	0	
51. 00	Total liabilities (sum of lines 45 and 50)	38, 313, 212) 0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	170, 476, 292				52.00
53. 00	Specific purpose fund	170, 470, 272				53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			O		55. 00
56.00	Governing body created - endowment fund balance			o		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	170, 476, 292	,		0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	208, 789, 504		j d	0	
55. 55	[59]	200,707,004		<u> </u>	O .	55. 55
		•		. '		•

Period: Worksheet G-1 Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0034

					To	06/30/2022	Date/Time Pre 11/22/2022 9:	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2. 00	3.00		4. 00	5. 00	
1.00 2.00 3.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		114, 313, 480 38, 172, 679 152, 486, 159			0		1. 00 2. 00 3. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Additions (credit adjustments) (specify) RESTRICTED CONTRIBUTIONS TRANSFERRED TO/FROM AFFILIATES	0 104, 625 17, 926, 861 0 0			0 0 0 0 0		0 0 0 0	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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) NET ASSETS RELEASED	0 41, 353 0 0 0	18, 031, 486 170, 517, 645		0 0 0 0 0	0	l	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		41, 353 170, 476, 292			0		18. 00 19. 00
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0			1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00	RESTRICTED CONTRIBUTIONS TRANSFERRED TO/FROM AFFILIATES		0 0 0 0					5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) NET ASSETS RELEASED	0	0 0 0 0 0		0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			18. 00 19. 00

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

			To 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Cost Center Description	Inpatient	Outpati ent	Total	J - GIII
		1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	66, 904, 83	7	66, 904, 837	1.00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF	7, 500, 87	5	7, 500, 875	3. 00
4.00	SUBPROVI DER	,		, , .	4.00
5.00	Swing bed - SNF		o	0	5.00
6.00	Swing bed - NF		O	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, 405, 71	2	74, 405, 712	
	Intensive Care Type Inpatient Hospital Services	1	= <u> </u>	,,	
11. 00	INTENSIVE CARE UNIT	16, 527, 14	2	16, 527, 142	11.00
12. 00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL I NTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	16, 527, 14	2	16, 527, 142	16. 00
10.00	11-15)	10,027,11	_	.0,02,,	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	90, 932, 85	4	90, 932, 854	17. 00
18. 00	Ancillary services	323, 339, 81		323, 339, 811	
19. 00	Outpati ent servi ces		784, 179, 611	784, 179, 611	1
20. 00	RURAL HEALTH CLINIC		0 0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY		5, 559, 456		
23. 00	AMBULANCE SERVICES		0,007,100	0,007,100	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	PHYSI CI AN REVENUE	1, 05	3 1, 806, 044	1, 807, 097	27. 00
27. 01	TAXABLE LAB		0 4, 642, 014		27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	414, 273, 71		1, 210, 460, 843	28. 00
	G-3, line 1)			, ., .,,	
	PART II - OPERATING EXPENSES		<u>'</u>		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		280, 830, 575		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32. 00
33.00			0		33. 00
34.00			0		34.00
35.00			0		35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40.00			0		40. 00
41.00			0		41. 00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	fer	280, 830, 575		43. 00
	to Wkst. G-3, line 4)				

llool +h	CT_MADV_MEDICAL_C	ENTED INC	ا ما	u of Form CMC (DEE2 10
	Financial Systems ST. MARY MEDICAL C ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0034	Peri od:	u of Form CMS-2 Worksheet G-3	2552-10
STATEM	LINI OF REVENUES AND EXPENSES	Flovidei CCN. 15-0034	From 07/01/2021	WOLKSHEET G-3	
				Date/Time Pre	
			1	11/22/2022 9:	31 am
				1 00	
4 00	T. I. I. I. O. O. D. I. I. O. I.	20)		1.00	4 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			1, 210, 460, 843	1.00
2.00	Less contractual allowances and discounts on patients' account	TS .		905, 388, 413	2.00
3.00	Net patient revenues (line 1 minus line 2)	40)		305, 072, 430	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		280, 830, 575	
5.00	Net income from service to patients (line 3 minus line 4)			24, 241, 855	5. 00
	OTHER I NCOME			1 107 105	/ 00
6.00	Contributions, donations, bequests, etc			1, 187, 105	
7.00	Income from investments			183, 545	
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guests			986, 654	
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to other the	nan patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
	Rental of vending machines			9, 038	
	Rental of hospital space			1, 194, 511	
	Governmental appropriations			0	23. 00
	OTHER OPERATING INCOME			138, 455	
	RELEASED TEMP ASSETS			39, 501	
	UBI I NCOME			162, 615	
24 02	CLACCEC			0 100	24 02

8, 189

10, 209

0 28. 00

38, 172, 679 29. 00

8, 556, 993 1, 454, 009

13, 930, 824

38, 172, 679

24. 03

24.04

24.05 24.50

25.00

26.00 27. 00 0

24. 02 UBI I NCOME 24. 03 CLASSES

24. 04 GAIN ON SALE OF ASSETS

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

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)

24. 05 VMD FMV I NCREASE 24. 50 COVI D-19 PHE Fundi ng

0

0

3, 246, 084

0

0

3, 246, 084

23.50

24.00

Tel emedi ci ne

24.00 Total (sum of lines 1-23)

23. 50

				051155 1110			6.5	
	Financial Systems LLOCATION - HHA GENERAL SERVICE		T. MARY MEDICAL		F	In Lie Period: From 07/01/2021 To 06/30/2022	u of Form CMS-: Worksheet H-1 Part I Date/Time Pre 11/22/2022 9:	pared:
						Home Health Agency I	PPS	
			Capital Rela	ated Costs		Agency 1		
		Net Expenses for Cost Allocation (from Wkst. H,	BI dgs & Fixtures	Movable Equi pment	PI ant Operation & Maintenance	Transportati on	Subtotal (cols. 0-4)	
		col . 10) 0	1.00	2.00	3.00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	69, 193	69, 193		1		0	1.00
	Fixtures	07, 173	07, 173				O	
2. 00	Capital Related - Movable Equipment	0		C			0	2. 00
3.00	Plant Operation & Maintenance	8, 178	0	C	8, 178		0	
4. 00 5. 00	Transportation Administrative and General	0 892, 765	0 69, 193	C		-	970, 136	4. 00 5. 00
	HHA REIMBURSABLE SERVICES							
6. 00 7. 00	Skilled Nursing Care Physical Therapy	1, 008, 710 750, 939	0	C	1		1, 008, 710 750, 939	
8.00	Occupational Therapy	257, 877	Ö	C			257, 877	1
9.00	Speech Pathology	42, 616	0	C	1		42, 616	1
10. 00 11. 00	Medical Social Services Home Health Aide	0 109, 224	0	C			0 109, 224	
12. 00	Supplies (see instructions)	106, 582	O	C		-	106, 582	1
13. 00 14. 00	Drugs DME	0	0	C	1		0	
14.00	HHA NONREI MBURSABLE SERVI CES	0	0		,) <u> </u>		14.00
	Home Dialysis Aide Services	0	0	C	•		0	
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	C			0	
18. 00	Clinic	O	o	C	1		0	1
19. 00	Health Promotion Activities	0	0	C	1		0	
20. 00 21. 00	Day Care Program Home Delivered Meals Program		0	C		-	0	20.00
22. 00	Homemaker Service	O	O	C	Ò	-	0	22. 00
23. 00 23. 50	All Others (specify) Telemedicine	0	0	C			0	23. 00
23. 50	Total (sum of lines 1-23)	3, 246, 084	69, 193	C		- 1	3, 246, 084	
		Admi ni strati ve						
		& General 5.00	4A + 5) 6.00					1
1 00	GENERAL SERVICE COST CENTERS							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 HHA REIMBURSABLE SERVICES	970, 136						5. 00
6.00	Skilled Nursing Care	429, 969	1, 438, 679					6.00
7.00	Physical Therapy	320, 092	1, 071, 031					7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	109, 922 18, 165	367, 799 60, 781					8. 00 9. 00
10. 00	Medical Social Services	0	00, 701					10.00
11.00	Home Heal th Ai de	46, 557	155, 781					11.00
12. 00 13. 00	Supplies (see instructions) Drugs	45, 431 0	152, 013					12. 00 13. 00
14. 00	DME	0	0					14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	l ol	0					15. 00
16. 00	Respiratory Therapy	0	0					16. 00
17. 00	Private Duty Nursing	0	0					17. 00
18. 00 19. 00	Clinic Health Promotion Activities	0	0					18. 00 19. 00
20.00	Day Care Program	o	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	0					23. 50
∠4. 00	Total (sum of lines 1-23)	1	3, 246, 084					24. 00

COST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provi der Co	CN: 15-0034	Peri od:	Worksheet H-1	
				HHA CCN:	15-7313	From 07/01/2021 To 06/30/2022	Part II Date/Time Pre 11/22/2022 9:	pared: 31 am
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportati d	nReconciliation	Admi ni strati ve	1
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
				(SQUARE FEET)				
	CENEDAL CEDVICE COCT CENTEDS	1.00	2. 00	3. 00	4. 00	5A. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	100				0		1.00
1.00	Fixtures	100				0		1.00
2. 00	Capital Related - Movable		0			0		2.00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	100		0		3.00
4. 00	Transportation (see	0	0	0		0		4.00
	instructions)							
5. 00	Administrative and General	100	0	100		0 -970, 136	2, 275, 948	5.00
	HHA REI MBURSABLE SERVI CES			_			1 222 712	
6. 00	Skilled Nursing Care	0	0	0		0 0		
7.00	Physical Therapy	0	0	0		0 0		
8. 00 9. 00	Occupational Therapy	0	0	0		0 0	20,,0,,	
9. 00 10. 00	Speech Pathology Medical Social Services	0	0	0		0 0	,,	
11. 00	Home Health Aide	0	0	0				
12. 00	Supplies (see instructions)	0	0	0		0 0		
13. 00	Drugs	0	0	0				1
14. 00	DME	0	0	0		0 0	1	
	HHA NONREIMBURSABLE SERVICES			-	I.			1
15. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16. 00	Respi ratory Therapy	0	0	0		0	l o	16.00
17. 00	Private Duty Nursing	0	0	0		0	0	17. 00
18. 00	Clinic	0	0	0		0	0	18. 00
19. 00	Health Promotion Activities	0	0	0		0	0	19.00
20. 00	Day Care Program	0	0	0		0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0		0	0	21.00
22. 00	Homemaker Servi ce	0	0	0		0 0	0	
23. 00	All Others (specify)	0	0	0		0	01	23. 00
23. 50	Telemedicine	0	0	0		0	01	23. 50
24.00	Total (sum of lines 1-23)	100	0	100		0 -970, 136		
25. 00	Cost To Be Allocated (per Worksheet H-1, Part I)	69, 193	0	8, 178		U	970, 136	25. 00
	WOLKSHEEL H-I, Part I)	I			I	1	1	I

Peri od: Worksheet H-2
From 07/01/2021 Part I
To 06/30/2022 Date/Time Prepared: 11/22/2022 9:31 am
Home Health PPS HHA CCN: 15-7313

						Home Health Agency I	PPS	
			CAPITAL REI	_ATED COSTS		Agency 1		
	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 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	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	0 1, 438, 679 1, 071, 031 367, 799 60, 781 0 155, 781 152, 013 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	2, 461 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	137, 979 152, 819 126, 326 31, 428 5, 863 0 15, 783 0 0 0 0 0 0 0 0 0 470, 198	58 0 0 0 0 0 0 0 0 0 0 0	16, 837 16, 837 0 0 0 0 0 0 0 0 0 0 0 0 0	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. 00 19. 50
	of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal	OTHER ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 03	5A. 03	5. 04	7. 00	8. 00	9. 00	
	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	14, 158 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	171, 493 1, 591, 498 1, 197, 357 399, 227 66, 644 01 171, 564 152, 013 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23, 160 214, 934 161, 704 53, 916 9, 000 0 23, 170 20, 530 0 0 0 0 0 0 0 0 0		0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

⁽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. MA
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 11/22/2022 9:31 am Peri od: From 07/01/2021 To 06/30/2022 Provider CCN: 15-0034 HHA CCN: 15-7313

						Home Health Agency I	PPS	<u> </u>
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & 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 10. 00 11. 00 12. 00 13. 00 15. 00 16. 00 17. 00 18. 00 19. 50 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.	000000000000000000000000000000000000000	12, 686				13, 007 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
	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 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 19. 50 20. 00 21. 00	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0 0	220, 346 1, 806, 432 1, 359, 061 453, 143 75, 644 172, 543 172, 543 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		220, 346 1, 806, 432 1, 359, 061 453, 143 75, 644 0 194, 734 172, 543 0 0 0 0 0 0 0 0 0 0 4, 281, 903	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

⁽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.

					11/22/2022 9:	31 am_
				Home Health Agency I	PPS	
	Cost Center Description	Allocated HHA	Total HHA	Agency		
	cost center beserretron	A&G (see Part	Costs			
		11)	00010			
		27. 00	28. 00			
1.00	Administrative and General					1. 00
2.00	Skilled Nursing Care	98, 000	1, 904, 432			2.00
3.00	Physical Therapy	73, 732	1, 432, 793			3.00
4.00	Occupational Therapy	24, 584	477, 727			4.00
5. 00	Speech Pathology	4, 104	79, 748			5. 00
6.00	Medical Social Services	0	0			6.00
7. 00	Home Health Aide	10, 565	205, 299			7. 00
8.00	Supplies (see instructions)	9, 361	181, 904			8.00
9. 00	Drugs	0	0			9. 00
10. 00	DME	o	o			10.00
11. 00	Home Dialysis Aide Services	o	o			11. 00
12. 00	Respiratory Therapy		0			12.00
13. 00	Private Duty Nursing		0			13.00
14. 00	Clinic		0			14. 00
15. 00	Health Promotion Activities		0			15. 00
16. 00	Day Care Program		0			16.00
17. 00	Home Delivered Meals Program		0			17. 00
18. 00	Homemaker Service		0			18.00
19. 00	All Others (specify)		0			19.00
19. 50	Tel emedi ci ne		0			19.50
20. 00	Total (sum of lines 1-19) (2)	220, 346	4, 281, 903			20.00
21. 00	Unit Cost Multiplier: column	0. 054252	1, 201, 700			21.00
21.00	26, line 1 divided by the sum					21.00
	of column 26, line 20 minus					
	column 26, line 1, rounded to					
	6 decimal places.					
		'	1			'

⁽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 H	HA COST CENTERS STATISTICAL Provider CCN: 15-0034	Peri od: Worksheet H-2
BASIS		From 07/01/2021 Part II

HHA CCN:

15-7313 To

06/30/2022 Date/Time Prepared:

11/22/2022 9:31 am Home Health **PPS** Agency I CAPITAL RELATED COSTS MVBLE EQUIP **EMPLOYEE** ADMI TTI NG CASHI ERI NG/ACC Cost Center Description BLDG & FIXT PURCHASI NG 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 0 771, 834 1.00 Administrative and General 6,014 50 5, 558, 610 5, 558, 610 1.00 2.00 Skilled Nursing Care 854, 843 2.00 3.00 Physical Therapy 0 0 706, 648 0 3.00 0 Occupational Therapy 0 0 4.00 175, 804 0 4.00 0 οĺ 32, 797 5.00 Speech Pathology 5.00 6.00 Medical Social Services 0 0 0 0 0 6.00 0000000 0 7.00 Home Health Aide 88, 286 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) 6,014 20.00 2, 630, 212 50 5, 558, 610 5, 558, 610 20.00 21.00 Total cost to be allocated 2.461 470, 198 58 16, 837 14, 158 21.00 0. 178768 0.002547 22.00 Unit cost multiplier 0.000000 0.409212 1.160000 0.003029 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 171, 493 0 0 1.00 2.00 Skilled Nursing Care 0 1, 591, 498 0 0 0 0 0 0 0 0 0 0 2.00 Physical Therapy 0 0 1, 197, 357 0 3.00 3.00 0 0 4.00 Occupational Therapy 399, 227 0 4.00 5.00 Speech Pathology 0 66, 644 0 0 5.00 0 0 6.00 Medical Social Services 6.00 0 0 7.00 Home Health Aide 171, 564 0 O 7 00 0 0 8.00 Supplies (see instructions) 152, 013 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 12.00 Respiratory Therapy 0 12.00 0 13.00 Private Duty Nursing 0 0 0 00000 0 13.00 Ω 0 14 00 14 00 Clinic 0 0 15.00 Health Promotion Activities 15.00 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, 749, 796 0 0 0 20.00 20.00 0 Total cost to be allocated 0 21.00 506, 414 0 21 00

0. 135051

0.000000

0.000000

0.000000

0. 000000

22.00

22.00 Unit cost multiplier

	Financial Systems NTION OF GENERAL SERVICE COSTS T		T. MARY MEDICAL TERS STATISTICAL		N: 15-0034 15-7313	In Lie Period: From 07/01/2021 To 06/30/2022		pared:
						Home Health	11/22/2022 9: PPS	31 am_
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	Agency I MEDI CAL	SOCIAL SERVICE	
	·	(NUMBER OF FTES)	ADMINISTRATION (NURSING HO URS)	SERVICES & SUPPLY (COSTED REQUIS.)	(COSTED REQUIS.)	RECORDS & LI BRARY (GROSS REVE NUE)	(TIME SPENT)	
	T	11. 00	13.00	14.00	15. 00	16.00	17. 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 19.00 19.50 20.00 21.00 22.00	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) Total cost to be allocated Unit cost multiplier	11 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.0000	0 5, 558, 610 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00
22.00	Cost Center Description	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	PARAMEDI CAL EDUCATI ON PROGRAM EMS (ASSI GNED TI ME) 23.00	0.000000	0.0000	0.002340	0.00000	22.00
1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 19. 00 20. 00 21. 00 22. 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) Total cost to be allocated Unit cost multiplier	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0					1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00 22. 00

leal th	ı Financial Systems	S	T. MARY MEDICAL	CENTER, INC.		In Li€	eu of Form CMS-2	2552-10
APPOR	TIONMENT OF PATIENT SERVICE COST	rs .		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:		From 07/01/2021 To 06/30/2022	Part I Date/Time Prep 11/22/2022 9:3	pared: 31 am
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	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	3.00	4.00	4) 5. 00	
	PART I - COMPUTATION OF LESSER					4.00		
	BENEFICIARY COST LIMITATION Cost Per Visit Computation	OI AGGILLATE I	ROUNAM COST, A	OUNEUATE OF TH	IL TROOKAW ETW	TIATION COST, OF	`	1
1. 00	Skilled Nursing Care	2.00	1, 904, 432		1, 904, 43	2 13, 384	142. 29	1.00
2. 00	Physi cal Therapy	3.00		0				
3. 00	Occupational Therapy	4. 00		0				3.00
1. 00	Speech Pathology	5. 00		0	79, 74	8 431	185. 03	4.00
5. 00	Medical Social Services	6. 00			1	0		
6. 00	Home Heal th Aide	7. 00			205, 29			
7. 00	Total (sum of lines 1-6)		4, 099, 999	0	.,			7. 00
			1		Program Visit			-
	Coot Conton Decemintion	Coot Limita	CDCA No. (1)	Dorst A	Not Subject t	rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	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	1			11.00
12.00	Medical Social Services		23844	0	1	0		12.00
13.00	Home Health Aide Total (sum of lines 8-13)		23844	0				13. 00 14. 00
14.00	Cost Center Description	From Wkst H-2	Facility Costs	Shared	Total HHA	Total Charges	Ratio (col. 3	14.00
	oost center bescriptron	Part I, col.	(from Wkst.		Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
		0	1.00	Part II) 2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput		1.00	2.00	3.00	4.00	5.00	
15. 00	Cost of Medical Supplies	8.00	181, 904	0	181, 90	4 167, 229	1. 087754	15. 00
	Cost of Drugs	9. 00		0	1	0 0	1	l
			Program Visits		Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to	Subject to	
			Deductibles &	Deductibles &		Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
	DADT I COMPUTATION OF LEGIS	6. 00	7. 00	8. 00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE I	PRUGRAM CUSI, A	GGREGATE OF TH	IE PROGRAM LIM	ITATION COST, OF	₹	
	Cost Per Visit Computation							1
1. 00	Skilled Nursing Care		5, 790			0 823, 859		1.00
2. 00	Physical Therapy				1	0 608, 293		2.00
3. 00	Occupational Therapy		1, 567		1	0 207, 769		3.00
4. 00	Speech Pathology	0	151			0 27, 940		4.00
5. 00	Medical Social Services	0	0		1	0 0		5. 00
6. 00	Home Health Aide	0	1, 042			0 115, 693		6. 00
7. 00	Total (sum of lines 1-6)	0	12, 087			0 1, 783, 554		7. 00
	Cost Center Description	6. 00	7. 00	8. 00	9.00	10.00	11.00	
	Limitation Cost Computation							
								8.00
3. 00	Skilled Nursing Care				ĺ			9.00
	Skilled Nursing Care Physical Therapy							
9. 00	Physical Therapy Occupational Therapy							
9. 00 10. 00 11. 00	Physical Therapy Occupational Therapy Speech Pathology							10. 00 11. 00
9. 00 10. 00 11. 00 12. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services							11. 00 12. 00
9.00 10.00 11.00 12.00 13.00	Physical Therapy Occupational Therapy Speech Pathology							11.00

Heal th	Financial Systems	S	T. MARY MEDICA	L CENTER, INC.		In Lie	u of Form CMS-:	2552-10
APPORT	TONMENT OF PATIENT SERVICE COST	S		Provider CO	15-7313	Peri od: From 07/01/2021 To 06/30/2022	11/22/2022 9:	pared:
					XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Not Subject to	t B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance		
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Computa							
	Cost of Medical Supplies Cost of Drugs	0	159, 269 0			0 173, 245 0	0	15. 00 16. 00
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION		PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	₹	
	Cost Per Visit Computation		,					
1.00	Skilled Nursing Care	823, 859						1. 00
2.00	Physi cal Therapy	608, 293						2. 00
3.00	Occupational Therapy	207, 769						3. 00
4.00	Speech Pathology	27, 940						4. 00
5.00	Medical Social Services	0						5. 00
6. 00 7. 00	Home Heal th Ai de	115, 693 1, 783, 554						6. 00 7. 00
7.00	Total (sum of lines 1-6) Cost Center Description	1, 783, 554						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. 00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11. 00
12.00	Medical Social Services							12. 00
13.00	Home Health Aide							13. 00
14.00	Total (sum of lines 8-13)							14. 00

Heal th	Financial Systems	S	CENTER, INC.		In Lie	u of Form CMS-2	2552-10	
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7313	From 07/01/2021 To 06/30/2022	Part II	narad.
				HHA CCN:	15-7313	10 06/30/2022	Date/Time Prep 11/22/2022 9:	
				Ti tl e	e XVIII	Home Health		
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2. 00	3.00	4. 00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS								
1.00	Physi cal Therapy	66. 00	0. 282663	0		0 col. 2, line 2	. 00	1.00
2.00	Occupati onal Therapy	67. 00	0. 193432	0		0 col. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	0. 473140	0)	0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 385425	0		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 185329	0		0 col. 2, line 1	6. 00	5. 00

	Financial Systems ST. MARY MEDICAL CE ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-0034	Peri od:	u of Form CMS-2 Worksheet H-4	
000	THE STATE OF THE S	HHA CCN:	15-7313	From 07/01/2021 To 06/30/2022	Part I-II	pare
		Title	XVIII	Home Health Agency I	PPS	31 6
					t B	
			Part A	Not Subject to Deductibles & Coinsurance		
			1. 00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTON Reasonable Cost of Part A & Part B Services	MARY CHARGES				
0	Reasonable cost of services (see instructions)			0 0		
0	Total charges Customary Charges			0 0	0	1
0	Amount actually collected from patients liable for payment for	servi ces		0 0	0	1 3
	on a charge basis (from your records)					
0	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0 0	0	4
0	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	
0	Total customary charges (see instructions)			0 0	0	
0	Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only in the cost over customary charges)	·		0 0	0	
,	1 exceeds line 6)	y II IIIle		0	U	'
)	Primary payer amounts			0 3, 784	0	L
				Part A Servi ces	Part B Servi ces	
				1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					Ι.
00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers			0	-3, 784 1, 748, 224	
	Total PPS Reimbursement - Full Episodes with Outliers			0	330, 947	
00	Total PPS Reimbursement - LUPA Epi sodes			0	34, 384	
00	Total PPS Reimbursement - PEP Episodes			0	39, 510	1.
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	86, 157	1
00	Total PPS Outlier Reimbursement - PEP Episodes			0	4, 311	1
00	Total Other Payments			0	0	1
00	DME Payments			0	0	
00	Oxygen Payments			0	0	1
00	Prosthetic and Orthotic Payments	,		0	0	1
	Part B deductibles billed to Medicare patients (exclude coinsu	rance)			0	
00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 9)			0	2, 239, 749	1 .
00	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			0	0 2, 239, 749	
00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)				2, 239, 749 0	1 -
00	Net cost (line 24 minus line 25)			0	2, 239, 749	
	Reimbursable bad debts (from your records)			0	2, 239, 749	
	Reimbursable bad debts for dual eligible beneficiaries (see in	structions)			0	
	Total costs - current cost reporting period (line 26 plus line			0		
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	0	1
0	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	
99	Demonstration payment adjustment amount before sequestration	,		0	0	1
00	Subtotal (see instructions)			0	2, 239, 749	
01	Sequestration adjustment (see instructions)			0	5, 992	
02	Demonstration payment adjustment amount after sequestration			0	0	
75	Sequestration adjustment for non-claims based amounts (see ins	tructions)		0	0	3
വ	Interim payments (see instructions)	•		0	2, 233, 757	3:
-	Tentative settlement (for contractor use only)			0	0	
	rentative settiement (for contractor use only)					
	Balance due provider/program (line 31 minus lines 31.01, 32, a	nd 33)		0	0	34

In Lieu of Form CMS-2552-10

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 07/01/2021 To 06/30/2022 Worksheet H-5 Date/Time Prepared: 11/22/2022 9:31 am HHA CCN: 15-7313

				Home Health Agency I	PPS	<u> </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 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2, 233, 757 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0	0	3. 03 3. 04
3. 04				0		3. 04
0.00	Provider to Program			<u> </u>	Ŭ	0.00
3.50				0	0	3. 50
3.51				0	0	3. 51
3.52				0	0	3. 52
3. 53				0	0	3. 53
3.54	Subtatal (sum of lines 2 01 2 40 minus sum of lines			0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			O .	١	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	2, 233, 757	4. 00
	TO BE COMPLETED BY CONTRACTOR			_		
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01				0	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
3.03	Provider to Program			0	0	5. 05
5. 50 5. 51	Trovide: 20 Trogram			0	0	5. 50 5. 51
5. 51				0		5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			Ö		6. 02
7. 00	Total Medicare program liability (see instructions)			0	2, 233, 757	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor				1 1	8. 00

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0034	Period: From 07/01/2021 To 06/30/2022	Worksheet L Parts I-III Date/Time Pre 11/22/2022 9:		
		Title XVIII	Hospi tal	PPS	or a	
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD					
	CAPITAL FEDERAL AMOUNT					
00	Capital DRG other than outlier			2, 369, 283		
01	Model 4 BPCI Capital DRG other than outlier			0		
00	Capital DRG outlier payments			13, 454		
. 01	Model 4 BPCI Capital DRG outlier payments			0		
. 00	Total inpatient days divided by number of days in the cost	reporting period (see inst	tructions)	101. 97		
. 00	Number of interns & residents (see instructions)			0.00		
. 00	Indirect medical education percentage (see instructions)			0.00		
. 00	Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)			0	6.	
00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	, , , , , , , , , , , , , , , , , , , ,	±, part A line	2. 72 17. 07	7	
00	Percentage of Medicaid patient days to total days (see instructions)					
. 00	Sum of lines 7 and 8				9	
0.00				4. 09		
1.00	Disproporti onate share adjustment (see instructions)			96, 904		
2. 00	Total prospective capital payments (see instructions)		,	2, 479, 641	12	
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST			1.00		
00	Program inpatient routine capital cost (see instructions)			0	1	
00	Program inpatient ancillary capital cost (see instructions	.)		0	2	
00	Total inpatient program capital cost (line 1 plus line 2)	•		0	3	
. 00	Capital cost payment factor (see instructions)			0	4	
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5	
				1. 00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
00	Program inpatient capital costs (see instructions)			0		
00	Program inpatient capital costs for extraordinary circumst	ances (see instructions)		0	. –	
00	Net program inpatient capital costs (line 1 minus line 2)			0	-	
00	Applicable exception percentage (see instructions)			0.00		
00	Capital cost for comparison to payments (line 3 x line 4)			0		
00	Percentage adjustment for extraordinary circumstances (see	,		0.00		
00	Adjustment to capital minimum payment level for extraordin	ary circumstances (line 2)	x line 6)	0		
00	Capital minimum payment level (line 5 plus line 7)			0		
00	Current year capital payments (from Part I, line 12, as ap			0		
0. 00	Current year comparison of capital minimum payment level t			0		
. 00	Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14)		,	0		
2. 00	Net comparison of capital minimum payment level to capital			0		
3. 00	Current year exception payment (if line 12 is positive, en			0		
4. 00	Carryover of accumulated capital minimum payment level ove (if line 12 is negative, enter the amount on this line)		following period	0		
		! 4 4! >		0	15	
5. 00	Current year allowable operating and capital payment (see	instructions)		U	'~	
6. 00	Current year allowable operating and capital payment (see Current year operating and capital costs (see instructions Current year exception offset amount (see instructions)	*		0	16	