Heal th Financia	al Systems	ST. MARY'S MEDICAL	CENTER	In Lieu	J of Form CMS-2552-10			
This report is	required by law (42 USC 1395g; 4	42 CFR 413.20(b)). Failu	re to report can re	sult in all interim	FORM APPROVED			
payments made	since the beginning of the cost r	reporting period being d	eemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY AND SETTLEMENT SUMMARY Provider CCN: 150100 Period: From 07/01/2015 To 06/30/2016 Verts I-III Date/Time Prepared: 11/22/2016 2:05 pm								
PART I - COST	REPORT STATUS							
Provi der	1. [X] Electronically filed cos	•		Date: 11/22/20	D16 Time: 2:05 pm			
use only	 2. [] Manually submitted cost 3. [0] If this is an amended reg 4. [F] Medicare Utilization. En 	port enter the number of		resubmitted this co	ost report			
Contractor use only	4. [F] Medicare Utilization. Enter "F" for full or "L" for low. Contractor 5. [1] Cost Report Status 6. Date Received: 10. NPR Date:							
PART II - CERT	I FI CATI ON							
MI SREPRESENTAT	ION OR FALSIFICATION OF ANY INFOR	RMATION CONTAINED IN THI	S COST REPORT MAY B	E PUNISHABLE BY CRIM	INAL, CIVIL AND			
	ACTION, FINE AND/OR IMPRISONMENT							
PROVIDED OR PR	OCURED THROUGH THE PAYMENT DIRECT	TLY OR INDIRECTLY OF A K	ICKBACK OR WERE OTH	ERWISE ILLEGAL, CRIM	INAL, CIVIL AND			

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY'S MEDICAL CENTER (150100) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 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.



Title

			Date				
			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	·	1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	751, 472	129, 308	-45, 510	0	1.00
2.00	Subprovider - IPF	0	4, 207	0		0	2.00
3.00	Subprovider - IRF	0	48, 024	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	803, 703	129, 308	-45, 510	0	200.00

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

		IDENTIFICATION DA	ATA	Provi d	er CCN	l: 150100	Period: From 07/01 To 06/30	/2015)/2016	Part	heet S-2 I Time Pre	
	1.00		22				10 00/30			/2016 8:	
	1.00 Hospital and Hospital Health Care Co		. 00	3	. 00			4.00			
00	Street: 3700 WASHINGTON AVE	P0 Box:									1.00
00	City: EVANSVILLE	State: I		ip Code:			nty: VANDERB		1.0	L (D	2.00
		Component Na		CCN umber	CBSA Number	Provi de Type	r Date Certified		, 0, c	stem (P, or N)	
								V	XVII		1
		1.00		2.00	3.00	4.00	5.00	6.00	7.0	0 8.00	
00	Hospital and Hospital-Based Componer Hospital	It Identification: ST. MARY'S MEDIC		50100	21780	1	07/01/196	6 N	P	0	3.00
00		CENTER		30100	21700		077017190		F		3.0
00	Subprovider - IPF	ST. MARY'S STRES	S 1	5S100	21780	4	07/01/198	7 N	P	0	4.0
00	Subprovider - IRF	CENTER ST. MARY'S REHAB		5T100	21780	5	07/01/199	9 N	P	0	5.0
00	Subprovider - (Other)	SI. WART S KENAD		51100	21760	5	077017199	9 11	P		6.0
00	Swing Beds - SNF										7.0
00	Swing Beds - NF										8.0
00	Hospi tal -Based SNF Hospi tal -Based NF										9.0
. 00	Hospi tal -Based OLTC										11.0
2. 00	Hospital-Based HHA										12.0
8.00	Separately Certified ASC										13.0
. 00 5. 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14.0
. 00	Hospital -Based Health Clinic - FQHC										16.0
. 00	Hospital-Based (CMHC) I										17.0
3.00 9.00	Renal Dialysis Other										18.0
. 00	other						Fror	n:		To:	19.0
							1.0			. 00	
0. 00	Cost Reporting Period (mm/dd/yyyy)						07/01/	2015	06/3	0/2016	20.0
. 00	Type of Control (see instructions) Inpatient PPS Information						1				21.0
2. 00	Does this facility qualify and is it	currently receiv	/ing paymer	nts for a	di sprop	portionat	e Y			N	22.0
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				106(c)) (2) (Pi ck	le				
2. 01	Did this hospital receive interim un				cost r	conortina	Y			Y	22.0
	period? Enter in column 1, "Y" for y	os or "N" for no				epor tring	Ť			T	22.0
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	reporting period occurring prior to	October 1. Enter	in column	ortion of 2, "Y" 1	F the c For yes	cost s or "N"	Y			T	22.0
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	Financial Systems ST. MAR FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		ICAL CENTER Provider (eriod:	V	of Form C Worksheet		552-10
				Fr To	rom 07/01/201 0 06/30/201		Part I Date/Time	Prep	ared:
					Urban/Rural		<u>11/21/2016</u>		19 pm
					1.00	3 0	2.00	ogi	
26.00	Enter your standard geographic classification (not wa			inning of the		1			26.00
27 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa			of the cost		1			27.00
27.00	reporting period. Enter in column 1, "1" for urban or					'			27.00
	enter the effective date of the geographic reclassifi	cati on	in column 2.						
35.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	number	of periods SC	H status in		0			35.00
	erreet in the cost reporting perrod.				Begi nni ng:		Endi ng:		
					1.00		2.00		
36.00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for number					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter		umber of period	s MDH status		0			37.00
	is in effect in the cost reporting period.								
37.01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo				N				37.01
	instructions)	i yes u	in tot no.	(366					
38.00	If line 37 is 1, enter the beginning and ending dates								38.00
	greater than 1, subscript this line for the number of enter subsequent dates.	peri od	ls in excess of	one and					
	Jenter subsequent dates.				Y/N		Y/N		
					1.00		2.00		
39.00	Does this facility qualify for the inpatient hospital				N		N		39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req								
	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	or "N"	for no. (see i	nstructions)	1				
40.00	Is this hospital subject to the HAC program reduction				N		Y		40.00
	"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.			es or in tor					
						V		IX	
	Drocpostive Dovmont System (DDS) Canital				1.	00	2.00 3.	00	
45.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for d	li sproporti onat	e share in acc	ordance	N	Y	N	45.00
	with 42 CFR Section §412.320? (see instructions)								
46.00	Is this facility eligible for additional payment exce					N	N	N	46.00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	. L, Pt	. III and WKST	. L-I, Pt. I t	nrougn				
47.00	Is this a new hospital under 42 CFR §412.300 PPS capi	tal? E	inter "Y for ye	s or "N" for n	o. 1	N	N	N	47.00
48.00	Is the facility electing full federal capital payment	? Ente	er "Y" for yes	or "N" for no.		N	N	N	48.00
56.00	Teaching Hospitals Is this a hospital involved in training residents in	annrove	d GME programs	2 Enter "V" f	or ves	Y			56.00
50.00	or "N" for no.	appiove	a ome programs		UT yes				50.00
57.00	If line 56 is yes, is this the first cost reporting p					N			57.00
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont								
	for yes or "N" for no in column 2. If column 2 is "Y	", comp	olete Worksheet						
F0 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II	, if ap							
58.00			pplicable.		_	M			50.00
20.00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub 15-1 chapter 21 §21482 If yes		nt for physicia	ns' services a	s i	N			58.00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	complet	nt for physicia te Wkst. D-5.			N N			58. 00 59. 00
59. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health	complet , compl costs f	nt for physicia te Wkst. D-5. ete Wkst. D-2, for a program t	Pt. I. hat meets the					
59. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	complet , compl costs f	nt for physicia te Wkst. D-5. ete Wkst. D-2, for a program t	Pt. I. hat meets the		N	Direct G	ЛЕ	59.00
59. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health	complet , compl costs f for yes Y/N	nt for physicia te Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME	Pt. I. hat meets the . (see instruc Direct GME	tions) IME	N		ЛЕ	59.00
59. 00 60. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"	complet , compl costs f for yes Y/N 1.00	nt for physicia te Wkst. D-5. ete Wkst. D-2, for a program t <u>s or "N" for no</u>	Pt. I. hat meets the . (see instruc	tions) IME 4.00	N N	5.00		59. 00 60. 00
59. 00 60. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA	complet , compl costs f for yes Y/N	nt for physicia te Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME	Pt. I. hat meets the . (see instruc Direct GME	tions) IME 4.00	N	5.00		59.00
59. 00 60. 00 61. 00	<pre>defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</pre>	complet , compl costs f for yes Y/N 1.00	nt for physicia ce Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00	Pt. I. hat meets the . (see instruc Direct GME 3.00	tions) IME 4.00 0.	N N	5.00		59. 00 60. 00 61. 00
59. 00 60. 00 61. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care	complet , compl costs f for yes Y/N 1.00	nt for physicia te Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME	Pt. I. hat meets the . (see instruc Direct GME 3.00	tions) IME 4.00 0.	N N	5.00		59. 00 60. 00
59. 00 60. 00 61. 00	<pre>defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports</pre>	complet , compl costs f for yes Y/N 1.00	nt for physicia ce Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00	Pt. I. hat meets the . (see instruc Direct GME 3.00	tions) IME 4.00 0.	N N	5.00		59. 00 60. 00 61. 00
59. 00 60. 00 61. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care	complet , compl costs f for yes Y/N 1.00	nt for physicia ce Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00	Pt. I. hat meets the . (see instruc Direct GME 3.00	tions) IME 4.00 0.	N N	5.00		59. 00 60. 00 61. 00
59. 00 60. 00 61. 00 61. 01	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care	complet , compl costs f for yes Y/N 1.00	nt for physicia ce Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00	Pt. I. hat meets the . (see instruc Direct GME 3.00 0.00	tions) IME 4.00 0.	N N	5.00		59. 00 60. 00 61. 00
59. 00 60. 00 61. 00 61. 01	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,	complet , compl costs f for yes Y/N 1.00	nt for physicia ce Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00	Pt. I. hat meets the . (see instruc Direct GME 3.00 0.00	tions) IME 4.00 0.	N N	5.00		59.00 60.00 61.00 61.01
59. 00 60. 00 61. 00 61. 01	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care	complet , compl costs f for yes Y/N 1.00	nt for physicia ce Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00	Pt. I. hat meets the <u>(see instruc</u> Direct GME <u>3.00</u> 0.00	tions) IME 4.00 0.	N N	5.00		59.00 60.00 61.00 61.01
59. 00 60. 00 61. 00 61. 01 61. 02	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care	complet , compl costs f for yes Y/N 1.00	nt for physicia ce Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00	Pt. I. hat meets the <u>(see instruc</u> Direct GME <u>3.00</u> 0.00	tions) I ME 4.00 0.	N N	5.00		59.00 60.00 61.00 61.01
59. 00 60. 00 61. 00 61. 01 61. 02	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for	complet , compl costs f for yes Y/N 1.00	nt for physicia ce Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00 0.00	Pt. I. hat meets the <u>. (see instruc</u> Direct GME <u>3.00</u> 0.00	tions) I ME 4.00 0.	N N	5.00		59. 00 60. 00 61. 00 61. 01 61. 02
59. 00 60. 00 61. 01 61. 02 61. 03	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 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)	complet , compl costs f for yes Y/N 1.00	nt for physicia ce Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00 0.00	Pt. I. hat meets the <u>. (see instruc</u> Direct GME <u>3.00</u> 0.00	tions) I ME 4.00 0.	N N	5.00		59. 00 60. 00 61. 00 61. 01 61. 02
59. 00 60. 00 61. 01 61. 02 61. 03	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 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) Enter the number of unweighted primary care/or	complet , compl costs f for yes Y/N 1.00	nt for physicia ce Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00 0.00	Pt. I. hat meets the <u>. (see instruc</u> Direct GME <u>3.00</u> 0.00	ti ons) I ME 4. 00 0.	N N	5.00		59. 00 60. 00 61. 00 61. 01 61. 02
59. 00 60. 00 61. 00 61. 01 61. 02 61. 03	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 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) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the	complet , compl costs f for yes Y/N 1.00	nt for physicia e Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00 0.00	Pt. I. hat meets the <u>(see instruc</u> Direct GME <u>3.00</u> 0.00 0.00	ti ons) I ME 4. 00 0.	N N	5.00		59. 00 60. 00 61. 00 61. 01 61. 02 61. 03
59. 00 60. 00 61. 00 61. 01 61. 02 61. 03 61. 04	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 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) Enter the number of unweighted primary care/or	complet , compl costs f for yes Y/N 1.00	nt for physicia e Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00 0.00	Pt. I. hat meets the . (see instruc Direct GME 3.00 0.00 0.00 0.00	tions) IME 4.00 0.	N N	5.00		59. 00 60. 00 61. 00 61. 01 61. 02 61. 03
59. 00 60. 00 61. 00 61. 01 61. 02 61. 03 61. 04	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 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) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's	complet , compl costs f for yes Y/N 1.00	nt for physicia e Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00 0.00 0.00 0.00	Pt. I. hat meets the . (see instruc Direct GME 3.00 0.00 0.00 0.00	tions) IME 4.00 0.	N N	5.00		59.00 60.00 61.00 61.01 61.02 61.03 61.04
59. 00 60. 00 61. 00 61. 01 61. 02 61. 03 61. 04	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 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) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary	complet , compl costs f for yes Y/N 1.00	nt for physicia e Wkst. D-5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00 0.00 0.00 0.00	Pt. I. hat meets the . (see instruc Direct GME 3.00 0.00 0.00 0.00	tions) IME 4.00 0.	N N	5.00		59.00 60.00 61.00 61.01 61.02 61.03 61.04

IUSPI	TAL AND HOSPITAL HEALTH CARE COMPL	LEX IDENTIFICATION DA	IA	Provi der (eriod: com 07/01/2015 o 06/30/2016	Worksheet S-2 Part I Date/Time Pre 11/21/2016 8:4	pared
			Y/N	I ME	Direct GME	IME	Direct GME	
	1		1.00	2.00	3.00	4.00	5.00	
1. 06	Enter the amount of ACA §5503 aw. used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0.00			61. (
		·	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
1. 10	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.
1. 20	-	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0.00	61. :
							1.00	
> ^^	ACA Provisions Affecting the Hea Enter the number of FTE resident					od for which	0.00	62.
	your hospital received HRSA PCRE	funding (see instruc	ctions)					
2. 01	Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	riod of HRSA THC prog	gram. (s	ee instruction		your hospital	0.00	62.
3. 00		nts in nonprovider se	ettings	during this co		eriod? Enter	N	63.
					Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te 1. 00	2.00	3.00	
	Section 5504 of the ACA Base Yea		•	0			eporting	
4. 00	period that begins on or after J 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 in	ty trair n-primar all nor n columr	ed residents y care provider imary care 3 the ratio	0.00	0.00	0. 000000	64. (
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site		Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column				0.00	0.00	0. 000000	

Heal th	Financial Systems	ST. MAR	Y'S MEDICAL	CENTER		1	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA	Provi der	F	eriod: rom 07/01/ o 06/30/		Workshe Part I Date/Ti 11/21/2	me Prem	oared:
					Unweighted FTEs Nonprovider Site	Unwei gh FTEs i Hospi t	n al	Ratio (c (col. 1 2)	col. 1/ + col.)	
	Section 5504 of the ACA Current	Year FTF Residents in	n Nonprovide	r Setting	1.00	2.00 2.00		<u>3.0</u> na perio		
((00	beginning on or after July 1, 20 Enter in column 1 the number of	10		0	1		·	<u> </u>	000000	((00
88.00	FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider sett ry care resi 3 the ratio	ings. dent	0.00		0.00	0.	000000	88.00
		Program Name	Program	Code	Unweighted FTEs Nonprovider Site	Unweigh FTEs i Hospit	n	Ratio (c (col. 3 4)	+ col .	
		1.00	2.0	0	3.00	4.00		5. C		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0. 00)	0.00	0.	000000	67.00
							1.00	2.00	3.00	
	Inpatient Psychiatric Facility P							2.00	3.00	
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	pproved GME 004? Enter lity train (D)? Enter	teaching "Y" for yo residents "Y" for yo	, program in the es or "N" for r in a new teach es or "N" for r	most no. (see ni ng no.	N	N	0	70. 00 71. 00
75.00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re	<u>y PPS</u> habilitation Facility	/(IRF), or	does it c	ontain an IRF		Y			75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	oproved GME ember 15, 20 new teachin for no. Col	teaching 04? Enter g program umn 3: If	program in the "Y" for yes or in accordance column 2 is Y,	"N" for with 42	N	N	0	76.00
								1. 0	0	
	Long Term Care Hospital PPS									
	Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no.					period? E	nter	N		80. 00 81. 00
85.00	TEFRA Providers Is this a new hospital under 42	CFR Section §413.40(f	F)(1)(i) TEF	RA? Ente	r "Y" for yes o	or "N" for	no.	N		85.00
	Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excluded un							86.00
87.00	Is this hospital a "subclause (I for yes or "N" for no.			n 1886(d)	(1)(B)(iv)(II)?	? Enter "Y		Ν		87.00
						V 1.00		XI 2. 0		
90.00	<u>Title V and XIX Services</u> Does this facility have title V	and/or XIX inpatient	hospital se	rvi ces? E	nter "Y" for	N		Y		90.00
	yes or "N" for no in the applica Is this hospital reimbursed for	ble column.	•			N		N		91.00
	full or in part? Enter "Y" for y Are title XIX NF patients occupy	es or "N" for no in t	the applicab	le column				N		92.00
	instructions) Enter "Y" for yes	or "N" for no in the	appl i cabl e	column.	, ,					
	Does this facility operate an IC "Y" for yes or "N" for no in the	applicable column.				N		N		93.00
94.00	Does title V or XIX reduce capit applicable column.	al cost? Enter "Y" fo	or yes, and	"N" for n	o in the	N		Ν		94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	DI CAL CENTER Provi der		Period: From 07/01/ To 06/30/	2015	Workshe Part I Date/Ti 11/21/2	et S-2 me Pre	epared:
			V		XI		
			1.00		2.0	0	
 95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column. 			0. 00 N		0. C N		95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	plicable colum	n.	0.00		0.0	0	97.00
105.00 Does this hospital qualify as a critical access hospital (C/ 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of paymen	t N				105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst . 25 and the p	ructions) lf rogram is cos	t N				107.00
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	-	Description		108.00
	Physi cal 1.00	Occupationa 2.00	Speec 3. 00		Respir 4.(-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		4. C		109.00
					1.0	0	-
110.00 Did this hospital participate in the Rural Community Hospit: the current cost reporting period? Enter "Y" for yes or "N"		on project (4	10A Demo)for	-	N		110.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information							
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	. If column 2 nt for long te	is "E", enter rm care (incl	in column udes	N		0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu			"N" for	N Y			116. 00 117. 00
no. 118.00 is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	if the policy	is	2			118.00
		Premi ums	Losses	5	Insur	ance	
		1.00	2.00		3.0	10	_
118.01 List amounts of malpractice premiums and paid losses:		1, 135, 0		0	0.0		0118.01
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher and amounts contained therein.		than the	1.00		2.0	0	110.00
	dule listing c		N		2.0		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 qu Hold Harmless provision in ACA §3121 and applicable amendment	d Harmless pro n column 1, "Y ualifies for t	ost centers vision in ACA " for yes or he Outpatient	N		N		118. 02 119. 00 120. 00
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 qu	d Harmless pro n column 1, "Y ualifies for t nts? (see inst	ost centers vision in ACA " for yes or he Outpatient ructions)					119.00
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 qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N"	N				119. 00 120. 00
 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. 121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for 	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for he Worksheet A	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	N		N		119. 00 120. 00 121. 00
 119.00 D0 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. 121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter enter for the set of the	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for he Worksheet A or yes and "N" nter the certi	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If	N Y Y		N		119.00 120.00 121.00 122.00
 119.00 D0 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. 121.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 there these taxes are included. 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for he Worksheet A or yes and "N" nter the certi 2. ter the certif 2.	ost centers vision in ACA "for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	N Y Y		N		119.00 120.00 121.00 122.00 125.00 126.00 127.00
 119.00 D0 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. 121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 1 128.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for he Worksheet A or yes and "N" nter the certif 2. ter the certif 2.	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	N Y Y		N		119.00 120.00 121.00 122.00 125.00 126.00 127.00 128.00
 119.00 D0 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. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, entified heart transplant center, entified h	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for he Worksheet A or yes and "N" nter the certif 2. ter the certif 2. er the certific	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date cation date in	N Y Y		N		119.00 120.00 121.00 122.00 125.00 126.00 127.00
 119.00 D0 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 Harnless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 	d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for he Worksheet A or yes and "N" nter the certif 2. ter the certif 2. er the certif 2. enter the certif 2. enter the certif 2. enter the certif 2. enter the certif 3. enter the certif 3. enter the certif 4. enter the certif 5. enter 5. enter	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date ication date cation date in tification	N Y Y		N		119.00 120.00 121.00 122.00 125.00 126.00 127.00 128.00 129.00

Health Financial Systems	ST. MARY'S MED	OICAL CENTER			In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider (CCN: 15010			Worksheet S-2	
					07/01/2015	Part I Date/Time Pre	narod
					0/ 30/ 2010	11/21/2016 8:	
122 00 f this is a Madisona contified at	her trancologt conter or	tan tha aantifi	aati an da	+ 0	1.00	2.00	122.00
133.00 If this is a Medicare certified ot in column 1 and termination date,			cation da	te			133.00
134.00 If this is an organ procurement or			n column	1			134.00
and termination date, if applicabl							
All Providers							
140.00 Are there any related organization					Y	15H056	140.00
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the				ISTS			
1.00	2.0				3.00		
If this facility is part of a chai	n organization, enter on	lines 141 throu	igh 143 th	ne name an		of the	
home office and enter the home off							
141.00 Name: ST MARY'S HEALTH	Contractor's Name: WP	S	Contr	actor's Nu	umber: 8101		141.00
142.00 Street: 3700 WASHINGTON AVE 143.00 City: EVANSVILLE	PO Box: State: IN		Zip C	odo:	4775	0-0002	142.00 143.00
143. 00 CT LY. EVANSVILLE				oue.	4773	0-0002	143.00
						1.00	
144.00 Are provider based physicians' cos	ts included in Worksheet A	٩?					144.00
	· · · · · · · · · · · · · · · · · · ·		6		1.00	2.00	1.15 00
145.00 If costs for renal services are cl inpatient services only? Enter "Y"				-	Y		145.00
no, does the dialysis facility inc							
period? Enter "Y" for yes or "N"			· opor tring	·			
146.00 Has the cost allocation methodolog					N		146.00
Enter "Y" for yes or "N" for no in		15-2, chapter 4	0, §4020)	lf			
yes, enter the approval date (mm/d	d/yyyy) in column 2.						
						1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" for v	ves or "N" for	no.			N	147.00
148.00 Was there a change in the order of	allocation? Enter "Y" for	, r yes or "N" fo	r no.			N	148.00
149.00 Was there a change to the simplifi	ed cost finding method? Er					N	149.00
		Part A	Part		<u>Fitle V</u>	Title XIX	
Does this facility contain a provi	dor that qualifies for an	1.00	2.00		3.00 f the lowe	4.00	
or charges? Enter "Y" for yes or "							
155. 00 Hospi tal	······	N	N		N	N	155.00
156.00 Subprovider - IPF		N	Ν		N	N	156.00
157.00 Subprovider - IRF		N	N		N		157.00
158. 00 SUBPROVI DER 159. 00 SNF		N	N		N		158.00 159.00
160.00 HOME HEALTH AGENCY		N N	N N		N N	N N	160.00
161. 00 CMHC		N.	N		N		161.00
		11					
						1.00	
Multicampus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has one	e or more campu	ses in di	TTERENT C	BSAS?	Ν	165.00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each						0.00	166.00
campus enter the name in column							
0, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Heal th Information Technology (HIT) Incentive in the America	an Recovery and	Reinves	ment Act		V	167 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10	under SISSO(N)? Enter " 5 is "Y") and is a meaning	n lui yes of " nful user (line	167 is "	i. Y") ontoi	r the	Y O	167.00 168.00
reasonable cost incurred for the H			107 13	. ,, sine			
168.01 If this provider is a CAH and is n	ot a meaningful user, does	s this provider			dshi p	N	168. 01
exception under §413.70(a)(6)(ii)?	Enter "Y" for yes or "N"	for no. (see i	nstructic	ns)			
169.00 If this provider is a meaningful u		ıs not a CAH (II ne 105	IS "N"), (enter the	0.50	169.00
transition factor. (see instruction	113)					1	I

Health Financial Systems	ST. MARY'S MEDICAL	CENTER	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	CATION DATA	Provider CCN: 150100	Period:	Worksheet S-2	2
			From 07/01/2015 To 06/30/2016		pared.
				11/21/2016 8:	<u>49 pm</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	date and ending date	for the reporting	10/01/2014	09/30/2015	170.00
				1.00	
171.00 If line 167 is "Y", does this provider have Medicare cost plans reported on Wkst. S-3, (see instructions)				N	171.00

10SPI T.	Financial Systems ST. MARY'S MED AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	DI CAL CENTER Provi der	CCN: 150100	Period: From 07/01/2015	Worksheet S- Part II Date/Time Pr 11/21/2016 8	·2 repared:
				Y/N	Date	5. 49 piii
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	sponses. Ent	er all dates in [.]	the	
	Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c			5)		
			Y/N	Date	V/I	_
2.00	Has the provider terminated participation in the Medicare P	rogram2 lf	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in colum voluntary or "l" for involuntary.	n 3, "V" for				
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members or of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
1.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4.0
5.00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.0
			1	Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities	1.6		N		-
5.00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	IT yes, is tr	ie provider i	s N		6.0
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing school and/or allied health programs approved		during the	N N		7. 0 8. 0
9.00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medic	al education	n Y		9.0
10.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	S.		N		10. 0
1.00	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	roved	Ν		11. C
					Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	soo instruct	ions		Y	12.0
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	N	13.0
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? If	yes, see ir	nstructions.	N	14.0
	Did total beds available change from the prior cost reporti		yes, see ins t A		N N	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6.00	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	Y	10/03/2010	5 Y	10/03/2016	16. 0
	date of the PS&R Report used in columns 2 and 4 . (see instructions)					
7.00	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	Ν		N		17. C
8. 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	Ν		Ν		18.0
19.00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19.0

Heal th	Fi nanci al	Systems	

ST. MARY'S MEDICAL CENTER

In Lieu of Form CMS-2552-10

Health Financial Systems		EDICAL CENTER		In Lie	U OT FORM CM	5-2552-10
HOSPITAL AND HOSPITAL HE	ALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 150100	Period: From 07/01/2015 To 06/30/2016		repared:
		Descri	ption	Y/N	Y/N	
		()	1.00	3.00	
	is yes, were adjustments made to PS&R ther? Describe the other adjustments:			N	Ν	20.00
· · ·		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00 Was the cost report records? If yes,	rt prepared only using the provider's see instructions.	N		N		21.00
		·			1.00	
COMPLETED BY COST	REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS H	OSPLTALS)		1.00	
Capital Related Co						
	relifed for Medicare purposes? If yes, se	ee instructions			Ν	22.00
23.00 Have changes occu	rred in the Medicare depreciation expense If yes, see instructions.		als made duri	ng the cost	N	23.00
24.00 Were new leases a	nd/or amendments to existing leases enter	red into during	this cost rep	orting period?	Ν	24.00
	ew capitalized leases entered into during	g the cost repor	ting period?	lf yes, see	Ν	25.00
	ct to Sec.2314 of DEFRA acquired during	the cost reporti	ng period? If	yes, see	Ν	26.00
i nstructi ons. 27.00 Has the provider'	s capitalization policy changed during th	ne cost reportin	g period?lf	yes, submit	Ν	27.00
copy. Interest Expense						_
28.00 Were new Loans, m period? If yes, s	ortgage agreements or letters of credit e ee instructions.	entered into dur	ing the cost	reporti ng	Ν	28.00
29.00 Did the provider	have a funded depreciation account and/or ed depreciation account? If yes, see ins	•	bt Service Re	serve Fund)	Ν	29.00
	been replaced prior to its scheduled ma		debt? If yes,	see	Ν	30.00
31.00 Has debt been rec	alled before scheduled maturity without i	ssuance of new	debt? If yes,	see	Ν	31.00
instructions. Purchased Service						
arrangements with	ew agreements occurred in patient care se suppliers of services? If yes, see inst	ructions.	0		Ν	32.00
33.00 If line 32 is yes no, see instructi	, were the requirements of Sec. 2135.2 apons.	oplied pertainin	g to competit	ive bidding? If	Ν	33.00
Provider-Based Phy						
	ished at the provider facility under an a	arrangement with	provi der-bas	ed physi ci ans?	Y	34.00
If yes, see instr 35.00 If line 34 is yes	uctions. , were there new agreements or amended ex	xisting agreemen	ts with the r	rovi der-based	N	35.00
	the cost reporting period? If yes, see i			lovi del based	N	00.00
				Y/N	Date	
				1.00	2.00	
Home Office Costs						
	costs claimed on the cost report? , has a home office cost statement been p	prepared by the	home office?	Y Y		36.00 37.00
lf yes, see instr				N		38.00
the provider? If	yes, enter in column 2 the fiscal year er , did the provider render services to oth	nd of the home o	ffi ce.	N		39.00
see instructions.	, did the provider render services to the		J .	N		40.00
instructions.				11		40.00
		1.	00	2.	00	
	rer Contact Information					41.00
held by the cost	ame, last name and the title/position report preparer in columns 1, 2, and 3,	JILL		HILL		41.00
	r/company name of the cost report	ST. VINCENT HE	ALTH			42.00
	ne number and email address of the cost	317-583-3519		JI LL. HI LL@STVI I	NCENT. ORG	43.00
report preparer i	n columns 1 and 2, respectively.					

Heal th	Financial Systems ST. MA	RY'S MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAL	I RE	Provi der	CCN: 150100	Period:	Worksheet S-2	
					From 07/01/2015 To 06/30/2016		pared: 49 pm
			3.	00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/positi	on R	EIMBURSEMENT	MANAGER			41.00
	held by the cost report preparer in columns 1, 2, ar	nd 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the	cost					43.00
	report preparer in columns 1 and 2, respectively.						

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Ρ	rovi der	CCN: 150100		eriod: com 07/01/2015 0 06/30/2016	Worksheet S- Part I Date/Time Pro 11/21/2016 8	ера	
	Component	Worksheet A Line Number	No. o	f Beds	Bed Days Avai I abl e			I/P Days / O/I Visits / Trips Title V	P	7 pm
		1.00	2.	00	3.00		4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00		294	107, 6	04	0.00	(0	1.00
2.00 3.00 4.00	HMO I PF Subprovider HMO I RF Subprovider									2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			294	107, 6	04	0.00	(0	5.00 6.00 7.00
7.00	beds) (see instructions)			271	107,0	0.	0.00		1	7.00
8.00	INTENSIVE CARE UNIT	31.00		62			0.00		0	8.00
8.02	NI CU	31.02		40			0.00		0	8. 02
9.00	CORONARY CARE UNI T	32.00		9	3, 2	94	0.00	(0	9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11.00	SURGICAL INTENSIVE CARE UNIT									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)									12.00
13.00	NURSERY	43.00		105		~ ~				13.00
14.00	Total (see instructions)			405	148, 2	30	0.00			14.00
15.00	CAH visits	10.00		1.4	F 1	~ 4			- 1	15.00
16.00	SUBPROVIDER - IPF	40.00	1	14						16.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER	41.00		24	8, 7	84		l l		17.00 18.00
18.00	SUBPROVIDER SKILLED NURSING FACILITY	44.00		0		0				19.00
20.00	NURSING FACILITY	44.00	1	0		0				20.00
20.00	OTHER LONG TERM CARE	45.00		0		0				20.00
21.00	HOME HEALTH AGENCY	101.00						(22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	101.00						,		23.00
24.00	HOSPICE									24.00
24.10	HOSPICE (non-distinct part)	30, 00								24.10
25.00	CMHC - CMHC	99.00	•					(25.00
26.00	RURAL HEALTH CLINIC	88.00							- 1	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	1							26.25
27.00	Total (sum of lines 14-26)	0,100		443					- 1	27.00
28.00	Observation Bed Days							(28.00
29.00	Ambul ance Trips								- 1	29.00
30.00	Employee discount days (see instruction)									30.00
31.00	Employee discount days - IRF									31.00
32.00	Labor & delivery days (see instructions)			0		0				32.00
32.01	Total ancillary labor & delivery room					-				32.01
	outpatient days (see instructions)									
33 00	LTCH non-covered days									33.00

10SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	F	Period: From 07/01/2015 Fo 06/30/2016	Worksheet S-3 Part I Date/Time Pre 11/21/2016 8:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	21, 831	5, 266	49, 598	3		1.00
2.00	HMO and other (see instructions)	7, 258	8, 214				2.00
3.00	HMO IPF Subprovider	115	0				3.00
4.00	HMO IRF Subprovider	295	541				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	(5.00
5.00	Hospital Adults & Peds. Swing Bed NF		0	(6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	21, 831	5, 266	49, 598	3		7.00
3.00	INTENSIVE CARE UNIT	6, 321	111	13, 828	3		8.00
3. 02	NI CU	0	3, 626	5, 93	7		8. 02
9.00	CORONARY CARE UNIT	666	88	1, 45	7		9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		736	3, 06'	1		13.00
14.00	Total (see instructions)	28, 818	9,827	73, 88		1, 933. 18	
15.00	CAH visits	20,010	,, 027	, 0, 00	0.00	1, 700. 10	15.00
16.00	SUBPROVIDER - IPF	1,087	1, 238	3, 398	0.00	18.44	
17.00	SUBPROVIDER - IRF	2, 313	282			29.81	
18.00	SUBPROVIDER	2, 515	202	4,750	0.00	27.01	18.00
19.00	SKILLED NURSING FACILITY	0	0	(0.00	0.00	
20.00	NURSING FACILITY	0	0			0.00	
	OTHER LONG TERM CARE		0		0.00	0.00	20.00
21.00 22.00		0	0	(0.00	0.00	
	HOME HEALTH AGENCY	U	0		0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						
24.00	HOSPICE		0				24.00
24.10	HOSPICE (non-distinct part)	0	0			0.00	24.10
25.00	CMHC - CMHC	0	0	(0.00	0.00	
26.00	RURAL HEALTH CLINIC	0	0	(0.00	0.00	
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0.00	0.00	
27.00	Total (sum of lines 14-26)				6.00	1, 981. 43	
28.00	Observation Bed Days		0	6, 990	ן ו		28.00
29.00	Ambul ance Trips	102					29.00
30.00	Employee discount days (see instruction)			1, 238			30.00
31.00	Employee discount days - IRF			59			31.00
32.00	Labor & delivery days (see instructions)	0	268	1, 243	3		32.00
32.01	Total ancillary labor & delivery room			(32.01
	outpatient days (see instructions)						
22 00	LTCH non-covered days	0					33.0

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150100	Period: From 07/01/2015 To 06/30/2016		pared:
		Full Time Equivalents		Di s	scharges		
	Component	Nonpai d Workers	Title V	Title XVII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider		0		14 766	16, 542	1.00 2.00 3.00
4.00 5.00 6.00 7.00 8.00 8.02 9.00 10.00 11.00 12.00 13.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT NICU CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY				54		4. 00 5. 00 6. 00 7. 00 8. 00 8. 02 9. 00 10. 00 11. 00 12. 00 13. 00
14.00 15.00	Total (see instructions) CAH visits	0.00	0	6, 4	14 766	16, 542	
16. 00 17. 00 18. 00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER	0. 00 0. 00	0 0		12 26 74 17		16.00 17.00 18.00
19. 00 20. 00 21. 00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0. 00 0. 00					19.00 20.00 21.00
22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0.00 0.00 0.00 0.00 0.00					22. 00 23. 00 24. 00 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01 33. 00

	Financial Systems AL WAGE INDEX INFORMATION		ST. MARY'S MEI			eriod: rom 07/01/2015		pared:
		Worksheet A Line Number		Reclassificati on of Salaries (from Worksheet A-6)	Sal ari es (col . 2 ± col .		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
I. 00	Total salaries (see	200. 00	143, 851, 752	0	143, 851, 752	4, 642, 120. 00	30. 99	1.00
2.00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0.00	2.00
8.00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3.00
1.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
1.01	Physicians - Part A - Teaching		0	-	0	0.00		
5.00	Physician-Part B		2, 802, 772	0	2, 802, 772			
5.00 7.00	Non-physician-Part B Interns & residents (in an	21.00	0 341, 638		341, 638	0.00 14,987.00		
. 00	approved program)	21.00	541, 050		341,030	14, 707.00	22.00	/.00
7.01	Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7.01
3. 00	programs) Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00		
0.00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		49, 242, 545	603, 846	49, 846, 391	1, 170, 017. 00	42.60	10.00
1.00	Contract Labor: Direct Patient		1, 947, 104	0	1, 947, 104	32, 107. 00	60. 64	11.00
2.00	Care Contract Labor: Top Level		0		0	0.00	0.00	12.00
12.00	management and other management and administrative services		0			0.00	0.00	12.00
3.00	Contract Labor: Physician-Part		0	0	0	0.00	0.00	13.00
4 00	A - Administrative		40 (70 (/)		40 (70 (/)	(12 (14 00	(1.00	14 00
4.00	Home office salaries & wage-related costs		40, 679, 663	0	40, 679, 663	663, 664. 00	61.30	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
6.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS		22 454 044		22 454 044			17.00
7.00	Wage-related costs (core) (see instructions)		33, 454, 946	0	33, 454, 946			17.00
8.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
	Excluded areas Non-physician anesthetist Part		14, 276, 442 0		,,			19.00 20.00
21.00	A Non-physician anesthetist Part		0	-	0			21.00
22.00	B Physician Part A -		0		0			22.00
0.01	Administrative							00.01
22.01 23.00	Physician Part A - Teaching Physician Part B		0	-	0			22.01 23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an		139, 577	0	139, 577			25.00
	approved program) OVERHEAD COSTS - DIRECT SALARIE	<u>c</u>						
26.00	Employee Benefits Department	4.00	477, 761	0	477, 761	9, 735. 00	49.08	26.00
27.00 28.00	Administrative & General Administrative & General under	5.00	8, 368, 191 0				22. 77	27.00
29.00	contract (see inst.) Maintenance & Repairs	6.00	0	_		0.00	0.00	29.00
30.00	Operation of Plant	7.00	841, 962	0	841, 962			
31.00	Laundry & Linen Service	8.00	620, 873	0	620, 873	47, 876. 00	12.97	31.00
32.00 33.00	Housekeeping Housekeeping under contract (see instructions)	9.00	94 3, 735, 603	-	94 3, 735, 603			
34.00	(see instructions) Dietary	10.00	241, 033	-145, 343	95, 690	3, 444. 00	27. 78	34.00
35.00	Dietary under contract (see instructions)		3, 034, 834		3, 034, 834			
36.00	Cafeteri a	11.00	0		145, 343			
37.00 38.00	Maintenance of Personnel	12.00	0 1 726 144	°	0	0. 00 44, 592. 00		37.00
	Nursing Administration	13.00	1, 736, 144					
39.00	Central Services and Supply	14.00	1, 262, 270	0	1, 262, 270	70, 518. 00	17.90	39.00

Health Financial Systems		ST. MARY'S ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3	
					From 07/01/2015		
					Го 06/30/2016	Date/Time Pre 11/21/2016 8:4	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical	16.00	1, 679, 406	0	1, 679, 40	6 94, 033. 00	17.86	41.00
Records Library	17.00						
42.00 Social Service	17.00	0	0	(0.00		42.00
43.00 Other General Service	18.00	0	0	(0.00	0.00	43.00

Heal th	Financial Systems		ST. MARY'S ME	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
HOSPI	AL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3	
						From 07/01/2015 To 06/30/2016		bared:
							11/21/2016 8:	49 pm
		Worksheet A	Amount	Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				-1		
1.00	Net salaries (see		147, 477, 779	0	147, 477, 77	9 4, 901, 874. 00	30. 09	1.00
	instructions)							
2.00	Excluded area salaries (see		49, 242, 545	603, 846	49, 846, 39	1 1, 170, 017. 00	42.60	2.00
	instructions)							
3.00	Subtotal salaries (line 1		98, 235, 234	-603, 846	97, 631, 38	8 3, 731, 857. 00	26. 16	3.00
	minus line 2)							
4.00	Subtotal other wages & related		42, 626, 767	0	42, 626, 76	7 695, 771. 00	61.27	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		33, 454, 946	0	33, 454, 94	6 0.00	34.27	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		174, 316, 947	-603, 846	173, 713, 10	1 4, 427, 628. 00	39. 23	6.00
7.00	Total overhead cost (see		25, 969, 525	-603, 846	25, 365, 67	9 1,072,055.00	23.66	7.00
	instructions)							

Heal th	Financial Systems	ST. MARY'S MEDICAL	_ CENTER		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provider CCN:	150100	Period: From 07/01/2015 To 06/30/2016		pared: 49 pm
						Amount	
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
1 00	RETIREMENT COST 401K Employer Contributions					(700 000	1 00
1.00		iti on				6, 799, 900	1.00 2.00
2.00 3.00	Tax Sheltered Annuity (TSA) Employer Contribu Nonqualified Defined Benefit Plan Cost (see i					0	2.00
3.00 4.00	Qualified Defined Benefit Plan Cost (see inst					2, 346, 916	3.00 4.00
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External O					2, 340, 910	4.00
5.00	401K/TSA Plan Administration fees	n yanı zatron)				60, 665	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	, ,				00,005	6.00
7.00	Employee Managed Care Program Administration					0	7.00
7.00	HEALTH AND INSURANCE COST	1003				0	7.00
8.00	Heal th Insurance (Purchased or Self Funded)					22, 129, 771	8.00
9.00	Prescription Drug Plan					4, 606, 856	
10.00	Dental, Hearing and Vision Plan					848, 826	
11.00	Life Insurance (If employee is owner or benef	ĩ ci arv)				205, 571	
12.00	Accident Insurance (If employee is owner or b					10, 130	
13.00	Disability Insurance (If employee is owner or					1, 219, 858	
14.00	Long-Term Care Insurance (If employee is owned					0	
15.00	'Workers' Compensation Insurance	57				543, 431	15.00
16.00	Retirement Health Care Cost (Only current yea	ar, not the extraor	dinary accrual	requi re	d by FASB 106.	0	16.00
	Non cumulative portion)		-		-		
	TAXES						
	FICA-Employers Portion Only					8, 338, 658	
	Medicare Taxes - Employers Portion Only					0	18.00
19.00	Unemployment Insurance					0	19.00
20.00	State or Federal Unemployment Taxes					88, 762	20.00
	OTHER						
21.00	Executive Deferred Compensation (Other Than F instructions))	Retirement Cost Rep	orted on lines	1 throu	gh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement					671, 620	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)					47, 870, 964	24.00
	Part B - Other than Core Related Cost						
25.00						0	25.00

Health Financial Systems	ST. MARY'S MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15010		Worksheet S-3	
			From 07/01/2015 To 06/30/2016		narad
			To 06/30/2016	11/21/2016 8:	
Cost Center Description			Contract Labor		
			1.00	2.00	
PART V - Contract Labor and Benefit Cost					
Hospital and Hospital-Based Component Identi					
1.00 Total facility's contract labor and benefit	cost		1, 947, 104		1.00
2.00 Hospital			1, 947, 104	33, 454, 946	2.00
3.00 Subprovider - IPF			0	302, 872	1
4.00 Subprovider - IRF			0	522, 180	4.00
5.00 Subprovider - (Other)			0	0	5.00
6.00 Swing Beds - SNF			0	0	6.00
7.00 Swing Beds - NF			0	0	7.00
8.00 Hospital-Based SNF			0	0	8.00
9.00 Hospital-Based NF			0	0	9.00
10.00 Hospital-Based OLTC					10.00
11.00 Hospital-Based HHA			0	0	11.00
12.00 Separately Certified ASC					12.00
13.00 Hospi tal -Based Hospi ce					13.00
14.00 Hospital-Based Health Clinic RHC			0	0	14.00
15.00 Hospital-Based Health Clinic FQHC			0	0	15.00
16.00 Hospital-Based-CMHC			0	0	16.00
17.00 Renal Dialysis			0	0	17.00
18.00 Other			0	13, 590, 966	18.00

Heal th	Financial Systems ST. MARY'S MEDICAL CENTI	R	In Lie	eu of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Provi	der CCN: 150100	Peri od:	Worksheet S-1	0
			From 07/01/2015		nored.
			To 06/30/2016	Date/Time Pre 11/21/2016 8:	
				1	
				1.00	
	Uncompensated and indigent care cost computation			.	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided b	y line 202 colum	n 8)	0. 212025	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			21, 121, 666	
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is "yes", does line 2 include all DSH or supplemental payme	nto from Modiosi	40	N	3.00
4.00 5.00	If line 4 is "no", then enter DSH or supplemental payments from Medic		u?		
5.00 6.00	Medicaid charges	aru		255, 385, 143	
7.00	Medicaid cost (line 1 times line 6)			54, 148, 035	
8.00	Difference between net revenue and costs for Medicaid program (line 7	minus sum of li	nes 2 and 5 [.] if	33, 026, 369	
0.00	< zero then enter zero)			0070207007	
	State Children's Health Insurance Program (SCHIP) (see instructions f	or each line)			
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line	11 minus line 9;	if < zero then	0	12.00
	enter zero)	<u> </u>			-
12 00	Other state or local government indigent care program (see instruction				12 00
13.00 14.00	Net revenue from state or local indigent care program (Not included or Charges for patients covered under state or local indigent care progr				
14.00	10)	am (Not Included	In Thes 6 of		14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent	care program (Li	ne 15 minus line	-	
	13; if < zero then enter zero)	our o program (ri			
	Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding	charity care		125, 483	17.00
18.00	Government grants, appropriations or transfers for support of hospita			0	
19.00		gent care progra	ms (sum of lines	33, 026, 369	19.00
	8, 12 and 16)	Unincured	Incurred	Total (col. 1	
		Uni nsured pati ents	Insured patients	+ col. 2	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at fu				20.00
	charges excluding non-reimbursable cost centers) for the entire facil				
21.00	Cost of initial obligation of patients approved for charity care (lir	e 1 6, 914, 5	520, 779	7, 435, 282	21.00
	times line 20)				
22.00	Partial payment by patients approved for charity care	477,0			
23.00	Cost of charity care (line 21 minus line 22)	6, 437, 4	440, 696	6, 878, 105	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days	hovend a Longth	of ctoy limit	1.00 N	24.00
24.00	imposed on patients covered by Medicaid or other indigent care progra		or stay frint	IN IN	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent car		th of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructi			15, 076, 565	
27.00	Medicare bad debts for the entire hospital complex (see instructions)			732, 921	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26			14, 343, 644	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (e 28)	3, 041, 211	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			9, 919, 316	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			42, 945, 685	31.00

				T	0 06/30/2016	Date/Time Pre 11/21/2016 8:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS	1		11.050.107		11.01/.005	
	DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-MVBLE EQUIP		14, 250, 497 8, 910, 739			14, 316, 935 8, 910, 739	1.00 2.00
	DO300 OTHER CAP REL COSTS		0	0	0	0	3.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	477, 761	37, 026, 641		-45, 272	37, 459, 130	4.00
	DO500 ADMINISTRATIVE & GENERAL DO700 OPERATION OF PLANT	8, 368, 191 841, 962	20, 059, 510 13, 237, 453		-415, 124 0	28, 012, 577 14, 079, 415	5.00 7.00
	DO800 LAUNDRY & LINEN SERVICE	620, 873	305, 826			926, 699	8.00
	DO900 HOUSEKEEPING	94	4, 549, 383			4, 549, 477	9.00
	01000 DI ETARY 01100 CAFETERI A	241, 033	4,811,769	5, 052, 802 0	-3, 046, 840 3, 046, 840	2, 005, 962 3, 046, 840	
	D1300 NURSI NG ADMI NI STRATI ON	1, 736, 144	268, 463	-	0,040,040	2, 004, 607	13.00
	01400 CENTRAL SERVICES & SUPPLY	1, 262, 270	1, 138, 429			2, 400, 699	14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	3, 971, 354 1, 679, 406	641, 059 313, 458			4, 612, 413 1, 992, 864	15.00 16.00
	D2100 I &R SERVICES-SALARY & FRINGES APPRV	341, 638	261, 497			603, 135	21.00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	21, 460, 636 7, 432, 500	3, 232, 793 3, 713, 794			23, 580, 059 11, 146, 294	30.00 31.00
	D3102 NI CU	3, 072, 895	1, 325, 086			4, 397, 981	31.00
00 0	D3200 CORONARY CARE UNIT	1, 025, 869	432, 843	1, 458, 712	0	1, 458, 712	32.00
	04000 SUBPROVIDER - IPF	1, 100, 119	667,007			1, 767, 126	40.00
	04100 SUBPROVI DER – I RF 04300 NURSERY	1, 896, 709	109, 779 0	2, 006, 488	0 1, 113, 370	2, 006, 488 1, 113, 370	41.00 43.00
	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	04500 NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS	6, 521, 988	42, 945, 388	49, 467, 376	0	49, 467, 376	50.00
	D5100 RECOVERY ROOM	1, 455, 486	68, 649			1, 524, 135	
	D5200 DELIVERY ROOM & LABOR ROOM	2, 284, 391	271, 213		0	2, 555, 604	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	45, 423 4, 111, 676	3, 744, 045 1, 169, 729			3, 789, 468 5, 281, 405	53.00 54.00
	05402 ULTRASOUND	558, 049	64, 950			622, 999	54.02
	05403 NUCLEAR MEDICINE	693, 328	984, 899		0	1, 678, 227	
	D5600 RADI OI SOTOPE D5700 CT_SCAN	0 882, 179	0 178, 849	0 1, 061, 028	0	0 1, 061, 028	56.00 57.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	448, 710	51, 523			500, 233	58.00
	05900 CARDI AC CATHETERI ZATI ON	1, 185, 284	292, 145			1, 477, 429	
	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	1, 681, 480	12, 428, 029 1, 565, 644		0	14, 109, 509 1, 565, 644	60. 0 63. 0
	06400 I NTRAVENOUS THERAPY	1, 962, 045	1, 335, 033		Ű	3, 297, 078	
	06500 RESPI RATORY THERAPY	2, 578, 283	530, 647			3, 108, 930	
	D6600 PHYSI CAL THERAPY D6700 OCCUPATI ONAL THERAPY	2, 565, 128 1, 270, 029	210, 950 29, 984			2, 776, 078 1, 300, 013	66.00 67.00
	06800 SPEECH PATHOLOGY	414, 219	17, 411	431, 630		431, 630	68.0
	06900 ELECTROCARDI OLOGY	937, 969	157, 942		0	1, 095, 911	69.00
	06902 CARDI AC REHAB 06903 DI ABETI C EDUCATI ON	488, 159 181, 346	23, 369 347, 928			511, 528 529, 274	69.0 69.0
	D7000 ELECTROENCEPHALOGRAPHY	590, 016	274, 688		0	864, 704	70.0
00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 424, 557	7, 424, 557	0	7, 424, 557	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13, 794, 476		0	13, 794, 476	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	962, 035	19, 266, 151 346, 446		0	19, 266, 151 1, 308, 481	73.00
	03951 ECT	125, 238	4, 769		0	130, 007	76.00
	03950 MOBILE OUTREACH CLINIC	673, 038	106, 461	779, 499	0	779, 499	76.01
	DUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
	09000 CLINIC	507, 079	467, 967			975, 046	90.00
	09001 OUTPATIENT PSYCH 09002 PEDS CLINIC	45, 141	5, 215 0	50, 356 0	0	50, 356 0	90.01 90.02
	09002 PEDS CLINIC	311, 322	35, 277	-	0	346, 599	90.02
00 0	D9100 EMERGENCY	6, 606, 826	5, 249, 930	11, 856, 756	0	11, 856, 756	91.00
	09101 DI AGNOSTI C TREATMENT CENTER	1, 181, 285	800, 980	1, 982, 265	0	1, 982, 265	
	D9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			<u> </u>			92.00
00 0	09500 AMBULANCE SERVI CES	2, 580, 000	2, 300, 733	4, 880, 733	0	4, 880, 733	95.00
00 0	09700 DURABLE MEDICAL EQUIP-SOLD	809, 429	1, 433, 524			2, 242, 953	
	D9850 HOME OFFICE D9900 CMHC	19, 266, 796 0	40, 657, 408 0		393, 958 0	60, 318, 162 0	
00 V		. U	0	. 0	. UI	0	・ ファ い

11/21/2016 8:49 pm Y: \27100 - St. Mary's Medical Center - Evansville\300 - Medicare Cost Report\20160630\27100-16.mcrx

Health Financial Systems	ST. MARY'S MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der		Period:	Worksheet A	
				From 07/01/2015 To 06/30/2016	Date/Time Pre	narod
				10 00/30/2010	11/21/2016 8:	
Cost Center Description	Sal ari es	Other	Total (col.	I Reclassi fi cati		
			+ col. 2)	ons (See A-6)		
					(col. 3 +-	
	1.00	0.00		1.00	col . 4)	
	1.00	2.00	3.00	4.00	5.00	
SPECIAL PURPOSE COST CENTERS		0			0	10/ 00
106.00 10600 HEART ACQUI SI TI ON	110 452 021	0	202 205 7/	0 0 6 0		106.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	119, 452, 831	273, 842, 935	393, 295, 76	0 0	393, 295, 766	118.00
NONREI MBURSABLE COST CENTERS		0			0	191.00
191.00 19100 RESEARCH 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	17, 117, 254	8, 942, 663	26, 059, 91	7 0	26, 059, 917	
192.0019200 PHISICIANS PRIVATE OFFICES	17, 117, 234	0, 942, 003	20, 039, 91			192.00
194. 01 07951 APOTHECARY	492, 408	5, 199, 201	5, 691, 60		5, 691, 609	
194. 02 07952 OCCUPATI ONAL MEDI CI NE	1, 230, 468	671, 997			1, 902, 465	
194. 03 07953 CANCER CNETER/PHYSICIAN RECRUITMENT	1, 230, 400	071, 337	1, 902, 40			194.02
194. 04 07954 MARKETI NG	13, 981	27,098	41, 07	9 0	41,079	
194. 06 07956 MOB	89	421, 992			422, 081	
194. 07 07 957 SENI OR PARTNERS	0	0	122,00	0 0		194.07
194. 08 07958 ASCENSI ON PHYSI CI AN RECRUI TMENT	0	-1, 048, 959	-1,048,95	9 0	-1, 048, 959	
194. 09 07959 CONV CARE	5, 288, 357	2, 617, 686			7, 906, 043	
194. 10 07960 EMPLOYEE FI TNESS CENTER	0	0		0 0		194.10
194. 11 07961 ST ELI ZABETH	0	0		0 0	0	194.11
194. 14 07964 FREE STANDING CATH LAB	0	0		0 0	0	194.14
194. 15 07965 FAMILY PRACTICE	0	0		0 0	0	194. 15
194.17 07967 FOUNDATI ON/UNUSED SPACE	256, 364	-87, 951	168, 41	3 0	168, 413	194. 17
200.00 TOTAL (SUM OF LINES 118-199)	143, 851, 752	290, 586, 662	434, 438, 41	4 0	434, 438, 414	200. 00

CLASS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (ST. MARY'S ME DF EXPENSES		CCN: 150100	Period: From 07/01/2015	Worksheet A	-2552
					To 06/30/2016	Date/Time Pro 11/21/2016 8:	
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		- L	111/21/2010 0.	
C	GENERAL SERVICE COST CENTERS	0.00	7.00				
	00100 CAP REL COSTS-BLDG & FIXT	-4, 395, 017					1.
	00200 CAP REL COSTS-MVBLE EQUIP	1,900					2.
	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	-9, 148, 166	-				3.
	00500 ADMINI STRATI VE & GENERAL	47, 639, 758					5.
	00700 OPERATION OF PLANT	-401, 994					7.
	00800 LAUNDRY & LINEN SERVICE	-231, 686					8
	00900 HOUSEKEEPING	-357, 505					9
	01000 DI ETARY 01100 CAFETERI A	-110 -1, 834, 388					10
	01300 NURSI NG ADMI NI STRATI ON	-1, 834, 388					13
	01400 CENTRAL SERVICES & SUPPLY	1, 222					14
00 0	01500 PHARMACY	-112, 940	4, 499, 473				15
	01600 MEDICAL RECORDS & LIBRARY	-3, 222					16
	02100 I &R SERVICES-SALARY & FRINGES APPRV	-397	602, 738				21
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	-100, 089	23, 479, 970				30
	03100 I NTENSI VE CARE UNI T	-1, 308, 549					31
02 0	03102 NI CU	-56, 765	4, 341, 216				31
	03200 CORONARY CARE UNI T	-7					32
	04000 SUBPROVIDER - IPF	-7, 317					40
	04100 SUBPROVIDER - IRF 04300 NURSERY	-190, 488					41
	04400 SKI LLED NURSI NG FACI LI TY						44
	04500 NURSING FACILITY	C					45
	ANCILLARY SERVICE COST CENTERS		1				
	05000 OPERATING ROOM	-650, 459					50
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	2 254					51
	05300 ANESTHESI OLOGY	-3, 256					53
	05400 RADI OLOGY-DI AGNOSTI C	-1, 092, 567					54
	05402 ULTRASOUND	-12, 694					54
	05403 NUCLEAR MEDICINE	-11, 354					54
	05600 RADI OI SOTOPE	C	-				56
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	-5, 774					57
	05900 CARDI AC CATHETERI ZATI ON	-53, 926					59
	06000 LABORATORY	-546, 399					60
	06300 BLOOD STORING, PROCESSING & TRANS.	-2,640					63
	06400 I NTRAVENOUS THERAPY	-369, 378					64
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	-135 -4, 052					65
	06700 OCCUPATI ONAL THERAPY	-4,052	1 000 00/				67
	06800 SPEECH PATHOLOGY	- 4					68
	06900 ELECTROCARDI OLOGY	-104, 430					69
	06902 CARDI AC REHAB	-78, 321					69
	06903 DI ABETI C EDUCATI ON 07000 ELECTROENCEPHALOGRAPHY	-1, 742					69
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17,010	7, 424, 557				71
	07200 IMPL. DEV. CHARGED TO PATIENTS	C					72
1	07300 DRUGS CHARGED TO PATIENTS	C	1772007101				73
	07400 RENAL DI ALYSI S	-429, 621					74
	03951 ECT 03950 MOBILE OUTREACH CLINIC	-1 -147, 456					76
-	OUTPATIENT SERVICE COST CENTERS	-147,450	052,043				$+$ $^{\prime 0}$
00	08800 RURAL HEALTH CLINIC	C	0				88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0				89
	09000 CLINIC	-255, 240					90
	09001 OUTPATIENT PSYCH 09002 PEDS CLINIC	- 39, 061					90
	09002 PEDS CEINIC 09004 BARI ATRI CS	-93, 243	-				90
	09100 EMERGENCY	-4, 167, 982					91
	09101 DI AGNOSTI C TREATMENT CENTER	10, 385					91
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	OTHER REIMBURSABLE COST CENTERS	44 750	4.075.001				
	09500 AMBULANCE SERVI CES 09700 DURABLE MEDI CAL EQUI P-SOLD	-14, 752 -1, 081					95
	09850 HOME OFFICE	-60, 318, 162					98
	09900 CMHC	C					99
. 00	10100 HOME HEALTH AGENCY	C	0				101
	SPECIAL PURPOSE COST CENTERS						-
	10600 HEART ACQUISITION SUBTOTALS (SUM OF LINES 1-117)	42 700 220	-				106
3.00		-42, 709, 320	350, 586, 446				118

Health Financial Systems	ST. MARY'S ME	DICAL CENTER		In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 150100	Peri od:	Worksheet A
				From 07/01/2015	
				To 06/30/2016	Date/Time Prepared: 11/21/2016 8:49 pm
Cost Center Description	Adjustments	Net Expenses			11/21/2010 8.49 pli
cost center bescription		For Allocation			
	6.00	7.00			
NONREI MBURSABLE COST CENTERS	0.00	1 1100			
191. 00 19100 RESEARCH	0	0 0			191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	26, 059, 917			192.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0			194.00
194. 01 07951 APOTHECARY	0	5, 691, 609			194.01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	0	1, 902, 465			194.02
194.03 07953 CANCER CNETER/PHYSICIAN RECRUITMENT	0	0			194.03
194. 04 07954 MARKETI NG	0	41, 079			194.04
194.0607956 MOB	0	422, 081			194.06
194. 07 07957 SENI OR PARTNERS	0	0			194.07
194.08 07958 ASCENSION PHYSICIAN RECRUITMENT	0	-1, 048, 959			194.08
194.0907959 CONV CARE	0	7, 906, 043			194.09
194. 10 07960 EMPLOYEE FITNESS CENTER	0	0			194.10
194. 11 07961 ST ELI ZABETH	0	0			194. 11
194.14 07964 FREE STANDING CATH LAB	0	0			194.14
194. 15 07965 FAMILY PRACTICE	0	0			194. 15
194. 17 07967 FOUNDATI ON/UNUSED SPACE	0	168, 413			194. 17
200.00 TOTAL (SUM OF LINES 118-199)	-42, 709, 320	391, 729, 094			200.00

	Financial Systems		ST. MARY'S ME				u of Form CMS	
RECLAS	SIFICATIONS			Provi der	CCN: 150100	Period: From 07/01/2015	Worksheet A-	6
						To 06/30/2016	Date/Time Pr 11/21/2016 8	epared: :49 pm
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	B – CAFETERIA							
1.00	CAFETERIA	11.00	145, 343	2, 901, 497				1.00
	TOTALS		145, 343	2, 901, 497				
	C – NURSERY							
1.00	NURSERY	43.00	<u>951, 8</u> 66	<u> </u>				1.00
	TOTALS		951, 866	161, 504				
	D - RECLASS HOME OFFICE EXPEN	ISE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66, 438				1.00
2.00	HOME OFFICE	98.00	0	45, 272				2.00
3.00	HOME OFFICE	98.00	603, 846					3.00
4.00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>188, 7</u> 22				4.00
	TOTALS		603, 846					
500.00	Grand Total: Increases		1, 701, 055	3, 363, 433				500.00

Heal th	Financial Systems		ST. MARY'S ME	DI CAL CENTER		In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provi der	CCN: 150100	Period: From 07/01/2015	Worksheet A-	6
						To 06/30/2016	Date/Time Pr 11/21/2016 8	epared: :49 pm
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	B – CAFETERIA							
1.00	DI ETARY	10.00	145, 343	2, 901, 497		0		1.00
	TOTALS		145, 343	2,901,497				
	C – NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	95 <u>1, 8</u> 66	<u> </u>		o		1.00
	TOTALS		951, 866	161, 504				
	D - RECLASS HOME OFFICE EXPEN	ISE						
1.00	HOME OFFICE	98.00	0	66, 438	1	o		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45, 272		o		2.00
3.00	ADMI NI STRATI VE & GENERAL	5.00	603, 846	0		o		3.00
4.00	HOME_OFFICE	98.00	0	<u>188, 7</u> 22		o		4.00
	TOTALS		603, 846	300, 432				
500.00	Grand Total: Decreases		1, 701, 055	3, 363, 433				500.00

	Financial Systems	ST. MARY'S MED	OF CAL_CENTER		In Lie	eu of Form CMS-:	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150100	Period: From 07/01/2015 To 06/30/2016		pared:
				Acqui si ti on	S		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		_			
1.00	Land	7, 736, 792	0		0 0	0	1.00
2.00	Land Improvements	8, 228, 653	120, 108		0 120, 108	0	2.00
3.00	Buildings and Fixtures	175, 895, 163	6, 954, 321		0 6, 954, 321	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	139, 901, 421	3, 332, 625		0 3, 332, 625	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	331, 762, 029	10, 407, 054		0 10, 407, 054	0	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	331, 762, 029	10, 407, 054		0 10, 407, 054	0	
		Ending Balance					
			Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	7, 736, 792	0				1.00
2.00	Land Improvements	8, 348, 761	0				2.00
3.00	Buildings and Fixtures	182, 849, 484	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	o	0				5.00
6.00	Movable Equipment	143, 234, 046	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	342, 169, 083	0				8.00
9.00	Reconciling Items	0000	0				9.00
10.00		342, 169, 083	0				10.00

Heal th	Financial Systems	ST. MARY'S ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period:	Worksheet A-7	
					From 07/01/2015 To 06/30/2016		pared:
						11/21/2016 8:	49 pm
			SL	IMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	10.00	11.00		instructions)	
	DADT LL DECONCLULATION OF ANOUNTS FROM WOD	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR						
1.00	CAP REL COSTS-BLDG & FIXT	5, 015, 235				139, 570	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7, 158, 206	1, 714, 472		0 34, 350	0	2.00
3.00	Total (sum of lines 1-2)	12, 173, 441	6, 672, 210	4, 137, 27	7 35, 027	139, 570	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	14, 250, 497				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 711	8, 910, 739				2.00
3.00	Total (sum of lines 1-2)	3, 711		1			3.00

Health Financial Systems	ST. MARY'S ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet A-7 Part III Date/Time Prep 11/21/2016 8:4	pared:
	COM	PUTATION OF RAT	-1 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	198, 935, 037 143, 234, 046 342, 169, 083	0	143, 234, 04 342, 169, 08	6 0. 418606 3 1. 000000		1.00 2.00 3.00
	ALLOCA	TION OF OTHER O	APITAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS				5 004 474	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		0 4, 672, 288 0 7, 158, 206 0 11, 830, 494	5, 024, 176 1, 714, 472 6, 738, 648	1.00 2.00 3.00
		SL	IMMARY OF CAPI		0,100,010	0.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT	NTERS 85, 207				9, 921, 918	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0 85, 207	34, 350 35, 027		0 5, 611 0 5, 611	8, 912, 639 18, 834, 557	2.00 3.00

ADJUST	MENTS TO EXPENSES				eriod: rom 07/01/2015	Worksheet A-8	
					o 06/30/2016	Date/Time Pre 11/21/2016 8:4	
				Expense Classification on To/From Which the Amount is			
					,		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В		CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		O		0.00	0	7.00
	stations excluded) (chapter 21)		-			-	
8.00	Television and radio service (chapter 21)	А	-11, 550	ADMI NI STRATI VE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	
10.00	Provider-based physician adjustment	A-8-2	-13, 496, 318	3		0	
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-3, 217, 868	3		0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -1,635,366		0.00 11.00	0	
15.00	Rental of quarters to employee		1, 033, 300		0.00	0	
16.00	and others Sale of medical and surgical	В	-1, 684	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
	supplies to other than patients						
17.00	Sale of drugs to other than patients	В	-109, 511	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	В	-3, 111	MEDI CAL RECORDS & LI BRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20. 00 21. 00	Vending machines Income from imposition of		0		0.00 0.00	0	20.00
21.00	interest, finance or penalty		0		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
24 00	(chapter 21)		0		1.00	0	
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT	1.00	0	
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 29.00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00	0	28.00 29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
20.00	limitation (chapter 14)		~		20.00		20.00
30.99	Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
33.00	Depreciation and Interest		ſ		0.00	0	33.00
	MISC INCOME - OTHER A&G	В	-114, 449	ADMI NI STRATI VE & GENERAL	5.00	-	33.01

Health Financial Systems ADJUSTMENTS TO EXPENSES		ST. MARY'S ME	Provider CCN: 150100 P	eriod:	u of Form CMS-: Worksheet A-8	
			T T	rom 07/01/2015 o 06/30/2016	Date/Time Pre 11/21/2016 8:	
			Expense Classification on To/From Which the Amount is			
				to be Aujusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
· .	1.00	2.00	3.00	4.00	5.00	
33. 02 MI SC I NCOME - PLANT 33. 03 MI SC I NCOME - LAUNDRY	B		OPERATION OF PLANT	7.00 8.00	0	
33. 04 MISC INCOME - HOUSEKEEPING	В	-669	HOUSEKEEPI NG	9.00	0	33.04
33. 05 MISC INCOME - NURSING ADMIN 33. 06 MISC INCOME - I&R	B		NURSING ADMINISTRATION	13.00 21.00		33.05 33.06
			FRINGES APPRV			
33.07 MISC INCOME - ADULTS & PEDS 33.08 MISC INCOME - IPF	B		ADULTS & PEDIATRICS SUBPROVIDER – IPF	30. 00 40. 00		1
33.10 MISC INCOME - IRF	В	-14, 343	SUBPROVI DER – I RF	41.00	0	33. 10
33.11 MISC INCOME - L&D 33.12 MISC INCOME - RADIOLOGY	B		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52.00 54.00	0	33. 11 33. 12
33.13 MISC INCOME - ULTRASOUND	В	-12, 689	ULTRASOUND	54.02		33.13
33. 14 MISC INCOME - CARDIAC CATH 33. 15 MISC INCOME - LAB	B		CARDIAC CATHETERIZATION	59.00 60.00	0	
33. 16 MISC INCOME - IV THERAPY	B		INTRAVENOUS THERAPY	64.00		33.16
33. 17MI SC I NCOME - RT33. 18MI SC I NCOME - CARDI AC REHAB	B		RESPI RATORY THERAPY CARDI AC REHAB	65.00 69.02	0	33. 17 33. 18
33. 19 MISC INCOME - CARDIAC REHAD	В		DIABETIC EDUCATION	69.02	-	
EDUCATION 33.20 MISCINCOME - RENAL	В	420, 600		74.00	0	33. 20
33.20 MISC INCOME - RENAL 33.21 MISC INCOME - MOBILE CLINIC	В		RENAL DIALYSIS MOBILE OUTREACH CLINIC	74.00 76.01	0	1
33. 22 MISC INCOME - OP PSYCH	В		OUTPATIENT PSYCH	90.01	0	33.22
33. 23 MISC INCOME - ER 33. 25 MISC INCOME - AMBULANCE	B		EMERGENCY AMBULANCE SERVICES	91.00 95.00	0 0	33.23 33.25
33. 27 ADVERTISING - OTHER A&G	A	-195, 282	ADMI NI STRATI VE & GENERAL	5.00		33. 27
33. 28 ADVERTISING - NURSING ADMIN 33. 29 ADVERTISING - MEDICAL RECORDS	A A		NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY	13.00 16.00		
33. 30 ADVERTISING - A&P	Â		ADULTS & PEDIATRICS	30.00		
33. 31 ADVERTISING - PSYCH	A		SUBPROVIDER - IPF	40.00		
33. 32 ADVERTISING - REHAB 33. 33 ADVERTISING - OR	A A		SUBPROVIDER – IRF OPERATING ROOM	41.00 50.00	0	33.32 33.33
33. 34 ADVERTISING - RADIOLOGY	A	-859	RADI OLOGY-DI AGNOSTI C	54.00		33.34
33. 35 ADVERTISING - IV THERAPY 33. 36 ADVERTISING - PT	A A		I NTRAVENOUS THERAPY PHYSI CAL THERAPY	64.00 66.00	0	
33. 37 ADVERTISING - ER	A	-795	EMERGENCY	91.00	0	33. 37
33.38 ADVERTISING - DME 33.39 VARIOUS N/A EXP - EMPLOYEE	A		DURABLE MEDICAL EQUIP-SOLD	97.00 4.00	0	
BENEFI TS						
33. 40 VARIOUS N/A EXP- A&G 33. 41 VARIOUS N/A EXP - PLANT OPS	A A		ADMINISTRATIVE & GENERAL	5.00 7.00		
33. 42 VARIOUS N/A EXP - DIETARY	Â		DIETARY	10.00		
33. 43 VARIOUS N/A EXP - NURSING ADMIN	A	-1, 596	NURSING ADMINISTRATION	13.00	0	33.43
33. 44 VARIOUS N/A EXP - CS & SUPPLY	A	-175	CENTRAL SERVICES & SUPPLY	14.00	0	33.44
33. 45VARIOUS N/A EXP - PHARMACY33. 46VARIOUS N/A EXP - MEDICAL	A A		PHARMACY MEDICAL RECORDS & LIBRARY	15.00 16.00		
RECORDS	A	-50	MEDICAL RECORDS & EIDRART	10.00		33.40
33. 47 VARIOUS N/A EXP - A&P 33. 48 VARIOUS N/A EXP - I CU	A		ADULTS & PEDIATRICS	30.00		
33. 48 VARIOUS N/A EXP - ICU 33. 49 VARIOUS N/A EXP - NICU	A A		NI NTENSI VE CARE UNI T	31.00 31.02		
33.50 VARIOUS N/A EXP - PSYCH	A		SUBPROVIDER - IPF	40.00		
33. 51 VARIOUS N/A EXP - REHAB 33. 52 VARIOUS N/A EXP - OR	A A		SUBPROVIDER – IRF	41.00 50.00		
33.53 VARIOUS N/A EXP - DELIVERY &	A		DELIVERY ROOM & LABOR ROOM	52.00		
LABOR 33. 54 VARIOUS N/A EXP - RADIOLOGY	А	-7.844	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 54
33. 55 VARIOUS N/A EXP - IV THERAPY	A		INTRAVENOUS THERAPY	64.00	0	33.55
33. 56 VARIOUS N/A EXP - RT 33. 57 VARIOUS N/A EXP - PT	A A		RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00		
33.58 VARIOUS N/A EXP - EEG	A		ELECTROENCEPHALOGRAPHY	70.00		
33. 59 VARIOUS N/A EXP - MOBILE	A		MOBILE OUTREACH CLINIC	76.01	0	33. 59
OUTREACH 33.60 VARIOUS N/A EXP - CLINIC	А	-2, 441	CLINIC	90.00	0	33.60
33. 61 VARIOUS N/A EXP - BARIATRICS	A	-83	BARI ATRI CS	90.04	0	33.61
33. 62 VARIOUS N/A EXP - ER 33. 63 VARIOUS N/A EXP - DIAG TREAT	A		EMERGENCY	91.00 91.01	0	
CENTER						
33. 64 VARIOUS N/A EXP - AMBULANCE 33. 65 PV LAB BENEFITS	A A		AMBULANCE SERVICES	95.00 4.00		
SS. SS IN END DEMENTIO		1 132,171	I STEL DENELLIS DELANTMENT	4.00	. 0	1 55.05

.67 PR. .68 LO. .69 PH. .70 PH. .71 PH. .72 PH. .73 PH. .74 PH. .75 PH. .76 PA. .77 PA. .78 PA. .80 PA. .81 PA. .82 PA. .83 PA. .84 PA. .85 PA. .84 PA. .85 PA. .86 PA. .87 PA. .88 PA. .89 PA. .90 PA. .91 PA. .92 PA. .93 PA.	Cost Center Description ROVIDER ASSESSMENT ROFESSIONAL LIABILITY OBBYING YSICIAN BILLING YSICIAN BILLIN	Basi s/Code (2) 1.00 A A A A A A A A A A A A A	-237, 165 -5, 633 -424 -7, 270 -48, 430 134 -1, 500 -6, 564 -5, 143 -1 -33, 441 -20	Expense CI assi fi cati on on To/From Which the Amount is Cost Center 3.00 ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL ADULTS & PEDI ATRI CS I NTENSI VE CARE UNI T NI CU SUBPROVI DER - I PF DI ABETI C EDUCATI ON	to be Adjusted	Date/Time Pre 11/21/2016 8: Wkst. A-7 Ref. 5.00 C C C C C C C C C C C C C C C C C C	49 pm 0 33.0 0 33.0 0 33.0 0 33.0 0 33.0
.67 PR. .68 LO. .69 PH. .70 PH. .71 PH. .72 PH. .73 PH. .74 PH. .75 PH. .76 PA. .77 PA. .78 PA. .80 PA. .81 PA. .82 PA. .83 PA. .84 PA. .85 PA. .84 PA. .85 PA. .86 PA. .87 PA. .88 PA. .89 PA. .90 PA. .91 PA. .92 PA. .93 PA.	ROVI DER ASSESSMENT ROFESSI ONAL LI ABILI TY DBBYI NG YYSI CI AN BILLI NG IYSI CI AN BILLI NG IYI ENT PHONES IT ENT PHONES	1.00 A A A A A A A A A A A A A A A A A A	2.00 -14,116,347 -237,165 -5,633 -424 -7,270 -48,430 134 -1,500 -6,564 -5,143 -1 -33,441 -20	To/From Which the Amount is Cost Center 3.00 ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS INTENSIVE CARE UNIT NICU SUBPROVIDER - IPF DIABETIC EDUCATION CLINIC BARIATRICS	to be Adjusted <u>Line #</u> <u>4.00</u> <u>5.00</u> <u>5.00</u> <u>5.00</u> <u>30.00</u> <u>31.02</u> <u>40.00</u> <u>69.03</u>	5.00 C C C C C C C C C C C C C C C C C C) 33. () 33. () 33. (
.67 PR. .68 LO. .69 PH. .70 PH. .71 PH. .72 PH. .73 PH. .74 PH. .75 PH. .76 PA. .77 PA. .78 PA. .80 PA. .81 PA. .82 PA. .83 PA. .84 PA. .85 PA. .84 PA. .85 PA. .86 PA. .87 PA. .88 PA. .89 PA. .90 PA. .91 PA. .92 PA. .93 PA.	ROVI DER ASSESSMENT ROFESSI ONAL LI ABILI TY DBBYI NG YYSI CI AN BILLI NG IYSI CI AN BILLI NG IYI ENT PHONES IT ENT PHONES	1.00 A A A A A A A A A A A A A A A A A A	2.00 -14,116,347 -237,165 -5,633 -424 -7,270 -48,430 134 -1,500 -6,564 -5,143 -1 -33,441 -20	3.00 ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL ADULTS & PEDI ATRI CS I NTENSI VE CARE UNI T NI CU SUBPROVI DER - I PF DI ABETI C EDUCATI ON CLI NI C BARI ATRI CS	4.00 5.00 5.00 30.00 31.00 31.02 40.00 69.03	5.00 C C C C C C C C C C C C C C C C C C) 33.) 33.) 33.
.67 PR. .68 LO. .69 PH. .70 PH. .71 PH. .72 PH. .73 PH. .74 PH. .75 PH. .76 PA. .77 PA. .78 PA. .80 PA. .81 PA. .82 PA. .83 PA. .84 PA. .85 PA. .84 PA. .85 PA. .86 PA. .87 PA. .88 PA. .89 PA. .90 PA. .91 PA. .92 PA. .93 PA.	ROVI DER ASSESSMENT ROFESSI ONAL LI ABILI TY DBBYI NG YYSI CI AN BILLI NG IYSI CI AN BILLI NG IYI ENT PHONES IT ENT PHONES	1.00 A A A A A A A A A A A A A A A A A A	2.00 -14,116,347 -237,165 -5,633 -424 -7,270 -48,430 134 -1,500 -6,564 -5,143 -1 -33,441 -20	3.00 ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL ADULTS & PEDI ATRI CS I NTENSI VE CARE UNI T NI CU SUBPROVI DER - I PF DI ABETI C EDUCATI ON CLI NI C BARI ATRI CS	4.00 5.00 5.00 30.00 31.00 31.02 40.00 69.03	5.00 C C C C C C C C C C C C C C C C C C) 33. 33. 33. 33.
.67 PR. .68 LO. .69 PH. .70 PH. .71 PH. .72 PH. .73 PH. .74 PH. .75 PH. .76 PA. .77 PA. .78 PA. .80 PA. .81 PA. .82 PA. .83 PA. .84 PA. .85 PA. .84 PA. .85 PA. .86 PA. .87 PA. .88 PA. .89 PA. .90 PA. .91 PA. .92 PA. .93 PA.	ROFESSIONAL LIABILITY DBBYING IYSICIAN BILLING IYSICIAN BILLING	A A A A A A A A A A A A A A A A A A	-14, 116, 347 -237, 165 -5, 633 -424 -7, 270 -48, 430 134 -1, 500 -6, 564 -5, 143 -1 -33, 441 -20	ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL ADULTS & PEDI ATRI CS I NTENSI VE CARE UNI T NI CU SUBPROVI DER - I PF DI ABETI C EDUCATI ON CLI NI C BARI ATRI CS	5.00 5.00 30.00 31.00 31.02 40.00 69.03) 33.) 33.) 33.
.68 LO .69 PH .70 PH .71 PH .72 PH .73 PH .74 PH .75 PH .76 PA .77 PA .78 PA .80 PA .81 PA .82 PA .83 PA .84 PA .85 PA .84 PA .85 PA .84 PA .85 PA .84 PA .85 PA .86 PA .87 PA .88 PA .89 PA .90 PA .91 PA .92 PA .93 PA	DBBYING IYSICIAN BILLING IYSICIAN BILLING IYS	A A A A A A A A A A A A	-5, 633 -424 -7, 270 -48, 430 134 -1, 500 -6, 564 -5, 143 -1 -33, 441 -20	ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS INTENSIVE CARE UNIT NICU SUBPROVIDER - IPF DIABETIC EDUCATION CLINIC BARIATRICS	5.00 30.00 31.00 31.02 40.00 69.03) 33.) 33.
.69 PH .70 PH .71 PH .72 PH .73 PH .73 PH .74 PH .75 PH .76 PA .77 PA .78 PA .79 PA .80 PA .81 PA .82 PA .83 PA .84 PA .85 PA .84 PA .85 PA .86 PA .87 PA .88 PA .89 PA .89 PA .89 PA .90 PA .91 PA .92 PA .93 PA	IYSI CI AN BILLING IYSI CI AN BI	A A A A A A A A A A A	-424 -7, 270 -48, 430 134 -1, 500 -6, 564 -5, 143 -1 -33, 441 -20	ADULTS & PEDIATRICS INTENSIVE CARE UNIT NICU SUBPROVIDER - IPF DIABETIC EDUCATION CLINIC BARIATRICS	30. 00 31. 00 31. 02 40. 00 69. 03	C C C	33.
.70 PH .71 PH .72 PH .73 PH .74 PH .75 PH .76 PA .77 PA .78 PA .79 PA .80 PA .81 PA .82 PA .83 PA .84 PA .85 PA .86 PA .87 PA .88 PA .89 PA .90 PA .91 PA .92 PA .93 PA	IYSI CI AN BILLING IYSI CI AN BI	A A A A A A A A A	-7, 270 -48, 430 134 -1, 500 -6, 564 -5, 143 -1 -33, 441 -20	INTENSIVE CARE UNIT NICU SUBPROVIDER - IPF DIABETIC EDUCATION CLINIC BARIATRICS	31. 02 40. 00 69. 03	C) 33
. 72 PH . 73 PH . 74 PH . 75 PH . 76 PA . 77 PA . 78 PA . 79 PA . 80 PA . 82 PA . 83 PA . 84 PA . 85 PA . 86 PA . 87 PA . 88 PA . 89 PA . 90 PA . 91 PA . 92 PA	IYSI CI AN BILLING IYSI CI AN BILLING IYSI CI AN BILLING IYSI CI AN BILLING IYSI CI AN BILLING ITI ENT PHONES ITI ENT PHONES	A A A A A A A A	134 -1, 500 -6, 564 -5, 143 -1 -33, 441 -20	SUBPROVIDER - IPF DIABETIC EDUCATION CLINIC BARIATRICS	40. 00 69. 03		
.73 PH .74 PH .75 PH .76 PA .77 PA .78 PA .80 PA .82 PA .83 PA .84 PA .85 PA .86 PA .87 PA .88 PA .89 PA .90 PA .91 PA .92 PA .93 PA	IYSI CI AN BI LLING IYSI CI AN BI LLING IYSI CI AN BI LLING IYSI CI AN BI LLING ITI ENT PHONES ITI ENT PHONES	A A A A A A A	-1, 500 -6, 564 -5, 143 -1 -33, 441 -20	DI ABETI C EDUCATI ON CLI NI C BARI ATRI CS	69.03	L L	
.74 PH .75 PH .76 PA .77 PA .78 PA .79 PA .80 PA .81 PA .82 PA .83 PA .84 PA .85 PA .86 PA .87 PA .88 PA .89 PA .89 PA .90 PA .91 PA .92 PA .93 PA	IYSI CI AN BI LLI NG IYSI CI AN BI LLI NG ITI ENT PHONES ITI ENT PHONES	A A A A A A	-6, 564 -5, 143 -1 -33, 441 -20	CLINIC BARIATRICS		C	
.76 PA .77 PA .78 PA .79 PA .80 PA .81 PA .82 PA .83 PA .84 PA .85 PA .86 PA .87 PA .88 PA .89 PA .90 PA .91 PA .92 PA .93 PA	ATI ENT PHONES ATI ENT PHONES	A A A A	-5, 143 -1 -33, 441 -20	BARI ATRI CS		C	
.77 PA .78 PA .79 PA .80 PA .81 PA .82 PA .83 PA .84 PA .85 PA .86 PA .87 PA .88 PA .89 PA .89 PA .89 PA .89 PA .90 PA .91 PA .92 PA .93 PA	ATI ENT PHONES ATI ENT PHONES	A A A A	-33, 441 -20	EMPLOYEE BENEFITS DEPARTMENT	90.04	C	33.
.78 PA .79 PA .80 PA .81 PA .82 PA .83 PA .84 PA .85 PA .86 PA .87 PA .88 PA .89 PA .90 PA .91 PA .92 PA .93 PA	ATI ENT PHONES ATI ENT PHONES ATI ENT PHONES ATI ENT PHONES ATI ENT PHONES ATI ENT PHONES ATI ENT PHONES	A A A	-20		4.00	C	
. 79 PA . 80 PA . 81 PA . 82 PA . 83 PA . 84 PA . 85 PA . 86 PA . 87 PA . 88 PA . 90 PA . 91 PA . 92 PA	NTI ENT PHONES NTI ENT PHONES NTI ENT PHONES NTI ENT PHONES NTI ENT PHONES NTI ENT PHONES	A A		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	C	
.81 PA .82 PA .83 PA .84 PA .85 PA .86 PA .87 PA .88 PA .89 PA .90 PA .91 PA .92 PA	NTI ENT PHONES NTI ENT PHONES NTI ENT PHONES NTI ENT PHONES		-1	LAUNDRY & LINEN SERVICE	8.00	C	
.82 PA .83 PA .84 PA .85 PA .86 PA .87 PA .88 PA .90 PA .91 PA .92 PA	ATI ENT PHONES ATI ENT PHONES ATI ENT PHONES			DI ETARY	10.00	C	
. 83 PA . 84 PA . 85 PA . 85 PA . 87 PA . 87 PA . 88 PA . 89 PA . 90 PA . 91 PA . 92 PA . 93 PA	ATI ENT PHONES ATI ENT PHONES	A		NURSING ADMINISTRATION	13.00	C	
. 84 PA . 85 PA . 86 PA . 87 PA . 88 PA . 89 PA . 90 PA . 91 PA . 92 PA . 93 PA	TI ENT PHONES	A A		CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	C C	
. 87 PA . 88 PA . 89 PA . 90 PA . 91 PA . 92 PA . 93 PA		A	-1 -7	MEDICAL RECORDS & LIBRARY I&R SERVICES-SALARY &	16. 00 21. 00	C	33.
. 87 PA . 88 PA . 89 PA . 90 PA . 91 PA . 92 PA . 93 PA	TI ENT PHONES	А		FRINGES APPRV ADULTS & PEDIATRICS	30.00	C	33.
. 88 PA . 89 PA . 90 PA . 91 PA . 92 PA . 93 PA	ATIENT PHONES	A		INTENSIVE CARE UNIT	31.00		
. 90 PA . 91 PA . 92 PA . 93 PA	TI ENT PHONES	A	-8, 129		31.02	C	
. 91 PA . 92 PA . 93 PA	TI ENT PHONES	А		CORONARY CARE UNIT	32.00	C	
. 92 PA . 93 PA	ATLENT PHONES	A A		SUBPROVI DER – I PF SUBPROVI DER – I RF	40. 00 41. 00	C	
. 93 PA	ATIENT PHONES	A		OPERATING ROOM	50.00	C	
	TI ENT PHONES	A		DELIVERY ROOM & LABOR ROOM	52.00	C	
1	TI ENT PHONES	А		RADI OLOGY-DI AGNOSTI C	54.00	C	
	ATLENT PHONES	A		ULTRASOUND NUCLEAR MEDICINE	54.02 54.03	C C	
-	ATIENT PHONES	A		CT SCAN	57.00	C	
1	TI ENT PHONES	А	-29	CARDIAC CATHETERIZATION	59.00	C	34.
	ATIENT PHONES	A			60.00	C	
	ATLENT PHONES	A A		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	64.00 65.00		
	TI ENT PHONES	A		PHYSICAL THERAPY	66.00	C	
	TI ENT PHONES	А		OCCUPATI ONAL THERAPY	67.00	C	
	ATIENT PHONES	A		SPEECH PATHOLOGY	68.00	C	
	ATLENT PHONES	A A		ELECTROCARDI OLOGY CARDI AC REHAB	69.00 69.02		
	TI ENT PHONES	A		DIABETIC EDUCATION	69.03	C	
	TI ENT PHONES	А		ELECTROENCEPHALOGRAPHY	70.00	C	
	ATLENT PHONES	A A		RENAL DI ALYSI S ECT	74.00 76.00	C	
	TI ENT PHONES	A		MOBILE OUTREACH CLINIC	76.01	C	
. 17 PA	TI ENT PHONES	A	- 1	CLINIC	90.00	C	34
1	ATLENT PHONES	A			90.04	C	
1	ATLENT PHONES	A A		EMERGENCY DIAGNOSTIC TREATMENT CENTER	91.00 91.01		
1	ATIENT PHONES	A		AMBULANCE SERVICES	91.01	C	
. 22 PA	TI ENT PHONES	А	-777	DURABLE MEDICAL EQUIP-SOLD	97.00	C	34.
		A		EMPLOYEE BENEFITS DEPARTMENT	4.00	C	
. 24 SE . 25	ELF-INSURANCE	A	-9, 948, 309 0	EMPLOYEE BENEFITS DEPARTMENT	4.00 0.00		
. 26			0		0.00	C	
. 27			0		0.00	C	
. 28			0		0.00	C	
. 29 . 30			0		0.00 0.00	C	
. 00 T0 [*] (T)TAL (sum of lines 1 thru 49) ransfer to Worksheet A,		-42, 709, 320		0.00		50.
	olumn 6, line 200.)					<u> </u>	1
	ription - all chapter referend s for adjustment (see instruc		umn pertain to	CMS Pub. 15-1.			
	ts - if cost, including applic						

Health Financial Systems		ST. MARY'S ME	DI CAL_CENTER	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Period: From 07/01/2015	Worksheet A-8	
					Date/Time Prep 11/21/2016 8:4	pared: 49 pm
			Expense Classification o			
			To/From Which the Amount is	s to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
·	1.00	2.00	3.00	4.00	5.00	

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

Heal th	Financial Systems	ST. MARY'S M	EDI CAL CENTER	In Lie	eu of Form CMS-	2552-10
STATEME OFFICE			ME Provider CCN: 150100	Period: From 07/01/2015 To 06/30/2016	11/21/2016 8:	pared:
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	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 (ORGANIZATIONS OR	CLAI MED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ST. MARY'S HOME OFFICE	0	342, 947	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ST. MARY'S HOME OFFICE	0	3, 769, 260	2.00
3.00	7.00	OPERATION OF PLANT	ST. MARY'S HOME OFFICE	0	1, 056, 141	3.00
4.00	9.00	HOUSEKEEPING	ST. MARY'S HOME OFFICE	0	356, 836	4.00
4.01	11.00	CAFETERIA	ST. MARY'S HOME OFFICE	0	199, 022	4.01
4.02	98.00	HOME OFFICE	ST. MARY'S HOME OFFICE	0	60, 318, 162	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	ST. MARY'S HOME OFFICE	0	9, 488	4.03
4.04	0.00			0	0	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	ST. MARY'S HOME OFFICE	63, 390, 874	0	4.05
4.06	0.00			0	0	4.06
4.07	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION BOND AMORTIZATION	3, 836, 177	4, 137, 089	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	0	483, 597	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	0	171, 515	4.12
4.13	0.00			0	0	4.13
4.14	7.00	OPERATION OF PLANT	TRIMEDX	9, 589, 427	8, 629, 559	4.14
4.15	14.00	CENTRAL SERVICES & SUPPLY	TRIMEDX	30, 820	27, 735	4.15
4.16	50.00	OPERATING ROOM	TRIMEDX	81, 977	73, 772	4.16
4.18	65.00	RESPI RATORY THERAPY	TRIMEDX	5, 545	4, 990	4.18
4.19	91.01	DIAGNOSTIC TREATMENT CENTER	TRIMEDX	104, 634	94, 161	4.19
4.20	2.00	CAP REL COSTS-MVBLE EQUIP	TRIMEDX	11, 388	0	4.20
4.21	4.00	EMPLOYEE BENEFITS DEPARTMENT	TRIMEDX	-31, 585	-28, 423	4.21
4.22	0.00			0	0	4.22
4.23	4.00	EMPLOYEE BENEFITS DEPARTMENT	AH COSTS	0	591, 274	4.23
5.00	0		0	77, 019, 257	80, 237, 125	5.00

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

1100										
				Related Organization(s) and/	or Home Office					
	Symbol (1)	Name	Percentage of	Name	Percentage of					
			Ownershi p		Ownershi p					
	1.00	2.00	3.00	4.00	5.00					

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	В	0.00 ST MARY'S HLTH 100.00	6.00
7.00	В	0.00 ASCENSI 0N 100.00	7.00
8.00	В	0. 00 ST VINCENT HLTH 100. 00	8.00
9.00	А	0. 00 TRI MEDX 0. 00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

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

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

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

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

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

Health Financial Systems	ST. MARY'S MEDICAL CENTER	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELA OFFICE COSTS	TED ORGANIZATIONS AND HOME Provider CCN: 150100	Period: Worksheet A-8-1 From 07/01/2015 To 06/30/2016 Date/Time Prepared:

					10 00/30/2016 Dat	21/2016 8:49 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			ENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED O	RGANIZATIONS OR CLAI	MED
	HOME OFFICE CO					
1.00	-342, 947					1.00
2.00	-3, 769, 260					2.00
3.00	-1, 056, 141					3.00
4.00	-356, 836					4.00
4.01	-199, 022					4. 01
4.02	-60, 318, 162					4. 02
4.03	-9, 488					4.03
4.04	0	0				4.04
4.05	63, 390, 874	0				4.05
4.06	0	0				4.06
4.07	-300, 912	11				4.07
4.08	0	0				4.08
4.09	0	0				4.09
4.10	0	0				4.10
4.11	-483, 597					4.11
4.12	-171, 515	0				4.12
4.13	0					4.13
4.14	959, 868					4.14
4.15	3, 085					4. 15
4.16	8, 205					4.16
4.18	555					4.18
4.19	10, 473					4.19
4.20	11, 388					4.20
4.21	-3, 162	0				4. 21
4.22	0					4. 22
4.23	-591, 274					4. 23
5.00	-3, 217, 868					5.00

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

nas not	been posted to worksheet A,	corumns r and/or 2,	, the amount	arrowabre	should be	I ndi cated	in coiumn	4 OF THE	s part.	
	Related Organization(s)									
	and/or Home Office									
	Type of Business	1								
	51									
	6.00	1								
			AND (00 110115	0551.05						

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

rerinbur	Sement under title Aviii.	
6.00	SYSTEM HOME OFF	6.00
7.00	ADMI NI STRATI ON	7.00
8.00	CASHI ERI NG/AR	8.00
9.00	TECHNOLOGY MGMT	9.00
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.

Heal th	Fi	nanci a	I Sys	tems	
PROVI D	FR	BASED	PHYSI	CLAN	AD JUSTME

ST. MARY'S MEDICAL CENTER In Lieu of Form CMS-2552-10

	Financial Syste		SI. MARY'S M	DICAL CENTER	001 450400		eu of Form CMS-	
PROVI DE	ER BASED PHYSIC	IAN ADJUSIMENI		Provi der	1	Period: From 07/01/2015 Fo 06/30/2016		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component		Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMINISTRATIVE & GENERAL	554, 031	554, 031				1.00
2.00	30.00	ADULTS & PEDIATRICS	3, 600	3, 600	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	1, 299, 268	1, 299, 268	0	0	0	3.00
4.00	41.00	SUBPROVIDER – IRF	171, 912	171, 912	0	0	0	4.00
5.00	50.00	OPERATING ROOM	646, 107	646, 107	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	1, 300	1, 300	0	0	0	6.00
7.00	53.00	ANESTHESI OLOGY	3, 743, 168	3, 743, 168	0	0	0	7.00
8.00		RADI OLOGY-DI AGNOSTI C	1, 008, 636			0	0	8.00
9.00		NUCLEAR MEDICINE	11, 352				0	9.00
10.00		CT SCAN	5, 764				0	10.00
11.00		CARDIAC CATHETERIZATION	46, 247				0	11.00
12.00		LABORATORY	341, 906				-	12.00
13.00	63.00	BLOOD STORING, PROCESSING &	2, 640	2, 640	0	0	0	13.00
14.00	64.00	TRANS. I NTRAVENOUS THERAPY	369, 032	369, 032	0	0	0	14.00
14.00		ELECTROCARDI OLOGY	104, 419				0	15.00
16.00		ELECTROENCEPHALOGRAPHY	17,000		-		0	16.00
17.00		MOBILE OUTREACH CLINIC	103, 423		-		0	17.00
18.00		CLINIC	246, 234		-		°,	18.00
19.00		OUTPATIENT PSYCH	4, 500			0	0	19.00
20.00		BARI ATRI CS	88, 015			0	0	20.00
21.00		EMERGENCY	4, 131, 709			0	0	21.00
22.00		AMBULANCE SERVICES	3, 385			0	0	22.00
23.00		EMPLOYEE BENEFITS DEPARTMENT	592, 670			0	0	23.00
200.00			13, 496, 318				0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1 00	1.00		8.00	9.00	12.00	13.00	14.00	1 00
1.00 2.00		ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	0				-	1.00 2.00
2.00 3.00		INTENSIVE CARE UNIT	0				-	2.00
4.00		SUBPROVIDER - IRF	0				0	3.00 4.00
4.00 5.00		OPERATI NG ROOM	0				0	5.00
6.00		DELIVERY ROOM & LABOR ROOM	0	0		0	0	6.00
7.00		ANESTHESI OLOGY	0	0	-	0	0	7.00
8.00		RADI OLOGY-DI AGNOSTI C	0			0	0	8.00
9.00		NUCLEAR MEDI CI NE	0	0		0	0	9.00
10.00		CT SCAN	0	0	0	0	0	10.00
11.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	11.00
12.00	60.00	LABORATORY	0	0	0	0	0	12.00
13.00	63.00	BLOOD STORING, PROCESSING &	0	0	0	0	0	13.00
		TRANS.						
14.00		INTRAVENOUS THERAPY	0				-	
15.00		ELECTROCARDI OLOGY	0				-	15.00
16.00		ELECTROENCEPHALOGRAPHY	0				-	16.00
17.00		MOBILE OUTREACH CLINIC	0	-			-	17.00
18.00		CLINIC OUTPATIENT PSYCH	0	0	0	0	0	18. 00 19. 00
19. 00 20. 00		BARI ATRI CS	0	0	0	0	0	20.00
20.00		EMERGENCY	0	0	0		0	20.00
21.00		AMBULANCE SERVICES		0	0	0	0	21.00
23.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	
200.00			0	0		-	-	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I 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		ADMINISTRATIVE & GENERAL	0					1.00
2.00		ADULTS & PEDIATRICS	0					2.00
3.00		INTENSIVE CARE UNIT	0					3.00
4.00		SUBPROVIDER - IRF	0	-	0	171, 912		4.00
5.00		OPERATING ROOM	0			646, 107		5.00
6.00		DELIVERY ROOM & LABOR ROOM	0	-	-	1,300		6.00
7.00			0	0				7.00
8.00		RADI OLOGY-DI AGNOSTI C	0	-				8.00
9.00		NUCLEAR MEDICINE	0	0		11, 352		9.00
10.00		CT SCAN CARDI AC CATHETERI ZATI ON	0					10.00
11. 00 12. 00		LABORATORY	0					11. 00 12. 00
12.00	1 00.00		0	0	0	1 341,700	I	12.00

Heal th	Financial Syste	ems	ST. MARY'S ME	EDI CAL CENTER		In Lie	eu of Form CMS-2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi dei	- CCN: 150100	Peri od:	Worksheet A-8-2
						From 07/01/2015 To 06/30/2016	
	Wkst. A Line #	, , , , , , , , , , , , , , , , , , ,	Provi der	Adjusted RCE	RCE	Adjustment	
		I denti fi er	Component	Limit	Di sal I owance		
			Share of col.				
	1.00	2.00	14	1(00	17.00	10.00	
	1.00	2.00	15.00	16.00	17.00	18.00	
13.00	63.00	BLOOD STORING, PROCESSING &	0	()	0 2,640	13.00
		TRANS.					
14.00	64.00	INTRAVENOUS THERAPY	0	()	0 369, 032	14.00
15.00	69.00	ELECTROCARDI OLOGY	0	()	0 104, 419	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	0	()	0 17,000	16.00
17.00	76.01	MOBILE OUTREACH CLINIC	0	()	0 103, 423	17.00
18.00	90.00	CLINIC	0	()	0 246, 234	18.00
19.00	90.01	OUTPATIENT PSYCH	0	()	0 4,500	19.00
20.00	90.04	BARI ATRI CS	0	()	0 88,015	20.00
21.00		EMERGENCY	0	C)	0 4, 131, 709	21.00
22.00		AMBULANCE SERVICES	0	()	0 3, 385	22.00
23.00		EMPLOYEE BENEFITS DEPARTMENT	0	(0 592,670	
200.00			0			0 13, 496, 318	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ST. MARY'S MEL		F	In Lie Period: From 07/01/2015 Fo 06/30/2016	u of Form CMS-2 Worksheet B Part I Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		11/21/2016 8:	49 pm
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00 2.00 4.00 5.00 7.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	9, 921, 918 8, 912, 639 28, 310, 964 75, 652, 335 13, 677, 421	7, 837 972, 362 904, 375	8, 912, 639 (1, 901, 416 545, 02	28, 318, 801 5 1, 780, 333 1 193, 059	80, 306, 446 15, 319, 876	
8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 21.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRV	695, 013 4, 191, 972 2, 005, 852 1, 212, 452 1, 954, 583 2, 401, 921 4, 499, 473 1, 989, 642 602, 738	86, 676 192, 685 252, 503 0 373, 500 179, 867 63, 257 60, 625 0	9, 43 67, 38 98, 45 124, 63 27, 05 1, 62	3 22 5 21, 941 0 33, 327 0 398, 091 3 289, 433 5 910, 616 2 385, 081	952, 402 4, 394, 117 2, 347, 682 1, 245, 779 2, 824, 624 2, 995, 859 5, 500, 401 2, 436, 970 681, 074	10.00 11.00 13.00 14.00 15.00 16.00
30. 00 31. 00 31. 02 32. 00 40. 00 41. 00 43. 00 44. 00 45. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03102 NI CU 03200 CORONARY CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	23, 479, 970 9, 837, 745 4, 341, 216 1, 458, 705 1, 759, 809 1, 816, 000 1, 113, 370 0	1, 751, 252 427, 478 128, 027 56, 923 116, 711 356, 163 0 0 0	179, 788 114, 974 117, 49 1, 62 33, 48 (2 4, 702, 552 3 1, 704, 243 4 704, 603 1 235, 228 7 252, 253 1 434, 908 2 218, 259 0 0	30, 168, 896 12, 149, 254 5, 288, 820 1, 868, 347 2, 130, 400 2, 640, 552 1, 331, 629 0 0	30. 00 31. 00 31. 02 32. 00 40. 00 41. 00 43. 00 44. 00
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 02\\ 54.\ 02\\ 54.\ 03\\ 56.\ 00\\ 57.\ 00\\ 63.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 67.\ 00\\ 69.\ 02\\ 69.\ 03\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 76.\ 01\\ 88.\ 00\\ 76.\ 01\\ 88.\ 00\\ 76.\ 01\\ 88.\ 00\\ 76.\ 01\\ 88.\ 00\\ 76.\ 01\\ 76.\ $	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 ULTRASOUND 05403 NUCLEAR MEDI CI NE 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 06900 DELECTROCARDI OLOGY 06900 DI ABETI C EDUCATI ON 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03951 ECT 03950 MOBI LE OUTREACH CLI NI C 0UTPATI ENT SERVICE COST CENTERS	48, 816, 917 1, 524, 135 2, 552, 348 46, 300 4, 188, 838 610, 305 1, 666, 873 0 1, 055, 254 500, 233 1, 423, 503 13, 563, 110 1, 563, 004 2, 927, 700 3, 108, 795 2, 772, 026 1, 300, 006 431, 626 991, 481 433, 207 527, 532 847, 688 7, 424, 557 13, 794, 476 19, 266, 151 878, 860 130, 006 632, 043	442, 909 94, 482 244, 102 0 217, 284 18, 860 71, 043 0 52, 334 64, 951 129, 368 145, 273 6, 253 12, 526 29, 047 59, 747 0 0 370, 182 77, 457 46, 737 72, 263 0 0 0 0 2, 955 0 0	15, 742 36, 52 99, 75 1, 292, 438 20, 77 5, 49 (245, 874 15, 448 690, 142 35, 044 1, 344 246, 683 59, 716 6, 422 (12, 166 117, 055 83 ² 50, 92 (31, 958 (31, 958 (10, 14, 14, 14, 14, 14, 14, 14, 14, 14, 14	2 333, 737 7 523, 802 3 10, 415 3 942, 791 7 127, 958 7 158, 977 0 0 4 202, 280 5 102, 887 2 271, 781 4 385, 557 0 0 3 449, 889 5 591, 190 3 588, 174 0 94, 979 2 215, 073 1 111, 933 4 415, 582 0 0 0 0 0 0 0 0 111, 933 41, 582 135, 288 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td>3, 636, 798 3, 788, 748 3, 426, 375 1, 591, 219 538, 765 1, 693, 788 623, 248 616, 682 1, 106, 162 7, 424, 557 13, 794, 476 19, 266, 151 1, 134, 361 158, 723 948, 645</td> <td>51.00 52.00 53.00 54.02 54.02 54.03 56.00 57.00 58.00 59.00 63.00 63.00 64.00 65.00 66.00 67.00 68.00 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.00 71.00 72.00 73.00 74.00 74.00 76.01</td>	3, 636, 798 3, 788, 748 3, 426, 375 1, 591, 219 538, 765 1, 693, 788 623, 248 616, 682 1, 106, 162 7, 424, 557 13, 794, 476 19, 266, 151 1, 134, 361 158, 723 948, 645	51.00 52.00 53.00 54.02 54.02 54.03 56.00 57.00 58.00 59.00 63.00 63.00 64.00 65.00 66.00 67.00 68.00 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.00 71.00 72.00 73.00 74.00 74.00 76.01
88.00 89.00 90.00 90.01 90.02 90.04 91.00 91.01 92.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 OUTPATIENT PSYCH 09002 PEDS CLINIC 09004 BARIATRICS 09100 EMERGENCY 09101 DIAGNOSTIC TREATMENT CENTER 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 719, 806 11, 295 0 253, 356 7, 688, 774 1, 992, 650	0 0 10, 307 133, 826 0 0 242, 599 119, 121	((125 464, 498	0 10, 351 0 0 5 71, 385 3 1, 514, 919	0 848, 259 155, 472 0 324, 866 9, 910, 790 2, 524, 354 0	89.00 90.00 90.01 90.02 90.04 91.00 91.01
95.00 97.00 98.00 99.00	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD 09850 HOME OFFICE 09900 CMHC	4, 865, 981 2, 241, 872 0 0	0 0 0 0	82, 376 1, 193 (5, 539, 941 2, 428, 664 0 0	97.00

Health Financial Systems	ST. MARY'S MED	DI CAL CENTER		In Lie	u of Form CMS-2552-1	10
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet B Part I Date/Time Prepared: 11/21/2016 8:49 pm	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0 101. 0	0
SPECIAL PURPOSE COST CENTERS						
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	0 106. 0	
118.00 SUBTOTALS (SUM OF LINES 1-117)	350, 586, 446	8, 593, 867	8, 788, 81	2 22, 724, 227	<u>343, 539, 994</u> 118. 0	10
NONREI MBURSABLE COST CENTERS						
191.00 19100 RESEARCH	0	0		0 0	0 191.0	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	26, 059, 917			1 3, 924, 918		
194.00079500THER NONREIMBURSABLE COST CENTERS	5, 691, 609	178, 212 1, 836		0 112,907	178, 212 194. 0 5, 806, 352 194. 0	
194. 02 07952 OCCUPATI ONAL MEDI CI NE	1, 902, 465			0 282, 141	2, 583, 118 194. 0	
194. 03 07953 CANCER CNETER/PHYSI CI AN RECRUI TMENT	1, 902, 403	370, 312		0 202, 141	2, 565, 118 194. 0	
194. 04 07954 MARKETI NG	41,079	0		0 3, 206		
194. 06 07956 MOB	422, 081	0		0 20	422, 101 194. 0	
194. 07 07957 SENI OR PARTNERS	0	0		0 0	0 194. 0	
194. 08 07958 ASCENSI ON PHYSI CI AN RECRUI TMENT	-1, 048, 959	9, 188		0 0	-1, 039, 771 194. 0	
194, 09 07959 CONV CARE	7, 906, 043		39, 91	6 1, 212, 599	9, 158, 558 194. 0	
194. 10 07960 EMPLOYEE FI TNESS CENTER	0	0		0 0	0 194. 1	0
194. 11 07961 ST ELI ZABETH	0	11, 064		0 0	11,064 194.1	.1
194.14 07964 FREE STANDING CATH LAB	0	10, 449		0 0	10, 449 194. 1	4
194. 15 07965 FAMILY PRACTICE	0	35, 027		0 0	35, 027 194. 1	5
194. 17 07967 FOUNDATI ON/UNUSED SPACE	168, 413	420, 922		0 58, 783	648, 118 194. 1	7
200.00 Cross Foot Adjustments					0 200. 0	
201.00 Negative Cost Centers		0		0 0	0 201. 0	
202.00 TOTAL (sum lines 118-201)	391, 729, 094	9, 921, 918	8, 912, 63	28, 318, 801	391, 729, 094 202. 0	0

Γ ALL	LOCATI ON – GENERAL SERVI CE COSTS		Provi der	F	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part I Date/Time Prep 11/21/2016 8:4
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY
C	ENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00
	0100 CAP REL COSTS-BLDG & FIXT					
	0200 CAP REL COSTS-MVBLE EQUIP					
	0400 EMPLOYEE BENEFITS DEPARTMENT					
	0500 ADMINISTRATIVE & GENERAL	80, 306, 446				
	0700 OPERATION OF PLANT	3, 937, 392			,	
	0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	244, 779 1, 129, 341	165, 746 368, 463			
	1000 DI ETARY	603, 382	482, 850			3, 585, 861
	1100 CAFETERI A	320, 180	C	C	0 0	0
	1300 NURSI NG ADMI NI STRATI ON	725, 962	747, 129	C	235, 112	0
	1400 CENTRAL SERVICES & SUPPLY	769, 972			108, 237	0
		1, 413, 669				0
	1600 MEDICAL RECORDS & LIBRARY 2100 I &R SERVICES-SALARY & FRINGES APPRV	626, 331 175, 044		1		0
	NPATIENT ROUTINE SERVICE COST CENTERS	175,044			/ 0	0
	3000 ADULTS & PEDIATRICS	7, 753, 768	3, 352, 331	510, 453	1, 054, 938	2, 478, 635
	3100 INTENSIVE CARE UNIT	3, 122, 504				517, 510
	3102 NI CU	1, 359, 290				0
	3200 CORONARY CARE UNIT	480, 188	108, 851			55, 379
	4000 SUBPROVI DER – I PF 4100 SUBPROVI DER – I RF	547, 538 678, 654			101202	174, 560 241, 299
	4300 NURSERY	342, 245		00, 374	0	241, 277
	4400 SKILLED NURSING FACILITY	0	0	C	0	0
	4500 NURSING FACILITY	0	0	C	0	0
	NCI LLARY SERVICE COST CENTERS	10,100,01/			004.440	0.10
	5000 OPERATING ROOM	13, 420, 816				963
	5100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM	505, 824 862, 732	466, 784			1, 534 49, 716
	5300 ANESTHESI OLOGY	40, 214		43, 731	0	47,710
	5400 RADI OLOGY-DI AGNOSTI C	1, 706, 907	643, 157	23, 075	202, 394	18, 476
	5402 ULTRASOUND	199, 930	58, 302	C	18, 347	0
	5403 NUCLEAR MEDICINE	488, 937	214, 270	2,066	67, 428	0
	5600 RADI OI SOTOPE	0	140.000		0	0
	5700 CT SCAN 5800 MAGNETIC RESONANCE IMAGING (MRI)	399, 844 175, 672	149, 892 173, 441			0
	5900 CARDI AC CATHETERI ZATI ON	646, 332				0
	6000 LABORATORY	3, 631, 318				0
	6300 BLOOD STORING, PROCESSING & TRANS.	403, 665	11, 957	C	3, 763	0
	6400 I NTRAVENOUS THERAPY	934, 701	23, 953	1		40, 869
		973, 754			,	0
	6600 PHYSI CAL THERAPY 6700 OCCUPATI ONAL THERAPY	880, 619 408, 962	288, 869	6, 220	90, 904	0
	6800 SPEECH PATHOLOGY	138, 469			0	0
	6900 ELECTROCARDI OLOGY	435, 324	1, 334, 047	7, 887	419, 808	0
	6902 CARDI AC REHAB	160, 182	292, 321			0
	6903 DI ABETI C EDUCATI ON	158, 495			79, 457	0
	7000 ELECTROENCEPHALOGRAPHY 7100 MEDICAL SUPPLIES CHARGED TO PATIENT	284, 297 1, 908, 200	138, 186	5, 414	43, 485	1, 175
	7200 IMPL. DEV. CHARGED TO PATIENTS	3, 545, 346				0
	7300 DRUGS CHARGED TO PATIENTS	4, 951, 632		C	0	0
	7400 RENAL DIALYSIS	291, 544	21, 832	2, 265	6, 870	0
	3951 ECT	40, 794		C	0 0	0
	3950 MOBILE OUTREACH CLINIC	243, 813	67, 560	C	21, 260	0
	UTPATIENT SERVICE COST CENTERS	0				0
	8800 RURAL HEALTH CLINIC 8900 FEDERALLY QUALIFIED HEALTH CENTER	0				0
	9000 CLINIC	218, 013	109, 372	20, 272	34, 418	0
0 10	9001 OUTPATI ENT PSYCH	39, 958	360, 942		113, 584	0
	9002 PEDS CLINIC	0	0	C	0	0
	9004 BARI ATRI CS	83, 494	0	C	0 0	0
	9100 EMERGENCY	2, 547, 192				5, 402
	9101 DIAGNOSTIC TREATMENT CENTER 9200 OBSERVATION BEDS (NON-DISTINCT PART	648, 789	227, 790	39, 473	71, 683	343
	THER REIMBURSABLE COST CENTERS		1	1		
	9500 AMBULANCE SERVICES	1, 423, 831	C	C	0	0
0 00	9700 DURABLE MEDICAL EQUIP-SOLD	624, 196	63, 375	C	19, 943	0
	9850 HOME OFFICE	0	0	C	0	0
	9900 CMHC	0		C C	0	0
	0100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS	0	0	1 C	0	0
	0600 HEART ACQUI SI TI ON	0	0	0		0
	SUBTOTALS (SUM OF LINES 1-117)	67, 654, 035	15, 225, 889	1, 362, 927	4, 623, 294	

Health Financial Systems	ST. MARY'S ME	DICAL CENTER		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B
				rom 07/01/2015	Part I
				o 06/30/2016	Date/Time Prepared:
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPING	11/21/2016 8: 49 pm DI ETARY
cost center bescription	& GENERAL	PLANT	LINEN SERVICE		DIETART
	5.00	7.00	8.00	9,00	10.00
NONREI MBURSABLE COST CENTERS	5.00	7.00	0.00	7.00	10.00
191. 00 19100 RESEARCH	0	0	(0 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	7, 795, 582	554, 363		174, 451	0 192.00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	45, 803			107, 242	0 194.00
194. 01 07951 APOTHECARY	1, 492, 302			18, 584	0 194.00
194. 02 07952 OCCUPATI ONAL MEDI CI NE	663, 892			239, 810	0 194.02
194. 03 07953 CANCER CNETER/PHYSICIAN RECRUITMENT	000,072	6, 114		1, 924	0 194.03
194. 04 07954 MARKETI NG	11, 382			0	0 194.04
194. 06 07956 MOB	108, 485			0	0 194.06
194. 07 07 957 SENI OR PARTNERS	0	22, 719		7, 149	0 194.07
194. 08 07958 ASCENSI ON PHYSI CI AN RECRUI TMENT	0	17, 570		5, 529	0 194. 08
194. 09 07959 CONV_CARE	2, 353, 859			100, 317	0 194.09
194. 10/07960 EMPLOYEE FI TNESS CENTER	2,000,007	010,702		0	0 194.10
194. 11 07961 ST ELI ZABETH	2,844	21, 157		6,658	0 194, 11
194. 14 07964 FREE STANDING CATH LAB	2,686			6, 288	0 194. 14
194. 15 07965 FAMILY PRACTICE	9,002			111,065	0 194, 15
194. 17 07967 FOUNDATI ON/UNUSED SPACE	166, 574			489, 610	0 194, 17
200.00 Cross Foot Adjustments	1007071	1,000,000		10,7,010	200.00
201.00 Negative Cost Centers	0	0		0	0 201.00
202.00 TOTAL (sum lines 118-201)	80, 306, 446	19, 257, 268	1, 362, 927	5, 891, 921	3, 585, 861 202. 00

					From 07/01/2015 To 06/30/2016	Part I Date/Time Pre 11/21/2016 8:	epared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00 2.00 4.00 5.00 7.00 3.00 9.00 10.00 11.00 13.00 14.00 15.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-NVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 565, 959 19, 028 30, 092 44, 449 40, 126	4, 551, 855 0 0	4, 248, 11	10 0 7, 117, 548 0 0	3, 329, 267	1. 0 2. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0
	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	6, 395	0		0 0	0	21.0
30.00 31.00 31.02 32.00 40.00 41.00 43.00 44.00 45.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03102 NI CU 03200 CORONARY CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY	344, 579 115, 423 40, 420 15, 144 16, 364 26, 458 14, 225 0 0	524, 200 154, 773 108, 709 0 211, 430 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	129, 661 53, 212 19, 623 6, 944 10, 828 9, 690 4, 922 0 0	31.0 31.0 32.0 40.0 41.0 43.0 44.0
	ANCI LLARY SERVI CE COST CENTERS	93 664	153 736		0 0	552 996	50 0
51.00 52.00 53.00 54.00 54.03 56.00 57.00 58.00 59.00 50.00 55.00 55.00 56.00 55.00 56.00 57.00 58.00 59.00 50.00 70.00 71.00 72.00 74.00 76.00 76.00 76.00 77.00 77.00 76.00 77.00 76	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05402 ULTRASOUND 05403 NUCLEAR MEDICINE 05600 RADIOISOTOPE 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 06900 ELECTROCARDIOLOGY 06902 CARDIAC REHAB 06903 DIABETIC EDUCATION 07000 ELECTROCREPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03951 ECT 03950 MOBILE OUTREACH CLINIC	93, 664 18, 166 30, 630 906 52, 835 7, 714 9, 047 0 11, 794 5, 851 14, 393 36, 563 0 25, 051 38, 196 37, 083 18, 157 5, 039 15, 731 6, 787 2, 827 11, 625 0 0 0 11, 620 1, 977 12, 552	166, 749 418, 715 0 0 0 0 0 0 106, 406 0 105, 024 65, 986 0 0 146, 020 65, 986 0 0 0 0 99, 036 0 0	1, 486, 41 2, 761, 69	91 0 0 7, 117, 548 0 0 0 0 0 0	552, 996 63, 945 26, 831 42, 764 158, 199 38, 628 80, 912 0 117, 777 39, 553 172, 445 222, 195 17, 801 42, 513 24, 832 39, 624 24, 365 8, 080 125, 652 2, 504 445 19, 050 288, 402 223, 291 342, 122 8, 049 6, 228 1, 427	51.0 52.0 53.0 54.0 54.0 54.0 54.0 57.0 58.0 59.0 63.0 64.0 63.0 64.0 65.0 64.0 67.0 68.0 69.0 69.0 69.0 70.0 71.0 72.0 71.0 72.0 74.0
39.00 90.00 90.01 90.02 90.04 91.00 91.01 92.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 OUTPATIENT PSYCH 09002 PEDS CLINIC 09004 BARIATRICS 09100 EMERGENCY 09101 DIAGNOSTIC TREATMENT CENTER 09200 OBSERVATION BEDS (NON-DISTINCT PART 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 5, 559 585 0 4, 835 104, 947 16, 497	0 0 0 0 643, 504		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 7, 481 860 0 0 296, 551 61, 333	89.0 90.0 90.0 90.0 90.0 91.0
95.00 97.00 98.00 99.00 101.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD 09850 HOME OFFICE 09900 CMHC 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	53, 257 18, 390 0 0			0 0 0 0 0 0 0 0 0 0 0 0	24, 557 12, 975 0 0 0	97.0 98.0
	10600 HEART ACQUI SI TI ON	0			0 0 10 7, 117, 548		106. (

Health Financial Systems	ST. MARY'S ME	DICAL CENTER		In Lie	u of Form CMS-2552-1	10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150100	Period:	Worksheet B	
				From 07/01/2015	Part I	
				To 06/30/2016	Date/Time Prepared	11
Cost Conton Deparintion	CAFETERIA	NURSI NG	CENTRAL	PHARMACY	11/21/2016 8: 49 pm MEDICAL	<u> </u>
Cost Center Description	CAFETERIA	ADMI NI STRATI ON		PHARMACY	RECORDS &	
		ADMINI STRATI UN	SUPPLY		LIBRARY	
	11.00	13.00	14.00	15.00	16.00	_
NONREI MBURSABLE COST CENTERS	11.00	13.00	14.00	15.00	18.00	_
191. 00 19100 RESEARCH		0			0 191. 0	20
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	96, 157	0		0 0	0191.0	
192. 00 19200 PHYSICIANS PRIVATE OFFICES	90, 157	0		0 0	0192.0	
		0		0 0		
	5, 366			0 0	0 194. 0	
194. 02 07952 OCCUPATI ONAL MEDI CI NE	15, 979	0		0 0	0 194. 0	
194. 03 07953 CANCER CNETER/PHYSICIAN RECRUITMENT	C	0		0 0	0 194. 0	
194. 04 07954 MARKETI NG	210	0		0 0	0 194.0	
194.06 07956 MOB	2	0		0 0	0 194.0	
194.07 07957 SENI OR PARTNERS	C	0		0 0	0 194. 0	
194.0807958 ASCENSION PHYSICIAN RECRUITMENT	C	0		0 0	0 194. 0	
194.0907959 CONV CARE	58, 931	0		0 0	0 194. 0	
194.1007960 EMPLOYEE FITNESS CENTER	C	0		0 0	0 194. 1	10
194. 11 07961 ST_ELI ZABETH	C	0		0 0	0 194. 1	11
194.14 07964 FREE STANDING CATH LAB	C	0		0 0	0 194. 1	14
194. 15 07965 FAMILY PRACTICE	C	0		0 0	0 194. 1	15
194.17 07967 FOUNDATI ON/UNUSED SPACE	4, 333	0	1	0 0	0 194. 1	17
200.00 Cross Foot Adjustments					200. 0	00
201.00 Negative Cost Centers	C	0		0 0	0 201.0	00
202.00 TOTAL (sum lines 118-201)	1, 565, 959	4, 551, 855	4, 248, 11	0 7, 117, 548	3, 329, 267 202. 0)0

IST ALI	LOCATI ON - GENERAL SERVI CE COSTS		Provi der	CCN: 150100	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part I Date/Time Prepar 11/21/2016 8:49
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES APPRV	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		11/21/2010 6. 49
		21.00	24.00	25.00	26.00	
	ENERAL SERVICE COST CENTERS	- F F		1		
00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0	10100 CAP REL COSTS-BLDG & FLXT 10200 CAP REL COSTS-MVBLE EQUIP 10400 EMPLOYEE BENEFITS DEPARTMENT 10500 ADMI NI STRATI VE & GENERAL 10700 OPERATION OF PLANT 10800 LAUNDRY & LINEN SERVICE 10900 HOUSEKEEPING					1 1 1 1 1 1
	1600 MEDICAL RECORDS & LIBRARY 12100 I &R SERVICES-SALARY & FRINGES APPRV	862, 513				10 2 ⁻
	NPATIENT ROUTINE SERVICE COST CENTERS	002,010		1		
	3000 ADULTS & PEDI ATRI CS	862, 513	47, 981, 819			30
	3100 I NTENSI VE CARE UNI T	0	17, 693, 732		0 17, 693, 732 0 7, 224, 072	3
	13102 NI CU 13200 CORONARY CARE UNI T	0	7, 224, 072 2, 713, 254		0 7, 224, 072 0 2, 713, 254	3:
	4000 SUBPROVIDER - IPF	0	3, 173, 102		0 3, 173, 102	40
	4100 SUBPROVI DER – I RF	0	4, 763, 876		0 4, 763, 876	4
	4300 NURSERY	0	1, 693, 02		0 1, 693, 021	4
	4400 SKI LLED NURSI NG FACI LI TY	0	(0 0	4.
	14500 NURSING FACILITY NCILLARY SERVICE COST CENTERS	0			0 0	4
	5000 OPERATI NG ROOM	0	67, 775, 004	4	0 67, 775, 004	50
	5100 RECOVERY ROOM	0	3, 155, 633		0 3, 155, 633	5
	5200 DELIVERY ROOM & LABOR ROOM	0	5, 405, 009	9	0 5, 405, 009	5.
	5300 ANESTHESI OLOGY	0	240, 352		0 240, 352	5
	95400 RADI OLOGY-DI AGNOSTI C 95402 ULTRASOUND	0	9, 446, 394 1, 100, 821		0 9, 446, 394 0 1, 100, 821	54
	15403 NUCLEAR MEDICINE	0	2, 765, 050		0 2, 765, 050	5
	5600 RADI OI SOTOPE	0	_,,	5	0 0	5
	5700 CT SCAN	0	2, 305, 33		0 2, 305, 335	5
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 137, 348		0 1, 137, 348 0 3, 796, 512	51
	15900 CARDI AC CATHETERI ZATI ON 16000 LABORATORY	0	3, 796, 512 18, 721, 353		0 3, 796, 512 0 18, 721, 353	51
	6300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	2,007,792		0 2,007,792	6
	6400 INTRAVENOUS THERAPY	0	4, 816, 44		0 4, 816, 447	6
	6500 RESPI RATORY THERAPY	0	4, 898, 553		0 4, 898, 553	6
	16600 PHYSI CAL THERAPY 16700 OCCUPATI ONAL THERAPY	0	4, 769, 694 2, 042, 703		0 4, 769, 694 0 2, 042, 703	6
	6800 SPEECH PATHOLOGY	0	690, 353		0 2, 042, 703 0 690, 353	6
	6900 ELECTROCARDI OLOGY	0	4, 178, 25		0 4, 178, 257	6
	6902 CARDI AC REHAB	0	1, 251, 580	c	0 1, 251, 580	6
	6903 DI ABETI C EDUCATI ON	0	1, 110, 40		0 1, 110, 401	6
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	1, 609, 394 11, 107, 578		0 1, 609, 394 0 11, 107, 578	70
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	20, 324, 804		0 20, 324, 804	7
	7300 DRUGS CHARGED TO PATIENTS	Ő	31, 677, 453		0 31, 677, 453	7
	17400 RENAL DI ALYSI S	0	1, 575, 57		0 1, 575, 577	7
		0	207, 722		0 207, 722	70
	3950 MOBILE OUTREACH CLINIC UTPATIENT SERVICE COST CENTERS	0	1, 295, 25	/	0 1, 295, 257	70
	8800 RURAL HEALTH CLINIC	0	(b	0 0	8
00 0	8900 FEDERALLY QUALI FI ED HEALTH CENTER	0	(c	0 0	8
		0	1, 243, 374		0 1, 243, 374	90
	19001 OUTPATI ENT PSYCH 19002 PEDS CLINIC	0	671, 40 [°]		0 671, 401	90
	19002 PEDS CETNIC 19004 BARI ATRI CS	0	413, 195	5	0 413, 195	91
. 00 0	9100 EMERGENCY	0	14, 302, 464		0 14, 302, 464	9
	9101 DI AGNOSTI C TREATMENT CENTER	0	3, 697, 129	9	0 3, 697, 129	9
	9200 OBSERVATION BEDS (NON-DISTINCT PART				0	93
	THER REIMBURSABLE COST CENTERS		7, 256, 24	1	0 7, 256, 241	9
	19500 AMBULANCE SERVICES 19700 DURABLE MEDICAL EQUIP-SOLD	0	7, 256, 24 3, 167, 543		0 7, 256, 241	9
	19850 HOME OFFICE	0	5, 157, 040	b	0 0	9
	9900 CMHC		(า	0 0	9

Health Financial Systems	ST. MARY'S MEDI	CAL CENTER		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet B Part I Date/Time Prepared: 11/21/2016 8:49 pm
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES APPRV	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total st	
	21.00	24.00	25.00	26.00	
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	101.00
SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	106.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	862, 513	325, 406, 599	-862, 51	3 324, 544, 086	118.00
NONREI MBURSABLE COST CENTERS	· · · · · ·				
191. 00 19100 RESEARCH	0	0		0 0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	38, 952, 140		0 38, 952, 140	192.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	672, 044		0 672, 044	194.00
194. 01 07951 APOTHECARY	0	7, 381, 658		0 7, 381, 658	194.01
194.0207952 OCCUPATIONAL MEDICINE	0	4, 264, 855	1	0 4, 264, 855	194.02
194.0307953 CANCER CNETER/PHYSICIAN RECRUITMENT	0	8, 038		0 8, 038	194.03
194. 04 07954 MARKETI NG	0	55, 877		0 55, 877	194.04
194.0607956 MOB	0	530, 588		0 530, 588	194.06
194. 07 07957 SENI OR PARTNERS	0	29, 868		0 29, 868	194.07
194.08 07958 ASCENSI ON PHYSI CI AN RECRUI TMENT	0	-1,016,672		0 -1,016,672	194.08
194. 09 07959 CONV CARE	0	11, 990, 447		0 11, 990, 447	194.09
194. 10 07960 EMPLOYEE FITNESS CENTER	0	0		0 0	194.10
194. 11 07961 ST ELI ZABETH	0	41, 723		0 41, 723	194.11
194. 14 07964 FREE STANDING CATH LAB	0	39, 404		0 39, 404	194.14
194. 15 07965 FAMILY PRACTICE	0	508, 032		0 508,032	194. 15
194. 17 07967 FOUNDATI ON/UNUSED SPACE	0	2, 864, 493		0 2, 864, 493	194. 17
200.00 Cross Foot Adjustments	0	_,, , , , 0		0 0	200.00
201.00 Negative Cost Centers	0	0		0 0	201.00
202.00 TOTAL (sum Lines 118-201)	862, 513	391, 729, 094	-862, 51	3 390, 866, 581	
		,			1-121 00

	Financial Systems TION OF CAPITAL RELATED COSTS	ST. MARY'S MEL			Period: From 07/01/2015 To 06/30/2016	u of Form CMS-2 Worksheet B Part II Date/Time Pre	
	· · · · · · · · · · · · · · · · · · ·		CAPITAL RE	LATED COSTS		11/21/2016 8:	49 pm
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS			1			1 1 00
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I & SERVICES-SALARY & FRINGES APPRV			1,901,41 545,02 28,34 6,9,43 6,9,43 7,90 9,43 1,90,43 9,43 1,90,43 9,44 9,43 9,44 9,44 9,45 1,44,63 1,62 <td>1 1, 449, 396 9 115, 025 8 202, 123 6 319, 889 0 0 0 471, 950 8 304, 505 5 90, 312</td> <td>7, 837 489 53 39 0 6 9 109 80 250 106 22</td> <td>16.00</td>	1 1, 449, 396 9 115, 025 8 202, 123 6 319, 889 0 0 0 471, 950 8 304, 505 5 90, 312	7, 837 489 53 39 0 6 9 109 80 250 106 22	16.00
30.00 31.00 31.02 32.00 40.00 41.00 43.00 44.00 45.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03102 NI CU 03200 CORONARY CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS		1, 751, 252 427, 472 128, 027 56, 922 116, 711 356, 163 (((3 179, 78 7 114, 97 3 117, 49 1, 62 3 33, 48	8 607, 266 4 243, 001 1 174, 414 7 118, 338	1, 347 468 194 65 69 119 60 0 0	
64.00 65.00 66.00 67.00 69.00 69.02 69.03 70.00 71.00 72.00 73.00 74.00 76.01	ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 ULTRASOUND 05402 ULTRASOUND 05403 NUCLEAR MEDI CINE 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 06900 DI ABETI C EDUCATI ON 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03951 ECT 03950 MOBI LE OUTREACH CLI NI C			2 15, 74 36, 52 99, 75 1, 292, 43 20, 77 2 5, 49 2 245, 87 15, 44 690, 14 3 35, 04 4 245, 87 15, 44 690, 14 3 5, 04 4 246, 68 5 1, 34 5 246, 68 7 59, 71 6 42 12, 16 117, 05 5 31, 95 3 50, 92 3 50, 22	2 110, 224 7 280, 629 3 99, 753 8 1, 509, 722 7 39, 637 7 76, 540 0 0 4 298, 208 5 80, 396 2 819, 510 4 180, 317 9 7, 602 3 259, 209 6 88, 763 8 66, 175 0 0 1 78, 108 1 47, 568 3 123, 186 0 0 0 0 0 0 1 47, 568 3 123, 186 0 0 0 0 0 0 0 0 0 0 0 0	411 92 144 3 259 35 44 0 56 28 75 106 0 124 162 162 162 162 162 30 26 59 31 11 11 37 0 0 0 0 0 61 8 8 0 26	$\begin{array}{c} 53.\ 00\\ 54.\ 02\\ 54.\ 02\\ 54.\ 03\\ 56.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 67.\ 00\\ 67.\ 00\\ 69.\ 02\\ 69.\ 03\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 73.\ 00\\ 74.\ 00\\ 76.\ 00\\ \end{array}$
89.00 90.00 90.01 90.02 90.04 91.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 OUTPATIENT PSYCH 09002 PEDS CLINIC 09004 BARIATRICS 09100 EMERGENCY 09101 DIAGNOSTIC TREATMENT CENTER 09200 OBSERVATION BEDS (NON-DISTINCT PART		10, 307 133, 826 242, 599 119, 121	1, 87 1, 87 12 464, 49	0 0 5 12, 182 0 133, 826 0 0 5 125 8 707, 097	0 0 32 3 0 20 416 74	89.00 90.00 90.01 90.02 90.04
97.00 98.00 99.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD 09850 HOME OFFICE 09900 CMHC 10100 HOME HEALTH AGENCY) 82, 37) 1, 19)		163 51 0 0 0	97.00 98.00

Health Financial Systems	ST. MARY'S MED	DI CAL CENTER		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
				From 07/01/2015 To 06/30/2016		narod
				10 00/30/2010	11/21/2016 8:	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS	
	Capi tal				DEPARTMENT	
	Rel ated Costs				DEFARTMENT	
	0	1.00	2.00	2A	4.00	
SPECIAL PURPOSE COST CENTERS						
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	8, 593, 867	8, 788, 81	2 17, 382, 679	6, 300	118.00
NONREI MBURSABLE COST CENTERS 191. 00 19100 RESEARCH	0	0			0	191.00
191.00 19100 RESEARCH 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	262, 841	83, 91	1 346, 752		191.00
194. 00/07950 OTHER NONREI MBURSABLE COST CENTERS	0	178, 212		0 178, 212		194.00
194. 01 07951 APOTHECARY	0	1, 836		0 1,836		194.01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	0	398, 512		0 398, 512	78	194. 02
194.0307953 CANCER CNETER/PHYSICIAN RECRUITMENT	0	0		0 0	0	194.03
194. 04 07954 MARKETI NG	0	0		0 0		194.04
194. 06 07956 MOB	0	0		0 0		194.06
194. 07 07957 SENI OR PARTNERS	0	0		0 0		194.07
194. 08 07958 ASCENSI ON PHYSI CI AN RECRUI TMENT 194. 09 07959 CONV CARE	0	9, 188		0 9, 188		194. 08 194. 09
194. 10/07959 CONV CARE 194. 10/07960 EMPLOYEE FITNESS CENTER	0	0	39, 91	6 39, 916		194. 09
194. 11 07961 ST ELIZABETH	0	11,064		0 11,064		194.10
194. 14 07964 FREE STANDING CATH LAB	0	10, 449		0 10, 449		194.14
194. 15 07965 FAMILY PRACTICE	0	35, 027		0 35, 027		194. 15
194. 17 07967 FOUNDATI ON/UNUSED SPACE	0	420, 922		0 420, 922	16	194. 17
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	0	9, 921, 918	8, 912, 63	9 18, 834, 557	7,837	202.00

LOCA	Financial Systems TION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 07/01/2015 To 06/30/2016	u of Form CMS-2 Worksheet B Part II Date/Time Pre 11/21/2016 8:	pared
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE		DI ETARY	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
00	00100 CAP REL COSTS-BLDG & FIXT						1.0
00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0.074.047					4.0
00 00	00500 ADMINI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT	2, 874, 267 140, 928	1, 590, 377				5.0
00	00800 LAUNDRY & LINEN SERVICE	8, 761	13, 688		3		8.0
00	00900 HOUSEKEEPI NG	40, 421	30, 430				9.0
. 00	01000 DI ETARY	21, 596	39, 877	(C	7, 040	388, 408	10.0
. 00		11, 460	0		-	0	
. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	25, 984 27, 559	61, 702 28, 405			0	
. 00	01500 PHARMACY	50, 598	28, 403		-,	0	
. 00	01600 MEDI CAL RECORDS & LI BRARY	22, 418				0	
. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	6, 265	0	0	0 0	0	21.0
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	277, 524	276, 853			268, 478	
. 00 . 02	03100 INTENSIVE CARE UNIT	111, 761 48, 652	67, 509 20, 219			56, 055 0	
. 02	03200 CORONARY CARE UNI T	48, 032	8, 990			5, 998	
.00	04000 SUBPROVIDER - IPF	19, 598	18, 432			18, 908	
. 00	04100 SUBPROVI DER – I RF	24, 290	56, 247	6, 093	9, 930	26, 137	
. 00	04300 NURSERY	12, 250	0		-	0	
. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0			0	
. 00	ANCI LLARY SERVICE COST CENTERS	0	0	η (<u> </u>	0	45.0
. 00	05000 OPERATING ROOM	480, 289	74, 575	14, 778	3 13, 165	104	50.
. 00	05100 RECOVERY ROOM	18, 105	24, 341	4, 423	4, 297	166	51.
00	05200 DELIVERY ROOM & LABOR ROOM	30, 879	38, 550			5, 385	
. 00	05300 ANESTHESI OLOGY	1,439	0		-	0	
. 00 . 02	05400 RADI OLOGY-DI AGNOSTI C 05402 ULTRASOUND	61, 094 7, 156	53, 116 4, 815			2, 001 0	
. 02	05403 NUCLEAR MEDICINE	17, 500	17, 696			0	
. 00	05600 RADI OI SOTOPE	0	0			0	
. 00	05700 CT SCAN	14, 311	12, 379	2, 332	2, 185	0	57.
. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	6, 288	14, 324			0	
. 00	05900 CARDI AC CATHETERI ZATI ON	23, 134	20, 430			0	
. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	129, 973 14, 448	44, 116 988			0	
. 00	06400 I NTRAVENOUS THERAPY	33, 455	1, 978			4, 427	
00	06500 RESPI RATORY THERAPY	34, 853	4, 587			0	
. 00	06600 PHYSI CAL THERAPY	31, 519	23, 856			0	
. 00	06700 OCCUPATIONAL THERAPY	14, 638	0			0	
00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	4, 956 15, 581	110, 173	η C	, i	0	
. 00	06902 CARDI AC REHAB	5, 733	24, 142			0	
03	06903 DIABETIC EDUCATION	5, 673	20, 853			0	
	07000 ELECTROENCEPHALOGRAPHY	10, 176	11, 412	546	2, 015	127	
. 00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	68, 298	0		-	0	
. 00 . 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	126, 895 177, 229	0			0	
. 00	07400 RENAL DI ALYSI S	10, 435	1, 803			0	
. 00	03951 ECT	1, 460		(0	
. 01	03950 MOBILE OUTREACH CLINIC	8, 727	5, 579	0	985	0	76.
	OUTPATIENT SERVICE COST CENTERS						ł
. 00	08800 RURAL HEALTH CLINIC	0	0			0	
. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 7, 803	0 9, 033		-	0	
. 00	09000 CETNIC 09001 OUTPATIENT PSYCH	1, 430	9, 033 29, 809		5, 262	0	
. 02	09002 PEDS CLINIC	0	0		0	0	
. 04	09004 BARI ATRI CS	2, 988	0	c c	0	0	
. 00	09100 EMERGENCY	91, 169				585	
. 01	09101 DI AGNOSTI C TREATMENT CENTER	23, 222	18, 812	3, 983	3, 321	37	
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		L	1			92.
. 00	09500 AMBULANCE SERVICES	50, 962	0	0	0	0	95.
. 00	09700 DURABLE MEDICAL EQUIP-SOLD	22, 341	5, 234		-	0	
. 00	09850 HOME OFFICE	0	0	(C	0 0	0	98.
	09900 CMHC	0	0	0	0	0	
1. OC	10100 HOME HEALTH AGENCY	0	0	(<u> </u>	0	0	101.
	SPECIAL PURPOSE COST CENTERS	0	0			0	106.
6 (11)		. 0	. 0	- U	/I UI	0	1100.

Health Financial Systems	ST. MARY'S ME	DI CAL CENTER		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B
				From 07/01/2015	
				To 06/30/2016	
Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	11/21/2016 8: 49 pm DIETARY
COST CENTER DESCRIPTION	& GENERAL	PLANT	LINEN SERVICE		DIETART
	5.00	7.00	8.00	9,00	10.00
NONREI MBURSABLE COST CENTERS	5.00	7.00	0.00	7.00	10.00
191. 00 19100 RESEARCH	0	0		0 0	0 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	279,020	45, 783		8, 082	0 192.00
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	1,639	28, 144		0 4, 969	
194. 01 07951 APOTHECARY	53, 413			0 861	0 194, 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	23, 762			0 11, 110	0 194. 02
194.0307953 CANCER CNETER/PHYSICIAN RECRUITMENT	0	505		0 89	0 194. 03
194. 04 07954 MARKETI NG	407	0		0 0	0 194.04
194.0607956MOB	3, 883	0		0 0	0 194.06
194. 07 07957 SENI OR PARTNERS	0	1, 876		0 331	0 194. 07
194.08 07958 ASCENSI ON PHYSI CI AN RECRUI TMENT	0	1, 451		0 256	0 194. 08
194. 09 07959 CONV CARE	84, 250	26, 327		0 4, 648	0 194. 09
194. 10 07960 EMPLOYEE FITNESS CENTER	0	0		0 0	0 194. 10
194. 11 07961 ST ELI ZABETH	102	1, 747		0 308	0 194. 11
194.14 07964 FREE STANDING CATH LAB	96	1, 650		0 291	0 194. 14
194. 15 07965 FAMILY PRACTICE	322	29, 148		0 5, 146	0 194. 15
194. 17 07967 FOUNDATI ON/UNUSED SPACE	5, 962	128, 492		0 22, 684	0 194. 17
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 TOTAL (sum lines 118-201)	2, 874, 267	1, 590, 377	137, 51	3 272, 974	388, 408 202. 00

ALLOCAT	ION OF CAPITAL RELATED COSTS		Provi der	CCN: 150100	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Pre 11/21/2016 8:	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	49 pm
		11.00	13.00	14.00	15.00	16.00	
1.00 C 2.00 C 4.00 C 5.00 C 7.00 C 8.00 C 9.00 C 11.00 C 13.00 C 14.00 C 15.00 C 15.00 C 12.00 C 12.00 C 12.00 C	SENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-NVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL DO500 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY D2100 I& SERVICES-SALARY & FRINGES APPRV NPATIENT ROUTINE SERVICE COST CENTERS	11, 469 139 220 326 294 47	570, 777 0 0 0	365, 78	34 0 153, 240 0 0 0 0	101, 757 0	
31.00 0 31.02 0 32.00 0 40.00 0 41.00 0 43.00 0 44.00 0 45.00 0	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03102 NICU 032000 CORONARY CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY NCILLARY SERVICE COST CENTERS	2, 524 845 296 111 120 194 104 0	65, 732 19, 408 13, 632 0 26, 512 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 935 1, 615 595 211 329 294 149 0 0	31.0 31.0 32.0 40.0 41.0 43.0 44.0
50.00 C 51.00 C 52.00 C 53.00 C 54.02 C 54.03 C 55.00 C 56.00 C 57.00 C 58.00 C 59.00 C 60.00 C 63.00 C 64.00 C 65.00 C 66.00 C 69.00 C 69.01 C 69.02 C 69.03 C 71.00 C 73.00 C 74.00 C 74.00 C 76.01 C	NUCLELARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05200 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 ULTRASOUND 05403 NUCLEAR MEDICINE 05600 RADI OLSOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 SEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 DELECTROCARDI OLOGY 06900 DI CAL SUPPLIES CHARGED TO PATI ENT 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 RENAL DI ALYSI S 03950 MOBILE OUTREACH CLINI C 0000 MEDI CAL SUPVICE COST CENTERS	686 133 224 7 387 56 66 00 86 43 105 268 0 183 280 272 272 133 37 115 50 21 85 50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20, 909 52, 504 0 0 0 0 0 0 13, 343 0 0 13, 169 0 13, 169 0 0 0 13, 169 0 0 0 18, 310 0 0 0 0 18, 310 0 0 0 0 0 0 18, 314 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	127, 98 237, 79		76 14 578 8, 752 6, 776 10, 382 244	$\begin{array}{c} 51. \\ 0\\ 52. \\ 0\\ 53. \\ 0\\ 54. \\ 0\\ 54. \\ 0\\ 57. \\ 0\\ 58. \\ 0\\ 57. \\ 0\\ 58. \\ 0\\ 59. \\ 0\\ 63. \\ 0\\ 64. \\ 0\\ 65. \\ 0\\ 64. \\ 0\\ 65. \\ 0\\ 66. \\ 0\\ 67. \\ 0\\ 69. \\ 0\\ 69. \\ 0\\ 70. \\ 0\\ 71. \\ 0\\ 71. \\ 0\\ 71. \\ 0\\ 74. \\ 0\\ 74. \\ 0\\ 74. \\ 0\\ 76. \\ 0\\ 0\\ 76. \\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0$
89.00 0 90.00 0 90.01 0 90.02 0 90.04 0 91.00 0 91.01 0 92.00 0 92.00 0 92.00 0	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 OUTPATIENT PSYCH 09002 PEDS CLINIC 09004 BARIATRICS 09100 EMERGENCY 09101 DIAGNOSTIC TREATMENT CENTER 09200 OBSERVATION BEDS (NON-DISTINCT PART 09100 DISERVATION BEDS (NON-DISTINCT PART 09100 DISERVATION DEDS (NON-DISTINCT PART 09100 DISERVATION DESS (NON-DISTINCT PART 09100 DISERVATION DISTINCT PART 09100 DISTINCT PART	0 0 41 4 0 35 769 121	0 0 0 80, 692 13, 400			0 0 227 26 0 0 8, 999 1, 861	89.0 90.0 90.0 90.0 90.0 91.0 91.0 92.0
97.00 0 98.00 0 99.00 0 101.00 1	D9500 AMBULANCE SERVICES D9700 DURABLE MEDICAL EQUIP-SOLD D9850 HOME OFFICE D9900 CMHC 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	390 135 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0	394 0 0	
	10600 HEART ACQUISITION SUBTOTALS (SUM OF LINES 1-117)	0 10, 143	570, 777	365, 78 are Cost Repo		101, 757	106. 118.

Health Financial Systems	ST. MARY'S ME	DICAL CENTER		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150100	Peri od:	Worksheet B
				From 07/01/2015	Part II
				To 06/30/2016	Date/Time Prepared: 11/21/2016 8:49 pm
Cost Center Description	CAFETERIA	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
cost center beschiption		ADMI NI STRATI ON		THANWACT	RECORDS &
			SUPPLY		LIBRARY
	11.00	13.00	14.00	15.00	16.00
NONREI MBURSABLE COST CENTERS					
191. 00 19100 RESEARCH	0	0		0 0	0 191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	704	0		0 0	0 192.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0 194.00
194. 01 07951 APOTHECARY	39	0		0 0	0 194.01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	117	0		0 0	0 194.02
194. 03 07953 CANCER CNETER/PHYSICIAN RECRUITMENT	0	0		0 0	0 194.03
194. 04 07954 MARKETI NG	2	0		0 0	0 194.04
194. 06 07956 MOB	0	0		0 0	0 194.06
194. 07 07957 SENI OR PARTNERS	0	0		0 0	0 194.07
194.08 07958 ASCENSI ON PHYSI CI AN RECRUI TMENT	0	0		0 0	0 194.08
194. 09 07959 CONV CARE	432	0		0 0	0 194.09
194. 10 07960 EMPLOYEE FITNESS CENTER	0	0		0 0	0 194. 10
194. 11 07961 ST_ELIZABETH	0	0		0 0	0 194. 11
194. 14 07964 FREE STANDING CATH LAB	0	0		0 0	0 194. 14
194. 15 07965 FAMILY PRACTICE	0	0		0 0	0 194. 15
194. 17 07967 FOUNDATI ON/UNUSED SPACE	32	0		0 0	0 194. 17
200.00 Cross Foot Adjustments	_				200.00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 TOTAL (sum lines 118-201)	11, 469	570, 777	365, 78	4 153, 240	101, 757 202. 00

	I Financial Systems	ST. MARY'S MED		F	Period: From 07/01/2015 To 06/30/2016	u of Form CMS-2552- Worksheet B Part II Date/Time Prepared 11/21/2016 8:49 pm
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
	CENEDAL SEDVICE COST CENTEDS	21.00	24.00	25.00	26.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 21.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I & SERVICES-SALARY & FRINGES APPRV INPATIENT ROUTINE SERVICE COST CENTERS	6, 334				1. 2. 4. 5. 7. 8. 9. 10. 11. 13. 14. 15. 14. 15. 21.
30.00 31.00 31.02 32.00 40.00 41.00 43.00 44.00 45.00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T		3, 083, 690 936, 986 339, 898 225, 771 179, 048 539, 460 12, 563 0		936, 986 339, 898 225, 771 179, 048 539, 460 12, 563 0	30. 31. 31. 32. 40. 41. 43. 44. 45.
74. 00 76. 00 76. 01	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 ULTRASOUND 05403 NUCLEAR MEDI CINE 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 06900 DI ABETI C EDUCATI ON 07000 ELECTROEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03951 ECT 03950 MOBI LE OUTREACH CLI NI C 0UTPATI ENT SERVI CE COST CENTERS		2, 527, 610 184, 630 420, 569 102, 500 1, 643, 085 53, 721 117, 633 0 333, 131 105, 286 887, 143 369, 310 23, 752 314, 184 130, 209 128, 026 15, 590 17, 424 655, 531 121, 540 77, 821 148, 162 205, 035 371, 470 340, 851 60, 504 1, 671 177, 745		184, 630 420, 569 102, 500 1, 643, 085 53, 721 117, 633 0 333, 131 105, 286 887, 143 369, 310 23, 752 314, 184 130, 209 128, 026 177, 424 655, 531 121, 540 77, 821 148, 162 205, 035 371, 470 340, 851 60, 504 1, 671 177, 745	50. 51. 52. 53. 54. 54. 54. 55. 55. 57. 58. 59. 60. 63. 64. 65. 66. 65. 66. 67. 68. 69. 69. 69. 70. 71. 73. 73. 73. 74.
88.00 89.00 90.01 90.02 90.04 91.00 91.01 92.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 OUTPATIENT PSYCH 09002 PEDS CLINIC 09004 BARIATRICS 09100 EMERGENCY 09101 DIAGNOSTIC TREATMENT CENTER 09200 OBSERVATION BEDS (NON-DISTINCT PART		0 32, 958 170, 360 0 3, 168 953, 386 325, 671		0 32, 958 170, 360 0 3, 168 0 953, 386 325, 671	88. 89. 90. 90. 90. 90. 91. 91. 92.
95.00 97.00 98.00 99.00	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES 09700 DURABLE MEDI CAL EQUI P-SOLD 09850 HOME OFFI CE 09900 CMHC		161, 552 30, 272 0 0		30, 272 0 0	95. 97. 98. 98.

 Image: Note of the second se

Health Financial Systems	ST. MARY'S MED	ICAL CENTER		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/21/2016 8:49 pm
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES APPRV	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total st	
	21.00	24.00	25.00	26.00	
101.00 10100 HOME HEALTH AGENCY		0		0 0	101.00
SPECIAL PURPOSE COST CENTERS					
106.00 10600 HEART ACQUI SI TI ON		0	I	0 0	106.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	16, 528, 916		0 16, 528, 916	118.00
NONREI MBURSABLE COST CENTERS					
191. 00 19100 RESEARCH		0	1	0 0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		681, 419		0 681, 419	192.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS		212, 964		0 212, 964	194.00
194. 01 07951 APOTHECARY		61, 057		0 61,057	194.01
194.0207952 OCCUPATIONAL MEDICINE		496, 514		0 496, 514	194. 02
194.0307953 CANCER CNETER/PHYSICIAN RECRUITMENT		594		0 594	194. 03
194. 04 07954 MARKETI NG		410		0 410	194.04
194.0607956M0B		3, 883		0 3, 883	194.06
194. 07 07957 SENI OR PARTNERS		2, 207		0 2,207	194.07
194.0807958 ASCENSION PHYSICIAN RECRUITMENT		10, 895		0 10, 895	194.08
194. 09 07959 CONV CARE		155, 906		0 155, 906	194.09
194. 1007960 EMPLOYEE FITNESS CENTER		0		0 0	194. 10
194, 11 07961 ST ELI ZABETH		13, 221		0 13, 221	194. 11
194. 14 07964 FREE STANDING CATH LAB		12, 486		0 12, 486	194, 14
194. 15 07965 FAMILY PRACTICE		69, 643		0 69,643	194, 15
194. 17 07967 FOUNDATI ON/UNUSED SPACE		578, 108		0 578, 108	194. 17
200.00 Cross Foot Adjustments	6, 334	6, 334		0 6, 334	200.00
201.00 Negative Cost Centers	0,001	0,001		0 0	201.00
202.00 TOTAL (sum Lines 118-201)	6, 334	18, 834, 557		0 18, 834, 557	202.00
	2,001	,,,.	1		1 00

	Financial Systems LLOCATION - STATISTICAL BASIS	ST. MARY'S ME				Period:	worksheet B-1	
						rom 07/01/2015 o 06/30/2016		
		CAPITAL RE	LATED COSTS	5			111/21/2010 0.	
	Cost Center Description	BLDG & FIXT (HOSPITAL S QUARE FEE)	MVBLE EQU (DOLLAR VA		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci l i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	r	1.00	2.00		4.00	5A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	983, 771						1.00
1.00 2.00 4.00 5.00 7.00 8.00	00100 CAP REL COSTS-BLOG & FIAT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	983, 771 777 96, 411 89, 670 8, 594	7, 657 1, 633 468	0	123, 503, 349 7, 764, 349 841, 962 620, 873	5 -80, 306, 446 2 0	15, 319, 876	2.00 4.00 5.00 7.00
9.00 10.00 11.00 13.00 14.00 15.00	00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	19, 105 25, 036 0 37, 033 17, 834 6, 272	8 57 84 107 23	, 109 , 898 0 , 589 , 090 , 246	94 95, 69(145, 34 1, 736, 144 1, 262, 27(3, 971, 354	4 0 0 0 3 0 4 0 0 0 4 0	4, 394, 117 2, 347, 682 1, 245, 779 2, 824, 624 2, 995, 859 5, 500, 401	9.00 10.00 11.00 13.00 14.00 15.00
16.00 21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	6, 011 C		, 394 0	1, 679, 406 341, 638		1	
	INPATIENT ROUTINE SERVICE COST CENTERS					1	-	
30. 00 31. 00 31. 02 32. 00 40. 00 41. 00 43. 00 44. 00 45. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03102 NICU 03200 CORONARY CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	173, 639 42, 385 12, 694 5, 644 11, 572 35, 314 C C	154 98 100 1 28	, 018 , 475 , 786 , 949 , 398 , 767 0 0 0	20, 508, 77(7, 432, 500 3, 072, 895 1, 025, 866 1, 100, 11 1, 896, 700 951, 866		12, 149, 254 5, 288, 820 1, 868, 347 2, 130, 400 2, 640, 552 1, 331, 629 0	31.00 31.02 32.00 40.00 41.00 43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	43, 915	1, 257	794	6, 521, 988	3 0	52, 219, 196	50.00
51.00 52.00 53.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	9, 368 24, 203	13 13	, 526 , 384 , 708	1, 455, 486 2, 284, 39 ⁻ 45, 423	6 0 I 0	1, 968, 096 3, 356, 779 156, 468	51.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 544			4, 111, 676	5 0	6, 641, 351	54.00
54.02 54.03	05402 ULTRASOUND 05403 NUCLAR MEDICINE	1, 870 7, 044	4	, 852 , 723	558, 049 693, 328	3 0	777, 900 1, 902, 390	54.03
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	5, 189		0 , 256	(882, 179	-	0 1, 555, 742	56.00 57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	6, 440 12, 827		, 270 , 974	448, 710 1, 185, 284		683, 516 2, 514, 794	
59.00 60.00	06000 LABORATORY	12, 827		, 974	1, 185, 284		14, 128, 984	
	06300 BLOOD STORING, PROCESSING & TRANS.	620		, 159	1 0/2 0/1	-	1, 570, 606 3, 636, 798	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 242		, 951 , 308	1, 962, 045 2, 578, 283		3, 030, 798	
66.00	06600 PHYSI CAL THERAPY	5, 924		, 523	2, 565, 128		3, 426, 375	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY			0 , 448	1, 270, 029 414, 219		1, 591, 219 538, 765	
69.00	06900 ELECTROCARDI OLOGY	36, 704		, 572	937, 969		1, 693, 788	
69. 02 69. 03	06902 CARDI AC REHAB 06903 DI ABETI C EDUCATI ON	7,680		559 714	488, 159 181, 346		623, 248 616, 682	
70.00	07000 ELECTROENCEPHALOGRAPHY	7, 165		, 753	590, 016		1, 106, 162	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	C		0	(, ,	7, 424, 557	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	C		0	(13, 794, 476 19, 266, 151	
74.00	07400 RENAL DI ALYSI S	293	27	, 456	962, 035		1, 134, 361	
76.00	03951 ECT	C		0	125, 238	3 0	158, 723	76.00
76. 01	03950 MOBILE OUTREACH CLINIC OUTPATIENT SERVICE COST CENTERS	C	139	, 429	673, 038		948, 645	
88.00 89.00	08800 RURAL HEALTH CLINIC	C		0	(0	88.00
90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	1, 022	1	, 611	507, 079	-	848, 259	89.00 90.00
90. 01	09001 OUTPATI ENT PSYCH	13, 269	1	0	45, 14		155, 472	90.01
	09002 PEDS CLINIC	C		0	(0	90.02
90. 04 91. 00	09004 BARI ATRI CS 09100 EMERGENCY	24, 054		107	311, 322 6, 606, 826		324, 866 9, 910, 790	
91.00 91.01	09101 DI AGNOSTI C TREATMENT CENTER	11, 811		, 099	1, 181, 285		2, 524, 354	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						_,,,,,	92.00
05 05	OTHER REIMBURSABLE COST CENTERS			770	0.500.500		E 500 011	
	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD			, 778 , 025	2, 580, 000 809, 429		5, 539, 941 2, 428, 664	
97.00 98.00	09850 HOME OFFICE			, 025	009, 42			
	09900 CMHC	C		0	(0 0	0	99.00

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Health Financial Systems	ST. MARY'S ME	DICAL CENTER		In Lie	u of Form CMS-2552	-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 07/01/2015 To 06/30/2016	Date/Time Prepare	٠he
				10 00/ 50/ 2010	11/21/2016 8:49 p	
	CAPI TAL REI	ATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci I i ati on		
	•	(DOLLAR VALUE)	BENEFITS DEPARTMENT		& GENERAL	
	QUARE FEE)		(GROSS		(ACCUM. COST)	
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0 101.	. 00
SPECIAL PURPOSE COST CENTERS						
106. 00 10600 HEART ACQUI SI TI ON	0	-		0 0	0 106.	
118.00 SUBTOTALS (SUM OF LINES 1-117)	852, 093	7, 551, 394	99, 104, 42	8 -80, 306, 446	<u>263, 233, 548</u> 118.	. 00
NONREI MBURSABLE COST CENTERS						
191. 00 19100 RESEARCH	0			0 0	0 191.	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	26, 061		17, 117, 25	4 0	30, 331, 587 192.	
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	17, 670			0 0	178, 212 194.	
	182		492, 40		5, 806, 352 194.	
194. 02 07952 OCCUPATI ONAL MEDI CI NE 194. 03 07953 CANCER CNETER/PHYSI CI AN RECRUI TMENT	39, 513	0	1, 230, 46		2, 583, 118 194. 0 194.	
194. 04 07954 MARKETI NG	0	0	13, 98	1 0	44, 285 194.	
194. 06 07956 MOB	0	0	13, 98		44, 203 194.	
194. 07 07957 SENI OR PARTNERS	0	0	0		422, 1011194.	
194. 08 07958 ASCENSI ON PHYSI CI AN RECRUI TMENT	911	0		1, 039, 771	0 194.	
194. 09 07959 CONV CARE	0	34, 296	5, 288, 35		9, 158, 558 194.	
194. 10 07960 EMPLOYEE FI TNESS CENTER	0	0	-,,	0 0	0 194.	
194. 11 07961 ST ELI ZABETH	1,097	0		0 0	11, 064 194.	. 11
194.14 07964 FREE STANDING CATH LAB	1, 036	0		o o	10, 449 194.	. 14
194. 15 07965 FAMILY PRACTICE	3, 473			o o	35, 027 194.	. 15
194. 17 07967 FOUNDATI ON/UNUSED SPACE	41, 735	0	256, 36	4 0	648, 118 194.	
200.00 Cross Foot Adjustments					200.	
201.00 Negative Cost Centers					201.	
202.00 Cost to be allocated (per Wkst. B, Part I)	9, 921, 918	8, 912, 639	28, 318, 80	1	80, 306, 446 202.	. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	10. 085597	1. 163866	0. 22929	6	0. 257012 203.	. 00
204.00 Cost to be allocated (per Wkst. B,			7, 83		2, 874, 267 204.	
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0.00006	3	0. 009199 205.	. 00
		· ·		· ·		

	Financial Systems NLLOCATION - STATISTICAL BASIS	ST. MARY'S MEE			'eri od:	u of Form CMS-: Worksheet B-1	
					rom 07/01/2015 o 06/30/2016		
	Cost Center Description	OPERATION OF PLANT (TOTAL SQUA RE FEET)		HOUSEKEEPING (TOTAL SQUA RE FEET)	DI ETARY (MEALS SERVED)	11/21/2016 8: CAFETERI A (MANHOURS)	
	L	7.00	8.00	9.00	10.00	11.00	
1 00	GENERAL SERVICE COST CENTERS			1			1 1 00
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 21.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-WVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I & SERVICES-SALARY & FRINGES APPRV INPATIENT ROUTINE SERVICE COST CENTERS	998, 499 8, 594 19, 105 25, 036 0 38, 739 17, 834 6, 272 8, 907 0	3, 549, 830 C C C C C C C C C C C C C C C C	970, 800 25, 036 0 38, 739 17, 834 6, 272 8, 907	219, 700 0 0 0 0 0 0 0	3, 669, 734 44, 592 70, 518 104, 164 94, 033 14, 987	13.00 14.00 15.00
30.00	03000 ADULTS & PEDIATRICS	173, 820				807, 500	
 31. 00 31. 02 32. 00 40. 00 41. 00 43. 00 44. 00 45. 00 	03100 I NTENSI VE CARE UNI T 03102 NI CU 03200 CORONARY CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	42, 385 12, 694 5, 644 11, 572 35, 314 0 0	356, 676 102, 320 92, 300 157, 300 0 157, 300 0 0 0 0	12, 694 5, 644 11, 572 35, 314 C	0 3, 393 10, 695 14, 784 0 0	270, 487 94, 723 35, 489 38, 347 62, 003 33, 336 0 0	32.00 40.00 41.00
50.00	05000 OPERATING ROOM	46, 821	381, 490	46, 821	59	219, 495	50.00
51.00	05100 RECOVERY ROOM	15, 282	114, 180	15, 282	94	42, 572	51.00
52.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	24, 203	119, 630			71, 780	
53.00 54.00	05400 RADI OLOGY - DI AGNOSTI C	33, 348	60, 100	0 33, 348	-	2, 122 123, 816	
54.02	05402 ULTRASOUND	3, 023	C	3, 023		18, 077	
54.03	05403 NUCLEAR MEDICINE	11, 110	5, 380			21, 201	54.03
56.00	05600 RADI 0I SOTOPE 05700 CT SCAN	0	0 210		-	0 27, 638	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	7,772	60, 210 12, 333			13, 712	
59.00	05900 CARDI AC CATHETERI ZATI ON	12, 827	44, 040			33, 730	
60.00	06000 LABORATORY	27, 698		27, 698		85, 683	
63.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	620	C	020		0	63.00
64.00 65.00	06500 RESPIRATORY THERAPY	1, 242 2, 880		1, 242 2, 880		58, 706 89, 511	
66.00	06600 PHYSI CAL THERAPY	14, 978				86, 902	
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0	42, 550	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 69, 171	20, 541	69, 171	0	11, 808 36, 865	
69.02	06902 CARDI AC REHAB	15, 157	20, 341			15, 905	
69.03	06903 DIABETIC EDUCATION	13, 092	C			6, 626	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	7, 165	14, 100	7, 165	72	27, 242	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	C	0	0	
74.00	07400 RENAL DI ALYSI S	1, 132	5, 900	1, 132	0	27, 230	
76. 00 76. 01	03951 ECT 03950 MOBILE OUTREACH CLINIC	3, 503		3, 503		4, 632 29, 416	
, 0. 01	OUTPATIENT SERVICE COST CENTERS	5, 503		3, 303	0	27,410	, 5. 01
88.00	08800 RURAL HEALTH CLINIC	0	C	C	0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0 5,671	52, 800	C 5, 671	0	0 13, 027	
90.00 90.01	09001 OUTPATI ENT PSYCH	18, 715	52,800	18, 715		1, 370	
90. 02	09002 PEDS CLINIC	0	C	C		0	1
90.04	09004 BARI ATRI CS	0	0	0	0	11, 330	
91.00 91.01	09100 EMERGENCY 09101 DI AGNOSTI C TREATMENT CENTER	24, 054 11, 811	479, 710 102, 810			245, 936 38, 660	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	11,011	102, 010		21	56, 660	92.00
95.00	09500 AMBULANCE SERVICES	0	C	C	0	124, 805	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	3, 286	C	3, 286	0	43, 095	
98.00	09850 HOME OFFICE	0	C	C	0	0	
99.00 101.00	09900 CMHC 10100 HOME HEALTH AGENCY	0			0	0	99.00 101.00
2.1.50	SPECIAL PURPOSE COST CENTERS						
106.00	10600 HEART ACQUI SI TI ON	0	C	C	0	0	106.00

Health Financial Systems	ST. MARY'S ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 07/01/2015 To 06/30/2016	Date/Time Pre	narod
				10 00/ 30/ 2010	11/21/2016 8:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
	PLANT			(MEALS SERVED)	(MANHOURS)	
	(TOTAL SQUA RE	X	FEET)			
	FEET)	LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	110.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	789, 470	3, 549, 830	761, 77	1 219, 700	3, 245, 621	118.00
NONREI MBURSABLE COST CENTERS						101 00
191.00 19100 RESEARCH	0	0		, i i i i i i i i i i i i i i i i i i i		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	28, 744		28, 74		225, 339	
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	17,670		17,670			194.00
	3, 062		3, 062		12, 576	
194. 02 07952 OCCUPATI ONAL MEDI CI NE	39, 513		39, 51		37, 445	
194. 03 07953 CANCER CNETER/PHYSICIAN RECRUITMENT	317	0	31	0		194. 03 194. 04
194. 04 07954 MARKETI NG 194. 06 07956 M0B	0					194.04
194. 07 07 956 MOB	1, 178		1 170			194.06
194. 07/07957 SENTOR PARTNERS 194. 08/07958 ASCENSI ON PHYSI CI AN RECRUI TMENT	911		1, 178 91 ⁻			194.07
194. 09 07959 CONV CARE	16, 529		16, 529		138, 102	
194. 10/07960 EMPLOYEE FI TNESS CENTER	10, 529		10, 52			194.09
194. 11 07961 ST ELIZABETH	1, 097		1, 09	7 0		194.10
194. 14/07964 FREE STANDING CATH LAB	1,037		1,03			194.11
194. 15 07965 FAMILY PRACTICE	18, 300		18, 300			194.15
194. 17 07967 FOUNDATI ON/UNUSED SPACE	80, 672		80, 67		10, 153	
200.00 Cross Foot Adjustments	00,072		00,072			200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	19, 257, 268	1, 362, 927	5, 891, 92 [.]	3, 585, 861	1, 565, 959	
Part I)	17,207,200	1,002,727	0,0,1,,2	0,000,001	1,000,707	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	19. 286217	0. 383941	6. 069140	16. 321625	0. 426723	203.00
204.00 Cost to be allocated (per Wkst. B,	1, 590, 377				11, 469	
Part II)			,		,	
205.00 Unit cost multiplier (Wkst. B, Part	1. 592768	0. 038738	0. 28118	1. 767902	0.003125	205.00
11)						

ST ALLOC	ancial Systems ATION – STATISTICAL BASIS		Provi der	CCN: 150100	Period: From 07/01/2015	Worksheet B-1	
					To 06/30/2016	Date/Time Pre	
						11/21/2016 8: INTERNS &	<u>49 p</u>
	Cast Capton Description		CENTRAL	DUADMACY	MEDICAL	RESI DENTS	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SERVICES-SALAR Y & FRINGES	
			SUPPLY	REQUIS.)	LI BRARY	APPRV	
		(DI RECT NRSI NG	(COSTED		(GROSS CHAR	(ASSI GNED	
		HRS)	REQUIS.)	15.00	GES)	TIME)	<u> </u>
GENE	RAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	21.00	
0 0010	DO CAP REL COSTS-BLDG & FIXT						1
	DO CAP REL COSTS-MVBLE EQUIP						2
	DO EMPLOYEE BENEFITS DEPARTMENT						4
	DO ADMINISTRATIVE & GENERAL DO OPERATION OF PLANT						5
	DO LAUNDRY & LINEN SERVICE						
	DO HOUSEKEEPING						9
	DO DI ETARY						10
00 0110	DO CAFETERI A						11
	DO NURSING ADMINISTRATION	39, 527					13
	DO CENTRAL SERVICES & SUPPLY	0	21, 219, 033		20		14
	DO PHARMACY DO MEDICAL RECORDS & LIBRARY	0	0	.,	0 1, 530, 688, 903		15
1	00 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0 0	100	
	ATIENT ROUTINE SERVICE COST CENTERS						
	DO ADULTS & PEDIATRICS	11, 515	0		0 59, 614, 041	100	
	DO I NTENSI VE CARE UNI T D2 NI CU	4, 552 1, 344	0		0 24, 465, 340 0 9, 021, 881	0	
	DO CORONARY CARE UNI T	944	0		0 3, 192, 512	0	
	DO SUBPROVIDER - IPF	0	0		0 4, 978, 413	0	
00 0410	00 SUBPROVI DER – I RF	1, 836	0		0 4, 455, 076	0	41
	DO NURSERY	0	0		0 2, 262, 770	0	
	DO SKILLED NURSING FACILITY	0	0		0 0	0	
	DO NURSING FACILITY LLARY SERVICE COST CENTERS	0	0		0 0	0	45
	DO OPERATING ROOM	1, 335	0		0 254, 243, 352	0	50
	DO RECOVERY ROOM	1, 448	0		0 29, 400, 083	0	
00 0520	DO DELIVERY ROOM & LABOR ROOM	3, 636	0		0 12, 336, 250	0	52
	DO ANESTHESI OLOGY	0	0		0 19, 661, 385	0	
	DO RADI OLOGY-DI AGNOSTI C	0	0		0 72, 735, 001	0	
	02 ULTRASOUND 03 NUCLEAR MEDICINE	0	0		0 17, 760, 039 0 37, 201, 063	0	
	DO RADI OI SOTOPE	0	0		0 37, 201, 003	0	
	DO CT SCAN	0	0		0 54, 150, 217	0	
00 0580	DO MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 18, 185, 504	0	58
	DO CARDI AC CATHETERI ZATI ON	924	0		0 79, 284, 944	0	59
	DO LABORATORY	0	0		0 102, 158, 590	0	
	DO BLOOD STORING, PROCESSING & TRANS.	0	0		0 8, 184, 416	0	
1	00 I NTRAVENOUS THERAPY 00 RESPI RATORY THERAPY	912	0		0 19, 546, 003 0 11, 416, 923	0	
	DO PHYSI CAL THERAPY	0	0		0 18, 217, 768	-	
	DO OCCUPATIONAL THERAPY	0	0		0 11, 202, 329		
00 0680	DO SPEECH PATHOLOGY	0	0		0 3, 714, 964		
	DO ELECTROCARDI OLOGY	1, 268	0		0 57, 771, 227	0	
	D2 CARDI AC REHAB	573	0		0 1, 151, 040		
	D3 DI ABETI C EDUCATI ON D0 ELECTROENCEPHALOGRAPHY	0	0		0 204, 756 0 8, 758, 452	0	
	DO MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 424, 557		0 132, 598, 567	0	
	DO I MPL. DEV. CHARGED TO PATIENTS	0	13, 794, 476		0 102, 662, 594	0	
00 0730	DO DRUGS CHARGED TO PATIENTS	0	0	1, 00	00 157, 297, 529	0	
	DO RENAL DI ALYSI S	860	0		0 3, 700, 694		
00 0395		0	0		0 2, 863, 562		
	50 MOBILE OUTREACH CLINIC PATIENT SERVICE COST CENTERS	0	0	1	0 656, 053	0	76
	DO RURAL HEALTH CLINIC	0	0		0 0	0	88
	DO FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
		0	0		0 3, 439, 518	0	
	01 OUTPATIENT PSYCH 02 PEDS CLINIC	0	0		0 395, 481	0	
	D4 BARI ATRI CS	0	0			0	
	DO EMERGENCY	5, 588	0		0 136, 345, 221	0	
	DI DI AGNOSTI C TREATMENT CENTER	928	0		0 28, 199, 173	0	
00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART						92
	R REIMBURSABLE COST CENTERS						
	00 AMBULANCE SERVICES	1, 864	0		0 11, 290, 556	0	
	DO DURABLE MEDICAL EQUIP-SOLD 50 HOME OFFICE	0	0		0 5, 965, 616	0	
	DO CMHC	0	0		0 0		98

Health Financial Systems	ST. MARY'S MED	LCAL CENTER		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS			CCN: 150100	Period: From 07/01/2015	Worksheet B-1	
				To 06/30/2016		
			I		11/21/2016 8: INTERNS &	49 pm
		CENTRAL	DUADMACY		RESI DENTS	
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SERVICES-SALAR Y & FRINGES	
		SUPPLY	REQUIS.)	LI BRARY	APPRV	
	(DI RECT NRSI NG	(COSTED		(GROSS CHAR	(ASSI GNED	
	HRS) 13.00	REQUIS.) 14.00	15.00	GES) 16.00	TIME) 21.00	
101.00 10100 HOME HEALTH AGENCY	0	0	15.00	0 0		101.00
SPECIAL PURPOSE COST CENTERS	· · · · ·			<u> </u>		
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		106. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	39, 527	21, 219, 033	1,00	0 1, 530, 688, 903	100	118.00
NONREI MBURSABLE COST CENTERS 191. 00 19100 RESEARCH	0	o		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		191.00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.00
194. 01 07951 APOTHECARY	0	0		0 0		194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	0	0		0 0		194. 02
194. 03 07953 CANCER CNETER/PHYSI CI AN RECRUI TMENT	0	0		0 0		194.03
194. 04 07954 MARKETI NG 194. 06 07956 MOB	0	0		0 0		194.04 194.06
194.07/07957 SENI OR PARTNERS	0	0				194.00
194. 08 07958 ASCENSI ON PHYSI CI AN RECRUI TMENT	0	0		0 0		194.08
194.0907959 CONV CARE	0	0		0 0	0	194.09
194.1007960 EMPLOYEE FITNESS CENTER	0	0		0 0		194. 10
194. 11 07961 ST ELIZABETH	0	0		0 0		194. 11
194. 14 07964 FREE STANDING CATH LAB 194. 15 07965 FAMILY PRACTICE	0	0		0 0		194. 14 194. 15
194. 15 07965 FAMILY PRACTICE 194. 17 07967 FOUNDATION/UNUSED SPACE	0	0		0 0		194. 15
200.00 Cross Foot Adjustments	Ŭ	0		0	0	200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	4, 551, 855	4, 248, 110	7, 117, 54	3, 329, 267	862, 513	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	115. 158120	0. 200203	7, 117. 54800	0. 002175	8, 625. 130000	
204.00 Cost to be allocated (per Wkst. B, Part II)	570, 777	365, 784	153, 24	101, 757	6, 334	204.00
205.00 Unit cost multiplier (Wkst. B, Part	14. 440180	0. 017238	153.24000	0. 000066	63.340000	205.00

COMPUTA	Financial Systems TION OF RATIO OF COSTS TO CHARGES		DI CAL CENTER Provi der		Period:	worksheet C	2002 10
					From 07/01/2015 To 06/30/2016	Date/Time Pre	
			Ti tl	e XVIII	Hospi tal	11/21/2016 8: PPS	49 pm
					Costs		
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col.	Auj .		Di Sal i Owalice		
		26)					
1	NPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	03000 ADULTS & PEDIATRICS	47, 119, 306		47, 119, 30	6 0	47, 119, 306	30.00
31.00	D3100 INTENSIVE CARE UNIT	17, 693, 732		17, 693, 73	2 0	17, 693, 732	31.00
	03102 NI CU	7, 224, 072		7, 224, 07		7, 224, 072	
	03200 CORONARY CARE UNI T	2, 713, 254		2, 713, 25		2, 713, 254	
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	3, 173, 102 4, 763, 876		3, 173, 10 4, 763, 87		3, 173, 102 4, 763, 876	
	04300 NURSERY	1, 693, 021		1, 693, 02		1, 693, 021	
	04400 SKILLED NURSING FACILITY	0			0 0	0	
	D4500 NURSING FACILITY	0			0 0	0	45.00
	ANCILLARY SERVICE COST CENTERS		1	[
	D5000 OPERATING ROOM	67, 775, 004		67, 775, 00			
	D5100 RECOVERY ROOM D5200 DELIVERY ROOM & LABOR ROOM	3, 155, 633		3, 155, 63		3, 155, 633 5, 405, 009	
	25200 DELIVERY ROOM & LABOR ROOM	5, 405, 009 240, 352		5, 405, 00 240, 35		240, 352	
	05400 RADI OLOGY-DI AGNOSTI C	9, 446, 394		9, 446, 39		9, 446, 394	
	05402 ULTRASOUND	1, 100, 821		1, 100, 82		1, 100, 821	
	05403 NUCLEAR MEDICINE	2, 765, 050		2, 765, 05	0 0	2, 765, 050	54.03
	D5600 RADI OI SOTOPE	0			0 0	0	
	05700 CT SCAN	2, 305, 335		2, 305, 33		2, 305, 335	
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	1, 137, 348		1, 137, 34		1, 137, 348	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	3, 796, 512 18, 721, 353		3, 796, 51 18, 721, 35		3, 796, 512 18, 721, 353	
	D6300 BLOOD STORING, PROCESSING & TRANS.	2,007,792		2,007,79		2,007,792	
	06400 I NTRAVENOUS THERAPY	4, 816, 447		4, 816, 44		4, 816, 447	
65.00	06500 RESPI RATORY THERAPY	4, 898, 553	0	4, 898, 55	3 0	4, 898, 553	65.00
	D6600 PHYSI CAL THERAPY	4, 769, 694				4, 769, 694	
	06700 OCCUPATI ONAL THERAPY	2,042,703		_, = , = , . = ,		2,042,703	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	690, 353		690, 35		690, 353	
	06902 CARDI AC REHAB	4, 178, 257 1, 251, 580		4, 178, 25 1, 251, 58		4, 178, 257 1, 251, 580	
	D6903 DI ABETI C EDUCATI ON	1, 110, 401		1, 110, 40		1, 110, 401	
	07000 ELECTROENCEPHALOGRAPHY	1, 609, 394		1, 609, 39		1, 609, 394	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 107, 578		11, 107, 57	8 0	11, 107, 578	
	07200 I MPL. DEV. CHARGED TO PATIENTS	20, 324, 804		20, 324, 80		20, 324, 804	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	31, 677, 453		31, 677, 45		31, 677, 453	
	D3951 ECT	1, 575, 577 207, 722		1, 575, 57 207, 72		1, 575, 577 207, 722	
	D3950 MOBILE OUTREACH CLINIC	1, 295, 257		1, 295, 25			
	DUTPATIENT SERVICE COST CENTERS						
	D8800 RURAL HEALTH CLINIC	0			0 0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
	29000 CLINIC	1, 243, 374		1, 243, 37		1, 243, 374	
	09001 OUTPATIENT PSYCH 09002 PEDS CLINIC	671, 401		671, 40		671, 401 0	
	29002 PEDS CETNIC	413, 195		413, 19		413, 195	
	D9100 EMERGENCY	14, 302, 464		14, 302, 46		14, 302, 464	
91.01	09101 DIAGNOSTIC TREATMENT CENTER	3, 697, 129		3, 697, 12		3, 697, 129	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 820, 363		5, 820, 36	3	5, 820, 363	92.00
	OTHER RELIMBURSABLE COST CENTERS	7 054 011	1	7 054 01	1	7.054.011	05 00
	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD	7, 256, 241		7, 256, 24		7, 256, 241	
	09850 HOME OFFICE	3, 167, 543 0		3, 167, 54		3, 167, 543 0	1
	09900 CMHC	0			0	0	
	10100 HOME HEALTH AGENCY	0			0		101.00
\$	SPECIAL PURPOSE COST CENTERS	T	1	1	I	1	
	10600 HEART ACQUI SI TI ON	0			0		106.00
	Subtotal (see instructions)	330, 364, 449					
200. 00 201. 00	Less Observation Beds	5, 820, 363		5, 820, 36	2	5, 820, 363	1201 00

COMPUT	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	ST. MARY'S MED			Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Pre 11/21/2016 8:	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	50, 670, 660		50, 670, 66			30.00
	03100 I NTENSI VE CARE UNI T	24, 465, 340		24, 465, 34			31.00
		9,021,881		9, 021, 88			31.02
	03200 CORONARY CARE UNI T 04000 SUBPROVI DER – I PF	3, 192, 512 4, 978, 413		3, 192, 51 4, 978, 41			32.00
	04100 SUBPROVIDER - IRF	4, 455, 076		4, 455, 07			40.00
	04300 NURSERY	2, 262, 770		2, 262, 77			43.00
	04400 SKILLED NURSING FACILITY	0			0		44.00
	04500 NURSING FACILITY	0			0		45.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	88, 374, 441	165, 868, 911			0. 000000	
	05100 RECOVERY ROOM	11, 696, 185	17, 703, 898			0.00000	
	05200 DELIVERY ROOM & LABOR ROOM	11, 852, 635	483, 615			0.000000	
	05300 ANESTHESI OLOGY	11, 303, 210	8, 358, 175			0.00000	
	05400 RADI OLOGY-DI AGNOSTI C	20, 828, 544	51, 906, 457			0.000000	•
	05402 ULTRASOUND 05403 NUCLEAR MEDICINE	7, 231, 430 8, 118, 932	10, 528, 609 29, 082, 131			0. 000000 0. 000000	
	05600 RADI OI SOTOPE	0, 110, 932	29,062,131		0.00000	0.000000	
	05700 CT SCAN	18, 783, 593	35, 366, 624			0.000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 294, 428	13, 891, 076			0.000000	
	05900 CARDI AC CATHETERI ZATI ON	50, 670, 860	28, 614, 084			0.000000	
	06000 LABORATORY	38, 965, 338	63, 193, 252			0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	6, 131, 202	2, 053, 214			0. 000000	
64.00	06400 INTRAVENOUS THERAPY	6, 262, 513	13, 283, 490	19, 546, 00	3 0. 246416	0. 000000	64.00
	06500 RESPI RATORY THERAPY	10, 343, 204	1, 073, 719	11, 416, 92		0. 000000	
	06600 PHYSI CAL THERAPY	11, 345, 020	6, 872, 748			0.00000	
	06700 OCCUPATI ONAL THERAPY	10, 746, 676	455, 653			0.00000	
	06800 SPEECH PATHOLOGY	3, 488, 355	226, 609			0.00000	
	06900 ELECTROCARDI OLOGY	22, 260, 368	35, 510, 859			0.000000	
	06902 CARDI AC REHAB 06903 DI ABETI C EDUCATI ON	4, 860 724	1, 146, 180 204, 032			0. 000000 0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	3, 301, 248	5, 457, 204			0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	73, 346, 594	59, 251, 973			0.000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	65, 230, 009	37, 432, 585			0.000000	
	07300 DRUGS CHARGED TO PATIENTS	83, 183, 347	74, 114, 182			0.000000	
74.00	07400 RENAL DIALYSIS	3, 456, 518	244, 176	3, 700, 69	4 0. 425752	0. 000000	74.00
	03951 ECT	736, 615	2, 126, 947	2, 863, 56	2 0. 072540	0.000000	76.00
	03950 MOBILE OUTREACH CLINIC	0	656, 053	656, 05	3 1. 974318	0.00000	76. 0 [°]
	OUTPATIENT SERVICE COST CENTERS		-	J			
	08800 RURAL HEALTH CLINIC	0	0		0		88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0 2 11 2 51	2 420 54	0 0 0 0 1 4 0 7	0 00000	89.0
	09000 CLINIC 09001 OUTPATIENT PSYCH	25, 167 348, 051	3, 414, 351 47, 430			0.000000 0.000000	
	09002 PEDS CLINIC	340, 051	47,430	390,48	0.00000	0.000000	
	09002 PEDS CETIFIC 09004 BARI ATRI CS	0	0		0.000000	0.000000	
	09100 EMERGENCY	38, 407, 817	97, 937, 404	136, 345, 22		0.000000	
	09101 DI AGNOSTI C TREATMENT CENTER	11, 522, 849	16, 676, 324			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 433, 650	7, 509, 731			0.000000	
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	17, 475	11, 273, 081			0. 000000	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	5, 965, 616	5, 965, 61		0.00000	
	09850 HOME OFFICE	0	0		0 0.00000	0.000000	
		0	0		U		99.0
+	10100 HOME HEALTH AGENCY	0	0	1	0		101.0
	SPECIAL PURPOSE COST CENTERS 10600 HEART ACQUISITION	0	0		0		106. 00
200.00	Subtotal (see instructions)	722, 758, 510	02 020 202	1, 530, 688, 90	-		200. 00
200.00	Less Observation Beds	, 22, 730, 310	007, 700, 373	, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,			200.00
	Total (see instructions)	722, 758, 510	007 000 000	1, 530, 688, 90			202.0

Health Financial Sys	tems) OF COSTS TO CHARGES	ST. MARY'S MEDIC	CAL CENTER Provider CCN: 150100	Period:	u of Form CMS-2552 Worksheet C
COMPUTATION OF RATIO	OF CUSIS TO CHARGES			From 07/01/2015 To 06/30/2016	Part I Date/Time Prepare 11/21/2016 8:49 p
			Title XVIII	Hospi tal	PPS
Cost Cer	nter Description	PPS Inpatient			
		Ratio 11.00			
I NPATI ENT ROU	TINE SERVICE COST CENTERS	11100			
30.00 03000 ADULTS a					30
31.00 03100 I NTENSI	/E CARE UNIT				31
31.02 03102 NI CU					31
32.00 03200 CORONAR					32
40. 00 04000 SUBPROV 41. 00 04100 SUBPROV					40
43.00 04300 NURSERY	DER - TRI				43
	NURSING FACILITY				44
45.00 04500 NURSI NG					45
ANCI LLARY SER	VICE COST CENTERS				
50.00 05000 OPERATI I		0. 266575			50
51.00 05100 RECOVER		0. 107334			51
	Y ROOM & LABOR ROOM	0. 438140			52
53.00 05300 ANESTHES		0. 012225			53
54.00 05400 RADI 0L00 54.02 05402 ULTRAS0		0. 129874 0. 061983			54 54
54. 03 05403 NUCLEAR		0. 074327			54
56.00 05600 RADIOIS		0. 000000			56
57.00 05700 CT SCAN		0. 042573			57
58.00 05800 MAGNETI	C RESONANCE IMAGING (MRI)	0. 062541			58
1 1	CATHETERI ZATI ON	0. 047884			59
60.00 06000 LABORAT		0. 183258			60
	FORING, PROCESSING & TRANS.	0. 245319			63
64. 00 06400 I NTRAVE 65. 00 06500 RESPI RA		0. 246416			64
66. 00 06600 PHYSI CAI		0. 429061 0. 261815			66
67. 00 06700 0CCUPAT		0. 182346			67
68.00 06800 SPEECH I		0. 185830			68
69.00 06900 ELECTRO		0. 072324			69
69. 02 06902 CARDI AC	REHAB	1. 087347			69
69.03 06903 DI ABETI (5. 423045			69
	ENCEPHALOGRAPHY	0. 183753			70
	SUPPLIES CHARGED TO PATIENT	0. 083768			71
	EV. CHARGED TO PATIENTS HARGED TO PATIENTS	0. 197977 0. 201386			72
74.00 07400 RENAL D		0. 425752			73
76.00 03951 ECT	ALI OLO	0. 072540			76
	DUTREACH CLINIC	1. 974318			76
OUTPATIENT SE	RVICE COST CENTERS				
88.00 08800 RURAL HI					88
	_Y QUALIFIED HEALTH CENTER	0.044.00			89
90.00 09000 CLINIC	ENT DSVCH	0. 361497			90
90. 01 09001 0UTPATI I 90. 02 09002 PEDS CL		1. 697682 0. 000000			90 90
90. 02 09002 PEDS CL		0. 000000			90
91.00 09100 EMERGEN		0. 104899			91
	FIC TREATMENT CENTER	0. 131108			91
92.00 09200 OBSERVA	TION BEDS (NON-DISTINCT PART	0. 650801			92
	SABLE COST CENTERS				
95.00 09500 AMBULAN		0. 642682			95
97.00 09700 DURABLE		0. 530967			97
98.00 09850 HOME OFI 99.00 09900 CMHC	TUE	0. 000000			98 99
101.00 10100 HOME HE	ALTH AGENCY				101
	SE COST CENTERS				
106.00 10600 HEART A					106
	(see instructions)				200
	servation Beds				201
202.00 Total (s	see instructions)				202

	ancial Systems DN OF RATIO OF COSTS TO CHARGES	ST. MARY'S ME		CCN: 150100	Period:	u of Form CMS- Worksheet C	2002-10
			TTOVIGET	1	From 07/01/2015 To 06/30/2016	Part I Date/Time Pre	
			Ti t	le XIX	Hospi tal	11/21/2016 8: Cost	49 pm
					Costs		
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col.	Auj .		Disarrowance		
		26)					
		1.00	2.00	3.00	4.00	5.00	
	ATIENT ROUTINE SERVICE COST CENTERS	47, 119, 306		47, 119, 300	6 0	47, 119, 306	30.00
	00 INTENSIVE CARE UNIT	17, 693, 732		17, 693, 732			
	02 NI CU	7, 224, 072		7, 224, 072		7, 224, 072	
	00 CORONARY CARE UNI T	2, 713, 254		2, 713, 254	4 0	2, 713, 254	32.00
	00 SUBPROVIDER - IPF	3, 173, 102		3, 173, 102		3, 173, 102	
	00 SUBPROVI DER – I RF 00 NURSERY	4, 763, 876		4, 763, 870		4, 763, 876	
	00 SKILLED NURSING FACILITY	1, 693, 021		1, 693, 02		1, 693, 021 0	1
	00 NURSING FACILITY	0			0 0	0	
	I LLARY SERVICE COST CENTERS	-	I	· · · ·	-		
	OO OPERATING ROOM	67, 775, 004		67, 775, 004		67, 775, 004	
	00 RECOVERY ROOM	3, 155, 633		3, 155, 633		-,,	
	00 DELIVERY ROOM & LABOR ROOM 00 ANESTHESIOLOGY	5, 405, 009		5, 405, 00		5, 405, 009	
	00 RADI OLOGY – DI AGNOSTI C	240, 352 9, 446, 394		240, 352 9, 446, 394		240, 352 9, 446, 394	
	02 ULTRASOUND	1, 100, 821		1, 100, 82		1, 100, 821	
	03 NUCLEAR MEDICINE	2, 765, 050		2, 765, 050		2, 765, 050	
	00 RADI OI SOTOPE	0			0 0	0	
	00 CT SCAN	2, 305, 335		2, 305, 33		2, 305, 335	
	00 MAGNETIC RESONANCE IMAGING (MRI)	1, 137, 348		1, 137, 348		1, 137, 348	
	00 CARDI AC CATHETERI ZATI ON 00 LABORATORY	3, 796, 512 18, 721, 353		3, 796, 512		3, 796, 512	
	00 BLOOD STORING, PROCESSING & TRANS.	2,007,792		18, 721, 35 2, 007, 792		18, 721, 353 2, 007, 792	
	00 I NTRAVENOUS THERAPY	4, 816, 447		4, 816, 44		4, 816, 447	
	00 RESPI RATORY THERAPY	4, 898, 553				4, 898, 553	
	00 PHYSI CAL THERAPY	4, 769, 694				4, 769, 694	
	00 OCCUPATI ONAL THERAPY	2,042,703		_, =, =, . =,		2, 042, 703	
	00 SPEECH PATHOLOGY 00 ELECTROCARDI OLOGY	690, 353 4, 178, 257		690, 353 4, 178, 25		690, 353 4, 178, 257	
	02 CARDI AC REHAB	1, 251, 580		1, 251, 580		1, 251, 580	
	03 DI ABETI C EDUCATI ON	1, 110, 401		1, 110, 40		1, 110, 401	
70.00 070	00 ELECTROENCEPHALOGRAPHY	1, 609, 394		1, 609, 394	4 0	1, 609, 394	70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 107, 578		11, 107, 578		11, 107, 578	
	00 IMPL. DEV. CHARGED TO PATIENTS	20, 324, 804		20, 324, 804		20, 324, 804	
	00 DRUGS CHARGED TO PATIENTS 00 RENAL DIALYSIS	31, 677, 453 1, 575, 577		31, 677, 45 1, 575, 57		31, 677, 453 1, 575, 577	
	51 ECT	207, 722		207, 72		207, 722	
	50 MOBILE OUTREACH CLINIC	1, 295, 257		1, 295, 25			
	PATIENT SERVICE COST CENTERS		I	1	-	-	
	00 RURAL HEALTH CLINIC	0			0 0	0	
	00 FEDERALLY QUALIFIED HEALTH CENTER 00 CLINIC	1 242 274		1 242 27	0	1 242 274	
	00 CLINIC 01 OUTPATI ENT PSYCH	1, 243, 374 671, 401		1, 243, 374 671, 401		1, 243, 374 671, 401	
	02 PEDS CLINIC	071,401				0/1,401	
	04 BARI ATRI CS	413, 195		413, 19	-	413, 195	
	00 EMERGENCY	14, 302, 464		14, 302, 464	4 0	14, 302, 464	91.00
	01 DI AGNOSTI C TREATMENT CENTER	3, 697, 129		3, 697, 129		3, 697, 129	
	00 OBSERVATION BEDS (NON-DISTINCT PART	5, 820, 363		5, 820, 363	3	5, 820, 363	92.00
	ER REIMBURSABLE COST CENTERS	7, 256, 241	1	7, 256, 24	1 0	7, 256, 241	95.00
	00 DURABLE MEDICAL EQUIP-SOLD	3, 167, 543		3, 167, 543		3, 167, 543	
	50 HOME OFFICE	0			0 0	0	
	оо смнс	0			С	0	
	00 HOME HEALTH AGENCY	0		(D	0	101.00
	CIAL PURPOSE COST CENTERS	^	1			2	104 00
106.00106 200.00	00 HEART ACQUISITION Subtotal (see instructions)	0 330, 364, 449		330, 364, 44	9 0		106.00
200.00	Less Observation Beds	5, 820, 363		5, 820, 364		5, 820, 363	
	Total (see instructions)	324, 544, 086					

COMPUTA	Financial Systems TION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Pre 11/21/2016 8:	pared:
			Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
-	INPATIENT ROUTINE SERVICE COST CENTERS			.			
	03000 ADULTS & PEDIATRICS	50, 670, 660		50, 670, 66			30.0
	03100 INTENSIVE CARE UNIT	24, 465, 340		24, 465, 34			31.0
	03102 NI CU 03200 CORONARY CARE UNI T	9, 021, 881 3, 192, 512		9, 021, 88 3, 192, 51			31.0
	04000 SUBPROVIDER - IPF	4, 978, 413		4, 978, 41			40.0
	04100 SUBPROVIDER - IRF	4, 455, 076		4, 455, 07			41.0
	04300 NURSERY	2, 262, 770		2, 262, 77			43.0
	04400 SKILLED NURSING FACILITY	0			0		44.0
45.00	04500 NURSING FACILITY	0			0		45.0
	ANCILLARY SERVICE COST CENTERS	-					
	05000 OPERATING ROOM	88, 374, 441	165, 868, 911			0.00000	
	05100 RECOVERY ROOM	11, 696, 185	17, 703, 898			0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	11, 852, 635	483,615			0. 000000 0. 000000	
	05300 ANEST HEST OLOGY 05400 RADI OLOGY-DI AGNOSTI C	11, 303, 210 20, 828, 544	8, 358, 175 51, 906, 457			0. 000000	
	05400 NADI OLOGI - DI AGNOSTI C 05402 ULTRASOUND	7, 231, 430	10, 528, 609			0. 000000	
	05403 NUCLEAR MEDICINE	8, 118, 932	29, 082, 131			0. 000000	
	05600 RADI OI SOTOPE	0	,,,		0 0.000000	0.000000	
	05700 CT SCAN	18, 783, 593	35, 366, 624	54, 150, 21		0.00000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 294, 428	13, 891, 076	18, 185, 50	0. 062541	0. 000000	58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	50, 670, 860	28, 614, 084	79, 284, 94	0. 047884	0. 000000	59.0
	06000 LABORATORY	38, 965, 338	63, 193, 252	102, 158, 59	0. 183258	0. 000000	60.0
	06300 BLOOD STORING, PROCESSING & TRANS.	6, 131, 202	2,053,214			0.00000	
	06400 I NTRAVENOUS THERAPY	6, 262, 513	13, 283, 490			0.00000	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	10, 343, 204	1,073,719			0. 000000 0. 000000	
	06700 OCCUPATIONAL THERAPY	11, 345, 020 10, 746, 676	6, 872, 748 455, 653			0. 000000	
	06800 SPEECH PATHOLOGY	3, 488, 355	226, 609			0. 000000	
	06900 ELECTROCARDI OLOGY	22, 260, 368	35, 510, 859			0. 000000	
	06902 CARDI AC REHAB	4, 860	1, 146, 180			0.00000	
69.03	06903 DIABETIC EDUCATION	724	204, 032	204, 75	5. 423045	0. 000000	69.0
	07000 ELECTROENCEPHALOGRAPHY	3, 301, 248	5, 457, 204			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	73, 346, 594	59, 251, 973			0.00000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	65, 230, 009	37, 432, 585			0.00000	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	83, 183, 347	74, 114, 182 244, 176			0. 000000 0. 000000	
	03951 ECT	3, 456, 518 736, 615	2, 126, 947			0. 000000	
	03950 MOBILE OUTREACH CLINIC	, 30, 013	656, 053			0. 000000	
	DUTPATIENT SERVICE COST CENTERS					01000000	1 / 0/ 0
	08800 RURAL HEALTH CLINIC	0	C)	0 0.000000	0. 000000	88.0
39.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0.000000		
	09000 CLI NI C	25, 167	3, 414, 351			0. 000000	
1	09001 OUTPATI ENT PSYCH	348, 051	47, 430	395, 48		0.00000	
	09002 PEDS CLINIC	0	0		0 0.000000	0.00000	
				124 245 25	0 0.00000	0.00000	
	09100 EMERGENCY 09101 DIAGNOSTIC TREATMENT CENTER	38, 407, 817 11, 522, 849	97, 937, 404 16, 676, 324			0. 000000 0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 433, 650	7, 509, 731			0. 000000	
	OTHER REIMBURSABLE COST CENTERS	1, 400, 000	,, 307, 731	0,740,00	0.00001	0.00000	, , 2. 0
	09500 AMBULANCE SERVICES	17, 475	11, 273, 081	11, 290, 55	0. 642682	0. 000000	95.0
7.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	5, 965, 616			0. 000000	97.0
	09850 HOME OFFICE	0	C		0 0.000000	0. 000000	
	09900 CMHC	0	C		0		99. C
	10100 HOME HEALTH AGENCY	0	0		0		101. C
	SPECIAL PURPOSE COST CENTERS			J	0		10/ 0
106.00 200.00	10600 HEART ACQUISITION Subtotal (see instructions)	0 722, 758, 510	0 202 202 202	1, 530, 688, 90	0		106. 0 200. 0
200.00	Less Observation Beds	122,150,510	001, 730, 373	, 1, 330, 000, 90			200.0
		1	807, 930, 393	1, 530, 688, 90			201.0

	Financial Systems	ST. MARY'S MEDIC			u of Form CMS-255	52-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150100	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepar 11/21/2016 8:49	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 I NTENSI VE CARE UNI T 03102 NI CU					31.00 31.02
	03200 CORONARY CARE UNIT					32.002
	04000 SUBPROVI DER – I PF					10. 00
	04100 SUBPROVI DER – I RF					1.00
	04300 NURSERY				43	13.00
44.00	04400 SKILLED NURSING FACILITY				44	14.00
-	04500 NURSING FACILITY				4	15.00
	ANCI LLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 000000				50.00
	05100 RECOVERY ROOM	0. 000000				51.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0. 000000 0. 000000				52.00 53.00
	05400 RADI OLOGY-DI AGNOSTI C	0.000000				54.00
	05402 ULTRASOUND	0.000000				54. 00 54. 02
	05403 NUCLEAR MEDICINE	0. 000000				54. 03
	05600 RADI OI SOTOPE	0. 000000				56.00
	05700 CT SCAN	0. 000000				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58	58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59	59.00
	06000 LABORATORY	0. 000000				60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				53.00
	06400 I NTRAVENOUS THERAPY	0. 000000				54.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0. 000000				55.00 56.00
	06000 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	0.000000				57.00
	06800 SPEECH PATHOLOGY	0.000000				58.00
	06900 ELECTROCARDI OLOGY	0. 000000				59.00
	06902 CARDI AC REHAB	0. 000000				59.02
69.03	06903 DIABETIC EDUCATION	0. 000000			69	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				2.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	07400 RENAL DIALYSIS 03951 ECT	0. 000000 0. 000000				74.00 76.00
	03950 MOBILE OUTREACH CLINIC	0.000000				76. 00 76. 01
	DUTPATIENT SERVICE COST CENTERS	0.000000				0.01
	08800 RURAL HEALTH CLINIC	0. 000000			88	38.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				39.00
	09000 CLI NI C	0. 000000				90.00
	09001 OUTPATI ENT PSYCH	0. 000000				90.01
	09002 PEDS CLINIC	0. 000000				90.02
	09004 BARI ATRI CS	0.000000				90.04
	09100 EMERGENCY 09101 DI AGNOSTI C TREATMENT CENTER	0. 000000 0. 000000				91.00 91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000				91.01 92.00
	OTHER REIMBURSABLE COST CENTERS	0.000000			7.	2.00
	09500 AMBULANCE SERVICES	0. 000000			9!	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				7.00
98.00	09850 HOME OFFICE	0. 000000			98	8. 00
	09900 СМНС					99.00
	10100 HOME HEALTH AGENCY				10	01. 00
-	SPECIAL PURPOSE COST CENTERS					
	10600 HEART ACQUI SI TI ON)6.00
200.00 201.00	Subtotal (see instructions) Less Observation Beds)0. 00)1. 00
201.00	Total (see instructions))1.00)2.00
_000		I I			20.	00

		ATLOG NET OF	B 1 1	0.011 450400			2552-1
20071	ATION OF OUTPATIENT SERVICE COST TO CHARGE R IONS FOR MEDICAID ONLY	ATTOS NET OF	Provi der		Period: From 07/01/2015 To 06/30/2016		pared: 50 pm
				le XIX	Hospi tal	Cost	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
		1.00	2.00	col . 2)	4.00	F 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	05000 OPERATING ROOM	67, 775, 004	2, 527, 610	65, 247, 39	4 0	0	50.00
	05100 RECOVERY ROOM	3, 155, 633	184, 630				
	05200 DELIVERY ROOM & LABOR ROOM	5, 405, 009	420, 569				
	05300 ANESTHESI OLOGY	240, 352	102, 500				
	05400 RADI OLOGY-DI AGNOSTI C	9, 446, 394	1, 643, 085				
	05402 ULTRASOUND	1, 100, 821	53, 721				
	05403 NUCLEAR MEDICINE	2, 765, 050	117, 633		-		
	05600 RADI OI SOTOPE	2,700,000	,		0 0		56.00
	05700 CT SCAN	2, 305, 335	333, 131		-		57.0
	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 137, 348	105, 286				
	05900 CARDI AC CATHETERI ZATI ON	3, 796, 512	887, 143				
	06000 LABORATORY	18, 721, 353	369, 310				
	06300 BLOOD STORING, PROCESSING & TRANS.	2,007,792	23, 752				
	06400 INTRAVENOUS THERAPY	4, 816, 447	314, 184		-		
	06500 RESPIRATORY THERAPY	4, 878, 553	130, 209				
	06600 PHYSI CAL THERAPY						66.0
	06700 OCCUPATIONAL THERAPY	4, 769, 694 2, 042, 703	128, 026				
	06800 SPEECH PATHOLOGY		15, 590				67.0
		690, 353	17, 424				
	06900 ELECTROCARDI OLOGY	4, 178, 257	655, 531				
	06902 CARDI AC REHAB	1, 251, 580	121, 540				
	06903 DI ABETI C EDUCATI ON	1, 110, 401	77, 821				
	07000 ELECTROENCEPHALOGRAPHY	1,609,394	148, 162				
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	11, 107, 578	205, 035				
	07200 I MPL. DEV. CHARGED TO PATIENTS	20, 324, 804	371, 470				
	07300 DRUGS CHARGED TO PATIENTS	31, 677, 453	340, 851			0	
	07400 RENAL DI ALYSI S	1, 575, 577	60, 504				
1	03951 ECT	207, 722	1, 671				
	03950 MOBILE OUTREACH CLINIC	1, 295, 257	177, 745	1, 117, 51	2 0	0	76.0
	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	C	1	0 0	0	88. 0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0		
	09000 CLINIC	1, 243, 374	32, 958		-		
	09001 OUTPATIENT PSYCH	671, 401	170, 360			0	90.0
	09002 PEDS CLINIC	071,401	170, 300		0 0	0	90.0
	09004 BARI ATRI CS	413, 195	3, 168			0	
	09100 EMERGENCY	14, 302, 464	953, 386		-	0	
	09101 DI AGNOSTI C TREATMENT CENTER	3, 697, 129	325, 671				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 820, 363	380, 908				
	OTHER REIMBURSABLE COST CENTERS	5, 820, 303	300, 900	0 5,457,45	0	0	72.0
-	09500 AMBULANCE SERVICES	7, 256, 241	161, 552	7, 094, 68	9 0	0	95.0
	09700 DURABLE MEDICAL EQUIP-SOLD	3, 167, 543	30, 272	1		0	
	09850 HOME OFFICE	3, 107, 343	30, 272	5, 137, 27		0	
	09900 CMHC				0 0	0	
	10100 HOME HEALTH AGENCY	0			0 0		101.0
	SPECIAL PURPOSE COST CENTERS	0	C	<u> </u>	0	0	101.0
1	10600 HEART ACQUI SI TI ON	0	ſ		0 0	0	106. 0
				1	-		
06.00		245, 984, 086	11,592 408	234 391 67	8 0	0	200 00
06.00 200.00	Subtotal (sum of lines 50 thru 199)	245, 984, 086 5, 820, 363	11, 592, 408 380, 908				200.0
06.00	Subtotal (sum of lines 50 thru 199) Less Observation Beds	245, 984, 086 5, 820, 363 240, 163, 723	380, 908	5, 439, 45	5 0	0	200. 0 201. 0 202. 0

ALCULATION OF OUTPATIEN	T SERVICE COST TO CHARGE		DI CAL CENTER Provi der	CCN: 150100	Peri od:	u of Form CMS-25 Worksheet C
EDUCTIONS FOR MEDICAID	ONLY				From 07/01/2015 To 06/30/2016	Part II Date/Time Prepa 11/21/2016 8:50
			Ti t	le XIX	Hospi tal	Cost
Cost Center	Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,	Cost to Char	ge	
		Operating Cost	Part I, column	Ratio (col.	6	
		Reduction	8)	/ col. 7)		
		6.00	7.00	8.00		
ANCI LLARY SERVICE		(7 77 004	254 242 252	0.04/5	76	
0.00 05000 OPERATING RC		67, 775, 004				Ę
		3, 155, 633				Ę
2. 00 05200 DELIVERY ROC 3. 00 05300 ANESTHESIOLO		5, 405, 009				Ę
		240, 352				Ę
	AGNUSTIC	9, 446, 394				3
I. 02 05402 ULTRASOUND I. 03 05403 NUCLEAR MEDI	CLNE	1, 100, 821				5
		2, 765, 050				5
5. 00 05600 RADI 0I SOTOPE 7. 00 05700 CT SCAN		2 205 225	-			5
	ONANCE IMAGING (MRI)	2, 305, 335 1, 137, 348				5
2. 00 05900 CARDI AC CATH						5
0.00 05900 CARDIAC CATE 0.00 06000 LABORATORY		3, 796, 512 18, 721, 353				
	IG, PROCESSING & TRANS.	2,007,792				
1. 00 06400 I NTRAVENOUS						
5. 00 06500 RESPI RATORY		4, 816, 447 4, 898, 553				
5. 00 06600 PHYSI CAL THE 7. 00 06700 OCCUPATI ONAL		4, 769, 694				
		2,042,703				
		690, 353				
		4, 178, 257				e
2. 02 06902 CARDI AC REHA		1, 251, 580				e
0. 03 06903 DI ABETI C EDU 0. 00 07000 ELECTROENCEF		1, 110, 401	204, 756			
	LIES CHARGED TO PATIENT	1, 609, 394				
	HARGED TO PATIENTS	11, 107, 578				
8. 00 07300 DRUGS CHARGE		20, 324, 804				
1. 00 07400 RENAL DI ALYS		31, 677, 453				
	15	1, 575, 577				
		207,722				
0. 01 03950 MOBILE OUTRE OUTPATIENT SERVICE		1, 295, 257	656, 053	1. 9743	18	
. 00 08800 RURAL HEALTH		0	C	0.0000	00	
	ALIFIED HEALTH CENTER	0				8
0. 00 09000 CLINIC	AEITTED HEAEITT GENTER	1, 243, 374	-			
). 01 09001 OUTPATIENT F	NAN SALAN	671, 401	395, 481			
0. 02 09002 PEDS CLINIC	5101	0/1,401				
0. 04 09004 BARI ATRI CS		413, 195				
. 00 09100 EMERGENCY		14, 302, 464				
00 09100 EMERGENCI	REATMENT CENTER	3, 697, 129				
	BEDS (NON-DISTINCT PART	5, 820, 363				
OTHER REIMBURSABLE		3, 020, 303	0, 743, 301	0.0000		
5. 00 09500 AMBULANCE SE		7, 256, 241	11, 290, 556	0.6426	82	
7. 00 09700 DURABLE MEDI		3, 167, 543				C
3. 00 09850 HOME OFFICE		0, 107, 545	3, 703, 010			
2. 00 09900 CMHC		0				
01.00 10100 HOME HEALTH	AGENCY	0				10
SPECIAL PURPOSE CO		0		0.0000		
6. 00 10600 HEART ACQUIS		0	0	0.0000	00	10
	m of lines 50 thru 199)	245 984 086	1, 431, 642, 251			20
01.00 Less Observa		5, 820, 363				20
	200 minus line 201)		1, 431, 642, 251			20

Health Financial Systems	ST. MARY'S ME	DICAL CENTER		١r	n Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL			CCN: 150100	Peri od:		Worksheet D	
				From 07/01/ To 06/30/			nared
						11/21/2016 8:	49 pm
			e XVIII	Hospi tal		PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		i ent	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days		3 / col. 4)	
	(from Wkst. B,		Related Cos (col. 1 - co				
	Part II, col. 26)		2)				
	1.00	2.00	3.00	4,00		5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	4.00		3.00	
30. 00 ADULTS & PEDIATRICS	3, 083, 690	C	3, 083, 6	90 56	, 588	54.49	30.00
31.00 INTENSIVE CARE UNIT	936, 986		936, 9	36 13	, 8, 828	67.76	31.00
31. 02 NI CU	339, 898		339, 8	98 5	5, 937	57.25	31.02
32.00 CORONARY CARE UNIT	225, 771		225, 7	71 1	, 457	154.96	32.00
40. 00 SUBPROVIDER – IPF	179, 048	C	179, 0	48 3	3, 398	52.69	40.00
41.00 SUBPROVIDER – IRF	539, 460	0	539, 4		l, 750	113.57	
43.00 NURSERY	12, 563		12, 5	53 3	8, 061	4.10	
44.00 SKILLED NURSING FACILITY	0			0	0		44.00
45.00 NURSING FACILITY	0			0	0	0.00	45.00
200.00 Total (lines 30-199)	5, 317, 416		5, 317, 4	16 89	9, 019		200.00
Cost Center Description	Inpatient	Inpati ent					
	Program days	Program					
		Capital Cost (col. 5 x col.					
		(COL 5 X COL) 6)					
	6,00	7.00	1				
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	1100	1				
30. 00 ADULTS & PEDIATRICS	21, 831	1, 189, 571					30.00
31.00 INTENSIVE CARE UNIT	6, 321	428, 311					31.00
31. 02 NI CU	0	C					31.02
32. 00 CORONARY CARE UNI T	666						32.00
40. 00 SUBPROVI DER – I PF	1,087		•				40.00
41.00 SUBPROVIDER - IRF	2, 313	262, 687					41.00
43.00 NURSERY	0	C					43.00
44.00 SKILLED NURSING FACILITY	0	0					44.00
45.00 NURSING FACILITY	0						45.00
200.00 Total (lines 30-199)	32, 218	2,041,046	1				200. 00

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der	CCN: 150100	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Pre 11/21/2016 8:	pared: 49 pm
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	· ·		•			
D. 00 05000 OPERATI NG ROOM	2, 527, 610	254, 243, 352	0.00994	42 39, 169, 021	389, 418	50.00
1.00 05100 RECOVERY ROOM	184, 630			7, 338, 864	46, 088	51.00
2. 00 05200 DELIVERY ROOM & LABOR ROOM	420, 569				1, 235	
3. 00 05300 ANESTHESI OLOGY	102, 500				30, 178	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 643, 085		0. 02259		133, 033	
4. 02 05400 ULTRASOUND	53, 721				10, 389	
	117, 633				13, 153	
5. 00 05600 RADI 0I SOTOPE	0	· ·	0.0000		0	
7. 00 05700 CT SCAN	333, 131				48, 626	57.00
3.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	105, 286		0.00579		10, 044	58.00
9. 00 05900 CARDI AC CATHETERI ZATI ON	887, 143	79, 284, 944	0. 01118	39 23, 879, 554	267, 188	59.00
D. 00 06000 LABORATORY	369, 310	102, 158, 590	0. 00361	15 17, 184, 561	62, 122	60.00
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	23, 752	8, 184, 416	0.00290	2, 550, 166	7, 401	63.00
4. 00 06400 I NTRAVENOUS THERAPY	314, 184	19, 546, 003	0. 01607	2, 593, 277	41, 684	64.00
5. 00 06500 RESPI RATORY THERAPY	130, 209				43, 895	65.00
5. 00 06600 PHYSI CAL THERAPY	128, 026				27, 987	66.00
7. 00 06700 OCCUPATI ONAL THERAPY	15, 590				4, 786	•
3. 00 06800 SPEECH PATHOLOGY	17, 424				4, 300	
2. 00 06900 ELECTROCARDI OLOGY			0. 00404			
	655, 531				123, 360	
9. 02 06902 CARDI AC REHAB	121, 540				242	
P. 03 06903 DIABETIC EDUCATION	77, 821				0	69.03
0. 00 07000 ELECTROENCEPHALOGRAPHY	148, 162				23, 452	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	205, 035		0. 00154		46, 861	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	371, 470		0. 00361		102, 110	
3.00 07300 DRUGS CHARGED TO PATIENTS	340, 851	157, 297, 529	0. 00216	57 31, 141, 318	67, 483	73.00
4.00 07400 RENAL DIALYSIS	60, 504	3, 700, 694	0. 01634	49 2, 318, 597	37, 907	74.00
5. 00 03951 ECT	1, 671	2, 863, 562	0. 00058	34 2, 152	1	76.00
5.01 03950 MOBILE OUTREACH CLINIC	177, 745	656, 053	0. 27093	31 0	0	76.01
OUTPATIENT SERVICE COST CENTERS			•			1
3. 00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	1 88. 00
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89.00
0. 00 09000 CLINIC	32, 958	-			43	90.00
0. 01 09001 0UTPATI ENT PSYCH	170, 360		0. 43076		43	90.01
D. 02 09002 PEDS CLINIC	170, 300				0	90.02
D. 04 09002 PEDS CETNIC D. 04 09004 BARI ATRI CS	0	l o	0.00000		0	90.02
	3, 168				-	
1. 00 09100 EMERGENCY	953, 386				102, 928	
1. 01 09101 DI AGNOSTI C TREATMENT CENTER	325, 671				40, 778	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	380, 908	8, 943, 381	0. 04259	91 592, 308	25, 227	92.00
OTHER REIMBURSABLE COST CENTERS		•	1			
5. 00 09500 AMBULANCE SERVI CES						95.00
7.00 09700 DURABLE MEDICAL EQUIP-SOLD	30, 272	5, 965, 616	0.00507	74 0	0	97.00
3. 00 09850 HOME OFFICE	0	0	0. 00000	0 0	0	98.00
00.00 Total (lines 50-199)	11, 430, 856	1, 420, 351, 695		256, 953, 730	1, 711, 919	200.00

Health Financial Systems	ST. MARY'S MEI	DICAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS	TS Provi der		Period: From 07/01/2015 To 06/30/2016		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swing-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0)	0	0	31.00
31. 02 03102 NI CU	0	0)	0	0	31.02
32.00 03200 CORONARY CARE UNIT	0	0)	0	0	32.00
40. 00 04000 SUBPROVI DER – I PF	0	0)	0 0	0	40.00
41. 00 04100 SUBPROVI DER – I RF	0	0		0 0	0	41.00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0	0	44.00
45.00 04500 NURSING FACILITY	0	0)	0	0	45.00
200.00 Total (lines 30-199)	0	0)	0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS			1	1		
30. 00 03000 ADULTS & PEDI ATRI CS	56, 588					30.00
31.00 03100 INTENSIVE CARE UNIT	13, 828			1 0		31.00
31. 02 03102 NI CU	5, 937			0 0		31.02
32.00 03200 CORONARY CARE UNI T	1, 457					32.00
40. 00 04000 SUBPROVIDER - IPF	3, 398					40.00
41.00 04100 SUBPROVIDER – IRF	4, 750			3 0		41.00
43. 00 04300 NURSERY	3, 061			0 0		43.00
44.00 04400 SKILLED NURSING FACILITY	0			0 0		44.00
45.00 04500 NURSING FACILITY	0	0.00		0 0		45.00
200.00 Total (lines 30-199)	89, 019		32, 21	8 0		200. 00

Health Financial Systems	ST. MARY'S MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provi der		Period: From 07/01/2015 To 06/30/2016		pared: 49 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician N Anesthetist Cost	lursi ng School	Allied Healt	n All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 02 05402 ULTRASOUND	0	0		0 0	0	54.02
54. 03 05403 NUCLEAR MEDICINE	0	0		0 0	0	54.03
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	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
69. 02 06902 CARDI AC REHAB	0	0		0 0	0	69.02
69. 03 06903 DIABETIC EDUCATION	0	0		0 0	0	69.03
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76. 00 03951 ECT	0	0		0 0	0	76.00
76.01 03950 MOBILE OUTREACH CLINIC	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS	- · ·			-		1
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 OUTPATI ENT PSYCH	0	0		0 0	0	90.01
90. 02 09002 PEDS CLINIC	0	0		0 0	0	90.02
90. 04 09004 BARI ATRI CS	0	0		0 0	0	90.04
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
91. 01 09101 DI AGNOSTI C TREATMENT CENTER	0	0		0 0	0	91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	92.00
95. 00 09500 AMBULANCE SERVICES	1					95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	•
98. 00 09850 HOME OFFICE	0	0		0 0		
200.00 Total (lines 50-199)	0	0		0 0		200.00
	, Ч	0	I	о ₁ 0	0	1200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PAS	S Provi der	CCN: 150100	Peri od:	Worksheet D	
HROUGH COSTS				From 07/01/2015 To 06/30/2016	Part IV Date/Time Pre	pared:
					11/21/2016 8:	49 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00	0.00	7)	10.00	
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
0. 00 05000 OPERATI NG ROOM	0	254, 243, 352	0.0000	0. 000000	39, 169, 021	50.00
1. 00 05100 RECOVERY ROOM	0				7, 338, 864	
2. 00 05200 DELIVERY ROOM & LABOR ROOM					36, 231	•
3. 00 05300 ANESTHESI OLOGY					5, 788, 973	
4. 00 05400 RADI OLOGY-DI AGNOSTI C					5, 889, 043	•
4. 02 05400 ULTRASOUND	0				3, 434, 241	
4. 03 05403 NUCLEAR MEDICINE					4, 159, 837	
6. 00 05600 RADI OI SOTOPE	0		0.00000		4, 159, 857	
7. 00 05700 CT SCAN	0				7, 904, 067	
			0.00000			
					1, 734, 750	
					23, 879, 554	
0.00 06000 LABORATORY					17, 184, 561	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0				2, 550, 166	
4.00 06400 I NTRAVENOUS THERAPY	0				2, 593, 277	
5. 00 06500 RESPI RATORY THERAPY	0				3, 848, 725	
6.00 06600 PHYSI CAL THERAPY	0				3, 982, 270	
7.00 06700 OCCUPATIONAL THERAPY	0				3, 438, 540	
8.00 06800 SPEECH PATHOLOGY	0				916, 930	
9.00 06900 ELECTROCARDI OLOGY	0				10, 871, 555	
9. 02 06902 CARDI AC REHAB	0				2, 288	
9. 03 06903 DI ABETI C EDUCATI ON	0				0	
0.00 07000 ELECTROENCEPHALOGRAPHY	0				1, 386, 406	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				30, 311, 051	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0				28, 222, 805	
3.00 07300 DRUGS CHARGED TO PATIENTS	0				31, 141, 318	
4.00 07400 RENAL DIALYSIS	0				2, 318, 597	
6.00 03951 ECT	0				2, 152	
6. 01 03950 MOBILE OUTREACH CLINIC	0	656, 053	0.00000	0.000000	0	76.0
OUTPATIENT SERVICE COST CENTERS						1
8.00 08800 RURAL HEALTH CLINIC	0				0	
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	
0. 00 09000 CLINIC	0				4, 509	
0. 01 09001 OUTPATI ENT PSYCH	0				0	
0. 02 09002 PEDS CLINIC	0				0	
0. 04 09004 BARI ATRI CS	0				0	
1.00 09100 EMERGENCY	0				14, 720, 780	
1. 01 09101 DI AGNOSTI C TREATMENT CENTER	0				3, 530, 911	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	8, 943, 381	0.00000	0. 000000	592, 308	92.00
OTHER REIMBURSABLE COST CENTERS		1	1	-		
5. 00 09500 AMBULANCE SERVICES						95.0
7. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0				0	
8.00 09850 HOME OFFICE	0		0,00000	0. 000000	0	
00.00 Total (lines 50-199)	0	1, 420, 351, 695			256, 953, 730	200.0

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PASS	Provi der	CCN: 150100	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Pre 11/21/2016 8:	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpatient			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through	ר		
		Costs (col. 8		Costs (col.	9		
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	41, 847, 978		0		50.00
51.00	05100 RECOVERY ROOM	0	17, 411, 361		0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	527		0		52.00
53.00	05300 ANESTHESI OLOGY	0	6, 820, 325		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	7, 050, 896		0		54.00
54.02	05402 ULTRASOUND	0			0		54.00
		-	3, 117, 294		-		
54.03	05403 NUCLEAR MEDICINE	0	10, 806, 354		0		54.03
6. 00	05600 RADI OI SOTOPE	0	0		0		56.00
57.00	05700 CT SCAN	0	10, 672, 473		0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4, 752, 515		0		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	12, 596, 416		0		59.00
60.00	06000 LABORATORY	0	7, 570, 565		0		60.00
53.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 301, 586		0		63.00
54.00	06400 INTRAVENOUS THERAPY	0	2, 920, 230		0		64.00
5.00	06500 RESPI RATORY THERAPY	0	334, 491		0		65.00
6.00	06600 PHYSI CAL THERAPY	0	126, 028		0		66.00
57.00	06700 OCCUPATI ONAL THERAPY	0	74, 819		0		67.00
		-			0		
68.00	06800 SPEECH PATHOLOGY	0	24, 590				68.00
9.00	06900 ELECTROCARDI OLOGY	0	12,099,859		0		69.00
9. 02	06902 CARDI AC REHAB	0	614, 391		0		69.02
69.03	06903 DIABETIC EDUCATION	0	0		0		69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1, 242, 778		0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	18, 265, 689		0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14, 155, 219		0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	25, 289, 514		0		73.00
74.00	07400 RENAL DI ALYSI S	0	237, 266	1	0		74.00
76.00	03951 ECT	0	419, 174		0		76.00
76.01	03950 MOBILE OUTREACH CLINIC	0	0		0		76.01
0.01	OUTPATIENT SERVICE COST CENTERS						1
38.00	08800 RURAL HEALTH CLINIC	0	0		0		88. 00
39.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90.00	09000 CLINIC	0	225, 780		0		90.00
		0					
90.01	09001 OUTPATI ENT PSYCH	0	0		0		90.01
90. 02	09002 PEDS CLINIC	0	0		0		90.02
90.04	09004 BARI ATRI CS	0	0		0		90.04
91.00	09100 EMERGENCY	0	14, 765, 201		0		91.00
91.01	09101 DIAGNOSTIC TREATMENT CENTER	0	4, 080, 851		0		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 137, 357		0		92.00
	OTHER REIMBURSABLE COST CENTERS			•			1
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0		97.00
98.00	09850 HOME OFFICE		0		0		98.00
		0	0	1	U		1 /0.00

APPORTI ONM	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST			Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Pre 11/21/2016 8:	
			Titl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C, Part I, col. 9	inst.)	Services Subject To	Services Not Subject To		
				Ded. & Coins	-		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS	-					
50.00 0500	OO OPERATING ROOM	0. 266575	41, 847, 978		0 0	11, 155, 625	50.00
51.00 0510	DO RECOVERY ROOM	0. 107334	17, 411, 361		0 0	1, 868, 831	51.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	0. 438140	527		0 0	231	52.00
53.00 0530	00 ANESTHESI OLOGY	0. 012225	6, 820, 325		0 0	83, 378	53.00
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	0. 129874	7, 050, 896		0 0	915, 728	54.00
54.02 0540	02 ULTRASOUND	0. 061983			0 0	193, 219	54.02
	03 NUCLEAR MEDICINE	0. 074327			0 0	803, 204	54.03
	DO RADI OI SOTOPE	0. 000000			0 0	0	56.00
	DO CT SCAN	0. 042573			0 0	454, 359	57.00
	DO MAGNETIC RESONANCE IMAGING (MRI)	0. 062541	4, 752, 515		0 0	297, 227	58.00
	OO CARDIAC CATHETERIZATION	0. 047884			0 0	603, 167	59.00
	DO LABORATORY	0. 183258				1, 387, 367	60.00
	DO BLOOD STORING, PROCESSING & TRANS.	0. 245319			0 0	319, 304	63.00
	00 I NTRAVENOUS THERAPY	0. 246416			0 0	719, 591	64.00
	00 RESPIRATORY THERAPY	0. 429061	334, 491		0 0	143, 517	65.00
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	0. 261815			0 0	32, 996	
	DO SPEECH PATHOLOGY	0. 182346			0 0	13, 643	67.00 68.00
	DO ELECTROCARDI OLOGY	0. 072324			0 0	4, 570 875, 110	
	D2 CARDI AC REHAB	1. 087347			0 0	668, 056	1
	03 DI ABETI C EDUCATI ON	5. 423045			0 0	000,000	69.02
	DO ELECTROENCEPHALOGRAPHY	0. 183753			0 0	228, 364	1
	DO MEDICAL SUPPLIES CHARGED TO PATIENT	0. 083768			0 0	1, 530, 080	
	DO I MPL. DEV. CHARGED TO PATIENTS	0. 197977			0 0	2, 802, 408	
	DO DRUGS CHARGED TO PATIENTS	0. 201386			0 41, 652	5, 092, 954	73.00
	DO RENAL DIALYSIS	0. 425752			0 0	101, 016	74.00
76.00 0395	51 ECT	0. 072540	419, 174		0 0	30, 407	76.00
76.01 0395	50 MOBILE OUTREACH CLINIC	1. 974318	0		0 0	0	76.01
	PATIENT SERVICE COST CENTERS						
	DO RURAL HEALTH CLINIC	0. 000000				0	88.00
	00 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
	DO CLINIC	0. 361497			0 0	81, 619	90.00
	01 OUTPATI ENT PSYCH	1. 697682			0 0	0	90.01
	D2 PEDS CLINIC	0. 000000			0 0	0	90.02
	04 BARI ATRI CS	0. 000000			0 0	0	90.04
	DO EMERGENCY	0. 104899			0 0	1, 548, 855	
	01 DI AGNOSTI C TREATMENT CENTER	0. 131108			0 0	535, 032	
	00 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 650801	2, 137, 357		0 0	1, 390, 994	92.00
	R REIMBURSABLE COST CENTERS	0. 642682		1	0		95.00
	00 AMBULANCE SERVICES 00 DURABLE MEDICAL EQUIP-SOLD	0. 530967			0	0	
	50 HOME OFFICE	0. 530967			0 0	0	97.00
200.00	Subtotal (see instructions)	0.00000	220, 961, 527	31, 99	41,652	33, 880, 852	
200.00	Less PBP Clinic Lab. Services-Program		220, 701, 327	51, 75	0 41,052	55,000,052	200.00
201.00	Only Charges						201.00
	Net Charges (line 200 +/- line 201)	1	220, 961, 527	31, 99	41, 652	33, 880, 852	

Heal th Finar	ncial Systems	ST. MARY'S MEI	DI CAL_CENTER		In Lie	u of Form CMS-2	2552-10
APPORTI ONMEI	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150100	Period: From 07/01/2015 To 06/30/2016		pared:
						11/21/2016 8:	49 pm
		Cor		e XVIII	Hospi tal	PPS	
	Cost Center Description	Cost	sts Cost	-			
	cost center bescription	Reimbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	LARY SERVICE COST CENTERS						1
	OPERATING ROOM	0					50.00
	RECOVERY ROOM	0	-				51.00
	DELIVERY ROOM & LABOR ROOM	0					52.00 53.00
	RADI OLOGY-DI AGNOSTI C	0					54.00
	ULTRASOUND	0					54.00
	NUCLEAR MEDICINE	0	-				54.02
	RADI OI SOTOPE	0					56.00
	CT SCAN	0					57.00
	MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
	CARDI AC CATHETERI ZATI ON	0	C				59.00
	LABORATORY	5, 863	0				60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64.00 06400	INTRAVENOUS THERAPY	0	(c				64.00
65.00 06500	RESPI RATORY THERAPY	0	C				65.00
	PHYSI CAL THERAPY	0					66.00
	OCCUPATIONAL THERAPY	0	-	1			67.00
	SPEECH PATHOLOGY	0	-	•			68.00
	ELECTROCARDI OLOGY	0	0	1			69.00
	CARDI AC REHAB	0	0				69.02
		0	0	1			69.03
	ELECTROENCEPHALOGRAPHY	0					70.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
	DRUGS CHARGED TO PATIENTS	0					73.00
	RENAL DIALYSIS	0		1			74.00
76.00 03951		0	-				76.00
	MOBILE OUTREACH CLINIC	0					76.01
	TIENT SERVICE COST CENTERS						1
88.00 08800	RURAL HEALTH CLINIC	0	C				88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	C				89.00
90.00 09000	CLINIC	0	0				90.00
	OUTPATI ENT PSYCH	0	0	p			90.01
	PEDS CLINIC	0	C				90.02
	BARIATRICS	0	C				90.04
	EMERGENCY	0					91.00
	DI AGNOSTI C TREATMENT CENTER	0	-				91.01
	OBSERVATION BEDS (NON-DISTINCT PART	0	C	יייייייייייייייייייייייייייייייייייייי			92.00
	REIMBURSABLE COST CENTERS						95.00
	DURABLE MEDICAL EQUIP-SOLD	0					95.00
	HOME OFFICE	0		1			97.00
200.00	Subtotal (see instructions)	5, 863	-				200.00
200.00	Less PBP Clinic Lab. Services-Program	0,003	0, 300	í l			200.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	5, 863	8, 388	3			202.00
_02.00		1 0,000	, 5,500	.1			1-02.00

Health Financial Systems	ST. MARY'S ME				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi der	CCN: 150100	Period: From 07/01/2015	Worksheet D Part II	
		Componen	t CCN: 15S100	To 06/30/2016	Date/Time Pre	pared:
		T: +1	e XVIII	Subprovider -	11/21/2016 8: PPS	49 pm
			e vvili	IPF	PP3	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		2100	0.00		0100	
50. 00 05000 OPERATI NG ROOM	2, 527, 610	254, 243, 352	0.00994	42 0	0	50.00
51.00 05100 RECOVERY ROOM	184, 630	29, 400, 083	0.00628	30 48, 730	306	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	420, 569	12, 336, 250	0. 0340	92 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	102, 500				216	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 643, 085			90 17, 982	406	54.00
54. 02 05402 ULTRASOUND	53, 721				9	54.02
54. 03 05403 NUCLEAR MEDICINE	117, 633				50	
56. 00 05600 RADI OI SOTOPE	0		0.0000		0	56.00
57.00 05700 CT SCAN	333, 131	54, 150, 217			111	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	105, 286				31	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	887, 143				231	
60. 00 06000 LABORATORY	369, 310				362	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	23, 752				2	
64. 00 06400 I NTRAVENOUS THERAPY	314, 184				19	
65. 00 06500 RESPI RATORY THERAPY	130, 209				15	
66. 00 06600 PHYSI CAL THERAPY	128, 026				120	
67.00 06700 OCCUPATIONAL THERAPY	15, 590			92 16, 934	24	67.00
68.00 06800 SPEECH PATHOLOGY	17, 424				0	
69. 00 06900 ELECTROCARDI OLOGY	655, 531	57, 771, 227	0. 01134	47 26, 484	301	69.00
69. 02 06902 CARDI AC REHAB	121, 540	1, 151, 040	0. 10559	91 0	0	69.02
69. 03 06903 DIABETIC EDUCATION	77, 821				0	69.03
70. 00 07000 ELECTROENCEPHALOGRAPHY	148, 162				0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	205, 035				53	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	371, 470				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	340, 851	157, 297, 529	0.00210	57 377, 462	818	73.00
74.00 07400 RENAL DIALYSIS	60, 504	3, 700, 694	0. 01634	49 9, 296	152	74.00
76.00 03951 ECT	1,671	2, 863, 562	0. 00058	91, 460	53	76.00
76.01 03950 MOBILE OUTREACH CLINIC	177, 745			31 0	0	76.01
OUTPATIENT SERVICE COST CENTERS				1		
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	0 00	0	89.00
90. 00 09000 CLINIC	32, 958	3, 439, 518	0. 00958	32 0	0	90.00
90. 01 09001 OUTPATIENT PSYCH	170, 360	395, 481	0. 43076	67 94, 187	40, 573	90.01
90. 02 09002 PEDS CLINIC	0	0	0.0000	0 00	0	90.02
90. 04 09004 BARI ATRI CS	3, 168	0	0.0000	0 00	0	90.04
91. 00 09100 EMERGENCY	953, 386		0.00699	92 28, 235	197	91.00
91.01 09101 DIAGNOSTIC TREATMENT CENTER	325, 671	28, 199, 173			95	91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	8, 943, 381	0.0000	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	T	1	1	1		
95.00 09500 AMBULANCE SERVICES						95.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	30, 272	5, 965, 616				
98.00 09850 HOME OFFICE	0	() C	0.0000		0	98.00
200.00 Total (lines 50-199)	44 040	1, 420, 351, 695		977, 833		200.00

Health Financial Systems	ST. MARY'S MEDI	ICAL CENTER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PASS	Provi der		Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15S100	From 07/01/2015 To 06/30/2016		narodi
		component	CCN. 155100	10 00/30/2010	11/21/2016 8:	49 pm
		Titl	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Non Physician N	lursing School	Allied Health		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	5.00	4.00	3.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	•
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 02 05402 ULTRASOUND	0	0		0 0	0	54.02
54. 03 05403 NUCLEAR MEDICINE	0	0		0 0	0	54.03
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		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
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	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
69. 02 06902 CARDI AC REHAB	0	0		0 0	0	
69. 03 06903 DI ABETI C EDUCATI ON	0	0		0 0	0	69.03
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	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	
76.00 03951 ECT	0	0		0 0		
76. 01 03950 MOBILE OUTREACH CLINIC	0	0		0 0	0	76.01
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	0	1	0 0	0	00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		
90. 00 09000 CLINIC	0	0		0 0	0	
	0	0		0 0	0	
90. 01 09001 0UTPATI ENT PSYCH 90. 02 09002 PEDS CLINIC	0	0		0 0	0	
90. 02 09002 PEDS CEINIC 90. 04 09004 BARI ATRI CS	0	0		0 0	0	
90. 04 09004 BARTATRICS 91. 00 09100 EMERGENCY		0		0 0	0	
91. 01 09100 EMERGENCE 91. 01 09101 DI AGNOSTI C TREATMENT CENTER	0	0		0 0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	-	•
OTHER REIMBURSABLE COST CENTERS	UU	0	1	<u> </u>	0	12.00
95. 00 09500 AMBULANCE SERVICES	1					95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	•
98.00 09850 HOME OFFICE	0	0		0 0		•
200.00 Total (lines 50-199)	0	0		0 0		200.00

Health Financial Systems	ST. MARY'S ME				u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PAS	S Provider	CCN: 150100	Period: From 07/01/2015	Worksheet D Part IV	
THROUGH COSTS		Componen	t CCN: 15S100	To 06/30/2016		pared:
					11/21/2016 8:	49 pm
		Tit	le XVIII	Subprovider - IPF	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cos		I npati ent	
·	Outpati ent	(from Wkst. C		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00		7)	10.00	
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
50. 00 05000 OPERATING ROOM	C	254, 243, 35	2 0.0000	0. 000000	0	50.00
51. 00 05100 RECOVERY ROOM	C				48, 730	•
52. 00 05200 DELIVERY ROOM & LABOR ROOM					40,730	52.00
53. 00 05300 ANESTHESI OLOGY					41, 398	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C					54.00
54. 02 05402 ULTRASOUND					2, 925	54.02
54. 03 05403 NUCLEAR MEDICINE					15, 708	
56. 00 05600 RADI OI SOTOPE	C		0. 00000		0	56.00
57. 00 05700 CT SCAN	C	54, 150, 21			18, 041	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C			0. 000000	5, 414	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	79, 284, 94	4 0. 00000	0. 000000	20, 633	59.00
60. 00 06000 LABORATORY	C			0. 000000	100, 052	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	8, 184, 41	6 0. 00000	0. 000000	768	63.00
64. 00 06400 I NTRAVENOUS THERAPY	C	19, 546, 00	3 0.0000	0. 000000	1, 200	64.00
65. 00 06500 RESPI RATORY THERAPY	C	11, 416, 92	3 0.00000	0. 000000	1, 331	65.00
66. 00 06600 PHYSI CAL THERAPY	C				17, 061	66.00
67.00 06700 OCCUPATI ONAL THERAPY	C					67.00
68.00 06800 SPEECH PATHOLOGY	C					68.00
69. 00 06900 ELECTROCARDI OLOGY	C					69.00
69. 02 06902 CARDI AC REHAB	C				0	69.02
69. 03 06903 DIABETIC EDUCATION	C				0	
70.00 07000 ELECTROENCEPHALOGRAPHY	C				0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	C				34, 347	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS					377, 462 9, 296	
						•
76.00 03951 ECT 76.01 03950 MOBILE OUTREACH CLINIC					91, 460 0	
OUTPATIENT SERVICE COST CENTERS		050, 05	sj 0.00000	0.00000	0	70.0
88.00 08800 RURAL HEALTH CLINIC	C		0.0000	0.00000	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0.00000		0	89.00
90. 00 09000 CLINIC					0	90.00
90. 01 09001 0UTPATI ENT PSYCH					94, 187	90.0
90. 02 09002 PEDS CLINIC			0.0000		0	90.02
90. 04 09004 BARI ATRI CS	C		0.0000		0	90.04
91. 00 09100 EMERGENCY	C	136, 345, 22			28, 235	91.00
91.01 09101 DIAGNOSTIC TREATMENT CENTER	C				8, 185	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C	8, 943, 38	0. 00000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	C					97.00
98.00 09850 HOME OFFICE	C		0. 00000	0. 000000	0	
200.00 Total (lines 50-199)	C	1, 420, 351, 69	5		977, 833	200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR	Y SERVICE OTHER PASS	5 Provi der	CCN: 150100	Peri od:	Worksheet D	
IROUGH COSTS		Componen	t CCN: 15S100	From 07/01/2015 To 06/30/2016	Part IV Date/Time Prepa	are
		Titl	e XVIII	Subprovider -	11/21/2016 8: 49 PPS	9 p
				I PF		
Cost Center Description	Inpatient	Outpatient	Outpatient			
	Program Pass-Through	Program	Program Pass-Throug	h		
	Costs (col. 8	Charges	Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
0. 00 05000 OPERATI NG ROOM	0	C		0	ţ	50.
. 00 05100 RECOVERY ROOM	0	C		0	1	51.
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0	1	52.
3. 00 05300 ANESTHESI OLOGY	0	C		0	Į	53.
I. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0	Į	54.
02 05402 ULTRASOUND	0	C		0	1	54.
03 05403 NUCLEAR MEDICINE	0	C		0	Į	54.
5. 00 05600 RADI OI SOTOPE	0	C		0	Į	56.
7.00 05700 CT SCAN	0	C		0	Į	57.
. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0	Į	58.
0. 00 05900 CARDIAC CATHETERIZATION	0	C		0	Į	59.
. 00 06000 LABORATORY	0	C		0		60.
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0		63
. 00 06400 I NTRAVENOUS THERAPY	0	C		0		64
00 06500 RESPI RATORY THERAPY	0	C		0		65.
0. 00 06600 PHYSI CAL THERAPY	0	C)	0		66.
7. 00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.
. 00 06800 SPEECH PATHOLOGY	0	C		0		68.
0. 00 06900 ELECTROCARDI OLOGY	0	C		0		69
0. 02 06902 CARDI AC REHAB	0	C		0		69.
9. 03 06903 DIABETIC EDUCATION	0	C		0		69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0		70.
00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	т о	C		0		71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72.
. 00 07300 DRUGS CHARGED TO PATIENTS	0	C	1	0		73
. 00 07400 RENAL DIALYSIS	0	C		0		74
0. 00 03951 ECT	0	C		0		76
0. 01 03950 MOBILE OUTREACH CLINIC	0	C		0		76
OUTPATIENT SERVICE COST CENTERS						~ ~
8.00 08800 RURAL HEALTH CLINIC	0	C		0		88
0.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89
	0	C		0		90.
0. 01 09001 0UTPATI ENT PSYCH 0. 02 09002 PEDS CLINIC	0	C		0		90.
	0	C C		0		90.
0. 04 09004 BARI ATRI CS . 00 09100 EMERGENCY	0			0		90. 91.
	0	C		0		
1.01 09101 DIAGNOSTIC TREATMENT CENTER 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR		C		0		91. 92.
OTHER REIMBURSABLE COST CENTERS	0	Ĺ	1	U	· · · · · · · · · · · · · · · · · · ·	72.
5. 00 09500 AMBULANCE SERVICES						95
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0		95. 97.
3. 00 09850 HOME OFFICE	0	C		0		97.
0.00 Total (lines 50-199)	0	C		0		98. 200.

ealth Financial Systems	ST. MARY'S ME				u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der	CCN: 150100	Period: From 07/01/2015	Worksheet D Part II	
		Componen	t CCN: 15T100	To 06/30/2016	Date/Time Pre 11/21/2016 8:	epared:
		Ti tl	e XVIII	Subprovider - IRF	PPS	17 pm
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	L. Charges	column 4)	
	Part II, col.	8)	2)			
	<u>26)</u> 1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	2, 527, 610	254, 243, 352	0.0099	42 9, 037	90	50.00
1. 00 05100 RECOVERY ROOM	184, 630				27	
2.00 05200 DELIVERY ROOM & LABOR ROOM	420, 569				0	
33. 00 05300 ANESTHESI OLOGY	102, 500				11	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 643, 085	72, 735, 001	0. 0225	90 27, 826	629	54.00
54. 02 05402 ULTRASOUND	53, 721	17, 760, 039	0. 00302	25 45, 745	138	54.0
54. 03 05403 NUCLEAR MEDICINE	117, 633	37, 201, 063	0. 0031	62 0	0	54.0
6. 00 05600 RADI 0I SOTOPE	C	0 0	0.0000	0 00	0	56.0
57.00 05700 CT SCAN	333, 131				71	57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	105, 286				51	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	887, 143				0	59.0
0. 00 06000 LABORATORY	369, 310				684	
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	23, 752				17	63.0
04.00 06400 INTRAVENOUS THERAPY	314, 184				227	
5.00 06500 RESPI RATORY THERAPY	130, 209				274	
66.00 06600 PHYSI CAL THERAPY	128, 026				11, 755	
57.00 06700 OCCUPATI ONAL THERAPY	15, 590				2, 561	
08.00 06800 SPEECH PATHOLOGY	17, 424				3, 091	
99. 00 06900 ELECTROCARDI OLOGY 99. 02 06902 CARDI AC REHAB	655, 531 121, 540				73	
9. 03 06903 DI ABETI C EDUCATI ON	77, 821				0	
0.00 07000 ELECTROENCEPHALOGRAPHY	148, 162				0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	205, 035					
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	371, 470				13	
3. 00 07300 DRUGS CHARGED TO PATIENTS	340, 851				1, 782	
4.00 07400 RENAL DIALYSIS	60, 504				2, 161	
76. 00 03951 ECT	1, 671					
76.01 03950 MOBILE OUTREACH CLINIC	177, 745					
OUTPATIENT SERVICE COST CENTERS						
8.00 08800 RURAL HEALTH CLINIC	C) (0.0000	0 00	0	88.0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C) (0. 0000	0 00	0	89.0
0. 00 09000 CLINIC	32, 958	3, 439, 518	0. 0095	82 0	0	90.0
0. 01 09001 OUTPATIENT PSYCH	170, 360	395, 481	0. 4307	67 0	0	90.0
0. 02 09002 PEDS CLINIC	C	0 0	0.0000	0 00	0	90.0
0. 04 09004 BARI ATRI CS	3, 168		0.0000		0	
21.00 09100 EMERGENCY	953, 386				16	
01.01 09101 DI AGNOSTI C TREATMENT CENTER	325, 671				148	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C	8, 943, 381	0.0000	0 00	0	92.0
OTHER REI MBURSABLE COST CENTERS		1	T			
95.00 09500 AMBULANCE SERVICES					-	95.0
07.00 09700 DURABLE MEDICAL EQUIP-SOLD	30, 272	5, 965, 616				
28.00 09850 HOME OFFICE	11 040 040		0.0000		0	
200.00 Total (lines 50-199)	11, 049, 948	1, 420, 351, 695	2	5, 736, 930	24, 195	1200. O

Health Financial Systems	ST. MARY'S MED	I CAL CENTER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PASS	Provi der		Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15T100	From 07/01/2015 To 06/30/2016		narod
		component	. CCN. 151100	10 00/30/2010	11/21/2016 8:	49 pm
		Ti tl	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Non Physician N	lursing School	Allied Healt		Total Cost	
	Anesthetist			Medical	(sum of col 1	
	Cost			Education Cost		
	1.00	2.00	3.00	4.00	4)	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	•
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 02 05402 ULTRASOUND	0	0		0 0	0	54.02
54.03 05403 NUCLEAR MEDICINE	0	0		0 0	0	54.03
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		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
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
69. 02 06902 CARDI AC REHAB	0	0		0 0	-	
69. 03 06903 DI ABETI C EDUCATI ON	0	0		0 0	0	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	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	
76.00 03951 ECT 76.01 03950 MOBILE OUTREACH CLINIC	0	0		0 0 0 0		
76. 01 03950 MOBILE OUTREACH CLINIC OUTPATIENT SERVICE COST CENTERS	U	0		0 0	0	76.01
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		
90. 00 09000 CLINIC	0	0		0 0	0	
90. 01 09001 OUTPATI ENT PSYCH	0	0		0 0	0	
90. 02 09002 PEDS CLINIC	0	0		0 0	0	
90. 04 09004 BARI ATRI CS	0	0		0 0	0	
91. 00 09100 EMERGENCY	0	0		0 0	0	
91. 01 09101 DI AGNOSTI C TREATMENT CENTER	0	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	-	•
OTHER REIMBURSABLE COST CENTERS				-		1
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	97.00
98.00 09850 HOME OFFICE	0	0		0 0	0	98.00
200.00 Total (lines 50-199)	0	0		0 0	0	200. 00

	ancial Systems	ST. MARY'S ME					eu of Form CMS-2	2552-10
	MENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S	Provi der	CCN: 150100	Period: From 07/01/2015	Worksheet D Part IV	
THROUGH CO	JSTS			Component	CCN: 15T100	To 06/30/2016		nared
				oomponion		10 00,00,2010	11/21/2016 8:	49 pm
				Ti tl	e XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Total	Total	Charges	Ratio of Cos		Inpati ent	
	····	Outpati ent		Wkst. C,		Ratio of Cost	Program	
		Cost (sum of			(col. 5 ÷ col		Charges	
		col. 2, 3 and		8)	7)	(col. 6 ÷ col.	Ŭ	
		4)		-		7)		
		6.00		7.00	8.00	9.00	10.00	
	I LLARY SERVICE COST CENTERS	-						
	OO OPERATI NG ROOM	0		4, 243, 352				50.00
	00 RECOVERY ROOM	0		9, 400, 083				
	00 DELIVERY ROOM & LABOR ROOM	0		2, 336, 250				52.00
	00 ANESTHESI OLOGY	0		9,661,385				
	00 RADI OLOGY-DI AGNOSTI C	0		2, 735, 001	0.0000			54.00
		0		7,760,039				54.02
	03 NUCLEAR MEDICINE	0		7, 201, 063				54.03
	00 RADI OI SOTOPE	0		0	0.0000			56.00
	00 CT SCAN	0	-	4, 150, 217				57.00
	00 MAGNETIC RESONANCE I MAGING (MRI)	0		8, 185, 504	0.0000			58.00
	00 CARDI AC CATHETERI ZATI ON	0		9, 284, 944				59.00
	00 LABORATORY	0		2, 158, 590				60.00
	00 BLOOD STORING, PROCESSING & TRANS.	0		8, 184, 416				63.00
	00 I NTRAVENOUS THERAPY	0		9, 546, 003				
		0		1, 416, 923				
	00 PHYSI CAL THERAPY	0	1	8, 217, 768				66.00
	00 OCCUPATIONAL THERAPY	0		1, 202, 329				67.00
	00 SPEECH PATHOLOGY	0		3, 714, 964				68.00
		0		7,771,227				69.00
	02 CARDI AC REHAB	0		1, 151, 040				69.02
		0		204, 756				69.03
	00 ELECTROENCEPHALOGRAPHY	0		8, 758, 452				70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT 00 IMPL. DEV. CHARGED TO PATIENTS			2, 598, 567	0.0000			
	00 DRUGS CHARGED TO PATIENTS			2, 662, 594 7, 297, 529				73.00
	00 RENAL DIALYSIS							
	51 ECT			3, 700, 694				
	50 MOBILE OUTREACH CLINIC	0		2, 863, 562 656, 053				76.00 76.01
	PATIENT SERVICE COST CENTERS	0	'I	030, 033	0.0000		0	70.01
	00 RURAL HEALTH CLINIC	0		0	0.0000	0. 000000	0	88. 00
	00 FEDERALLY QUALIFIED HEALTH CENTER	0		0				89.00
	00 CLINIC	0		3, 439, 518				90.00
	01 OUTPATI ENT PSYCH	0		395, 481	0.00000			90.01
	02 PEDS CLINIC	0		0,401				90.02
	04 BARI ATRI CS	0		0				90.02
	00 EMERGENCY	0		6, 345, 221				91.00
	01 DI AGNOSTI C TREATMENT CENTER	0		8, 199, 173				91.01
	00 OBSERVATION BEDS (NON-DISTINCT PART			8, 943, 381				
	ER REIMBURSABLE COST CENTERS			.,,				1
	00 AMBULANCE SERVICES							95.00
	00 DURABLE MEDICAL EQUI P-SOLD	0		5, 965, 616	0.0000	0. 000000	0	97.00
97.00 097								
	50 HOME OFFICE	0		0	0.0000	0. 000000	0	98.00

PORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	Provi der	CCN: 150100	Peri od:	eu of Form CMS-2552- Worksheet D	
ROUGH COSTS		Componen	t CCN: 15T100	From 07/01/2015 To 06/30/2016	Part IV Date/Time Prepar	
		Titl	e XVIII	Subprovi der –	11/21/2016 8: 49 PPS	
				IRF		
Cost Center Description	Inpatient Program	Outpatient	Outpatient			
	Pass-Through	Program Charges	Program Pass-Throug	h		
	Costs (col. 8	charges	Costs (col.			
	x col. 10)		x col. 12)	·		
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						
. 00 05000 OPERATING ROOM	0	C		0	5	
. 00 05100 RECOVERY ROOM	0	C		0	5	
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0	5	
. 00 05300 ANESTHESI OLOGY	0	C		0	5	
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0	5	
. 02 05402 ULTRASOUND	0	C		0	5	
. 03 05403 NUCLEAR MEDICINE	0	C		0	5	
. 00 05600 RADI 0I SOTOPE	0	C		0	5	
	0	C		0	5	
. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	C		0	5	
. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0	5	
	0	C		0	6	
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0	6	
	0	C		0	6	
. 00 06500 RESPI RATORY THERAPY . 00 06600 PHYSI CAL_THERAPY	0	C	1	0	6	
. 00 06600 PHYSI CAL THERAPY . 00 06700 OCCUPATI ONAL THERAPY	0			0	6	
. 00 06800 SPEECH PATHOLOGY	0	C		0	6	
. 00 06900 ELECTROCARDI OLOGY	0	C		0	6	
. 02 06902 CARDI AC REHAB	0	C		0	6	
. 03 06903 DI ABETI C EDUCATI ON	0	C		0	6	
. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0	7	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-	C		0	7	
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0	7	
. 00 07300 DRUGS CHARGED TO PATIENTS	0	C		0	7	
00 07400 RENAL DIALYSIS	0	C)	0	7	
. 00 03951 ECT	0	C		0	7	
. 01 03950 MOBILE OUTREACH CLINIC	0	C)	0	7	
OUTPATIENT SERVICE COST CENTERS						
. 00 08800 RURAL HEALTH CLINIC	0	C		0	8	
. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0	8	
. 00 09000 CLINIC	0	C		0	9	
. 01 09001 OUTPATI ENT PSYCH	0	C		0	9	
. 02 09002 PEDS CLINIC	0	C		0	9	
. 04 09004 BARI ATRI CS	0	C		0	9	
. 00 09100 EMERGENCY	0	C		0	9	
. 01 09101 DI AGNOSTI C TREATMENT CENTER	0	C		0	9	
. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	C	1	0	9	
			1			
. 00 09500 AMBULANCE SERVICES		-		0	9	
. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0	9	
. 00 09850 HOME OFFICE	0	C		0	9	

PORTI ONMEN	T OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150100	Period: From 07/01/2015	Worksheet D Part V	
			Componen	t CCN: 15T100	To 06/30/2016	Date/Time Pre 11/21/2016 8:	
			Ti tl	e XVIII	Subprovider - IRF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge Ratio From	Services (see		Cost Reimbursed	PPS Services (see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(See Thst.)	
		Part I, col. 9		Subject To			
				Ded. & Coins			
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	ARY SERVICE COST CENTERS	0.044575	1	1		-	
	OPERATING ROOM	0. 266575			0 0	0	
	RECOVERY ROOM	0. 107334			0 0	0	
	DELIVERY ROOM & LABOR ROOM	0. 438140			0 0	0	
1 1	ANESTHESI OLOGY	0. 012225		1	0 0	0	
1 1	RADI OLOGY-DI AGNOSTI C ULTRASOUND	0. 129874 0. 061983			0 0 0 0	0	
	NUCLEAR MEDICINE	0. 074327			0 0	0	
	RADI OI SOTOPE	0. 000000			0 0	0	
	CT SCAN	0. 042573			0 0	0	
	MAGNETIC RESONANCE IMAGING (MRI)	0. 042573			0 0	0	
	CARDI AC CATHETERI ZATI ON	0. 047884			0 0	0	59.0
	LABORATORY	0. 183258			0 0	0	
	BLOOD STORING, PROCESSING & TRANS.	0. 245319			0 0	0	
	INTRAVENOUS THERAPY	0. 246416			0 0	0	
	RESPI RATORY THERAPY	0. 429061			0 0	0	
	PHYSI CAL THERAPY	0. 261815			0 0	0	
	OCCUPATIONAL THERAPY	0. 182346			0 0	0	
	SPEECH PATHOLOGY	0. 185830			0 0	0	68.0
	ELECTROCARDI OLOGY	0. 072324			0 0	0	
	CARDI AC REHAB	1. 087347			0 0	0	69.0
	DIABETIC EDUCATION	5. 423045	c		0 0	0	69.0
1 1	ELECTROENCEPHALOGRAPHY	0. 183753			0 0	0	70.0
. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 083768	C		0 0	0	71.0
. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 197977	C		0 0	0	72.0
. 00 07300	DRUGS CHARGED TO PATIENTS	0. 201386	C)	0 0	0	73.0
1.00 07400	RENAL DIALYSIS	0. 425752	C		0 0	0	74.0
0. 00 03951		0. 072540			0 0	0	76.0
	MOBILE OUTREACH CLINIC	1. 974318	C)	0 0	0	76.0
	I ENT SERVICE COST CENTERS		1	1			
1 1	RURAL HEALTH CLINIC	0. 000000				0	
	FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
		0. 361497			0 0	0	
	OUTPATIENT PSYCH	1. 697682			0 0	0	
	PEDS CLINIC BARIATRICS	0. 000000			0 0 0 0	0	
. 04 09004 . 00 09100		0. 000000 0. 104899			0 0	0	
	DIAGNOSTIC TREATMENT CENTER	0. 104899			0 0	0	
	OBSERVATION BEDS (NON-DISTINCT PART	0. 650801			0 0	0	
	REIMBURSABLE COST CENTERS	0.00001		/	0 0	0	72.0
	AMBULANCE SERVICES	0. 642682			0		95.0
	DURABLE MEDICAL EQUIP-SOLD	0. 530967			0 0	0	
	HOME OFFICE	0. 000000			0 0	0	
	Subtotal (see instructions)				0 0		200. 0
	Less PBP Clinic Lab. Services-Program				0 0	0	201.0
	Only Charges						
	Net Charges (line 200 +/- line 201)	1	C C	.1	0 0		202.0

PPORTI ONMENT	OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150100	Period:	Worksheet D	
			Componen	t CCN: 15T100	From 07/01/2015 To 06/30/2016	Part V Date/Time Pr 11/21/2016 8	epareo
			Ti t	le XVIII	Subprovider - IRF	PPS	
		Cos	ts			<u> </u>	
Co	ost Center Description	Cost	Cost				
		Reimbursed Services	Reimbursed Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	RY SERVICE COST CENTERS						
	PERATING ROOM	0		C			50.
	ECOVERY ROOM	0		C			51.
	ELIVERY ROOM & LABOR ROOM	0		C			52.
	NESTHESI OLOGY	0					53.
	ADI OLOGY-DI AGNOSTI C	0					54.
		0		D			54.
1 1	JCLEAR MEDICINE	0		D			54.
1 1	ADI OI SOTOPE	0					56.
7.00 05700 C		0					57.
	AGNETIC RESONANCE IMAGING (MRI) ARDIAC CATHETERIZATION	0					58. 59.
	ABORATORY	0					60.
	LOOD STORING, PROCESSING & TRANS.	0					63.
	VTRAVENOUS THERAPY	0					64.
	ESPIRATORY THERAPY	0					65.
	HYSI CAL THERAPY	0					66.
	CCUPATIONAL THERAPY	0					67.
	PEECH PATHOLOGY	0					68.
	LECTROCARDI OLOGY	0					69.
1 1	ARDI AC REHAB	0	(69.
9. 03 06903 DI	ABETIC EDUCATION	0	(b			69.
0. 00 07000 EI	LECTROENCEPHALOGRAPHY	0	(b			70.
1.00 07100 ME	EDICAL SUPPLIES CHARGED TO PATIENT	0	(b			71.
2.00 07200 11	MPL. DEV. CHARGED TO PATIENTS	0	(C			72.
3.00 07300 DF	RUGS CHARGED TO PATIENTS	0	(D			73.
	ENAL DIALYSIS	0		C			74.
6. 00 03951 E0		0		C			76.
	DBILE OUTREACH CLINIC	0	(0			76.
	ENT SERVICE COST CENTERS	a					
	JRAL HEALTH CLINIC	0		C			88.
9.00 08900 FE 0.00 09000 CI	EDERALLY QUALIFIED HEALTH CENTER	0					89.
	JTPATIENT PSYCH	0					90. 90.
	EDS CLINIC	0					90.
	ARIATRICS	0	(90.
1.00 09100 EN		0					91.
	AGNOSTIC TREATMENT CENTER	0					91.
	BSERVATION BEDS (NON-DISTINCT PART	0					92.
	EIMBURSABLE COST CENTERS						
	MBULANCE SERVICES	0					95.
7. 00 09700 DI	JRABLE MEDICAL EQUIP-SOLD	0	(D			97.
	DME OFFICE	0	(c			98.
00. 00 Si	ubtotal (see instructions)	0	(c			200.
01.00 Le	ess PBP Clinic Lab. Services-Program	0					201.
	nly Charges						
02.00 Ne	et Charges (line 200 +/- line 201)	0	(C			202.

Health Financial Systems	ST. MARY'S MEI	DICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 150100	Peri od: From 07/01/2015 To 06/30/2016		pared:
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos			
	Part II, col.		(col. 1 - co			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-	L				
30. 00 ADULTS & PEDIATRICS	3, 083, 690	0	3, 083, 6	90 56, 588	54.49	30.00
31.00 INTENSIVE CARE UNIT	936, 986		936, 9	36 13, 828	67.76	31.00
31. 02 NI CU	339, 898		339, 8	98 5, 937	57.25	31.02
32.00 CORONARY CARE UNIT	225, 771		225, 7	71 1, 457	154.96	32.00
40.00 SUBPROVIDER - IPF	179, 048	0	179, 0	48 3, 398	52.69	40.00
41.00 SUBPROVIDER - IRF	539, 460	0	539, 4	60 4, 750	113.57	41.00
43.00 NURSERY	12, 563		12, 5	53 3, 061	4.10	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
45.00 NURSING FACILITY	0			0 0	0.00	45.00
200.00 Total (lines 30-199)	5, 317, 416		5, 317, 4	16 89, 019		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 ADULTS & PEDIATRICS	5, 266					30.00
31.00 INTENSIVE CARE UNIT	111		•			31.00
31. 02 NI CU	3, 626					31.02
32.00 CORONARY CARE UNI T	88					32.00
40. 00 SUBPROVI DER – I PF	1, 238		•			40.00
41.00 SUBPROVIDER – IRF	282					41.00
43.00 NURSERY	736	3, 018				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
45.00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30-199)	11, 347	615, 965				200. 00

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der	CCN: 150100	Peri od: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Pre 11/21/2016 8:	epared: 50 pm
			le XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	- 1	1	-	1		
0. 00 05000 OPERATI NG ROOM	2, 527, 610	254, 243, 352	0.00994	1, 888, 322	18, 774	50.00
1.00 05100 RECOVERY ROOM	184, 630	29, 400, 083	0.00628	30 177, 152	1, 113	51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	420, 569	12, 336, 250	0. 03409	92 1, 004, 161	34, 234	52.00
3. 00 05300 ANESTHESI OLOGY	102, 500	19, 661, 385	0.0052	13 158, 355	826	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 643, 085			374, 466	8, 459	54.00
4. 02 05402 ULTRASOUND	53, 721				692	54.02
4. 03 05403 NUCLEAR MEDICINE	117, 633				428	
6. 00 05600 RADI OI SOTOPE	0		0.00000		0	
7. 00 05700 CT SCAN	333, 131	54, 150, 217			2, 523	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	105, 286				741	
9. 00 05900 CARDI AC CATHETERI ZATI ON	887, 143				6, 567	
0. 00 06000 LABORATORY						
	369, 310				4, 182	
3. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	23, 752				569	
4. 00 06400 I NTRAVENOUS THERAPY	314, 184				9, 358	
5. 00 06500 RESPI RATORY THERAPY	130, 209				10, 003	
6. 00 06600 PHYSI CAL THERAPY	128, 026				1, 239	
7.00 06700 OCCUPATI ONAL THERAPY	15, 590				337	
8.00 06800 SPEECH PATHOLOGY	17, 424				746	
9. 00 06900 ELECTROCARDI OLOGY	655, 531	57, 771, 227	0. 01134	441, 608	5, 011	69.00
9. 02 06902 CARDI AC REHAB	121, 540	1, 151, 040	0. 10559	91 0	0	69.02
9.03 06903 DIABETIC EDUCATION	77, 821	204, 756	0. 38006	57 0	0	69.03
0. 00 07000 ELECTROENCEPHALOGRAPHY	148, 162	8, 758, 452	0. 0169	16 29, 715	503	70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	205, 035	132, 598, 567	0. 00154	46 509, 103	787	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	371, 470				0	
3.00 07300 DRUGS CHARGED TO PATIENTS	340, 851				4, 756	
4.00 07400 RENAL DIALYSIS	60, 504				1, 102	
6. 00 03951 ECT	1, 671				0	
6.01 03950 MOBILE OUTREACH CLINIC	177, 745		1			
OUTPATIENT SERVICE COST CENTERS		000,000	012/0/		ŭ	/ 0. 0
8. 00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88. 00
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	
0. 00 09000 CLINIC	32, 958	-	0.00000		0	
0. 01 09001 0UTPATI ENT PSYCH	170, 360				0	
0. 02 09002 PEDS CLINIC	170, 300		1		0	
		0				
0. 04 09004 BARI ATRI CS	3, 168		0.00000		0	
1.00 09100 EMERGENCY	953, 386				5, 635	
1. 01 09101 DI AGNOSTI C TREATMENT CENTER	325, 671				3, 969	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	380, 908	8, 943, 381	0.04259	91 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	-1	1				
5. 00 09500 AMBULANCE SERVICES						95.00
7.00 09700 DURABLE MEDICAL EQUIP-SOLD	30, 272	5, 965, 616			0	
8.00 09850 HOME OFFICE	0	0	0.0000	0 00	0	
00.00 Total (lines 50-199)	11, 430, 856	1, 420, 351, 695		12, 873, 044	122, 554	200.00

Health Financial Systems ST. MARY'S MEDICAL CENTER In Lieu of Form	CMS-2552-10
Title XIX Hospital	Cost
Cost Center Description Nursing School Allied Health All Other Swing-Bed Total C	osts
Cost Medical Adjustment (sum of	col s.
Education Cost Amount (see 1 through	h 3,
instructions) minus co	. 4)
1.00 2.00 3.00 4.00 5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 0 0 0 0	0 30.00
31.00 03100 INTENSIVE CARE UNIT 0 0 0	0 31.00
31. 02 03102 NI CU 0 0	0 31.02
32.00 OS200 CORONARY CARE UNIT	0 32.00
40. 00 04000 SUBPROVIDER - IPF 0 0 0 0	0 40.00
41.00 04100 SUBPROVIDER - IRF 0 0 0 0	0 41.00
43. 00 04300 NURSERY 0 0 0	0 43.00
44. 00 04400 SKILLED NURSING FACILITY 0 0 0	0 44.00
45. 00 04500 NURSING FACILITY 0 0 0	0 45.00
200.00 Total (lines 30-199) 0 0 0	0 200.00
Cost Center Description Total Patient Per Diem (col. Inpatient Inpatient	
Days 5 ÷ col. 6) Program Days Program	
Pass-Through	
Cost (col. 7 x	
col. 8)	
6.00 7.00 8.00 9.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 56, 588 0. 00 5, 266 0	30.00
31. 00 03100 I NTENSI VE CARE UNIT 13, 828 0. 00 111 0	31.00
31. 02 03102 NI CU 5, 937 0. 00 3, 626 0	31.02
32. 00 03200 CORONARY CARE UNIT 1,457 0.00 88 0	32.00
40. 00 04000 SUBPROVIDER - IPF 3, 398 0. 00 1, 238 0	40.00
41.00 04100 SUBPROVIDER - IRF 4,750 0.00 282 0	41.00
43. 00 04300 NURSERY 3, 061 0. 00 736 0	43.00
44. 00 04400 SKILLED NURSING FACILITY 0 0.00 0	44.00
45. 00 04500 NURSING FACILITY 0 0.00 0	45.00
200.00 Total (lines 30-199) 89,019 11,347 0	200.00

Health Fi	nancial Systems	ST. MARY'S MED	ICAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTION THROUGH C	IMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF COSTS	RVICE OTHER PASS	Provi der		Period: From 07/01/2015 To 06/30/2016		pared: 50 pm
			Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description	Non Physician N Anesthetist Cost	lursing School	Allied Healt	n All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANG	CILLARY SERVICE COST CENTERS						
50.00 050	000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05	100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 052	200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 053	300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.02 054	402 ULTRASOUND	0	0		0 0	0	54.02
54.03 054	403 NUCLEAR MEDICINE	0	0		0 0	0	54.03
56.00 050	600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05	700 CT SCAN	0	0		0 0	0	57.00
58.00 058	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00 059	900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00 060	000 LABORATORY	0	0		0 0	0	60.00
63.00 063	300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 064	400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00 06	500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00 06	600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06	700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 068	800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 069	900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69.02 069	902 CARDI AC REHAB	0	0		0 0	0	69.02
69.03 06	903 DIABETIC EDUCATION	0	0		0 0	0	69.03
70.00 070	000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	400 RENAL DIALYSIS	0	0		0 0	0	74.00
	951 ECT	0	0		0 0	0	76.00
	950 MOBILE OUTREACH CLINIC	0	0		0 0	0	76.01
	TPATIENT SERVICE COST CENTERS	i i					
	800 RURAL HEALTH CLINIC	0	0		0 0		88.00
	900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		89.00
	000 CLINIC	0	0		0 0	0	90.00
	001 OUTPATIENT PSYCH	0	0		0 0	0	90.01
	002 PEDS CLINIC	0	0		0 0	0	90.02
	004 BARI ATRI CS	0	0		0 0	0	90.04
	100 EMERGENCY	0	0		0 0	0	91.00
	101 DI AGNOSTI C TREATMENT CENTER	0	0		0 0	0	91.01
OTH	200 OBSERVATION BEDS (NON-DISTINCT PART HER REIMBURSABLE COST CENTERS	0	0		0 0	0	92.00
	500 AMBULANCE SERVI CES						95.00
	700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0		
	850 HOME OFFICE	0	0		0 0		
200.00	Total (lines 50-199)	0	0		0 0	0	200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PAS	S Provi der	CCN: 150100	Peri od:	Worksheet D	
HROUGH COSTS				From 07/01/2015 To 06/30/2016	Date/Time Pre	pared:
			le XIX	Hospi tal	11/21/2016 8: Cost	50 pm
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	Inpatient	
cost center bescription	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	ondi goo	
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS						
0.00 05000 OPERATING ROOM	0	254, 243, 352	0.00000	0.00000	1, 888, 322	50.0
1.00 05100 RECOVERY ROOM	0	29, 400, 083	0.00000	0.00000	177, 152	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	12, 336, 250	0.00000	0.000000	1, 004, 161	52.0
3. 00 05300 ANESTHESI OLOGY	0	19, 661, 385	0.00000	0.000000	158, 355	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	72, 735, 001	0.00000	0.000000	374, 466	54.0
4. 02 05402 ULTRASOUND	0	17, 760, 039	0.00000	0.00000	228, 791	54.0
4. 03 05403 NUCLEAR MEDICINE	0	37, 201, 063	0.00000	0.00000	135, 307	54.0
6. 00 05600 RADI 0I SOTOPE	0	0	0.00000	0.00000	0	56.0
7.00 05700 CT SCAN	0	54, 150, 217	0. 00000	0.000000	410, 057	57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	18, 185, 504	0.00000	0.000000	127, 998	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	79, 284, 944	0.00000	0. 000000	586, 916	59.0
0. 00 06000 LABORATORY	0	102, 158, 590	0. 00000	0. 000000	1, 156, 793	60.0
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	8, 184, 416	0. 00000	0. 000000	196, 086	63.0
4.00 06400 INTRAVENOUS THERAPY	0	19, 546, 003	0.00000	0. 000000	582, 189	64.0
5. 00 06500 RESPI RATORY THERAPY	0	11, 416, 923	0.00000	0. 000000	877, 068	65.0
6. 00 06600 PHYSI CAL THERAPY	0	18, 217, 768	0.00000	0. 000000	176, 255	66.0
7.00 06700 OCCUPATI ONAL THERAPY	0			0. 000000	241, 997	67.0
8.00 06800 SPEECH PATHOLOGY	0	3, 714, 964	0.00000	0. 000000	159, 071	68.0
9. 00 06900 ELECTROCARDI OLOGY	0	57, 771, 227	0. 00000	0. 000000	441, 608	69.0
9. 02 06902 CARDI AC REHAB	0	1, 151, 040	0.00000	0. 000000	0	69.0
9. 03 06903 DIABETIC EDUCATION	0	204, 756	0. 00000	0. 000000	0	69.0
0. 00 07000 ELECTROENCEPHALOGRAPHY	0	8, 758, 452	0. 00000	0. 000000	29, 715	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	132, 598, 567	0. 00000	0. 000000	509, 103	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	102, 662, 594	0. 00000	0. 000000	0	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0	157, 297, 529	0. 00000	0. 000000	2, 194, 674	73.0
4.00 07400 RENAL DIALYSIS	0	3, 700, 694	0. 00000	0.00000	67, 390	74.0
6. 00 03951 ECT	0	2, 863, 562	0. 00000	0. 000000	0	76.0
6.01 03950 MOBILE OUTREACH CLINIC	0	656, 053	0.00000	0.00000	0	76.0
OUTPATIENT SERVICE COST CENTERS						
8.00 08800 RURAL HEALTH CLINIC	0	0			0	88.0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.0
0. 00 09000 CLINIC	0	3, 439, 518			0	90.0
0. 01 09001 OUTPATI ENT PSYCH	0	395, 481	0.00000	0.00000	0	90.0
0. 02 09002 PEDS CLINIC	0	0			0	90.0
0. 04 09004 BARI ATRI CS	0				0	90.0
1.00 09100 EMERGENCY	0				805, 922	•
1.01 09101 DIAGNOSTIC TREATMENT CENTER	0				343, 648	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	8, 943, 381	0.00000	0 0.000000	0	92.0
OTHER REIMBURSABLE COST CENTERS		1	1			
5. 00 09500 AMBULANCE SERVICES						95.0
7.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	5, 965, 616				
8.00 09850 HOME OFFICE	0		0.00000	0 0. 000000	0	98.0
00.00 Total (lines 50-199)	0	1, 420, 351, 695			12, 873, 044	200.0

APPORTI O THROUGH	inancial Systems NMENT OF INPATIENT/OUTPATIENT ANCILLARY SE COSTS	ST. MARY'S MED RVICE OTHER PASS		CCN: 150100	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV	2552-10
						11/21/2016 8:	
	Cost Center Description	I npati ent	Outpatient	le XIX Outpatient	Hospi tal	Cost	
	cost center bescription	Program	Program	Program			
		Pass-Through	Charges	Pass-Through	h		
		Costs (col. 8	charges	Costs (col.			
		x col. 10)		x col. 12)	7		
		11.00	12.00	13.00	_		
AN	NCI LLARY SERVI CE COST CENTERS	11.00	12.00	10.00			
	5000 OPERATING ROOM	0	3,005,752		0		50.00
	5100 RECOVERY ROOM	0	292, 537		0		51.00
	5200 DELIVERY ROOM & LABOR ROOM	0	49,609		0		52.00
	5300 ANESTHESI OLOGY	0	212, 679		0		53.00
	5400 RADI OLOGY-DI AGNOSTI C	0	710, 836		0		54.00
	5402 ULTRASOUND	0	329, 976		0		54.02
	5403 NUCLEAR MEDICINE	0	406, 475		0		54.03
	5600 RADI OI SOTOPE	0	400, 479		0		56.00
	5700 CT SCAN	0	784, 866		0		57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	338, 068		0		58.00
	5900 CARDI AC CATHETERI ZATI ON	0	292, 489		0		59.00
	6000 LABORATORY	0	1, 318, 233		0		60.00
		0			0		
	6300 BLOOD STORING, PROCESSING & TRANS.		56, 427		-		63.00
	6400 I NTRAVENOUS THERAPY	0	457, 429		0		64.00
	6500 RESPI RATORY THERAPY	0	73, 024		0		65.00
	6600 PHYSI CAL THERAPY	0	39, 494		0		66.00
	6700 OCCUPATI ONAL THERAPY	0	7, 545		0		67.00
	6800 SPEECH PATHOLOGY	0	6, 055		0		68.00
	6900 ELECTROCARDI OLOGY	0	759, 571		0		69.00
	6902 CARDI AC REHAB	0	0		0		69.02
	6903 DIABETIC EDUCATION	0	69, 678		0		69.03
	7000 ELECTROENCEPHALOGRAPHY	0	113, 450		0		70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	56, 283		0		71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
	7300 DRUGS CHARGED TO PATIENTS	0	939, 377		0		73.00
	7400 RENAL DIALYSIS	0	6, 910		0		74.00
	3951 ECT	0	0		0		76.00
	3950 MOBILE OUTREACH CLINIC	0	0		0		76.01
	UTPATIENT SERVICE COST CENTERS			1			
	8800 RURAL HEALTH CLINIC	0	0		0		88.00
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
	9000 CLINIC	0	0		0		90.00
90.01 09	9001 OUTPATI ENT PSYCH	0	9, 180		0		90.01
90. 02 09	9002 PEDS CLINIC	0	0		0		90.02
90.04 09	9004 BARI ATRI CS	0	0		0		90.04
91.00 09	9100 EMERGENCY	0	3, 667, 523		0		91.00
91.01 09	9101 DIAGNOSTIC TREATMENT CENTER	0	635, 949		0		91.01
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92.00
	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVICES						95.00
	9700 DURABLE MEDICAL EQUIP-SOLD	0	0		0		97.00
	9850 HOME OFFICE	0	0		0		98.00
200.00	Total (lines 50-199)	0	14, 639, 415		0		200.00

APPORTI ONM	IENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST		CCN: 150100	Period: From 07/01/2015 To 06/30/2016	Date/Time Pre 11/21/2016 8:	
			Tit	le XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C, Part I, col. 9	inst.)	Services Subject To	Services Not Subject To		
				Ded. & Coins	2		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS	-			!		
50.00 0500	DO OPERATING ROOM	0. 266575	3, 005, 752		0 0	801, 258	50.00
51.00 0510	DO RECOVERY ROOM	0. 107334	292, 537		0 0	31, 399	51.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	0. 438140	49, 609		0 0	21, 736	52.00
53.00 0530	DO ANESTHESI OLOGY	0. 012225	212, 679		0 0	2, 600	53.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	0. 129874	710, 836		0 0	92, 319	54.00
54.02 0540	D2 ULTRASOUND	0. 061983	329, 976		0 0	20, 453	54.02
	D3 NUCLEAR MEDICINE	0. 074327			0 0	30, 212	54.03
	DO RADI OI SOTOPE	0. 000000			0 0	0	56.00
	DO CT SCAN	0. 042573			0 0	33, 414	57.00
	DO MAGNETIC RESONANCE IMAGING (MRI)	0. 062541	338, 068	1	0 0	21, 143	
	DO CARDI AC CATHETERI ZATI ON	0. 047884			0 0	14, 006	•
	DO LABORATORY	0. 183258		1	0 0	241, 577	•
	DO BLOOD STORING, PROCESSING & TRANS.	0. 245319			0 0	13, 843	1
	DO INTRAVENOUS THERAPY	0. 246416			0 0	112, 718	•
		0. 429061	73, 024		0 0	31, 332	•
	DO PHYSI CAL THERAPY DO OCCUPATI ONAL THERAPY	0. 261815			0 0	10, 340	•
	DO SPEECH PATHOLOGY	0. 182346			0 0	1, 376 1, 125	
	DO ELECTROCARDI OLOGY	0. 072324			0 0	54, 935	
	D2 CARDI AC REHAB	1. 087347		1	0 0	0	69.02
	D3 DI ABETI C EDUCATI ON	5. 423045			0 0	377, 867	69.03
	DO ELECTROENCEPHALOGRAPHY	0. 183753			0 0	20, 847	•
	DO MEDICAL SUPPLIES CHARGED TO PATIENT	0. 083768			0 0	4, 715	
	DO I MPL. DEV. CHARGED TO PATIENTS	0. 197977	00,200		0 0	0	72.00
	DO DRUGS CHARGED TO PATIENTS	0. 201386	939, 377		0 0	189, 177	73.00
74.00 0740	DO RENAL DI ALYSI S	0. 425752	6, 910)	0 0	2, 942	74.00
76.00 039	51 ECT	0. 072540	0		0 0	0	76.00
76.01 039	50 MOBILE OUTREACH CLINIC	1. 974318	0		0 0	0	76.01
	PATIENT SERVICE COST CENTERS	1					
	DO RURAL HEALTH CLINIC	0. 000000				0	88.00
	DO FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
		0. 361497			0 0	0	90.00
	D1 OUTPATI ENT PSYCH	1. 697682			0 0	15, 585	1
	D2 PEDS CLINIC	0. 000000			0 0	0	90.02
	D4 BARI ATRI CS	0. 000000			0 0	0	90.04
		0. 104899			0 0 0 0	384, 719	•
	D1 DI AGNOSTI C TREATMENT CENTER D0 OBSERVATI ON BEDS (NON-DI STINCT PART	0. 131108			0 0		91.01
	ER REIMBURSABLE COST CENTERS	0.00001	0	1	0	0	72.00
	DO AMBULANCE SERVICES	0. 642682	486, 087		0		95.00
	DO DURABLE MEDICAL EQUIP-SOLD	0. 530967			0 0	n	97.00
	50 HOME OFFICE	0. 000000			0 0	0	98.00
200.00	Subtotal (see instructions)	3. 000000	14, 639, 415		0 0	2, 927, 415	
201.00	Less PBP Clinic Lab. Services-Program	1			0 0	_, .2., .10	201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	1	14, 639, 415		0 0	2, 927, 415	200 00

	ncial Systems INT OF MEDICAL, OTHER HEALTH SERVICES AND		DI CAL CENTER Provi der	CCN: 150100	Peri od: From 07/01/2015 To 06/30/2016		ared:
			Tit	le XIX	Hospi tal	Cost	<u> piii</u>
		Cos	sts				
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins.	Cost Reimbursed Services Not Subject To Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	LLARY SERVICE COST CENTERS			1			
	O OPERATING ROOM	0					50.00
	O RECOVERY ROOM	0		1			51.00
	O DELIVERY ROOM & LABOR ROOM	0	0				52.00
	O ANESTHESI OLOGY	0					53.00
	0 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	2 ULTRASOUND	0					54.02
	3 NUCLEAR MEDICINE	0	0				54.03
	O RADI OI SOTOPE	0					56.00 57.00
	O CT SCAN O MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
	O CARDI AC CATHETERI ZATI ON	0	0	•			59.00
	O LABORATORY	0	0	•			60.00
	O BLOOD STORING, PROCESSING & TRANS.	0	0	•			63. 00
	O I NTRAVENOUS THERAPY	0	0				64. 00
	O RESPIRATORY THERAPY	0	0				65.00
	O PHYSI CAL THERAPY	0	0	•			66. 00
	O OCCUPATIONAL THERAPY	0	Ö	•			67.00
	O SPEECH PATHOLOGY	0	0	•			68.00
	0 ELECTROCARDI OLOGY	0	0	•			69.00
	2 CARDI AC REHAB	0	0			6	69. 02
69.03 0690	J DIABETIC EDUCATION	0	0			6	69. 03
70.00 0700	0 ELECTROENCEPHALOGRAPHY	0	0			7	70.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			7	71.00
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	0	0			7.	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0	0			7	73.00
	ORENAL DIALYSIS	0	0			7	74.00
76.00 0395		0		1			76.00
	O MOBILE OUTREACH CLINIC	0	0			7	76. 01
	ATIENT SERVICE COST CENTERS						~ ~ ~
	O RURAL HEALTH CLINIC	0					88.00
	O FEDERALLY QUALIFIED HEALTH CENTER	0					89.00
	O CLINIC	0	0				90.00
	1 OUTPATIENT PSYCH	0					90.01
	2 PEDS CLINIC 4 BARIATRICS	0	0				90. 02 90. 04
	0 EMERGENCY	0					
	1 DI AGNOSTI C TREATMENT CENTER	0		•			91.00
	O OBSERVATION BEDS (NON-DISTINCT PART	0	-				91.01 92.00
	R REIMBURSABLE COST CENTERS	. 0	0	1		7.	,2.00
	O AMBULANCE SERVICES	0				9	95.00
	O DURABLE MEDICAL EQUIP-SOLD	0					97.00
	O HOME OFFICE	0	0				98.00
200.00	Subtotal (see instructions)	0	-				00.00
201.00	Less PBP Clinic Lab. Services-Program	0	ĺ				01.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	0	0			20	02.00

Health Financial Systems	ST. MARY'S ME				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT,	AL COSTS	Provi der	CCN: 150100	Peri od:	Worksheet D	
		Componen	t CCN: 15S100	From 07/01/2015 To 06/30/2016		pared:
					11/21/2016 8:	50 pm
		Tit	le XIX	Subprovider - IPF	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	<u>26)</u> 1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	2, 527, 610	254, 243, 352	0.00994	12 2, 550	25	50.00
51.00 05100 RECOVERY ROOM	184, 630				24	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	420, 569				0	
53.00 05300 ANESTHESI OLOGY	102, 500				20	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 643, 085	72, 735, 001	0. 02259	90 12, 872	291	54.00
54. 02 05402 ULTRASOUND	53, 721	17, 760, 039	0. 00302	1, 612	5	54.02
54. 03 05403 NUCLEAR MEDICINE	117, 633	37, 201, 063	0. 00316	52 0	0	54.03
56. 00 05600 RADI OI SOTOPE	0	C	0.0000	0 0	0	56.00
57.00 05700 CT SCAN	333, 131	54, 150, 217	0. 0061	52 15, 545	96	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	105, 286	18, 185, 504			73	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	887, 143				0	
60. 00 06000 LABORATORY	369, 310				354	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	23, 752				0	
64. 00 06400 I NTRAVENOUS THERAPY	314, 184				140	
65. 00 06500 RESPI RATORY THERAPY	130, 209				72	
66. 00 06600 PHYSI CAL THERAPY	128, 026				37	
67. 00 06700 OCCUPATIONAL THERAPY	15, 590				4	
68. 00 06800 SPEECH PATHOLOGY	17, 424				0	
69. 00 06900 ELECTROCARDI OLOGY	655, 531					
69. 02 06902 CARDI AC REHAB 69. 03 06903 DI ABETI C EDUCATI ON	121, 540 77, 821				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	148, 162				0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	205, 035					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	371, 470				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	340, 851					
74. 00 07400 RENAL DI ALYSI S	60, 504				0	
76. 00 03951 ECT	1, 671				35	
76. 01 03950 MOBILE OUTREACH CLINIC	177, 745					
OUTPATIENT SERVICE COST CENTERS			• • • • •			
88.00 08800 RURAL HEALTH CLINIC	0	C	0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0. 00000	0 0	0	89.00
90. 00 09000 CLINIC	32, 958	3, 439, 518			0	90.00
90. 01 09001 OUTPATIENT PSYCH	170, 360	395, 481			66	
90. 02 09002 PEDS CLINIC	0				0	
90. 04 09004 BARI ATRI CS	3, 168		0.00000		0	
91.00 09100 EMERGENCY	953, 386					
91. 01 09101 DI AGNOSTI C TREATMENT CENTER	325, 671				114	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	8, 943, 381	0.0000	000	0	92.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES						05 00
95. 00 09500 AMBULANCE SERVICES 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	20.020	5 0/E /1/		74 0	0	95.00 97.00
98. 00 09850 HOME OFFICE	30, 272	5, 965, 616	0.0050		0	
200.00 Total (lines 50-199)	11 049 049	1, 420, 351, 695		545, 584		200.00
200.00 10181 (11185 30-199)	11, 049, 948	1,420,351,695	1	545, 584] 3, 119	1200. OC

Health Financial Systems	ST. MARY'S MEDI	CAL CENTER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der		Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15S100	From 07/01/2015 To 06/30/2016		narodi
		component	. CCN. 155100	10 00/30/2010	11/21/2016 8:	50 pm
		Ti t	le XIX	Subprovider -	Cost	
Cost Center Description	Non Physician N	ursing School	Allied Healt	IPF All Other	Total Cost	
cost center bescription	Anesthetist	ursting school		Medical	(sum of col 1	
	Cost			Educati on Cost		
	0031				4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 02 05402 ULTRASOUND	0	0		0 0	0	54.02
54.03 05403 NUCLEAR MEDICINE	0	0		0 0	0	54.03
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		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
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	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
69. 02 06902 CARDI AC REHAB	0	0		0 0	0	69.02
69. 03 06903 DI ABETI C EDUCATI ON	0	0		0 0	0	69.03
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	
76. 00 03951 ECT	0	0		0 0		
76. 01 03950 MOBILE OUTREACH CLINIC	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		
90. 00 09000 CLINIC	0	0		0 0	0	
90. 01 09001 OUTPATI ENT PSYCH	0	0		0 0	0	
90. 02 09002 PEDS CLINIC	0	0		0 0	0	
90. 04 09004 BARI ATRI CS	0	0		0 0	0	
91.00 09100 EMERGENCY	0	0		0 0	0	
91. 01 09101 DI AGNOSTI C TREATMENT CENTER	0	0		0 0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0	0	I	0 0	0	92.00
	1					
95. 00 09500 AMBULANCE SERVICES		0		0		95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0		
98.00 09850 HOME OFFICE 200.00 Total (lines 50-199)	0	0 0		0 0 0 0		98.00 200.00
200.00 [10tal (11165 30-144)	I U	0	I	U U	I 0	1200. 00

Health Financial Systems	ST. MARY'S ME				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	ERVICE OTHER PAS	S Provi de	r CCN: 150100	Period: From 07/01/2015	Worksheet D Part IV	
		Compone	nt CCN: 15S100		Date/Time Pre 11/21/2016 8:	pared: 50 pm
		T	tle XIX	Subprovider - IPF	Cost	·
Cost Center Description	Total		s Ratio of Cos		Inpati ent	
	Outpati ent	(from Wkst.			Program	
	Cost (sum of	Part I, col			Charges	
	col. 2, 3 and 4)	8)	7)	(col. 6 ÷ col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS		1				
50. 00 05000 OPERATI NG ROOM	C				2, 550	
51.00 05100 RECOVERY ROOM	C				3, 885	
52.00 05200 DELIVERY ROOM & LABOR ROOM	C				0	
53. 00 05300 ANESTHESI OLOGY	C				3, 880	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C				12, 872	
54. 02 05402 ULTRASOUND	C				1, 612	
54.03 05403 NUCLEAR MEDICINE	C				0	
56. 00 05600 RADI 0I SOTOPE	C		0 0.0000		0	
57.00 05700 CT SCAN	C				15, 545	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C				12, 552	
59. 00 05900 CARDI AC CATHETERI ZATI ON	C				0	
60. 00 06000 LABORATORY	C				98, 033	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C				0	63.00
64.00 06400 INTRAVENOUS THERAPY	C				8, 738	
65. 00 06500 RESPI RATORY THERAPY	C				6, 303	65.00
66. 00 06600 PHYSI CAL THERAPY	C				5, 304	
67.00 06700 OCCUPATI ONAL THERAPY	C				2, 633	
68.00 06800 SPEECH PATHOLOGY	C	3, 714, 9	64 0.0000	00 0. 000000	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	C	57, 771, 2	0.0000	00 0. 000000	7, 723	69.00
69. 02 06902 CARDI AC REHAB	C	.,,.			0	
69. 03 06903 DIABETIC EDUCATION	C	204, 7	56 0.0000	00 0. 000000	0	69.03
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	8, 758, 4	52 0.0000	00 0. 000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C				1, 806	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	C	157, 297, 5	29 0.0000	00 0. 000000	77, 703	73.00
74.00 07400 RENAL DIALYSIS	C	3, 700, 6	94 0.0000	00 0. 000000	0	74.00
76. 00 03951 ECT	C	2, 863, 5	62 0.0000	00 0. 000000	59, 248	76.00
76.01 03950 MOBILE OUTREACH CLINIC	0	656, 0	53 0.0000	0. 000000	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	C		0 0.0000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C		0 0.0000		0	
90. 00 09000 CLINIC	C				0	
90. 01 09001 OUTPATI ENT PSYCH	C	395, 4			153	
90. 02 09002 PEDS CLINIC	C		0 0.0000		0	
90. 04 09004 BARI ATRI CS	C		0 0.0000		0	
91. 00 09100 EMERGENCY	C				215, 136	
91.01 09101 DIAGNOSTIC TREATMENT CENTER	C				9, 908	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C	8, 943, 3	0. 0000	00 0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS		1	-			
95. 00 09500 AMBULANCE SERVICES						95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	C				0	
98.00 09850 HOME OFFICE	0)	0 0.0000	0. 000000	0	98.00
200.00 Total (lines 50-199)		1, 420, 351, 6			545, 584	

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	SERVICE OTHER PASS	6 Provi der	CCN: 150100	Peri od:	Worksheet D	552-
IROUGH COSTS			t CCN: 15S100	From 07/01/2015	Part IV	are
		•			11/21/2016 8: 50	<u>j p</u>
		Ti t	le XIX	Subprovider - IPF	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.			
	x col. 10) 11.00	12.00	x col. 12) 13.00			
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00			_
0. 00 05000 OPERATING ROOM	0	C		0	5	50.
I. 00 05100 RECOVERY ROOM	0	C		0	5	51.
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0		52.
3. 00 05300 ANESTHESI OLOGY	0	C		0	5	53.
I. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0	5	54.
. 02 05402 ULTRASOUND	0	C		0	5	54.
. 03 05403 NUCLEAR MEDICINE	0	C		0		54.
. 00 05600 RADI OI SOTOPE	0	C		0	5	56.
.00 05700 CT SCAN	0	C		0	5	57.
.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0	5	58.
. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0	5	59.
00 06000 LABORATORY	0	C)	0	6	60.
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C)	0	6	63
. 00 06400 I NTRAVENOUS THERAPY	0	C		0	6	64
. 00 06500 RESPI RATORY THERAPY	0	C	D	0	6	65.
. 00 06600 PHYSI CAL THERAPY	0	C		0	6	66.
. 00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.
. 00 06800 SPEECH PATHOLOGY	0	C		0		68.
. 00 06900 ELECTROCARDI OLOGY	0	C		0	-	69.
. 02 06902 CARDI AC REHAB	0	C		0		69.
. 03 06903 DIABETIC EDUCATION	0	C		0		69.
. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0		70
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0		71
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0		72
00 07300 DRUGS CHARGED TO PATIENTS	0	C	'	0		73
. 00 07400 RENAL DIALYSIS	0	C		0		74
	0	C		0		76
01 03950 MOBILE OUTREACH CLINIC OUTPATIENT SERVICE COST CENTERS	0	C	/	0	/	76
00 08800 RURAL HEALTH CLINIC	0	C		0	g	88.
. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89.
. 00 09000 CLINIC	0	C		0		90.
. 01 09001 OUTPATIENT PSYCH	0	C		0		90.
. 02 09002 PEDS CLINIC	0	C		0		90.
. 04 09004 BARI ATRI CS	0	C		0		90.
. 00 09100 EMERGENCY	0	C		0		91.
. 01 09101 DI AGNOSTI C TREATMENT CENTER	0	C		0		91.
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92.
OTHER REIMBURSABLE COST CENTERS	· ·					
. 00 09500 AMBULANCE SERVICES					9	95.
. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0	9	97.
00 09850 HOME OFFICE	0	C		0	9	98.
0.00 Total (lines 50-199)	0	C		0	20	200.

lealth Financial Systems	ST. MARY'S ME				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150100	Period:	Worksheet D Part II	
		Component	t CCN: 15T100	From 07/01/2015 To 06/30/2016	Date/Time Pre 11/21/2016 8:	pared:
		Ti t	le XIX	Subprovider - IRF	Cost	<u>30 piii</u>
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00	0.00	1.00	F 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	2, 527, 610	254, 243, 352	0.00994	12 0	0	50.00
					-	
51.00 05100 RECOVERY ROOM	184, 630				0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	420, 569				0	
53. 00 05300 ANESTHESI OLOGY	102, 500				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 643, 085				0	
54. 02 05402 ULTRASOUND	53, 721				0	
54. 03 05403 NUCLEAR MEDICINE	117, 633				0	
56. 00 05600 RADI OI SOTOPE	0	-	0.0000		0	56.00
57. 00 05700 CT SCAN	333, 131				0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	105, 286				0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	887, 143				0	
50. 00 06000 LABORATORY	369, 310				1	
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	23, 752				0	
54. 00 06400 I NTRAVENOUS THERAPY	314, 184				0	
65. 00 06500 RESPI RATORY THERAPY	130, 209				0	
56. 00 06600 PHYSI CAL THERAPY	128, 026				136	
67. 00 06700 OCCUPATI ONAL THERAPY	15, 590				13	67.00
58.00 06800 SPEECH PATHOLOGY	17, 424	3, 714, 964	0.00469	90 9, 856	46	68.00
59. 00 06900 ELECTROCARDI OLOGY	655, 531	57, 771, 227	0. 01134	47 0	0	69.00
69. 02 06902 CARDI AC REHAB	121, 540	1, 151, 040	0. 10559	91 0	0	69.02
69.03 06903 DIABETIC EDUCATION	77, 821	204, 756	0. 38006	57 0	0	69.03
70. 00 07000 ELECTROENCEPHALOGRAPHY	148, 162	8, 758, 452	0. 01691	16 968	16	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	205, 035	132, 598, 567	0. 00154	16 3	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	371, 470	102, 662, 594	0.00361	18 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	340, 851	157, 297, 529	0.00216	57 1, 891	4	73.00
74.00 07400 RENAL DIALYSIS	60, 504	3, 700, 694	0. 01634	19 0	0	74.00
76. 00 03951 ECT	1,671	2, 863, 562	0. 00058	34 0	0	76.00
76.01 03950 MOBILE OUTREACH CLINIC	177, 745			31 0	0	
OUTPATIENT SERVICE COST CENTERS						
38. 00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	1 88. 00
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.00
90. 00 09000 CLINIC	32, 958	3, 439, 518			0	90.00
90. 01 09001 OUTPATI ENT PSYCH	170, 360				0	90.01
90. 02 09002 PEDS CLINIC	0				0	90.02
90. 04 09004 BARI ATRI CS	3, 168	0			0	
91. 00 09100 EMERGENCY	953, 386				0	
91.01 09101 DI AGNOSTI C TREATMENT CENTER	325, 671				0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
		2, 7, 10, 501			0	1 00
INTHER REIMBURSABLE CUST CENTERS			1			95.00
OTHER RELIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	30 272	5,965,616	0 00507	74 0	0	
	30, 272 0	5, 965, 616 0	0.00507		0	97.00

Health Financial Systems	ST. MARY'S MEDI	CAL CENTER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PASS	Provi der		Period:	Worksheet D	
THROUGH COSTS		Component		From 07/01/2015 To 06/30/2016		narod
		component	. CCN. 151100	10 00/30/2010	11/21/2016 8:	
		Ti t	le XIX	Subprovider -	Cost	
Cost Center Description	Non Physician Nu	ursing School	Allied Health	IRF AII Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 02 05402 ULTRASOUND	0	0		0 0	0	54.02
54. 03 05403 NUCLEAR MEDICINE	0	0		0 0	0	54.03
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		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
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	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
69. 02 06902 CARDI AC REHAB	0	0		0 0	0	69.02
69. 03 06903 DI ABETI C EDUCATI ON	0	0		0 0	0	69.03
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
76.00 03951 ECT	0	0		0 0	0	76.00
76. 01 03950 MOBILE OUTREACH CLINIC	0	0		0 0	0	76.01
	0	0		0 0	0	00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	-	0		0 0 0 0	0	88.00
	0	0		0 0	0	89.00
	0	0		0 0	0	90.00
90. 01 09001 0UTPATI ENT PSYCH 90. 02 09002 PEDS CLINIC	0	0		0 0	0	90.01
	0	0		0 0	0	90.02
90. 04 09004 BARI ATRI CS 91. 00 09100 EMERGENCY	0	0		0 0	0	90.04 91.00
91. 01 09100 EMERGENCY 91. 01 09101 DI AGNOSTI C TREATMENT CENTER	0	0		0 0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	91.01
0109200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	I	0 0	0	72.00
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		o o	0	97.00
98. 00 09850 HOME OFFICE	0	0		0 0	0	
200.00 Total (lines 50-199)	0	0		0 0		200.00
		Ū				

ealth Financial Systems	ST. MARY'S ME				u of Form CMS-2	2552-1
PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der	CCN: 150100	Peri od:	Worksheet D	
HROUGH COSTS		Componen	t CCN: 15T100	From 07/01/2015 To 06/30/2016	Part IV Date/Time Pre	nared
		component	1 0011. 101100	10 00/ 30/ 2010	11/21/2016 8:	50 pm
		Tit	tle XIX	Subprovider - IRF	Cost	
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00	0.00	7)	10.00	
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
0. 00 05000 OPERATING ROOM	0	254, 243, 352	0.0000	0. 000000	0	50.00
1. 00 05100 RECOVERY ROOM	0				0	
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0				0	
3. 00 05300 ANESTHESI OLOGY	0				0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0				0	
4. 02 05402 ULTRASOUND	0				0	
4. 03 05403 NUCLEAR MEDICINE	0				0	
6. 00 05600 RADI OI SOTOPE	0		0.00000		0	
7. 00 05700 CT SCAN	0	-			0	
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0				0	
9.00 05900 CARDI AC CATHETERI ZATI ON	0				0	
0. 00 06000 LABORATORY	0				378	
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0				0	63.00
4.00 06400 INTRAVENOUS THERAPY	0				0	64.00
5. 00 06500 RESPI RATORY THERAPY	0	11, 416, 923	0. 00000	0. 000000	0	65.00
6. 00 06600 PHYSI CAL THERAPY	0	18, 217, 768	0. 00000	0. 000000	19, 395	66.00
7.00 06700 OCCUPATIONAL THERAPY	0	11, 202, 329	0. 00000	0. 000000	9, 359	67.00
8.00 06800 SPEECH PATHOLOGY	0	3, 714, 964	0. 00000	0. 000000	9, 856	68.00
9. 00 06900 ELECTROCARDI OLOGY	0			0. 000000	0	69.00
9. 02 06902 CARDI AC REHAB	0	1, 151, 040	0.0000	0. 000000	0	69.02
9. 03 06903 DIABETIC EDUCATION	0	204, 756	0.0000	0. 000000	0	69.03
0.00 07000 ELECTROENCEPHALOGRAPHY	0				968	70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				3	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				0	
3.00 07300 DRUGS CHARGED TO PATIENTS	0				1, 891	
4.00 07400 RENAL DIALYSIS	0				0	
6.00 03951 ECT	0				0	
6. 01 03950 MOBILE OUTREACH CLINIC	0	656, 053	0.00000	0. 000000	0	76.01
OUTPATI ENT SERVI CE COST CENTERS	1				-	
8.00 08800 RURAL HEALTH CLINIC	0				0	
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			0	
	0				0	
0. 01 09001 0UTPATI ENT PSYCH 0. 02 09002 PEDS CLINIC	0				0	
0. 02 09002 PEDS_CLINIC 0. 04 09004 BARIATRICS		-			0	
1. 00 09100 EMERGENCY	0				0	
1.00 09100 EMERGENCY 1.01 09101 DIAGNOSTIC TREATMENT CENTER					0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	
OTHER REIMBURSABLE COST CENTERS	0	0, 743, 301	0.0000	0.00000	0	72.00
STHER REIMBORGADEE COST CENTERS						95.00
5 00 09500 AMBULANCE SERVICES						
75.00 09500 AMBULANCE SERVICES	0	5 965 614			Ω	
05.00 09500 AMBULANCE SERVICES 7.00 09700 DURABLE MEDICAL EQUIP-SOLD 8.00 09850 HOME OFFICE	0		0.0000		0	97.00

PORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	Provi der	CCN: 150100	Peri od:	Worksheet D	
ROUGH COSTS		Componen	t CCN: 15T100	From 07/01/2015 To 06/30/2016	Part IV Date/Time Prepa 11/21/2016 8:50	
		Ti t	le XIX	Subprovider -	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.			
	x col. 10)	10.00	x col. 12)			
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00			
. 00 05000 OPERATING ROOM	0	C		0		
. 00 05100 RECOVERY ROOM	0	C		0		
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0		
. 00 05300 ANESTHESI OLOGY	0	C		0		
00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		
02 05402 ULTRASOUND	0	C		0		
03 05403 NUCLEAR MEDICINE	0	C		0		
00 05600 RADI OI SOTOPE	0			0		
00 05700 CT SCAN	0	C		0		
	0	C		0		
00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 00 05900 CARDI AC CATHETERIZATI ON	0			0		
00 06000 LABORATORY	0	C		0		
	0	C		-		
00 06300 BLOOD STORING, PROCESSING & TRANS.	-			0		
. 00 06400 I NTRAVENOUS THERAPY	0	C		0		
	0	C		0		
. 00 06600 PHYSI CAL THERAPY . 00 06700 OCCUPATI ONAL THERAPY	0	C		0		
	0			0		
	0	C		-		
	0	C		0		
	0			-		
. 03 06903 DI ABETI C EDUCATI ON . 00 07000 ELECTROENCEPHALOGRAPHY	-	C		0		
	0	C		0		
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT . 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0		
. 00 07200 TMPL. DEV. CHARGED TO PATIENTS	0			0		
. 00 07300 DRUGS CHARGED TO PATTENTS	0	C		0		
. 00 03951 ECT	0	C		0		
	0	C		0		
. 01 03950 MOBILE OUTREACH CLINIC OUTPATIENT SERVICE COST CENTERS		L. L.	/	0		
. 00 08800 RURAL HEALTH CLINIC	0	C	1	0		
. 00 08800 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		
. 00 09900 CLINIC	0	C		0		
. 01 09001 0UTPATI ENT PSYCH	0	C		0		
. 02 09002 PEDS CLINIC	0	0		0		
. 04 09004 BARI ATRI CS	0			0		
. 00 09100 EMERGENCY	0	0		0		
. 01 09101 DIAGNOSTIC TREATMENT CENTER	0	C		0		
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		
OTHER REIMBURSABLE COST CENTERS	U		1	U		
. 00 09500 AMBULANCE SERVICES						
. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0		
. 00 09850 HOME OFFICE	0	C		0		
0.00 Total (lines 50-199)	0	C		0	20	

	Financial Systems ST. MARY ATION OF INPATIENT OPERATING COST	Provider CCN: 150100	Period: From 07/01/2015	u of Form CMS-2 Worksheet D-1	
			To 06/30/2016	Date/Time Pre 11/21/2016 8:	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-	-bed days excluding newborn)		56, 588	1 1.
. 00	Inpatient days (including private room days, excluding			56, 588	
. 00	Private room days (excluding swing-bed and observation	n bed days). If you have only p	rivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observ	vation bed days)		49, 598	4.
00	Total swing-bed SNF type inpatient days (including pri		er 31 of the cost	0	
00	reporting period	wate seem devel often December	21 of the east	0	
00	Total swing-bed SNF type inpatient days (including pri reporting period (if calendar year, enter 0 on this li		31 OF the Cost	0	6.
. 00	Total swing-bed NF type inpatient days (including priv		r 31 of the cost	0	7.
. 00	reporting period Total swing-bed NF type inpatient days (including priv	(ato room days) after December (21 of the cost	0	8.
. 00	reporting period (if calendar year, enter 0 on this li		of the cost	0	0.
00	Total inpatient days including private room days appli	cable to the Program (excluding	g swing-bed and	21, 831	9.
D. 00	newborn days) Swing-bed SNF type inpatient days applicable to title	XVIII only (including private)	room days)	0	10.
	through December 31 of the cost reporting period (see	instructions)	3,	Ũ	
1.00	Swing-bed SNF type inpatient days applicable to title December 31 of the cost reporting period (if calendar		room days) after	0	11.
2. 00	Swing-bed NF type inpatient days applicable to titles		te room davs)	0	12.
	through December 31 of the cost reporting period				
3. 00	Swing-bed NF type inpatient days applicable to titles after December 31 of the cost reporting period (if cal			0	13.
I. 00	Medically necessary private room days applicable to the			0	14.
	Total nursery days (title V or XIX only)		•	0	
5.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.
7.00	Medicare rate for swing-bed SNF services applicable to	o services through December 31 (of the cost	0.00	17.
	reporting period		+h+	0.00	10
8.00	Medicare rate for swing-bed SNF services applicable to reporting period	o services after December 31 of	the cost	0.00	18.
9.00	Medicaid rate for swing-bed NF services applicable to	services through December 31 of	f the cost	0.00	19.
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to	services after December 31 of	the cost	0.00	20.
0.00	reporting period			0.00	20.
	Total general inpatient routine service cost (see inst			47, 119, 306	
2.00	Swing-bed cost applicable to SNF type services through 5×10^{-10} x line 17)	n December 31 of the cost report	ting period (line	0	22.
3.00	Swing-bed cost applicable to SNF type services after [December 31 of the cost reportion	ng period (line 6	0	23.
1 00	x line 18)	December 21 of the cost report	ing pariod (line	0	24
4. 00	Swing-bed cost applicable to NF type services through 7×10^{-1} x line 19)	becember 31 of the cost report	ng period (inne	0	24.
5.00	Swing-bed cost applicable to NF type services after De	ecember 31 of the cost reporting	g period (line 8	0	25.
6. 00	x line 20) Total swing-bed cost (see instructions)			0	26.
	General inpatient routine service cost net of swing-be	ed cost (line 21 minus line 26)		47, 119, 306	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding s Private room charges (excluding swing-bed charges)	swing-bed and observation bed ci	harges)	0	
	Semi-private room charges (excluding swing-bed charges	5)		0	
	General inpatient routine service cost/charge ratio (I	<i>,</i>		0.000000	
	Average private room per diem charge (line 29 ÷ line 3			0.00	
	Average semi-private room per diem charge (line 30 ÷ l		-+!>	0.00	
	Average per diem private room charge differential (lin	, ,	utions)	0.00	
	Average per diem private room cost differential (line Private room cost differential adjustment (line 3 x li	-		0.00	
	General inpatient routine service cost net of swing-be		fferential (line	47, 119, 306	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	COST AD HISTMENTS			-
3. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH C Adjusted general inpatient routine service cost per di			832.67	38.
	Program general inpatient routine service cost (line 9			18, 178, 019	
	Medically necessary private room cost applicable to the	-		0	
1.00	Total Program general inpatient routine service cost ((line 39 + line 40)		18, 178, 019	41

alth Financial Systems MPUTATION OF INPATIENT OPERATING COST	ST. WART S WEDT	CAL CENTER	CCN: 150100 P	eriod:	u of Form CMS-2 Worksheet D-1	
				rom 07/01/2015		pared
Cont. Conton Deconintion	Tatal		e XVIII	Hospi tal	PPS	
Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.0
Intensive Care Type Inpatient Hospital Uni		10.000	1 070 5/	6.004	0.000.000	1
. 00 I NTENSI VE CARE UNI T . 02 NI CU	17, 693, 732	13, 828				
. 00 CORONARY CARE UNIT	7, 224, 072 2, 713, 254	5, 937 1, 457			-	
. 00 BURN INTENSIVE CARE UNIT	2,713,234	1, 437	1,002.22	000	1, 240, 207	45.
. 00 SURGI CAL I NTENSI VE CARE UNI T						46.
. 00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3,	line 200)			40, 919, 394	48.0
.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS			ns)		68, 425, 751	
0.00 Pass through costs applicable to Program i	npatient routine s	ervices (from	Wkst. D, sum	of Parts I and	1, 721, 085	50.
.00 Pass through costs applicable to Program i and IV)	npatient ancillary	v services (fr	om Wkst. D, su	m of Parts II	1, 711, 919	51. (
.00 Total Program excludable cost (sum of line	s 50 and 51)				3, 433, 004	52.0
.00 Total Program inpatient operating cost exc medical education costs (line 49 minus lin	luding capital rel	ated, non-phy	sician anesthe	tist, and	64, 992, 747	
TARGET AMOUNT AND LIMIT COMPUTATION					0	54.
.00 Program discharges .00 Target amount per discharge					0 0.00	
. 00 Target amount (line 54 x line 55)					0	
. 00 Difference between adjusted inpatient oper	ating cost and tar	get amount (I	ine 56 minus l	ine 53)	0	57.
00 Bonus payment (see instructions)					0	
.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period e	ending 1996, u	pdated and com	pounded by the	0.00	59.
00 Lesser of lines 53/54 or 55 from prior yea	r cost report. upd	lated by the m	arket basket		0.00	60.
.00 If line 53/54 is less than the lower of li				he amount by	0	
which operating costs (line 53) are less t		6 (lines 54 x	60), or 1% of	the target		
amount (line 56), otherwise enter zero (se .00 Relief payment (see instructions)	e instructions)				0	62.
.00 Relief payment (see instructions) .00 Allowable Inpatient cost plus incentive pa	vment (see instruc	tions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST						
.00 Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	osts through Decem	nber 31 of the	cost reportin	g period (See	0	64.
. 00 Medicare swing-bed SNF inpatient routine c instructions) (title XVIII only)	osts after Decembe	er 31 of the c	ost reporting	period (See	0	65.
. 00 Total Medicare swing-bed SNF inpatient rou	tine costs (line 6	4 plus line 6	5)(title XVIII	only). For	0	66.
CAH (see instructions) .00 Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 c	f the cost rep	orting period	0	67.
(line 12 x line 19) .00 Title V or XIX swing-bed NF inpatient rout	ine costs after De	ecember 31 of	the cost repor	ting period	0	68.
(line 13 x line 20) 0.00 Total title V or XIX swing-bed NF inpatien	t routine costs (l	ine 67 + line	68)		0	69.
PART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILITY,	AND ICF/IID	ONLY			
00 Skilled nursing facility/other nursing fac	2		• •			70.
.00 Adjusted general inpatient routine service .00 Program routine service cost (line 9 x lin		ne /U ÷ line	2)			71.
. 00 Medically necessary private room cost appl		(line 14 x li	ne 35)			73.
.00 Total Program general inpatient routine se						74.
.00 Capital-related cost allocated to inpatien 26, line 45)		costs (from W	orksheet B, Pa	rt II, column		75.
00 Per diem capital related costs (line 75 ÷						76.
.00 Program capital-related costs (line 9 x li .00 Inpatient routine service cost (line 74 mi						77.
00 Aggregate charges to beneficiaries for exc	,	ovider record	s)			79.
.00 Total Program routine service costs for co	mparison to the co			s line 79)		80.
. 00 Inpatient routine service cost per diem li						81.
.00 Inpatient routine service cost limitation.00 Reasonable inpatient routine service costs	• • •					82.
 .00 Reasonable inpatient routine service costs .00 Program inpatient ancillary services (see 	•	·)				83.
. 00 Utilization review - physician compensatio		is)				85.
1 5 1						86.
.00 Total Program inpatient operating costs (s						1
PART IV - COMPUTATION OF OBSERVATION BED P						1 67
	ns)	line 2)			6, 990 832. 67	

Health Financial Systems	ST.	MARY'S I	MEDIO	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Provi der		Period:	Worksheet D-1	
						From 07/01/2015 To 06/30/2016	Date/Time Pre 11/21/2016 8:	pared: 49 pm
				Titl	e XVIII	Hospi tal	PPS	
Cost Center Description		Cost	R	outine Cost	column 1 ÷	Total	Observati on	
			(f	rom 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		3,083,6	90	47, 119, 306	0. 06544	5, 820, 363	380, 908	90.00
91.00 Nursing School cost			0	47, 119, 306	0.0000	5, 820, 363	0	91.00
92.00 Allied health cost			0	47, 119, 306	0. 00000	5, 820, 363	0	92.00
93.00 All other Medical Education			0	47, 119, 306	0.00000	5, 820, 363	0	93.00

	Financial Systems ST. MARY'S MEDICA ATION OF INPATIENT OPERATING COST	Provi der CCN: 150100	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2015 To 06/30/2016		
		Title XVIII	Subprovider -	PPS	49 p
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed days			3, 398	1
00	Inpatient days (including private room days, excluding swing-be			3, 398	2
00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	ivate room days,	0	3
~~	do not complete this line.			2, 200	
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room		r 21 of the cost	3, 398 0	45
50	reporting period	in days) thi odgit becember	I ST UL LINE CUST	0	
00	Total swing-bed SNF type inpatient days (including private roo	m days) after December :	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	5 /			
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (oveluding	swing bod and	1, 087	9
50	newborn days)		swillig-bed allu	1,007	7
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruct				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, en				
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	o room dave)	0	13
. 00	after December 31 of the cost reporting period (if calendar year			0	13
. 00	Medically necessary private room days applicable to the Program			0	14
. 00	Total nursery days (title V or XIX only)			0	15
. 00	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 o	f the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service:	s after December 31 of	the cost	0.00	18
. 00	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
00	reporting period	、 、		2 172 102	21
. 00 . 00	Total general inpatient routine service cost (see instructions)		ing pariod (line	3, 173, 102	
. 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	r 31 of the cost report	ing period (ine	0	22
. 00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reporting	a period (line 6	0	23
	x line 18)		g por lou (i i ilo o		20
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportion	ng period (line	0	24
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3, 173, 102	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			0,110,102	
. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.00000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	us line 22) (see instruct	tions)	0. 00 0. 00	
()()	Average per diem private room cost differential (line 34 x line		1 0137	0.00	
	Private room cost differential adjustment (line 3 x line 35)	· /		0.00	36
. 00	General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	3, 173, 102	
. 00 . 00	deneral inpatrent routine service cost net or swing-bed cost a				
. 00 . 00	27 minus line 36)				1
00 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
. 00 . 00 . 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			000.01	
. 00 . 00 . 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see	instructions)		933.81	
. 00 . 00 . 00 . 00 . 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	instructions) 38)		933. 81 1, 015, 051 0	39

	Financial Systems TION OF INPATIENT OPERATING COST	ST. MARY'S MEL			CCN: 150100	Peri		eu of Form CMS Worksheet D	
JWPUTA	TION OF INFAILENT OPERATING COST				CCN: 150100	From	00. 07/01/2015 06/30/2016	Date/Time P	repar
				Ti tl	e XVIII	Sub	provider -	11/21/2016 PPS	
	Cost Center Description	Total Inpatient Cost	To [.] Inpatie		Average Pe Diem (col. 1		IPF rogram Days	Program Cos (col. 3 x col	
					col. 2)		4.00	4)	
2.00 1	NURSERY (title V & XIX only)	1.00	2.	00	3.00 0.	00	4.00	5.00	0 42
	ntensive Care Type Inpatient Hospital Units		1					T	
	INTENSIVE CARE UNIT NICU	0		0 0		00	C		0 43
	CORONARY CARE UNIT	0		0		00	C		0 43
	BURN INTENSIVE CARE UNIT								45
	SURGICAL INTENSIVE CARE UNIT								46
. 00 (OTHER SPECIAL CARE (SPECIFY) Cost Center Description								47
	cost center bescription							1.00	
B. 00 F	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line	200)				293, 7	96 48
	Total Program inpatient costs (sum of lines	41 through 48)(see ins	structio	ns)			1, 308, 84	47 49
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	sonvilor	s (from	Wkst D si	m of	Parts L and	57, 2	74 50
			301 11 00	3 (110	WKST. D, SC			57,2	/4 50
	Pass through costs applicable to Program inp	atient ancillar	ry servi	ces (fr	om Wkst. D,	sum c	f Parts II	44, 14	44 51
	and IV) Total Program excludable cost (sum of lines	FO						101 4	10 57
	Total Program excludable cost (sum of filles Total Program inpatient operating cost exclu	,	lated	non-nhv	sician anest	thetis	t and	101, 4	
	medical education costs (line 49 minus line		, atea,	non pny		incti a	t, and	1,207,42	2/ 00
	FARGET AMOUNT AND LIMIT COMPUTATION							1	
	Program discharges Target amount per discharge							0.0	0 54 00 55
	Target amount per discharge Target amount (line 54 x line 55)							0.0	00 56
	Difference between adjusted inpatient operat	ing cost and ta	nget am	nount (I	ine 56 minus	sline	53)		0 57
	Bonus payment (see instructions)	-	-						0 58
	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng	1996, u	pdated and c	compou	nded by the	0.0	00 59
	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated b	ov the m	arket basket	-		0.0	00 60
	If line 53/54 is less than the lower of line						amount by		0 61
	which operating costs (line 53) are less tha		s (line	es 54 x	60), or 1% c	of the	target		
1	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)							0 62
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)						0 63
	PROGRAM INPATIENT ROUTINE SWING BED COST		,						
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31	of the	cost report	ting p	eriod (See		0 64
. 00 1	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	or 31 c	of the c	ost reportir	na nar	ind (See		0 65
	instructions)(title XVIII only)					ig pei	100 (300		
	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus	s line 6	5)(title XVI	II on	ly). For		0 66
	CAH (see instructions)	a aaata thraugh	Decemb	05 01 0	f the east r		ing ported		0 /-
	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	Decenic	er 31 0	i the cost i	eport	ing period		0 67
	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember	31 of	the cost rep	portin	g period		0 68
	(line 13 x line 20)				(2)				
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N								0 69
	Skilled nursing facility/other nursing facil					7)			70
. 00 /	Adjusted general inpatient routine service c	ost per diem (l							71
	Program routine service cost (line 9 x line		(1)	14 14	25)				72
	Medically necessary private room cost applic Total Program general inpatient routine serv	, e	•		ne 35)				73
	Capital -related cost allocated to inpatient				orksheet B,	Part	II, column		75
	26, line 45)								_
	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line								76
	Inpatient routine service cost (line 74 minu								78
	Aggregate charges to beneficiaries for exces		orovi der	record	s)				79
	Total Program routine service costs for comp		cost lim	ni tati on	(line 78 mi	nus I	ine 79)		80
	Inpatient routine service cost per diem limi)						81
	Inpatient routine service cost limitation (l Reasonable inpatient routine service costs (· .						82
	Program inpatient ancillary services (see in								84
. 00 l	Utilization review - physician compensation	(see instructio							85
	Total Program inpatient operating costs (sum		nrough 8	85)					86
	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions								0 87
	Adjusted general inpatient routine cost per		line 2	2				0.0	00 88
. 00 /	najustea general inpatrent reatine cost per			-)					

Health Financial Systems	ST. MA	ARY'S N	IEDI CAL	CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Provi der		Period: From 07/01/2015	Worksheet D-1	
				Component	CCN: 15S100	To 06/30/2016	Date/Time Pre 11/21/2016 8:	
				Ti tl	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Co	ost	Rou	tine Cost	column 1 ÷	Total	Observati on	
			(fror	n 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		179, 04	18	3, 173, 102	0. 05642	27 0	0	90.00
91.00 Nursing School cost			0	3, 173, 102	0.0000	0 0	0	91.00
92.00 Allied health cost			0	3, 173, 102	0. 00000	0 0	0	92.00
93.00 All other Medical Education			0	3, 173, 102	0.0000	0 0	0	93.00

	Financial Systems ST. MARY'S MEDICA ATION OF INPATIENT OPERATING COST	Provider CCN: 150100	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15T100	From 07/01/2015 To 06/30/2016	Date/Time Prep 11/21/2016 8:4	
		Title XVIII	Subprovider -	PPS	1 7 p
	Cost Center Description		-	1.00	
	PART I – ALL PROVIDER COMPONENTS		l.		
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days			4, 750	1
00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivata raam dava	4, 750 0	2
00	do not complete this line.	s). If you have only pr	ivate room days,	U	3
00	Semi-private room days (excluding swing-bed and observation be	d days)		4, 750	4
00	Total swing-bed SNF type inpatient days (including private room	m days) through Decembe	r 31 of the cost	0	5
	reporting period				,
00	Total swing-bed SNF type inpatient days (including private room	m days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
00	reporting period	days) through becember	ST OF the cost	0	,
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
~~	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	2, 313	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	nom davs)	0	10
	through December 31 of the cost reporting period (see instruct		com dago)	Ũ	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11
~~	December 31 of the cost reporting period (if calendar year, en				4.0
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room davs)	0	13
	after December 31 of the cost reporting period (if calendar yes			-	
	Medically necessary private room days applicable to the Program	m (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	15
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to service:	s through December 31 o	f the cost	0.00	17
	reporting period	C			
. 00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 21 of	the cost	0.00	10
. 00	reporting period	through becenber 31 01	the cost	0.00	17
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instructions)			4, 763, 876	
. 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	r 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportin	a period (line 6	0	23
	x line 18)		5 1 2 2 2 2 2		
. 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) Swing bod cost applicable to NE type services after December 2	1 of the cost reporting	poriod (line 0	~	າະ
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	i of the cost reporting	period (Tine 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4, 763, 876	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	and share of the task			~~
. 00 . 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	28 29
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
00				0.00	32
00 00 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00 00 00 00	Average semi-private room per diem charge (line 30 ÷ line 4)	11 00) (tions)	0.00	
00 00 00 00 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	, ,	(10113)	0.001	25
. 00 . 00 . 00 . 00 . 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line	, ,		0.00	
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	e 31)		0	36
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	e 31)			36
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	e 31) nd private room cost di		0	36
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	e 31) nd private room cost di STMENTS		0 4, 763, 876	36 37
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost al 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see	e 31) nd private room cost di STMENTS i nstructi ons)		0 4, 763, 876	36 37 38
. 00 . 00 . 00 . 00 . 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	e 31) nd private room cost di STMENTS instructions) 38)		0 4, 763, 876	36 37 38

	Financial Systems ATION OF INPATIENT OPERATING COST	ST. MARY'S MEE			CCN: 150100	Peri		eu of Form CM Worksheet D	
JWPUT	ATTON OF THPATTENT OPERATING COST				CCN: 150100	From	07/01/2015 06/30/2016	5 Date/Time P	repar
				Ti tl	e XVIII	Sub	provider -	11/21/2016 PPS	
	Cost Center Description	Total Inpatient Cost		otal ent Davs	Average Pe Diem (col. 1		IRF rogram Days	Program Cos (col. 3 x co	
				2.00	<u>col.2)</u> 3.00		4.00	4)	
	NURSERY (title V & XIX only)	1.00		<u>2.00</u> 00		. 00	4.00 C		0 42
	Intensive Care Type Inpatient Hospital Units							-	
	INTENSIVE CARE UNIT NICU	0		0		. 00 . 00	C		0 43
	CORONARY CARE UNI T	0		0		00	C		0 44
	BURN INTENSIVE CARE UNIT								45
	SURGICAL INTENSIVE CARE UNIT								46
. 00	OTHER SPECIAL CARE (SPECIFY)								47
	Cost Center Description							1.00	
. 00	Program inpatient ancillary service cost (W	kst. D-3. col. 3	3. lin	e 200)				1, 201, 5	66 48
	Total Program inpatient costs (sum of lines				ns)			3, 521, 3	
	PASS THROUGH COST ADJUSTMENTS								
. 00	Pass through costs applicable to Program inp	patient routine	servi	ces (from	Wkst. D, su	um of	Parts I and	262, 6	87 50
. 00	<pre>III) Pass through costs applicable to Program ing</pre>	ationt ancillar		dicos (fr	om What D	SUM O	f Darte II	24, 1	95 51
	and IV)		y ser	vi 662 (11	UII WKSL. U,	Jun U		24, 1	/5 51
	Total Program excludable cost (sum of lines	50 and 51)						286, 8	82 52
	Total Program inpatient operating cost exclu		elated	non-phy	sician anest	chetis	t, and	3, 234, 4	38 53
	medical education costs (line 49 minus line	52)							_
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges							1	0 54
	Target amount per discharge							0	00 55
	Target amount (line 54 x line 55)								0 56
	Difference between adjusted inpatient operat	ting cost and ta	arget	amount (I	ine 56 minus	s line	53)		0 57
	Bonus payment (see instructions)								0 58
	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi n	g 1996, u	pdated and c	compou	nded by the	0.	00 59
	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	hatehe	hy tha m	arkat haskat	÷		0	00 60
	If line 53/54 is less than the lower of line						amount by	0.	0 61
	which operating costs (line 53) are less that								0 0.
	amount (line 56), otherwise enter zero (see	instructions)					-		
	Relief payment (see instructions)								0 62
	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	JCTION	5)				<u> </u>	0 63
	Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember	31 of the	cost report	tina n	eriod (See	1	0 64
	instructions)(title XVIII only)	0			•	0.			
. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	oer 31	of the c	ost reportin	ng per	iod (See		0 65
00	instructions)(title XVIII only)								
. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 pi	us line 6	5)(title XVI	II on	Ty). For		0 66
	Title V or XIX swing-bed NF inpatient routir	ne costs through	n Dece	mber 31 d	of the cost r	report	ina period		0 67
	(line 12 x line 19)	5				•	51		
. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	Decemb	er 31 of	the cost rep	portin	g period		0 68
00	(line 13 x line 20)		<i>.</i>		(0)				
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N		•						0 69
	Skilled nursing facility/other nursing facil					7)		1	70
	Adjusted general inpatient routine service of					/			71
	Program routine service cost (line 9 x line								72
	Medically necessary private room cost applic	U U	•						73
. 00	Total Program general inpatient routine serv					Dort			74
. 00	Capital-related cost allocated to inpatient 26, line 45)	Toutine Service	= COST	s (irom W	UIKSHEEL B,	rdit	n, corumn		75
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)							76
. 00	Program capital-related costs (line 9 x line	e 76)							77
	Inpatient routine service cost (line 74 minu		-						78
	Aggregate charges to beneficiaries for exces	• •					1 20 70		79
00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		JUST I	in cation	(ine /8 mi	nus í	ine /9)		80
	Inpatient routine service cost per drem film		1)						82
	Reasonable inpatient routine service costs (· .						83
	Program inpatient ancillary services (see in	•							84
1	Utilization review - physician compensation								85
00	Total Program inpatient operating costs (sun		nrough	85)					86
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST						1	
Į		=)							010
00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		⊧line	2)				0.	0 87

Health Financial Systems	ST. I	MARY'S	MEDI C	AL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Provi der		Period: From 07/01/2015	Worksheet D-1	
				Component	CCN: 15T100		Date/Time Pre 11/21/2016 8:	
				Titl	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Cost	Rc	outine Cost	column 1 ÷	Total	Observati on	
			(fr	rom 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		539, 4	60	4, 763, 876	0. 11324	10 0	0	90.00
91.00 Nursing School cost			0	4, 763, 876	0.0000	0 00	0	91.00
92.00 Allied health cost	1		0	4, 763, 876	0. 00000	0 0	0	92.00
93.00 All other Medical Education			0	4, 763, 876	0. 00000	0 0	0	93.00

	Financial Systems ST. MARY'S MEDICA ATION OF INPATIENT OPERATING COST	Provider CCN: 150100	Period:	Worksheet D-1	
			From 07/01/2015 To 06/30/2016	Date/Time Pre 11/21/2016 8:4	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	cost center beschiptron			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		56, 588	1.
00	Inpatient days (including private room days, excluding swing-b			56, 588	2
00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3
00	do not complete this line.	d dave)		49, 598	4
00	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	49, 598	4 5
	reporting period	·····		-	
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	davs) through December	31 of the cost	0	7
00	reporting period	r days) thi odgi becember	ST OF the cost	0	'
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			5.044	
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	5, 266	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruct				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12
	through December 31 of the cost reporting period	· · · · · · · · · · · · · · · · · · ·		-	
. 00	Swing-bed NF type inpatient days applicable to titles V or XL>			0	13
. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter 0 on this lin	e) davs)	0	14
	Total nursery days (title V or XIX only)	in (excluding swing-bed	uays)	3, 061	
	Nursery days (title V or XIX only)			736	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	t the cost	0.00	11
. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions			47, 119, 306	
. 00	Swing-bed cost applicable to SNF type services through December 5×10^{-1} x line 17)	er 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25
	x line 20)				
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Tine 21 minus Tine 26)		47, 119, 306	27
. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		5.00	0	29
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 +	- line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mir		tions)	0.00	
	Average per diem private room cost differential (line 34 x lin	ie 31)		0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 47, 119, 306	36
	27 minus line 36)			,,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		1	000 (7	20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			832.67 4,384,840	
	Medically necessary private room cost applicable to the Progra			4, 384, 840	40
	5 5 1 mm	+ line 40)		4, 384, 840	

MPUTATION OF INPATIENT OPERATING COST		Provi der	CCN: 150100	Period:	Worksheet D-1	
				From 07/01/2015 To 06/30/2016		
			le XIX	Hospi tal	Cost	
Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
			col . 2)		4)	
	1.00	2.00	3.00	4.00	5.00	
00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	1, 693, 021	3, 061	553.0	9 736	407, 074	42
00 INTENSIVE CARE UNIT	17, 693, 732	13, 828	1, 279. 5	6 111	142, 031	43
02 NICU	7, 224, 072					
00 CORONARY CARE UNI T	2, 713, 254					
00 BURN INTENSIVE CARE UNIT						45
00 SURGI CAL I NTENSI VE CARE UNI T						46
00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
bost center bescription					1.00	
00 Program inpatient ancillary service cost (W	/kst. D-3, col. 3	3, line 200)	-		2, 670, 744	48
00 Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ons)		12, 180, 645	49
00 Pass through costs applicable to Program in	patient routine	services (from	n Wkst. D, sum	of Parts I and	0	50
<pre>1111) 00 Pass through costs applicable to Program in</pre>	nationt ancillar	sy sorvicos (fr	com What D a	um of Parts II	0	51
and IV)	ipatrent anci i ai	y services (II	UNI WKSt. D, S		0	
.00 Total Program excludable cost (sum of lines					0	52
00 Total Program inpatient operating cost excl	5 1	elated, non-phy	vsician anesth	etist, and	0	53
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
00 Program di scharges					0	54
00 Target amount per discharge					0.00	55
00 Target amount (line 54 x line 55)					0	
00 Difference between adjusted inpatient opera	iting cost and ta	arget amount (I	ine 56 minus	line 53)	0	
00 Bonus payment (see instructions) 00 Lesser of lines 53/54 or 55 from the cost r	enorting period	ending 1996 i	undated and co	mounded by the		
market basket	opol tring pollod	charng 1770, c		inpounded 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 lin					0	61
which operating costs (line 53) are less th amount (line 56), otherwise enter zero (see		s (Tines 54 x	60), or 1% or	the target		
00 Relief payment (see instructions)	i filoti detrolloj				0	62
00 Allowable Inpatient cost plus incentive pay	ment (see instru	ictions)			0	63
PROGRAM INPATIENT ROUTINE SWING BED COST 00 Medicare swing-bed SNF inpatient routine co	oto through Door	mbar 21 of the	ant report	ng paried (Cao	0	64
00 Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	SIS IN OUGH DECE		e cost reporti	ng period (see	0	04
00 Medicare swing-bed SNF inpatient routine co	sts after Decemb	per 31 of the c	cost reporting	period (See	0	65
instructions) (title XVIII only)	ino coste (lino	44 plus lips 4	E) (+; + o V)/		0	44
00 Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	The costs (The	o4 prus rifie d	5)(title xvii	i oniy). Foi	0	66
.00 Title V or XIX swing-bed NF inpatient routi	ne costs through	n December 31 c	of the cost re	porting period	0	67
(line 12 x line 19)						
.00 Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after D	ecember 31 of	the cost repo	rting period	0	68
.00 Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	69
PART III - SKILLED NURSING FACILITY, OTHER						
.00 Skilled nursing facility/other nursing faci						70
.00 Adjusted general inpatient routine service.00 Program routine service cost (line 9 x line		ine /U ÷ line	2)			71
00 Medically necessary private room cost appli		n (line 14 x li	ne 35)			73
00 Total Program general inpatient routine ser						74
00 Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from W	lorksheet B, P	art II, column		75
00 Per diem capital-related costs (line 75 ÷ l	ine 2)					76
00 Program capital-related costs (line 9 x lin	ie 76)					77
00 Inpatient routine service cost (line 74 min		unavid				78
00 Aggregate charges to beneficiaries for exce 00 Total Program routine service costs for com	• •			us line 70)		80
00 Inpatient routine service costs for com	•			do TTHC / 7)		81
00 Inpatient routine service cost limitation ()				82
00 Reasonable inpatient routine service costs	•	ıs)				83
00 Program inpatient ancillary services (see i						84
00 Utilization review - physician compensation 00 Total Program inpatient operating costs (su						85
PART IV - COMPUTATION OF OBSERVATION BED PA		n ough 00)			1	
.00 Total observation bed days (see instruction					6, 990	87
.00 Adjusted general inpatient routine cost per					832. 67 5, 820, 363	
00 Observation bed cost (line 87 x line 88) (s						

Health Financial Systems	ST.	MARY'S I	MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Provi der	CCN: 150100	Period:	Worksheet D-1	
						From 07/01/2015 To 06/30/2016		pared: 49 pm
				Tit	le XIX	Hospi tal	Cost	
Cost Center Description		Cost	R	Routine Cost	column 1 ÷	Total	Observati on	
			(f	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		3,083,6	90	47, 119, 306	0. 06544	14 5, 820, 363	380, 908	90.00
91.00 Nursing School cost			0	47, 119, 306	0.0000	5, 820, 363	0	91.00
92.00 Allied health cost			0	47, 119, 306	0.0000	5, 820, 363	0	92.00
93.00 All other Medical Education			0	47, 119, 306	0.0000	5, 820, 363	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150100	Period:	Worksheet D-1	
		Component CCN: 15S100	From 07/01/2015 To 06/30/2016	Date/Time Pre 11/21/2016 8:	
		Title XIX	Subprovider - IPF	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		•		
	INPATIENT DAYS			2, 200	1 1
00 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be	5 ,		3, 398 3, 398	
00	Private room days (excluding swing-bed and observation bed days		vate room days	3, 370	
00	do not complete this line.	b). It you have only pri	vate room days,	0	0.
00	Semi-private room days (excluding swing-bed and observation bed			3, 398	4.
00	Total swing-bed SNF type inpatient days (including private room	m days) through Decembe	r 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private room	m days) after December (1 of the cost	0	6
50	reporting period (if calendar year, enter 0 on this line)	a days) al tel becember :		0	
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing_bed_and	1, 238	9
50	newborn days)	the mogram (exchanning	swing-bed and	1,230	7
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	ly (including private ro	oom days)	0	10
	through December 31 of the cost reporting period (see instructi				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
	through December 31 of the cost reporting period	5	5 /		
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
00	after December 31 of the cost reporting period (if calendar yea				1.1
. 00 . 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	m (excluding swing-bed (lays)	0 3, 061	
	Nursery days (title V or XIX only)			736	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 of	f the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0.00	18
	reporting period			0100	
. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19
00	reporting period	often December 21 of th	a aaat	0.00	20
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	arter becember 31 01 th	ie cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions))		3, 173, 102	21
. 00	Swing-bed cost applicable to SNF type services through December	r 31 of the cost reporti	ng period (line	0	22
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reporting	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportion	ng period (line	0	24
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December 37	1 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (I	line 21 minus line 26)		3, 173, 102	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00 . 00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		tions)	0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	5 51)		0.00	
. 00	General inpatient routine service cost net of swing-bed cost ar	nd private room cost di	fferential (line	3, 173, 102	
	27 minus line 36)	· · · · · · · · · · · · · · · · · · ·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTO			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			933.81	38
	Adjusted deneral innatient routine service cost per diem (soo i			755.01	1 20
. 00	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3			1, 156, 057	39
. 00 . 00	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	38)		1, 156, 057 0	

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	ST. MARY'S MEDIC		CCN: 150100	Peri od:	worksheet D-1	
				From 07/01/2015 To 06/30/2016		epare
		Ti t	le XIX	Subprovider -	Cost	
Cost Center Description	Total Inpatient CostInp	Total atient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
	1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
.00 NURSERY (title V & XIX only)	0	2.00) 42
Intensive Care Type Inpatient Hospital l	1		1		1	
B. OO INTENSIVE CARE UNIT	0	0				
. 02 NI CU . 00 CORONARY CARE UNI T	0	0			-	
. OO BURN INTENSIVE CARE UNIT		0				45
. 00 SURGICAL INTENSIVE CARE UNIT						46
00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	+
.00 Program inpatient ancillary service cos	t (Wkst. D-3, col. 3, I	ine 200)			73, 837	7 48
.00 Total Program inpatient costs (sum of li			ns)		1, 229, 894	1 49
PASS THROUGH COST ADJUSTMENTS					-	_
0.00 Pass through costs applicable to Program (111)	n inpatient routine ser	vices (from	i Wkst. D, sur	n of Parts I and	C	50
.00 Pass through costs applicable to Program	n inpatient ancillary s	ervices (fr	om Wkst. D.	sum of Parts II	c c	51
and IV)						
2.00 Total Program excludable cost (sum of li					C	
3.00 Total Program inpatient operating cost of medical education costs (line 49 minus)		ed, non-phy	sician anesti	netist, and	C	53
TARGET AMOUNT AND LIMIT COMPUTATION	The 52)				1	
I. 00 Program di scharges					C	54
6.00 Target amount per discharge					0.00	
 D. 00 Target amount (line 54 x line 55) 7. 00 Difference between adjusted inpatient op 	anating cost and tang	t omount (l	ing E(minug	Line E2)		
3.00 Bonus payment (see instructions)	Jerating Cost and targe	t amount (i	The so minus	TTHE 53)		
0.00 Lesser of lines 53/54 or 55 from the cos	st reporting period end	ing 1996, ι	pdated and co	ompounded by the		
market basket		C .				
0.00 Lesser of lines 53/54 or 55 from prior				the emount by	0.00	
1.00 If line 53/54 is less than the lower of which operating costs (line 53) are less					C) 61
amount (line 56), otherwise enter zero			00), 01 1.0 0	the target		
2.00 Relief payment (see instructions)					C	
3.00 Allowable Inpatient cost plus incentive PROGRAM INPATIENT ROUTINE SWING BED COST		ons)			C	63
4.00 Medicare swing-bed SNF inpatient routing		r 31 of the	cost reporti	na period (See	C	64
instructions)(title XVIII only)						
5.00 Medicare swing-bed SNF inpatient routine	e costs after December	31 of the c	ost reporting	g period (See	C) 65
instructions)(title XVIII only) 5.00 Total Medicare swing-bed SNF inpatient i	coutine costs (line 64	nlus lina A	5)(title XV/	L only) For	c c	66
CAH (see instructions)	outilie costs (The 04	prus rine c	5)(title xii	T only). To		
7.00 Title V or XIX swing-bed NF inpatient re	outine costs through De	cember 31 c	of the cost re	eporting period	C	67
(line 12 x line 19)	uting goots often Door	mbor 21 of	the east rep	anting pariod		
8.00 Title V or XIX swing-bed NF inpatient ro (line 13 x line 20)	Juline Costs after Dece		the cost rep	bitting period		68
9.00 Total title V or XIX swing-bed NF inpati	ent routine costs (lir	e 67 + line	68)		C) 69
PART III - SKILLED NURSING FACILITY, OTH					1	
0.00 Skilled nursing facility/other nursing 1 1.00 Adjusted general inpatient routine servi	2)		70
2.00 Program routine service cost (line 9 x l		70 ÷ THe	2)			72
8.00 Medically necessary private room cost a	,	ine 14 x li	ne 35)			73
.00 Total Program general inpatient routine						74
 Control Control C	ent routine service co	sts (from W	orksheet B, I	art II, column		75
0.00 Per diem capital-related costs (line 75	÷line 2)					76
.00 Program capital-related costs (line 9 x	line 76)					77
. 00 Inpatient routine service cost (line 74		d ala sa s	- >			78
0.00 Aggregate charges to beneficiaries for 0.00 Total Program routine service costs for			· · · · · · · · · · · · · · · · · · ·	nus line 70)		80
. 00 Inpatient routine service costs for	•	rimitati U		103 I I I C /7)		81
2.00 Inpatient routine service cost limitation						82
8.00 Reasonable inpatient routine service cos	sts (see instructions)					83
00 Program inpatient ancillary services (se						84
5.00 Utilization review - physician compensation						85
5.00 Total Program inpatient operating costs PART IV - COMPUTATION OF OBSERVATION BED		gn 00)			I	
7.00 Total observation bed days (see instruct					C	87
8.00 Adjusted general inpatient routine cost		ne 2)			0.00	
9.00 Observation bed cost (line 87 x line 88)) (see instructions)				I C) 89

Health Financial Systems	ST.	MARY'S	MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Provi der		Period: From 07/01/2015	Worksheet D-1	
				Component	CCN: 15S100			pared: 50 pm
	_			Tit	le XIX	Subprovider -	Cost	
Cost Center Description		Cost	R	Routine Cost	column 1 ÷	Total	Observati on	
			(f	rom 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		179, 0	048	3, 173, 102	0. 05642	27 0	0	90.00
91.00 Nursing School cost			0	3, 173, 102	0.00000	0 0	0	91.00
92.00 Allied health cost			0	3, 173, 102	0.0000	0 0	0	92.00
93.00 All other Medical Education			0	3, 173, 102	0.00000	0 0	0	93.00

OMPUT	Financial Systems ST. MARY'S MEDICAL CE ATION OF INPATIENT OPERATING COST Pr	ovider CCN: 150100	Peri od:	u of Form CMS-2 Worksheet D-1	
		mponent CCN: 15T100	From 07/01/2015	Date/Time Pre 11/21/2016 8:	pared
		Title XIX	Subprovider -	Cost	<u>oo pi</u>
	Cost Center Description			1.00	
	PART I – ALL PROVIDER COMPONENTS		I		
	INPATIENT DAYS				
. 00	Inpatient days (including private room days and swing-bed days, ex			4, 750	
00	Inpatient days (including private room days, excluding swing-bed an Private room days (excluding swing-bed and observation bed days).		ivata room dave	4, 750 0	2.
00	do not complete this line.	i you nave only pr	I vate i oolii uays,	0	3.
00	Semi-private room days (excluding swing-bed and observation bed day	vs)		4, 750	4.
00	Total swing-bed SNF type inpatient days (including private room day	ys) through Decembe	r 31 of the cost	0	5.
	reporting period				
00	Total swing-bed SNF type inpatient days (including private room day	ys) after December	31 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days	s) through December	31 of the cost	0	7.
00	reporting period	s) through becember	ST OF the cost	0	^{/.}
. 00	Total swing-bed NF type inpatient days (including private room days	s) after December 3	1 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable to the	Program (excluding	swing-bed and	282	9.
0. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (i	including privato r	noom dave)	0	10.
5. 00	through December 31 of the cost reporting period (see instructions)		oom days)	0	10.
1.00	Swing-bed SNF type inpatient days applicable to title XVIII only (i	including private r	oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, enter (-		
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX only	y (including privat	e room days)	0	12
3. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only	v (including privat	e room dave)	0	13
5.00	after December 31 of the cost reporting period (if calendar year, e			0	13
4.00	Medically necessary private room days applicable to the Program (ex			0	14
5.00	Total nursery days (title V or XIX only)			3, 061	15
5.00	Nursery days (title V or XIX only)			736	16
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services th	nough Docombon 21 a	f the east	0.00	17
7.00	reporting period	ough beceniber 31 0	the cost	0.00	
3. 00	Medicare rate for swing-bed SNF services applicable to services af	ter December 31 of	the cost	0.00	18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to services through the services applicable to service through the service of the service s	ough December 31 of	the cost	0.00	19.
D. 00	reporting period Medicaid rate for swing-bed NF services applicable to services afte	er December 31 of t	he cost	0.00	20.
5. 00	reporting period		ne cost	0.00	20.
1.00	Total general inpatient routine service cost (see instructions)			4, 763, 876	21
2.00	Swing-bed cost applicable to SNF type services through December 31	of the cost report	ing period (line	0	22.
2 00	5 x line 17)	6 the sect monorth		0	0.00
3.00	Swing-bed cost applicable to SNF type services after December 31 of x line 18)	r the cost reportin	g period (iine 6	0	23
4.00	Swing-bed cost applicable to NF type services through December 31 (of the cost reporti	ng period (line	0	24
	7 x line 19)		51 (
5.00	Swing-bed cost applicable to NF type services after December 31 of	the cost reporting	period (line 8	0	25.
< 00	x line 20) Total aming had east (ass instructions)			0	24
6.00 7.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line	21 minus line 26)		0 4, 763, 876	
/.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT		I	4, 703, 070	2/
3. 00	General inpatient routine service charges (excluding swing-bed and	observation bed ch	arges)	0	28
9.00	Private room charges (excluding swing-bed charges)			0	
0.00	Semi-private room charges (excluding swing-bed charges)	- 20)		0	
1.00 2.00	General inpatient routine service cost/charge ratio (line 27 ÷ line	e 28)		0.000000	
2.00 8.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
l. 00	Average per diem private room charge differential (line 32 minus li	ine 33)(see instruc	tions)	0.00	
5.00	Average per diem private room cost differential (line 34 x line 31)			0.00	
5.00	Private room cost differential adjustment (line 3 x line 35)			0	
7.00	General inpatient routine service cost net of swing-bed cost and p	rivate room cost di	fferential (line	4, 763, 876	37
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN	VTS			1
3. 00	Adjusted general inpatient routine service cost per diem (see insti			1,002.92	38
	Program general inpatient routine service cost (line 9 x line 38)	- /		282, 823	
9.00					
D. 00	Medically necessary private room cost applicable to the Program (li Total Program general inpatient routine service cost (line 39 + lin			0 282, 823	

	Financial Systems TION OF INPATIENT OPERATING COST	ST. MARY'S MEE			CCN: 150100	Peri o	d:	eu of Form CM Worksheet D	
			C	omponent	CCN: 15T100		07/01/2015 06/30/2016		repare
					le XIX	Subn	rovider -	11/21/2016 Cost	
							I RF		
	Cost Center Description	Total Inpatient Cost		tal ent Days	Average Per Diem (col. 1 col. 2)		ogram Days	Program Cos (col. 3 x co 4)	
i		1.00		00	3.00		4.00	5.00	
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0	0.	00	(0 42
	INTENSIVE CARE UNIT	0	1	0	0.	00	(D	0 43
	NI CU	0		0		00	(0 43
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0		0	0.	00	(D	0 44 45
	SURGICAL INTENSIVE CARE UNIT								45
	OTHER SPECIAL CARE (SPECIFY)								47
	Cost Center Description							1.00	_
3. 00 F	Program inpatient ancillary service cost (W	kst. D-3. col. 3	B. Line	200)				1.00	45 48
	Total Program inpatient costs (sum of lines				ns)			292, 0	
	PASS THROUGH COST ADJUSTMENTS		<u> </u>	(6				1	0 50
	Pass through costs applicable to Program inp III)	patient routine	service	es (trom	WKST. D, SU	IM OT P	arts I and		0 50
1	Pass through costs applicable to Program in	patient ancillar	ry servi	ces (fr	om Wkst. D,	sum of	Parts II		0 51
	and IV)	FO and F1)							
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated	non-nhv	sician anest	hetist	and		0 52 0 53
r	medical education costs (line 49 minus line		si a toa,	non phy	si ei un unest	notist	, and		000
-	TARGET AMOUNT AND LIMIT COMPUTATION							1	
	Program discharges Target amount per discharge							0.0	0 54 00 55
	Target amount (line 54 x line 55)								0 56
	Difference between adjusted inpatient opera	ting cost and ta	arget ar	nount (I	ine 56 minus	line	53)		0 57
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	enorting period	ondi na	1006 11	ndated and c	ompoup	ded by the	0.0	0 58 00 59
	market basket	eporting period	enurng	1770, u		ompour	ueu by the	0.1	50 57
	Lesser of lines 53/54 or 55 from prior year							0.0	
	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha								0 61
	amount (line 56), otherwise enter zero (see			.5 01 X			tul got		
	Relief payment (see instructions)								0 62
	Allowable Inpatient cost plus incentive payr PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see Instru	JCTI ONS;						0 63
	Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31	of the	cost report	ing pe	riod (See		0 64
	instructions)(title XVIII only)	ata aftar Daaamb	2012 21	f the e	oot reportin	-	ad (Saa		0 / 5
	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	ber 31 d	or the c	ost reportin	ig peri	od (See		0 65
5. 00 1	Total Medicare swing-bed SNF inpatient routi	ine costs (line	64 plus	s line 6	5)(title XVI	II onl	y). For		0 66
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routiu	no costs through	Docom	or 21 o	f the cost r	oporti	na nori od		0 67
	(line 12 x line 19)	ne costs through	Decenii		i the cost i	eporti	ng periou		0 0/
	Title V or XIX swing-bed NF inpatient routin	ne costs after D	December	- 31 of	the cost rep	orting	peri od		0 68
1	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino coste ((lino 6	Lino	60)				0 69
	PART III - SKILLED NURSING FACILITY, OTHER N		•						0 09
D. 00 🛛	Skilled nursing facility/other nursing facil	lity/ICF/IID rou	utine se	ervice c	ost (line 37	')			70
	Adjusted general inpatient routine service (Program routine service cost (line 9 x line		ine 70	÷line	2)				71
	Medically necessary private room cost applic		n (line	14 x li	ne 35)				73
1.00	Total Program general inpatient routine serv	vice costs (line	e 72 + I	ine 73)	,				74
	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs	(from W	orksheet B,	Part I	I, column		75
	Per diem capital-related costs (line 75 ÷ li	ine 2)							76
	Program capital-related costs (line 9 x line	· · · · · · · · · · · · · · · · · · ·							77
	Inpatient routine service cost (line 74 minu		novi dov						78
	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp					nus li	ne 79)		80
. 00	Inpatient routine service cost per diem limi								81
	Inpatient routine service cost limitation (I								82
	Reasonable inpatient routine service costs Program inpatient ancillary services (see in	•	1S)						83
	Utilization review - physician compensation		ons)						85
5.00	Total Program inpatient operating costs (sur	m of lines 83 th		35)					86
	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions								0 87
	Adjusted general inpatient routine cost per	· · · · · · · · · · · · · · · · · · ·	⊦line 2	2)				0.0	20 87
	Observation bed cost (line 87 x line 88) (se			-					0 89

Health Financial Systems	ST.	MARY'S	MEDI C	AL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Provi der		Period: From 07/01/2015	Worksheet D-1	
				Component			Date/Time Pre 11/21/2016 8:	
	_			Tit	le XIX	Subprovider -	Cost	
Cost Center Description		Cost	R	outine Cost	column 1 ÷	Total	Observati on	
			(fi	rom 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		539, 4	160	4, 763, 876	0. 11324	10 0	0	90.00
91.00 Nursing School cost			0	4, 763, 876	0.0000	0 0	0	91.00
92.00 Allied health cost	1		0	4, 763, 876	0.0000	0 0	0	92.00
93.00 All other Medical Education			0	4, 763, 876	0. 00000	0 0	0	93.00

	ANCI AL SYSTEMS ST. MARY'S MEDI CAL		CCN: 150100	Peri od:	u of Form CMS- Worksheet D-3	
				From 07/01/2015 To 06/30/2016	Date/Time Pre	
		Ti +1	e XVIII	Hospi tal	11/21/2016 8: PPS	49 pm
	Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
LND	ATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	DO ADULTS & PEDI ATRI CS			21, 190, 232		30.0
	DO INTENSIVE CARE UNIT			11, 239, 038		31.0
1. 02 0310	D2 NI CU			0		31.0
	DO CORONARY CARE UNI T			1, 441, 005		32.0
	DO SUBPROVIDER - IPF			0		40.0
	DO SUBPROVIDER - IRF			0		41.0
	DO NURSERY					43.0
	LLARY SERVICE COST CENTERS		0. 2665	75 39, 169, 021	10, 441, 482	50.0
	DO RECOVERY ROOM		0. 2003		787, 710	
	DO DELIVERY ROOM & LABOR ROOM		0. 4381		15, 874	52.0
	DO ANESTHESI OLOGY		0.0122		70, 770	
	DO RADI OLOGY-DI AGNOSTI C		0. 1298		764, 834	
4. 02 0540	D2 ULTRASOUND		0.0619	83 3, 434, 241	212, 865	54.0
	D3 NUCLEAR MEDICINE		0. 0743		309, 188	
	DO RADI OI SOTOPE		0.0000		0	56.0
	DO CT SCAN		0.0425		336, 500	57.C
	DO MAGNETIC RESONANCE I MAGI NG (MRI)		0.0625		108, 493	58.0
	DO CARDI AC CATHETERI ZATI ON DO LABORATORY		0. 0478		1, 143, 449 3, 149, 208	
	DO BLOOD STORING, PROCESSING & TRANS.		0. 1832		625, 604	63.0
	DO INTRAVENOUS THERAPY		0. 2464		639, 025	
	DO RESPIRATORY THERAPY		0. 4290		1, 651, 338	
	DO PHYSI CAL THERAPY		0. 2618		1, 042, 618	
7.00 0670	DO OCCUPATI ONAL THERAPY		0. 1823	46 3, 438, 540	627, 004	
	DO SPEECH PATHOLOGY		0. 1858	30 916, 930	170, 393	68.0
	DO ELECTROCARDI OLOGY		0.0723		786, 274	69. C
	D2 CARDI AC REHAB		1.0873		2, 488	
	D3 DI ABETI C EDUCATI ON		5. 4230		0	69.0
	DO ELECTROENCEPHALOGRAPHY DO MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1837		254, 756 2, 539, 096	70. C
1	DO IMPL. DEV. CHARGED TO PATIENTS		0. 1979		5, 587, 466	
	DO DRUGS CHARGED TO PATIENTS		0. 2013			
	DO RENAL DI ALYSI S		0. 4257		987, 147	74.0
6.00 039	51 ECT		0. 0725		156	76.0
	50 MOBILE OUTREACH CLINIC		1. 9743	18 0	0	76. C
	PATIENT SERVICE COST CENTERS		1			
	DO RURAL HEALTH CLINIC		0.0000		0	88.0
	00 FEDERALLY QUALIFIED HEALTH CENTER 00 CLINIC		0.0000		0	
	DI OUTPATI ENT PSYCH		0.3614		1, 630 0	
	D2 PEDS CLINIC		0. 0000		0	
	D4 BARI ATRI CS		0.0000		0	
	DO EMERGENCY		0. 1048		1, 544, 195	
	D1 DI AGNOSTI C TREATMENT CENTER		0. 1311	08 3, 530, 911	462, 931	
	DO OBSERVATION BEDS (NON-DISTINCT PART		0.6508	01 592, 308	385, 475	92.0
	R REIMBURSABLE COST CENTERS		1			
	DO AMBULANCE SERVICES					95.0
	DO DURABLE MEDI CAL EQUI P-SOLD		0.5309		0	
	Total (sum of lines 50.04 and 06.08)		0.0000		40 010 204	
00.00 01.00	Total (sum of lines 50-94 and 96-98) Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		256, 953, 730	40, 919, 394	200.0
02.00	Net Charges (line 200 minus line 201)	116 01)		256, 953, 730		201.0

Heal th	Financial Systems ST. MARY'S MEDICAL	CENTER		Inlie	eu of Form CMS-	2552-10
			CCN: 150100	Peri od:	Worksheet D-3	
		Component	CCN: 15S100	From 07/01/2015 To 06/30/2016		
		Ti tl	e XVIII	Subprovider - IPF	PPS	<u>17 piii</u>
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
	03000 ADULTS & PEDI ATRI CS			C		30.00
	03100 I NTENSI VE CARE UNI T			C		31.00
	03102 NI CU			C		31.02
	03200 CORONARY CARE UNIT			1 (07 104		32.00
	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF			1, 687, 184		40.00
	04300 NURSERY					43.00
-	ANCI LLARY SERVICE COST CENTERS					1
50.00	05000 OPERATING ROOM		0. 2665	75 C	0	50.00
	05100 RECOVERY ROOM		0. 1073:			
	05200 DELIVERY ROOM & LABOR ROOM		0. 43814		0	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C		0. 01222 0. 1298			•
	05400 RADI OLOGI - DI AGNOSTI C 05402 ULTRASOUND		0. 06198			1
	05403 NUCLEAR MEDI CI NE		0.07432			
	05600 RADI OI SOTOPE		0. 00000			
57.00	05700 CT SCAN		0. 0425	73 18, 041	768	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 06254			•
	05900 CARDI AC CATHETERI ZATI ON		0.04788			•
			0. 1832			
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY		0. 2453 0. 2464			•
	06500 RESPIRATORY THERAPY		0. 42900			•
	06600 PHYSI CAL THERAPY		0. 2618			
67.00	06700 OCCUPATI ONAL THERAPY		0. 18234	16, 934	3, 088	67.00
	06800 SPEECH PATHOLOGY		0. 1858:		-	•
	06900 ELECTROCARDI OLOGY		0. 07232			
	06902 CARDI AC REHAB 06903 DI ABETI C EDUCATI ON		1. 08734 5. 42304			•
	07000 ELECTROENCEPHALOGRAPHY		0. 18375			•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 08376			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1979		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 20138	36 377, 462	76, 016	73.00
	07400 RENAL DI ALYSI S		0. 42575			1
			0.07254			
	03950 MOBILE OUTREACH CLINIC DUTPATIENT SERVICE COST CENTERS		1. 9743	18 C	0	76.01
	08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90.00	09000 CLINIC		0. 3614	97 C	0	•
	09001 OUTPATIENT PSYCH		1.69768			
	09002 PEDS CLINIC		0.0000		0	•
	09004 BARI ATRI CS 09100 EMERGENCY		0. 00000			•
	09101 DI AGNOSTI C TREATMENT CENTER		0. 13110			
	09200 OBSERVATI ON BEDS (NON-DI STINCT PART		0. 65080			
	OTHER REIMBURSABLE COST CENTERS		P	Г	1	
	09500 AMBULANCE SERVI CES					95.00
	09700 DURABLE MEDI CAL EQUI P-SOLD		0.53090		0	•
98.00 200.00	09850 HOME OFFICE Total (sum of lines 50-94 and 96-98)		0.0000	977, 833	0 293, 796	
200.00	Less PBP Clinic Laboratory Services-Program only charges (1	ine 61)		977,833	293, 190	200.00
202.00	Net Charges (line 200 minus line 201)	,		977, 833		202.00
1						•

Health Financial Systems ST. MARY'S MEDICA	AL CENTER		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150100	Period:	Worksheet D-3	
	Componen	t CCN: 15T100	From 07/01/2015 To 06/30/2016	Date/Time Pre 11/21/2016 8:	
	Ti tl	e XVIII	Subprovider - IRF	PPS	<u>17 piii</u>
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
31. 02 03102 NI CU			0		31.02
32.00 03200 CORONARY CARE UNI T			0		32.00
40.00 04000 SUBPROVIDER - IPF			0		40.00
41. 00 O4100 SUBPROVIDER - IRF			2, 143, 357		41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0.04/5		0.400	1 - 0 - 0 - 0
50. 00 05000 OPERATI NG ROOM		0. 2665		2,409	1
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 10733		466	1
53. 00 05300 ANESTHESI OLOGY		0. 01222		-	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12987		3, 614	1
54. 02 05402 ULTRASOUND		0. 06198		2, 835	
54. 03 05403 NUCLEAR MEDICINE		0.07432		0	1
56. 00 05600 RADI 0I SOTOPE		0.0000		0	56.00
57.00 05700 CT SCAN		0.04257	73 11, 476	489	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.06254	1 8, 728	546	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.04788		0	
60. 00 06000 LABORATORY		0. 18325		34, 696	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2453		1,474	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY		0. 24642		3, 475 10, 318	
66. 00 06600 PHYSI CAL THERAPY		0. 2618		437, 908	
67. 00 06700 0CCUPATI ONAL THERAPY		0. 18234		335, 522	
68. 00 06800 SPEECH PATHOLOGY		0. 18583			
69. 00 06900 ELECTROCARDI OLOGY		0.07232		466	1
69. 02 06902 CARDI AC REHAB		1.08734	17 0	0	69.02
69. 03 06903 DIABETIC EDUCATION		5. 42304		0	1
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 18375		0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0.08376			1
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0. 19797		684	
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS		0. 20138		165, 625 56, 275	
76. 00 03951 ECT		0. 07254		0	1
76. 01 03950 MOBILE OUTREACH CLINIC		1. 9743			1
OUTPATI ENT SERVICE COST CENTERS					1
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89.00
90. 00 09000 CLINIC		0. 36149		0	
90. 01 09001 OUTPATIENT PSYCH		1.69768		0	
90. 02 09002 PEDS CLINIC		0.0000		0	
90. 04 09004 BARI ATRI CS 91. 00 09100 EMERGENCY		0. 00000		0	
91. 00 [09100] EMERGENCY 91. 01 [09101] DI AGNOSTI C TREATMENT CENTER		0. 10489		235	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 65080			1
OTHER REIMBURSABLE COST CENTERS					1
95. 00 09500 AMBULANCE SERVI CES					95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD		0. 53096		0	1
98.00 09850 HOME OFFICE		0.0000		0	
200.00 Total (sum of lines 50-94 and 96-98)	(1) (1)		5, 736, 930	1, 201, 566	1
201.00 Less PBP Clinic Laboratory Services-Program only charges 202.00 Net Charges (line 200 minus line 201)	(TINE 61)		5 726 020		201.00 202.00
202.00 Net Charges (line 200 minus line 201)		I	5, 736, 930	I	1202.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150100	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Pre 11/21/2016 8:	pare
Cost Conton Description		le XIX	Hospital	Cost	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs	
			Charges	$(col \cdot 1 \times col \cdot$	
			5	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
00 03000 ADULTS & PEDIATRICS			540, 197		30.
00 03100 I NTENSI VE CARE UNI T			779, 719		31.
02 03102 NI CU 00 03200 CORONARY CARE UNI T			1, 949, 333 52, 579		31.
00 04000 SUBPROVIDER - IPF			52, 579		40.
00 04100 SUBPROVIDER - I RF			68, 524		41.
00 04300 NURSERY			926, 250		43.
ANCI LLARY SERVICE COST CENTERS		1			1
00 05000 OPERATI NG ROOM		0. 2665	75 1, 888, 322	503, 379	50.
00 05100 RECOVERY ROOM		0. 1073	34 177, 152	19, 014	51.
00 05200 DELIVERY ROOM & LABOR ROOM		0. 4381		439, 963	
00 05300 ANESTHESI OLOGY		0. 0122		1, 936	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 1298		48, 633	
02 05402 ULTRASOUND		0.0619		14, 181	
03 05403 NUCLEAR MEDICINE		0.0743		10, 057	
00 05600 RADI 0I SOTOPE 00 05700 CT SCAN		0.0000		17 457	
00 05700 CT SCAN 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)		0. 0425		17, 457 8, 005	
00 05900 CARDIAC CATHETERIZATION		0.0478		28, 104	
00 06000 LABORATORY		0. 1832		211, 992	
00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2453		48, 104	
00 06400 I NTRAVENOUS THERAPY		0. 2464		143, 461	
00 06500 RESPI RATORY THERAPY		0. 4290		376, 316	
00 06600 PHYSI CAL THERAPY		0. 2618	15 176, 255	46, 146	66
00 06700 OCCUPATI ONAL THERAPY		0. 1823	46 241, 997	44, 127	67
00 06800 SPEECH PATHOLOGY		0. 1858		29, 560	
00 06900 ELECTROCARDI OLOGY		0. 0723		31, 939	
02 06902 CARDI AC REHAB		1.0873		0	
		5. 4230		0	
00 07000 ELECTROENCEPHALOGRAPHY 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1837		5, 460 42, 647	
00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1979		42,047	
00 07300 DRUGS CHARGED TO PATIENTS		0. 2013		441, 977	
00 07400 RENAL DIALYSIS		0. 4257		28, 691	
00 03951 ECT		0.0725		0	
01 03950 MOBILE OUTREACH CLINIC		1. 9743	18 0	0	76
OUTPATIENT SERVICE COST CENTERS					
00 08800 RURAL HEALTH CLINIC		0.0000		0	
00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
		0.3614		0	1
01 09001 OUTPATIENT PSYCH		1.6976		0	
02 09002 PEDS CLINIC 04 09004 BARIATRICS		0.0000		0	
00 09100 EMERGENCY		0. 1048		84, 540	
01 09101 DIAGNOSTIC TREATMENT CENTER		0. 1048			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.6508		0	
OTHER REI MBURSABLE COST CENTERS					1 -
00 09500 AMBULANCE SERVICES					95
00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.5309		0	
00 09850 HOME OFFICE		0.0000		0	
D.00 Total (sum of lines 50-94 and 96-98)			12, 873, 044	2, 670, 744	
1.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201
2.00 Net Charges (line 200 minus line 201)		1	12, 873, 044		202

Health Financial Systems ST. MARY'S MEDICA	L CENTER		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150100	Peri od:	Worksheet D-3	
	Component	CCN: 15S100	From 07/01/2015 To 06/30/2016		
	Ti t	le XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
31. 02 03102 NI CU			0		31.02
32.00 03200 CORONARY CARE UNI T			0		32.00
40. 00 04000 SUBPROVI DER - I PF			276, 555		40.00
41. 00 04100 SUBPROVIDER - IRF			0		41.00
43.00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS		0.0445		(00	
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM		0. 26657			
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 10733 0. 43814			
53. 00 05300 ANESTHESI OLOGY		0. 01222		-	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12987			•
54. 02 05402 ULTRASOUND		0. 06198			•
54. 03 05403 NUCLEAR MEDICINE		0. 07432	27 0	0	54.03
56. 00 05600 RADI 0I SOTOPE		0.00000		-	
57.00 05700 CT SCAN		0.04257			•
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.06254			•
59. 00 05900 CARDI AC_CATHETERI ZATI ON 60. 00 06000 LABORATORY		0. 04788		-	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 24531			1
64. 00 06400 I NTRAVENOUS THERAPY		0. 24641			•
65.00 06500 RESPI RATORY THERAPY		0. 42906			1
66. 00 06600 PHYSI CAL THERAPY		0. 26181	5 5, 304	1, 389	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 18234			•
68.00 06800 SPEECH PATHOLOGY		0. 18583		-	•
69. 00 06900 ELECTROCARDI OLOGY		0.07232			•
69. 02 06902 CARDI AC REHAB 69. 03 06903 DI ABETI C EDUCATI ON		1. 08734 5. 42304		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 18375			•
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 08376			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 19797	7 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 20138	36 77, 703	15, 648	73.00
74. 00 07400 RENAL DIALYSI S		0. 42575		0	
76.00 03951 ECT		0.07254			•
76. 01 03950 MOBILE OUTREACH CLINIC OUTPATIENT SERVICE COST CENTERS		1. 97431	8 0	0	76.01
88. 00 08800 RURAL HEALTH CLINIC		0.00000	0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000			•
90. 00 09000 CLINIC		0.36149	07 0		•
90. 01 09001 OUTPATI ENT PSYCH		1. 69768	32 153	260	90.01
90. 02 09002 PEDS CLINIC		0.00000		-	•
90. 04 09004 BARI ATRI CS		0.0000		-	
91. 00 09100 EMERGENCY 91. 01 09101 DI AGNOSTI C TREATMENT CENTER		0. 10489			•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 13110 0. 65080			•
OTHER REIMBURSABLE COST CENTERS		0.0000	0	0	12.00
95. 00 09500 AMBULANCE SERVICES					95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD		0. 53096		0	•
98.00 09850 HOME OFFICE		0.00000		0	
200.00 Total (sum of lines 50-94 and 96-98)	(1) (1)		545, 584	73, 837	200.00
201.00Less PBP Clinic Laboratory Services-Program only charges202.00Net Charges (line 200 minus line 201)	(TINE 61)		0 545, 584		201.00 202.00
202.00 Ince ondiges (The 200 Influs The 201)		I	545, 564	I	1202.00

Heal th I	Financial Systems ST. MARY'S MEDICAL	CENTER		In Lie	eu of Form CMS-2	2552-10
			CCN: 150100	Peri od:	Worksheet D-3	
		Component	CCN: 15T100	From 07/01/2015 To 06/30/2016		
		Ti t	le XIX	Subprovider - IRF	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3.00	
I	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	03000 ADULTS & PEDI ATRI CS			0		30.00
	03100 I NTENSI VE CARE UNI T			0		31.00
	03102 NI CU			0		31.02
	03200 CORONARY CARE UNI T			0		32.00
	04000 SUBPROVIDER - IPF			0		40.00
	04100 SUBPROVI DER – I RF			13, 890		41.00
	04300 NURSERY INCI LLARY SERVI CE COST CENTERS			0		43.00
	D5000 OPERATI NG ROOM		0. 2665	75 0	0	50.00
	05100 RECOVERY ROOM		0. 10733			51.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 43814			52.00
53.00 0	05300 ANESTHESI OLOGY		0. 01222	25 0	0	53.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C		0. 12987	4 0	0	54.00
	05402 ULTRASOUND		0. 06198		-	54.02
	05403 NUCLEAR MEDICINE		0. 07432			54.03
	D5600 RADI OI SOTOPE		0.0000		-	56.00
	05700 CT SCAN		0.0425		-	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION		0. 06254			58.00 59.00
	06000 LABORATORY		0. 18325			60.00
	06300 BLOOD STORING, PROCESSING & TRANS.		0. 2453			63.00
	06400 I NTRAVENOUS THERAPY		0. 2464		-	64.00
	06500 RESPIRATORY THERAPY		0. 42906			65.00
66.00 0	06600 PHYSI CAL THERAPY		0. 2618	5 19, 395	5, 078	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 18234	6 9, 359	1, 707	67.00
	06800 SPEECH PATHOLOGY		0. 18583			1
	06900 ELECTROCARDI OLOGY		0.07232		-	69.00
	06902 CARDI AC REHAB		1.08734		-	69.02
	06903 DI ABETI C EDUCATI ON 07000 ELECTROENCEPHALOGRAPHY		5. 42304 0. 18375		-	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 08376			70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1979			72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 20138		381	73.00
	07400 RENAL DIALYSIS		0. 42575			74.00
76.00 0	03951 ECT		0. 07254	0 0	0	76.00
	03950 MOBILE OUTREACH CLINIC		1. 9743	8 0	0	76.01
	DUTPATIENT SERVICE COST CENTERS			-	-	
	08800 RURAL HEALTH CLINIC		0.0000			1
	08900 FEDERALLY_QUALI FI ED_HEALTH_CENTER 09000 CLI NI C		0.0000	-	-	89.00 90.00
	09000 CET NTC 09001 OUTPATI ENT PSYCH		0. 36149			90.00
	09002 PEDS CLINIC		0. 00000		0	90.01
	09004 BARI ATRI CS		0. 00000			90.04
	09100 EMERGENCY		0. 10489			
91.01	D9101 DIAGNOSTIC TREATMENT CENTER		0. 13110	0 8	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 65080	01 0	0	92.00
	THER REIMBURSABLE COST CENTERS		1		1	0.5
	09500 AMBULANCE SERVICES		0 5000	7	_	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD 09850 HOME OFFICE		0. 53096 0. 00000		0	
200.00	Total (sum of lines 50-94 and 96-98)		0.0000	41, 850		200.00
200.00	Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		-1,000	, 243	200.00
202.00	Net Charges (line 200 minus line 201)	,		41, 850		202.00
.1						•

ALCUL	Financial Systems ST. MARY'S MEDICAL CE ATI ON OF REIMBURSEMENT SETTLEMENT Pr	rovider CCN: 150100	Period: From 07/01/2015	u of Form CMS-: Worksheet E Part A			
			To 06/30/2016	Date/Time Pre 11/21/2016 8:			
		Title XVIII	Hospi tal	PPS			
				1.00			
. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1 1.0		
. 01	DRG amounts other than outlier payments for discharges occurring p instructions)	rior to October 1 (see	13, 536, 294			
. 02	DRG amounts other than outlier payments for discharges occurring o instructions)	n or after October	1 (see	43, 594, 160	1.0		
. 03	DRG for federal specific operating payment for Model 4 BPCI for di 1 (see instructions)	scharges occurring	orior to October	0	1.0		
. 04	DRG for federal specific operating payment for Model 4 BPCI for di October 1 (see instructions)	scharges occurring	on or after	0			
. 00	Outlier payments for discharges. (see instructions)			1, 310, 740			
. 01 . 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)			0			
. 00	Managed Care Simulated Payments			12, 973, 021	3.0		
. 00	Bed days available divided by number of days in the cost reporting Indirect Medical Education Adjustment	period (see instru	ctions)	385.90			
. 00	FTE count for allopathic and osteopathic programs for the most rec or before 12/31/1996. (see instructions)	ent cost reporting	period ending on	16. 42	5.0		
. 00	FTE count for allopathic and osteopathic programs which meet the c for new programs in accordance with 42 CFR 413.79(e)			0.00			
. 00	MMA Section 422 reduction amount to the IME cap as specified under			5.20			
. 01	ACA Section 5503 reduction amount to the IME cap as specified unde If the cost report straddles July 1, 2011 then see instructions.	6.56	7.				
00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).						
01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.						
02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)						
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)						
0. 00	FTE count for allopathic and osteopathic programs in the current y	ear from your recor	ds	0.00			
1.00	FTE count for residents in dental and podiatric programs.			6.00			
2.00	Current year allowable FTE (see instructions)				12.		
3.00 4.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year en	ded on or after Sep	tember 30, 1997,	6.00 5.00			
F 00	otherwise enter zero.			F /7	15		
5.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			5.67 0.00			
7.00	Adjustment for residents displaced by program or hospital closure			0.00			
	Adjusted rolling average FTE count			5.67			
9.00	Current year resident to bed ratio (line 18 divided by line 4).			0.014693			
D. 00	Prior year resident to bed ratio (see instructions)			0.016190			
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.014693	21.		
2.00	IME payment adjustment (see instructions)			456, 987			
2. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 4	22 of the MMA		103, 771	22.		
3. 00	Number of additional allopathic and osteopathic IME FTE resident $c(f)(1)(iv)(C)$.	ap slots under 42 S	ec. 412.105	0.00	23.		
4.00	IME FTE Resident Count Over Cap (see instructions)			-4.66			
5.00	If the amount on line 24 is greater than -O-, then enter the lower instructions)	ofline 23 or line	24 (see	0.00			
5.00	Resident to bed ratio (divide line 25 by line 4)			0.000000			
7.00	IME payments adjustment factor. (see instructions)			0.000000			
B. 00	IME add-on adjustment amount (see instructions)			0			
8. 01 9. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)			456, 987			
. 00 . 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			456, 987 103, 771			
	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patien	t dave (coo i petrus	tions)	4 00	20		
		i udys (see Enstruc	(10115)	4.89 23.98			
1.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			23.98 28.87			
	Allowable disproportionate share percentage (see instructions)			13.03			
	printendere di spi opor ci una ce snare per centrage (see i instructi UIS)			15.05	1 00.		

ALCUL	Financial Systems ST. MARY'S MEDICA ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150100	Peri od:	u of Form CMS-2 Worksheet E	
			From 07/01/2015 To 06/30/2016	Date/Time Pre	par
			llooni tol	11/21/2016 8: 4	49
		Title XVIII	Hospital Prior to 10/1	PPS	
			1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		0	0	
5. 01	Factor 3 (see instructions)		0. 00000000	0.00000000	
6. 02	Hospital uncompensated care payment (If line 34 is zero, ente	r zero on this line)	3, 729, 641	3, 136, 511	35
. 03	(see instructions) Pro rata share of the hospital uncompensated care payment amou	nt (soo instructions)	940, 075	2, 348, 099	35
. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		3, 288, 174		36
. 00	Additional payment for high percentage of ESRD beneficiary disc				
. 00	Total Medicare discharges on Worksheet S-3, Part I excluding d		0		40
	652, 682, 683, 684 and 685 (see instructions)	3			
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	3, 684 an 685. (see	0		41
	instructions)				
. 01	Total ESRD Medicare covered and paid discharges excluding MS-D	RGs 652, 682, 683, 684	0		41
~~	an 685. (see instructions)		0.00		
. 00	Divide line 41 by line 40 (if less than 10%, you do not qualif	.	0.00		42
. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682 instructions)	, oø3, oø4 an 685. (see	0		43
. 00	Ratio of average length of stay to one week (line 43 divided b	v line 41 divided by 7	0.00000		44
. 00	days)	y The Franklace by /	0.000000		1
5. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45
. 00	Total additional payment (line 45 times line 44 times line 41.	01)	0		46
. 00	Subtotal (see instructions)		64, 047, 380		47
. 00	Hospital specific payments (to be completed by SCH and MDH, sm	all rural hospitals	0		48
	only. (see instructions)				
				Amount 1.00	-
. 00	Total payment for inpatient operating costs (see instructions)			64, 151, 151	49
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and			4, 865, 695	
. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	5
. 00	Direct graduate medical education payment (from Wkst. E-4, lin	e 49 see instructions).		171, 953	52
. 00	Nursing and Allied Health Managed Care payment			0	53
. 00	Special add-on payments for new technologies			3, 777	
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69			0	
. 00	Cost of physicians' services in a teaching hospital (see intru			0	
. 00	Routine service other pass through costs (from Wkst. D, Pt. II		hrough 35).	0	5
. 00 . 00	Ancillary service other pass through costs from Wkst. D, Pt. I'	v, col. II line 200)		0 40 102 574	
. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			69, 192, 576 19, 489	
. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		69, 173, 087	
. 00	Deductibles billed to program beneficiaries			5, 721, 535	
. 00	Coinsurance billed to program beneficiaries			222, 131	
. 00	Allowable bad debts (see instructions)			329, 730	
. 00	Adjusted reimbursable bad debts (see instructions)			214, 325	
. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		254, 437	
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	-		63, 443, 746	
. 00	Credits received from manufacturers for replaced devices for a	pplicable to MS-DRGs (s	ee instructions)	0	68
00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instruction	s)	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 00	RURAL DEMONSTRATION PROJECT			0	
. 00 . 50	SCH or MDH volume decrease adjustment			0	
. 00 . 50 . 88	,	uctions)		0	
. 00 . 50 . 88 . 89	Pioneer ACO demonstration payment adjustment amount (see instr			0	70
). 00). 50). 88). 89). 90	Pioneer ACO demonstration payment adjustment amount (see instr HSP bonus payment HVBP adjustment amount (see instructions)				1 7/
). 00). 50). 88). 89). 90). 91	Pioneer ACO demonstration payment adjustment amount (see instr HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	
). 00). 50). 88). 89). 90). 91). 92	Pioneer ACO demonstration payment adjustment amount (see instr HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0 0	70
 9. 00 9. 00 9. 00 9. 50 9. 88 90 91 92 93 94 	Pioneer ACO demonstration payment adjustment amount (see instr HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70 70

Health Financial Systems ST. MARY'S MI	EDICAL CENTER		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		CCN: 150100	Period: From 07/01/2015 To 06/30/2016	11/21/2016 8:	
	Titl	e XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1.00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/			0	0	70. 96
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or			0	0	70. 97
70.98 Low Volume Payment-3	,			0	70, 98
70.99 HAC adjustment amount (see instructions)				517, 016	70, 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lir	nes 69 & 70)			61, 948, 520	
71.01 Sequestration adjustment (see instructions)				1, 238, 970	
72.00 Interim payments				59, 958, 078	
73.00 Tentative settlement (for contractor use only)				0	73.00
74.00 Balance due provider (Program) (line 71 minus lines 71.01,	72, and 73)			751, 472	74.00
75.00 Protested amounts (nonallowable cost report items) in acco				497, 166	
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 (see	instructions)			0	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (see in	nstructions)			0	92.00
93.00 Capital outlier reconciliation adjustment amount (see inst	tructions)			0	93.00
94.00 The rate used to calculate the time value of money (see in	nstructions)			0.00	94.00
95.00 Time value of money for operating expenses (see instruction	ons)			0	95.00
96.00 Time value of money for capital related expenses (see inst	tructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment					
101.00 HVBP adjustment factor (see instructions)			0.000000000	0.000000000	
102.00 HVBP adjustment amount for HSP bonus payment (see instruct	tions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00 HRR adjustment factor (see instructions)			0.0000	0.0000	
104.00 HRR adjustment amount for HSP bonus payment (see instructi	ons)		0	0	104.00

VO	DLUME CALCULATION EXHIBIT 4				F	Period: From 07/01/2015 To 06/30/2016	11/21/2016 8:	pare
					e XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
0	DRG amounts other than outlier	1.00	0	0	C	0 0	0	1
1	payments DRG amounts other than outlier payments for discharges	1.01	13, 536, 294	0	13, 536, 294	Ļ	13, 536, 294	1
2	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1.02	43, 594, 160	0		43, 594, 160	43, 594, 160	1
	occurring on or after October 1							
3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0			0	1
4	DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1	1.04	0	0		0	0	1
0	Outlier payments for discharges (see instructions)	2.00	1, 310, 740	0	330, 530	980, 210	1, 310, 740	2
1	Outlier payments for	2.02	0	0	C	0	0	2
0	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	0	0	с	0	0	3
0	Managed care simulated payments Indirect Medical Education Adju	3.00	12, 973, 021	0	2, 820, 873	8 10, 152, 148	12, 973, 021	4
0	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 014693	0. 014693				5
0	IME payment adjustment (see instructions)	22.00	456, 987	0	108, 277	348, 710	456, 987	6
1	IME payment adjustment for managed care (see instructions)	22.01	103, 771	0	С	103, 771	103, 771	6
	Indirect Medical Education Adju	stment for the	e Add-on for Se	ction 422 of t	he MMA			
0	IME payment adjustment factor	27.00	0. 000000	0.00000	0.000000	0. 000000		7
_	(see instructions)		_	_				
0	IME adjustment (see instructions)	28.00	0	0	C	0	0	8
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	С	0 0	0	8
0	Total IME payment (sum of lines 6 and 8)	29.00	456, 987	0	108, 277			
1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	103, 771	0	C	103, 771	103, 771	9
	Disproportionate Share Adjustme	ent						1
00	Allowable disproportionate share percentage (see	33.00	0. 1303	0. 1303	0. 1303	0. 1303		10
00	instructions) Disproportionate share adjustment (see instructions)	34.00	1, 861, 025	0	440, 945	5 1, 420, 080	1, 861, 025	11
01	Uncompensated care payments	36.00	3, 288, 174		940, 075	2, 348, 099	3, 923, 220	11
00	Additional payment for high per Total ESRD additional payment (see instructions)	46.00		di scharges 0		_	0	
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	64, 047, 380 0	0	15, 356, 121 C	48, 691, 259 0 0	64, 047, 380 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	64, 151, 151	0	15, 356, 121	48, 795, 030	64, 151, 151	15
00	Payment for inpatient program capital	50.00	4, 865, 695	0	.,,			
00 01	Special add-on payments for new technologies Net organ aquisition cost	54.00 55.00	3, 777	0	1, 705 C	5 2, 071 0 0	3, 776 0	
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	C		0	
00	Capital outlier reconciliation adjustment amount (see	93.00	0	0	c	0 0	0	18

Health Financial Systems		ST. MARY'S MED	DI CAL CENTER		In Lie	u of Form CMS-2	2552-10
LOW VOLUME CALCULATION EXHIBIT 4			Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Exhibi Date/Time Pre 11/21/2016 8:	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
	line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
	0	1.00	2.00	3.00	4.00	5.00	
19.00 SUBTOTAL			0	16, 505, 98	5 52, 514, 637	69, 020, 622	19.00
	W/SL, line	(Amounts from L)					
	0	1.00	2.00	3.00	4.00	5.00	
20.00 Capital DRG other than outlier	1.00	4, 535, 603	0	1, 069, 07	9 3, 466, 523	4, 535, 602	20.00
20.01 Model 4 BPCI Capital DRG other than outlier		0	0		0 0	0	
21.00 Capital DRG outlier payments	2.00	20, 764	0	6, 16	B 14, 596	20, 764	21.00
21.01 Model 4 BPCI Capital DRG	2.01	0	0	-,	0	0	21.01
outlier payments							
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0080	0.0080	0.008	0.0080		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	36, 285	0	8, 55	3 27, 732	36, 285	23.00
24.00 Al lowable disproportionate share percentage (see instructions)	10.00	0. 0602	0. 0602	0. 060	2 0.0602		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	273, 043	0	64, 35	9 208, 684	273, 043	25.00
26.00 Total prospective capital payments (see instructions)	12.00	4, 865, 695	0	1, 148, 15	9 3, 717, 536	4, 865, 695	26.00
	W/S E, Part A	(Amounts to E,					
	line	Part A)					
	0	1.00	2.00	3.00	4.00	5.00	
27.00 Low volume adjustment factor				0.00000	0. 000000		27.00
28.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96					0	28.00
29.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00 Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

IOSPI I	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der	CCN: 150100	Period:	Worksheet E	
				-	From 07/01/2015 To 06/30/2016	Part A Exhibi	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
. 00	DRG amounts other than outlier payments	1.00					1.0
. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	13, 536, 294	13, 536, 29	4	13, 536, 294	1.0
. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	43, 594, 160		43, 594, 160	43, 594, 160	1.0
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0			0	1.0
. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.0
. 00	Outlier payments for discharges (see instructions)	2.00	1, 310, 740	330, 530	980, 210	1, 310, 740	2.0
. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0	(0 0	0	
. 00	Operating outlier reconciliation	2.01	0	(0 0	0	3.0
. 00	Managed care simulated payments	3.00	12, 973, 021	2, 820, 87	3 10, 152, 148	12, 973, 021	4. C
	Indirect Medical Education Adjustment		-				
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 014693				5.0
. 00	IME payment adjustment (see instructions)	22.00	456, 987				6.0
. 01	IME payment adjustment for managed care (see	22.01	103, 771	22, 56	4 81, 207	103, 771	6.0
	instructions)		100 6 1				-
00	Indirect Medical Education Adjustment for the	27.00	0. 000000		0. 000000		1 - 6
. 00	IME payment adjustment factor (see instructions)	27.00	0.00000	0.00000	0.00000		7.0
. 00	IME adjustment (see instructions)	28.00	0		0 0	0	8.0
. 00	IME payment adjustment add on for managed	28.00	0			0	
. 01	care (see instructions)	20.01	0) í	0	0	0.
. 00	Total IME payment (sum of lines 6 and 8)	29.00	456, 987	108, 27	7 348, 710	456, 987	9.1
. 00	Total IME payment for managed care (sum of	29.00	103, 771	22, 56		103, 771	
. 01	lines 6.01 and 8.01)	29.01	103,771	22, 30	4 01,207	103,771	7. 1
	Disproportionate Share Adjustment		1				1
0. 00		33.00	0. 1303	0. 130	3 0. 1303		10.0
	(see instructions)	00100		000	0.1000		
1. 00	Disproportionate share adjustment (see instructions)	34.00	1, 861, 025	440, 94	5 1, 420, 080	1, 861, 025	11. (
1. 01	Uncompensated care payments	36.00	3, 288, 174	940, 07	5 2, 348, 099	3, 288, 174	11.0
	Additional payment for high percentage of ESR	D beneficiary	di scharges]
2. 00	Total ESRD additional payment (see instructions)	46.00	0	(0 0	_	
3.00		47.00	64, 047, 380	15, 356, 12	1 48, 691, 259	64, 047, 380	13.
4. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	(0 0	0	14.
5. 00	· · · · · · · · · · · · · · · · · · ·	49.00	64, 151, 151	15, 378, 68	5 48, 772, 466	64, 151, 151	15. (
5.00	Payment for inpatient program capital	50.00	4, 865, 695	1, 148, 15	9 3, 717, 536	4, 865, 695	16. (
7.00	Special add-on payments for new technologies	54.00	3, 777	1, 70	5 2,072	3, 777	17.0
7.01	Net organ aquisition cost	55.00	0	(0 C	0	17.
7. 02	replaced devices for applicable MS-DRGs	68.00	0	(0 0	0	17.
3. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	(0 0	0	
	SUBTOTAL			16, 528, 54	9 52, 492, 074	69, 020, 623	

Heal th	Financial Systems	ST. MARY'S ME	DICAL CENTER		In Lie	eu of Form CMS-:	2552-10
HOSPI 1	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		CCN: 150100	Period: From 07/01/2015 To 06/30/2016		pared:
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	4, 535, 603	1,069,0	79 3, 466, 524	4, 535, 603	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	20, 764	6, 10	58 14, 596	20, 764	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
22.00		5.00	0.0080	0.008	0.0080		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	36, 285	8, 5	53 27, 732	36, 285	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0602	0.060	0. 0602	2	24.00
25.00		11.00	273, 043	64, 3	59 208, 684	273, 043	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4, 865, 695	1, 148, 1	59 3, 717, 536	4, 865, 695	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70, 96	0		0	0	28.00
29.00	Low volume adjustment on or after October 1	70, 97	0		0	0	29.00
30,00	HVBP payment adjustment (see instructions)	70, 93	-283, 285	-33, 40	-249, 877		
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	
31.00	HRR adjustment (see instructions)	70, 94	-694, 925	-154, 3	-540, 593	-694, 925	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	
	· · · · · · · · · · · · · · · · · · ·					(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 517, 016	517, 016	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150100	Period:	Worksheet E	2552-
			From 07/01/2015 To 06/30/2016	Date/Time Pre	
		Title XVIII	Hospi tal	11/21/2016 8: PPS	49 pi
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
	Medical and other services (see instructions)			14, 251	1.
	Medical and other services reimbursed under OPPS (see instructi	ons)		33, 880, 852	
	PPS payments Outlier payment (see instructions)			32, 824, 705 421, 784	
	Enter the hospital specific payment to cost ratio (see instruct	tions)		0.000	
	Line 2 times line 5			0	6.
	Sum of line 3 plus line 4 divided by line 6			0.00	
	Transitional corridor payment (see instructions)			0	
	Ancillary service other pass through costs from Wkst. D, Pt. IN Organ acquisitions	7, col. 13, line 200		0	
	Total cost (sum of lines 1 and 10) (see instructions)			14, 251	
	COMPUTATION OF LESSER OF COST OR CHARGES			11/201	1
	Reasonabl e charges				1
	Ancillary service charges			73, 644	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	ne 69)		0 73, 644	13
t t	Total reasonable charges (sum of lines 12 and 13) Customary charges			/3, 044	14
	Aggregate amount actually collected from patients liable for pa	ayment for services on	a charge basis	0	15
	Amounts that would have been realized from patients liable for	5	Ų	0	16
	had such payment been made in accordance with 42 CFR §413.13(e))			
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	/ifling 18 exceeds li	ng 11) (see	73, 644 59, 393	
	instructions)	IT THE TO EXCEEDS IT		57, 575	17
	Excess of reasonable cost over customary charges (complete only	/ifline 11 exceeds li	ne 18) (see	0	20
	instructions)				
	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		14, 251	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	(ctions)		0	22
	Total prospective payment (sum of lines 3, 4, 8 and 9)	ictions)		33, 246, 489	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
	Deductibles and coinsurance (for CAH, see instructions)			5, 040	
	Deductibles and Coinsurance relating to amount on line 24 (for		L 00] (6, 214, 596	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl instructions)	us the sum of lines 22	and 23] (see	27, 041, 104	27
	Direct graduate medical education payments (from Wkst. E-4, lin	ne 50)		79, 577	28
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			27, 120, 681	
	Primary payer payments			2, 819	
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	-67		27, 117, 862	32
	Composite rate ESRD (from Wkst. I-5, line 11)	.3)		0	33
	Allowable bad debts (see instructions)			780, 797	
	Adjusted reimbursable bad debts (see instructions)			507, 518	
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		646, 593	
	Subtotal (see instructions)			27, 625, 380	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			-275 0	
	Pioneer ACO demonstration payment adjustment (see instructions)			0	39
	Partial or full credits received from manufacturers for replace		tions)	0	39
	RECOVERY OF ACCELERATED DEPRECIATION			0	39
00	Subtotal (see instructions)			27, 625, 655	40
	Sequestration adjustment (see instructions)			552, 513	
	Interim payments Tentative settlement (for contractors use only)			26, 943, 834 0	41
	Balance due provider/program (see instructions)			129, 308	
	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2.	chapter 1,	127, 300	44
ļ	§115. 2				1
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	
	Time Value of Money (see instructions)			0.00	
					94

Component CCN: 15S100 To 06/30/2016 Da 11 Title XVIII Subprovider 11 Interview of the service of the services Interview of the service of the services (see instructions) PART B - MEDICAL AND OTHER HEALTH SERVICES Interview of the services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 PPS payments 4.00 Outlier payment (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of line 3 plus line 4 divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	ate/Time Prep 1/21/2016 8:4 PPS 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0	49 pm
PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 PPS payments 4.00 Outlier payment (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of line 3 plus line 4 divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions)	0 0 0 0 0.000	
 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 PPS payments 4.00 Outlier payment (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of line 3 plus line 4 divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 	0 0 0 0 0.000	
 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 PPS payments 4.00 Outlier payment (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of line 3 plus line 4 divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 	0 0 0 0. 000	
 3.00 PPS payments 4.00 Outlier payment (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of line 3 plus line 4 divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 	0 0 0. 000	1.00
 4.00 Outlier payment (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of line 3 plus line 4 divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 	0 0. 000	2.00
 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of line 3 plus line 4 divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 	0.000	3.00 4.00
 7.00 Sum of line 3 plus line 4 divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 	1	5.00
 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 	0	6.00
9.00Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 20010.00Organ acquisitions11.00Total cost (sum of lines 1 and 10) (see instructions)	0.00 0	7.00 8.00
11.00 Total cost (sum of lines 1 and 10) (see instructions)	0	9.00
	0	10.00
CUMPUTATION OF LESSER OF COST OR CHARGES	0	11.00
Reasonable charges		
12.00 Ancillary service charges		
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00 14.00
14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges	0	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
18.00 Total customary charges (see instructions)	0	18.00
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19.00
instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
instructions)	0	20.00
21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00 Interns and residents (see instructions) 23.00 Cost of physicians' services in a teaching hospital (see instructions)	0	22. 00 23. 00
24. 00 Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
 25.00 Deductibles and coinsurance (for CAH, see instructions) 26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 	0	25.00 26.00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	Ő	27.00
instructions)	0	20.00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 29.00 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)	0	30.00
31.00 Primary payer payments	0	31.00
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	0	32.00
33. 00 Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00 Allowable bad debts (see instructions)	0	34.00
35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)	0	35.00 36.00
37. 00 Subtotal (see instructions)	0	37.00
38.00 MSP-LCC reconciliation amount from PS&R	0	38.00
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00 20.50
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 50 39. 98
39. 99 RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00 Subtotal (see instructions)	0	40.00
40.01 Sequestration adjustment (see instructions) 41.00 Interim payments	0	40. 01 41. 00
42.00 Tentative settlement (for contractors use only)	0	42.00
43.00 Balance due provider/program (see instructions)	0	43.00
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
TO BE COMPLETED BY CONTRACTOR		
90.00 Original outlier amount (see instructions)		90.00
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money		91.00 92.00
93.00 Time Value of Money (see instructions)	0	93.00
94.00 Total (sum of lines 91 and 93)	0	94.00

	Financial Systems ST. MARY'S MEDICA TION OF REIMBURSEMENT SETTLEMENT	L CENTER Provider CCN: 150100 Component CCN: 15T100	Period: From 07/01/2015	u of Form CMS-2 Worksheet E Part B Date/Time Pre	
		Title XVIII	Subprovi der -	11/21/2016 8: PPS	49 pm
			I RF		
				1.00	
- F	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	i ons)		0	2.00
	PPS payments			0	
	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	
6.00	Line 2 times line 5			0	
	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00	•
	Ancillary service other pass through costs from Wkst. D, Pt. 1	V, col. 13, line 200		0	
10.00	Organ acqui si ti ons			0	•
	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0	11.00
	Reasonable charges				
	Ancillary service charges	(0)		0	
1	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li Total reasonable charges (sum of lines 12 and 13)		0	•	
	Customary charges				1
	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for			0	•
	had such payment been made in accordance with 42 CFR §413.13(e		i a chargebasis	0	16.00
	Ratio of line 15 to line 16 (not to exceed 1.000000)	, ,		0. 000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete onl	vifling 19 overade li	20, 11) (500	0	
	instructions)	y IT THE TO exceeds IT	le II) (see	0	19.00
	Excess of reasonable cost over customary charges (complete on)	y if line 11 exceeds lin	ne 18) (see	0	20.00
	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		0	21.00
	Interns and residents (see instructions)	instructions)		0	
	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	•
	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			0	
	Deductibles and Coinsurance relating to amount on line 24 (for		and 221 (and	0	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p instructions)	Tus the sum of Thes 22	anu 23] (see	0	27.00
	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0	
	Primary payer payments			0	31.00
	Subtotal (line 30 minus line 31)	>		0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC Composite rate ESRD (from Wkst. I-5, line 11)	ES)		0	33.00
	Allowable bad debts (see instructions)			0	
1	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	uctions)		0	
	MSP-LCC reconciliation amount from PS&R			0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
	Pioneer ACO demonstration payment adjustment (see instructions			0	•
	Partial or full credits received from manufacturers for replac	ed devices (see instruc	tions)	0	•
	RECOVERY OF ACCELERATED DEPRECIATION			0	•
1	Subtotal (see instructions)			0	•
1	Sequestration adjustment (see instructions) Interim payments			0	
	Tentative settlement (for contractors use only)			0	1
	Balance due provider/program (see instructions)			0	1
44.00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2, o	chapter 1,	0	
	§115.2 TO BE COMPLETED BY CONTRACTOR				-
	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	•
92.00	The rate used to calculate the Time Value of Money				92.00
93 00	Time Value of Money (see instructions)				93.00
	Total (sum of lines 91 and 93)				94.00

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150100	Peri od:	Worksheet E-1	2552-
				From 07/01/2015 To 06/30/2016	Part I Date/Time Pre 11/21/2016 8:4	parec
		Ti tl	e XVIII	Hospi tal	PPS	47 pii
			t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		59, 958, 0	78 0	26, 943, 834 0	1. (2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04 05				0	0	
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	
53 54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
	3. 50-3. 98)			-		
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)		59, 958, 0	78	26, 943, 834	4
	TO BE COMPLETED BY CONTRACTOR	1				
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider	1	L	_		
01 02	TENTATI VE TO PROVIDER			0	0	
02				0	0	
-	Provider to Program	·				1
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on				0	6
~ -	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		751, 4		129, 308	
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		60, 709, 5	0	0 27, 073, 142	6
50			00,707,5	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150100 CCN: 15S100	Peri od: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part I Date/Time Prep 11/21/2016 8:4	pared:
		Ti tl	e XVIII	Subprovider - IPF	PPS	<u>17 pii</u>
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		859, 0	0	0 0	1. 0 2. 0
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. 0
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02			1	0	0	3.0
03				0	0	3.0
04				0	0	3. C
05				0	0	3. C
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54				0	0	3. !
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 9
	3. 50-3. 98)					
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)		859, 0 ⁻	15	0	4. (
	TO BE COMPLETED BY CONTRACTOR		I			
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. C
	Program to Provider			-	-	
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5.
- 0	Provider to Program		1	0	0	-
50	TENTATI VE TO PROGRAM			0	0	5.
51 52				0	0	5. 5.
				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.
00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		4, 20	דר	0	6.
)1)2	SETTLEMENT TO PROVIDER		4, 20	0	0	о. 6.
			040 01	U	-	
00	Total Medicare program liability (see instructions)		863, 23		0 NPR Date	7.
				Contractor Number	(Mo/Day/Yr)	
		()	1.00	2.00	

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150100 CCN: 15T100	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part I Date/Time Prep 11/21/2016 8:4	pared:
		Ti tl	e XVIII	Subprovider - IRF	PPS	
		Inpatien	it Part A	Par	t B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 135, 8	0	0 0	1.00 2.00
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02				0	0	3. 02
03				0	0	3.03
04				0	0	3.04
05				0	0	3. 0
	Provider to Program		1			
50	ADJUSTMENTS TO PROGRAM			0	0	3.5
51				0	0	3.5
52				0	0	3.5
53				0	0	3.5
64				0	0	3.5
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.9
	3. 50-3. 98)					
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 135, 8	47	0	4.0
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.0
	Program to Provider		1			
)1	TENTATI VE TO PROVIDER			0	0	5. C
)2				0	0	
03				0	0	5.0
	Provider to Program		1	-	-	
0	TENTATI VE TO PROGRAM			0	0	5.5
1				0	0	5.5
2				0	0	5.5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
0	5.50-5.98) Determined net settlement amount (balance due) based on					6. C
11	the cost report. (1)		40.0	24	~	1.
)1	SETTLEMENT TO PROVIDER		48, 02		0	6.0
)2	SETTLEMENT TO PROGRAM		2 400 0	0	0	
00	Total Medicare program liability (see instructions)		3, 183, 8		0	7.0
				Contractor Number	NPR Date (Mo/Day/Yr) 2.00	
			C	1.00		

Heal th	Financial Systems	ST. MARY'S MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150100	Peri od:	Worksheet E-1	
				From 07/01/2015 To 06/30/2016		nared.
				10 00/ 30/ 2010	11/21/2016 8:	
			Title XVIII	Hospi tal	PPS	
					1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAR	RD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					
1.00	Total hospital discharges as defined in AAR			14	16, 542	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6		2		28, 818	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, co				7, 258	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8		2		70, 820	4.00
5.00	Total hospital charges from Wkst C, Pt. I, (col. 8 line 200			1, 530, 688, 903	5.00
6.00	Total hospital charity care charges from Wks	st. S-10, col. 3 lin [,]	e 20		35, 067, 947	6.00
7.00	CAH only - The reasonable cost incurred for	the purchase of cer	tified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168					
8.00	Calculation of the HIT incentive payment (se				1, 323, 737	
9.00	Sequestration adjustment amount (see instru	ctions)			26, 475	9.00
10.00	Calculation of the HIT incentive payment af		ee instructions)		1, 297, 262	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS &					
	Initial/interim HIT payment adjustment (see	instructions)			1, 342, 772	
	Other Adjustment (specify)				0	31.00
32.00	Balance due provider (line 8 (or line 10) m	inus line 30 and line	e 31) (see instruction	s)	-45, 510	32.00

	Financial Systems ST. MARY'S MEDIC			u of Form CMS-2	2552-
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150100 Component CCN: 15S100	Period: From 07/01/2015 To 06/30/2016		
		Title XVIII	Subprovider - IPF	11/21/2016 8: PPS	49 pi
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medi	ical education payments)		809, 364	1.
. 00	Net IPF PPS Outlier Payments			146, 611	2.
. 00	Net IPF PPS ECT Payments			24, 017	3.
. 00	Unweighted intern and resident FTE count in the most recent co 15, 2004. (see instructions)	ost report filed on or be	efore November	0.00	4.
. 01	Cap increases for the unweighted intern and resident FTE coun program or hospital closure, that would not be counted withou CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	4.
. 00	New Teaching program adjustment. (see instructions)			0.00	5.
. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth pe	eriod of a "new	0.00	6.
. 00	teaching program" (see instuctions) Current year's unweighted I&R FTE count for residents within "	the new program growth pe	eriod of a "new	0.00	7.
	teaching program" (see instuctions)				
. 00	Intern and resident count for IPF PPS medical education adjust	tment (see instructions)		0.00	8.
. 00	Average Daily Census (see instructions)			9. 284153	
D. 00 1. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to Teaching Adjustment (line 1 multiplied by line 10).	the power of .5150 -1}.		0.000000	10 11
2.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			0 979, 992	12
3.00	Nursing and Allied Health Managed Care payment (see instruction	on)		0	13
1.00	Organ acquisition (DO NOT USE THIS LINE)				14
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	15
. 00	Subtotal (see instructions)			979, 992	16
. 00	Primary payer payments			0	17
. 00	Subtotal (line 16 less line 17).			979, 992	
. 00	Deducti bl es			91, 952	19
. 00	Subtotal (line 18 minus line 19)			888, 040	
. 00	Coinsurance			11, 480	21
. 00	Subtotal (line 20 minus line 21)	cos) (coo instructions)		876, 560	
. 00	Allowable bad debts (exclude bad debts for professional servid Adjusted reimbursable bad debts (see instructions)	ces) (see first uctions)		6, 583 4, 279	23
. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		5, 323	
. 00	Subtotal (sum of lines 22 and 24)			880, 839	26
. 00	Direct graduate medical education payments (from Wkst. E-4, li	ine 49)		0	27
. 00	Other pass through costs (see instructions)			0	28
. 00	Outlier payments reconciliation			0	29
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	30
). 99	Recovery of Accelerated Depreciation			0	30
. 00	Total amount payable to the provider (see instructions)			880, 839	
. 01	Sequestration adjustment (see instructions)			17, 617	
	Interim payments Tentative settlement (for contractor use only)			859, 015 0	
. 00 . 00	Balance due provider/program (line 31 minus lines 31.01, 32 a	nd 33)		4, 207	
5. 00	Protested amounts (nonallowable cost report items) in accordar §115.2		chapter 1,	4,207	35
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Worksheet E-3, Part II, line 2			146, 611	
1.00	Outlier reconciliation adjustment amount (see instructions)			0	51
2.00	The rate used to calculate the Time Value of Money			0.00	52

	Financial Systems ST. MARY'S MEDICA ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150100	Peri od:	u of Form CMS-2 Worksheet E-3	2002-1
CALCUL		Component CCN: 15T100	From 07/01/2015	Part III Date/Time Prep	
		Title XVIII	Subprovider - IRF	<u>11/21/2016 8: 4</u> PPS	49 pili
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
1.00	Net Federal PPS Payment (see instructions)			3, 085, 647	1.0
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0104	2. C
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			167, 859	3.0
1.00	Outlier Payments			43, 976	4.0
. 00	Unweighted intern and resident FTE count in the most recent co	st reporting period en	ding on or prior	0.00	5.0
- 01	to November 15, 2004 (see instructions)			0.00	- <i>(</i>
5. 01	Cap increases for the unweighted intern and resident FTE count program or hospital closure, that would not be counted without			0.00	5.0
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		lient under 42		
6.00	New Teaching program adjustment. (see instructions)			0.00	6. C
7.00	Current year's unweighted FTE count of I&R excluding FTEs in th	he new program growth p	eriod of a "new	0.00	7.0
	teaching program" (see instructions)				
B. 00	Current year's unweighted I&R FTE count for residents within the	he new program growth p	eriod of a "new	0.00	8. C
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education adjust	ment (see instructions)		0.00	9.1
0.00	Average Daily Census (see instructions)			12.978142	
1.00	Teaching Adjustment Factor (see instructions)			0.00000	
2.00	Teaching Adjustment (see instructions)			0	12.
3.00	Total PPS Payment (see instructions)			3, 297, 482	13.
4.00	Nursing and Allied Health Managed Care payments (see instruction	on)		0	14.
5.00 6.00	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see instru	uctions)		0	15. 16.
7.00	Subtotal (see instructions)			3, 297, 482	17.
	Primary payer payments			3, 277, 402	18.
9.00	Subtotal (line 17 less line 18).			3, 297, 482	19.
0.00	Deducti bl es			41, 916	
1.00	Subtotal (line 19 minus line 20)			3, 255, 566	
2.00	Coinsurance			13, 517	22.
3.00	Subtotal (line 21 minus line 22)			3, 242, 049	23.
4.00	Allowable bad debts (exclude bad debts for professional service	es) (see instructions)		10, 460	24.0
5.00	Adjusted reimbursable bad debts (see instructions)			6, 799	25.
6.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		8, 432	26.
7.00	Subtotal (sum of lines 23 and 25)			3, 248, 848	27.
8.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 49)		0	28.
9.00	Other pass through costs (see instructions)			0	29.
0.00	Outlier payments reconciliation			0	30.
1.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	31.
1.50 1.99	Pioneer ACO demonstration payment adjustment (see instructions) Recovery of Accelerated Depreciation)		0	31. 31.
2.00	Total amount payable to the provider (see instructions)			3, 248, 848	
2.00	Sequestration adjustment (see instructions)			64, 977	
	Interim payments			3, 135, 847	
4.00	Tentative settlement (for contractor use only)			0, 100, 017	34.0
5.00	Balance due provider/program (line 32 minus lines 32.01, 33, and	nd 34)		48, 024	35.0
6.00	Protested amounts (nonallowable cost report items) in accordance	-	chapter 1,	10, 800	
	§115.2 TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			43, 976	50.
51.00	Outlier reconciliation adjustment amount (see instructions)			43, 970	50. 51.
52.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)				53.0

CALCUL	Financial Systems ST. MARY'S MEDICAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150100	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 07/01/2015 To 06/30/2016	Part VII Date/Time Pre 11/21/2016 8:5	
		Title XIX	Hospi tal	Cost	,
			I npati ent	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV			2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	ICES FOR TITLES V OR A	IN SERVICES		-
1.00	Inpati ent hospi tal /SNF/NF servi ces		12, 180, 645		1.00
2.00	Medical and other services		, ,	0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		12, 180, 645	0	
5.00	Inpatient primary payer payments		0		5.00
6.00 7.00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		12, 180, 645	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		12, 160, 045	0	7.00
	Reasonabl e Charges				1
8.00	Routi ne servi ce charges		4, 321, 710		8.00
9.00	Ancillary service charges		12, 873, 044	14, 639, 415	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		17, 194, 754	14, 639, 415	12.00
13.00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
15.00	basi s	services on a charge	Ŭ	0	15.00
14.00	Amounts that would have been realized from patients liable for	payment for services o	n 0	0	14.00
	a charge basis had such payment been made in accordance with 42				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.00000	•
16.00	Total customary charges (see instructions)	if line 1/ evenede	17, 194, 754	14, 639, 415	
17.00	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	IT THE TO exceeds	5, 014, 109	14, 639, 415	17.00
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	e 0	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instru		0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16		12, 180, 645	0	21.00
22. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co Other than outlier payments	ompleted for PPS provid		0	22.00
22.00	Outlier payments		0	0	
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		12, 180, 645	0	29.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		12, 180, 645	0	
32.00	Deducti bl es		0	0	
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	•
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	12, 180, 645	0	•
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)		0 12, 180, 645	0	
30 00	Direct graduate medical education payments (from Wkst. E-4)		12, 100, 045	0	38.00
38.00 39.00	prior graduate mean our equation payments (110m most. E-4)		12, 180, 645	0	
38.00 39.00 40.00	Total amount payable to the provider (sum of lines 38 and 39)		12, 100, 0401		
39. 00	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		12, 180, 645	0	•
39. 00 40. 00				-	41.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT F	rovider CCN: 150100	Peri od:	Worksheet E-3	
	c	component CCN: 15S100	From 07/01/2015 To 06/30/2016	Part VII Date/Time Pre 11/21/2016 8:	par 50
		Title XIX	Subprovider - IPF	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES FOR TITLES V OR X	X SERVICES		4
20	COMPUTATION OF NET COST OF COVERED SERVICES		1 220 204		4.
00 00	Inpatient hospital/SNF/NF services Medical and other services		1, 229, 894	0	
00	Organ acquisition (certified transplant centers only)		0	0	
00	Subtotal (sum of lines 1, 2 and 3)		1, 229, 894	0	
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		1, 229, 894	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
00	Routi ne servi ce charges		276, 555	_	8
00	Ancillary service charges		545, 584	0	
. 00 . 00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		1(
. 00	Total reasonable charges (sum of lines 8 through 11)		0 822, 139	0	1
00	CUSTOMARY CHARGES		022, 139	0	1 '
. 00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	1:
	basi s	5			
. 00	Amounts that would have been realized from patients liable for pa	yment for services o	n 0	0	14
	a charge basis had such payment been made in accordance with 42 C	FR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.00000	
00	Total customary charges (see instructions)		822, 139	0	
. 00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	0	0	1
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only i	fling 1 avcords lin	e 407, 755	0	18
. 00	16) (see instructions)			0	
. 00	Interns and Residents (see instructions)		0	0	10
. 00	Cost of physicians' services in a teaching hospital (see instruct	i ons)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line 16)		822, 139	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provid			
. 00	Other than outlier payments		0	0	
. 00	Outlier payments		0	0	
. 00	Program capital payments		0		2
. 00 . 00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		822, 139	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
. 00	Excess of reasonable cost (from line 18)		407, 755	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		822, 139	0	3
. 00	Deducti bl es		0	0	-
00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	-
00	Utilization review	\ \	0	0	3!
00 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY))	822, 139	0	
. 00	Subtotal (line 36 ± 1 line 37)		822, 139	0	
00	Direct graduate medical education payments (from Wkst. E-4)		022, 139	0	3
. 00	Total amount payable to the provider (sum of lines 38 and 39)		822, 139	0	
. 00	Interim payments		822, 139	0	
. 00	Balance due provider/program (line 40 minus line 41)		0	0	
. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	
	chapter 1, §115.2				1

LCUL		Provider CCN: 150100 Component CCN: 15T100	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Pre	
		Title XIX	Subprovider -	11/21/2016 8: Cost	
			I RF		
			Inpatient 1.00	Outpatient 2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIO	CES FOR TITLES V OR XI		2100	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		292, 068] 1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		292, 068	0	
00 00	Inpatient primary payer payments Outpatient primary payer payments		0	0	
00 00	Subtotal (line 4 less sum of lines 5 and 6)		292, 068	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES		272,000	0	1 1
	Reasonable Charges				1
00	Routi ne servi ce charges		13, 890		8
00	Ancillary service charges		41, 850	0	
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		55, 740	0	1:
00	CUSTOMARY CHARGES		0	0	1 1
. 00	Amount actually collected from patients liable for payment for so basis	ervices on a charge	0	0	13
. 00	Amounts that would have been realized from patients liable for pa	avment for services o	n 0	0	14
	a charge basis had such payment been made in accordance with 42 (5		Ũ	·
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	,	0.000000	0.000000	1!
. 00	Total customary charges (see instructions)		55, 740	0	10
. 00	Excess of customary charges over reasonable cost (complete only	ifline 16 exceeds	0	0	1
	line 4) (see instructions)			_	
. 00	Excess of reasonable cost over customary charges (complete only i	if line 4 exceeds line	e 236, 328	0	18
. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see instruct	tions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line 16)		55, 740	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be cor	mpleted for PPS provid			1 -
. 00	Other than outlier payments	· · ·	0	0	22
. 00	Outlier payments		0	0	2
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		2!
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00 . 00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		55, 740	0	
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		55,740	0	- 21
. 00	Excess of reasonable cost (from line 18)		236, 328	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		55, 740	0	
	Deducti bl es		0	0	
. 00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review	•	0		3!
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	3)	55, 740	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 00	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from West E_4)		55, 740	0	38
. 00 . 00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		55, 740	0	
. 00	Interim payments		55, 740	0	
. 00	Balance due provider/program (line 40 minus line 41)		0	0	
. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2.	0	0	
	chapter 1, §115.2			-	1

DI RECT	Financial Systems ST. MARY'S MEDICA GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT		CCN: 150100	Peri od:	u of Form CMS-2 Worksheet E-4	
	_ EDUCATI ON COSTS			From 07/01/2015 To 06/30/2016	Date/Time Pre	pared
		Ti +1	e XVIII	Hospi tal	11/21/2016 8: • PPS	49 pii
				10301 tu	115	
					1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathic prending on or before December 31, 1996.	rograms for	cost reporti	ng periods	18.00	1.0
	Unweighted FTE resident cap add-on for new programs per 42 CFR	413.79(e)(1) (see instr	uctions)	0.00	2.
	Amount of reduction to Direct GME cap under section 422 of MMA $$				0.00 7.29	3. 3.
	DI Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					
. 00	Adjustment (plus or minus) to the FTE cap for allopathic and os GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	steopathi c	programs due	to a Medicare	0.00	4.
	ACA Section 5503 increase to the Direct GME FTE Cap (see instru straddling 7/1/2011)	uctions for	cost reporti	ng periods	0.00	4.
	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	(see inst	ructions for	cost reporting	0.00	4.
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus 4.02 plus applicable subscripts	s or minus	line 4 plus l	ines 4.01 and	10. 71	5.
	Unweighted resident FTE count for allopathic and osteopathic purecords (see instructions)	rograms for	the current	year from your	0.00	6.
. 00	Enter the lesser of line 5 or line 6				0.00	7.
Ì			Primary Care	e Other	Total	
			1.00	2.00	3.00	
	Weighted FTE count for physicians in an allopathic and osteopar program for the current year.	thi c	0.0	0.00	0.00	8.
	If line 6 is less than 5 enter the amount from line 8, otherwis multiply line 8 times the result of line 5 divided by the amoun 6.		0.0	0.00	0.00	9.
0. 00	Weighted dental and podiatric resident FTE count for the currer	nt year		6.00		10.
	Total weighted FTE count	5	0.0	6.00		11.
2.00	Total weighted resident FTE count for the prior cost reporting	year (see	0.0	5.00		12.
3.00	instructions) Total weighted resident FTE count for the penultimate cost reponse.	orting	0.0	4.50		13.
	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided b	3)	0.0	5.17		14.
	Adjustment for residents in initial years of new programs	Jy 3).	0.0			14.
	Adjustment for residents displaced by program or hospital closu	IFA	0.0			16.
	Adjusted rolling average FTE count	ar c	0.0			17.
	Per resident amount		106, 209. 4			18.
	Approved amount for resident costs		100, 207	0 519, 952	519, 952	
					1.00	
0. 00	Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4)	E resident	cap slots rec	eived under 42	0.00	20.
1.00	Direct GME FTE unweighted resident count over cap (see instruct	tions)			0.00	21.
2.00	Allowable additional direct GME FTE Resident Count (see instruc	ctions)			0.00	22.
3.00	Enter the locally adjustment national average per resident amou	unt (see in	structions)		0.00	23.
4.00	Multiply line 22 time line 23					24.
5.00	Total direct GME amount (sum of lines 19 and 24)				519, 952	25.
			Inpatient Par A	t Managed care		
			1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
	Inpatient Days (see instructions)		32, 21	8 7,668		26.
	Total Inpatient Days (see instructions)		80, 21			27.
1	Ratio of inpatient days to total inpatient days		0. 40166			28.
	Program direct GME amount		208, 84			29.
29.00						
	Reduction for direct GME payments for Medicare Advantage			7, 023		30.

Heal th	Financial Systems	ST. MARY'S MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OU	TPATIENT DIRECT	Provider CCN: 150100	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 07/01/2015	Data /Tima Dray	norod.
				To 06/30/2016	Date/Time Pre 11/21/2016 8:4	
			Title XVIII	Hospi tal	PPS	
					1.00	
-	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COM	IPOSITE RATE - TITLE	KVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
	EDUCATION COSTS)					
32.00	Renal dialysis direct medical education cos	sts (from Wkst. B, Pt	. I, sum of col. 20 an	d 23, lines 74	0	32.00
	and 94)					
33.00	Renal dialysis and home dialysis total char			74 and 94)	3, 700, 694	
34.00	Ratio of direct medical education costs to		32 ÷ line 33)		0.00000	
35.00	Medicare outpatient ESRD charges (see instr				0	35.00
36.00	Medicare outpatient ESRD direct medical edu				0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE	COST - TITLE XVIII O	NLY			
07.00	Part A Reasonable Cost				70.055.040	07.00
37.00	Reasonable cost (see instructions)				73, 255, 918	
38.00	Organ acquisition costs (Wkst. D-4, Pt. III		-+:>		0	38.00
39.00	Cost of physicians' services in a teaching	nospital (see instru	ctions)		0 19, 489	39.00 40.00
40.00 41.00	Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines	27 through 20 minute	Line (0)		19, 489 73, 236, 429	
41.00	Part B Reasonable Cost	37 through 39 minus	TTTTE 40)		73, 230, 429	41.00
42.00	Reasonable cost (see instructions)				33, 895, 103	12 00
43.00	Primary payer payments (see instructions)				2, 819	
44.00	Total Part B reasonable cost (line 42 minus	Line 43)			33, 892, 284	
45.00	Total reasonable cost (sum of lines 41 and				107, 128, 713	
46.00	Ratio of Part A reasonable cost to total re		41 ÷ line 45)		0. 683630	
47.00	Ratio of Part B reasonable cost to total re				0. 316370	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BET				2. 2. 2070	
48.00	Total program GME payment (line 31)				251, 530	48.00
	Part A Medicare GME payment (line 46 x 48)	(title XVIII only) (see instructions)		171, 953	49.00
	Part B Medicare GME payment (line 47 x 48)				79, 577	50.00
		- · · ·				-

	SHEET (If you are nonproprietary and do not maintain be accounting records, complete the General Fund column onl		F	Period: From 07/01/2015 To 06/30/2016	Worksheet G Date/Time Pre 11/21/2016 8:	epare 49 r
		General Fund	Specific Purpose Fund	Endowment Fund		
CI	JRRENT ASSETS	1.00	2.00	3.00	4.00	-
	ash on hand in banks	11, 241, 992	0	0	0	1 1
	emporary investments	0	(0	
0 N	otes recei vabl e	0	0	0 0	0	3
	ccounts receivable	245, 685, 171	0	0 0	0	
	ther receivable	10, 844, 469		-	0	
	llowances for uncollectible notes and accounts receivable	-168, 232, 112		, i	0	
	nventory repaid expenses	7, 942, 925 1, 390, 662		0	0	
	ther current assets	1, 370, 002			0	
	ue from other funds	98, 686		, v	0	
00 T	otal current assets (sum of lines 1-10)	108, 971, 793	0	0 0	0	11
FI	I XED ASSETS					
	and	7, 736, 792			0	
	and improvements	8, 348, 761	(0	
	ccumulated depreciation uildings	-6, 465, 686		-	0	
	ccumulated depreciation	170, 478, 067 -138, 871, 312		-	0	
	easehold improvements	12, 371, 416	· · · · · ·	, v	0	
	ccumul ated depreciation	-7, 380, 146		, v	0	
	i xed equi pment	0	0	0	0	
00 A	ccumulated depreciation	0	(0 0	0	20
	utomobiles and trucks	2, 055, 185		, v	0	
	ccumulated depreciation	-987, 028		-	0	
	ajor movable equipment	141, 178, 861		, i	0	
	ccumulated depreciation inor equipment depreciable	-115, 603, 247			0	
	ccumul ated depreciation				0	
	IT designated Assets	0		0	0	
	ccumulated depreciation	0	0	0 0	0	28
	i nor equi pment-nondepreci abl e	0	(0	29
	otal fixed assets (sum of lines 12-29)	72, 861, 663	(00	0	30
	THER ASSETS	(54 410 (14		0	0	31
	eposits on Leases	654, 418, 614 0			0	
	ue from owners/officers	0		-	0	
	ther assets	26, 908, 988	C	0	0	
00 T	otal other assets (sum of lines 31-34)	681, 327, 602	0	0 0	0	35
	otal assets (sum of lines 11, 30, and 35)	863, 161, 058	(00	0	36
	JRRENT LI ABI LI TI ES	10 004 740				
	ccounts payable	12, 224, 742 9, 050, 868			0 0	
	alaries, wages, and fees payable ayroll taxes payable	9,050,888			0	
	otes and loans payable (short term)	1, 729, 859		0	0	
	eferred income	0	(0 0	0	
00 A	ccelerated payments	0				42
	ue to other funds	11, 217, 843			0	
	ther current liabilities	160, 178, 510			0	
	otal current liabilities (sum of lines 37 thru 44)	194, 401, 822	(0 0	0	45
	DNG TERM LIABILITIES	334, 384	0	0	0	46
	otes payable	001,001			0	
	nsecured Loans	0	C	0	0	
00 0	ther long term liabilities	20, 657, 937	0	0 0	0	49
	otal long term liabilities (sum of lines 46 thru 49)	20, 992, 321		0 0	0	
	otal liabilities (sum of lines 45 and 50)	215, 394, 143	(0 0	0	51
	APITAL ACCOUNTS	(47 7(/ 015				1 6 4
	eneral fund balance pecific purpose fund	647, 766, 915				52
	onor created - endowment fund balance - restricted					54
	onor created - endowment fund balance - unrestricted			0		55
	overning body created - endowment fund balance			0		56
	lant fund balance - invested in plant				0	57
	lant fund balance - reserve for plant improvement,				0	58
	eplacement, and expansion	(47 7 () ~ ~ ~ ~			-	
	otal fund balances (sum of lines 52 thru 58)	647, 766, 915			0	
1111	otal liabilities and fund balances (sum of lines 51 and	863, 161, 058	1 (ں U	0	1 0

Heal th	Financial Systems	ST. MARY'S MED	ICAL CENTER			In Lie	u of Form CMS-	2552-10
STATEN	ENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 150100		eriod:	Worksheet G-1	
					Tc	rom 07/01/2015 06/30/2016	Date/Time Pre 11/21/2016 8:	
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fund	
		1.00	2.00	3.00		4.00	5.00	
1.00	Fund balances at beginning of period		572, 959, 795			0		1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		66, 154, 350 639, 114, 145			0		2.00 3.00
4.00	RESTRICTED CONTRIBUTIONS OF PROPERTY	1, 272, 968	037, 114, 143		0	0	C	
5.00	OTHER	184, 715			0		C C	
6.00	TRANSFER TO / FROM AFFILIATES	21, 968, 404			0		0	
7.00		0			0		C	7.00
8.00		0			0		C	8.00
9.00		0			0		C	9.00
10.00	Total additions (sum of line 4-9)		23, 426, 087			0		10.00
11.00	Subtotal (line 3 plus line 10)		662, 540, 232			0		11.00
12.00	OTHER	14, 773, 317			0		C	
13.00		0			0		0	1
14.00		0			0		0	
15.00		0			0		0	
16. 00 17. 00		0			0			
18.00	Total deductions (sum of lines 12-17)	0	14, 773, 317		0	0	U	18.00
19.00	Fund balance at end of period per balance		647, 766, 915			0		19.00
17100	sheet (line 11 minus line 18)		01177007710			Ĵ		17100
		Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00				
1.00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2)	0			0			3.00
4.00	RESTRICTED CONTRIBUTIONS OF PROPERTY		C					4.00
5.00	OTHER		C					5.00
6.00	TRANSFER TO / FROM AFFILIATES		0					6.00
7.00			0					7.00
8.00 9.00			0					8.00 9.00
9.00 10.00	Total additions (sum of line 4-9)	0	U		0			10.00
11.00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	OTHER	0	0		Ŭ			12.00
13.00			Ő					13.00
14.00			0					14.00
15.00			C					15.00
16.00			C					16.00
17.00			C					17.00
18.00	Total deductions (sum of lines 12-17)	0			0			18.00
19.00	Fund balance at end of period per balance	0			0			19.00
	sheet (line 11 minus line 18)	I I		I				1

				From 07/01/2015 To 06/30/2016	Parts I & II Date/Time Pre 11/21/2016 8:-	
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					4
	General Inpatient Routine Services		(7.400.0		(7.400.007	
00	Hospi tal		67, 102, 9		67, 102, 907	
00	SUBPROVIDER - IPF		5, 326, 4		5, 326, 464	
00	SUBPROVIDER - IRF		4, 524, 9	64	4, 524, 964	
00 00	SUBPROVIDER Swing bed - SNF			0	0	4. (5. (
00	Swing bed - NF			0	0	
00	SKILLED NURSING FACILITY			0	0	
00	NURSING FACILITY			0	0	
00	OTHER LONG TERM CARE			0	Ũ	9.0
0.00	Total general inpatient care services (sum of lines 1-9)		76, 954, 3	35	76, 954, 335	
	Intensive Care Type Inpatient Hospital Services			1		
1.00	INTENSIVE CARE UNIT		26, 014, 2	33	26, 014, 233	11. (
1.02	NI CU		9, 102, 8		9, 102, 835	11.0
2.00	CORONARY CARE UNIT		3, 255, 4	95	3, 255, 495	12.
3.00	BURN INTENSIVE CARE UNIT					13.0
1.00	SURGI CAL I NTENSI VE CARE UNI T					14.0
5.00	OTHER SPECIAL CARE (SPECIFY)					15.
5.00	Total intensive care type inpatient hospital services (sum of li 11-15)	nes	38, 372, 5	63	38, 372, 563	16.
7.00	Total inpatient routine care services (sum of lines 10 and 16)		115, 326, 8	98	115, 326, 898	17.
3.00	Ancillary services		570, 125, 9		1, 224, 985, 095	
9.00	Outpatient services		52, 045, 7	56 122, 377, 156	174, 422, 912	
0. 00	RURAL HEALTH CLINIC			0 0	0	
	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
2.00	HOME HEALTH AGENCY		47.4	0	0	
3.00	AMBULANCE SERVICES		17, 4	75 11, 273, 081	11, 290, 556	
1.00				0	0	
5.00 5.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE					25. 26.
7.00	OTHER OPERATING REVENUE		64, 7	00 19,049	83, 749	
7.01	PHYSICIAN'S PRIVATE OFFICES		18, 890, 1			
7.02	DME		10, 070, 1	0 5, 510, 235	5, 510, 235	
7.03	APOTHECARY			0 124, 076	124, 076	
7.04	CONV CARE			0 14, 893, 002		
3. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst.	756, 470, 8		1, 576, 856, 645	
I	G-3, line 1)					
	PART II - OPERATING EXPENSES		1			4
9.00	Operating expenses (per Wkst. A, column 3, line 200)			434, 438, 414		29.
0.00				0		30.
1.00				0		31.
2.00 3.00				0		32.
4.00				0		33. 34.
5.00				0		34.
5.00	Total additions (sum of lines 30-35)			0		36.
7.00				0		37.
3.00				0		38.
9.00				0		39.
0.00				0		40.
. 00				0		41.
2.00	Total deductions (sum of lines 37-41)			0		42.
3.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		434, 438, 414		43.

Heal th	Financial Systems	ST. MARY'S MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES		Provider CCN: 150100	Period: From 07/01/2015	Worksheet G-3	
				To 06/30/2016	Date/Time Pre 11/21/2016 8:	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part		28)		1, 576, 856, 645	1.00
2.00	Less contractual allowances and discounts on	patients' accounts			1, 081, 078, 550	2.00
3.00	Net patient revenues (line 1 minus line 2)				495, 778, 095	3.00
4.00	Less total operating expenses (from Wkst. G-	2, Part II, line 43))		434, 438, 414	4.00
5.00	Net income from service to patients (line 3	minus line 4)			61, 339, 681	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellane	ous communication se	ervi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				231, 685	13.00
14.00	Revenue from meals sold to employees and gue	sts			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical su	pplies to other than	n patients		1, 684	16.00
17.00	Revenue from sale of drugs to other than pat	ients			5, 945	17.00
18.00	Revenue from sale of medical records and abs	tracts			6, 911	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	nd canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00					734, 773	22.00
23.00					0	23.00
24.00	OTHER OPERATING INCOME				19, 993, 092	24.00
24.01					0	24.01
	Total other income (sum of lines 6-24)				20, 974, 090	
26.00					82, 313, 771	
27.00					16, 159, 421	
	Total other expenses (sum of line 27 and sub	scrints)			16, 159, 421	
	Net income (or loss) for the period (line 26	1 2			66, 154, 350	
27.00	The through (of 1033) for the period (The 20			I	00, 104, 300	27.00

	Financial Systems	ST. MARY'S MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
CALCUL	_ATION OF REIMBURSABLE BAD DEBTS - TITLE XVII	I – PART B	Provider CCN:		Period:	Worksheet I-5	
					From 07/01/2015 To 06/30/2016	Date/Time Prep	arad
					10 00/ 30/ 2010	11/21/2016 8:5	
					1.00	2.00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEE						
1.00	Total expenses related to care of program be				0		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, I				0	0	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.0						2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02,	line 11) (see inst	ructions)			_	2.02
2.03	Total payment due (see instructions)				0	0	2.03
2.04	Outlier payments				0		2.04
3.00	Deductibles billed to Medicare (Part B) pati				0	0	3.00
3.01	Deductibles billed to Medicare (Part B) pati						3.01
3.02	Deductibles billed to Medicare (Part B) pati						3.02
3.03	Total deductibles billed to Medicare (Part E		tructions)		0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) pati				0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) pati						4.01
4.02	Coinsurance billed to Medicare (Part B) pati		,				4.02
4.03	Total coinsurance billed to Medicare (Part E				0	0	4.03
5.00	Bad debts for deductibles and coinsurance, r				0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for a			bad debt	0	0	5.01
	recoveries for services rendered on or after						
5.02	Transition period 2 (50-50%) bad debts for a			bad debt	0	0	5.02
	recoveries for services rendered on or after						
5.03	Transition period 3 (25-75%) bad debts for a			bad debt	0	0	5.03
	recoveries for services rendered on or after					_	
5.04	100% PPS bad debts for deductibles and coins	surance net of bad d	ebt recoveries	for	0	0	5.04
F 0F	services rendered on or after 1/1/2014	5.04)					F 0F
5.05	Total bad debts (sum of line 5 through line	5.04)			0	0	5.05
6.00	Allowable bad debts (see instructions)	C···· · · · · ·			0		6.00
7.00	Reimbursable bad debts for dual eligible ber		,		0		7.00
8.00	Net deductibles and coinsurance billed to Me	edicare (Part B) pat	ents (see		0	0	8.00
0 00	instructions)						0 00
9.00	Program payment (see instructions)				0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients						10.00
11.00				ne 33)	0		11.00
10.00	PART II - CALCULATION OF FACILITY SPECIFIC (UMPUSITE CUST PERCEI	TAGE				12.00
		2 Line 11)			0		12.00
	Total composite costs (from Wkst. I-4, col.		1:00 12)		0.00000		13.00
14.00	Facility specific composite cost percentage	(The is divided by	rine iz)		0.000000		14.00

	ATION OF CAPITAL PAYMENT	Provider CCN: 150100	Period: From 07/01/2015 To 06/30/2016		
		Title XVIII	Hospi tal	PPS	49 pi
				1.00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				-
00	Capital DRG other than outlier			4, 535, 603	1 1.
01	Model 4 BPCI Capital DRG other than outlier			1, 000, 000	1.
00	Capital DRG outlier payments			20, 764	
D1	Model 4 BPCI Capital DRG outlier payments			20,701	
00	Total inpatient days divided by number of days in the cost rep	orting period (see inst	ructions)	200. 28	
00	Number of interns & residents (see instructions)				4.
00	Indirect medical education percentage (see instructions)			0.80	5.
00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.01	, columns 1 and	36, 285	6.
	1.01)(see instructions)				
00	Percentage of SSI recipient patient days to Medicare Part A pa 30) (see instructions)	-	, part A line	4.89	
00	Percentage of Medicaid patient days to total days (see instruc	tions)		23.98	
00	Sum of lines 7 and 8			28.87	
. 00	Allowable disproportionate share percentage (see instructions)			6.02	
. 00	Disproportionate share adjustment (see instructions)			273, 043	
. 00	Total prospective capital payments (see instructions)			4, 865, 695	12.
				1.00	
	PART II – PAYMENT UNDER REASONABLE COST			1.00	
00	Program inpatient routine capital cost (see instructions)			0	1 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			1.00	
00	Program inpatient capital costs (see instructions)			0	1 1
00	Program inpatient capital costs for extraordinary circumstance	es (see instructions)		0	
00	Net program inpatient capital costs (line 1 minus line 2)			0	3
00	Applicable exception percentage (see instructions)			0.00	4
00	Capital cost for comparison to payments (line 3 x line 4)			0	5
00	Percentage adjustment for extraordinary circumstances (see ins	tructions)		0.00	6
00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	line 6)	0	7.
00	Capital minimum payment level (line 5 plus line 7)			0	8
00	Current year capital payments (from Part I, line 12, as applic			0	
. 00	Current year comparison of capital minimum payment level to ca		· · ·	0	
00	Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14)		5	0	
	Net comparison of capital minimum payment level to capital pay			0	1 . ~ .
	Current year exception payment (if line 12 is positive, enter			0	
. 00			ollowing period	0	14.
. 00	Carryover of accumulated capital minimum payment level over ca	pital payment for the f	orrowing period	Ŭ	1
. 00 . 00 . 00	(if line 12 is negative, enter the amount on this line)		orrowing period		
. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see inst		orrowing perrou	0	15.