KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/28/2017 Time: 15:29 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY MEDICAL CENTER, INC (15-0034) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2016 and ending 06/30/2017, 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.

ECR Encryption: 11/28/2017 15:29
qx eK1cgY9 m8DvPmAKPWFAD5S z0
Xnlh006sb7MQCKLuz7B0Yx6Wce6ac6
Aonz1zyBCD0YTdl2

PI Encryption: 11/28/2017 15:29
iw8MYqGiLCd ONKsItOnJBQ0NU5oY0
uAN0h0lhipyyxXumaBSL5e 9I9p lh
7X5u06wfIK0kKBj7

(Signed) Mary Andrig
Officer or Administrator of Provider(s)

Chief Financial Officer
Title

11/29/2017
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		168,091	-100,597			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		94,494	-39			3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		262,585	-100,636			200

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 resopnd 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 this 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 this 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.

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 1500 SOUTH LAKE AVENUE	P.O. Box:			1
2	City: HOBART	State: IN	ZIP Code: 46342	County: LAKE	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ST. MARY MEDICAL CENTER, INC.	15-0034	23844	1	07 / 01 / 1966	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF	SMMC REHABILITATION UNIT	15-T034	23844	5	01 / 01 / 2001	N	P	P	5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	SMMC HOME HEALTH AGENCY	15-7313	23844		02 / 08 / 1996	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2016	To: 06 / 30 / 2017	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,010	2,424		202	4,080		24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		89		15	277		25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	Y			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N		76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers		1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	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 each therapy.		N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	1			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	15H054	140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name: COMMUNITY FOUNDATION OF NW IN,	Contractor's Name: NGS	Contractor's Number: 00450		141
142	Street: STREET: STREET: 10010 DONALD	P.O. Box: 201			142
143	City: MUNSTER	State: IN	ZIP Code: 46321		143
144	Are provider based physicians' costs included in Worksheet A?			Y	144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.			Y	N 145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.			N	146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.			N	147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.			N	148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.			N	149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N	N	N	160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	Y		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/05/2017	Y	10/05/2017	17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: JANE	Last name: BACHMANN	Title: CONSULTANT	41
42	Employer: BACHMANN ASSOCIATES			42
43	Phone number: 3122852828	E-mail Address: JBOPIL@ATT.NET		43

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	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)	30	160	58,400			20,341	749	43,206	1
2	HMO and other (see instructions)						10,639	6,572		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider						820	381		4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		160	58,400			20,341	749	43,206	7
8	Intensive Care Unit	31	20	7,300			1,933	69	5,403	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						192	1,754	13
14	Total (see instructions)		180	65,700			22,274	1,010	50,363	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41	20	7,300			4,157		6,065	17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					20,460		33,709	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		200							27
28	Observation Bed Days								4,389	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							134	226	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	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)					4,296	160	9,735	1
2	HMO and other (see instructions)					1,717	1,268		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider						38		4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		1,064.22			4,296	160	9,735	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF		28.55			412		593	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		23.12						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		1,115.89						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	66,677,471		66,677,471	2,314,694.00	28.81	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		620,280		620,280	10,608.00	58.47	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		3,512,402	253,038	3,765,440	100,804.00	37.35	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		2,345,427		2,345,427	33,954.00	69.08	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		621,130		621,130	4,165.00	149.13	13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		16,155,732		16,155,732			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		761,018		761,018			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		981,855		981,855	26,188.00	37.49	26
27	Administrative & General		6,006,963	-229,566	5,777,397	287,269.00	20.11	27
28	Administrative & General under contract (see instructions)		2,064,977		2,064,977	14,525.00	142.17	28
29	Maintenance & Repairs		1,471,636		1,471,636	40,893.00	35.99	29
30	Operation of Plant		1,006,347		1,006,347	45,011.00	22.36	30
31	Laundry & Linen Service		77,731		77,731	5,892.00	13.19	31
32	Housekeeping		1,774,671		1,774,671	106,731.00	16.63	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		1,901,104	-1,158,634	742,470	38,496.00	19.29	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			1,158,634	1,158,634	66,198.00	17.50	36
37	Maintenance of Personnel							37
38	Nursing Administration		2,584,318		2,584,318	61,510.00	42.01	38
39	Central Services and Supply		484,464		484,464	17,995.00	26.92	39
40	Pharmacy		2,588,015	-443,018	2,144,997	62,751.00	34.18	40
41	Medical Records & Medical Records Library		37,657		37,657	1,254.00	30.03	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	68,122,168		68,122,168	2,318,611.00	29.38	1
2	Excluded area salaries (see instructions)	3,512,402	253,038	3,765,440	100,804.00	37.35	2
3	Subtotal salarles (line 1 minus line 2)	64,609,766	-253,038	64,356,728	2,217,807.00	29.02	3
4	Subtotal other wages & related costs (see instructions)	2,966,557		2,966,557	38,119.00	77.82	4
5	Subtotal wage-related costs (see instructions)	16,155,732		16,155,732		25.10%	5
6	Total (sum of lines 3 through 5)	83,732,055	-253,038	83,479,017	2,255,926.00	37.00	6
7	Total overhead cost (see instructions)	20,979,738	-672,584	20,307,154	774,713.00	26.21	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	381,461	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)	2,478,573	3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	707,273	10
11	Life Insurance (If employee is owner or beneficiary)	52,840	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	257,911	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	217,952	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	3,484,252	17
18	Medicare Taxes - Employers Portion Only	786,188	18
19	Unemployment Insurance	73,260	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	53,464	23
24	Total Wage Related cost (Sum of lines 1-23)	8,493,174	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	2,345,427		1
2	Hospital	2,345,427		2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 15-7313** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA County: LAKE

		Title V	Title XVIII	Title XIX	Other	Total	
	Description	1	2	3	4	5	
1	Home Health Aide Hours		2,803		1,362	4,165	1
2	Unduplicated Census Count (see instructions)		628.00		480.00	1,108.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week 40.00	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)	1.72		1.72	4
5	Other Administrative Personnel	6.34		6.34	5
6	Direct Nursing Service	6.83		6.83	6
7	Nursing Supervisor	3.95		3.95	7
8	Physical Therapy Service	0.08	3.84	3.92	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service		0.89	0.89	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service		0.25	0.25	12
13	Speech Pathology Supervisor				13
14	Medical Social Service	0.18		0.18	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	4.23		4.23	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	3	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	23844	20
20.01		33140	20.01
20.02		99915	20.02

PPS ACTIVITY

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		1	2	3	4	5	
21	Skilled Nursing Visits	8,666	1,970	192	158	10,986	21
22	Skilled Nursing Visit Charges	1,460,330	331,186	32,360	26,518	1,850,394	22
23	Physical Therapy Visits	4,415	450	26	26	4,917	23
24	Physical Therapy Visit Charges	868,827	88,590	5,103	5,098	967,618	24
25	Occupational Therapy Visits	1,156	162	5	15	1,338	25
26	Occupational Therapy Visit Charges	227,798	31,986	985	2,955	263,724	26
27	Speech Pathology Visits	232	7	1	13	253	27
28	Speech Pathology Visit Charges	44,685	1,386	189	2,529	48,789	28
29	Medical Social Service Visits	98	62		3	163	29
30	Medical Social Service Visit Charges	22,166	13,897		657	36,720	30
31	Home Health Aide Visits	2,045	713	8	37	2,803	31
32	Home Health Aide Visit Charges	256,227	89,463	984	4,593	351,267	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	16,612	3,364	232	252	20,460	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,880,033	556,508	39,621	42,350	3,518,512	35
36	Total Number of Episodes (standard/non-outlier)	806		91	16	913	36
37	Total Number of Ourlier Episodes		79		2	81	37
38	Total Non-Routine Medical Supply Charges	221,120	64,276	5,813	9,507	300,716	38

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.224386	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	11,506,784	2
3	Did you receive DSH or supplemental payments from Medicaid?	N	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	117,932,241	6
7	Medicaid cost (line 1 times line 6)	26,462,344	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	14,955,560	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	14,955,560	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	11,696,492	9,309,471	21,005,963	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,624,529	9,309,471	11,934,000	21
22	Payments received from patients for amounts previously written off as charity care	96,960	508,102	605,062	22
23	Cost of charity care (line 21 minus line 22)	2,527,569	8,801,369	11,328,938	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	7,742,548	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	796,850	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,225,923	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	6,516,625	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,891,312	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	13,220,250	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	28,175,810	31

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				9,382,493	9,382,493	-1,498,583	7,883,910	1
2	00200	Cap Rel Costs-Mvble Equip				8,881,311	8,881,311	1,076,633	9,957,944	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	87,241	-2,211,320	-2,124,079	11,883,824	9,759,745	-778	9,758,967	4
4.01	00401	MAINTENANCE OF PERSONNEL	894,614	743,278	1,637,892	-418,806	1,219,086		1,219,086	4.01
5.01	00540	NON-PATIENT TELEPHONES						622,394	622,394	5.01
5.02	00560	PURCHASING, RECEIVING & STORES	370,952	588,572	959,524		959,524		959,524	5.02
5.03	00570	PATIENT REGISTRATION	1,583,351	719,403	2,302,754	-449,697	1,853,057		1,853,057	5.03
5.04	00580	PATIENT ACCOUNTING		63	63	-63		2,604,152	2,604,152	5.04
5.05	00590	ADMINISTRATIVE & GENERAL	4,052,660	61,369,348	65,422,008	-7,744,400	57,677,608	-35,249,479	22,428,129	5.05
6	00600	Maintenance & Repairs	1,471,636	9,836,547	11,308,183	-2,865,808	8,442,375		8,442,375	6
7	00700	Operation of Plant	1,006,347	1,748,412	2,754,759	-195,713	2,559,046		2,559,046	7
8	00800	Laundry & Linen Service	77,731	647,956	725,687	-30,958	694,729		694,729	8
9	00900	Housekeeping	1,774,671	1,272,088	3,046,759	-556,130	2,490,629	-2	2,490,627	9
10	01000	Dietary	1,901,104	2,249,450	4,150,554	-3,022,612	1,127,942	-5,367	1,122,575	10
11	01100	Cafeteria				2,529,569	2,529,569	-936,403	1,593,166	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	2,584,318	2,542,837	5,127,155	-396,765	4,730,390	-24,293	4,706,097	13
14	01400	Central Services & Supply	484,464	508,025	992,489	-394,294	598,195		598,195	14
15	01500	Pharmacy	2,588,015	12,159,737	14,747,752	-11,633,038	3,114,714		3,114,714	15
16	01600	Medical Records & Library	37,657	99,443	137,100	-12,376	124,724	2,781,521	2,906,245	16
17	01700	Social Service		44,358	44,358	-44,358				17
19	01900	Nonphysician Anesthetists								19
23	02300	PARAMED ED PRGM-(SPECIFY)				297,671	297,671	-84,676	212,995	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	15,908,630	7,012,010	22,920,640	-5,089,899	17,830,741	-6,141	17,824,600	30
31	03100	Intensive Care Unit	3,381,246	2,117,894	5,499,140	-1,212,771	4,286,369	-3,825	4,282,544	31
41	04100	Subprovider - IRF	1,636,980	1,288,878	2,925,858	-372,202	2,553,656		2,553,656	41
43	04300	Nursery				1,278,780	1,278,780		1,278,780	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	4,272,462	26,757,110	31,029,572	-18,135,548	12,894,024	-9,751	12,884,273	50
51	05100	Recovery Room	1,489,479	695,261	2,184,740	-364,983	1,819,757		1,819,757	51
52	05200	Delivery Room & Labor Room				1,158,962	1,158,962		1,158,962	52
53	05300	Anesthesiology		4,036,000	4,036,000	-180,170	3,855,830	-3,428,109	427,721	53
54	05400	Radiology-Diagnostic	3,273,682	4,434,210	7,707,892	-2,746,102	4,961,790	-40,906	4,920,884	54
54.01	03630	RADIOLOGY - ULTRASOUND	755,404	548,541	1,303,945	-96,183	1,207,762		1,207,762	54.01
56	05600	Radioisotope	424,542	791,066	1,215,608	-208,179	1,007,429		1,007,429	56
57	05700	CT Scan	812,498	770,940	1,583,438	-224,047	1,359,391		1,359,391	57
59	05900	Cardiac Catheterization	1,447,695	5,242,370	6,690,065	-4,147,000	2,543,065	-751	2,542,314	59
60	06000	Laboratory	3,419,881	5,169,637	8,589,518	-746,333	7,843,185	-99,708	7,743,477	60
62	06200	Whole Blood & Packed Red Blood Cells	193,796	1,033,872	1,227,668	-60,630	1,167,038		1,167,038	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,958,671	884,675	2,843,346	-426,950	2,416,396	-54,838	2,361,558	65
66	06600	Physical Therapy		2,693,973	2,693,973	-19,543	2,674,430	-1,270	2,673,160	66
67	06700	Occupational Therapy	228,830	886,413	1,115,243	-19,626	1,095,617	-169,260	926,357	67
68	06800	Speech Pathology	156	409,151	409,307	-1,251	408,056		408,056	68
70	07000	Electroencephalography	518,046	4,495,608	5,013,654	-4,218,097	795,557	-4,569	790,988	70
71	07100	Medical Supplies Charged to Patients				8,303,368	8,303,368		8,303,368	71
72	07200	Impl. Dev. Charged to Patients				14,851,821	14,851,821		14,851,821	72
73	07300	Drugs Charged to Patients				10,339,235	10,339,235		10,339,235	73
74	07400	Renal Dialysis		672,912	672,912		672,912		672,912	74
76.97	07697	CARDIAC REHABILITATION	582,895	228,894	811,789	-103,453	708,336	-53,459	654,877	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	2,153,245	1,772,543	3,925,788	-732,615	3,193,173	-577,113	2,616,060	90
91	09100	Emergency	3,429,150	2,426,687	5,855,837	-1,222,279	4,633,558	-8,750	4,624,808	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	1,809,734	1,522,911	3,332,645	-279,621	3,053,024	-2,002	3,051,022	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	66,611,783	168,209,753	234,821,536	534,534	235,356,070	-35,175,333	200,180,737	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	14,964	36,643	51,607	-9,748	41,859		41,859	192
194	07950	OTHER NON-REIMBURSEABLE COST CENTERS	50,724	937,008	987,732	-524,786	462,946		462,946	194
194.01	07951	OTHER NONREIMBURSABLE								194.01
200		TOTAL (sum of lines 118-199)	66,677,471	169,183,404	235,860,875		235,860,875	-35,175,333	200,685,542	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	MEDICAL SUPPLY RECLASS	A	Medical Supplies Charged to P	71		7,892,607	1
2			Impl. Dev. Charged to Patient	72		14,851,821	2
3			Medical Supplies Charged to P	71		410,761	3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
500	Total reclassifications					23,155,189	500
	Code Letter - A						
1	RECLASS DEPRECIATION EXPENSE	B	Cap Rel Costs-Bldg & Fixt	1		7,444,898	1
2			Cap Rel Costs-Mvble Equip	2		7,426,541	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
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26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
500	Total reclassifications					14,871,439	500
	Code Letter - B						
1	RECLASS SOCIAL SERVICE COSTS	C	ADMINISTRATIVE & GENERAL	5.05		44,358	1
2	RECLASS PATIENT ACCT	C	ADMINISTRATIVE & GENERAL	5.05		63	2
500	Total reclassifications					44,421	500
	Code Letter - C						
1	RECLASS LDRP COSTS	D	Nursery	43	764,900	513,880	1
2			Delivery Room & Labor Room	52	693,231	465,731	2
500	Total reclassifications				1,458,131	979,611	500
	Code Letter - D						
1	RECLASS EMS PARAMEDICAL ED COSTS	E	PARAMED ED PRGM-(SPECIFY)	23	229,566	38,986	1
2			PARAMED ED PRGM-(SPECIFY)	23		16,639	2
3			PARAMED ED PRGM-(SPECIFY)	23	12,480		3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications				242,046	55,625	500
	Code Letter - E						
1	CAFETERIA EXPENSES RECLASS	F	Cafeteria	11	1,158,634	1,370,935	1

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
500	Total reclassifications				1,158,634	1,370,935	500
	Code Letter - F						
1	BENEFITS RECLASS	G	Employee Benefits Department	4		9,557,942	1
2			Employee Benefits Department	4		2,325,882	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
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22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
500	Total reclassifications					11,883,824	500
	Code Letter - G						
1	UTILITIES EXPENSE RECLASS	H	Operation of Plant	7		648,345	1
2			Radiology-Diagnostic	54		72	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					648,417	500
	Code Letter - H						
1	INTEREST EXPENSE RECLASS	I	Cap Rel Costs-Bldg & Fixt	1		1,391,918	1
500	Total reclassifications					1,391,918	500
	Code Letter - I						
1	PHARMACY RECLASS EXPENSE	J	Drugs Charged to Patients	73		10,335,687	1
2			ADMINISTRATIVE & GENERAL	5.05		34	2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					10,335,721	500
	Code Letter - J						
1	RECLASS SERVICE CONTRACTS	K	Operation of Plant	7		187,500	1
2			Adults & Pediatrics	30		83,470	2
3			Operating Room	50		106,097	3
4			Radiology-Diagnostic	54		352,435	4
5			CT Scan	57		183,718	5
6			Cardiac Catheterization	59		81,519	6
500	Total reclassifications					994,739	500

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
	Code Letter - K						
1	BUILDING RENT EXPENSE RECLASS	L	Cap Rel Costs-Bldg & Fixt	1		347,379	1
2							2
3							3
500	Total reclassifications					347,379	500
	Code Letter - L						
1	EQUIPMENT RENT EXPENSE RECLASS	M	Cap Rel Costs-Mvble Equip	2		1,454,770	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
500	Total reclassifications					1,454,770	500
	Code Letter - M						
1	RECLASS REPAIRS AND MAINTENANCE COS	N	ADMINISTRATIVE & GENERAL	5.05		19,544	1
2			Dietary	10		31,907	2
3			Central Services & Supply	14		46,342	3
4			Adults & Pediatrics	30		145,679	4
5			Intensive Care Unit	31		12,974	5
6			Subprovider - IRF	41		1,763	6
7			Operating Room	50		369,220	7
8			Recovery Room	51		1,392	8
9			Radiology-Diagnostic	54		280,261	9
10			RADIOLOGY - ULTRASOUND	54.01		142,792	10
11			Radioisotope	56		4,953	11
12			CT Scan	57		42,848	12
13			Cardiac Catheterization	59		61,554	13
14			Laboratory	60		64,865	14
15			Respiratory Therapy	65		19,436	15
16			Drugs Charged to Patients	73		3,548	16
17			CARDIAC REHABILITATION	76.97		3,118	17
18			Clinic	90		18,500	18
19			Emergency	91		5,000	19
20			Home Health Agency	101		1,240	20
500	Total reclassifications					1,276,936	500
	Code Letter - N						
1	RECLASS PROPERTY INSURANCE	O	Cap Rel Costs-Bldg & Fixt	1		198,298	1
500	Total reclassifications					198,298	500
	Code Letter - O						
1	RECLASS IV COSTS	P	Adults & Pediatrics	30	298,301	258,492	1
2			Intensive Care Unit	31	31,245	27,075	2
3			Operating Room	50	21,498	18,629	3
4			Clinic	90	50,618	43,863	4
5			Emergency	91	25,992	22,523	5
6			Subprovider - IRF	41	10,992	9,525	6
7			Radiology-Diagnostic	54	4,372	3,789	7
500	Total reclassifications				443,018	383,896	500
	Code Letter - P						
	GRAND TOTAL (Increases)				3,301,829	69,393,118	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	MEDICAL SUPPLY RECLASS	A						1
2			Adults & Pediatrics	30		26,658		2
3			Adults & Pediatrics	30		230,223		3
4			Intensive Care Unit	31		106,391		4
5			Subprovider - IRF	41		21,395		5
6			Operating Room	50		14,980,101		6
7			Recovery Room	51		17,519		7
8			Anesthesiology	53		54,583		8
9			Electroencephalography	70		3,992,782		9
10			Clinic	90		25,868		10
11			Emergency	91		26,094		11
12			Cardiac Catheterization	59		3,608,187		12
13			Radiology-Diagnostic	54		65,388		13
500	Total reclassifications					23,155,189		500
	Code letter - A							
1	RECLASS DEPRECIATION EXPENSE	B	MAINTENANCE OF PERSONNEL	4.01		8,312	9	1
2			PATIENT REGISTRATION	5.03		82,913	9	2
3			ADMINISTRATIVE & GENERAL	5.05		4,695,528		3
4			Maintenance & Repairs	6		312,745		4
5			Operation of Plant	7		274,673		5
6			Laundry & Linen Service	8		5,883		6
7			Housekeeping	9		5,057		7
8			Dietary	10		28,849		8
9			Nursing Administration	13		968		9
10			Central Services & Supply	14		100,652		10
11			Pharmacy	15		286,951		11
12			Medical Records & Library	16		4,136		12
13			Adults & Pediatrics	30		492,036		13
14			Intensive Care Unit	31		685,165		14
15			Subprovider - IRF	41		51,809		15
16			Operating Room	50		2,397,762		16
17			Recovery Room	51		89,061		17
18			Anesthesiology	53		52,380		18
19			Radiology-Diagnostic	54		2,394,126		19
20			RADIOLOGY - ULTRASOUND	54.01		112,969		20
21			Radioisotope	56		68,214		21
22			CT Scan	57		298,716		22
23			Cardiac Catheterization	59		464,241		23
24			Laboratory	60		235,563		24
25			Whole Blood & Packed Red Bloo	62		18,356		25
26			Respiratory Therapy	65		71,861		26
27			Physical Therapy	66		17,366		27
28			Occupational Therapy	67		2,231		28
29			Speech Pathology	68		1,226		29
30			Electroencephalography	70		132,147		30
31			CARDIAC REHABILITATION	76.97		962		31
32			Clinic	90		357,687		32
33			Emergency	91		676,122		33
34			Home Health Agency	101		30,892		34
35			OTHER NON-REIMBURSEABLE COST	194		413,880		35
500	Total reclassifications					14,871,439		500
	Code letter - B							
1	RECLASS SOCIAL SERVICE COSTS	C	Social Service	17		44,358		1
2	RECLASS PATIENT ACCT	C	PATIENT ACCOUNTING	5.04		63		2
500	Total reclassifications					44,421		500
	Code letter - C							
1	RECLASS LDRP COSTS	D	Adults & Pediatrics	30	764,900	513,880		1
2			Adults & Pediatrics	30	693,231	465,731		2
500	Total reclassifications				1,458,131	979,611		500
	Code letter - D							
1	RECLASS EMS PARAMEDICAL ED COSTS	E	ADMINISTRATIVE & GENERAL	5.05	229,566	38,986		1
2			ADMINISTRATIVE & GENERAL	5.05		16,639		2
3			Adults & Pediatrics	30	1,920			3
4			Intensive Care Unit	31	960			4
5			Operating Room	50	960			5
6			Cardiac Catheterization	59	320			6
7			Laboratory	60	640			7
8			Emergency	91	7,680			8
500	Total reclassifications				242,046	55,625		500
	Code letter - E							

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	CAFETERIA EXPENSES RECLASS	F	Dietary	10	1,158,634	1,370,935		1
500	Total reclassifications				1,158,634	1,370,935		500
	Code letter - F							
1	BENEFITS RECLASS	G						1
2			MAINTENANCE OF PERSONNEL	4.01		409,252		2
3			PATIENT REGISTRATION	5.03		366,784		3
4			ADMINISTRATIVE & GENERAL	5.05		555,011		4
5			Maintenance & Repairs	6		269,373		5
6			Operation of Plant	7		279,893		6
7			Laundry & Linen Service	8		25,075		7
8			Housekeeping	9		550,923		8
9			Dietary	10		462,542		9
10			Nursing Administration	13		395,797		10
11			Central Services & Supply	14		193,464		11
12			Pharmacy	15		381,431		12
13			Medical Records & Library	16		8,240		13
14			Adults & Pediatrics	30		2,685,947		14
15			Intensive Care Unit	31		491,549		15
16			Subprovider - IRF	41		321,278		16
17			Operating Room	50		801,163		17
18			Recovery Room	51		259,795		18
19			Radiology-Diagnostic	54		714,720		19
20			RADIOLOGY - ULTRASOUND	54.01		72,523		20
21			Radioisotope	56		63,291		21
22			CT Scan	57		82,880		22
23			Cardiac Catheterization	59		210,407		23
24			Laboratory	60		563,336		24
25			Whole Blood & Packed Red Bloo	62		42,274		25
26			Respiratory Therapy	65		283,536		26
27			Occupational Therapy	67		16,162		27
28			Speech Pathology	68		25		28
29			Electroencephalography	70		92,253		29
30			CARDIAC REHABILITATION	76.97		98,755		30
31			Clinic	90		407,448		31
32			Emergency	91		565,898		32
33			Home Health Agency	101		201,867		33
34			Physicians' Private Offices	192		6,078		34
35			OTHER NON-REIMBURSEABLE COST	194		4,854		35
500	Total reclassifications					11,883,824		500
	Code letter - G							
1	UTILITIES EXPENSE RECLASS	H						1
2			ADMINISTRATIVE & GENERAL	5.05		81,245		2
3			Operation of Plant	7		452,481		3
4			Operating Room	50		683		4
5			Laboratory	60		4,350		5
6			Respiratory Therapy	65		6,920		6
7			CARDIAC REHABILITATION	76.97		6,655		7
8			Clinic	90		3,120		8
9			Home Health Agency	101		1,138		9
10			OTHER NON-REIMBURSEABLE COST	194		91,825		10
500	Total reclassifications					648,417		500
	Code letter - H							
1	INTEREST EXPENSE RECLASS	I	ADMINISTRATIVE & GENERAL	5.05		1,391,918	11	1
500	Total reclassifications					1,391,918		500
	Code letter - I							
1	PHARMACY RECLASS EXPENSE	J	Pharmacy	15		10,134,152		1
2			Operating Room	50		7,509		2
3			Physicians' Private Offices	192		3,670		3
4			Anesthesiology	53		73,207		4
5			Radioisotope	56		67,871		5
6			Respiratory Therapy	65		43,107		6
7			Clinic	90		4,972		7
8			Occupational Therapy	67		1,233		8
500	Total reclassifications					10,335,721		500
	Code letter - J							
1	RECLASS SERVICE CONTRACTS	K	Maintenance & Repairs	6		994,739		1
2								2
3								3
4								4
5								5

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
6								6
500	Total reclassifications					994,739		500
	Code letter - K							
1	BUILDING RENT EXPENSE RECLASS	L	ADMINISTRATIVE & GENERAL	5.05		294,715	10	1
2			OTHER NON-REIMBURSEABLE COST	194		5,700		2
3			Home Health Agency	101		46,964		3
500	Total reclassifications					347,379		500
	Code letter - L							
1	EQUIPMENT RENT EXPENSE RECLASS	M	MAINTENANCE OF PERSONNEL	4.01		1,242	10	1
2			ADMINISTRATIVE & GENERAL	5.05		306,493		2
3			Maintenance & Repairs	6		31,251		3
4			Operation of Plant	7		13,354		4
5			Housekeeping	9		150		5
6			Dietary	10		33,559		6
7			Central Services & Supply	14		146,520		7
8			Pharmacy	15		3,590		8
9			Adults & Pediatrics	30		1,315		9
10			Operating Room	50		462,814		10
11			Radiology-Diagnostic	54		212,797		11
12			RADIOLOGY - ULTRASOUND	54.01		53,483		12
13			Radioisotope	56		13,756		13
14			CT Scan	57		69,017		14
15			Cardiac Catheterization	59		6,918		15
16			Laboratory	60		7,309		16
17			Respiratory Therapy	65		40,962		17
18			Physical Therapy	66		2,177		18
19			Electroencephalography	70		915		19
20			CARDIAC REHABILITATION	76.97		199		20
21			Clinic	90		46,501		21
22			OTHER NON-REIMBURSEABLE COST	194		448		22
500	Total reclassifications					1,454,770		500
	Code letter - M							
1	RECLASS REPAIRS AND MAINTENANCE COS	N	Maintenance & Repairs	6		1,257,700		1
2			Operation of Plant	7		11,157		2
3			OTHER NON-REIMBURSEABLE COST	194		8,079		3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
500	Total reclassifications					1,276,936		500
	Code letter - N							
1	RECLASS PROPERTY INSURANCE	O	ADMINISTRATIVE & GENERAL	5.05		198,298	12	1
500	Total reclassifications					198,298		500
	Code letter - O							
1	RECLASS IV COSTS	P	Pharmacy	15	443,018	383,896		1
2								2
3								3
4								4
5								5
6								6
7								7
500	Total reclassifications				443,018	383,896		500
	Code letter - P							
	GRAND TOTAL (Decreases)				3,301,829	69,393,118		

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	12,964,239				1,671,450	11,292,789		2
3	Buildings and Fixtures	151,696,211	7,405,933		7,405,933	31,415	159,070,729		3
4	Building Improvements	186,632	311,780		311,780		498,412		4
5	Fixed Equipment								5
6	Movable Equipment	110,158,315	5,562,170		5,562,170	2,230,635	113,489,850		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	275,005,397	13,279,883		13,279,883	3,933,500	284,351,780		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	275,005,397	13,279,883		13,279,883	3,933,500	284,351,780		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)								3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	170,861,930		170,861,930	0.600882					1
2	Cap Rel Costs-Mvble Equ	113,489,850		113,489,850	0.399118					2
3	Total (sum of lines 1-2)	284,351,780		284,351,780	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	7,338,233	347,379		198,298			7,883,910	1
2	Cap Rel Costs-Mvble Equip	8,503,174	1,454,770					9,957,944	2
3	Total (sum of lines 1-2)	15,841,407	1,802,149		198,298			17,841,854	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-156	Cap Rel Costs-Mvble Equip	2	9	7
8	Television and radio service (chapter 21)	A	-10,661	Cap Rel Costs-Mvble Equip	2	9	8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-233,163				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-3,188,575				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-936,403	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-5,367	Dietary	10		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures	A	-231,557	Cap Rel Costs-Bldg & Fixt	1	9	26
27	Depreciation--movable equipment	A	96,924	Cap Rel Costs-Mvble Equip	2	9	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	OFFSET CRNA/ANESTHESIOLOGIST FEES	A	-3,428,109	Anesthesiology	53		33
33.01	AHA LIFE 1991 PHILLIPS EQ	A	5,750	Cap Rel Costs-Mvble Equip	2	9	33.01
33.07	1990 ASSETS-INSTALLMENTS	A	-1,397	Cap Rel Costs-Mvble Equip	2	9	33.07
34	PHOTOGRAPHIC FEES	B	-5,338	Radiology-Diagnostic	54		34
34.03	OFFSET OTHER OP REV	B	-84,676	PARAMED ED PRGM-(SPECIFY)	23		34.03
34.04	OFFSET OTHER INCOME	B	-112	Adults & Pediatrics	30		34.04
34.06	OFFSET OTHER REV	B	-780	ADMINISTRATIVE & GENERAL	5.05		34.06
35	ADVERTISING OFFSET	A	-671,782	ADMINISTRATIVE & GENERAL	5.05		35
35.07	OFFSET PHYSICIAN SALARIES	A	-169,260	Occupational Therapy	67		35.07
35.08	OFFSET PA/NP SALARIES	A	-451,020	Clinic	90		35.08
36	OFFSET OTHER INCOME	B	-32	Operating Room	50		36
37	OTHER OP REV/EP	B	-1,538	Electroencephalography	70		37
38	OFFSET LAB INCOME	B	-89,592	Laboratory	60		38
39	OFFSET HHA PR COSTS	A	-1,870	Home Health Agency	101		39
40	OTHER INCOME OFFSET	B	-18,900	ADMINISTRATIVE & GENERAL	5.05		40
41	OTHER REVENUE	B	-1,190	Clinic	90		41
41.03	OFFSET OTHER INCOME	B	-528	Employee Benefits Department	4		41.03
42	OFFSET OTHER INCOME	B	-3,193	Clinic	90		42
42.01	OFFSET PHO REVENUE	B	-34,100	ADMINISTRATIVE & GENERAL	5.05		42.01
42.03	OTHER INCOME	B	-19,068	ADMINISTRATIVE & GENERAL	5.05		42.03
43	OFFSET OTHER INCOME	B	-8,750	Emergency	91		43
43.03	OFFSET CONTRIBUTION EXPENSE	A	-116,566	ADMINISTRATIVE & GENERAL	5.05		43.03
43.04	OFFSET CONTRIBUTION EXPENSE	A	-250	Employee Benefits Department	4		43.04
43.05	OFFSET CONTRIBUTION EXPENSE	A	-61	Clinic	90		43.05
43.06	OFFSET CONTRIBUTION EXPENSE	A	-2	Housekeeping	9		43.06
44	PHONE OFFSET	A	-69,625	NON-PATIENT TELEPHONES	5.01		44
45	OFFSET OTHER INCOME	B	-132	Home Health Agency	101		45
46	OTHER INCOME RESP THERAPY	B	-50,640	Respiratory Therapy	65		46
46.01	OFFSET CARDIAC INCOME	B	-53,459	CARDIAC REHABILITATION	76.97		46.01
46.02	OFFSET PHYSICIAN MALP COST	A	-12,140	ADMINISTRATIVE & GENERAL	5.05		46.02
47	OFFSET INTEREST EXPENSE	A	-1,391,918	Cap Rel Costs-Bldg & Fixt	1	11	47
47.01	BARIATRIC COSTS/DEPT 4266	A	-86,823	Clinic	90		47.01
48	OFFSET RENTAL INCOME	B	-25,200	Radiology-Diagnostic	54		48

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
49	PROVIDER TAX	A	-13,453,940	ADMINISTRATIVE & GENERAL	5.05		49
49.01	OFFSET PHYSICIAN CORP ALLOCATIONS	A	-10,420,134	ADMINISTRATIVE & GENERAL	5.05		49.01
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-35,175,333				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5.05	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE	13,775,297	24,152,629	-10,377,332		1
2	1	Cap Rel Costs-Bldg & Fixt	DEP INT	124,892		124,892	9	2
3	2	Cap Rel Costs-Mvble Equip	EQ DEPR	986,173		986,173	9	3
3.01	5.01	NON-PATIENT TELEPHONES	TELECOMMUNICATIONS	692,019		692,019		3.01
3.02	16	Medical Records & Library	MEDICAL RECORDS	2,781,521		2,781,521		3.02
3.03	5.04	PATIENT ACCOUNTING	PATIENT ACCTING	2,604,152		2,604,152		3.03
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			20,964,054	24,152,629	-3,188,575		5

* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B	CFNI	100.00				6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the 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.
G. Other (financial Or non-financial) specify:

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5.05	ADMINISTRATIVE & GEN AGGREGATE	322,917	48,750	274,167	211,500	1,949	198,180	9,909	1
2	13	Nursing Administrati	71,270		71,270	211,500	462	46,977	2,349	2
3	30	Adults & Pediatrics	10,706		10,706	211,500	46	4,677	234	3
4	31	Intensive Care Unit	18,671		18,671	211,500	146	14,846	742	4
5	50	Operating Room	25,000		25,000	246,400	129	15,281	764	5
6	54	Radiology-Diagnostic	22,917		22,917	271,900	96	12,549	627	6
7	60	Laboratory	54,167		54,167	260,300	352	44,051	2,203	7
8	59	Cardiac Catheterizat	1,463		1,463	211,500	7	712	36	8
9	65	Respiratory Therapy	21,687		21,687	211,500	172	17,489	874	9
10	66	Physical Therapy	2,083		2,083	211,500	8	813	41	10
11	70	Electroencephalograp	16,250		16,250	211,500	130	13,219	661	11
12	90	Clinic	102,750		102,750	211,500	668	67,924	3,396	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	669,881	48,750	621,131		4,165	436,718	21,836	200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5.05	ADMINISTRATIVE & GEN AGGREGATE					198,180	75,987	124,737	1
2	13	Nursing Administrati					46,977	24,293	24,293	2
3	30	Adults & Pediatrics					4,677	6,029	6,029	3
4	31	Intensive Care Unit					14,846	3,825	3,825	4
5	50	Operating Room					15,281	9,719	9,719	5
6	54	Radiology-Diagnostic					12,549	10,368	10,368	6
7	60	Laboratory					44,051	10,116	10,116	7
8	59	Cardiac Catheterizat					712	751	751	8
9	65	Respiratory Therapy					17,489	4,198	4,198	9
10	66	Physical Therapy					813	1,270	1,270	10
11	70	Electroencephalograp					13,219	3,031	3,031	11
12	90	Clinic					67,924	34,826	34,826	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					436,718	184,413	233,163	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINTENACE OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	7,883,910	7,883,910					1
2	Cap Rel Costs-Mvble Equip	9,957,944		9,957,944				2
4	Employee Benefits Department	9,758,967	5,503	6,950	9,771,420			4
4.01	MAINTENANCE OF PERSONNEL	1,219,086	31,451	39,724	131,276	1,421,537		4.01
5.01	NON-PATIENT TELEPHONES	622,394	28,859	36,451			687,704	5.01
5.02	PURCHASING, RECEIVING & STORES	959,524	61,765	78,013	54,433	13,092		5.02
5.03	PATIENT REGISTRATION	1,853,057	35,775	45,187	232,341	53,362	17,326	5.03
5.04	PATIENT ACCOUNTING	2,604,152						5.04
5.05	ADMINISTRATIVE & GENERAL	22,428,129	858,650	1,084,536	561,001	66,467	181,255	5.05
6	Maintenance & Repairs	8,442,375	687,785	868,722	215,948	28,377	16,659	6
7	Operation of Plant	2,559,046	346,678	437,880	147,671	33,240	7,330	7
8	Laundry & Linen Service	694,729	5,544	7,003	11,406	3,315	666	8
9	Housekeeping	2,490,627	66,561	84,071	260,415	69,859	2,666	9
10	Dietary	1,122,575	98,330	124,198	108,950	27,435	8,663	10
11	Cafeteria	1,593,166	124,777	157,602	170,018	42,824		11
12	Maintenance of Personnel							12
13	Nursing Administration	4,706,097	36,358	45,922	379,223	45,597	5,331	13
14	Central Services & Supply	598,195	55,306	69,855	71,090	13,995	7,330	14
15	Pharmacy	3,114,714	53,656	67,771	314,757	34,620	13,994	15
16	Medical Records & Library	2,906,245	36,260	45,800	5,526	774	4,665	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)	212,995			35,518	6,849		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	17,824,600	1,149,771	1,452,248	2,163,927	322,555	103,289	30
31	Intensive Care Unit	4,282,544	182,120	230,031	500,608	61,282	16,659	31
41	Subprovider - IRF	2,553,656	152,056	192,057	241,823	36,826	12,661	41
43	Nursery	1,278,780	44,757	56,532	112,241	13,466		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,884,273	433,047	546,969	629,955	89,581	49,312	50
51	Recovery Room	1,819,757	88,087	111,260	218,566	27,165	5,997	51
52	Delivery Room & Labor Room	1,158,962	51,009	64,428	101,725	13,582		52
53	Anesthesiology	427,721	4,602	5,812			1,333	53
54	Radiology-Diagnostic	4,920,884	254,891	321,945	481,022	68,673	33,985	54
54.01	RADIOLOGY - ULTRASOUND	1,207,762	33,516	42,333	110,848	11,622	5,331	54.01
56	Radioisotope	1,007,429	49,248	62,204	62,297	5,508	14,660	56
57	CT Scan	1,359,391	44,161	55,779	119,226	14,653	6,664	57
59	Cardiac Catheterization	2,542,314	59,270	74,862	212,388	23,850	18,659	59
60	Laboratory	7,743,477	155,632	196,574	501,739	83,996	19,325	60
62	Whole Blood & Packed Red Blood Cells	1,167,038	12,364	15,617	28,438	3,431	2,666	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,361,558	45,908	57,985	287,415	38,864	1,333	65
66	Physical Therapy	2,673,160	217,563	274,798			13,328	66
67	Occupational Therapy	926,357	41,334	52,207	33,579	3,715	7,997	67
68	Speech Pathology	408,056	3,063	3,869	23		1,999	68
70	Electroencephalography	790,988	33,405	42,193	76,018	10,912	9,996	70
71	Medical Supplies Charged to Patients	8,303,368						71
72	Impl. Dev. Charged to Patients	14,851,821						72
73	Drugs Charged to Patients	10,339,235						73
74	Renal Dialysis	672,912						74
76.97	CARDIAC REHABILITATION	654,877	94,810	119,751	85,534	11,028	11,328	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,616,060	207,846	262,525	323,395	42,940	48,646	90
91	Emergency	4,624,808	207,098	261,579	505,881	66,415	18,659	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,051,022			265,560	29,822	17,992	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	200,180,737	6,098,816	7,703,243	9,761,781	1,419,692	687,704	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		9,869	12,465				190
192	Physicians' Private Offices	41,859	441,280	557,368	2,196	555		192
194	OTHER NON-REIMBURSEABLE COST CENTERS	462,946	927,262	1,171,198	7,443	1,290		194
194.01	OTHER NONREIMBURSABLE		406,683	513,670				194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	200,685,542	7,883,910	9,957,944	9,771,420	1,421,537	687,704	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING & STORES	PATIENT REGISTRATN	PATIENT ACCOUNTING	SUBTOTAL (cols.0-4)	ADMINI-STRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	
		5.02	5.03	5.04	4A	5.05	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES	1,166,827						5.02
5.03	PATIENT REGISTRATION	37,331	2,274,379					5.03
5.04	PATIENT ACCOUNTING			2,604,152				5.04
5.05	ADMINISTRATIVE & GENERAL	61,843			25,241,881	25,241,881		5.05
6	Maintenance & Repairs	310,635			10,570,501	1,520,831	12,091,332	6
7	Operation of Plant	89,230			3,621,075	520,982	787,022	7
8	Laundry & Linen Service	14,198			736,861	106,016	12,587	8
9	Housekeeping	123,017			3,097,216	445,612	151,105	9
10	Dietary	127,097			1,617,248	232,682	223,227	10
11	Cafeteria				2,088,387	300,467	283,266	11
12	Maintenance of Personnel							12
13	Nursing Administration	9,039			5,227,567	752,116	82,538	13
14	Central Services & Supply	6,386			822,157	118,288	125,553	14
15	Pharmacy	16,089			3,615,601	520,195	121,809	15
16	Medical Records & Library	154			2,999,424	431,542	82,318	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)				255,362	36,740		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	62,190	168,947	193,426	23,440,953	3,372,491	2,610,189	30
31	Intensive Care Unit	7,286	28,712	32,872	5,342,114	768,597	413,445	31
41	Subprovider - IRF	6,548	16,824	19,262	3,231,713	464,963	345,193	41
43	Nursery		9,706	11,112	1,526,594	219,639	101,607	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	121,359	255,262	292,247	15,302,005	2,201,576	983,093	50
51	Recovery Room	4,565	31,955	36,584	2,343,936	337,234	199,973	51
52	Delivery Room & Labor Room		8,792	10,065	1,408,563	202,657	115,799	52
53	Anesthesiology	3,473	51,948	59,474	554,363	79,759	10,447	53
54	Radiology-Diagnostic	15,931	211,617	242,278	6,551,226	942,558	578,647	54
54.01	RADIOLOGY - ULTRASOUND	1,802	44,972	51,488	1,509,674	217,204	76,087	54.01
56	Radioisotope	2,559	30,386	34,789	1,269,080	182,589	111,802	56
57	CT Scan	3,406	164,401	188,221	1,955,902	281,405	100,254	57
59	Cardiac Catheterization	25,271	135,465	155,092	3,247,171	467,187	134,553	59
60	Laboratory	32,573	293,294	336,032	9,362,642	1,347,050	353,312	60
62	Whole Blood & Packed Red Blood Cells	1,386	13,277	15,201	1,259,418	181,199	28,069	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,394	54,243	62,102	2,914,802	419,367	104,219	65
66	Physical Therapy	5,244	45,571	52,173	3,281,837	472,174	493,907	66
67	Occupational Therapy	1,448	17,699	20,264	1,104,600	158,924	93,835	67
68	Speech Pathology	516	3,211	3,676	424,413	61,062	6,954	68
70	Electroencephalography	4,445	46,058	52,732	1,066,747	153,478	75,836	70
71	Medical Supplies Charged to Patients		58,975	67,520	8,429,863	1,212,847		71
72	Impl. Dev. Charged to Patients		87,184	99,815	15,038,820	2,163,710		72
73	Drugs Charged to Patients		232,738	266,459	10,838,432	1,559,379		73
74	Renal Dialysis		8,079	9,249	690,240	99,308		74
76.97	CARDIAC REHABILITATION	4,241	4,785	5,478	991,832	142,700	215,234	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	17,958	33,233	38,048	3,590,651	516,605	471,848	90
91	Emergency	13,681	204,578	234,219	6,136,918	882,949	470,149	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	10,045	12,467	14,274	3,401,182	489,345		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,146,340	2,274,379	2,604,152	196,108,971	24,583,427	9,963,877	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				22,334	3,213	22,405	190
192	Physicians' Private Offices	210			1,043,468	150,129		192
194	OTHER NON-REIMBURSEABLE COST CENTERS	20,277			2,590,416	372,696	2,105,050	194
194.01	OTHER NONREIMBURSABLE				920,353	132,416		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,166,827	2,274,379	2,604,152	200,685,542	25,241,881	12,091,332	202

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant	4,929,079						7
8	Laundry & Linen Service	5,042	860,506					8
9	Housekeeping	60,523	5,709	3,760,165				9
10	Dietary	89,411		69,127	2,231,695			10
11	Cafeteria	113,459		87,720		2,873,299		11
12	Maintenance of Personnel							12
13	Nursing Administration	33,060		25,560		124,331	6,245,172	13
14	Central Services & Supply	50,289		38,880		38,161		14
15	Pharmacy	48,789		37,721		94,400		15
16	Medical Records & Library	32,972		25,492		2,110		16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)					18,676		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,045,485	381,144	808,302	1,790,522	879,532	3,138,099	30
31	Intensive Care Unit	165,601	28,164	128,033	154,509	167,100	596,237	31
41	Subprovider - IRF	138,264	43,584	106,897	230,039	100,415	358,332	41
43	Nursery	40,698		31,465		36,719	131,040	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	393,768	62,960	304,437		244,266	871,571	50
51	Recovery Room	80,097		61,926		74,071	264,336	51
52	Delivery Room & Labor Room	46,382		35,860		37,036	132,126	52
53	Anesthesiology	4,184		3,235				53
54	Radiology-Diagnostic	231,771	83,538	179,191		187,253		54
54.01	RADIOLOGY - ULTRASOUND	30,476	3,766	23,562		31,690		54.01
56	Radioisotope	44,781	6,098	34,622		15,018		56
57	CT Scan	40,156	8,220	31,046		39,955		57
59	Cardiac Catheterization	53,894	10,002	41,667		65,032		59
60	Laboratory	141,515	4,895	109,411		229,037		60
62	Whole Blood & Packed Red Blood Cells	11,243		8,692		9,356		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	41,744		32,274		105,972		65
66	Physical Therapy	197,829	35,980	152,949				66
67	Occupational Therapy	37,585	15,596	29,058		10,129		67
68	Speech Pathology	2,785	2,855	2,154				68
70	Electroencephalography	30,375	3,694	23,484		29,755		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION	86,210	3,218	66,652		30,072	107,342	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	188,994	11,608	146,118		117,086		90
91	Emergency	188,313	145,655	145,592	56,625	181,098	646,089	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,675,695	856,686	2,791,127	2,231,695	2,868,270	6,245,172	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	8,974		6,938				190
192	Physicians' Private Offices	401,254		310,225		1,512		192
194	OTHER NON-REIMBURSEABLE COST CENTERS	843,156	3,820	651,875		3,517		194
194.01	OTHER NONREIMBURSABLE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,929,079	860,506	3,760,165	2,231,695	2,873,299	6,245,172	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	23	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	1,193,328						14
15	Pharmacy		4,438,515					15
16	Medical Records & Library			3,573,858				16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)				310,778			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			265,470	47,812	37,779,999		30
31	Intensive Care Unit			45,116	23,906	7,832,822		31
41	Subprovider - IRF			26,436		5,045,836		41
43	Nursery			15,252		2,103,014		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			401,099	23,906	20,788,681		50
51	Recovery Room			50,211		3,411,784		51
52	Delivery Room & Labor Room			13,814		1,992,237		52
53	Anesthesiology			81,626		733,614		53
54	Radiology-Diagnostic			332,519		9,086,703		54
54.01	RADIOLOGY - ULTRASOUND			70,666		1,963,125		54.01
56	Radioisotope			47,746		1,711,736		56
57	CT Scan			258,326		2,715,264		57
59	Cardiac Catheterization			212,859	7,969	4,240,334		59
60	Laboratory			460,943	15,937	12,024,742		60
62	Whole Blood & Packed Red Blood Cells			20,862		1,518,839		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			85,233		3,703,611		65
66	Physical Therapy			71,606		4,706,282		66
67	Occupational Therapy			27,811		1,477,538		67
68	Speech Pathology			5,045		505,268		68
70	Electroencephalography			72,372		1,455,741		70
71	Medical Supplies Charged to Patients	414,101		92,668		10,149,479		71
72	Impl. Dev. Charged to Patients	779,227		136,993		18,118,750		72
73	Drugs Charged to Patients		4,438,515	365,706		17,202,032		73
74	Renal Dialysis			12,694		802,242		74
76.97	CARDIAC REHABILITATION			7,518		1,650,778		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			52,219		5,095,129		90
91	Emergency			321,458	191,248	9,366,094		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			19,590		3,910,117		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,193,328	4,438,515	3,573,858	310,778	191,091,791		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					63,864		190
192	Physicians' Private Offices					1,906,588		192
194	OTHER NON-REIMBURSEABLE COST CENTERS					6,570,530		194
194.01	OTHER NONREIMBURSABLE					1,052,769		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,193,328	4,438,515	3,573,858	310,778	200,685,542		202

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	37,779,999						30
31	Intensive Care Unit	7,832,822						31
41	Subprovider - IRF	5,045,836						41
43	Nursery	2,103,014						43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	20,788,681						50
51	Recovery Room	3,411,784						51
52	Delivery Room & Labor Room	1,992,237						52
53	Anesthesiology	733,614						53
54	Radiology-Diagnostic	9,086,703						54
54.01	RADIOLOGY - ULTRASOUND	1,963,125						54.01
56	Radioisotope	1,711,736						56
57	CT Scan	2,715,264						57
59	Cardiac Catheterization	4,240,334						59
60	Laboratory	12,024,742						60
62	Whole Blood & Packed Red Blood Cells	1,518,839						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,703,611						65
66	Physical Therapy	4,706,282						66
67	Occupational Therapy	1,477,538						67
68	Speech Pathology	505,268						68
70	Electroencephalography	1,455,741						70
71	Medical Supplies Charged to Patients	10,149,479						71
72	Impl. Dev. Charged to Patients	18,118,750						72
73	Drugs Charged to Patients	17,202,032						73
74	Renal Dialysis	802,242						74
76.97	CARDIAC REHABILITATION	1,650,778						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	5,095,129						90
91	Emergency	9,366,094						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,910,117						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	191,091,791						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	63,864						190
192	Physicians' Private Offices	1,906,588						192
194	OTHER NON-REIMBURSEABLE COST CENTERS	6,570,530						194
194.01	OTHER NONREIMBURSABLE	1,052,769						194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	200,685,542						202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	MAINTENACE OF PERSONNEL	
		0	1	2	2A	4	4.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		5,503	6,950	12,453	12,453		4
4.01	MAINTENANCE OF PERSONNEL		31,451	39,724	71,175	167	71,342	4.01
5.01	NON-PATIENT TELEPHONES		28,859	36,451	65,310			5.01
5.02	PURCHASING, RECEIVING & STORES		61,765	78,013	139,778	69	657	5.02
5.03	PATIENT REGISTRATION		35,775	45,187	80,962	296	2,678	5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL		858,650	1,084,536	1,943,186	715	3,336	5.05
6	Maintenance & Repairs		687,785	868,722	1,556,507	275	1,424	6
7	Operation of Plant		346,678	437,880	784,558	188	1,668	7
8	Laundry & Linen Service		5,544	7,003	12,547	15	166	8
9	Housekeeping		66,561	84,071	150,632	332	3,506	9
10	Dietary		98,330	124,198	222,528	139	1,377	10
11	Cafeteria		124,777	157,602	282,379	217	2,149	11
12	Maintenance of Personnel							12
13	Nursing Administration		36,358	45,922	82,280	483	2,288	13
14	Central Services & Supply		55,306	69,855	125,161	91	702	14
15	Pharmacy		53,656	67,771	121,427	401	1,737	15
16	Medical Records & Library		36,260	45,800	82,060	7	39	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)					45	344	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,149,771	1,452,248	2,602,019	2,759	16,191	30
31	Intensive Care Unit		182,120	230,031	412,151	638	3,076	31
41	Subprovider - IRF		152,056	192,057	344,113	308	1,848	41
43	Nursery		44,757	56,532	101,289	143	676	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		433,047	546,969	980,016	803	4,496	50
51	Recovery Room		88,087	111,260	199,347	279	1,363	51
52	Delivery Room & Labor Room		51,009	64,428	115,437	130	682	52
53	Anesthesiology		4,602	5,812	10,414			53
54	Radiology-Diagnostic		254,891	321,945	576,836	613	3,446	54
54.01	RADIOLOGY - ULTRASOUND		33,516	42,333	75,849	141	583	54.01
56	Radioisotope		49,248	62,204	111,452	79	276	56
57	CT Scan		44,161	55,779	99,940	152	735	57
59	Cardiac Catheterization		59,270	74,862	134,132	271	1,197	59
60	Laboratory		155,632	196,574	352,206	639	4,215	60
62	Whole Blood & Packed Red Blood Cells		12,364	15,617	27,981	36	172	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		45,908	57,985	103,893	366	1,950	65
66	Physical Therapy		217,563	274,798	492,361			66
67	Occupational Therapy		41,334	52,207	93,541	43	186	67
68	Speech Pathology		3,063	3,869	6,932			68
70	Electroencephalography		33,405	42,193	75,598	97	548	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION		94,810	119,751	214,561	109	553	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		207,846	262,525	470,371	412	2,155	90
91	Emergency		207,098	261,579	468,677	645	3,333	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency					338	1,497	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		6,098,816	7,703,243	13,802,059	12,441	71,249	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		9,869	12,465	22,334			190
192	Physicians' Private Offices		441,280	557,368	998,648	3	28	192
194	OTHER NON-REIMBURSEABLE COST CENTERS		927,262	1,171,198	2,098,460	9	65	194
194.01	OTHER NONREIMBURSABLE		406,683	513,670	920,353			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		7,883,910	9,957,944	17,841,854	12,453	71,342	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	NONPATIENT TELEPHONES	PURCHASING RECEIVING & STORES	PATIENT REGISTRATN	ADMINI-STRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
		5.01	5.02	5.03	5.05	6	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES	65,310						5.01
5.02	PURCHASING, RECEIVING & STORES		140,504					5.02
5.03	PATIENT REGISTRATION	1,645	4,495	90,076				5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL	17,214	7,447		1,971,898			5.05
6	Maintenance & Repairs	1,582	37,408		118,802	1,715,998		6
7	Operation of Plant	696	10,745		40,697	111,694	950,246	7
8	Laundry & Linen Service	63	1,710		8,282	1,786	972	8
9	Housekeeping	253	14,813		34,810	21,445	11,668	9
10	Dietary	823	15,304		18,176	31,680	17,237	10
11	Cafeteria				23,471	40,201	21,873	11
12	Maintenance of Personnel							12
13	Nursing Administration	506	1,088		58,753	11,714	6,373	13
14	Central Services & Supply	696	769		9,240	17,819	9,695	14
15	Pharmacy	1,329	1,937		40,636	17,287	9,406	15
16	Medical Records & Library	443	19		33,711	11,683	6,356	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)				2,870			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,809	7,489	6,705	263,540	370,436	201,552	30
31	Intensive Care Unit	1,582	877	1,139	60,040	58,676	31,925	31
41	Subprovider - IRF	1,202	789	668	36,321	48,990	26,655	41
43	Nursery			385	17,157	14,420	7,846	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,683	14,613	10,130	171,979	139,520	75,912	50
51	Recovery Room	570	550	1,268	26,343	28,380	15,441	51
52	Delivery Room & Labor Room			349	15,831	16,434	8,942	52
53	Anesthesiology	127	418	2,062	6,230	1,483	807	53
54	Radiology-Diagnostic	3,228	1,918	8,398	73,629	82,121	44,682	54
54.01	RADIOLOGY - ULTRASOUND	506	217	1,785	16,967	10,798	5,875	54.01
56	Radioisotope	1,392	308	1,206	14,263	15,867	8,633	56
57	CT Scan	633	410	6,524	21,982	14,228	7,741	57
59	Cardiac Catheterization	1,772	3,043	5,376	36,495	19,096	10,390	59
60	Laboratory	1,835	3,922	11,456	105,227	50,142	27,282	60
62	Whole Blood & Packed Red Blood Cells	253	167	527	14,155	3,983	2,167	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	127	649	2,153	32,759	14,791	8,048	65
66	Physical Therapy	1,266	631	1,808	36,885	70,095	38,138	66
67	Occupational Therapy	759	174	702	12,415	13,317	7,246	67
68	Speech Pathology	190	62	127	4,770	987	537	68
70	Electroencephalography	949	535	1,828	11,989	10,763	5,856	70
71	Medical Supplies Charged to Patients			2,340	94,743			71
72	Impl. Dev. Charged to Patients			3,460	169,021			72
73	Drugs Charged to Patients			9,236	121,813			73
74	Renal Dialysis			321	7,758			74
76.97	CARDIAC REHABILITATION	1,076	511	190	11,147	30,546	16,620	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	4,620	2,162	1,319	40,355	66,965	36,435	90
91	Emergency	1,772	1,647	8,119	68,973	66,723	36,304	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,709	1,210	495	38,226			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	65,310	138,037	90,076	1,920,461	1,414,070	708,614	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				251	3,180	1,730	190
192	Physicians' Private Offices		25		11,728		77,355	192
194	OTHER NON-REIMBURSEABLE COST CENTERS		2,442		29,114	298,748	162,547	194
194.01	OTHER NONREIMBURSABLE				10,344			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	65,310	140,504	90,076	1,971,898	1,715,998	950,246	202

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	25,541						8
9	Housekeeping	169	237,628					9
10	Dietary		4,369	311,633				10
11	Cafeteria		5,544		375,834			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,615		16,263	181,363		13
14	Central Services & Supply		2,457		4,992		171,622	14
15	Pharmacy		2,384		12,348			15
16	Medical Records & Library		1,611		276			16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)				2,443			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,311	51,085	250,028	115,045	91,133		30
31	Intensive Care Unit	836	8,091	21,576	21,857	17,315		31
41	Subprovider - IRF	1,294	6,755	32,122	13,134	10,406		41
43	Nursery		1,988		4,803	3,805		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,869	19,239		31,951	25,311		50
51	Recovery Room		3,913		9,689	7,676		51
52	Delivery Room & Labor Room		2,266		4,844	3,837		52
53	Anesthesiology		204					53
54	Radiology-Diagnostic	2,480	11,324		24,493			54
54.01	RADIOLOGY - ULTRASOUND	112	1,489		4,145			54.01
56	Radioisotope	181	2,188		1,964			56
57	CT Scan	244	1,962		5,226			57
59	Cardiac Catheterization	297	2,633		8,506			59
60	Laboratory	145	6,914		29,959			60
62	Whole Blood & Packed Red Blood Cells		549		1,224			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,040		13,861			65
66	Physical Therapy	1,068	9,666					66
67	Occupational Therapy	463	1,836		1,325			67
68	Speech Pathology	85	136					68
70	Electroencephalography	110	1,484		3,892			70
71	Medical Supplies Charged to Patients						59,558	71
72	Impl. Dev. Charged to Patients						112,064	72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION	96	4,212		3,933	3,117		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	345	9,234		15,315			90
91	Emergency	4,323	9,201	7,907	23,688	18,763		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	25,428	176,389	311,633	375,176	181,363	171,622	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		438					190
192	Physicians' Private Offices		19,605		198			192
194	OTHER NON-REIMBURSEABLE COST CENTERS	113	41,196		460			194
194.01	OTHER NONREIMBURSABLE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	25,541	237,628	311,633	375,834	181,363	171,622	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	208,892						15
16	Medical Records & Library		136,205					16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)			5,702				23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		10,120		4,009,222		4,009,222	30
31	Intensive Care Unit		1,720		641,499		641,499	31
41	Subprovider - IRF		1,008		525,613		525,613	41
43	Nursery		581		153,093		153,093	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		15,291		1,495,813		1,495,813	50
51	Recovery Room		1,914		296,733		296,733	51
52	Delivery Room & Labor Room		527		169,279		169,279	52
53	Anesthesiology		3,112		24,857		24,857	53
54	Radiology-Diagnostic		12,676		845,844		845,844	54
54.01	RADIOLOGY - ULTRASOUND		2,694		121,161		121,161	54.01
56	Radioisotope		1,820		159,629		159,629	56
57	CT Scan		9,848		169,625		169,625	57
59	Cardiac Catheterization		8,115		231,323		231,323	59
60	Laboratory		17,532		611,474		611,474	60
62	Whole Blood & Packed Red Blood Cells		795		52,009		52,009	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,249		183,886		183,886	65
66	Physical Therapy		2,730		654,648		654,648	66
67	Occupational Therapy		1,060		133,067		133,067	67
68	Speech Pathology		192		14,018		14,018	68
70	Electroencephalography		2,759		116,408		116,408	70
71	Medical Supplies Charged to Patients		3,533		160,174		160,174	71
72	Impl. Dev. Charged to Patients		5,223		289,768		289,768	72
73	Drugs Charged to Patients	208,892	13,942		353,883		353,883	73
74	Renal Dialysis		484		8,563		8,563	74
76.97	CARDIAC REHABILITATION		287		286,958		286,958	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		1,991		651,679		651,679	90
91	Emergency		12,255		732,330		732,330	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		747		44,222		44,222	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	208,892	136,205		13,136,778		13,136,778	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				27,933		27,933	190
192	Physicians' Private Offices				1,107,590		1,107,590	192
194	OTHER NON-REIMBURSEABLE COST CENTERS				2,633,154		2,633,154	194
194.01	OTHER NONREIMBURSABLE				930,697		930,697	194.01
200	Cross Foot Adjustments			5,702	5,702		5,702	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	208,892	136,205	5,702	17,841,854		17,841,854	202

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINTENACE OF PERSONNEL NUMBER OF FTES	NONPATIENT TELEPHONES NUMBER OF PHONES	PURCHASING RECEIVING & STORES SUPPLY EXPENSE	
		1	2	4	4.01	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	568,782						1
2	Cap Rel Costs-Mvble Equip		568,782					2
4	Employee Benefits Department	397	397	66,590,230				4
4.01	MAINTENANCE OF PERSONNEL	2,269	2,269	894,614	110,208			4.01
5.01	NON-PATIENT TELEPHONES	2,082	2,082			1,032		5.01
5.02	PURCHASING, RECEIVING & STORES	4,456	4,456	370,952	1,015		2,021,165	5.02
5.03	PATIENT REGISTRATION	2,581	2,581	1,583,351	4,137	26	64,665	5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL	61,947	61,947	3,823,094	5,153	272	107,124	5.05
6	Maintenance & Repairs	49,620	49,620	1,471,636	2,200	25	538,080	6
7	Operation of Plant	25,011	25,011	1,006,347	2,577	11	154,563	7
8	Laundry & Linen Service	400	400	77,731	257	1	24,594	8
9	Housekeeping	4,802	4,802	1,774,671	5,416	4	213,088	9
10	Dietary	7,094	7,094	742,470	2,127	13	220,156	10
11	Cafeteria	9,002	9,002	1,158,634	3,320			11
12	Maintenance of Personnel							12
13	Nursing Administration	2,623	2,623	2,584,318	3,535	8	15,657	13
14	Central Services & Supply	3,990	3,990	484,464	1,085	11	11,062	14
15	Pharmacy	3,871	3,871	2,144,997	2,684	21	27,870	15
16	Medical Records & Library	2,616	2,616	37,657	60	7	267	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)			242,046	531			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	82,950	82,950	14,746,880	25,007	155	107,725	30
31	Intensive Care Unit	13,139	13,139	3,411,531	4,751	25	12,620	31
41	Subprovider - IRF	10,970	10,970	1,647,972	2,855	19	11,343	41
43	Nursery	3,229	3,229	764,900	1,044			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	31,242	31,242	4,293,000	6,945	74	210,217	50
51	Recovery Room	6,355	6,355	1,489,479	2,106	9	7,907	51
52	Delivery Room & Labor Room	3,680	3,680	693,231	1,053			52
53	Anesthesiology	332	332			2	6,016	53
54	Radiology-Diagnostic	18,389	18,389	3,278,054	5,324	51	27,596	54
54.01	RADIOLOGY - ULTRASOUND	2,418	2,418	755,404	901	8	3,122	54.01
56	Radioisotope	3,553	3,553	424,542	427	22	4,432	56
57	CT Scan	3,186	3,186	812,498	1,136	10	5,899	57
59	Cardiac Catheterization	4,276	4,276	1,447,375	1,849	28	43,775	59
60	Laboratory	11,228	11,228	3,419,241	6,512	29	56,422	60
62	Whole Blood & Packed Red Blood Cells	892	892	193,796	266	4	2,401	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,312	3,312	1,958,671	3,013	2	9,343	65
66	Physical Therapy	15,696	15,696			20	9,083	66
67	Occupational Therapy	2,982	2,982	228,830	288	12	2,508	67
68	Speech Pathology	221	221	156		3	893	68
70	Electroencephalography	2,410	2,410	518,046	846	15	7,700	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION	6,840	6,840	582,895	855	17	7,346	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	14,995	14,995	2,203,863	3,329	73	31,107	90
91	Emergency	14,941	14,941	3,447,462	5,149	28	23,698	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			1,809,734	2,312	27	17,399	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	439,997	439,997	66,524,542	110,065	1,032	1,985,678	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	712	712					190
192	Physicians' Private Offices	31,836	31,836	14,964	43		364	192
194	OTHER NON-REIMBURSEABLE COST CENTERS	66,897	66,897	50,724	100		35,123	194
194.01	OTHER NONREIMBURSABLE	29,340	29,340					194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	7,883,910	9,957,944	9,771,420	1,421,537	687,704	1,166,827	202
203	Unit Cost Multiplier (Wkst. B, Part I)	13.861040	17.507488	0.146740	12.898673	666.379845	0.577304	203
204	Cost to be allocated (Per Wkst. B, Part II)			12,453	71,342	65,310	140,504	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000187	0.647340	63.284884	0.069516	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PATIENT REGISTRATN GROSS REVENUE	PATIENT ACCOUNTING GROSS REVENUE	RECON-CILIATION	ADMINI-STRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.03	5.04	5A.05	5.05	6	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION	851,620,422						5.03
5.04	PATIENT ACCOUNTING		851,620,422					5.04
5.05	ADMINISTRATIVE & GENERAL			-25,241,881	175,443,661			5.05
6	Maintenance & Repairs				10,570,501	384,254		6
7	Operation of Plant				3,621,075	25,011	391,079	7
8	Laundry & Linen Service				736,861	400	400	8
9	Housekeeping				3,097,216	4,802	4,802	9
10	Dietary				1,617,248	7,094	7,094	10
11	Cafeteria				2,088,387	9,002	9,002	11
12	Maintenance of Personnel							12
13	Nursing Administration				5,227,567	2,623	2,623	13
14	Central Services & Supply				822,157	3,990	3,990	14
15	Pharmacy				3,615,601	3,871	3,871	15
16	Medical Records & Library				2,999,424	2,616	2,616	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)				255,362			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	63,252,392	63,252,392		23,440,953	82,950	82,950	30
31	Intensive Care Unit	10,749,621	10,749,621		5,342,114	13,139	13,139	31
41	Subprovider - IRF	6,298,865	6,298,865		3,231,713	10,970	10,970	41
43	Nursery	3,633,908	3,633,908		1,526,594	3,229	3,229	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	95,568,041	95,568,041		15,302,005	31,242	31,242	50
51	Recovery Room	11,963,497	11,963,497		2,343,936	6,355	6,355	51
52	Delivery Room & Labor Room	3,291,500	3,291,500		1,408,563	3,680	3,680	52
53	Anesthesiology	19,448,743	19,448,743		554,363	332	332	53
54	Radiology-Diagnostic	79,227,740	79,227,740		6,551,226	18,389	18,389	54
54.01	RADIOLOGY - ULTRASOUND	16,837,260	16,837,260		1,509,674	2,418	2,418	54.01
56	Radioisotope	11,376,325	11,376,325		1,269,080	3,553	3,553	56
57	CT Scan	61,550,246	61,550,246		1,955,902	3,186	3,186	57
59	Cardiac Catheterization	50,716,926	50,716,926		3,247,171	4,276	4,276	59
60	Laboratory	109,919,340	109,919,340		9,362,642	11,228	11,228	60
62	Whole Blood & Packed Red Blood Cells	4,970,784	4,970,784		1,259,418	892	892	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	20,308,014	20,308,014		2,914,802	3,312	3,312	65
66	Physical Therapy	17,061,305	17,061,305		3,281,837	15,696	15,696	66
67	Occupational Therapy	6,626,451	6,626,451		1,104,600	2,982	2,982	67
68	Speech Pathology	1,202,160	1,202,160		424,413	221	221	68
70	Electroencephalography	17,243,822	17,243,822		1,066,747	2,410	2,410	70
71	Medical Supplies Charged to Patients	22,079,661	22,079,661		8,429,863			71
72	Impl. Dev. Charged to Patients	32,640,773	32,640,773		15,038,820			72
73	Drugs Charged to Patients	87,135,125	87,135,125		10,838,432			73
74	Renal Dialysis	3,024,599	3,024,599		690,240			74
76.97	CARDIAC REHABILITATION	1,791,325	1,791,325		991,832	6,840	6,840	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	12,441,993	12,441,993		3,590,651	14,995	14,995	90
91	Emergency	76,592,378	76,592,378		6,136,918	14,941	14,941	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	4,667,628	4,667,628		3,401,182			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	851,620,422	851,620,422	-25,241,881	170,867,090	316,645	291,634	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				22,334	712	712	190
192	Physicians' Private Offices				1,043,468		31,836	192
194	OTHER NON-REIMBURSEABLE COST CENTERS				2,590,416	66,897	66,897	194
194.01	OTHER NONREIMBURSABLE				920,353			194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,274,379	2,604,152		25,241,881	12,091,332	4,929,079	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.002671	0.003058		0.143875	31.467030	12.603794	203
204	Cost to be allocated (Per Wkst. B, Part II)	90,076			1,971,898	1,715,998	950,246	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000106			0.011239	4.465791	2.429806	205

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA NUMBER OF FTES	NURSING ADMINIS-TRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY SUPPLY EXPENSE	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	801,967						8
9	Housekeeping	5,321	385,877					9
10	Dietary		7,094	177,196				10
11	Cafeteria		9,002		81,694			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,623		3,535	1,035,145		13
14	Central Services & Supply		3,990		1,085		22,744,428	14
15	Pharmacy		3,871		2,684			15
16	Medical Records & Library		2,616		60			16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)				531			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	355,215	82,950	142,167	25,007	520,144		30
31	Intensive Care Unit	26,248	13,139	12,268	4,751	98,827		31
41	Subprovider - IRF	40,619	10,970	18,265	2,855	59,394		41
43	Nursery		3,229		1,044	21,720		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	58,677	31,242		6,945	144,464		50
51	Recovery Room		6,355		2,106	43,814		51
52	Delivery Room & Labor Room		3,680		1,053	21,900		52
53	Anesthesiology		332					53
54	Radiology-Diagnostic	77,855	18,389		5,324			54
54.01	RADIOLOGY - ULTRASOUND	3,510	2,418		901			54.01
56	Radioisotope	5,683	3,553		427			56
57	CT Scan	7,661	3,186		1,136			57
59	Cardiac Catheterization	9,322	4,276		1,849			59
60	Laboratory	4,562	11,228		6,512			60
62	Whole Blood & Packed Red Blood Cells		892		266			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,312		3,013			65
66	Physical Therapy	33,532	15,696					66
67	Occupational Therapy	14,535	2,982		288			67
68	Speech Pathology	2,661	221					68
70	Electroencephalography	3,443	2,410		846			70
71	Medical Supplies Charged to Patients						7,892,607	71
72	Impl. Dev. Charged to Patients						14,851,821	72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION	2,999	6,840		855	17,792		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	10,818	14,995		3,329			90
91	Emergency	135,746	14,941	4,496	5,149	107,090		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	798,407	286,432	177,196	81,551	1,035,145	22,744,428	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		712					190
192	Physicians' Private Offices		31,836		43			192
194	OTHER NON-REIMBURSEABLE COST CENTERS	3,560	66,897		100			194
194.01	OTHER NONREIMBURSABLE							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	860,506	3,760,165	2,231,695	2,873,299	6,245,172	1,193,328	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.072994	9.744465	12.594500	35.171481	6.033137	0.052467	203
204	Cost to be allocated (Per Wkst. B, Part II)	25,541	237,628	311,633	375,834	181,363	171,622	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.031848	0.615813	1.758691	4.600509	0.175205	0.007546	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	PARAMED EDUCATION ASSIGNED TIME				
		15	16	23				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	10,000						15
16	Medical Records & Library		851,620,422					16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)			3,744				23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		63,252,392	576				30
31	Intensive Care Unit		10,749,621	288				31
41	Subprovider - IRF		6,298,865					41
43	Nursery		3,633,908					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		95,568,041	288				50
51	Recovery Room		11,963,497					51
52	Delivery Room & Labor Room		3,291,500					52
53	Anesthesiology		19,448,743					53
54	Radiology-Diagnostic		79,227,740					54
54.01	RADIOLOGY - ULTRASOUND		16,837,260					54.01
56	Radioisotope		11,376,325					56
57	CT Scan		61,550,246					57
59	Cardiac Catheterization		50,716,926	96				59
60	Laboratory		109,919,340	192				60
62	Whole Blood & Packed Red Blood Cells		4,970,784					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		20,308,014					65
66	Physical Therapy		17,061,305					66
67	Occupational Therapy		6,626,451					67
68	Speech Pathology		1,202,160					68
70	Electroencephalography		17,243,822					70
71	Medical Supplies Charged to Patients		22,079,661					71
72	Impl. Dev. Charged to Patients		32,640,773					72
73	Drugs Charged to Patients	10,000	87,135,125					73
74	Renal Dialysis		3,024,599					74
76.97	CARDIAC REHABILITATION		1,791,325					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		12,441,993					90
91	Emergency		76,592,378	2,304				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		4,667,628					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,000	851,620,422	3,744				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	OTHER NON-REIMBURSEABLE COST CENTERS							194
194.01	OTHER NONREIMBURSABLE							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	4,438,515	3,573,858	310,778				202
203	Unit Cost Multiplier (Wkst. B, Part I)	443.851500	0.004197	83.006944				203
204	Cost to be allocated (Per Wkst. B, Part II)	208,892	136,205	5,702				204

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	PARAMED EDUCATION ASSIGNED TIME				
		15	16	23				
205	Unit Cost Multiplier (Wkst. B, Part II)	20.889200	0.000160	1.522970				205

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	37,779,999		37,779,999	6,029	37,786,028	30
31	Intensive Care Unit	7,832,822		7,832,822	3,825	7,836,647	31
41	Subprovider - IRF	5,045,836		5,045,836		5,045,836	41
43	Nursery	2,103,014		2,103,014		2,103,014	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	20,788,681		20,788,681	9,719	20,798,400	50
51	Recovery Room	3,411,784		3,411,784		3,411,784	51
52	Delivery Room & Labor Room	1,992,237		1,992,237		1,992,237	52
53	Anesthesiology	733,614		733,614		733,614	53
54	Radiology-Diagnostic	9,086,703		9,086,703	10,368	9,097,071	54
54.01	RADIOLOGY - ULTRASOUND	1,963,125		1,963,125		1,963,125	54.01
56	Radioisotope	1,711,736		1,711,736		1,711,736	56
57	CT Scan	2,715,264		2,715,264		2,715,264	57
59	Cardiac Catheterization	4,240,334		4,240,334	751	4,241,085	59
60	Laboratory	12,024,742		12,024,742	10,116	12,034,858	60
62	Whole Blood & Packed Red Blood Cells	1,518,839		1,518,839		1,518,839	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	3,703,611		3,703,611	4,198	3,707,809	65
66	Physical Therapy	4,706,282		4,706,282	1,270	4,707,552	66
67	Occupational Therapy	1,477,538		1,477,538		1,477,538	67
68	Speech Pathology	505,268		505,268		505,268	68
70	Electroencephalography	1,455,741		1,455,741	3,031	1,458,772	70
71	Medical Supplies Charged to Patients	10,149,479		10,149,479		10,149,479	71
72	Impl. Dev. Charged to Patients	18,118,750		18,118,750		18,118,750	72
73	Drugs Charged to Patients	17,202,032		17,202,032		17,202,032	73
74	Renal Dialysis	802,242		802,242		802,242	74
76.97	CARDIAC REHABILITATION	1,650,778		1,650,778		1,650,778	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	5,095,129		5,095,129	34,826	5,129,955	90
91	Emergency	9,366,094		9,366,094		9,366,094	91
92	Observation Beds (Non-Distinct Part)	3,484,471		3,484,471		3,484,471	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	3,910,117		3,910,117		3,910,117	101
200	Subtotal (sum of lines 30 thru 199)	194,576,262		194,576,262	84,133	194,660,395	200
201	Less Observation Beds	3,484,471		3,484,471		3,484,471	201
202	Total (line 200 minus line 201)	191,091,791		191,091,791		191,175,924	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	53,971,619		53,971,619				30
31	Intensive Care Unit	10,749,621		10,749,621				31
41	Subprovider - IRF	6,298,865		6,298,865				41
43	Nursery	3,633,908		3,633,908				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	34,861,343	60,706,698	95,568,041	0.217528	0.217528	0.217629	50
51	Recovery Room	4,094,562	7,868,935	11,963,497	0.285183	0.285183	0.285183	51
52	Delivery Room & Labor Room	2,410,935	880,565	3,291,500	0.605267	0.605267	0.605267	52
53	Anesthesiology	6,927,951	12,520,792	19,448,743	0.037720	0.037720	0.037720	53
54	Radiology-Diagnostic	13,689,678	65,538,062	79,227,740	0.114691	0.114691	0.114822	54
54.01	RADIOLOGY - ULTRASOUND	3,650,339	13,186,921	16,837,260	0.116594	0.116594	0.116594	54.01
56	Radioisotope	3,360,515	8,015,810	11,376,325	0.150465	0.150465	0.150465	56
57	CT Scan	19,365,550	42,184,696	61,550,246	0.044115	0.044115	0.044115	57
59	Cardiac Catheterization	21,765,397	28,951,529	50,716,926	0.083608	0.083608	0.083623	59
60	Laboratory	38,242,750	71,676,590	109,919,340	0.109396	0.109396	0.109488	60
62	Whole Blood & Packed Red Blood Cells	3,220,443	1,750,341	4,970,784	0.305553	0.305553	0.305553	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	18,830,167	1,477,847	20,308,014	0.182372	0.182372	0.182579	65
66	Physical Therapy	7,434,308	9,626,997	17,061,305	0.275845	0.275845	0.275920	66
67	Occupational Therapy	4,842,821	1,783,630	6,626,451	0.222976	0.222976	0.222976	67
68	Speech Pathology	929,974	272,186	1,202,160	0.420300	0.420300	0.420300	68
70	Electroencephalography	4,219,643	13,024,179	17,243,822	0.084421	0.084421	0.084597	70
71	Medical Supplies Charged to Patients	10,867,131	11,212,530	22,079,661	0.459675	0.459675	0.459675	71
72	Impl. Dev. Charged to Patients	20,860,009	11,780,764	32,640,773	0.555096	0.555096	0.555096	72
73	Drugs Charged to Patients	49,266,409	37,868,716	87,135,125	0.197418	0.197418	0.197418	73
74	Renal Dialysis	2,911,999	112,600	3,024,599	0.265239	0.265239	0.265239	74
76.97	CARDIAC REHABILITATION	360,201	1,431,124	1,791,325	0.921540	0.921540	0.921540	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	530,154	11,911,839	12,441,993	0.409511	0.409511	0.412310	90
91	Emergency	24,684,126	51,908,252	76,592,378	0.122285	0.122285	0.122285	91
92	Observation Beds (Non-Distinct Part)	1,324,971	7,955,802	9,280,773	0.375451	0.375451	0.375451	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		4,667,628	4,667,628				101
200	Subtotal (sum of lines 30 thru 199)	373,305,389	478,315,033	851,620,422				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	373,305,389	478,315,033	851,620,422				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[XX] Title XVIII, Part A
[ ] Title XIX
[XX] PPS
[ ] TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	4,009,222		4,009,222	47,595	84.24	20,341	1,713,526	30
31	Intensive Care Unit	641,499		641,499	5,403	118.73	1,933	229,505	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF	525,613		525,613	6,065	86.66	4,157	360,246	41
42	Subprovider I								42
43	Nursery	153,093		153,093	1,754	87.28			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	5,329,427		5,329,427	60,817		26,431	2,303,277	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-0034** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V [XX] Hospital [ ] SUB (Other) [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] TEFRA
[ ] Title XIX [ ] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26) 1	Total Charges (from Wkst. C, Part I, (col. 8) 2	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3	Inpatient Program Charges 4	Capital Costs (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,495,813	95,568,041	0.015652	14,641,901	229,175	50
51	Recovery Room	296,733	11,963,497	0.024803	1,739,681	43,149	51
52	Delivery Room & Labor Room	169,279	3,291,500	0.051429	11,577	595	52
53	Anesthesiology	24,857	19,448,743	0.001278	3,044,879	3,891	53
54	Radiology-Diagnostic	845,844	79,227,740	0.010676	5,561,197	59,371	54
54.01	RADIOLOGY - ULTRASOUND	121,161	16,837,260	0.007196	1,578,917	11,362	54.01
56	Radioisotope	159,629	11,376,325	0.014032	1,519,437	21,321	56
57	CT Scan	169,625	61,550,246	0.002756	8,636,418	23,802	57
59	Cardiac Catheterization	231,323	50,716,926	0.004561	9,017,380	41,128	59
60	Laboratory	611,474	109,919,340	0.005563	16,925,064	94,154	60
62	Whole Blood & Packed Red Blood	52,009	4,970,784	0.010463	1,507,562	15,774	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	183,886	20,308,014	0.009055	8,571,533	77,615	65
66	Physical Therapy	654,648	17,061,305	0.038370	2,268,849	87,056	66
67	Occupational Therapy	133,067	6,626,451	0.020081	981,775	19,715	67
68	Speech Pathology	14,018	1,202,160	0.011661	280,383	3,270	68
70	Electroencephalography	116,408	17,243,822	0.006751	2,305,198	15,562	70
71	Medical Supplies Charged to Pat	160,174	22,079,661	0.007254	4,761,383	34,539	71
72	Impl. Dev. Charged to Patients	289,768	32,640,773	0.008877	10,040,109	89,126	72
73	Drugs Charged to Patients	353,883	87,135,125	0.004061	20,711,393	84,109	73
74	Renal Dialysis	8,563	3,024,599	0.002831	1,501,228	4,250	74
76.97	CARDIAC REHABILITATION	286,958	1,791,325	0.160193	165,259	26,473	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	651,679	12,441,993	0.052377	133,419	6,988	90
91	Emergency	732,330	76,592,378	0.009561	11,320,263	108,233	91
92	Observation Beds (Non-Distinct	369,713	9,280,773	0.039836	716,610	28,547	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	8,132,842	772,298,781		127,941,415	1,129,205	200

(A) Worksheet A line numbers

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)		47,812			47,812	30
31	Intensive Care Unit		23,906			23,906	31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)		71,718			71,718	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[XX] Title XVIII, Part A [ ] TEFRA
[ ] Title XIX [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	47,595	1.00	20,341	20,341	30
31	Intensive Care Unit	5,403	4.42	1,933	8,544	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF	6,065		4,157		41
42	Subprovider I					42
43	Nursery	1,754				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	60,817		26,431	28,885	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0034** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

(A)	Cost Center Description	Non Physician Anesth-etist Cost (1)	Nursing School (2)	Allied Health (3)	All Other Medical Education Cost (4)	Total Cost (sum of col. 1 through col. 4) (5)	Total Outpatient Cost (sum of col. 2, 3, and 4) (6)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			23,906		23,906	23,906	50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY - ULTRASOUND							54.01
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization			7,969		7,969	7,969	59
60	Laboratory			15,937		15,937	15,937	60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency			191,248		191,248	191,248	91
92	Observation Beds (Non-Distinct			4,408		4,408	4,408	92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			243,468		243,468	243,468	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0034** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	95,568,041	0.000250	0.000250	14,641,901	3,660	17,261,062	4,315	50
51	Recovery Room	11,963,497			1,739,681		1,806,370		51
52	Delivery Room & Labor Room	3,291,500			11,577		4,052		52
53	Anesthesiology	19,448,743			3,044,879		3,918,364		53
54	Radiology-Diagnostic	79,227,740			5,561,197		19,698,638		54
54.01	RADIOLOGY - ULTRASOUND	16,837,260			1,578,917		3,399,518		54.01
56	Radioisotope	11,376,325			1,519,437		3,072,025		56
57	CT Scan	61,550,246			8,636,418		12,747,916		57
59	Cardiac Catheterization	50,716,926	0.000157	0.000157	9,017,380	1,416	11,823,468	1,856	59
60	Laboratory	109,919,340	0.000145	0.000145	16,925,064	2,454	8,615,198	1,249	60
62	Whole Blood & Packed Red Blood	4,970,784			1,507,562		592,131		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,308,014			8,571,533		594,684		65
66	Physical Therapy	17,061,305			2,268,849		54,150		66
67	Occupational Therapy	6,626,451			981,775		17,029		67
68	Speech Pathology	1,202,160			280,383		6,620		68
70	Electroencephalography	17,243,822			2,305,198		5,311,139		70
71	Medical Supplies Charged to Pat	22,079,661			4,761,383		4,146,487		71
72	Impl. Dev. Charged to Patients	32,640,773			10,040,109		5,435,003		72
73	Drugs Charged to Patients	87,135,125			20,711,393		16,757,535		73
74	Renal Dialysis	3,024,599			1,501,228		105,195		74
76.97	CARDIAC REHABILITATION	1,791,325			165,259		611,203		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	12,441,993			133,419		4,654,912		90
91	Emergency	76,592,378	0.002497	0.002497	11,320,263	28,267	9,800,603	24,472	91
92	Observation Beds (Non-Distinct	9,280,773	0.000475	0.000475	716,610	340	2,546,724	1,210	92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	772,298,781			127,941,415	36,137	132,980,026	33,102	200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-0034** **WORKSHEET D PART V**

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.217528	17,261,062		17,640	3,754,764		3,837	50
51	Recovery Room	0.285183	1,806,370			515,146			51
52	Delivery Room & Labor Room	0.605267	4,052			2,453			52
53	Anesthesiology	0.037720	3,918,364			147,801			53
54	Radiology-Diagnostic	0.114691	19,698,638			2,259,256			54
54.01	RADIOLOGY - ULTRASOUND	0.116594	3,399,518			396,363			54.01
56	Radioisotope	0.150465	3,072,025			462,232			56
57	CT Scan	0.044115	12,747,916			562,374			57
59	Cardiac Catheterization	0.083608	11,823,468			988,537			59
60	Laboratory	0.109396	8,615,198		650	942,468		71	60
62	Whole Blood & Packed Red Blood	0.305553	592,131			180,927			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.182372	594,684			108,454			65
66	Physical Therapy	0.275845	54,150			14,937			66
67	Occupational Therapy	0.222976	17,029			3,797			67
68	Speech Pathology	0.420300	6,620			2,782			68
70	Electroencephalography	0.084421	5,311,139			448,372			70
71	Medical Supplies Charged to Pat	0.459675	4,146,487			1,906,036			71
72	Impl. Dev. Charged to Patients	0.555096	5,435,003			3,016,948			72
73	Drugs Charged to Patients	0.197418	16,757,535		119,296	3,308,239		23,551	73
74	Renal Dialysis	0.265239	105,195			27,902			74
76.97	CARDIAC REHABILITATION	0.921540	611,203			563,248			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.409511	4,654,912			1,906,238			90
91	Emergency	0.122285	9,800,603			1,198,467			91
92	Observation Beds (Non-Distinct	0.375451	2,546,724			956,170			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		132,980,026		137,586	23,673,911		27,459	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		132,980,026		137,586	23,673,911		27,459	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-T034** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V **[ ] Hospital** **[ ] SUB (Other)** **[XX] PPS**
[XX] Title XVIII, Part A **[ ] IPF** **[ ] TEFRA**
[ ] Title XIX **[XX] IRF**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,495,813	95,568,041	0.015652	152,192	2,382	50
51	Recovery Room	296,733	11,963,497	0.024803	22,349	554	51
52	Delivery Room & Labor Room	169,279	3,291,500	0.051429			52
53	Anesthesiology	24,857	19,448,743	0.001278	31,563	40	53
54	Radiology-Diagnostic	845,844	79,227,740	0.010676	183,395	1,958	54
54.01	RADIOLOGY - ULTRASOUND	121,161	16,837,260	0.007196	17,484	126	54.01
56	Radioisotope	159,629	11,376,325	0.014032	32,810	460	56
57	CT Scan	169,625	61,550,246	0.002756	186,954	515	57
59	Cardiac Catheterization	231,323	50,716,926	0.004561	84,604	386	59
60	Laboratory	611,474	109,919,340	0.005563	903,276	5,025	60
62	Whole Blood & Packed Red Blood	52,009	4,970,784	0.010463	56,655	593	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	183,886	20,308,014	0.009055	518,144	4,692	65
66	Physical Therapy	654,648	17,061,305	0.038370	2,014,438	77,294	66
67	Occupational Therapy	133,067	6,626,451	0.020081	1,947,428	39,106	67
68	Speech Pathology	14,018	1,202,160	0.011661	298,679	3,483	68
70	Electroencephalography	116,408	17,243,822	0.006751	1,640	11	70
71	Medical Supplies Charged to Pat	160,174	22,079,661	0.007254	475,247	3,447	71
72	Impl. Dev. Charged to Patients	289,768	32,640,773	0.008877	6,912	61	72
73	Drugs Charged to Patients	353,883	87,135,125	0.004061	2,284,025	9,275	73
74	Renal Dialysis	8,563	3,024,599	0.002831	560,380	1,586	74
76.97	CARDIAC REHABILITATION	286,958	1,791,325	0.160193			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	651,679	12,441,993	0.052377			90
91	Emergency	732,330	76,592,378	0.009561			91
92	Observation Beds (Non-Distinct		9,280,773				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	7,763,129	772,298,781		9,778,175	150,994	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-T034** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [ ] Hospital [ ] IPF [XX] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School 2	Allied Health 3	All Other Medical Education Cost 4	Total Cost (sum of col. 1 through col. 4) 5	Total Outpatient Cost (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			23,906		23,906	23,906	50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY - ULTRASOUND							54.01
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization			7,969		7,969	7,969	59
60	Laboratory			15,937		15,937	15,937	60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency			191,248		191,248	191,248	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			239,060		239,060	239,060	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-T034** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [ ] Hospital [ ] IPF [XX] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	95,568,041	0.000250	0.000250	152,192	38			50
51	Recovery Room	11,963,497			22,349				51
52	Delivery Room & Labor Room	3,291,500							52
53	Anesthesiology	19,448,743			31,563				53
54	Radiology-Diagnostic	79,227,740			183,395				54
54.01	RADIOLOGY - ULTRASOUND	16,837,260			17,484				54.01
56	Radioisotope	11,376,325			32,810				56
57	CT Scan	61,550,246			186,954				57
59	Cardiac Catheterization	50,716,926	0.000157	0.000157	84,604	13			59
60	Laboratory	109,919,340	0.000145	0.000145	903,276	131			60
62	Whole Blood & Packed Red Blood	4,970,784			56,655				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,308,014			518,144				65
66	Physical Therapy	17,061,305			2,014,438				66
67	Occupational Therapy	6,626,451			1,947,428				67
68	Speech Pathology	1,202,160			298,679				68
70	Electroencephalography	17,243,822			1,640				70
71	Medical Supplies Charged to Pat	22,079,661			475,247				71
72	Impl. Dev. Charged to Patients	32,640,773			6,912				72
73	Drugs Charged to Patients	87,135,125			2,284,025		545		73
74	Renal Dialysis	3,024,599			560,380				74
76.97	CARDIAC REHABILITATION	1,791,325							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	12,441,993							90
91	Emergency	76,592,378	0.002497	0.002497					91
92	Observation Beds (Non-Distinct	9,280,773							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	772,298,781			9,778,175	182	545		200

(A) Worksheet A line numbers

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-T034** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[XX] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.217528							50
51	Recovery Room	0.285183							51
52	Delivery Room & Labor Room	0.605267							52
53	Anesthesiology	0.037720							53
54	Radiology-Diagnostic	0.114691							54
54.01	RADIOLOGY - ULTRASOUND	0.116594							54.01
56	Radioisotope	0.150465							56
57	CT Scan	0.044115							57
59	Cardiac Catheterization	0.083608							59
60	Laboratory	0.109396							60
62	Whole Blood & Packed Red Blood	0.305553							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.182372							65
66	Physical Therapy	0.275845							66
67	Occupational Therapy	0.222976							67
68	Speech Pathology	0.420300							68
70	Electroencephalography	0.084421							70
71	Medical Supplies Charged to Pat	0.459675							71
72	Impl. Dev. Charged to Patients	0.555096							72
73	Drugs Charged to Patients	0.197418	545		1,200	108		237	73
74	Renal Dialysis	0.265239							74
76.97	CARDIAC REHABILITATION	0.921540							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.409511							90
91	Emergency	0.122285							91
92	Observation Beds (Non-Distinct	0.375451							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		545		1,200	108		237	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		545		1,200	108		237	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX
[XX] PPS
[ ] TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	4,009,222		4,009,222	47,595	84.24	749	63,096	30
31	Intensive Care Unit	641,499		641,499	5,403	118.73	69	8,192	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF	525,613		525,613	6,065	86.66			41
42	Subprovider I								42
43	Nursery	153,093		153,093	1,754	87.28	192	16,758	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	5,329,427		5,329,427	60,817		1,010	88,046	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-0034** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[XX] PPS** **[ ] TEFRA**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,495,813	95,568,041	0.015652	335,218	5,247	50
51	Recovery Room	296,733	11,963,497	0.024803	32,115	797	51
52	Delivery Room & Labor Room	169,279	3,291,500	0.051429	67,800	3,487	52
53	Anesthesiology	24,857	19,448,743	0.001278	59,749	76	53
54	Radiology-Diagnostic	845,844	79,227,740	0.010676	166,511	1,778	54
54.01	RADIOLOGY - ULTRASOUND	121,161	16,837,260	0.007196	49,361	355	54.01
56	Radioisotope	159,629	11,376,325	0.014032	14,490	203	56
57	CT Scan	169,625	61,550,246	0.002756	267,278	737	57
59	Cardiac Catheterization	231,323	50,716,926	0.004561	122,212	557	59
60	Laboratory	611,474	109,919,340	0.005563	578,525	3,218	60
62	Whole Blood & Packed Red Blood	52,009	4,970,784	0.010463	16,020	168	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	183,886	20,308,014	0.009055	121,016	1,096	65
66	Physical Therapy	654,648	17,061,305	0.038370	43,123	1,655	66
67	Occupational Therapy	133,067	6,626,451	0.020081	17,341	348	67
68	Speech Pathology	14,018	1,202,160	0.011661	18,799	219	68
70	Electroencephalography	116,408	17,243,822	0.006751	7,178	48	70
71	Medical Supplies Charged to Pat	160,174	22,079,661	0.007254	196,682	1,427	71
72	Impl. Dev. Charged to Patients	289,768	32,640,773	0.008877	91,918	816	72
73	Drugs Charged to Patients	353,883	87,135,125	0.004061	954,577	3,877	73
74	Renal Dialysis	8,563	3,024,599	0.002831	19,800	56	74
76.97	CARDIAC REHABILITATION	286,958	1,791,325	0.160193			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	651,679	12,441,993	0.052377	246	13	90
91	Emergency	732,330	76,592,378	0.009561	274,673	2,626	91
92	Observation Beds (Non-Distinct	369,713	9,280,773	0.039836	17,202	685	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	8,132,842	772,298,781		3,471,834	29,489	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V **[XX] PPS**
[ ] Title XVIII, Part A **[ ] TEFRA**
[XX] Title XIX **[ ] Other**

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)		47,812			47,812	30
31	Intensive Care Unit		23,906			23,906	31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)		71,718			71,718	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	47,595	1.00	749	749	30
31	Intensive Care Unit	5,403	4.42	69	305	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF	6,065				41
42	Subprovider I					42
43	Nursery	1,754		192		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	60,817		1,010	1,054	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0034** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School 2	Allied Health 3	All Other Medical Education Cost 4	Total Cost (sum of col. 1 through col. 4) 5	Total Outpatient Cost (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			23,906		23,906	23,906	50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY - ULTRASOUND							54.01
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization			7,969		7,969	7,969	59
60	Laboratory			15,937		15,937	15,937	60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency			191,248		191,248	191,248	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			239,060		239,060	239,060	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0034** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	95,568,041	0.000250	0.000250	335,218	84			50
51	Recovery Room	11,963,497			32,115				51
52	Delivery Room & Labor Room	3,291,500			67,800				52
53	Anesthesiology	19,448,743			59,749				53
54	Radiology-Diagnostic	79,227,740			166,511				54
54.01	RADIOLOGY - ULTRASOUND	16,837,260			49,361				54.01
56	Radioisotope	11,376,325			14,490				56
57	CT Scan	61,550,246			267,278				57
59	Cardiac Catheterization	50,716,926	0.000157	0.000157	122,212	19			59
60	Laboratory	109,919,340	0.000145	0.000145	578,525	84			60
62	Whole Blood & Packed Red Blood	4,970,784			16,020				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,308,014			121,016				65
66	Physical Therapy	17,061,305			43,123				66
67	Occupational Therapy	6,626,451			17,341				67
68	Speech Pathology	1,202,160			18,799				68
70	Electroencephalography	17,243,822			7,178				70
71	Medical Supplies Charged to Pat	22,079,661			196,682				71
72	Impl. Dev. Charged to Patients	32,640,773			91,918				72
73	Drugs Charged to Patients	87,135,125			954,577				73
74	Renal Dialysis	3,024,599			19,800				74
76.97	CARDIAC REHABILITATION	1,791,325							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	12,441,993			246				90
91	Emergency	76,592,378	0.002497	0.002497	274,673	686			91
92	Observation Beds (Non-Distinct	9,280,773			17,202				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	772,298,781			3,471,834	873			200

(A) Worksheet A line numbers

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-0034** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[ ] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[XX] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.217528							50
51	Recovery Room	0.285183							51
52	Delivery Room & Labor Room	0.605267							52
53	Anesthesiology	0.037720							53
54	Radiology-Diagnostic	0.114691							54
54.01	RADIOLOGY - ULTRASOUND	0.116594							54.01
56	Radioisotope	0.150465							56
57	CT Scan	0.044115							57
59	Cardiac Catheterization	0.083608							59
60	Laboratory	0.109396							60
62	Whole Blood & Packed Red Blood	0.305553							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.182372							65
66	Physical Therapy	0.275845							66
67	Occupational Therapy	0.222976							67
68	Speech Pathology	0.420300							68
70	Electroencephalography	0.084421							70
71	Medical Supplies Charged to Pat	0.459675							71
72	Impl. Dev. Charged to Patients	0.555096							72
73	Drugs Charged to Patients	0.197418							73
74	Renal Dialysis	0.265239							74
76.97	CARDIAC REHABILITATION	0.921540							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.409511							90
91	Emergency	0.122285							91
92	Observation Beds (Non-Distinct	0.375451							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-T034** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V **[ ] Hospital** **[ ] SUB (Other)** **[XX] PPS**
[ ] Title XVIII, Part A **[ ] IPF** **[ ] TEFRA**
[XX] Title XIX **[XX] IRF**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,495,813	95,568,041	0.015652			50
51	Recovery Room	296,733	11,963,497	0.024803			51
52	Delivery Room & Labor Room	169,279	3,291,500	0.051429			52
53	Anesthesiology	24,857	19,448,743	0.001278			53
54	Radiology-Diagnostic	845,844	79,227,740	0.010676			54
54.01	RADIOLOGY - ULTRASOUND	121,161	16,837,260	0.007196			54.01
56	Radioisotope	159,629	11,376,325	0.014032			56
57	CT Scan	169,625	61,550,246	0.002756			57
59	Cardiac Catheterization	231,323	50,716,926	0.004561			59
60	Laboratory	611,474	109,919,340	0.005563			60
62	Whole Blood & Packed Red Blood	52,009	4,970,784	0.010463			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	183,886	20,308,014	0.009055			65
66	Physical Therapy	654,648	17,061,305	0.038370			66
67	Occupational Therapy	133,067	6,626,451	0.020081			67
68	Speech Pathology	14,018	1,202,160	0.011661			68
70	Electroencephalography	116,408	17,243,822	0.006751			70
71	Medical Supplies Charged to Pat	160,174	22,079,661	0.007254			71
72	Impl. Dev. Charged to Patients	289,768	32,640,773	0.008877			72
73	Drugs Charged to Patients	353,883	87,135,125	0.004061			73
74	Renal Dialysis	8,563	3,024,599	0.002831			74
76.97	CARDIAC REHABILITATION	286,958	1,791,325	0.160193			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	651,679	12,441,993	0.052377			90
91	Emergency	732,330	76,592,378	0.009561			91
92	Observation Beds (Non-Distinct		9,280,773				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	7,763,129	772,298,781				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-T034** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V **[ ] Title XVIII, Part A** **[XX] Title XIX**
[ ] Hospital **[ ] IPF** **[XX] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] ICF/IID
[XX] PPS **[ ] TEFRA** **[ ] Other**

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			23,906		23,906	23,906	50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY - ULTRASOUND							54.01
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization			7,969		7,969	7,969	59
60	Laboratory			15,937		15,937	15,937	60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency			191,248		191,248	191,248	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			239,060		239,060	239,060	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-T034** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [ ] Title XVIII, Part A [XX] Title XIX
[ ] Hospital [ ] IPF [XX] IRF
[ ] SUB (Other) [ ] SNF [ ] NF
[ ] ICF/IID
[XX] PPS [ ] TEFRA [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	95,568,041	0.000250	0.000250					50
51	Recovery Room	11,963,497							51
52	Delivery Room & Labor Room	3,291,500							52
53	Anesthesiology	19,448,743							53
54	Radiology-Diagnostic	79,227,740							54
54.01	RADIOLOGY - ULTRASOUND	16,837,260							54.01
56	Radioisotope	11,376,325							56
57	CT Scan	61,550,246							57
59	Cardiac Catheterization	50,716,926	0.000157	0.000157					59
60	Laboratory	109,919,340	0.000145	0.000145					60
62	Whole Blood & Packed Red Blood	4,970,784							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,308,014							65
66	Physical Therapy	17,061,305							66
67	Occupational Therapy	6,626,451							67
68	Speech Pathology	1,202,160							68
70	Electroencephalography	17,243,822							70
71	Medical Supplies Charged to Pat	22,079,661							71
72	Impl. Dev. Charged to Patients	32,640,773							72
73	Drugs Charged to Patients	87,135,125							73
74	Renal Dialysis	3,024,599							74
76.97	CARDIAC REHABILITATION	1,791,325							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	12,441,993							90
91	Emergency	76,592,378	0.002497	0.002497					91
92	Observation Beds (Non-Distinct	9,280,773							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	772,298,781							200

(A) Worksheet A line numbers

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-T034** **WORKSHEET D PART V**

Check Applicable Boxes:

[ ] Title V - O/P	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
[XX] Title XIX - O/P	[XX] IRF	[ ] NF	[ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.217528							50
51	Recovery Room	0.285183							51
52	Delivery Room & Labor Room	0.605267							52
53	Anesthesiology	0.037720							53
54	Radiology-Diagnostic	0.114691							54
54.01	RADIOLOGY - ULTRASOUND	0.116594							54.01
56	Radioisotope	0.150465							56
57	CT Scan	0.044115							57
59	Cardiac Catheterization	0.083608							59
60	Laboratory	0.109396							60
62	Whole Blood & Packed Red Blood	0.305553							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.182372							65
66	Physical Therapy	0.275845							66
67	Occupational Therapy	0.222976							67
68	Speech Pathology	0.420300							68
70	Electroencephalography	0.084421							70
71	Medical Supplies Charged to Pat	0.459675							71
72	Impl. Dev. Charged to Patients	0.555096							72
73	Drugs Charged to Patients	0.197418							73
74	Renal Dialysis	0.265239							74
76.97	CARDIAC REHABILITATION	0.921540							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.409511							90
91	Emergency	0.122285							91
92	Observation Beds (Non-Distinct	0.375451							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0034** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	47,595	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	47,595	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	43,206	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	20,341	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	37,786,028	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	37,786,028	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	37,786,028	37

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[ ] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					793.91	38
39	Program general inpatient routine service cost (line 9 x line 38)					16,148,923	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					16,148,923	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	7,836,647	5,403	1,450.43	1,933	2,803,681	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					25,136,863	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					44,089,467	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,971,916	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,165,342	51
52	Total Program excludable cost (sum of lines 50 and 51)					3,137,258	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					40,952,209	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [ ] NF [ ] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					4,389	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					793.91	88
89	Observation bed cost (line 87 x line 88) (see instructions)					3,484,471	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	4,009,222	37,786,028	0.106103	3,484,471	369,713	90
91	Nursing School						91
92	Allied Health	47,812	37,786,028	0.001265	3,484,471	4,408	92
93	Other Medical Education						93

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-T034** **WORKSHEET D-1**
PART I

Check Applicable Boxes:	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[XX] IRF**	**[ ] NF**		**[ ] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,065	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,065	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	6,065	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,157	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	5,045,836	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,045,836	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,045,836	37

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-T034** **WORKSHEET D-1 PART II**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[XX] IRF**		**[ ] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	831.96	38
39	Program general inpatient routine service cost (line 9 x line 38)	3,458,458	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	3,458,458	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,232,420	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	5,690,878	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	360,246	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	151,176	51
52	Total Program excludable cost (sum of lines 50 and 51)	511,422	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	5,179,456	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0034** **WORKSHEET D-1**
PART I

Check	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
Applicable	**[ ] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[XX] Title XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	47,595	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	47,595	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	43,206	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	749	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	1,754	15
16	Nursery days (title V or XIX only)	192	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	37,786,028	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	37,786,028	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	37,786,028	37

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0034** **WORKSHEET D-1 PART II**

Check Applicable Boxes:
[ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					793.91	38
39	Program general inpatient routine service cost (line 9 x line 38)					594,639	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					594,639	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)	2,103,014	1,754	1,198.98	192	230,204	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	7,836,647	5,403	1,450.43	69	100,080	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					664,357	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,589,280	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					89,100	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					30,362	51
52	Total Program excludable cost (sum of lines 50 and 51)					119,462	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					1,469,818	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] NF [ ] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					4,389	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-T034** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[XX] IRF**	**[ ] NF**		**[ ] Other**

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,065	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,065	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	6,065	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	5,045,836	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,045,836	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,045,836	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-T034** **WORKSHEET D-1 PART II**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[XX] IRF**		**[ ] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	831.96	38
39	Program general inpatient routine service cost (line 9 x line 38)		39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)		41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)		49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-0034** **WORKSHEET D-3**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/IID** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		24,897,000		30
31	Intensive Care Unit		4,807,051		31
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.217629	14,641,901	3,186,502	50
51	Recovery Room	0.285183	1,739,681	496,127	51
52	Delivery Room & Labor Room	0.605267	11,577	7,007	52
53	Anesthesiology	0.037720	3,044,879	114,853	53
54	Radiology-Diagnostic	0.114822	5,561,197	638,548	54
54.01	RADIOLOGY - ULTRASOUND	0.116594	1,578,917	184,092	54.01
56	Radioisotope	0.150465	1,519,437	228,622	56
57	CT Scan	0.044115	8,636,418	380,996	57
59	Cardiac Catheterization	0.083623	9,017,380	754,060	59
60	Laboratory	0.109488	16,925,064	1,853,091	60
62	Whole Blood & Packed Red Blood Cells	0.305553	1,507,562	460,640	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.182579	8,571,533	1,564,982	65
66	Physical Therapy	0.275920	2,268,849	626,021	66
67	Occupational Therapy	0.222976	981,775	218,912	67
68	Speech Pathology	0.420300	280,383	117,845	68
70	Electroencephalography	0.084597	2,305,198	195,013	70
71	Medical Supplies Charged to Patients	0.459675	4,761,383	2,188,689	71
72	Impl. Dev. Charged to Patients	0.555096	10,040,109	5,573,224	72
73	Drugs Charged to Patients	0.197418	20,711,393	4,088,802	73
74	Renal Dialysis	0.265239	1,501,228	398,184	74
76.97	CARDIAC REHABILITATION	0.921540	165,259	152,293	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.412310	133,419	55,010	90
91	Emergency	0.122285	11,320,263	1,384,298	91
92	Observation Beds (Non-Distinct Part)	0.375451	716,610	269,052	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		127,941,415	25,136,863	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		127,941,415		202

(A) Worksheet A line numbers

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-T034** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[XX] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
41	Subprovider - IRF		4,110,604		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.217629	152,192	33,121	50
51	Recovery Room	0.285183	22,349	6,374	51
52	Delivery Room & Labor Room	0.605267			52
53	Anesthesiology	0.037720	31,563	1,191	53
54	Radiology-Diagnostic	0.114822	183,395	21,058	54
54.01	RADIOLOGY - ULTRASOUND	0.116594	17,484	2,039	54.01
56	Radioisotope	0.150465	32,810	4,937	56
57	CT Scan	0.044115	186,954	8,247	57
59	Cardiac Catheterization	0.083623	84,604	7,075	59
60	Laboratory	0.109488	903,276	98,898	60
62	Whole Blood & Packed Red Blood Cells	0.305553	56,655	17,311	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.182579	518,144	94,602	65
66	Physical Therapy	0.275920	2,014,438	555,824	66
67	Occupational Therapy	0.222976	1,947,428	434,230	67
68	Speech Pathology	0.420300	298,679	125,535	68
70	Electroencephalography	0.084597	1,640	139	70
71	Medical Supplies Charged to Patients	0.459675	475,247	218,459	71
72	Impl. Dev. Charged to Patients	0.555096	6,912	3,837	72
73	Drugs Charged to Patients	0.197418	2,284,025	450,908	73
74	Renal Dialysis	0.265239	560,380	148,635	74
76.97	CARDIAC REHABILITATION	0.921540			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.412310			90
91	Emergency	0.122285			91
92	Observation Beds (Non-Distinct Part)	0.375451			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		9,778,175	2,232,420	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		9,778,175		202

(A) Worksheet A line numbers

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-0034** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII, Part A** **[XX] Title XIX**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] Swing Bed SNF **[ ] Swing Bed NF** **[ ] ICF/IID**
[XX] PPS **[ ] TEFRA** **[ ] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		892,002		30
31	Intensive Care Unit		101,765		31
41	Subprovider - IRF				41
43	Nursery		443,008		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.217629	335,218	72,953	50
51	Recovery Room	0.285183	32,115	9,159	51
52	Delivery Room & Labor Room	0.605267	67,800	41,037	52
53	Anesthesiology	0.037720	59,749	2,254	53
54	Radiology-Diagnostic	0.114822	166,511	19,119	54
54.01	RADIOLOGY - ULTRASOUND	0.116594	49,361	5,755	54.01
56	Radioisotope	0.150465	14,490	2,180	56
57	CT Scan	0.044115	267,278	11,791	57
59	Cardiac Catheterization	0.083623	122,212	10,220	59
60	Laboratory	0.109488	578,525	63,342	60
62	Whole Blood & Packed Red Blood Cells	0.305553	16,020	4,895	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.182579	121,016	22,095	65
66	Physical Therapy	0.275920	43,123	11,898	66
67	Occupational Therapy	0.222976	17,341	3,867	67
68	Speech Pathology	0.420300	18,799	7,901	68
70	Electroencephalography	0.084597	7,178	607	70
71	Medical Supplies Charged to Patients	0.459675	196,682	90,410	71
72	Impl. Dev. Charged to Patients	0.555096	91,918	51,023	72
73	Drugs Charged to Patients	0.197418	954,577	188,451	73
74	Renal Dialysis	0.265239	19,800	5,252	74
76.97	CARDIAC REHABILITATION	0.921540			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.412310	246	101	90
91	Emergency	0.122285	274,673	33,588	91
92	Observation Beds (Non-Distinct Part)	0.375451	17,202	6,459	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,471,834	664,357	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,471,834		202

(A) Worksheet A line numbers

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-T034** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[XX] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.217629			50
51	Recovery Room	0.285183			51
52	Delivery Room & Labor Room	0.605267			52
53	Anesthesiology	0.037720			53
54	Radiology-Diagnostic	0.114822			54
54.01	RADIOLOGY - ULTRASOUND	0.116594			54.01
56	Radioisotope	0.150465			56
57	CT Scan	0.044115			57
59	Cardiac Catheterization	0.083623			59
60	Laboratory	0.109488			60
62	Whole Blood & Packed Red Blood Cells	0.305553			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.182579			65
66	Physical Therapy	0.275920			66
67	Occupational Therapy	0.222976			67
68	Speech Pathology	0.420300			68
70	Electroencephalography	0.084597			70
71	Medical Supplies Charged to Patients	0.459675			71
72	Impl. Dev. Charged to Patients	0.555096			72
73	Drugs Charged to Patients	0.197418			73
74	Renal Dialysis	0.265239			74
76.97	CARDIAC REHABILITATION	0.921540			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.412310			90
91	Emergency	0.122285			91
92	Observation Beds (Non-Distinct Part)	0.375451			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	9,253,454			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	28,918,318			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	670,932			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	167.98			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	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).				8
8.01	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.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0395			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1525			31
32	Sum of lines 30 and 31	0.1920			32
33	Allowable disproportionate share percentage (see instructions)	0.0523			33
34	Disproportionate share adjustment (see instructions)	499,096			34
		Prior to		**On or after**	
	Uncompensated Care Adjustment	**October 1 (1.00)**	**(1.01)**	**October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,370,786		1,219,956	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	344,569		912,460	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,257,029			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	40,598,829			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	40,598,829			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	3,243,327			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	7,250			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).	28,885			57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	36,137			58
59	Total (sum of amounts on lines 49 through 58)	43,914,428			59
60	Primary payer payments	5,000			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	43,909,428			61
62	Deductibles billed to program beneficiaries	3,805,816			62
63	Coinsurance billed to program beneficiaries	331,891			63
64	Allowable bad debts (see instructions)	546,369			64
65	Adjusted reimbursable bad debts (see instructions)	355,140			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	147,740			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	40,126,861			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (ADD BACK GME REIMBURSEMENT)				70
70.01	OTHER ADJ (NO DESC ENTERED)				70.01
70.02	OTHER ADJUSTMENTS PER PSR				70.02
70.93	HVBP payment adjustment amount (see instructions)	355,584			70.93
70.94	HRR adjustment amount (see instructions)	-579,390			70.94
71	Amount due provider (see instructions)	39,903,055			71
71.01	Sequestration adjustment (see instructions)	798,061			71.01
72	Interim payments	38,936,903			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	168,091			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	495,279			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100

	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	27,459			1
2	Medical and other services reimbursed under OPPS (see instructions)	23,640,809			2
3	PPS payments	23,259,756			3
4	Outlier payment (see instructions)	24,173			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	33,102			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	27,459			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	137,586			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	137,586			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	137,586			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	110,127			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	27,459			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	23,317,031			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	4,332,096			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	19,012,394			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	19,012,394			30
31	Primary payer payments	5,929			31
32	Subtotal (line 30 minus line 31)	19,006,465			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	648,683			34
35	Adjusted reimbursable bad debts (see instructions)	421,644			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	325,119			36
37	Subtotal (see instructions)	19,428,109			37
38	MSP-LCC reconciliation amount from PS&R	95			38
39	Other adjustments (FDO LOSS)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	19,428,014			40
40.01	Sequestration adjustment (see instructions)	388,560			40.01
41	Interim payments	19,140,051			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-100,597			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-T034** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [ ] IPF [XX] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	237			1
2	Medical and other services reimbursed under OPPS (see instructions)	108			2
3	PPS payments	151			3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	237			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	1,200			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	1,200			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	1,200			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	963			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	237			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	151			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	388			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	388			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	388			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	388			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	388			40
40.01	Sequestration adjustment (see instructions)	8			40.01
41	Interim payments	419			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-39			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 15-0034** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				38,448,954		18,588,731	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				487,949		551,320	2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				38,936,903		19,140,051	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 15-T034** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] IPF [XX] IRF [ ] SUB (Other) [ ] SNF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				7,314,557		419	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				7,314,557		419	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	9,735	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	22,274	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	10,639	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	48,609	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	851,620,422	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	21,005,963	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-T034** **WORKSHEET E-3 PART III**

Check Applicable Box: **[ ] Hospital** **[XX] Subprovider IRF**

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	7,333,221		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.030900		2
3	Inpatient Rehabilitation LIP payments (see instructions)	211,930		3
4	Outlier payments	95,825		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	16.616438		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	7,640,976		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	7,640,976		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	7,640,976		19
20	Deductibles	42,896		20
21	Subtotal (line 19 minus line 20)	7,598,080		21
22	Coinsurance	58,072		22
23	Subtotal (line 21 minus line 22)	7,540,008		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	30,871		24
25	Adjusted reimbursable bad debts (see instructions)	20,066		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,134		26
27	Subtotal (sum of lines 23 and 25)	7,560,074		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)	182		29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	7,560,256		32
32.01	Sequestration adjustment (see instructions)	151,205		32.01
33	Interim payments	7,314,557		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	94,494		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	74,799		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)			50
51	Outlier reconciliation adjustment amount (see instructions)			51
52	The rate used to calculate the Time Value of Money (see instructions)			52
53	Time Value of Money (see instructions)			53

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-0034** **WORKSHEET E-3 PART VII**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] NF**	**[XX] PPS**
	[XX] Title XIX	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] TEFRA**
		[ ] SNF		**[ ] Other**

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	1,436,775		8
9	Ancillary service charges	3,471,834		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	4,908,609		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	4,908,609		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,908,609		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs	1,927		26
27	Subtotal (sum of lines 22 through 26)	1,927		27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	1,927		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,927		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	1,927		36
37	OTHER ADJUSTMENTS (TO ZERO OUT SETTLEMENT, SINCE NO ADD)	-1,927		37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-T034** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[ ] Hospital** **[XX] Subprovider IRF** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	122,940		8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	122,940		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	122,940		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	122,940		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	2,298				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	30,268,477				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	6,311,864				7
8	Prepaid expenses	2,055,791				8
9	Other current assets					9
10	Due from other funds	71,485				10
11	Total current assets (sum of lines 1-10)	38,709,915				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	146,599,097				15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	146,599,097				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	7,139,003				34
35	Total other assets (sum of lines 31-34)	7,139,003				35
36	Total assets (sum of lines 11, 30 and 35)	192,448,015				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,320,772				37
38	Salaries, wages and fees payable	6,852,131				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	407,442				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	9,471,954				44
45	Total current liabilities (sum of lines 37 thru 44)	18,052,299				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	536,629				47
48	Unsecured loans					48
49	Other long term liabilities	17,087,473				49
50	Total long term liabilities (sum of lines 46 thru 49)	17,624,102				50
51	Total liabilities (sum of lines 45 and 50)	35,676,401				51
	CAPITAL ACCOUNTS					
52	General fund balance	156,771,614				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	156,771,614				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	192,448,015				60

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		155,965,419			1
2	Net income (loss) (from Worksheet G-3, line 29)		14,962,446			2
3	Total (sum of line 1 and line 2)		170,927,865			3
4	Additions (credit adjustments) (specify)					4
5	TRANSFER OF FUNDS	189,000				5
6	CONTRIBUTIONS	149,599				6
7	RELEASE RESTRICTED ASSETS					7
8						8
9						9
10	Total additions (sum of lines 4-9)		338,599			10
11	Subtotal (line 3 plus line 10)		171,266,464			11
12	Deductions (debit adjustments) (specify)					12
13	TRANSFER FUNDS	14,245,450				13
14	ASSETS RELEASED	249,400				14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		14,494,850			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		156,771,614			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	TRANSFER OF FUNDS					5
6	CONTRIBUTIONS					6
7	RELEASE RESTRICTED ASSETS					7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	TRANSFER FUNDS					13
14	ASSETS RELEASED					14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	62,241,739		62,241,739	1
2	Subprovider IPF				2
3	Subprovider IRF	6,403,269		6,403,269	3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	68,645,008		68,645,008	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	11,179,323		11,179,323	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	11,179,323		11,179,323	16
17	Total inpatient routine care services (sum of lines 10 and 16)	79,824,331		79,824,331	17
18	Ancillary services	293,481,058		293,481,058	18
19	Outpatient services		473,659,683	473,659,683	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		4,667,627	4,667,627	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	373,305,389	478,327,310	851,632,699	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		235,860,875	29
30	Add (specify)			30
31	BAD DEBTS			31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		235,860,875	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	851,632,699	1
2	Less contractual allowances and discounts on patients' accounts	603,435,905	2
3	Net patient revenues (line 1 minus line 2)	248,196,794	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	235,860,875	4
5	Net income from service to patients (line 3 minus line 4)	12,335,919	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	1,250	6
7	Income from investments	113,503	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	936,403	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	5,367	21
22	Rental of hosptial space	1,032,235	22
23	Governmental appropriations	-22,035	23
24	Other (OTHER OPERATING INCOME)	193,586	24
24.01	Other (CARDIO INCOME)		24.01
24.02	Other (RELEASED TEMP ASSETS)	59,655	24.02
24.03	Other (LAB INCOME)	89,592	24.03
24.04	Other (THERAPY INCOME)		24.04
24.05	Other (LAMAZE CLASSES)	101,739	24.05
24.06	Other (PHOTOGRAPHIC FEES)	5,337	24.06
24.07	Other (GAIN ON SALE OF ASSETS)	109,895	24.07
24.08	Other (ROUNDING)		24.08
25	Total other income (sum of lines 6-24)	2,626,527	25
26	Total (line 5 plus line 25)	14,962,446	26
29	Net income (or loss) for the period (line 26 minus line 28)	14,962,446	29

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 15-7313** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	711,521	383,473			139,245	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	907,483		59,550		4,007	6
7	Physical Therapy	36,585			584,260		7
8	Occupational Therapy	12,500			115,950		8
9	Speech Pathology				41,290		9
10	Medical Social Services	22,243					10
11	Home Health Aide	119,402		13,824			11
12	Supplies (see instructions)					181,312	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	1,809,734	383,473	73,374	741,500	324,564	24

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 15-7313** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	1,234,239	-279,621	954,618	-2,002	952,616	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	971,040		971,040		971,040	6
7	Physical Therapy	620,845		620,845		620,845	7
8	Occupational Therapy	128,450		128,450		128,450	8
9	Speech Pathology	41,290		41,290		41,290	9
10	Medical Social Services	22,243		22,243		22,243	10
11	Home Health Aide	133,226		133,226		133,226	11
12	Supplies (see instructions)	181,312		181,312		181,312	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	3,332,645	-279,621	3,053,024	-2,002	3,051,022	24

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

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 15-7313** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	952,616				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	971,040				6
7	Physical Therapy	620,845				7
8	Occupational Therapy	128,450				8
9	Speech Pathology	41,290				9
10	Medical Social Services	22,243				10
11	Home Health Aide	133,226				11
12	Supplies (see instructions)	181,312				12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	3,051,022				24

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 15-7313** **WORKSHEET H-1 PART I**

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		952,616	952,616		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		971,040	438,321	1,409,361	6
7	Physical Therapy		620,845	280,244	901,089	7
8	Occupational Therapy		128,450	57,981	186,431	8
9	Speech Pathology		41,290	18,638	59,928	9
10	Medical Social Services		22,243	10,040	32,283	10
11	Home Health Aide		133,226	60,137	193,363	11
12	Supplies (see instructions)		181,312	87,255	268,567	12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		3,051,022		3,051,022	24

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 15-7313** **WORKSHEET H-1 PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-952,616	2,110,397	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						971,040	6
7	Physical Therapy						620,845	7
8	Occupational Therapy						128,450	8
9	Speech Pathology						41,290	9
10	Medical Social Services						22,243	10
11	Home Health Aide						133,226	11
12	Supplies (see instructions)					11,991	193,303	12
13	Drugs							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-940,625	2,110,397	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						952,616	25
26	Unit Cost Multiplier						0.451392	26

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 15-7313** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINTENACE OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
1	Administrative and General				265,560	29,822	17,992	1
2	Skilled Nursing Care	1,409,361						2
3	Physical Therapy	901,089						3
4	Occupational Therapy	186,431						4
5	Speech Pathology	59,928						5
6	Medical Social Services	32,283						6
7	Home Health Aide	193,363						7
8	Supplies	268,567						8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	3,051,022			265,560	29,822	17,992	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 15-7313** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	PURCHASING RECEIVING & STORES	PATIENT REGISTRATN	PATIENT ACCOUNTING	SUBTOTAL (cols.0-4)	ADMINI-STRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	
		5.02	5.03	5.04	4A	5.05	6	
1	Administrative and General	10,045	12,467	14,274	350,160	50,379		1
2	Skilled Nursing Care				1,409,361	202,772		2
3	Physical Therapy				901,089	129,644		3
4	Occupational Therapy				186,431	26,823		4
5	Speech Pathology				59,928	8,622		5
6	Medical Social Services				32,283	4,645		6
7	Home Health Aide				193,363	27,820		7
8	Supplies				268,567	38,640		8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	10,045	12,467	14,274	3,401,182	489,345		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 15-7313** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)							20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 15-7313** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	
		13	14	15	16	17	19	
1	Administrative and General				19,590			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)				19,590			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 15-7313** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS	
		23	24	25	26	27	28	
1	Administrative and General		420,129		420,129			1
2	Skilled Nursing Care		1,612,133		1,612,133	194,071	1,806,204	2
3	Physical Therapy		1,030,733		1,030,733	124,081	1,154,814	3
4	Occupational Therapy		213,254		213,254	25,672	238,926	4
5	Speech Pathology		68,550		68,550	8,252	76,802	5
6	Medical Social Services		36,928		36,928	4,445	41,373	6
7	Home Health Aide		221,183		221,183	26,626	247,809	7
8	Supplies		307,207		307,207	36,982	344,189	8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		3,910,117		3,910,117	420,129	3,910,117	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.120381		21

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

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 15-7313** **WORKSHEET H-2 PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINTENACE OF PERSONNEL NUMBER OF FTES	NONPATIENT TELEPHONES NUMBER OF PHONES	PURCHASING RECEIVING & STORES SUPPLY EXPENSE	
		1	2	4	4.01	5.01	5.02	
1	Administrative and General			1,809,734	2,312	27	17,399	1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)			1,809,734	2,312	27	17,399	20
21	Total cost to be allocated			265,560	29,822	17,992	10,045	21
22	Unit Cost Multiplier			0.146740		666.370370		22
22	Unit Cost Multiplier				12.898789		0.577332	22

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 15-7313** **WORKSHEET H-2 PART II**

	HHA COST CENTER	PATIENT REGISTRATN GROSS REVENUE	PATIENT ACCOUNTING GROSS REVENUE	RECON-CILIATION	ADMINI-STRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.03	5.04	4A.05	5.05	6	7	
1	Administrative and General	4,667,628	4,667,628		350,160			1
2	Skilled Nursing Care				1,409,361			2
3	Physical Therapy				901,089			3
4	Occupational Therapy				186,431			4
5	Speech Pathology				59,928			5
6	Medical Social Services				32,283			6
7	Home Health Aide				193,363			7
8	Supplies				268,567			8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	4,667,628	4,667,628		3,401,182			20
21	Total cost to be allocated	12,467	14,274		489,345			21
22	Unit Cost Multiplier	0.002671						22
22	Unit Cost Multiplier		0.003058		0.143875			22

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 15-7313** **WORKSHEET H-2 PART II**

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA NUMBER OF FTES	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS-TRATION NURSING HOURS	
		8	9	10	11	12	13	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 15-7313** **WORKSHEET H-2 PART II**

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY SUPPLY EXPENSE	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	
		14	15	16	17	19	23	
1	Administrative and General			4,667,628				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)			4,667,628				20
21	Total cost to be allocated			19,590				21
22	Unit Cost Multiplier			0.004197				22
22	Unit Cost Multiplier							22

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation

	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	1,806,204		1,806,204	17,939	100.69	1
2	Physical Therapy	3	1,154,814		1,154,814	8,661	133.33	2
3	Occupational Therapy	4	238,926		238,926	2,150	111.13	3
4	Speech Pathology	5	76,802		76,802	518	148.27	4
5	Medical Social Services	6	41,373		41,373	276	149.90	5
6	Home Health Aide	7	247,809		247,809	4,165	59.50	6
7	Total (sum of lines 1-6)		3,565,928		3,565,928	33,709		7

Limitation Cost Comoputation

			Program Visits		
				PART B	
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1	2	3	4
8	Skilled Nursing Care	23844		10,970		8
8.01	Skilled Nursing Care	33140		10		8.01
8.02	Skilled Nursing Care	99915		6		8.02
9	Physical Therapy	23844		4,908		9
9.01	Physical Therapy	33140		9		9.01
9.02	Physical Therapy	99915				9.02
10	Occupational Therapy	23844		1,338		10
10.01	Occupational Therapy	33140				10.01
10.02	Occupational Therapy	99915				10.02
11	Speech Pathology	23844		253		11
11.01	Speech Pathology	33140				11.01
11.02	Speech Pathology	99915				11.02
12	Medical Social Services	23844		159		12
12.01	Medical Social Services	33140		4		12.01
12.02	Medical Social Services	99915				12.02
13	Home Health Aide	23844		2,799		13
13.01	Home Health Aide	33140		4		13.01
13.02	Home Health Aide	99915				13.02
14	Total (sum of lines 8-13)			20,460		14

Supplies and Drugs Cost Computations

	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8	344,189		344,189	358,165	0.960979	15
16	Cost of Drugs	9						16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.275845			col. 2, line 2	1
2	Occupational Therapy	67	0.222976			col. 2, line 3	2
3	Speech Pathology	68	0.420300			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.459675			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.197418			col. 2, line 16	5

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 15-7313** **WORKSHEET H-3**
PARTS I & II

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
			Part B			Part B			
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		10,986			1,106,180		1,106,180	1
2	Physical Therapy		4,917			655,584		655,584	2
3	Occupational Therapy		1,338			148,692		148,692	3
4	Speech Pathology		253			37,512		37,512	4
5	Medical Social Services		163			24,434		24,434	5
6	Home Health Aide		2,803			166,779		166,779	6
7	Total (sum of lines 1-6)		20,460			2,139,181		2,139,181	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6	7	8	9	10	11	
15	Cost of Medical Supplies			300,716			288,982	15
16	Cost of Drugs							16

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 15-7313** **WORKSHEET H-4**
PARTS I & II

Check applicable box: **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to excced 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts		6,277		9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)		-6,277	10
11	Total PPS Reimbursement - Full Episodes without Outliers		2,346,438	11
12	Total PPS Reimbursement - Full Episodes with Outliers		234,855	12
13	Total PPS Reimbursement - LUPA Episodes		36,369	13
14	Total PPS Reimbursement - PEP Episodes		21,616	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		57,723	15
16	Total PPS Outlier Reimbursement - PSP Episodes		675	16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		2,691,399	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		2,691,399	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		2,691,399	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		2,691,399	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		2,691,399	31
31.01	Sequestration adjustment (see instructions)		53,828	31.01
32	Interim payments (see instructions)		2,637,571	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 15-7313** **WORKSHEET H-5**

				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider						2,637,571	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	To	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		To	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)						2,637,571	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		To	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		To	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due)		.01					6.01
	based on the cost report (see instructions)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date: Month, Day, Year		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 15:29 Version: 2017.10 (10/09/2017)

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 15-0034** **WORKSHEET L**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] SUB (Other)**	**[ ] Cost Method**
	[ ] Title XIX		

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	3,083,250	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	37,672	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	133.79	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0395	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1525	8
9	Sum of lines 7 and 8	0.1920	9
10	Allowable disproportionate share percentage (see instructions)	0.0397	10
11	Disproportionate share adjustment (see instructions)	122,405	11
12	Total prospective capital payments (see instructions)	3,243,327	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 15-0034** **WORKSHEET L**

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[XX] PPS** **[ ] Cost Method**

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)		12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
41	Subprovider - IRF							41
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY - ULTRASOUND							54.01
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	OTHER NON-REIMBURSEABLE COST CENTERS							194
194.01	OTHER NONREIMBURSABLE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202