This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-0064 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/28/2024 8:02 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 2/28/2024 Time: 8:02 pm ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY MEDICAL CENTER (14-0064) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		ELECTRONI C SI GNATURE STATEMENT	
1	,		I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-87, 341	-71, 289	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
10.00	RURAL HEALTH CLINIC (RHC) I	0		50, 693		0	10. 00
10. 01	RURAL HEALTH CLINIC (RHC) II	0		817		0	10. 01
10. 02	RURAL HEALTH CLINIC (RHC) III	0		52, 630		0	10. 02
10. 03	RURAL HEALTH CLINIC (RHC) IV	0		11, 662		0	10. 03
10.04	RURAL HEALTH CLINIC (RHC) V	0		10, 760		0	10. 04
200.00	TOTAL	0	-87, 341	55, 273	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems ST. MARY MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0064 Peri od: Worksheet S-2 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/28/2024 8:02 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 3333 N SEMINARY 1.00 PO Box: 1.00 2.00 City: GALESBURG State: IL Zip Code: 61401 County: KNOX 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST. MARY MEDICAL CENTER 140064 99914 07/01/1966 Ν 3.00 Hospi tal Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF 5 00 Subprovi der - (Other) 6.00 6.00 7.00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospi tal -Based HHA 12.00 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital-Based Health Clinic - RHC OSF HEALTHCARE -99914 N 148651 03/02/2023 0 15.00 N MEDICAL GROUP - SEM Hospital-Based Health Clinic - RHC OSF PROMPTCARE -148646 99914 15.01 03/02/2023 0 Ν GALESBURG Hospital-Based Health Clinic - RHC OSF HEALTHCARE -148645 99914 03/02/2023 Ν 0 Ν 15.02 15.02 MEDICAL GROUP - GAL IIIIHospital-Based Health Clinic - RHC OSF HEALTHCARE -99914 03/02/2023 N 15.03 15.03 148648 N 0 MEDICAL GROUP - KNO I V Hospital-Based Health Clinic - RHC VOSF HEALTHCARE -148638 99914 03/02/2023 15.04 Ν 0 15.04 MEDICAL GROUP - ABI 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17 00 17 00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2022 09/30/2023 20.00 21.00 Type of Control (see instructions) 21.00 1 2. 00 1. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 Υ disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 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) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν 22.02 determined at cost report settlement? (see instructions) Enter in column period prior to October 1. Enter in column 2, "Y" for yes or "N" for no,

Ν

Ν

Ν

22.03

22.04

for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to

22.04 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

rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

yes or "N" for no.

yes or "N" for no.

Heal th	Financial Systems ST. MA	RY MEDICAL	CENTER			In Lie	u of F	orm CMS-2	2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ιΤΑ	Provi der CC	CN: 14-0064	Period: From 10/0 To 09/3	01/2022 30/2023	Part Date/	Time Pre	pared:
							2/28/	<u>/2024 8: 0</u>	2 pm
23. 00	Which method is used to determine Medicaid days on li	nes 24 and	1/or 25	1. 00		00 V	3	3. 00	23. 00
20.00	below? In column 1, enter 1 if date of admission, 2 i if date of discharge. Is the method of identifying the reporting period different from the method used in the reporting period? In column 2, enter "Y" for yes or	f census one days in the prior co	days, or 3 this cost ost						20.00
		In-State Medicaid paid days	In-State Medicaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da		Other ledi cai d days	
24 00	If this provider is an IPPS hospital, enter the	1. 00 597	2. 00 7 621	3.00	4. 00	5. 00	473	6. 00	24. 00
	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. If this provider is an IRF, enter the in-state	377			0	·	0	33	25. 00
25.00	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		)						25. 00
						Rural S 00		of Geogr 2.00	
26. 00	Enter your standard geographic classification (not was cost reporting period. Enter "1" for urban or "2" for		at the beg	ginning of t	he	2			26. 00
27. 00	Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status ^ "2" for r	rural. If ap		t	2			27. 00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		ni ng:	Fn	di ng:	35. 00
24.00	To 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0/ 6	1.	00	2	2. 00	0, 00
	Enter applicable beginning and ending dates of SCH stop of periods in excess of one and enter subsequent date of this is a Medicare dependent hospital (MDH), enter	es.	•			/2022 0	09/3	30/2023	36. 00 37. 00
	is in effect in the cost reporting period.  Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for	ne MDH tran	nsitional pa	ayment in	is	O			37. 01
38. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	s of MDH st	atus. If li	ne 37 is					38. 00
	enter subsequent dates.	·			V	/N		Y/N	
					1.	00		2. 00	
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii)	), (ii), or the mileage	(iii)? Ent e requiremer	ter in colum nts in	ın	N		N	39. 00
40. 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	oer 1. Ente	er "Y" for y			N		N	40. 00
			,			1. 00	XVI I		
45. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for disp	proporti onat	te share in	accordance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N	N	N	46. 00
47. 00 48. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47. 00 48. 00
56.00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter "cost reporting periods beginning on or after December the instructions. For column 2, if the response to coinvolved in training residents in approved GME programd are you are impacted by CR 11642 (or applicable 0"Y" for yes; otherwise, enter "N" for no in column 2.	'Y" for yes 27, 2020, olumn 1 is ams in the CRs) MA dir	or "N" for under 42 ( "Y", or if prior year	no in colu CFR 413.78(b this hospit or penultim	mn 1. For )(2), see al was ate year,	N			56. 00

Health Financial Systems ST. MARY MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0064 Peri od: Worksheet S-2 From 10/01/2022 To 09/30/2023 Part I Date/Time Prepared: 2/28/2024 8: 02 pm XVIII XIX 1. 00 2.00 3.00 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 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 Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as Ν 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for Ν 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in 0 00 0 00 61 00 N column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 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) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name Direct GME FTE FTE Count Count 1.00 2. 00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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 the IME FTE unweighted count. Enter in column 4,

the direct GME FTE unweighted count.

ealth Financial Systems		RY MEDICAL CENTER			u of Form CMS-2	
IOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DAT	FA Provider CO		Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Pre 2/28/2024 8:0	pared:
					1.00	
2.00 Enter the number of FTE residents your hospital received HRSA PCRE	s that your hospital	trained in this cost		riod for which	0.00	62. 0
2.01 Enter the number of FTE residents during in this cost reporting per	s that rotated from a riod of HRSA THC prog	Teaching Health Cen ram. (see instruction		o your hospital	0.00	62.0
Teaching Hospitals that Claim Res 3.00 Has your facility trained resider "Y" for yes or "N" for no in colu	nts in nonprovider se	ttings during this co			N	63. (
The year of the form core	amir r. rr yes, compre	te rines or through	Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
-			1. 00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after Ju			This base yea	r is your cost r	reporting	
4.00 Enter in column 1, if line 63 is in the base year period, the number resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column)	yes, or your facility per of unweighted non- tations occurring in a number of unweighted ur hospital. Enter in	y trained residents -primary care all nonprovider non-primary care column 3 the ratio	0. 0	0.00	0. 000000	64. (
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5. 00 0. 000000	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			University of the second	Unweighted	Datia (asl. 1/	
			Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current		Nonprovider Setting				
beginning on or after July 1, 20° 6.00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpro unweighted non-primar al. Enter in column 3	ovider settings. y care resident the ratio of	0. (	0.00	0. 000000	66. (
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	

Health Financial Systems ST. MARY MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0064 Peri od: Worksheet S-2 From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/28/2024 8:02 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 67.00 67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)
68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your 68.00 MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1. 00 2. 00 3. 00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71 00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no.

If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85 00 N 85 00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adjustment Permanent (Y/N) Adjustments 1.00 2.00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target 0 88.00 Ν amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.

Health Financial Systems ST. MARY MEDI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	CN: 14-0064	Peri od·	u of Form CMS- Worksheet S-2	
			From 10/01/2022 To 09/30/2023	Part I Date/Time Pre 2/28/2024 8:0	epared:
		Wkst. A Lin	e Effective Date		)E piii
		No.		Permanent Adjustment Amount Per	
		1. 00	2.00	Di scharge 3.00	+
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A I on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA taper discharge.  Column 3: Enter the amount of the approved permanent adjustment.	s based. g period arget amount	0.1			89.00
TEFRA target amount per discharge.				VI V	
			1. 00	XI X 2. 00	+
Title V and XIX Services			1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.			N N	Y N	90.00
full or in part? Enter "Y" for yes or "N" for no in the appl	P1.00 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. P2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see				
instructions) Enter "Y" for yes or "N" for no in the applica 93.00 Does this facility operate an ICF/IID facility for purposes	able column.		N	N	93. 00
"Y" for yes or "N" for no in the applicable column.  94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	o in the	N	N	94. 00
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 00 96. 00
97.00   If line 96 is "Y", enter the reduction percentage in the app 98.00   Does title V or XIX follow Medicare (title XVIII) for the ir stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	iterns and resi	dents post	0. 00 N	0. 00 N	97. 00 98. 00
column 1 for title V, and in column 2 for title XIX.  98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.				Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.			N	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.				N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no ir in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a column 2 for title XIX.	ack the RCE dis column 1 for ti	sallowance on tle V, and i	n N	Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98. 06
Rural Providers  105.00 Does this hospital qualify as a CAH?  106.00 If this facility qualifies as a CAH, has it elected the all-	inclusive meth	nod of paymen	N t		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for column training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IF	n 1. (see ins you train I&Rs PF and/or IRF (	tructions) s in an			107. 00
Enter "Y" for yes or "N" for no in column 2. (see instructi		dul 62 - Soo 42	N		100 00

for outpatient services? (see instructions)			
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R			107.00
training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)			
Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an			
approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?			
Enter "Y" for yes or "N" for no in column 2. (see instructions)			
108.00 s this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42	N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			
Physi cal Occupati onal	Speech	Respi ratory	
1.00 2.00	3.00	4. 00	
109.00 If this hospital qualifies as a CAH or a cost provider, are N N	N	N	109.00
therapy services provided by outside supplier? Enter "Y"			
for yes or "N" for no for each therapy.			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C	F	eri od: rom 10/01/2022 o 09/30/2023	u of Form CMS Worksheet S- Part I Date/Time Pr 2/28/2024 8:	2 epared:
			1.00	_
10.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, l applicable.	"N" for no. I1	yes,	N	110. C
		1. 00	2.00	+
11.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.	N N	2, 00	111. (
	1. 00	2. 00	3.00	+
12.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112. (
Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, \$2208.1.	N			0115. 0
16.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116. 0
17.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.  18.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1	Y			117. (
if the policy is claim-made. Enter 2 if the policy is occurrence.				110.
	Premi ums	Losses	I nsurance	
18.01 List amounts of malpractice premiums and paid losses:	1. 00	2.00	3. 00 546, 36	4 118 (
Total Control of man processes promise and para 1000000	7 07.1, 7.10			11101
18.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing c		1. 00 N	2.00	118.
and amounts contained therein.  19.00 DO NOT USE THIS LINE  20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for t Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no.	" for yes or he Outpatient	N	Y	119. 120.
21.00 Did this facility incur and report costs for high cost implantable device	es charged to	Y		121.
patients? Enter "Y" for yes or "N" for no.		N		122.
22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ente	er in corumn 2			
22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated org located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no.	sional and/or 1, enter "Y" 1, 50% of total ganizations	Y		123.
22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated org located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no.  Certified Transplant Center Information	sional and/or 1, enter "Y" 1,50% of total Janizations Y" for yes or			
22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.  23.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated org located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no.  Certified Transplant Center Information  25.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	sional and/or 1, enter "Y" 50% of total Janizations Y" for yes or	Y N		125.
<ul> <li>22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> <li>23.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated org located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no.  Certified Transplant Center Information</li> <li>25.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare-certified kidney transplant program, enter the cert in column 1 and termination date, if applicable, in column 2.</li> </ul>	sional and/or 1, enter "Y" 50% of total ganizations Y" for yes or "Y" for yes			125. 126.
<ul> <li>22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> <li>23.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated org located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no.  Certified Transplant Center Information</li> <li>25.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare-certified kidney transplant program, enter the cert in column 1 and termination date, if applicable, in column 2.</li> <li>27.00 If this is a Medicare-certified heart transplant program, enter the certified this is a Medicare-certified heart transplant program, enter the certified this is a Medicare-certified heart transplant program, enter the certified this is a Medicare-certified heart transplant program, enter the certified this is a Medicare-certified heart transplant program, enter the certified this is a Medicare-certified heart transplant program, enter the certified this is a Medicare-certified heart transplant program, enter the certified this is a Medicare-certified heart transplant program, enter the certified this is a Medicare-certified heart transplant program, enter the certified transplant program, enter the certified transplant program.</li> </ul>	sional and/or 1, enter "Y" 50% of total ganizations Y" for yes or "Y" for yes dification date fication date			123. 125. 126. 127. 128.

		DI CAL CENTER	1 14 00/4	D!!		u of Form CMS	
OSPITAL AND HOSPITAL HEALTH CARE COMPLEX	* IDENTIFICATION DATA	Provider CCN	1: 14-0064		0/01/2022 9/30/2023	Worksheet S- Part I Date/Time Pr 2/28/2024 8:	epared
					1. 00	2.00	_
31.00   If this is a Medicare-certified in			erti fi cati o				131. (
date in column 1 and termination d 32.00 If this is a Medicare-certified is in column 1 and termination date,	let transplant program, e	enter the certifi	cation date	е			132. (
33.00 Removed and reserved	ii appircabre, iii corumii	۷.					133. (
84.00 If this is a hospital-based organ in column 1 and termination date, All Providers			e OPO numbe	r			134. (
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. If home office chain number	f yes, and home o r. (see instructi	office cost	S	Y	HB1728	140. (
1.00 If this facility is part of a chai		00 lines 141 throug	ah 143 the	name and	3.00 Laddress	of the	
home office and enter the home off	ice contractor name and o	contractor number	r.				
41.00 Name: OSF HEALTHCARE SYSTEM	Contractor's Name: W	VISCONSIN PHYSICIA SERVICE	AN Contract	tor's Nu	mber: 0590	11	141. (
42.00 Street: 124 SW ADAMS	PO Box:	ERVIOL					142. (
43.00 City: PEORIA	State: I	L	Zi p Code	e:	6160	12	143.
						1.00	
44.00 Are provider based physicians' cos	ts included in Worksheet	A?				Y	144.
					1. 00	2. 00	-
45.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no ir lude Medicare utilization	n column 1. If co	olumn 1 is				145.
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	y changed from the previous column 1. (See CMS Pub.			f	N		146.
						1.00	
17.00 Was there a change in the statisti 18.00 Was there a change in the order of	allocation? Enter "Y" fo	or yes or "N" for	no.			N N	147. 148.
49.00 Was there a change to the simplifi	ed cost finding method? E	Enter "Y" for yes Part A	Part B		itle V	N Title XIX	149.
		1.00	2.00		3.00	4. 00	
Does this facility contain a provi or charges? Enter "Y" for yes or "							
5.00 Hospi tal	11 10 10 10 0001 00mpo.	N	N	(000 12	N	N	
					N.I.		
		N N	N		N	N	156.
7.00 Subprovi der - I RF		N N	N N		N N	N N	156. 157.
57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF		1	N N				156. 157. 158. 159.
57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY		N	N N N		N N N	N N N	156. 157. 158. 159. 160.
57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY		N N	N N		N N	N N N N	156. 157. 158. 159. 160.
57.00 Subprovider - IRF 88.00 SUBPROVIDER 99.00 SNF 90.00 HOME HEALTH AGENCY 11.00 CMHC		N N	N N N		N N N	N N N	155. 156. 157. 158. 159. 160. 161.
66.00 Subprovider - IPF 67.00 Subprovider - IRF 68.00 SUBPROVIDER 69.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC  Multicampus 65.00 Is this hospital part of a Multica	mpus hospital that has or	N N N	N N N N	erent CB	N N N	N N N N	156. 157. 158. 159. 160.
67.00 Subprovider - IRF 68.00 SUBPROVIDER 69.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC	· · · · · · · · · · · · · · · · · · ·	N N N	N N N N		N N N N	N N N N 1.00	156. 157. 158. 159. 160. 161.
7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multica	mpus hospital that has or  Name  0	N N N	N N N N	erent CB	N N N	N N N N	156. 157. 158. 159. 160. 161.
7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	Name	N N N	N N N N Sees in diffe	ip Code	N N N N SAs?	N N N N 1.00  N FTE/Campus 5.00	156. 157. 158. 159. 160. 161.
7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 is this hospital part of a Multica Enter "Y" for yes or "N" for no.  6.00 if line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name	N N N	N N N N Sees in diffe	ip Code	N N N N SAs?	N N N N N N N N N N N N N N N N N N N	156. 157. 158. 159. 160. 161.
7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 is this hospital part of a Multica Enter "Y" for yes or "N" for no.  6.00 if line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name 0	ne or more campus  County 1.00	N N N N Sees in diffe	i p Code 3.00	N N N N SAs?	N N N N 1.00  N FTE/Campus 5.00	156. 157. 158. 159. 160. 161.
7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10	Name 0  incentive in the Americ under \$1886(n)? Enter " is is "Y") and is a meanir	ne or more campus  County 1.00  can Recovery and "Y" for yes or "N ngful user (line	N N N N Sees in diffe  State Z 2.00  Reinvestme	ip Code 3.00	N N N N SAs?	N N N N N N N N N N N N N N N N N N N	156. 157. 158. 159. 160. 161.
7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT 7.00 Is this provider a meaningful user	Name 0  O  incentive in the Americ under §1886(n)? Enter " is is "Y") and is a meanir IIT assets (see instruction	ne or more campus  County 1.00  can Recovery and "Y" for yes or "M ngful user (line ons)	N N N N N N N N N N N N N N N N N N N	ip Code 3.00	N N N N SAs? CBSA 4.00	N N N N N N N N N N N N N N N N N N N	156. 157. 158. 159. 160. 161. 165. 00 166.

Health Financial Systems ST. MARY MEDICA	9				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					
		From 10/01/2022			
		To 09/30/2023	Date/Time Pre 2/28/2024 8:0		
				2 piii	
		Begi nni ng	Endi ng		
		1. 00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date period respectively (mm/dd/yyyy)			170. 00		
		1. 00	2.00	1	
171.00 If line 167 is "Y", does this provider have any days for indi	viduals enrolled in	N	C	171. 00	
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter				
"Y" for ves and "N" for no in column 1. If column 1 is ves. e	nter the number of section	n l			
period respectively (mm/dd/yyyy)  171.00  f   line 167 is "Y", does this provider have any days for indi	viduals enrolled in , line 2, col. 6? Enter	1. 00 N	2.00		

Health Financial Systems ST. MARY MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-0064 Peri od: Worksheet S-2 From 10/01/2022 Part II Date/Time Prepared: 09/30/2023 2/28/2024 8:02 pm Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost 1.00 N reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 4 00 Α 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. 5 00 Are the cost report total expenses and total revenues different from 5 00 Ν those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Υ 13.00 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part B Y/N Y/N Date Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 12/14/2023 12/14/2023 17 00 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed Ν Ν 18.00 but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

110011	Financial Systems ST. MARY MEDI TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN	l: 14-0064	Peri od:	u of Form CMS-2 Worksheet S-2		
				From 10/01/2022 To 09/30/2023	Part II Date/Time Pre		
		Descrip	nti on	Y/N	2/28/2024 8: 0. Y/N	2 pm	
		0		1.00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	incport data for other: bescribe the other day astments.	Y/N	Date	Y/N	Date		
	I 5	1.00	2. 00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 0	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS HO	SPI TALS)		1. 00		
	Capital Related Cost						
2.00	Have assets been relifed for Medicare purposes? If yes, see					22.0	
3. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to appraisa	Is made dur	ring the cost		23. 0	
4. 00	00 Were new leases and/or amendments to existing leases entered into during this cost reporting period?						
5. 00	Have there been new capitalized leases entered into during instructions.	the cost report	ing period?	Plf yes, see		25. 0	
6. 00	0 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see						
7. 00	instructions. Has the provider's capitalization policy changed during the	e cost reporting	period? If	yes, submit		27. 0	
	copy. Interest Expense	· · · ·		-			
8. 00	Were new Loans, mortgage agreements or Letters of credit er	ntered into duri	ng the cost	reporting		28. 0	
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (Deb	t Service F	Reserve Fund)		29.0	
0. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	ructions urity with new d	eht? If ves	See		30.0	
	instructions.						
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance or new d	ebt? IT yes	s, see		31.0	
2. 00	Purchased Services Have changes or new agreements occurred in patient care ser		through co	ontractual		32. 0	
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		to competi	tive hidding? If		33.0	
3.00	no, see instructions.		to competi	tive bruding: 11		33.0	
	Provi der-Based Physi ci ans						
4. 00	Were services furnished at the provider facility under an a lf yes, see instructions.	arrangement with	provi der-t	pased physicians?		34.0	
5. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		s with the	provi der-based		35. C	
	physicians during the cost reporting period: 11 yes, see it	istructions.		Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
	Were home office costs claimed on the cost report?		661	_		36.0	
7. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the h	ome office:	'		37.0	
	If line 36 is yes , was the fiscal year end of the home off			-		38. 0	
8. 00	the provider? If yes, enter in column 2 the fiscal year end		5,		39. C		
	If line 36 is yes, did the provider render services to other	er chain compone					
9. 00	If line 36 is yes, did the provider render services to othe see instructions.	•	,			40 0	
9. 00	If line 36 is yes, did the provider render services to other	•	,			40. 0	
9. 00	If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	home office? I	f yes, see	2	00	40. 0	
9. 00	If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	•	f yes, see	2.	00	40. 0	
9. 00	If line 36 is yes, did the provider render services to othe see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information	home office? I	f yes, see	2. SPRI NGER	00	40. 0	
9. 00	If line 36 is yes, did the provider render services to othe see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	home office? I	f yes, see		00	41. 0	
38. 00 39. 00 40. 00 41. 00 42. 00	If line 36 is yes, did the provider render services to othe see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report preparer.	home office? I	f yes, see				

Heal th	Health Financial Systems ST. MARY ME				DICAL CENTER In Lieu				2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NNAI RE		Provi der	CCN: 14-0064		ri od: om 10/01/2022 09/30/2023		epared:
	<u> </u>					ш,		2/28/2024 8:0	)2 pm
					3. 00				
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title/pos	si ti on	ST	RATEGIC RE	IMBURSEMENT				41.00
	held by the cost report preparer in columns 1, 2,	and 3	3, CC	NSULTANT					
	respecti vel y.								
42.00	Enter the employer/company name of the cost repor	t							42.00
	preparer.								
43.00	Enter the telephone number and email address of t	he cos	st						43.00
	report preparer in columns 1 and 2, respectively.								
	•		•						•

| Peri od: | Worksheet S-3 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: Health Financial Systems ST. MA
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-0064

						То	09/30/2023	Date/Time Pr 2/28/2024 8:		
								1/P Days / 0/I		pili
								Visits / Trips		
	Component	Worksheet A	No	of Beds	Bed Days	C	AH/REH Hours	Title V	+	
	55p51.6172	Li ne No.		0. 5040	Avai I abl e	ľ	, and the first thousand			
		1.00		2.00	3.00		4. 00	5. 00	T	
	PART I - STATISTICAL DATA									
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		72	26, 28	0	0.00	(	0	1.00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days) (see instructions for col. 2									
	for the portion of LDP room available beds)								1	
2.00	HMO and other (see instructions)								1	2. 00
3.00	HMO IPF Subprovider								-	3. 00
4.00	HMO IRF Subprovider							,	اه	4. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF									5. 00 6. 00
7. 00	Total Adults and Peds. (exclude observation			72	26, 28		0. 00			7. 00
7.00	beds) (see instructions)			12	20, 20	٩	0.00	`	٦	7.00
8. 00	INTENSIVE CARE UNIT	31. 00		9	3, 28	5	0. 00	(	ol	8. 00
9. 00	CORONARY CARE UNIT	011 00		ŕ	0,20		0.00			9. 00
10.00	BURN INTENSIVE CARE UNIT								1	10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT								1	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)								1	12.00
13.00	NURSERY	43. 00						(	0	13.00
14.00	Total (see instructions)			81	29, 56	5	0.00	(	0	14.00
15. 00	CAH visits							(	0	15. 00
15. 10	REH hours and visits								- 1	15. 10
16. 00	SUBPROVI DER - I PF									16. 00
17.00	SUBPROVI DER - I RF									17. 00
18.00	SUBPROVI DER								- 1	18.00
19.00	SKILLED NURSING FACILITY									19. 00
20.00	NURSING FACILITY								- 1	20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY									21. 00 22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )								- 1	23. 00
24. 00	HOSPI CE								- 1	24. 00
24. 10	HOSPICE (non-distinct part)	30. 00								24. 10
25. 00	CMHC - CMHC	00.00							- 1	25. 00
26. 00	RURAL HEALTH CLINIC (RHC)	88. 00						(		26. 00
26. 01	RURAL HEALTH CLINIC (RHC)	88. 01						(		26. 01
26. 02	RURAL HEALTH CLINIC (RHC)	88. 02						(	0	26. 02
26. 03	RURAL HEALTH CLINIC (RHC)	88. 03						(	0	26. 03
26. 04	RURAL HEALTH CLINIC (RHC)	88. 04						(	0	26. 04
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						(	0	26. 25
27. 00	Total (sum of lines 14-26)			81						27. 00
28. 00	Observation Bed Days							(	- 1	28. 00
29. 00	Ambul ance Tri ps								-	29. 00
30.00	Employee discount days (see instruction)								-	30.00
31.00	Employee discount days - IRF			_					- 1	31. 00
32. 00	Labor & delivery days (see instructions)			0	1	0			-	32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)									32. 01
33. 00	LTCH non-covered days								-	33. 00
33. 01	LTCH site neutral days and discharges									33. 01
	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0		o		(		34. 00
	•				•		,			

		_				2/28/2024 8:0	2 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6. 00	7. 00	Patients 8.00	& Residents 9.00	Payrol I 10. 00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	9.00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 006	491	13, 048			1.00
1.00	8 exclude Swing Bed, Observation Bed and	3,000	471	13, 040	,		1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	4, 453	3, 094				2.00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	o	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	l	)		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C	)		6. 00
7. 00	Total Adults and Peds. (exclude observation	5, 006	491	13, 048			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	684	67	1, 729	1		8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		39	1, 005			13.00
14.00	Total (see instructions)	5, 690	597	15, 782	0.00	469. 92	14. 00
15.00	CAH visits	o	0	C	)		15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC (RHC)	4, 036	5, 897	22, 218		•	
26. 01	RURAL HEALTH CLINIC (RHC)	994	3, 760	10, 503		l	
26. 02	RURAL HEALTH CLINIC (RHC)	3, 168	1, 942	11, 339		l .	
26. 03	RURAL HEALTH CLINIC (RHC)	413	510	2, 547		l .	
26. 04	RURAL HEALTH CLINIC (RHC)	273	323	1, 473		l .	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		l	
27. 00	Total (sum of lines 14-26)		705	2 050	0.00	523. 38	
28. 00 29. 00	Observation Bed Days	0	725	3, 059			28. 00 29. 00
	Ambulance Trips	٩		_			
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
32. 00	Labor & delivery days (see instructions)	0	55	82			32.00
32. 00	Total ancillary labor & delivery room	U	ວວ	02			32. 00
JZ. U1	outpatient days (see instructions)						32.01
33. 00		0					33. 00
33. 01	,	o					33. 00
	Temporary Expansion COVID-19 PHE Acute Care	o	0	c			34. 00
5 00	1. Impairs Si J Expansion South 17 The Model Odi C	١	٩	,	I .	ı	, 5 55

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-0064 Peri od: From 10/01/2022

Part I 09/30/2023 Date/Time Prepared: 2/28/2024 8:02 pm Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 15.00 12.00 13.00 14.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 1, 416 77 3, 451 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 955 668 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider ol 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 5 00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 1, 416 3, 451 14.00 0.00 77 14.00 CAH visits 15.00 15.00 15.10 REH hours and visits 15. 10 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24. 00 HOSPI CE 24.00

0.00

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24. 10

25 00

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26 03

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26. 25

27 00

28.00

29.00

30.00

31 00

32.00

32.01

33.00

33.01

34.00

24. 10

25.00

26.00

26. 01

26.02

26.03

26. 04

26. 25

27.00

28. 00

29. 00

30.00 31.00

32.00

32.01

33 00

33. 01

HOSPICE (non-distinct part)

RURAL HEALTH CLINIC (RHC)

Total (sum of lines 14-26)

Employee discount days - IRF

Observation Bed Days

LTCH non-covered days

Ambul ance Trips

FEDERALLY QUALIFIED HEALTH CENTER

Employee discount days (see instruction)

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

outpatient days (see instructions)

CMHC - CMHC

Provider CCN: 14-0064

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 10/01/2022 Part II

To 09/30/2023 Date/Time Prepared: 2/28/2024 8:02 pm

						09/30/2023	2/28/2024 8:0	
		Wkst. A Line	Amount	Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries (from Wkst.	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	SALARI ES							t
1.00	Total salaries (see	200. 00	45, 412, 776	415, 943	45, 828, 719	1, 088, 830. 00	42. 09	1.00
2. 00	instructions) Non-physician anesthetist Part		0	О	0	0.00	0.00	2. 00
3. 00	A Non-physician anesthetist Part		2, 437, 418	О	2, 437, 418	14, 963. 00	162. 90	3. 00
4. 00	Physician-Part A -		31, 822	О	31, 822	183. 00	173. 89	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0.00	l .	
5. 00	Physician and Non Physician-Part B		0		0	0. 00		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		8, 179, 405	-1, 642, 596	6, 536, 809	111, 339. 00	58. 71	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	О	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		0	С	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	С	0	0. 00	0.00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 111, 839	2, 133, 884	0 2, 245, 723	0. 00 51, 917. 00	l .	
10.00	instructions) OTHER WAGES & RELATED COSTS		111,037	2, 133, 004	2, 243, 723	31, 717.00	43. 20	10.00
11. 00	Contract labor: Direct Patient Care		1, 108, 720	C	1, 108, 720	9, 725. 00	114. 01	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	C	0	0.00	0.00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		103, 559	C	103, 559	498. 00	207. 95	13. 00
14. 00	Home office and/or related organization salaries and		0	О	0	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		10, 280, 630	l o	10, 280, 630	252, 312. 00	40.75	14. 01
14. 02	Related organization salaries		10, 200, 030		0	0.00	l .	14. 02
15. 00	Home office: Physician Part A		0	O	0	0.00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0. 00	16.00
14 01	Physicians Part A - Teaching		0		0	0.00	0.00	14 01
16. 01	Home office Physicians Part A - Teaching		U		,	0. 00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		0	C	0	0.00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		9, 426, 112	О	9, 426, 112			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		569, 549	0	569, 549			19. 00
20. 00	Non-physician anesthetist Part		0	ď	0			20. 00
21. 00	Non-physician anesthetist Part B		273, 634	С	273, 634			21. 00
22. 00	Physician Part A - Administrative		3, 349	C	3, 349			22. 00
22. 01	Physician Part A - Teaching		0	O	o			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0 1, 413, 117	0	0 1, 413, 117			23. 00 24. 00
25. 00	Interns & residents (in an		0 0	O	0			25. 00
25. 50	approved program) Home office wage-related		4, 237, 404	С	4, 237, 404			25. 50
25. 51	(core) Related organization		0	О	o			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	C	0			25. 52
	wage-related (core)			l			I	I

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0064

Peri od: Worksheet S-3 From 10/01/2022 Part II To 09/30/2023 Date/Time Prep.

Date/Time Prepared: 2/28/2024 8:02 pm Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col. 2 ± col. Salaries in A-6)3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES -633, 933 26.00 4 00 633, 933 26.00 Employee Benefits Department 00 0.00 0 27.00 Administrative & General 5.00 1, 876, 146 -121, 035 1, 755, 111 33, 808. 00 51.91 27.00 28.00 Administrative & General under 730, 094 730, 094 4,004.00 182. 34 28.00 contract (see inst.) Maintenance & Repairs 6.00 -150, 695 27, 693. 00 25. 97 29.00 869, 782 719, 087 29.00 Operation of Plant 0. 00 30.00 7.00 0.00 30.00 31.00 Laundry & Linen Service 8.00 47, 357 795 48, 152 2, 242. 00 21. 48 31.00 Housekeepi ng 20. 77 32.00 9.00 883, 527 13, 596 897, 123 43, 196. 00 32.00 33.00 Housekeeping under contract 0 0.00 0.00 33.00 (see instructions) 34.00 Di etary 10.00 801, 760 -527, 867 273, 893 12, 393.00 22. 10 34.00 Di etary under contract (see instructions) 0.00 35.00 0.00 35.00 0 25, 760. 00 36, 00 Cafeteri a 11.00 0 541, 327 541, 327 21.01 36.00 Maintenance of Personnel 0.00 37.00 12.00 0 0.00 37.00 38.00 Nursing Administration 13.00 792, 558 15,047 807, 605 13, 841. 00 58. 35 38.00 8, 444. 00 39.00 Central Services and Supply 14.00 152, 297 18. 04 39.00 0 152, 297 0.00 0.00 40.00 40.00 Pharmacy 15.00 0 0 41.00 Medical Records & Medical 16.00 0 0 0 0.00 0.00 41.00 Records Library Social Service 17.00 30.00 18. 37 42. 00 42.00 551 0 551 43.00 Other General Service ol 0.00 43.00 18.00 O 0 00

Health Financial Systems ST. MARY MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 14-0064 Peri od:

Worksheet S-3 Part III Date/Time Prepared: From 10/01/2022 To 09/30/2023 2/28/2024 8:02 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 35, 526, 047 2, 058, 539 37, 584, 586 966, 532. 00 38. 89 1.00 instructions) 2.00 111, 839 2, 133, 884 2, 245, 723 51, 917. 00 43. 26 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 35, 414, 208 -75, 345 35, 338, 863 914, 615. 00 38.64 3.00 minus line 2) 4.00 Subtotal other wages & related 11, 492, 909 11, 492, 909 262, 535. 00 43. 78 4.00 costs (see inst.) Subtotal wage-related costs 5.00 13, 666, 865 Ω 13, 666, 865 0.00 38.67 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 60, 573, 982 -75, 345 60, 498, 637 1, 177, 150. 00 51. 39

6, 635, 708

-710, 468

5, 925, 240

171, 411. 00

34.57

7.00

7.00

Total overhead cost (see

instructions)

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 14-0064	Peri od: Worksheet S-3
		From 10/01/2022   Part IV
		To 00/20/2022   Doto/Time December

	To 09/30/2023	Date/Time Prep 2/28/2024 8:02	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		1
1.00	401K Employer Contributions	1, 672, 442	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	346, 619	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	6, 042, 423	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	51, 101	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	304, 764	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ati ve porti on)		l
	TAXES		l
	FICA-Employers Portion Only	3, 186, 775	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		l
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		1
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	81, 638	1
24. 00	Total Wage Related cost (Sum of lines 1 -23)	11, 685, 762	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	1	25. 00

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 14-0064	Peri od: Worksheet S-3
		From 10/01/2022   Part V
		To 00/20/2022 Data/Time Dropared

		From 10/01/2022	Part V	
		To 09/30/2023	Date/Time Prep 2/28/2024 8:03	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1, 108, 720	11, 685, 762	1. 00
2.00	Hospi tal	1, 108, 720	11, 685, 762	2. 00
3.00	SUBPROVI DER - I PF			3. 00
4.00	SUBPROVI DER - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY			8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14. 01	Hospital-Based Health Clinic RHC 1	0	0	14. 01
14. 02	Hospital-Based Health Clinic RHC 2	0	0	14. 02
14. 03	Hospital-Based Health Clinic RHC 3	0	0	14. 03
14. 04	Hospital-Based Health Clinic RHC 4	0	0	14. 04
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16. 00	Hospi tal -Based-CMHC			16. 00
17. 00	RENAL DIALYSIS I			17. 00
18. 00	Other	0	0	18. 00

lealth Financial Systems		. MARY MED	ICAL CENTER			ieu of Form CM		552-
HOSPITAL-BASED RHC/FQHC STATISTICAL DAT	TA .				Peri od: From 10/01/202 To 09/30/202			0 m 0 d
			Component	CCN: 14-8651		2/28/2024	8: 02	
					RHC I	Cos	t	
						1. 00		
Clinic Address and Identification OO Street	n				3375 N SEMINA	ADV ST		1. (
. 00 Street			С	i ty	State	ZIP Code		1. (
00 6: + 6 710 6 6				. 00	2. 00	3.00		2
00   City, State, ZIP Code, County			GALESBURG			I L 61401		2.
						1.00		
00 HOSPITAL-BASED FQHCs ONLY: Desig	nation - Enter "	R" for rura	al or "U" for		t Award	Date	0	3.
					1. 00	2. 00		
Source of Federal Funds	220(d) DUC Act	`						4.
OO Community Health Center (Section OO Migrant Health Center (Section 3		)						4. 5.
00 Health Services for the Homeless		, PHS Act)						6.
OO Appal achi an Regional Commission Look-Alikes								7. 8.
00 OTHER (SPECIFY)								9.
					1. 00	2.00		
0.00 Does this facility operate as ot	her than a hospi	tal-based I	RHC or FQHC? E	nter "Y" for	N N	2.00	0	10.
yes or "N" for no in column 1. I 2. (Enter in subscripts of line 1 hours.)								
1.100.0			nday		onday	Tuesday		
		from 1.00	2. 00	from 3.00	4. 00	from 5.00		
Facility hours of operations (1)		1.00	2.00	3.00	4.00	3.00		
1. 00 CLINIC				07: 00	17: 00	07: 00		11.
					1. 00	2.00		
2.00 Have you received an approval fo					N			12.
3.00 Is this a consolidated cost repo 30.8? Enter "" for yes or "N" f number of providers included in	or no in column	1. If yes,	enter in colu	mn 2 the	N		0	13.
numbers below.				Provi	der name	CCN		
4 00 DUO (50UO				1	1. 00	2. 00		1.1
1.00 RHC/FQHC name, CCN		Y/N	V	XVIII	XIX	Total Visit		14.
		1.00	2.00	3.00	4. 00	5. 00		
5.00 Have you provided all or substan GME cost? Enter "Y" for yes or "								15.
column 1. If yes, enter in colum								
4 the number of program visits p Intern & Residents for titles V,								
XIX, as applicable. Enter in col								
number of total visits for this	provi der.							
			Co	unty				
(see instructions)				. 00				
								2.
		Tuocday	KNOX	aceday.	TL	uredov		
		Tuesday to	Wedr	nesday to		ursday to		
		Tuesday to 6.00		to 8.00	Th from 9.00	ursday to 10.00		

Health Financial Systems	ST. MARY MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 14-0064	Peri od:	Worksheet S-8	
			0011 44 0754	From 10/01/2022		
		Component	CCN: 14-8651	To 09/30/2023	2/28/2024 8:0	
				RHC I	Cost	
	Fri	day	Sa <sup>-</sup>	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00   CLINIC	07: 00	17: 00	08: 00	12: 00		11. 00

Heal th	Financial Systems	ST. MARY MED	ICAL CENTER		In Li	eu of Form CMS	S-2!	552-10
HOSPI T	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der	CCN: 14-0064	Peri od:	Worksheet S	-8	
			Component	CCN: 14-8646	From 10/01/2022 To 09/30/2023			
					RHC II	Cost		
	Clinic Address and Identification				1	. 00		
1. 00	Street				695 N KELLOG S	ST	$\neg$	1. 00
	1500 55,5			Ci ty	State	ZIP Code		
	Tarre to the second			1.00	2. 00	3.00		
2.00	City, State, ZIP Code, County		GALESBURG			L 61401		2. 00
						1.00	+	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for rura	al or "U" for	urban		11.00	0	3. 00
	·				nt Award	Date		
	0 05 1 15 1				1. 00	2. 00		
4. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)						4. 00
5. 00	Migrant Health Center (Section 329(d), PHS Ad							5. 00
6. 00	Health Services for the Homeless (Section 340							6. 00
7. 00	Appalachian Regional Commission							7. 00
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)							8. 00 9. 00
9.00	OTHER (SPECIFT)							9.00
					1. 00	2. 00		
10. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type or hours.)	ate number of d	other operatio	ons in column	N		0	10. 00
	Tiour s. )	Sun	nday	M	onday	Tuesday		
		from	to	from	to	from		
		1. 00	2.00	3. 00	4. 00	5. 00		
11 00	Facility hours of operations (1)	07: 00	19: 00	07: 00	19: 00	07: 00		11. 00
11.00	CETNI C	07.00	119.00	07.00	19.00	07.00		11.00
					1. 00	2. 00		
12. 00 13. 00	1 '	d in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	er 9, section umn 2 the	N N		0	12. 00 13. 00
	Thamber 8 28 em			Provi	der name	CCN		
	Tana and a same				1. 00	2. 00		
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	_	14. 00
		1.00	2.00	3.00	4. 00	5. 00	3	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and		2.00	0.00	33	3.00		15. 00
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		Сс	ounty				
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.			ounty 1.00				
2. 00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		KNOX	1. 00				2. 00
2.00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Tuesday	KNOX Wed	1.00 nesday		rsday		2. 00
2.00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	to	KNOX Wed	nesday to	from	to		2. 00
2.00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		KNOX Wed	1.00 nesday				2. 00

Health Financial Systems	ST. MARY MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0064	Peri od:	Worksheet S-8	
				From 10/01/2022		
		Component	CCN: 14-8646	To 09/30/2023	Date/Time Pre	
					2/28/2024 8:0	2 pm
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	19: 00	07: 00	19: 00		11. 00

Heal th	Financial Systems	ST. MARY MEDI	ICAL CENTER		In Lie	eu of Form CMS	-2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 14-0064	Peri od: From 10/01/2022	Worksheet S-	8
			Component	CCN: 14-8645	To 09/30/2023		
					RHC III	Cost	<u></u>
					1.	00	
	Clinic Address and Identification Street				3315 N SEMINAR	T2 VC	1.00
1. 00	Street		C	ty	State	ZIP Code	1.00
				00	2. 00	3.00	
2.00	City, State, ZIP Code, County		GALESBURG		IL	61401	2. 00
2 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	n "D" for runo	.l or "II" for .	unhan		1.00	0 2 00
3.00	HUSPITAL-BASED FUNCS UNLY: Designation - Ente	er k for rura	al or U for I		nt Award	Date	0 3.00
					1. 00	2.00	
	Source of Federal Funds			1			
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00	Migrant Health Center (Section 329(d), PHS Ac						5. 00
6.00	Health Services for the Homeless (Section 340	O(d), PHS Act)					6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes					-	7. 00 8. 00
9. 00	OTHER (SPECIFY)						9.00
	( ) ( )			1			
					1. 00	2. 00	
10. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of a	other operation	ns in column	N	1	0 10.00
	110di 3. )	Sun	day	Me	onday	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3.00	4. 00	5. 00	
	Facility hours of operations (1)		ı	1	1	1	
11. 00	CLINIC			08: 00	17: 00	08: 00	11. 00
					1. 00	2.00	
12. 00	Have you received an approval for an exception	on to the produ	uctivity standa	ard?	N N	2.00	12. 00
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	9, section nn 2 the	N		0 13.00
	Trailiber 3 borow.			Provi	der name	CCN	
					1. 00	2.00	
14. 00	RHC/FQHC name, CCN		1				14.00
		Y/N 1. 00	V 2.00	XVIII	XI X 4. 00	Total Visits	
		1.00	2.00	3.00	4.00	5. 00	15. 00
15 NN 1	Have you provided all or substantially all						
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.						10.00
15. 00	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						
15. 00	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.			unty			101.00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		4.	unty 00	_		
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Tuesday	KNOX 4.		Thur	rsday	
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		KNOX 4.	00	Thur from	to	2.00
2. 00	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Tuesday	KNOX Wedn	00 esday			

Health Financial Systems	ST. MARY MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0064	Peri od:	Worksheet S-8	
		Component	CCN, 14 0/4E	From 10/01/2022		nonod.
		Component	CCN: 14-8645	To 09/30/2023	2/28/2024 8: 0	pared: 12 pm
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00   CLI NI C	08: 00	17: 00				11. 00

moun en	Financial Systems	ST. MARY MEDI	CAL CENTER		In Li∈	eu of Form CMS-	-2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0064	Peri od: From 10/01/2022	Worksheet S-8	3
			Component	CCN: 14-8648	To 09/30/2023		
					RHC IV	Cost	
					1.	00	-
	Clinic Address and Identification						
1. 00	Street		C	+	904 E MAIN ST	7LD Code	1.00
				00	State 2.00	ZIP Code 3.00	+
2. 00	City, State, ZIP Code, County		KNOXVI LLE			61448	2. 00
						1.00	1
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	r "R" for rura	ıl or "II" for ı	ırhan		1.00	3.00
0.00	THOSE THE BROCK FUNDS ONET. BOST GRACT OF EACH	n roi rara	01 0 101 0		it Award	Date	0.00
					1. 00	2. 00	
4 00	Source of Federal Funds	A a + \					4
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac						4. 00 5. 00
5. 00	Health Services for the Homeless (Section 340						6. 0
7. 00	Appalachian Regional Commission						7. 0
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)						8. 0 9. 0
7.00	OTILE (SPECIFI)						7.0
					1. 00	2. 00	
10. 00	Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of a	ther operation	ns in column	N		10.00
	11001 3. )	Sun	day	Me	onday	Tuesday	
		from	to	from	to	from	
	Facility house of energtions (1)	1. 00	2. 00	3.00	4. 00	5. 00	
11. 00	Facility hours of operations (1)			08: 00	17: 00	08: 00	11.0
	,			1			
12.00				10	1.00	2.00	10.0
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In numbers below.	lin CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colur	9, section nn 2 the	N N	(	12. 00
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Provi	der name	CCN	
					1. 00	2. 00	
11 00	DUC/FOLIC name CCN						14 04
14. 00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	14. 00
14. 00	RHC/FQHC name, CCN	Y/N 1.00	V 2. 00	XVIII 3. 00	XI X 4. 00	Total Visits 5.00	14. 0
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.			-			
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		2.00	-			
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2. 00 Cot 4.	3.00			15.00
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2. 00 Cot 4. KNOX	3.00 unty 00	4.00	5. 00	15.00
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00 Tuesday	2.00  Cot 4.  KNOX  Wedn	3.00  unty 00  esday	4. 00 Thur	5. 00	15. 00
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2. 00 Cot 4. KNOX	3.00 unty 00	4.00	5. 00	14. 0C

Health Financial Systems	ST. MARY MEI	DI CAL	CENTER			In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN:	14-0064	Peri od:	Worksheet S-8	
			0	001	44.0440	From 10/01/2022		
			Component	CCN	: 14-8648	To 09/30/2023	2/28/2024 8:0	
						RHC IV	Cost	
	Fr	i day			Sa	turday		
	from		to		from	to		
	11. 00		12.00		13.00	14. 00		
Facility hours of operations (1)								
11. 00 CLINIC	08: 00	17: (	00					11. 00

	Financial Systems	ST. MARY MEDI	CAL CENTER		In Li€	eu of Form CMS	-2552
HOSPI T	FAL-BASED RHC/FQHC STATISTICAL DATA				Period: From 10/01/2022 To 09/30/2023		
			component	CCN: 14-8638	To 09/30/2023	Date/Time Pr 2/28/2024 8:	
					RHC V	Cost	
					1	00	-
	Clinic Address and Identification				1.	00	
. 00	Street			_	100 N MONROE S		1.
		-		ty	State	ZIP Code	
2. 00	City, State, ZIP Code, County		ABI NGDON	00	2.00	3.00	2.
. 00	jorty, State, 211 Sode, Sounty		ABT NOBON			01110	
	Tuespital Block Solls only B. J. J. J.					1. 00	
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	I or "U" for t		t Award	Date	0 3.
					. 00	2. 00	
	Source of Federal Funds						
. 00	Community Health Center (Section 330(d), PHS						4.
. 00 . 00	Migrant Health Center (Section 329(d), PHS Ad Health Services for the Homeless (Section 340						5. 6.
. 00	Appalachian Regional Commission	. ,					7.
. 00	Look-Alikes						8.
. 00	OTHER (SPECIFY)						9.
					1. 00	2. 00	
0. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	ther operation	ns in column	N		0 10.
	(110di 3. )	Sund	day	Mo	nday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1. 00	2. 00	3.00	4. 00	5. 00	_
1. 00	CLINIC			08: 00	17: 00		11.
2. 00	Have you received an approval for an exception	on to the produ	ctivity ctand	and?	1. 00 N	2. 00	12.
3. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. 10 umn 1. If yes,	00-04, chapter enter in colur	9, section nn 2 the	N N		0 13.
	number of providers included in this report.	LIST THE Halles	or arr provid	ders and			
	number of providers included in this report. numbers below.	LIST THE Hallies	or arr provid		der name	CCN	
4.00	numbers below.	LIST the fidnes	or arr provid	Provid	der name .00	CCN 2. 00	14
4. 00	·		V	Provi o	. 00	2. 00	14.
4. 00	numbers below.	Y/N 1.00	·	Provid			
	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N	V	Provi o	. 00 XI X	2.00 Total Visits	
	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	Y/N	V 2.00	Provi o	. 00 XI X	2.00 Total Visits	;
5. 00	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	V 2.00	XVIII 3.00	. 00 XI X	2.00 Total Visits	15.
5. 00	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	V 2.00	XVIII 3.00	XIX 4.00	2.00 Total Visits 5.00	;
5. 00	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	V 2.00 Cot 4. KNOX Wedn	XVIII 3.00  anty 00 esday	XI X 4. 00	2.00 Total Visits 5.00	15.
14. 00	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	V 2.00	XVIII 3.00	XIX 4.00	2.00 Total Visits 5.00	15.

Health Financial Systems	ST. MARY MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0064	Peri od:	Worksheet S-8	1
		Component	CCN: 14-8638	From 10/01/2022 To 09/30/2023		pared: 2 pm
				RHC V	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00   CLI NI C	08: 00	17: 00				11. 00

HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Prov	vider CCM	N: 14-0064	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Pre 2/28/2024 8:0	pared:	
					1. 00		
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00		
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
1.00	Cost to charge ratio (see instructions)				0. 176632	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				11, 447, 439	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental p	payments	from Medica	i d?	Υ	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from N	Medi cai d			0	5. 00	
6.00	Medi cai d charges				123, 441, 783		
7. 00	Medicaid cost (line 1 times line 6)				21, 803, 769		
8. 00	Difference between net revenue and costs for Medicaid program (see				10, 356, 330	8. 00	
0.00	Children's Health Insurance Program (CHIP) (see instructions for ea	ach line	)			0.00	
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	1	
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0		
12.00	Difference between net revenue and costs for stand-alone CHIP (see	instruc	tions)		0		
12.00	Other state or local government indigent care program (see instruct					12.00	
13. 00	Net revenue from state or local indigent care program (Not included			)	0	13. 00	
14. 00	Charges for patients covered under state or local indigent care pro				0		
	10)	,					
15.00	State or local indigent care program cost (line 1 times line 14)				0	15. 00	
16.00	Difference between net revenue and costs for state or local indiger				0	16. 00	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line)	nd state	/local indig	ent care program	ns (see		
17.00	Private grants, donations, or endowment income restricted to fundir	ng chari	ty care		0	17. 00	
18.00					0	18. 00	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local inc			(sum of lines	10, 356, 330	19. 00	
	8, 12 and 16)						
			Uni nsured	Insured	Total (col. 1		
		-	patients 1.00	pati ents 2.00	+ col . 2) 3.00		
	Uncompensated care cost (see instructions for each line)		1.00	2.00	3.00		
20. 00	Charity care charges and uninsured discounts (see instructions)		6, 584, 51	4 1, 063, 273	7, 647, 787	20.00	
21. 00	Cost of patients approved for charity care and uninsured discounts	(see	1, 163, 03		2, 226, 309		
	instructions)	(	, ,	, , , , ,			
22. 00	Payments received from patients for amounts previously written off	as		0 0	0	22. 00	
	chari ty care						
23. 00	Cost of charity care (see instructions)		1, 163, 03	1, 063, 273	2, 226, 309	23. 00	
					1. 00		
24. 00	Does the amount on line 20 col. 2, include charges for patient days	s bevond	a Length of	stav limit	N N	24. 00	
	imposed on patients covered by Medicaid or other indigent care prog		3.	,			
25.00	If line 24 is yes, enter the charges for patient days beyond the ir	ndi gent	care program	's length of	0	25. 00	
	stay limit	-		-		25. 01	
25. 01							
26. 00	,				3, 849, 341	1	
	Medicare reimbursable bad debts (see instructions)				315, 422	ł	
27. 01	Medicare allowable bad debts (see instructions)				485, 264	ı	
	Non-Medicare bad debt amount (see instructions)  Cost of non-Medicare and non-reimbursable Medicare bad debt amounts	c (coo :	netrueti oral		3, 364, 077 764 046		

764, 046 2, 990, 355 30. 00 13, 346, 685 31. 00

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

	Financial Systems ST. MARY MEDICAL ( AL UNCOMPENSATED AND INDIGENT CARE DATA		CN: 14-0064	Peri od: From 10/01/2022 To 09/30/2023	u of Form CMS-2 Worksheet S-1 Parts I & II Date/Time Pre 2/28/2024 8:0	0 pared:		
					1. 00			
	PART II - HOSPITAL DATA				1.00			
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
1.00	Cost to charge ratio (see instructions)				0. 158473	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid					2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?					3. 00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al payment	s from Medica	ni d?		4. 00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro	m Medicai	d			5. 00		
6.00	Medi cai d charges					6. 00		
7.00	Medicaid cost (line 1 times line 6)					7. 00		
8.00	Difference between net revenue and costs for Medicaid program (s					8. 00		
	Children's Health Insurance Program (CHIP) (see instructions for	each line	e)					
9.00	Net revenue from stand-alone CHIP					9. 00		
10.00	Stand-al one CHIP charges					10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)					11.00		
12. 00	Difference between net revenue and costs for stand-alone CHIP (s					12. 00		
12 00	Other state or local government indigent care program (see instr					12.00		
13.00	Net revenue from state or local indigent care program (Not inclu					13.00		
14. 00	Charges for patients covered under state or local indigent care 10)	program (	Not The udea	III IIIles 6 01		14. 00		
15. 00	State or local indigent care program cost (line 1 times line 14)					15. 00		
16. 00	Difference between net revenue and costs for state or local indi		nrogram (see	instructions)		16.00		
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)				ıs (see	10.00		
17. 00	Private grants, donations, or endowment income restricted to fur	ndi ng char	ity care			17. 00		
18. 00	Government grants, appropriations or transfers for support of ho	0	,			18. 00		
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local			(sum of lines		19.00		
	8, 12 and 16)	3	1 3					
			Uni nsured	Insured	Total (col. 1			
			pati ents	pati ents	+ col . 2)			
			1. 00	2. 00	3. 00			
	Uncompensated care cost (see instructions for each line)							
20.00	Charity care charges and uninsured discounts (see instructions)		6, 584, 51			1		
21. 00	Cost of patients approved for charity care and uninsured discour	its (see	1, 043, 46	1, 063, 273	2, 106, 741	21. 00		
22. 00	instructions)  Represents received from nationts for amounts proviously written of	eff oc		0	0	22. 00		
22.00	Payments received from patients for amounts previously written clearity care	) I I a5		U U	U	22.00		
23. 00	Cost of charity care (see instructions)		1, 043, 46	1, 063, 273	2, 106, 741	23 00		
23.00	cost of chartty care (see thistractions)		1, 043, 40	1,003,213	2, 100, 741	23.00		
					1. 00			
24. 00	Does the amount on line 20 col. 2, include charges for patient cimposed on patients covered by Medicaid or other indigent care p		d a Length of	stay limit	N	24. 00		
25. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit		care program	n's length of	0	25. 00		
25. 01	Charges for insured patients' liability (see instructions)				0	25. 01		
26. 00								
27. 00	Medicare reimbursable bad debts (see instructions)				315, 422			
27. 01	Medicare allowable bad debts (see instructions)				485, 264	1		
28. 00	Non-Medicare bad debt amount (see instructions)				3, 364, 077	ł		
	20 Cost of pap Modicare and pap reimburgable Modicare had dobt amounts (see instructions)							

702, 957 29. 00 2, 809, 698 30. 00 2, 809, 698 31. 00

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Heal th	Financial Systems	ST. MARY MEDIC	CAL CENTER		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CC	N: 14-0064	Peri od:	Worksheet A	
					From 10/01/2022 To 09/30/2023		nared.
					10 07/30/2023	2/28/2024 8: 0	
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS		0.044.040	2.044.07	040 540	4 454 004	1
1.00	00100 CAP REL COSTS-BLDG & FLXT		3, 841, 369	3, 841, 36			1
1. 01 2. 00	00101 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		1, 939, 156	1, 939, 15	406, 335 6 260, 091		
3.00	00300 OTHER CAP REL COSTS		1, 737, 130	1, 737, 131	0 200, 091	2, 199, 247	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	633, 933	11, 730, 017	12, 363, 950	9		1
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 876, 146	26, 848, 270	28, 724, 41			
6. 00	00600 MAI NTENANCE & REPAI RS	869, 782	2, 405, 854	3, 275, 63			
7. 00	00700 OPERATION OF PLANT	0	2, 620, 873	2, 620, 87			1
8.00	00800 LAUNDRY & LINEN SERVICE	47, 357	361, 102	408, 45			1
9.00	00900 HOUSEKEEPI NG	883, 527	460, 842	1, 344, 369	3, 004	1, 347, 373	9. 00
10.00	01000 DI ETARY	801, 760	677, 543	1, 479, 30	-985, 326	493, 977	10.00
11. 00	01100  CAFETERI A	0	0	(	998, 786	998, 786	11. 00
13.00	01300 NURSING ADMINISTRATION	792, 558	7, 608	800, 16			
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	-194, 903	-194, 90			
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	2, 493	2, 49:			1
17. 00	01700 SOCIAL SERVICE	551	265	810			1
19. 00	01900 NONPHYSICIAN ANESTHETISTS	2, 437, 418	593, 999	3, 031, 41	7 0	3, 031, 417	19. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS   03000   ADULTS & PEDIATRICS	10, 143, 870	4 0/4 207	15 100 15	1 500 044	12 (00 112	20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	1, 796, 411	4, 964, 287 412, 731	15, 108, 15 2, 209, 14			
43.00	04300 NURSERY	31, 767	412, 731	2, 209, 14. 31, 76			1
43.00	ANCI LLARY SERVI CE COST CENTERS	31,707	<u> </u>	31, 70	455, 651	403, 010	43.00
50. 00	05000 OPERATING ROOM	2, 498, 040	3, 859, 881	6, 357, 92	1 -3, 552, 238	2, 805, 683	50.00
51. 00	05100 RECOVERY ROOM	1, 315, 291	108, 866	1, 424, 15			1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		1, 015, 844		1
53. 00	05300 ANESTHESI OLOGY	44, 857	1, 712, 631	1, 757, 48			1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 829, 022	268, 062	2, 097, 08			
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0		0		1
56.00	05600 RADI 0I SOTOPE	158, 610	206, 514	365, 12	2, 663	367, 787	56. 00
57.00	05700  CT SCAN	548, 393	541, 515	1, 089, 90		1, 075, 134	57. 00
58.00	05800  MRI	347, 999	69, 548	417, 54			
60.00	06000 LABORATORY	2, 267, 022	2, 670, 637	4, 937, 65			1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	591, 366	591, 36			1
65. 00	06500 RESPI RATORY THERAPY	781, 478	201, 719	983, 19			1
65. 10	06501 CARDI AC STRESS LAB	438, 121	14, 055	452, 17			
65. 20	06502 CARDI AC REHAB	294, 242	11, 705	305, 94		l	1
66.00	06600 PHYSI CAL THERAPY	1, 089, 231	117, 998	1, 207, 22 <sup>1</sup> 293, 78!			1
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	285, 377 211, 871	8, 408 8, 578	293, 789			
69. 00	06900 ELECTROCARDI OLOGY	211, 671	0, 376		119, 984		1
	07000 ELECTROENCEPHALOGRAPHY	13, 833	0	13, 83			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10,000	0	•	1, 958, 745		
	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0		1, 680, 716		
73. 00	l l	902, 389	7, 519, 060	8, 421, 449			
	03610 SLEEP LAB	174, 488	166, 718	341, 20			1
76. 01	03020 PAIN CLINIC	61, 105	378, 635	439, 740			1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	O	0		0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC (RHC)	4, 025, 278	1, 860, 943	5, 886, 22			
88. 01	08801 RURAL HEALTH CLINIC (RHC)	1, 309, 647	471, 476	1, 781, 12			
88. 02	08802 RURAL HEALTH CLINIC (RHC)	2, 034, 199	570, 682	2, 604, 88		1, 911, 400	
88. 03	08803 RURAL HEALTH CLINIC (RHC)	614, 677	226, 005	840, 68:			
88. 04	08804 RURAL HEALTH CLINIC (RHC)	195, 602	112, 758	308, 36			
91.00	09100 EMERGENCY	3, 545, 085	4, 296, 828	7, 841, 91	-146, 984	7, 694, 929	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
102.00	OTHER REIMBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM	ol	ol		0 0		102. 00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u>U</u>		0		102.00
118.00		45, 300, 937	82, 666, 094	127, 967, 03	1 -3, 752, 055	124, 214, 976	118 00
110.00	NONREI MBURSABLE COST CENTERS	43, 300, 737	02, 000, 074	127, 707, 03	3, 732, 033	124, 214, 770	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	70, 261	103, 177	173, 43	1, 180	174, 618	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	31, 191	18, 420	49, 61		l	1
	19300 NONPALD WORKERS	0	8, 665	8, 66			193. 00
	07950 FOUNDATION AND OTHER	10, 387	471, 251	481, 63			1
194. 01	07951 FITNESS CENTER	О	0		196, 488	196, 488	1
	07952 VACANT SPACE	o	O		1, 374, 586		
200.00	TOTAL (SUM OF LINES 118 through 199)	45, 412, 776	83, 267, 607	128, 680, 38	3 0	128, 680, 383	200.00

	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	ST. MARY MEDI	CAL CENTER  Provi der CCN: 1	In Lieu of Form CMS-2	2552-10
KLULA	STITEATION AND ADJUSTMENTS OF TRIAL BALANCE OF	LAFLINGLS	Frovider CCN.	From 10/01/2022 To 09/30/2023 Date/Time Pres	nared:
	Cost Center Description	Adjustments	Net Expenses	2/28/2024 8: 02	
	cost center bescription	(See A-8)	For Allocation		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT	-14, 796	4, 137, 135		1. 00
1.01	00101 CAP REL COSTS-BLDG & FIXT	0	406, 335		1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 594, 489	3, 793, 736		2. 00
3. 00 4. 00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	0 -101, 567	0 11, 972, 826		3. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-7, 095, 290	19, 273, 079		5. 00
6. 00	00600 MAINTENANCE & REPAIRS	-33, 607	1, 852, 499		6. 00
7.00	00700 OPERATION OF PLANT	0	1, 759, 951		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	409, 254		8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	1, 347, 373		9. 00 10. 00
11. 00	01100 CAFETERI A	-330 -313, 434	493, 647 685, 352		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 532, 964	2, 347, 693		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	97, 112		14.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	26, 980	258, 592		16. 00
17. 00	01700 SOCIAL SERVICE	394, 953	1, 447, 448		17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	-3, 031, 417	0		19. 00
30. 00	03000 ADULTS & PEDI ATRI CS	-2, 513, 511	11, 086, 602		30. 00
31. 00	03100 INTENSIVE CARE UNIT	-83, 638	2, 165, 723		31.00
43. 00	04300 NURSERY	0	485, 618		43.00
50. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	-1.000	2, 804, 683		50. 00
51. 00	05100 RECOVERY ROOM	-1, 000 -2, 095	1, 451, 060		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 015, 844		52. 00
53. 00	05300 ANESTHESI OLOGY	-1, 536, 419	303, 423		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-50, 642	3, 121, 273		54.00
55. 00 56. 00	05500  RADI OLOGY - THERAPEUTI C   05600  RADI OI SOTOPE	0	0 367, 787		55. 00 56. 00
57. 00	05700 CT SCAN	0	1, 075, 134		57. 00
58. 00	05800 MRI	0	422, 667		58. 00
60.00	06000 LABORATORY	-9, 279	5, 167, 429		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	591, 366		63. 00
65. 00	06500 RESPIRATORY THERAPY	0	880, 340		65. 00 65. 10
65. 10 65. 20	06501 CARDI AC STRESS LAB 06502 CARDI AC REHAB	-44, 071	459, 846 71, 837		65. 20
66. 00	06600 PHYSI CAL THERAPY	4, 598	1, 246, 495		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	729	339, 670		67.00
68. 00	06800 SPEECH PATHOLOGY	-649	253, 647		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	119, 984		69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	14, 065 1, 958, 745		70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 680, 716		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-74, 698	8, 555, 137		73. 00
	03610 SLEEP LAB	0	344, 135		76. 00
76. 01 77. 00	03020 PAIN CLINIC 07700 ALLOGENEIC HSCT ACQUISITION	-312, 000 0	64, 316 0		76. 01 77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	ŭ,		70.00
88. 00	08800 RURAL HEALTH CLINIC (RHC)	-11, 922	4, 411, 731		88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC)	2, 109	1, 342, 885		88. 01
88. 02 88. 03	08802 RURAL HEALTH CLINIC (RHC) 08803 RURAL HEALTH CLINIC (RHC)	12, 338 0	1, 923, 738 614, 265		88. 02 88. 03
88. 04	08804 RURAL HEALTH CLINIC (RHC)	12, 585	249, 234		88. 04
91. 00	09100 EMERGENCY	-2, 401, 391	5, 293, 538		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
102.00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	0	0		102. 00
102.00	SPECIAL PURPOSE COST CENTERS	U <sub>I</sub>	U U		102.00
118.00		-14, 050, 011	110, 164, 965		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	174, 618		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	2, 533, 461		192. 00 193. 00
	07950 FOUNDATION AND OTHER	0	8, 665 177, 589		193.00
	07951 FI TNESS CENTER	0	196, 488		194. 01
194. 02	07952 VACANT SPACE	0	1, 374, 586		194. 02
200.00	TOTAL (SUM OF LINES 118 through 199)	-14, 050, 011	114, 630, 372		200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 14-0064 

					11	09/30/202	3 Date/lime Prepared: 2/28/2024 8:02 pm
		Increases		0.11			
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00			
	A - PROPERTY INS AND TAX	3.00	4.00	5.00			
1.00	OTHER CAP REL COSTS	3.00	0	976, 988			1.00
2.00		0.00	0	0			2. 00
3.00		0.00	•_	0			3. 00
	O DISTABLE		0	976, 988			
1. 00	B - CAFETERIA - DIETARY CAFETERIA	11.00	541, 327	457, 459			1.00
1.00	O IERIA	11.00	541, 327	457, 459			1.00
	D - REHAB ADMIN		011, 027	107, 107			
1.00	OCCUPATI ONAL THERAPY	67. 00	23, 142	2, 335			1.00
2.00	SPEECH PATHOLOGY	<u>68.</u> 00	1 <u>7, 3</u> 65	<u>1, 7</u> 53			2. 00
	0		40, 507	4, 088			
1 00	E - EKG SALARY	40.00	110 004	0			1 00
1. 00	ELECTROCARDI OLOGY	69.00	11 <u>9, 9</u> 84 119, 984	0			1.00
	F - IMPLANTABLE MEDICAL DEVICE		117, 704	<u> </u>			
1.00	I MPL. DEV. CHARGED TO	72.00	0	1, 680, 716			1.00
	PATI ENTS						
2.00		0. 00	0	0			2.00
3. 00		0.00	0	0			3. 00
	G - MSCTP		U	1, 680, 716			
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 958, 745			1.00
	PATI ENT		1				
2.00		0.00	0	0			2. 00
3.00		0.00	0_	0			3. 00
	U DDUCC CHARCED TO DATI FAITC		0	1, 958, 745			
1. 00	H - DRUGS CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	73. 00	0	53, 443			1.00
2. 00	DROGS CHARGED TO FATTERTS	0.00	0	0			2.00
3. 00		0. 00	Ö	Ö			3. 00
4.00		0.00	0	0			4. 00
5.00		000	0_	0			5. 00
	O CHORT TERM BLGARILLEY		0	53, 443			
1. 00	I - SHORT TERM DISABILITY	0.00	0	0			1.00
1.00			<del> </del>	0			1.00
	J - CARDIO PULMONARY REHAB	<u>.</u>					
1.00	FI TNESS CENTER	1 <u>94.</u> 01	18 <u>8, 9</u> 59	7, 529			1. 00
	O CENTER		188, 959	7, 529			
1. 00	K - ALTERNATI VE BIRTHING CENTER NURSERY	43.00	437, 550	15, 768			1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52.00	980, 510	35, 334			2.00
2.00	0	====	1, 418, 060	5 <u>1, 1</u> 02			2.00
	L - MINISTRY MEDICAL RECORDS						
1.00	MEDICAL RECORDS & LIBRARY	1600	•	229, 119			1.00
	M - MINISTRY ALLOCATION		0	229, 119			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	591, 805			1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	317, 587			2. 00
3. 00	PHYSI CAL THERAPY	66.00	Ö	61, 180			3. 00
4.00	OCCUPATI ONAL THERAPY	67. 00	o	14, 888			4. 00
5.00	SPEECH PATHOLOGY	68. 00	0	11, 172			5. 00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	139, 794			6. 00
7. 00	SOCI AL SERVI CE	<u>17.</u> 00	0	<u>1, 051, 6</u> 79 2, 188, 105			7. 00
	O - STD, TEAM AWARD & VACATION	RECLASS	U	2, 100, 100			
1.00		0.00	0	0			1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	33, 016	1, 763			2. 00
3.00	MAINTENANCE & REPAIRS	6.00	14, 602	476			3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	795	0			4. 00
5.00	HOUSEKEEPI NG	9.00	15, 311	1, 715			5.00
6. 00 7. 00	DIETARY NURSING ADMINISTRATION	10. 00 13. 00	13, 460 15, 047	0			6. 00
7. 00 8. 00	ADMINISTRATIVE & GENERAL	5. 00	13, 047	0			8.00
9. 00	ADULTS & PEDIATRICS	30.00	202, 237	36, 944			9. 00
10.00	INTENSIVE CARE UNIT	31.00	41, 166	0			10. 00
11. 00	NURSERY	43.00	533	0			11. 00
12.00	OPERATI NG ROOM	50.00	50, 514	2, 555			12. 00
13.00	RECOVERY ROOM	51.00	28, 998	0			13.00
14.00	ANESTHESI OLOGY	53.00	129, 698	0			14.00
15. 00 16. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-DI AGNOSTI C	54. 00 54. 00	31, 020 363	0			15. 00 16. 00
17. 00	RADI OLOGT - DI AGNOSTI C	56.00	2, 663	0			17. 00
		- 3. 00	_, 555	٥,			1 00

Health Financial Systems
RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: 2/28/2024 8:02 pm | Provider CCN: 14-0064

					2/28/2024 8	3: 02 pm
		Increases		·		
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
18. 00	CT SCAN	57.00	9, 631	0		18. 00
19. 00	MRI	58.00	5, 842	0		19. 00 20. 00
20. 00 21. 00	LABORATORY RESPIRATORY THERAPY	60. 00 65. 00	38, 824 16, 892	2, 077 1, 654		20.00
22. 00	CARDIAC STRESS LAB	65. 10	7, 760	1, 034		22.00
23. 00	CARDI AC STRESS EAD	65. 20	6, 449	0		23. 00
24. 00	PHYSI CAL THERAPY	66.00	18, 286	Ö		24. 00
25. 00	OCCUPATI ONAL THERAPY	67. 00	4, 791	0		25. 00
26.00	SPEECH PATHOLOGY	68. 00	3, 557	0		26. 00
27.00	ELECTROENCEPHALOGRAPHY	70. 00	232	0		27. 00
28. 00	DRUGS CHARGED TO PATIENTS	73. 00	15, 149	0		28. 00
29. 00	SLEEP LAB	76. 00	2, 929	0		29. 00
30. 00	PAIN CLINIC	76. 01	1, 026	0		30. 00
31. 00	RURAL HEALTH CLINIC (RHC)	88.00	52, 710	0		31.00
32. 00	RURAL HEALTH CLINIC (RHC)	88. 01	17, 369	0		32.00
33. 00 34. 00	RURAL HEALTH CLINIC (RHC) RURAL HEALTH CLINIC (RHC)	88. 02 88. 03	27, 320 7, 843	1, 347 0		33. 00 34. 00
35. 00	RURAL HEALTH CLINIC (RHC)	88. 04	2, 594	0		35. 00
36. 00	EMERGENCY (KIIO)	91.00	67, 205	1, 539		36. 00
37. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	1, 180	0		37. 00
	CANTEEN		.,			
38.00	PHYSICIANS' PRIVATE OFFICES	192. 00	30, 004	337		38. 00
39.00	FOUNDATION AND OTHER	194. 00	174	0		39. 00
	0		917, 199	50, 407		
	P - CONTRACT LABOR					
1. 00	<u> </u>		0	$\frac{0}{0}$		1. 00
	0		0	0		
1. 00	Q - PCI COST RADI OLOGY-DI AGNOSTI C	54.00	0	1, 043, 888		1.00
2. 00	LABORATORY	60.00	0	201, 084		2.00
2.00	n		— — <del> </del>	1, 244, 972		2.00
	R - OSFMG HOSP AND PALLIATIVE		9	1,211,712		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	31, 398		1.00
2.00	ADULTS & PEDIATRICS	30.00	183, 085	0		2. 00
	0 — — — — —		183, 085	31, 398		
	S - CENTRAL SUPPLY COST					
1.00	CENTRAL SERVICES & SUPPLY	14.00	15 <u>2, 2</u> 97	$\frac{0}{0}$		1. 00
	0		152, 297	0		
4 00	U - MINISTRY OSFMG	F 00	ما	4 070 704		4 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	5. 00 0. 00	0	1, 078, 721		1.00
3. 00	•	0.00	0	0		2. 00 3. 00
4.00		0.00	0	0		4. 00
5. 00		0.00	Ö	0		5. 00
6.00		0.00	o	0		6. 00
7.00		0.00	o	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0. 00	0	0		9. 00
	0		0	1, 078, 721		
4.05	V - FOUNDATION EXPENSE	= 1	1	A== 1		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	270, 867		1.00
2.00	ADULTS & PEDIATRICS RESPIRATORY THERAPY	30.00	0	29, 760		2.00
3. 00 4. 00	PHYSICIANS' PRIVATE OFFICES	65. 00 192. 00	0	235 3, 361		3. 00 4. 00
4.00	n PRIVATE OFFICES	192.00	— — <del> </del>	304, 223		4.00
	W - RHC SALARY ADJ - PRE CERT	DATE	<u> </u>	304, 223		
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	1, 752, 713	0		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0. 00	0	0		4. 00
5.00		0.00	0	0		5. 00
	TOTALS		1, 752, 713	0		
4.05	X - RHC RECLASS - PRE CERT OT		-	700		
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	700, 739		1.00
2.00		0.00	0	0		2.00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
4. 00 5. 00		0.00	0	0		5. 00
5. 50	TOTALS — — — — —		— — <del> </del>			3.00
	Y - RECLASS PREMIER ADMIN FEE	S	<u> </u>	. 55, 757		
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	139, 718		1. 00
	TOTALS		0	139, 718		

Health Financial Systems

ST. MARY MEDICAL CENTER

Provider CCN: 14-0064

Period:
From 10/01/2022
To 09/30/2023

Date/Time Prepared:
2/28/2024 8:02 pm

					 2/28/2024 8:0	J2 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	Z - RECLASS CFH DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	101	0	406, 335		1.00
	TOTALS		0	406, 335		
	AA - CFH EXPENSES					
1.00	RURAL HEALTH CLINIC (RHC)	88. 01	3, 629	27, 315		1.00
2.00	VACANT SPACE	194. 02	161, 192	1, 213, 394		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
	TOTALS		164, 821	1, 240, 709		
500.00	Grand Total: Increases		5, 478, 952	12, 804, 516		500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 14-0064 

Design Control   1 min   Senton   1 min						'	Date/lime Prepared: 2/28/2024 8:02 pm
1.00							
1.00							
1.00			7.00	8.00	9.00	10.00	
ADD   STATEMEN   CLINIC C. 1962   90.0   0   50.0   10   10   3.00   10   10   10   10   10   10   10	1. 00		5. 00	0	221, 222	12	1, 00
1.00   BILLARY   10.00   541,227   457,499   0   1.00   1.00   541,227   457,499   0   1.00				Ö	•		•
B		RURAL HEALTH CLINIC (RHC)		0			3. 00
1.00		0			976, 988		
STHAM ROWN							
DETERM ADMIN	1. 00	DI ETARY	1000				1.00
1.00		O DELIAR ADMINI		541, 327	457, 459		
1.00	1 00		66 00	40 507	4 088		1 00
1.00		FITTST CAL TITERAFT		40, 507			•
1.00	2.00			40.507			2.00
O		E - EKG SALARY		,	.,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	
1.00	1.00	RESPIRATORY THERAPY	65. 00	119, 984	0	0	1.00
1.00   LABORATORY		0		119, 984	0		
2.00   OPERATING ROOM							
ABORATORY				- 1			•
1.00		1		0			· ·
1.00   PAIN GOM   1.00   PAIN GOM   1.00   1.00   PAIN GOM   1.00   1.	3.00	0		<del> </del>			3.00
1.00		G - MSCTP		٩	1,000,710		
Departing Rooms	1.00		76. 01	O	55, 785	0	1.00
D	2.00	OPERATING ROOM		o	1, 902, 757	o	2. 00
H   DRUGS CHARGED TO PATIENTS	3.00	PHYSICAL THERAPY	<u>66.</u> 00	0			3. 00
1.00   OPERATI NG ROOM   50.00   0   19, 416   0   2.00   3.00   2.00   ABIOLOGY-DI AGNOSTI C   54.00   0   2255   0   2.00   3.00   0   17.00   5.00   0   7.722   0   0   4.00   4.00   MIR   58.00   0   7.722   0   0   4.00   6.00   1.00   0   0   0   0   0   0   0   0   0		0		0	1, 958, 745		
2.00						1 -1	
3. 00 CT SCAN 57. 00 0 24, 406 0 3. 00 5. 00 PALN CLI NIC 58. 00 0 722 0 0 4. 00 0 PALN CLI NIC 76. 01 0 53, 443  1. 00 I SHORT TERM DI SABILITY  1. 00 C			•	-	•		•
1.00   NRI				0			
1.00			•	0			
1.00			•	0		1	•
1.00	0.00	0	<del>/0.</del> 01				0.00
1.00		I - SHORT TERM DISABILITY	·	<u>'</u>	·	·	
1.00   Carbid Pullmonary Rehab   65, 20   188, 959   7, 529   0   0   0   0   0   0   0   0   0	1.00		0.00		0	0	1. 00
1.00		0		0	0		
1.00	1 00		ر <u>د</u> عما	100.050	7 520		1.00
1.00   2.00   0   0   0   0   0   0   0   0   0	1.00	CARDI AC REHAB					1.00
1.00		K - ALTERNATIVE BLRTHING CENTI	FR	100, 737	1, 527		
2.00	1.00			1, 418, 060	51, 102	. 0	1, 00
1.00				0	0		•
1.00		0		1, 418, 060	51, 102		
N - MINISTRY ALLOCATION							
M - MINISTRY ALLOCATION	1. 00	ADMI NI STRATI VE & GENERAL					1.00
1.00		M MINISTRY ALLOCATION		0	229, 119		
2.00 3.00 4.00 0.00 0.00 0.00 0.00 0.00 0	1 00		5.00	٥	2 199 105		1 00
3.00		ADMINISTRATIVE & GENERAL		0			•
4.00				0	0		<b>1</b>
6. 00 7. 00				Ö			<b>1</b>
7.00	5.00		0.00	0	0	o	5. 00
O				0	0	0	6. 00
1.00   EMPLOYEE BENEFITS DEPARTMENT   4.00   633, 933   278, 827   0   1.00	7. 00		0.00	0	0		7. 00
1. 00     EMPLOYEE BENEFITS DEPARTMENT     4. 00     633, 933     278, 827     0     1. 00       2. 00     ADMI NI STRATI VE & GENERAL     5. 00     1, 763     1, 469     0     2. 00       3. 00     MAIN TENANCE & REPAI RS     6. 00     476     0     0     3. 00       4. 00     HOUSEKEEPI NG     9. 00     1, 715     478     0     4. 00       5. 00     NURSI NG ADMI NI STRATI ON     13. 00     0     484     0     5. 00       6. 00     ADULTS & PEDI ATRI CS     30. 00     36, 944     0     0     6. 00       7. 00     INTENSI VE CARE UNIT     31. 00     0     947     0     7. 00       8. 00     OPERATI NG ROOM     50. 00     2, 555     0     0     8. 00       9. 00     RADI OLOGY-DI AGNOSTI C     54. 00     0     205     0     9. 00       10. 00     LABORATORY     60. 00     2, 077     765     0     10. 00       11. 00     RESPI RATORY THERAPY     65. 00     1, 564     0     0     11. 00       12. 00     CARDI AC STRESS LAB     65. 10     0     90     0     12. 00       14. 00     EMERGENCY     91. 00     1, 539     0     0     13. 00		O STD TEAM AWARD & MACATION	N DECLACE	0	2, 188, 105		
2. 00 ADMI NI STRATI VE & GENERAL 5. 00 1, 763 1, 469 0 3. 00 4. 00 6. 00 4. 00 4. 00 4. 00 4. 00 4. 00 4. 00 4. 00 4. 00 6. 00 4. 00 4. 00 6. 00 4. 00 6. 00 4. 00 6. 00 4. 00 6. 0	1 00			622 022	270 027		1 00
3. 00 MAINTENANCE & REPAIRS 6. 00 476 0 0 0 476 0 0 4. 00 4. 00 4. 00 4. 00 4. 00 5. 00 1, 715 478 0 5. 00 NURSI NG ADMINISTRATION 13. 00 0 484 0 0 5. 00 6. 00 ADULTS & PEDIATRICS 30. 00 36, 944 0 0 0 7. 00 INTENSI VE CARE UNIT 31. 00 0 947 0 0 7. 00 PERATI NG ROOM 50. 00 2, 555 0 0 0 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 205 0 9. 00 9. 00 11. 00 RESPIRATORY THERAPY 65. 00 1, 654 0 0 12. 00 13. 00 RURAL HEALTH CLINIC (RHC) 88. 02 1, 347 0 0 12. 00 14. 00 EMERGENCY 91. 00 15. 00 14. 00 15. 00 16. 00 17. 00 18. 00 17. 00 18. 00 0 0 0 0 0 0 0 0 0 0 17. 00 18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						_	1
4. 00       HOUSEKEEPI NG       9. 00       1, 715       478       0       4. 00         5. 00       NURSI NG ADMI NI STRATI ON       13. 00       0       484       0       5. 00         6. 00       ADULTS & PEDI ATRI CS       30. 00       36, 944       0       0       6. 00         7. 00       INTENSI VE CARE UNI T       31. 00       0       947       0       7. 00         8. 00       OPERATI NG ROOM       50. 00       2, 555       0       0       8. 00         9. 00       RADI OLOGY-DI AGNOSTI C       54. 00       0       205       0       0         10. 00       LABORATORY       60. 00       2, 077       765       0       10. 00         11. 00       RESPI RATORY THERAPY       65. 00       1, 654       0       0       11. 00         12. 00       CARDI AC STRESS LAB       65. 10       0       90       0       12. 00         13. 00       RURAL HEALTH CLI NI C (RHC)       88. 02       1, 347       0       0       13. 00         15. 00       PHYSI CI ANS' PRI VATE OFFI CES       192. 00       338       0       0       0       16. 00         17. 00       0       0       0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>•</td></td<>							•
5. 00         NURSING ADMINISTRATION         13. 00         0         484         0         5. 00           6. 00         ADULTS & PEDIATRICS         30. 00         36, 944         0         0         0         6. 00           7. 00         INTENSI VE CARE UNI T         31. 00         0         947         0         7. 00           8. 00         OPERATI NG ROOM         50. 00         2, 555         0         0         0           9. 00         RADI OLOGY-DI AGNOSTI C         54. 00         0         205         0         9. 00           10. 00         LABORATORY         60. 00         2, 077         765         0         10. 00           11. 00         RESPI RATORY THERAPY         65. 00         1, 654         0         0         11. 00           12. 00         CARDI AC STRESS LAB         65. 10         0         90         0         12. 00           13. 00         RURAL HEALTH CLINIC (RHC)         88. 02         1, 347         0         0         13. 00           15. 00         PHYSI CLANS' PRI VATE OFFI CES         192. 00         338         0         0         15. 00           17. 00         0         0         0         0         0         <						1	1
6. 00 ADULTS & PEDIATRICS 30. 00 36, 944 0 0 0 7. 00 1NTENSI VE CARE UNIT 31. 00 0 947 0 7. 00 8. 00 OPERATI NG ROOM 50. 00 2, 555 0 0 0 8. 00 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 205 0 9. 00 10. 00 LABORATORY 60. 00 2, 077 765 0 10. 00 RESPIRATORY THERAPY 65. 00 1, 654 0 11. 00 CARDI AC STRESS LAB 65. 10 0 90 0 12. 00 13. 00 RURAL HEALTH CLINIC (RHC) 88. 02 1, 347 0 0 13. 00 RURAL HEALTH CLINIC (RHC) 91. 00 1, 539 0 0 14. 00 15. 00 PHYSI CLANS' PRI VATE OFFICES 192. 00 338 0 0 15. 00 17. 00 18. 00 0 0 0 0 0 0 0 0 0 17. 00 18. 00 0 0 0 0 0 0 0 0 0 0 18. 00 0 18. 00 0 0 18. 00			•	. 1		1	•
8. 00       OPERATING ROOM       50. 00       2,555       0       0       8. 00         9. 00       RADI OLOGY-DI AGNOSTI C       54. 00       0       205       0       9. 00         10. 00       LABORATORY       60. 00       2, 077       765       0       10. 00         11. 00       RESPI RATORY THERAPY       65. 00       1, 654       0       0       0         12. 00       CARDI AC STRESS LAB       65. 10       0       90       0       12. 00         13. 00       RURAL HEALTH CLINIC (RHC)       88. 02       1, 347       0       0       13. 00         14. 00       EMERGENCY       91. 00       1, 539       0       0       15. 00         15. 00       PHYSI CLANS' PRI VATE OFFI CES       192. 00       338       0       0       0         16. 00       0. 00       0       0       0       0       16. 00         17. 00       0. 00       0       0       0       0       17. 00         18. 00       0. 00       0       0       0       0       18. 00			30.00	36, 944	-		1
9. 00     RADI OLOGY-DI AGNOSTI C     54. 00     0     205     0     9. 00       10. 00     LABORATORY     60. 00     2, 077     765     0     10. 00       11. 00     RESPI RATORY THERAPY     65. 00     1, 654     0     0     0       12. 00     CARDI AC STRESS LAB     65. 10     0     90     0     12. 00       13. 00     RURAL HEALTH CLINIC (RHC)     88. 02     1, 347     0     0     13. 00       14. 00     EMERGENCY     91. 00     1, 539     0     0     14. 00       15. 00     PHYSI CLANS' PRI VATE OFFI CES     192. 00     338     0     0     0     15. 00       16. 00     0     0     0     0     0     16. 00       17. 00     0     0     0     0     0       18. 00     0     0     0     0     0				0			1
10. 00     LABORATORY     60. 00     2, 077     765     0     10. 00       11. 00     RESPIRATORY THERAPY     65. 00     1, 654     0     0       12. 00     CARDI AC STRESS LAB     65. 10     0     90     0     12. 00       13. 00     RURAL HEALTH CLINIC (RHC)     88. 02     1, 347     0     0     13. 00       14. 00     EMERGENCY     91. 00     1, 539     0     0     14. 00       15. 00     PHYSI CLANS' PRI VATE OFFI CES     192. 00     338     0     0     0     15. 00       16. 00     0     0     0     0     0     0     16. 00       17. 00     0     0     0     0     0     17. 00       18. 00     0     0     0     0     0			•	2, 555	-	_	· · · · · · · · · · · · · · · · · · ·
11. 00 RESPIRATORY THERAPY 65. 00 1, 654 0 0 0 12. 00 12. 00 13. 00 PHYSI CI ANS' PRI VATE OFFI CES 19. 00 0 0 18. 00 18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			•	2 077		l l	•
12. 00 CARDI AC STRESS LAB 65. 10 0 90 0 12. 00 13. 00 RURAL HEALTH CLINIC (RHC) 88. 02 1, 347 0 0 13. 00 14. 00 EMERGENCY 91. 00 1, 539 0 0 14. 00 15. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 338 0 0 15. 00 16. 00 17. 00 0 0 0 0 0 0 0 17. 00 18. 00 0 0 0 0 0 0 0 0 18. 00						_	· · · · · · · · · · · · · · · · · · ·
13. 00 RURAL HEALTH CLINIC (RHC) 88. 02 1, 347 0 0 0 14. 00 14. 00 15. 00 15. 00 15. 00 16. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
14. 00     EMERGENCY     91. 00     1,539     0     0     14. 00       15. 00     PHYSI CI ANS' PRI VATE OFFI CES     192. 00     338     0     0     0     15. 00       16. 00     0     0     0     0     0     16. 00       17. 00     0     0     0     0     0     17. 00       18. 00     0     0     0     0     0     18. 00				٥,		1	
15. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 338 0 0 0 15. 00 16. 00 17. 00 0 0 0 0 17. 00 18. 00 0 0 0 0 0 18. 00		1				-	
17. 00     0. 00     0     0     0     17. 00       18. 00     0. 00     0     0     0     0						1	
18.00	16.00		0.00		0	o	16. 00
			I .	O		-	•
19.00   0 0 0 19.00							
	19.00		0.00	O	0	0	19.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/28/2024 8:02 pm Provider CCN: 14-0064

						2/28/2024	8: 02 pm
		Decreases				ı	
	Cost Center	Li ne #	Salary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
20. 00		0. 00	0	0		1	20. 00
21. 00		0. 00	0	0			21. 00
22. 00		0. 00	0	0		l .	22. 00
23. 00		0.00	0	0		l .	23. 00
24.00		0.00	0	0	0		24. 00
25.00		0.00	0	0	0		25. 00
26.00		0.00	0	0	0		26. 00
27.00		0.00	o	0	0		27. 00
28.00		0.00	o	0	0		28. 00
29. 00		0.00	0	0			29. 00
30. 00		0.00	0	0	0	l .	30.00
31. 00		0.00	Ö	0		l .	31. 00
32. 00		0.00	o	0	0	l .	32. 00
33. 00		0.00	0	0		l .	33. 00
34. 00		0.00	0	0	0	l .	34. 00
		0.00	0	0	0		35. 00
35. 00			U	0	0		
36.00		0.00	U	0	0		36.00
37. 00		0.00	0	0	0		37. 00
38. 00		0. 00	O	0	0		38. 00
39. 00			•	0	0		39. 00
	0		684, 341	283, 265			
	P - CONTRACT LABOR						
1.00		0.00	0	0	0		1. 00
	<u>o</u>						
	Q - PCI COST						
1.00	MAINTENANCE & REPAIRS	6. 00	0	1, 244, 972	0		1. 00
2.00		0.00	o	0	0		2. 00
				1, 244, 972			
	R - OSFMG HOSP AND PALLIATIVE		-1	., ,			
1.00	ADULTS & PEDIATRICS	30.00	0	214, 483	0		1. 00
2. 00	ABOLIO U I EDIMINI OS	0.00	Ö	0			2. 00
2.00			— — <del>ў</del>	214, 483			2.00
	S - CENTRAL SUPPLY COST		<u> </u>	214, 403			
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	152, 297	0	0		1.00
1.00	ADMINISTRATIVE & GENERAL			$\frac{0}{0}$	<u> </u>		1.00
	U - MINISTRY OSFMG		152, 297	U			
1 00		20.00	٥	220 401			1 00
1.00	ADULTS & PEDIATRICS	30.00	0	239, 481			1.00
2.00	ANESTHESI OLOGY	53.00	0	47, 344		l .	2. 00
3. 00	RURAL HEALTH CLINIC (RHC)	88. 00	0	296, 935			3. 00
4.00	RURAL HEALTH CLINIC (RHC)	88. 01	O	98, 568			4. 00
5.00	RURAL HEALTH CLINIC (RHC)	88. 02	O	138, 743			5. 00
6.00	RURAL HEALTH CLINIC (RHC)	88. 03	0	29, 484			6. 00
7. 00	RURAL HEALTH CLINIC (RHC)	88. 04	0	11, 054	0		7. 00
8.00	EMERGENCY	91.00	0	214, 146	0		8. 00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2, 966	0		9. 00
	0		0	1, 078, 721			
	V - FOUNDATION EXPENSE						
1.00	FOUNDATION AND OTHER	194.00	0	304, 223	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	o	0	0		3. 00
4.00		0.00	o	0	0		4. 00
				304, 223			
	W - RHC SALARY ADJ - PRE CERT	DATE	-1				
1.00	RURAL HEALTH CLINIC (RHC)	88.00	879, 629	0	0		1. 00
2. 00	RURAL HEALTH CLINIC (RHC)	88. 01	272, 497	0			2. 00
3.00	RURAL HEALTH CLINIC (RHC)	88. 02	411, 709	0		l .	3. 00
4. 00	RURAL HEALTH CLINIC (RHC)	88. 03	147, 539	0	_	ł	4. 00
5. 00	RURAL HEALTH CLINIC (RHC)	88. 04	41, 339	0		l .	5. 00
5.00	TOTALS		1, 752, 713	— — <u> </u>			3.00
	X - RHC RECLASS - PRE CERT OT	THED EVDENES	1, 732, 713	U			
1 00			ما	220 714			1 00
1.00	RURAL HEALTH CLINIC (RHC)	88.00	Ö	338, 714		l .	1.00
2.00	RURAL HEALTH CLINIC (RHC)	88. 01	0	117, 595			2.00
3.00	RURAL HEALTH CLINIC (RHC)	88. 02	0	165, 281			3. 00
4.00	RURAL HEALTH CLINIC (RHC)	88. 03	0	57, 237		l .	4. 00
5. 00	RURAL HEALTH CLINIC (RHC)	<u>88.</u> 04	•	2 <u>1, 9</u> 12			5. 00
	TOTALS		0	700, 739			
	Y - RECLASS PREMIER ADMIN FEE	.S					
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	139, 718	0		1. 00
	TOTALS			139, 718		<u> </u>	
	Z - RECLASS CFH DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	406, 335	9		1. 00
	TOTALS	— — — <del>'</del> †		406, 335		1	1
	. '	'	-1		•	•	•

Heal th Financial Systems

ST. MARY MEDICAL CENTER

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 14-0064
From 10/01/2022
To 09/30/2023

Date/Time Prepared:

						То	09/30/2023   Date/Ti m	e Prepared: 4 8:02 pm	
		Decreases						4 8.02 piii	
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.	.			
	6. 00	7. 00	8. 00	9. 00	10.00				
	AA - CFH EXPENSES								_
1.00	ADMINISTRATIVE & GENERAL	5.00	0	56, 032	(	О		1. 00	)
2.00	MAINTENANCE & REPAIRS	6.00	164, 821	311, 926	(	О		2. 00	)
3.00	OPERATION OF PLANT	7.00	0	860, 922	(	О		3. 00	)
4.00	HOUSEKEEPI NG	9.00	0	11, 829		О		4. 00	)
	TOTALS		164, 821	1, 240, 709					
500.00	Grand Total: Decreases		5, 063, 009	13, 220, 459				500.00	)

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS ST. MARY MEDICAL CENTER Provider CCN: 14-0064

				-	Го 09/30/2023	Date/Time Pre 2/28/2024 8:0	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	10, 809, 848	0	(	0	39, 416	1. 00
2.00	Land Improvements	1, 805, 082	128, 400	(	128, 400	0	2. 00
3.00	Buildings and Fixtures	92, 709, 972	684, 329	(	684, 329	148, 278	3. 00
4.00	Building Improvements	12, 520	0	(	0	0	4. 00
5.00	Fi xed Equipment	32, 631, 485	1, 061, 124	(	1, 061, 124	0	5. 00
6.00	Movable Equipment	129, 130	0	(	0	0	6. 00
7.00	HIT designated Assets	0	0	(	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	138, 098, 037	1, 873, 853	(	1, 873, 853	187, 694	8. 00
9.00	Reconciling Items	0	0	(	0	0	9. 00
10.00	Total (line 8 minus line 9)	138, 098, 037	1, 873, 853	(	1, 873, 853	187, 694	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	10, 770, 432	0				1. 00
2.00	Land Improvements	1, 933, 482	0				2. 00
3.00	Buildings and Fixtures	93, 246, 023	0				3. 00
4.00	Building Improvements	12, 520	0				4. 00
5.00	Fi xed Equipment	33, 692, 609	0				5. 00
6.00	Movable Equipment	129, 130	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	139, 784, 196	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	139, 784, 196	0				10. 00

Heal th	n Financial Systems	ST. MARY MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 14-0064	Peri od:	Worksheet A-7	
					From 10/01/2022 To 09/30/2023		oorod:
					10 09/30/2023	2/28/2024 8: 0	
			Sl	UMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
	DART II. DECONOLILIATION OF AMOUNTS FROM WORK	9.00	10.00	11.00	12.00	13. 00	
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK			ina 2	0		1 00
1. 00 1. 01	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT	3, 841, 369			0	0	1. 00 1. 01
2. 00	CAP REL COSTS-BLDG & FIXT	1, 939, 156			0	J 0	2. 00
3. 00	Total (sum of lines 1-2)	5, 780, 525			0	0	3. 00
3.00	Total (Suil of Titles 1-2)	SUMMARY 0		/	0 0	0	3.00
		JONINI II C	. O/11 1 1/12				
	Cost Center Description	Other	Total (1) (sum	า			
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM					
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 841, 369			ļ	1.00
1. 01	CAP REL COSTS BLDG & FIXT	0	1 020 15/	2		ļ	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 939, 156				2. 00 3. 00
3. 00	Total (sum of lines 1-2)	ı U	5, 780, 525	P		ļ	3.00

Provider CCN: 14-0064   Peri od: From 10/01/2022   Part III   Date/Time Prepared: 27/28/2024 8:02 pm   Provider CCN: 14-0064   Peri od: From 10/01/2022   Part III   Date/Time Prepared: 27/28/2024 8:02 pm   Part III   Part Prepared: 27/28	Heal th	Financial Systems	ST. MARY MEDI	ICAL CENTER		In Lie	u of Form CMS-2	552-10
Cost Center Description				Provi der C		From 10/01/2022 To 09/30/2023	Part III Date/Time Prep 2/28/2024 8:02	
Leases   Cor Ratio   Cool   1 - col   Cool   Cool   1 - col   Cool   Cool   Cool   1 - col   Cool			COME	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS   93, 258, 543   0   93, 258, 543   0   0   0   0   0   0   0   0   0		Cost Center Description	Gross Assets		for Ratio (col. 1 - col	instructions)	Insurance	
1.00   CAP REL COSTS-BLDG & FIXT   93, 258, 543   0   93, 258, 543   0   733783   162, 329   1.00			1.00	2. 00	3.00	4. 00	5. 00	
1. 01   CAP REL COSTS-BLDG & FIXT   0   0   0   0   0   0   0   0   0								
2.00   CAP REL COSTS-MVBLE EQUIP   33, 834, 259   0   33, 834, 259   1.000000   221, 222   3.00	1.00		93, 258, 543	C	93, 258, 54		162, 329	1.00
Total (sum of lines 1-2)   127, 092, 802   0   127, 092, 802   1.000000   221, 222   3.00	1.01	CAP REL COSTS-BLDG & FLXT	0	0	1		0	1. 01
ALLOCATION OF OTHER CAPITAL   SUMMARY OF CAPITAL	2.00	CAP REL COSTS-MVBLE EQUIP	33, 834, 259	0			58, 893	2.00
Cost Center Description	3.00	Total (sum of lines 1-2)		0				3. 00
Capital -Rel ate d Costs			ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY 0	F CAPITAL	
PART       - RECONCILIATION OF CAPITAL COSTS CENTERS		Cost Center Description		Capi tal -Rel ate	cols. 5	Depreciation	Lease	
1.00			6. 00	7.00	8.00	9. 00	10.00	
1. 01 CAP REL COSTS-BLDG & FIXT 0 0 0 260, 091 3, 533, 645 0 2. 00 3. 00 Total (sum of lines 1-2) 755, 766 0 976, 988 7, 360, 218 0 3. 00 SUMMARY OF CAPITAL  Cost Center Description Interest Insurance (see instructions) Capital -Related Costs (see instructions) 1. 00 12. 00 13. 00 14. 00 15. 00 15. 00 162, 329 554, 568 0 4, 137, 135 1. 00 1. 01 CAP REL COSTS-BLDG & FIXT 0 0 0 58, 893 201, 198 0 3, 793, 736 2. 00 1. 01 1. 0		PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
2.00 CAP REL COSTS-MVBLE EQUIP 201, 198 0 260, 091 3, 533, 645 0 2.00 755, 766 0 976, 988 7, 360, 218 0 3.00 SUMMARY OF CAPITAL  Cost Center Description Interest Insurance (see instructions) Instructions Instructi	1.00	CAP REL COSTS-BLDG & FIXT	554, 568	0	716, 89	7 3, 420, 238	0	1.00
Total (sum of lines 1-2)   755,766   0   976,988   7,360,218   0   3.00   SUMMARY OF CAPITAL     Cost Center Description	1.01	CAP REL COSTS-BLDG & FIXT	0	0		0 406, 335	0	1. 01
SUMMARY OF CAPITAL   Cost Center Description   Interest   Insurance (see instructions)   Instructions   Instr	2.00	CAP REL COSTS-MVBLE EQUIP	201, 198	0	260, 09	1 3, 533, 645	0	2.00
Cost Center Description	3.00	Total (sum of lines 1-2)	755, 766				0	3. 00
instructions   instructions   Capital -Relate   d Costs (see instructions)				Sl	JMMARY OF CAPI			
11.00   12.00   13.00   14.00   15.00		Cost Center Description	Interest			Capi tal -Rel ate	of cols. 9	
PART       - RECONCILIATION OF CAPITAL COSTS CENTERS						instructions)		
1. 00     CAP REL COSTS-BLDG & FIXT     0     162, 329     554, 568     0     4, 137, 135     1. 00       1. 01     CAP REL COSTS-BLDG & FIXT     0     0     0     0     406, 335     1. 01       2. 00     CAP REL COSTS-MVBLE EQUIP     0     58, 893     201, 198     0     3, 793, 736     2. 00				12.00	13. 00	14. 00	15. 00	
1.01     CAP REL COSTS-BLDG & FIXT     0     0     0     0     406, 335     1.01       2.00     CAP REL COSTS-MVBLE EQUIP     0     58, 893     201, 198     0     3, 793, 736     2.00			ENTERS					
2.00 CAP REL COSTS-MVBLE EQUIP 0 58, 893 201, 198 0 3, 793, 736 2.00			-	1				
			0	٧ -	1	٥		
3.00  Total (sum of lines 1-2)   0  221,222  755,766  0  8,337,206  3.00			-					
	3. 00	Total (sum of lines 1-2)	0	221, 222	2 755, 76	6 0	8, 337, 206	3. 00

				I	0 09/30/2023	Date/lime Prep   2/28/2024 8:03	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1. 00
1.00	COSTS-BLDG & FIXT (chapter 2)			CAL REE COSTS-BEDG & TTAT	1.00	0	1.00
1. 01	Investment income - CAP REL		О	CAP REL COSTS-BLDG & FIXT	1. 01	0	1. 01
0.00	COSTS-BLDG & FIXT (chapter 2)			OAR REL COCTO MARRIE FOLLIR			0.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		U.	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3.00	Investment income - other		o		0.00	0	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
7.00	stations excluded) (chapter		J		0.00		,, 00
	21)		_			_	
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking lot (chapter 21)		О		0.00	0	9. 00
10.00	Provi der-based physician	A-8-2	-6, 705, 613			0	10. 00
11 00	adjustment			ODERATION OF DIANT	7.00		11 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		O <sub>I</sub>	OPERATION OF PLANT	7. 00	0	11. 00
12. 00	Related organization	A-8-1	196, 910			0	12. 00
	transactions (chapter 10)						
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	B B	210 207	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee		-310, 267	CAFETERIA	0.00	0	15. 00
	and others						
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		О		0.00	0	17. 00
	pati ents						
18. 00	Sale of medical records and abstracts	В	-200	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health		o		0.00	0	19. 00
	education (tuition, fees,						
20.00	books, etc.)	D	2 147	CAFETERIA	11 00		20.00
20. 00 21. 00	Vending machines Income from imposition of	B B		CAFETERIA ADMINISTRATIVE & GENERAL	11. 00 5. 00	0	20. 00 21. 00
21.00	interest, finance or penalty		12, 00 1.	NOW WE A SENSION	0.00	J	21.00
	charges (chapter 21)		_			_	
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
	repay Medicare overpayments	ή					
23. 00	Adjustment for respiratory	A-8-3	О	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
	therapy costs in excess of						
05.00	limitation (chapter 14)						05 00
25. 00	Utilization review - physicians' compensation		O	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL	A	514, 710	CAP REL COSTS-BLDG & FIXT	1.00	9	26. 00
26 01	COSTS-BLDG & FLXT Depreciation - CAP REL			CAD DEL COSTS BLDC & ELVT	1. 01	0	26 01
26. 01	COSTS-BLDG & FLXT			CAP REL COSTS-BLDG & FIXT	1.01		26. 01
27. 00	Depreciation - CAP REL	A	281, 237	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
20.00	COSTS-MVBLE EQUIP	Δ.	0 407 440	MONDHYSI CI ANI ANESTUETI STO	10.00		20.00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant	A	-2, 43/, 418 ∩	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	Ö	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see			ADULTS & PEDIATRICS	30. 00		30. 99
50. 77	instructions)		ا	ADDETO & LEDIATIVIOS	30.00		JU. 17
	•	. '	'		•	. '	

Peri od: Worksheet A-8 From 10/01/2022 To 09/30/2023 Date/Time Prepared:

				To	09/30/2023	Date/Time Prep 2/28/2024 8:03	
				Expense Classification on To/From Which the Amount is		1272072021 010	, j
				10711 oili Will oil the Alliount 13	to be haj usted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	·	1.00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14)		0		0.00	0	22.00
32.00	CAH HIT Adjustment for Depreciation and Interest		O		0.00	U	32. 00
33. 00 33. 01	ADVERTISING AND MARKETING OTHER ADJUSTMENTS (SPECIFY)	A	-292 0	ADMINISTRATIVE & GENERAL	5. 00 0. 00	0	33. 00 33. 01
	(3)						
37. 06 37. 07	OTHER REVENUES - DIETARY PHARMACY 340B	B A		DIETARY DRUGS CHARGED TO PATIENTS	10. 00 73. 00	0	37. 06 37. 07
37. 09	DPA PROVI DER TAX	A		ADMI NI STRATI VE & GENERAL	5. 00	Ö	37. 09
37. 10	PHYS OFFICE AND RENT	В		ADMINISTRATIVE & GENERAL	5. 00	0	37. 10
37. 11	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5.00	0	37. 11
37. 12 37. 13	MOONLIGHTING RESIDENT PART B EMPLOYEE BENEFITS -	A A	· ·	ADULTS & PEDIATRICS EMPLOYEE BENEFITS DEPARTMENT	30. 00 4. 00	0	37. 12 37. 13
37. 13	CRNA		300, 307	EWI EGTEE BENEFT 13 BET AKTIMENT	4.00		37.13
37. 14	CRNA CONTRACT COST	A		NONPHYSICIAN ANESTHETISTS	19. 00	0	
37. 15	I HA, AHA, CHA DUES	A	· ·	ADMINISTRATIVE & GENERAL	5.00	0	37. 15
37. 16	OSFMG OUTSIDE TRAINING SESSIONS	A	-3, 1/0	ADULTS & PEDIATRICS	30. 00	0	37. 16
37. 17	ADVERTISING AND MARKETING	A		RECOVERY ROOM	51.00	0	37. 17
37. 18	OCCUPATI ONAL MEDI CI NE	A	•	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	37. 18
37. 20	VENDING MACHINE REVENUES	В		EMERGENCY CARDLAC DELIAR	91. 00	0	37. 20
37. 21 37. 22	CARDIAC REHAB RECRUITING - ICU	B A		CARDIAC REHAB INTENSIVE CARE UNIT	65. 20 31. 00	0	37. 21 37. 22
37. 23	RECRUITING - ADULTS & PEDS	A		ADULTS & PEDIATRICS	30. 00	Ö	37. 23
38. 00	RECRUITING - ADULTS & PEDS	A		ADULTS & PEDIATRICS	30. 00	0	38. 00
39. 00	RECRUITING - EMERGENCY	A		EMERGENCY	91. 00	0	39. 00
40. 00 45. 00	RECRUITING RHC RECRUITING RHC	A A		RURAL HEALTH CLINIC (RHC) RURAL HEALTH CLINIC (RHC)	88. 00 88. 02	0	40. 00 45. 00
46. 00	RECRUITING RHC	A		RURAL HEALTH CLINIC (RHC)	88. 01	0	46.00
47. 00	RECRUITING - OPERATING ROOM	A		OPERATING ROOM	50. 00	0	47. 00
47. 01	RECRUITING - RECOVERY ROOM	A		RECOVERY ROOM	51. 00	0	47. 01
47. 02	RECRUITING - PHYSICAL THERAPY	A		PHYSI CAL THERAPY	66.00	0	47. 02
47. 03 47. 04	RECRUITING - SPEECH PATHOLOGY RECRUITING - OCCUPATIONAL	A A		SPEECH PATHOLOGY OCCUPATIONAL THERAPY	68. 00 67. 00	0	47. 03 47. 04
47.04	THERAPY		1,071	OGGOTATTONAL THEMATT	07.00		47.04
47. 05	RECRUITING - PHARMACY	A		DRUGS CHARGED TO PATIENTS	73. 00	0	
47. 06	RECRUITING - ADMIN & GEN	A		ADMINISTRATIVE & GENERAL	5. 00	0	47. 06
47. 07	FOUNDATION EXPENSE - ADMIN & GENERAL	A	-69, 416	ADMINISTRATIVE & GENERAL	5. 00	0	47. 07
47. 08	MALPRACTICE FUNDING	Α	706, 187	ADMINISTRATIVE & GENERAL	5. 00	0	47. 08
47. 09	RHC PROVIDERS - HRS & SALARY	A	3, 009	RURAL HEALTH CLINIC (RHC)	88. 01	0	47. 09
47. 10	ADJ RHC PROVIDERS - HRS & SALARY	А	15, 193	RURAL HEALTH CLINIC (RHC)	88. 02	0	47. 10
47. 11	ADJ RHC PROVI DERS - HRS & SALARY	А	12. 585	RURAL HEALTH CLINIC (RHC)	88. 04	0	47. 11
	ADJ			, ,			
47. 12	RHC PROVIDERS - HRS & SALARY ADJ	A		RURAL HEALTH CLINIC (RHC)	88. 00	0	47. 12
47. 13	RHC PROVIDERS - HRS & SALARY ADJ	A	8, 450	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	47. 13
47. 14	FOUNDATION EXPENSE - ADULTS & PEDS	А	-7, 627	ADULTS & PEDIATRICS	30. 00	0	47. 14
47. 15	FOUNDATION EXPENSE - CARDIAC REHAB	А	-175	CARDI AC REHAB	65. 20	0	47. 15
47. 16	ADVERTISING & MARKETING -	А	-65	RADI OLOGY-DI AGNOSTI C	54. 00	0	47. 16
47. 17	RADI OLOGY PENSI ON	А	213 000	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	47. 17
47. 18	OTHER ADJUSTMENTS (SPECIFY)	^	210, 666	Emi corec beneriro berantimenti	0. 00	Ö	
47. 19	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	47. 19
47. 20	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	
	(3)				0.00		
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14, 050, 011				50. 00
(1) De	scription - all chapter referer	nces in this col	umn pertain to	CMS Pub 15-1			

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

Health Financial Systems		ST. MARY MED	ICAL CENTER	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 10/01/2022 To 09/30/2023	Date/Time Pre 2/28/2024 8:0	
			Expense Classification or	Norksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2. 00	3. 00	4. 00	5. 00	

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

Provider CCN: 14-0064

Worksheet A-8-1 From 10/01/2022

OTTTOL	60313			To 09/30/2023	Date/Time Prep 2/28/2024 8:02	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00			MI NI STRY BLDG	529, 571	1, 059, 077	1.00
2.00			MI NI STRY EQUI PMENT	1, 313, 252	0	2.00
3.00		l .	MINISTRY POOLED EB	591, 805	591, 805	3. 00
3. 01			MINISTRY POOLED A&G	7, 762, 544	11, 532, 702	3. 01
3. 03			MINISTRY POOLED ENGINEERII		317, 587	3. 03
3. 04			MINISTRY POOLED PHARMACY	139, 794	139, 794	3. 04
3.05			MINISTRY POOLED - OSFMG	1, 078, 721	1, 078, 721	3. 05
3.06			MINISTRY FUNCTIONAL REHAB	68, 578	61, 180	3. 06
3.07			MINISTRY FUNCTIONAL REHAB	16, 688	14, 888	3. 07
3.08			MINISTRY FUNCTIONAL REHAB	12, 523	11, 172	3. 08
3.09			MINISTRY FUNCTIONAL PHARM		0	3. 09
3. 10			MINISTRY FUNCTIONAL REVEN		4, 044, 422	3. 10
4.00			MINISTRY FUNCTIONAL MEDICA		229, 119	4. 00
4.03			MINISTRY FUNCTIONAL REGIO		0	4. 03
4.04			MINISTRY FUNCTIONAL NURSI		0	4. 04
4. 05			MINISTRY FUNCTIONAL CARE I		1, 051, 679	4. 05
4.06			MINISTRY FUNCTIONAL CARE I		0	4. 06
4. 07			MINISTRY FUNCTIONAL SAFET		0	4. 07
4. 08			MINISTRY FUNCTIONAL SUPPLY		0	4. 08
4. 09			PCI HTS - ENGINEERING	694, 707	728, 314	4. 09
4. 10			PCI HTS - I MAGI NG	995, 719	1, 043, 887	4. 10
4. 11			PCI HTS - LABORATORY	191, 805	201, 084	4. 11
4. 12		l l	PCI / SFI - EQUIPMENT RENTAL		5, 938	4. 12
4. 13		l .	PCI / SFI - CREDENTIALING	57, 278	57, 278	4. 13
4. 14			EICU PURCHASED SERVICES	148, 862	231, 600	4. 14
4. 15		l .	E-PHARMACY SERVICES	556, 788		4. 15
4. 16		l .	ST GABRIEL PURCHASED SERVIC	1	884, 446	4. 16
4. 17	0.00			0	00 044 404	4. 17
5.00	TOTALS (sum of lines 1-4).			24, 038, 391	23, 841, 481	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2, line 12.					
	amounts on lines 1-4 (and sub	poorinto ao appropriato\ ara t	transformed in detail to Was	kshoot A column	4 Lines as	

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

			Related Organization(s) and/or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2.00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

i ci ilibai	Sement ander the Aviii.					
6.00	В	OSF HEALTHCARE SYSTEMS	100.00	OSF HEALTHCARE	100.00	6. 00
7.00			0.00		0.00	7. 00
8.00			0.00		0.00	8. 00
9.00			0.00		0.00	9. 00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					I

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

OFFICE	00515		To 09/30/2	
	Net	Wkst. A-7 Ref.		,
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
	A. COSTS INCUR	RED AND ADJUSTME	ITS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS	OR CLAIMED
	HOME OFFICE CO	STS:		
1.00	-529, 506			1.00
2.00	1, 313, 252	9		2. 00
3.00	0	0		3. 00
3. 01	-3, 770, 158	0		3. 01
3.03	0	0		3. 03
3.04	0	0		3. 04
3.05	0	0		3. 05
3.06	7, 398	0		3. 06
3.07	1, 800	0		3. 07
3.08	1, 351	0		3. 08
3. 09	15, 224	0		3. 09
3. 10	644, 709	0		3. 10
4.00	27, 180	0		4. 00
4.03	216, 368	0		4. 03
4.04	1, 532, 964	0		4. 04
4.05	394, 953	0		4. 05
4.06	232, 570	0		4. 06
4. 07	53, 424	0		4. 07
4. 08	233, 660	0		4. 08
4.09	-33, 607	0		4. 09
4. 10	-48, 168	0		4. 10
4. 11	-9, 279	0		4. 11
4. 12	-2, 409	0		4. 12
4. 13	0	0		4. 13
4. 14	-82, 738	0		4. 14
4. 15	0	o		4. 15
4. 16	-2, 078	o		4. 16
4. 17	0	0		4. 17
5.00	196, 910			5.00

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

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	CATHOLIC SYSTEM	6.00
7.00		7.00
8. 00 9. 00		8.00
9.00		9.00
10. 00		10.00
100.00		100.00

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 14-0064 

							Fo 09/30/2023	B   Date/Time Pro   2/28/2024 8:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi on	al	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	t	Component		ider Component	
						·		Hours	
	1. 00	2. 00	3.00	4. 00		5. 00	6. 00	7. 00	
1.00	30. 00	ADULTS & PEDIATRICS	2, 466, 937			0	0	0	1. 00
2.00	53. 00	ANESTHESI OLOGY	1, 536, 419	1, 536,	419	0	0	0	2. 00
3.00	76. 01	PAIN CLINIC	312, 000	312,	000	0	0	0	3. 00
4.00	91. 00	EMERGENCY	2, 390, 257	2, 390,	257	0	0	0	4. 00
5.00	0.00		0		0	0	0	0	5. 00
6.00	0.00		0		0	0	0	0	6. 00
7.00	0.00		0		0	0	0	0	7. 00
8.00	0.00		0		0	0	0	0	8. 00
9.00	0.00		0		0	0	0	0	9. 00
10.00	0.00		0		0	0	0	0	10.00
200.00			6, 705, 613			0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent	of	Cost of	Provi der	Physician Cost	
		ldenti fi er	Limit		RCE I	Memberships &	Component	of Malpractice	
				Limit		Conti nui ng	Share of col.	Insurance	
						Educati on	12		
1.00	1. 00	2.00	8.00	9. 00		12. 00	13.00	14.00	4 00
1.00		ADULTS & PEDIATRICS	0	1	0	0			
2.00		ANESTHESI OLOGY	0		0	0	0		
3.00		PAIN CLINIC	0		0	0	0	0	
4.00		EMERGENCY	0		0	0	0	0	
5.00	0.00		0		0	0	0	0	0.00
6.00	0. 00 0. 00		0		0	0	0	0	
7.00			0		0	0	0	0	7. 00
8. 00 9. 00	0. 00 0. 00		0		0	0	0	0	0.00
			0		0	0	0	0	7.00
10. 00 200. 00	0. 00		0		0	0	0	0	10. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted R	CE	RCE	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit		Di sal I owance	Auj us tillerit		
		rdentifier	Share of col.	Lilli		Di Sai i Owance			
			14						
	1. 00	2.00	15. 00	16. 00		17. 00	18. 00		
1.00	30. 00	ADULTS & PEDIATRICS	0		0	0	2, 466, 937		1. 00
2.00	53. 00	ANESTHESI OLOGY	0		0	0	1, 536, 419		2. 00
3.00	76. 01	PAIN CLINIC	0		0	0	312,000		3. 00
4.00	91. 00	EMERGENCY	0		0	0	2, 390, 257		4. 00
5.00	0.00		0		0	0	0		5. 00
6.00	0.00		0		0	0	0		6. 00
7.00	0.00		0		0	0	0		7. 00
8.00	0.00		0		0	0	0		8. 00
9.00	0.00		0		0	0	0		9. 00
10.00	0.00		0		0	0	0		10. 00
200.00			0		0	0	6, 705, 613		200.00
			•	•			•	•	•

| Period: | Worksheet B | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0064

					T	09/30/2023	Date/Time Pre	
				CAP	TAL RELATED CO	STS	2/28/2024 8: 0	2 pm
		Cook Cooker December 1	Nat Francisco	DIDC & FLVT	DIDC & FLVT	MVDLE FOULD	EMDL OVEE	
		Cost Center Description	Net Expenses for Cost	BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	
			Allocation				DEPARTMENT	
			(from Wkst A col. 7)					
			0	1.00	1. 01	2. 00	4. 00	
1.00		AL SERVICE COST CENTERS						4 00
1. 00 1. 01	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT	4, 137, 135 406, 335					1. 00 1. 01
2.00		CAP REL COSTS-MVBLE EQUIP	3, 793, 736		100, 000	3, 793, 736		2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	11, 972, 826		0	0	11, 976, 337	4. 00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	19, 273, 079 1, 852, 499			1, 549, 590 2, 482	483, 893 198, 262	5. 00 6. 00
7. 00		OPERATION OF PLANT	1, 759, 951	292, 109		81, 665	0	7. 00
8.00		LAUNDRY & LINEN SERVICE	409, 254	15, 299		0	13, 276	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	1, 347, 373 493, 647	22, 197 60, 278		10, 776 13, 207	247, 348 75, 516	9. 00 10. 00
11. 00		CAFETERI A	685, 352	40, 143		16, 458	149, 251	•
13.00		NURSI NG ADMINI STRATI ON	2, 347, 693			231, 929	222, 667	13.00
14. 00 16. 00		CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY	97, 112 258, 592	14, 631 0	0	0	41, 990 0	14. 00 16. 00
17. 00	01700	SOCIAL SERVICE	1, 447, 448			0	0	17. 00
19. 00		NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	11, 086, 602	386, 956	0	76, 819	2, 501, 886	30. 00
31.00	03100	INTENSIVE CARE UNIT	2, 165, 723	126, 672	0	56, 777	506, 644	31. 00
43. 00		NURSERY LARY SERVICE COST CENTERS	485, 618	32, 117	0	17, 909	129, 544	43. 00
50. 00		OPERATING ROOM	2, 804, 683	311, 170	0	933, 738	701, 965	50. 00
51.00	05100	RECOVERY ROOM	1, 451, 060			24, 654	370, 638	
52.00		DELIVERY ROOM & LABOR ROOM	1, 015, 844	63, 413		40, 132	270, 339	52.00
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	303, 423 3, 121, 273	2, 215 107, 444		27, 947 118, 485	48, 127 512, 938	53. 00 54. 00
55. 00	1	RADI OLOGY - THERAPEUTI C	0	0		0	0	55. 00
56.00	1	RADI OI SOTOPE	367, 787	7, 678		1, 365	44, 465	
57. 00 58. 00	05800	CT SCAN MRI	1, 075, 134 422, 667	14, 226 14, 909		204, 404 69, 843	153, 854 97, 559	•
60.00		LABORATORY	5, 167, 429	77, 751		68, 713	635, 179	60.00
63.00		BLOOD STORING, PROCESSING & TRANS.	591, 366	0	_	0	0	63.00
65. 00 65. 10		RESPI RATORY THERAPY CARDI AC STRESS LAB	880, 340 459, 846			24, 301 55, 629	186, 584 122, 935	65. 00 65. 10
65. 20	1	CARDI AC REHAB	71, 837	10, 018		0	30, 806	
66.00	1	PHYSI CAL THERAPY	1, 246, 495		0	14, 375	294, 189	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	339, 670 253, 647	37, 454 4, 138		93 70	86, 384 64, 184	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	119, 984	0		0	33, 081	69. 00
70.00		ELECTROENCEPHALOGRAPHY	14, 065	0		4, 704	3, 878	70.00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	1, 958, 745 1, 680, 716		0	0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	8, 555, 137		Ö	21, 271	252, 977	
76. 00		SLEEP LAB	344, 135			369	48, 916	
76. 01 77. 00		PAIN CLINIC ALLOGENEIC HSCT ACQUISITION	64, 316	8, 569 0		4, 874 0	17, 130 0	76. 01 77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY	Ö	0		0	0	78. 00
00.00		TIENT SERVICE COST CENTERS	4 444 704	400 (00		40.047	00/ 004	00.00
88. 00 88. 01		RURAL HEALTH CLINIC (RHC) RURAL HEALTH CLINIC (RHC)	4, 411, 731 1, 342, 885	199, 630 0		13, 367 33, 992	886, 284 292, 575	88. 00 88. 01
88. 02		RURAL HEALTH CLINIC (RHC)	1, 923, 738			13, 149	458, 692	
88. 03	1	RURAL HEALTH CLINIC (RHC)	614, 265			5, 068	130, 958	
88. 04 91. 00		RURAL HEALTH CLINIC (RHC) EMERGENCY	249, 234 5, 293, 538		0	1, 914 49, 981	46, 717 995, 531	88. 04 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	0,270,000	127,000		17, 701	770,001	92. 00
400.00		REI MBURSABLE COST CENTERS				ام		100 00
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118.00	+	SUBTOTALS (SUM OF LINES 1 through 117)	110, 164, 965	3, 522, 375	6, 704	3, 790, 050	11, 357, 162	118. 00
100.00		MBURSABLE COST CENTERS	474 (60	40.40:		2 42	10 (07	100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	174, 618 2, 533, 461	10, 186 524, 260		3, 426 0	19, 697 500, 025	
193.00	19300	NONPALD WORKERS	8, 665	60, 542	0	0	0	193. 00
		FOUNDATION AND OTHER	177, 589			260		194. 00
		FITNESS CENTER VACANT SPACE	196, 488 1, 374, 586	18, 156 0		0	52, 098 44, 443	
200.00		Cross Foot Adjustments	1, 3, 4, 330		3,7,031			200. 00
201.00	)	Negative Cost Centers		0	0	0	0	201. 00

Health Financial Systems	ST. MARY MEDICAL CENTER In Lieu of Form C				u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO		Period: From 10/01/2022	Worksheet B Part I	
				To 09/30/2023	Date/Time Pre	pared:
					2/28/2024 8:0	2 pm
		CAPI	TAL RELATED C	0STS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	1. 01	2. 00	4.00	
202.00 TOTAL (sum lines 118 through 201)	114, 630, 372	4, 137, 135	406, 33	3, 793, 736	11, 976, 337	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0064

Peri od: Worksheet B From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared:

2/28/2024 8:02 pm Cost Center Description Subtotal ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & **REPAI RS** LINEN SERVICE & GENERAL **PLANT** 4A 7. 00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00101 CAP REL COSTS-BLDG & FIXT 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 21, 905, 399 21, 905, 399 5.00 00600 MAINTENANCE & REPAIRS 601, 525 3, 147, 761 6.00 2, 546, 236 6.00 7.00 00700 OPERATION OF PLANT 2, 133, 725 504, 073 302, 285 2, 940, 083 7.00 00800 LAUNDRY & LINEN SERVICE 103, 433 15, 832 573, 453 8.00 437, 829 16, 359 8.00 9.00 00900 HOUSEKEEPI NG 1, 627, 694 384, 528 22, 970 23, 734 9.00 0 10.00 01000 DI ETARY 642,648 151, 820 62, 378 64, 452 0 10.00 01100 CAFETERIA 42, 923 891, 204 210, 539 11 00 41, 542 11.00 0 01300 NURSING ADMINISTRATION 13.00 2, 813, 910 664, 761 12,026 12, 425 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 153, 733 36, 318 15, 140 15, 644 0 14.00 01600 MEDICAL RECORDS & LIBRARY 16.00 258, 592 61.090 16, 00 0 0 01700 SOCIAL SERVICE 0 341, 947 17.00 1, 447, 448 0 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 14, 052, 263 3, 319, 678 400, 436 274. 485 30.00 413, 750 03100 INTENSIVE CARE UNIT 59, 295 31.00 2, 855, 816 674, 661 131.085 135.444 31 00 04300 NURSERY 665, 188 <u>15</u>7, 145 34, 341 14,075 43.00 33, 236 43.00 ANCILLARY SERVICE COST CENTERS 4, 751, 556 1, 122, 512 332, 716 05000 OPERATING ROOM 322, 010 50.00 53, 102 50.00 05100 RECOVERY ROOM 51.00 1, 954, 242 461, 672 111, 648 115, 360 47, 654 51.00 328, 311 65, 622 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 389, 728 67,804 31, 542 52.00 05300 ANESTHESI OLOGY 53.00 381, 712 90, 176 2, 293 2, 369 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 3, 860, 140 911, 923 111, 187 114, 883 23, 282 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 0 55.00 C 05600 RADI OI SOTOPE 421, 295 99, 527 7, 945 8, 209 56.00 0 56.00 57.00 05700 CT SCAN 341. 987 14.722 15, 212 57.00 1, 447, 618 0 05800 MRI 15, 942 58.00 604.978 142, 921 15, 429 0 58.00 60.00 06000 LABORATORY 5, 949, 072 1, 405, 415 80, 459 83, 134 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 591, 366 139, 705 C 0 63.00 65 00 06500 RESPIRATORY THERAPY 1 101 118 260 129 10. 238 10, 578 0 65 00 06501 CARDI AC STRESS LAB 65.10 671, 628 158, 666 34, 375 35, 518 0 65.10 06502 CARDI AC REHAB 112, 661 26, 615 10, 367 10, 712 0 65.20 65.20 18, 293 66.00 06600 PHYSI CAL THERAPY 1, 681, 160 397, 159 130, 494 134, 833 66.00 06700 OCCUPATIONAL THERAPY 40, 048 38, 759 67.00 463,601 109, 522 0 67.00 68.00 06800 SPEECH PATHOLOGY 322, 039 76, 079 4, 283 4, 425 0 68.00 69.00 06900 ELECTROCARDI OLOGY 153, 065 36, 160 C 0 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 5, 350 0 0 Ω 70 00 22.647 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 1, 958, 745 462, 736 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 680, 716 397, 054 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 8, 852, 780 2,091,390 24, 210 25, 015 0 73.00 03610 SLEEP LAB 13, 990 76 00 406 504 96,033 13 540 0 76.00 76.01 03020 PAIN CLINIC 94, 889 22, 417 8, 868 9, 163 0 76.01 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 5, 511, 012 1, 301, 927 206, 584 213, 453 0 88.00 08801 RURAL HEALTH CLINIC (RHC) 0 88.01 1, 676, 156 395, 977 88.01 08802 RURAL HEALTH CLINIC (RHC) 2, 438, 732 576, 128 46, 141 88. 02 88.02 44.656 0 88 03 08803 RURAL HEALTH CLINIC (RHC) 798, 669 188.678 50 064 51, 728 0 88 03 08804 RURAL HEALTH CLINIC (RHC) 331, 766 78, 377 35, 082 36, 248 88.04 88.04 0 91 00 09100 EMERGENCY 6, 466, 433 1, 527, 637 131, 821 136, 203 51, 725 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 0 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 108, 527, 713 20, 463, 701 2, 511, 586 2, 282, 756 573, 453 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 207, 927 49, 121 10, 540 10, 891 0 190. 00 0 192.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 840, 485 3, 557, 746 542, 522 560, 560 193. 00 19300 NONPALD WORKERS 0 193.00 69, 207 16, 350 62,652 64, 735 194.00 07950 FOUNDATION AND OTHER 182, 377 43, 085 1,673 1, 728 0 194.00 194. 01 07951 FITNESS CENTER 266, 742 63, 015 18, 788 19, 413 0 194. 01 194. 02 07952 VACANT SPACE 0 194, 02 1,818,660 429, 642 0 0 200.00 Cross Foot Adjustments 200. 00 0 201.00 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) 114, 630, 372 21, 905, 399 3, 147, 761 2, 940, 083 573, 453 202. 00

Provider CCN: 14-0064

In Lieu of Form CMS-2552-10
Worksheet B
01/2022 Part I
30/2023 Date/Time Prepared:
2/28/2024 8:02 pm Peri od: From 10/01/2022 To 09/30/2023

	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	2 pm
	T	9. 00	10.00	11.00	13.00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 14. 00 17. 00	00101 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2, 058, 926 45, 759 30, 474 8, 822 11, 107 0 0	967, 057 0 0 0 0 0 0	1, 216, 682 20, 691 12, 633 ( (	3, 532, 635 0 0 0	244, 575 0 0 0	1. 01 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 16. 00 17. 00
30. 00	03000 ADULTS & PEDIATRICS	293, 753	780, 024	342, 140	2, 008, 835	22, 427	30.00
31.00	03100   NTENSI VE CARE UNI T	96, 162	106, 517	61, 389		4, 765	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	24, 382	24, 849	16, 646	97, 738	1, 722	43. 00
50. 00	05000 OPERATING ROOM	236, 221	0	100, 905	592, 457	0	50.00
51.00	05100 RECOVERY ROOM	81, 903	0	45, 770		3, 569	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	48, 139	55, 667	34, 817		3, 858	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 682 81, 565	0	24, 238 77, 196		6, 907 3, 870	
55. 00	05500 RADI OLOGY - THERAPEUTI C	01,505	o	,,,,,,		0, 0, 0	1
56. 00	05600 RADI OI SOTOPE	5, 828	0	4, 698	0	200	l
57. 00	05700 CT SCAN	10, 800	0	22, 372		5, 771	•
58. 00 60. 00	05800   MRI	11, 318 59, 024	0	12, 601 110, 738		2, 108 7, 967	•
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	o	110, 730		7, 707	1
65.00	06500 RESPIRATORY THERAPY	7, 510	0	24, 985	0	5, 954	
65. 10	06501 CARDI AC STRESS LAB	25, 217	0	15, 433		443	•
65. 20	06502 CARDI AC REHAB 06600 PHYSI CAL THERAPY	7, 605	0	4, 418		91	65. 20
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	95, 728 28, 433	0	36, 373 11, 699		37 8	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 142	o	9, 148		57	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	5, 165		0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	436		0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	77, 589	1
73. 00	07200   IMPL. DEV. CHARGED TO PATIENTS 07300   DRUGS CHARGED TO PATIENTS	17, 760	0	29, 217	-	66, 573 2, 773	
76. 00	03610 SLEEP LAB	9, 932	Ö	7, 374		1, 197	
76. 01	03020 PAIN CLINIC	6, 505	0	2, 427		1, 971	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(		0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	j Uj	U U		)l Ol	0	78. 00
88. 00		151, 547	0	C	0	3, 689	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC)	0	0	C		3, 118	
88. 02	08802 RURAL HEALTH CLINIC (RHC)	32, 759	0	37, 711	0	271	
88. 03 88. 04	08803 RURAL HEALTH CLINIC (RHC) 08804 RURAL HEALTH CLINIC (RHC)	36, 726 25, 736	0	(		85 372	
	09100 EMERGENCY	96, 701	0	134, 043	s ol	17, 168	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
102.00	OTHER REIMBURSABLE COST CENTERS	0	ol		y ol	0	102.00
102.00	10200   OPLOID TREATMENT PROGRAM   SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	(	0	0	102. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	1, 592, 240	967, 057	1, 205, 263	3, 532, 635	244, 560	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 732	0	3, 111	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	397, 984 45, 960	0	(			192. 00 193. 00
	07950 FOUNDATION AND OTHER	1, 227	o	436	-		194. 00
194. 01	07951 FITNESS CENTER	13, 783	ō	7, 872		0	194. 01
	07952 VACANT SPACE	0	0	C	0	0	194. 02
200. 00 201. 00						0	200. 00 201. 00
201.00		2, 058, 926	967, 057	1, 216, 682	3, 532, 635	244, 575	
			. ,	,	, , , , , , , , , , , , , , , , , , , ,	,	

| Period: | Worksheet B | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0064

				To	09/30/2023	Date/Time Pre	
	Cost Center Description		SOCIAL SERVICE		Subtotal	2/28/2024 8:0 Intern &	2 pili
		RECORDS & LI BRARY		ANESTHETI STS		Residents Cost & Post	
		LIBRARI				Stepdown	
		1/ 00	17.00	10.00	24.00	Adjustments	
	GENERAL SERVICE COST CENTERS	16. 00	17. 00	19. 00	24. 00	25. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 CAP REL COSTS-BLDG & FLXT						1. 01
2. 00 4. 00	OO200   CAP REL COSTS-MVBLE EQUIP   OO400   EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	O0800   LAUNDRY & LINEN SERVICE   O0900   HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 16. 00	01400   CENTRAL SERVICES & SUPPLY   01600   MEDICAL RECORDS & LIBRARY	319, 682					14. 00 16. 00
	01700 SOCIAL SERVICE	0	1, 789, 395				17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0				19. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	24.002	1 470 400		22 411 202		20.00
30. 00 31. 00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	24, 093 3, 666	1, 479, 408 196, 038	1	23, 411, 292 4, 685, 281	0	1
43. 00	04300 NURSERY	1, 263	113, 949		1, 184, 534		1
	ANCILLARY SERVICE COST CENTERS	,	-,		, ,		
50.00	05000 OPERATI NG ROOM	26, 580	0		7, 538, 059	l	
51. 00 52. 00	05100 RECOVERY ROOM   05200 DELIVERY ROOM & LABOR ROOM	7, 237 2, 570	0		3, 097, 789 2, 232, 486	l .	
53. 00	05300 ANESTHESI OLOGY	8, 750	0	1	2, 232, 460 518, 127	l .	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	17, 279	0	0	5, 201, 325		54.00
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	0	I -	0	0	55. 00
56. 00 57. 00	05600	3, 744 34, 804	0		551, 446 1, 893, 286	l .	56. 00 57. 00
58. 00	05800 MRI	8, 665	0		813, 962	i e	58. 00
60.00	06000 LABORATORY	54, 021	0		7, 749, 830	l .	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 578	0		732, 649		
65. 00 65. 10	06500 RESPIRATORY THERAPY	8, 824	0		1, 429, 336		65. 00 65. 10
65. 20	O6501   CARDI AC STRESS LAB   O6502   CARDI AC REHAB	7, 947 747	0	I -	949, 227 173, 216		65. 20
66. 00	06600 PHYSI CAL THERAPY	5, 846	Ō		2, 499, 923		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 374	0		693, 444		67. 00
68. 00	06800 SPEECH PATHOLOGY	890	0	I -	420, 063		
69. 00 70. 00	06900   ELECTROCARDI OLOGY   07000   ELECTROENCEPHALOGRAPHY	2, 577 60	0		196, 967 28, 493	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 905	0	· -	2, 500, 975		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 331	0		2, 149, 674	1	
73. 00	07300 DRUGS CHARGED TO PATIENTS	45, 538		1	11, 088, 683		
	03610 SLEEP LAB 03020 PAIN CLINIC	1, 739 2, 482			550, 309 148, 722		1
	07700 ALLOGENEIC HSCT ACQUISITION	2,402	0	1	140, 722	0	1
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS	F 022			7 204 145	1 0	1 00 00
88. 00 88. 01	08800   RURAL HEALTH CLINIC (RHC)   08801   RURAL HEALTH CLINIC (RHC)	5, 933 2, 305	0	1	7, 394, 145 2, 077, 556		
	08802 RURAL HEALTH CLINIC (RHC)	2, 303	0	Ö	3, 178, 845		88. 02
88. 03	08803 RURAL HEALTH CLINIC (RHC)	666	0	0	1, 126, 616	l .	1
88. 04	08804 RURAL HEALTH CLINIC (RHC)	344	0	0	507, 925	l .	88. 04
	O9100   EMERGENCY   O9200   OBSERVATION   BEDS   (NON-DISTINCT PART	28, 477	0	0	8, 590, 208	0	
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
440.00	SPECIAL PURPOSE COST CENTERS	040 400	4 700 005		105 011 000	1	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	319, 682	1, 789, 395	0	105, 314, 393	0	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	O	289, 323	0	190. 00
192. 00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		5, 899, 311	0	192. 00
	19300 NONPALD WORKERS	0	0	0	258, 904		193. 00
	07950 FOUNDATION AND OTHER	0	0	0	230, 526		194.00
	07951   FITNESS CENTER   07952   VACANT SPACE	0	0	0	389, 613 2, 248, 302		194. 01 194. 02
200.00					2, 240, 302		200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	319, 682	1, 789, 395	0	114, 630, 372	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 ST. MARY MEDICAL CENTER

| Peri od: | Worksheet B | From 10/01/2022 | Part I | To 09/30/2023 | Date/Time Prepared: Provider CCN: 14-0064

			10 09/30/2023 Date/Time Pro 2/28/2024 8:0	
	Cost Center Description	Total	272072021 0.0	JE PIII
		26.00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
1. 01	00101 CAP REL COSTS-BLDG & FLXT			1. 01
2. 00 4. 00	OO200   CAP REL COSTS-MVBLE EQUIP   OO400   EMPLOYEE BENEFITS DEPARTMENT			2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
6.00	00600 MAI NTENANCE & REPAI RS			6. 00
7. 00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14.00	01400 CENTRAL SERVI CES & SUPPLY			14. 00
	01600 MEDI CAL RECORDS & LI BRARY			16.00
	01700   SOCIAL SERVICE   01900   NONPHYSICIAN ANESTHETISTS			17. 00 19. 00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			19.00
30. 00	03000 ADULTS & PEDIATRICS	23, 411, 292		30.00
31. 00	03100   NTENSI VE CARE UNIT	4, 685, 281		31. 00
43.00	04300 NURSERY	1, 184, 534		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATI NG ROOM	7, 538, 059		50. 00
51.00	05100 RECOVERY ROOM	3, 097, 789		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 232, 486		52. 00
53. 00	05300 ANESTHESI OLOGY	518, 127		53. 00
54. 00	O5400   RADI OLOGY - DI AGNOSTI C	5, 201, 325		54. 00
55. 00 56. 00	05500   RADI OLOGY - THERAPEUTI C   05600   RADI OI SOTOPE	0 551, 446		55. 00 56. 00
57. 00	05700 CT SCAN	1, 893, 286		57. 00
58. 00	05800 MRI	813, 962		58. 00
60. 00	06000 LABORATORY	7, 749, 830		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	732, 649		63. 00
65.00	06500 RESPI RATORY THERAPY	1, 429, 336		65. 00
65. 10	06501 CARDI AC STRESS LAB	949, 227		65. 10
65. 20	06502 CARDI AC REHAB	173, 216		65. 20
66. 00	06600 PHYSI CAL THERAPY	2, 499, 923		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	693, 444		67. 00
68. 00	06800 SPEECH PATHOLOGY	420, 063		68. 00
69. 00 70. 00	06900   ELECTROCARDI OLOGY   07000   ELECTROENCEPHALOGRAPHY	196, 967 28, 493		69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 500, 975		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 149, 674		72. 00
	07300 DRUGS CHARGED TO PATIENTS	11, 088, 683		73. 00
76.00	03610 SLEEP LAB	550, 309		76. 00
76. 01	03020 PAIN CLINIC	148, 722		76. 01
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		78. 00
	OUTPATIENT SERVICE COST CENTERS			
88. 00	08800 RURAL HEALTH CLINIC (RHC)	7, 394, 145		88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC) 08802 RURAL HEALTH CLINIC (RHC)	2, 077, 556		88. 01
88. 02 88. 03	08803 RURAL HEALTH CLINIC (RHC)	3, 178, 845 1, 126, 616		88. 02 88. 03
88. 04	08804 RURAL HEALTH CLINIC (RHC)	507, 925		88. 04
91. 00	09100 EMERGENCY	8, 590, 208		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0,070,200		92. 00
	OTHER REIMBURSABLE COST CENTERS			
102.00	10200 OPIOID TREATMENT PROGRAM	0		102. 00
	SPECIAL PURPOSE COST CENTERS			
118.00		105, 314, 393		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	289, 323		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	5, 899, 311		192. 00
	19300 NONPALD WORKERS	258, 904		193. 00
	07950 FOUNDATION AND OTHER  07951 FITNESS CENTER	230, 526		194. 00 194. 01
	07951 FITNESS CENTER 07952 VACANT SPACE	389, 613 2, 248, 302		194. 01
200.00		2, 240, 302		200. 00
201.00		o		201. 00
202. 00		114, 630, 372		202. 00
	, , ,			•

| Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0064

					T		Date/Time Pre 2/28/2024 8:0	
				CAP	TAL RELATED CO	STS		
		Cost Center Description	Directly	BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP	Subtotal	
			Assigned New Capital					
			Related Costs					
	GENER	AL SERVICE COST CENTERS	0	1. 00	1. 01	2. 00	2A	
1.00	00100	CAP REL COSTS-BLDG & FIXT						1. 00
1.01		CAP REL COSTS MAYOUR FOUND						1. 01
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0	3, 511	0	О	3, 511	2. 00 4. 00
5.00	00500	ADMINISTRATIVE & GENERAL	1, 224	598, 837	0	1, 549, 590	2, 149, 651	5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	3, 370 10, 071	492, 993 292, 109		2, 482 81, 665	498, 845 383, 845	6. 00 7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15, 299		0	15, 299	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	258	22, 197 60, 278		10, 776 13, 207	33, 231 73, 485	9. 00 10. 00
11. 00		CAFETERIA	0	40, 143		16, 458	56, 601	11. 00
13.00		NURSI NG ADMINI STRATI ON	0	11, 621	0	231, 929	243, 550	
14. 00 16. 00		CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY	0	14, 631 0	0	0	14, 631 0	14. 00 16. 00
17. 00	01700	SOCIAL SERVICE	0	0		О	0	17. 00
19. 00		NONPHYSICIAN ANESTHETISTS IENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	19. 00
30.00	03000	ADULTS & PEDI ATRI CS	104, 715	386, 956		76, 819	568, 490	30. 00
31. 00 43. 00	1	INTENSIVE CARE UNIT NURSERY	4, 084 0	126, 672 32, 117		56, 777 17, 909	187, 533 50, 026	
43.00		LARY SERVICE COST CENTERS	0	32, 117	0	17, 909	50, 020	43.00
50.00		OPERATING ROOM	35, 577	311, 170		933, 738	1, 280, 485	50.00
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	107, 890 63, 413		24, 654 40, 132	132, 544 103, 545	
53.00	05300	ANESTHESI OLOGY	24	2, 215	0	27, 947	30, 186	53. 00
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY - THERAPEUTI C	1, 780	107, 444 0		118, 485 0	227, 709 0	54. 00 55. 00
56. 00	1	RADI OI SOTOPE	560	7, 678		1, 365	9, 603	
57. 00 58. 00	05700 05800	CT SCAN	0	14, 226		204, 404	218, 630 84, 752	
60.00		LABORATORY	32, 796	14, 909 77, 751	0	69, 843 68, 713	179, 260	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	_	0	0	63. 00
65. 00 65. 10	1	RESPI RATORY THERAPY CARDI AC STRESS LAB	39, 261 0	9, 893 33, 218		24, 301 55, 629	73, 455 88, 847	65. 00 65. 10
65. 20	06502	CARDI AC REHAB	O	10, 018		0	10, 018	65. 20
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	126, 101 37, 454	0	14, 375 93	140, 476 37, 547	
68. 00		SPEECH PATHOLOGY	0	4, 138		70	4, 208	
69.00		ELECTROCARDI OLOGY	0	0		0	0	69.00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		4, 704 0	4, 704 0	70. 00 71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 76. 00		DRUGS CHARGED TO PATIENTS SLEEP LAB	63, 155 3, 160	23, 395 13, 084	0 0	21, 271 369	107, 821 16, 613	
76. 01	03020	PAIN CLINIC	0	8, 569		4, 874	13, 443	76. 01
77. 00 78. 00		ALLOGENEIC HSCT ACQUISITION CAR T-CELL IMMUNOTHERAPY	0	0		0	0	
70.00	OUTPA	TIENT SERVICE COST CENTERS	Ŭ,	0		<u> </u>	0	70.00
88. 00		RURAL HEALTH CLINIC (RHC)	13, 069	199, 630		13, 367	226, 066	
88. 01 88. 02		RURAL HEALTH CLINIC (RHC) RURAL HEALTH CLINIC (RHC)	3, 947 6, 832	0 43, 153		33, 992 13, 149	44, 643 63, 134	
88. 03	08803	RURAL HEALTH CLINIC (RHC)	1, 145	48, 378	0	5, 068	54, 591	88. 03
88. 04 91. 00		RURAL HEALTH CLINIC (RHC) EMERGENCY	355 9, 847	33, 901 127, 383		1, 914 49, 981	36, 170 187, 211	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	7, 047	127, 303		47, 701	0	
102.00		REIMBURSABLE COST CENTERS OPIOID TREATMENT PROGRAM	l ol	0	0	0	0	102. 00
102.00		AL PURPOSE COST CENTERS	U U	0	0	<u> </u>	0	102.00
118.00	)	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	335, 230	3, 522, 375	6, 704	3, 790, 050	7, 654, 359	118. 00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 186		3, 426	13, 612	
		PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	0	524, 260 60, 542		0	524, 260 60, 542	
194.00	07950	FOUNDATION AND OTHER		1, 616	0	260	1, 876	194. 00
		FITNESS CENTER VACANT SPACE	0	18, 156 0	0 399, 631	0	18, 156 399, 631	
200.00		Cross Foot Adjustments		U	377, 031	U <sub>1</sub>	0	200. 00
201.00		Negative Cost Centers	225 222	0	0	0 700 701	0 (70 40)	201. 00
202. 00	η	TOTAL (sum lines 118 through 201)	335, 230	4, 137, 135	406, 335	3, 793, 736	8, 672, 436	1202.00

Provider CCN: 14-0064

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2022 Part II
To 09/30/2023 Date/Time Prepared: 2/28/2024 8:02 pm

			''	09/30/2023	2/28/2024 8: 0	
Cost Center Description			MAINTENANCE &	OPERATION OF	LAUNDRY &	
	BENEFITS	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	
	DEPARTMENT 4.00	5. 00	6. 00	7. 00	8. 00	
GENERAL SERVICE COST CENTERS	1.00	0.00	0.00	7. 00	0.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 CAP REL COSTS-BLDG & FLXT						1. 01
2. 00   00200   CAP REL COSTS-MVBLE EQUI P	2 511					2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL	3, 511 142	2, 149, 793				4. 00 5. 00
6. 00   00600 MAI NTENANCE & REPAI RS	58		1			6.00
7.00 OO700 OPERATION OF PLANT	0	l	1	486, 895		7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	4	10, 151		2, 709		8. 00
9. 00   00900   HOUSEKEEPI NG	73	1	l	3, 930		9. 00
10. 00   01000   DI ETARY	22	14, 900	1	10, 674	0	10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	44 65	20, 663 65, 241	1	7, 108 2, 058	0	11. 00 13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	12	3, 564	1	2, 591	ő	14. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	l		0	0	16. 00
17. 00   01700   SOCI AL   SERVI CE	0	· ·	1	0	0	17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	730	325, 767	70, 977	68, 519	14, 824	30.00
31. 00   03100   NTENSI VE CARE UNIT	149	1	1	22, 430	3, 202	31.00
43. 00   04300 NURSERY	38		1	5, 687	760	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	206	1	1			50.00
51. 00   05100   RECOVERY ROOM 52. 00   05200   DELIVERY ROOM & LABOR ROOM	109 79		l	19, 104 11, 229	2, 574 1, 703	51. 00 52. 00
53. 00   05300   ANESTHESI OLOGY	14	8, 850	l	392	1, 703	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	151	89, 497		19, 025	1, 257	54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	l .	0	0	0	55. 00
56. 00   05600   RADI OI SOTOPE	13			1, 359	0	56. 00
57. 00   05700   CT   SCAN 58. 00   05800   MRI	45 29		l	2, 519 2, 640	0	57. 00 58. 00
60. 00   06000   LABORATORY	187	137, 929	l	2, 640 13, 768	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	1	0	0	ő	63. 00
65. 00 06500 RESPI RATORY THERAPY	55	25, 529		1, 752	0	65. 00
65. 10   06501   CARDI AC STRESS LAB	36	l	l	5, 882	0	65. 10
65. 20   06502   CARDI AC   REHAB 66. 00   06600   PHYSI CAL   THERAPY	9		1	1, 774	0 988	65. 20 66. 00
67. 00   06700 OCCUPATI ONAL THERAPY	86 25		1	22, 329 6, 632	900	67.00
68. 00 06800 SPEECH PATHOLOGY	19		1	733	ő	68. 00
69. 00 06900 ELECTROCARDI OLOGY	10	l	1	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1	525	1	0	0	70.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0	1	1	0	0	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	74	38, 967 205, 252		4, 143	0	72. 00 73. 00
76. 00   03610   SLEEP LAB	14	9, 425	1	2, 317	Ö	76.00
76. 01   03020   PAIN CLINIC	5	l	1	1, 517	0	76. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		· ·	0	-	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS 88. 00   08800   RURAL HEALTH CLINIC (RHC)	260	127, 773	36, 617	35, 349	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC (RHC)	86	l	l	0	ő	88. 01
88.02 08802 RURAL HEALTH CLINIC (RHC)	135	l	7, 915	7, 641	0	88. 02
88.03 08803 RURAL HEALTH CLINIC (RHC)	38					88. 03
88. 04 08804 RURAL HEALTH CLINIC (RHC)	14	7, 692	1		0	88. 04
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATI ON   BEDS   (NON-DI STINCT   PART	292	149, 924	23, 365	22, 556	2, 793	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	3, 329	2, 008, 303	445, 175	378, 036	30, 969	]118. 00 
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6	4, 821	1, 868	1, 804	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	147	82, 486	1	92, 834		192.00
193. 00 19300 NONPALD WORKERS	0	ľ	11, 105	10, 720	0	193. 00
194. 00 07950 FOUNDATION AND OTHER	1	4, 228	1	286		194. 00
194. 01 07951 FI TNESS CENTER	15	1	1	3, 215		194. 01
194.02 07952 VACANT SPACE 200.00  Cross Foot Adjustments	13	42, 166	1	O	0	194. 02 200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	3, 511	2, 149, 793	557, 937	486, 895		

Provider CCN: 14-0064

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2022 Part II
To 09/30/2023 Date/Time Prepared: 2/28/2024 8:02 pm

			'	0 09/30/2023	2/28/2024 8:0	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	·
				ADMI NI STRATI ON	SERVICES &	
	9. 00	10. 00	11. 00	13.00	SUPPLY 14. 00	
GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	13.00	14.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01 O0101 CAP REL COSTS-BLDG & FLXT						1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00   00500   ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7. 00   00700   0PERATI ON OF PLANT						7. 00
8.00   00800   LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG	79, 043	444 004				9. 00
10. 00   01000   DI ETARY	1, 757	111, 894	02.046			10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMINI STRATI ON	1, 170	U	92, 949			11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	339 426	0	1, 581 965		24, 873	14. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	420	0	705		24, 673	16. 00
17. 00 01700 SOCI AL SERVI CE		0	C	_	0	17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	o o	Ö	C	_	0	19. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	<u>~</u> _		, <u> </u>		17.00
30. 00 03000 ADULTS & PEDI ATRI CS	11, 277	90, 253	26, 136	179, 105	2, 281	30.00
31.00 03100 INTENSIVE CARE UNIT	3, 692	12, 325	4, 690	32, 137	485	31. 00
43. 00   04300   NURSERY	936	2, 875	1, 272	8, 714	175	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	9, 069	0	7, 709	52, 823	0	50. 00
51.00   05100   RECOVERY ROOM	3, 144	0	3, 497		363	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 848	6, 441	2, 660		392	52. 00
53. 00 05300 ANESTHESI OLOGY	65	0	1, 852		702	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	3, 131	0	5, 897		394	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	0.50	_	0	55. 00
56. 00   05600   RADI OI SOTOPE	224	0	359		20	56.00
57. 00   05700   CT   SCAN	415	0	1, 709		587	57.00
58. 00   05800   MRI 60. 00   06000   LABORATORY	435	0	963		214 810	58. 00 60. 00
63.00   06300   BLOOD STORING, PROCESSING & TRANS.	2, 266	0	8, 460 0		0	63.00
65. 00 06500 RESPIRATORY THERAPY	288	0	1, 909	1 1	606	65. 00
65. 10   06501   CARDI AC   STRESS   LAB	968	0	1, 179		45	65. 10
65. 20 06502 CARDI AC REHAB	292	0	338		9	65. 20
66. 00   06600   PHYSI CAL THERAPY	3, 675	Ö	2, 779		4	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 092	ō	894		1	67. 00
68. 00 06800 SPEECH PATHOLOGY	121	o	699	o	6	68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	o	395	o o	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	33	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	7, 891	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	_	6, 770	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	682	0	2, 232		282	73. 00
76. 00   03610   SLEEP LAB	381	0	563		122	76. 00
76. 01   03020   PAIN CLINIC	250	0	185		200	76. 01
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	C	1	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0	78. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC (RHC)	5, 818	O		ol	375	88. 00
88. 01   08801   RURAL HEALTH CLINIC (RHC)	3, 818	0	(	_	317	88. 01
88. 02   08802   RURAL HEALTH CLINIC (RHC)	1, 258	0	2, 881		28	88. 02
88. 03   08803 RURAL HEALTH CLINIC (RHC)	1, 410	0	2,001		9	88. 03
88. 04   08804 RURAL HEALTH CLINIC (RHC)	988	0			38	88. 04
91. 00   09100   EMERGENCY	3, 712	0	10, 240		1, 746	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0,7.2	Ĭ	.0,2.0		.,,	92. 00
OTHER REIMBURSABLE COST CENTERS				'		
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	61, 129	111, 894	92, 077	314, 966	24, 872	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	297	0	238	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	15, 277	0	C	0		192. 00
193. 00 19300 NONPAI D WORKERS	1, 764	0	C	_		193. 00
194. 00 07950 FOUNDATION AND OTHER	47	0	33			194. 00
194. 01 07951 FI TNESS CENTER	529	0	601	이		194. 01
194. 02 07952 VACANT SPACE		0	C	이	0	194. 02
200.00 Cross Foot Adjustments			_	, ,	^	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	70 043	111 004	92, 949	214 044	0 24, 873	201.00
202.00   TOTAL (sum lines 118 through 201)	79, 043	111, 894	72, 747	314, 966	24, 0/3	1202. UU

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | 2007/2024 | 2007/2024 | Part II | Prepared: | 2007/2024 | Part II | Part II | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0064

			1	0 09/30/2023	Date/lime Pre 2/28/2024 8:0	
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown	
					Adjustments	
OFFICE AND ASSESSED OF ASSESSE	16. 00	17. 00	19. 00	24. 00	25. 00	
GENERAL SERVICE COST CENTERS   1.00						1. 00 1. 01 2. 00 4. 00 5. 00
6. 00 00600 MAINTSHATTVE & REPAIRS 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA						6. 00 7. 00 8. 00 9. 00 10. 00
13. 00	5, 995 0 0	33, 559 0	0			13. 00 14. 00 16. 00 17. 00 19. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	449			1, 386, 553	0	30.00
31. 00   03100   INTENSI VE CARE UNI T 43. 00   04300   NURSERY	68 24	3, 677 2, 137		359, 835 93, 957	0	31. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	24	2, 137		73, 737	0	1 43.00
50. 00 05000 OPERATING ROOM	496	0		1, 575, 997	0	50.00
51. 00   05100   RECOVERY ROOM	135	0		250, 528	0	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY	48 163	0		190, 024 42, 630	0	52. 00 53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	322	0		367, 091	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	70	0		22, 824	0	56. 00
57. 00   05700   CT   SCAN 58. 00   05800   MRI	649 162	0		260, 726	0	57. 00 58. 00
60. 00   06000   LABORATORY	1, 040	0		105, 956 357, 981	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	29	Ō		13, 740	Ö	63. 00
65. 00 06500 RESPI RATORY THERAPY	165	0		105, 574	0	65. 00
65. 10   06501   CARDI AC   STRESS   LAB	148	0		118, 770	0	65. 10
65. 20   06502   CARDI AC   REHAB 66. 00   06600   PHYSI CAL   THERAPY	14 109	0		16, 904 232, 554	0	65. 20 66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	26	0		63, 836	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	17	0		14, 028	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	48	0		4, 002	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1	0		5, 264	0	70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS	36 99	)   0		53, 341 45, 836	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	850	0		325, 627	Ö	73.00
76. 00   03610   SLEEP LAB	32	0		31, 867	0	76. 00
76. 01   03020   PAIN CLINIC	46	0		19, 418	0	76. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	0	0		<u> </u>	0	70.00
88.00 08800 RURAL HEALTH CLINIC (RHC)	111	0		432, 369	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC (RHC)	43	0		83, 951	0	88. 01
88. 02   08802   RURAL HEALTH CLINIC (RHC) 88. 03   08803   RURAL HEALTH CLINIC (RHC)	46 12	0		139, 580 92, 017	0	88. 02 88. 03
88. 04   08804   RURAL HEALTH CLINIC (RHC)	6	0		57, 129	Ö	88. 04
91. 00   09100   EMERGENCY	531	0		402, 370	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
OTHER REIMBURSABLE COST CENTERS  102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	I	O	0	102. 00
SPECIAL PURPOSE COST CENTERS	0	0		J	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 995	33, 559	0	7, 272, 279	0	118. 00
NONREI MBURSABLE COST CENTERS	1		T			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		22, 646 811, 168		190. 00 192. 00
193. 00 19300 NONPALD WORKERS	0	0		85, 736		193. 00
194.00 07950 FOUNDATION AND OTHER	0	0		6, 767		194. 00
194. 01 07951 FITNESS CENTER	0	0		32, 030		194. 01
194. 02 07952 VACANT SPACE	0	0	_	441, 810		194. 02
200.00   Cross Foot Adjustments 201.00   Negative Cost Centers	0	n		0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	5, 995	33, 559	ő	8, 672, 436		202. 00
· · · · · · · · · · · · · · · · · · ·				'		

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 10/01/2022 | Part II |
| To 09/30/2023 | Date/Time Prepared: | 2/28/2024 8:02 pm | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0064

				2/28/2024 8:0	
		Cost Center Description	Total		
	OFNED	AL CERVILOR COST OFFITERS	26. 00		
1 00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT			1 00
1. 00 1. 01	1	CAP REL COSTS-BLDG & FIXT			1. 00 1. 01
2. 00		CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	1	ADMINISTRATIVE & GENERAL			5. 00
6.00	00600	MAINTENANCE & REPAIRS			6. 00
7.00	1	OPERATION OF PLANT			7. 00
8.00	1	LAUNDRY & LINEN SERVICE			8. 00
9.00	1	HOUSEKEEPI NG			9.00
10. 00 11. 00	1	DI ETARY CAFETERI A	+		10. 00 11. 00
13. 00	1	NURSI NG ADMI NI STRATI ON			13. 00
14. 00		CENTRAL SERVICES & SUPPLY			14. 00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17. 00	01700	SOCIAL SERVICE			17. 00
19. 00		NONPHYSICIAN ANESTHETISTS			19. 00
		I ENT ROUTI NE SERVI CE COST CENTERS	4 00/ 550		
30.00		ADULTS & PEDIATRICS	1, 386, 553		30.00
31. 00 43. 00	1	INTENSIVE CARE UNIT NURSERY	359, 835 93, 957		31. 00 43. 00
43.00		LARY SERVICE COST CENTERS	73, 737		43.00
50.00		OPERATI NG ROOM	1, 575, 997		50. 00
51. 00	1	RECOVERY ROOM	250, 528		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	190, 024		52. 00
53.00	05300	ANESTHESI OLOGY	42, 630		53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	367, 091		54. 00
55. 00	1	RADI OLOGY - THERAPEUTI C	0		55. 00
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	22, 824		56. 00 57. 00
58. 00	05800		260, 726 105, 956		58. 00
60.00	1	LABORATORY	357, 981		60.00
63. 00	1	BLOOD STORING, PROCESSING & TRANS.	13, 740		63. 00
65.00	06500	RESPI RATORY THERAPY	105, 574		65. 00
65. 10	06501	CARDI AC STRESS LAB	118, 770		65. 10
65. 20	1	CARDI AC REHAB	16, 904		65. 20
66.00	1	PHYSI CAL THERAPY	232, 554		66.00
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	63, 836 14, 028		67. 00 68. 00
69. 00	1	ELECTROCARDI OLOGY	4, 002		69. 00
70. 00	1	ELECTROENCEPHALOGRAPHY	5, 264		70.00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	53, 341		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45, 836		72. 00
73.00	1	DRUGS CHARGED TO PATIENTS	325, 627		73. 00
76. 00	1	SLEEP LAB	31, 867		76. 00
76. 01 77. 00	1	PAIN CLINIC ALLOGENEIC HSCT ACQUISITION	19, 418 0		76. 01 77. 00
78.00	1	CAR T-CELL IMMUNOTHERAPY	0		78. 00
70.00		TIENT SERVICE COST CENTERS	<u> </u>		70.00
88. 00		RURAL HEALTH CLINIC (RHC)	432, 369		88. 00
88. 01		RURAL HEALTH CLINIC (RHC)	83, 951		88. 01
88. 02	1	RURAL HEALTH CLINIC (RHC)	139, 580		88. 02
88. 03		RURAL HEALTH CLINIC (RHC)	92, 017		88. 03
88. 04		RURAL HEALTH CLINIC (RHC) EMERGENCY	57, 129		88. 04 91. 00
91. 00 92. 00		OBSERVATION BEDS (NON-DISTINCT PART	402, 370		91.00
72.00		REI MBURSABLE COST CENTERS			72.00
102.00		OPIOID TREATMENT PROGRAM	0		102. 00
	SPECI.	AL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7, 272, 279		118. 00
40		I MBURSABLE COST CENTERS			
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	22, 646		190. 00
	1	PHYSI CLANS' PRI VATE OFFI CES	811, 168		192.00
		NONPALD WORKERS FOUNDATION AND OTHER	85, 736 6, 767		193. 00 194. 00
		FITNESS CENTER	32, 030		194. 00
		VACANT SPACE	441, 810		194. 02
200.00		Cross Foot Adjustments	0		200. 00
201.00	1	Negative Cost Centers	O		201. 00
202.00	)	TOTAL (sum lines 118 through 201)	8, 672, 436		202. 00

				F	rom 10/01/2022 o 09/30/2023		
		CAP	TAL RELATED CO	OSTS		2/28/2024 8: 0	2 pm
	Cost Center Description	BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	
	cost center bescription	(SQUARE FEET)		(DOLLAR VALUE)	BENEFI TS	Reconciliation	
					DEPARTMENT (GROSS		
					SALARI ES)		
	GENERAL SERVICE COST CENTERS	1.00	1. 01	2. 00	4. 00	5A	
1.00	00100 CAP REL COSTS-BLDG & FIXT	296, 913					1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT	0	338, 578	1			1. 01
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	252	l o	3, 530, 688 0			2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	42, 977	Ö	1			5. 00
6. 00	00600 MAINTENANCE & REPAIRS	35, 381	0	2, 310		0	6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	20, 964 1, 098	0	76, 003 0		0	7. 00 8. 00
9. 00	00900 HOUSEKEEPING	1, 593	Ö	1		Ö	9. 00
10.00	01000 DI ETARY	4, 326	l e				10. 00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	2, 881 834		1,		0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 050	1	0		0	14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	_	0	16. 00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0		_	0	17. 00 19. 00
19.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0		, <u> </u>	0	0	19.00
30.00	03000 ADULTS & PEDIATRICS	27, 771	C	1			30. 00
31. 00 43. 00	03100   NTENSI VE CARE UNI T 04300   NURSERY	9, 091 2, 305	0			0	31. 00 43. 00
43.00	ANCI LLARY SERVICE COST CENTERS	2, 305		10,007	409, 650	0	43.00
50.00	05000 OPERATING ROOM	22, 332	l e	1			50. 00
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	7,743	0	,		0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	4, 551 159					53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 711	O				54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	0	1	_	0	55. 00
56. 00 57. 00	05600	551 1, 021		1, 270 190, 231		0	56. 00 57. 00
58. 00	05800 MRI	1, 070		1		Ö	58. 00
60.00	06000 LABORATORY	5, 580	ł	1			60.00
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	710		٦ - "	_	0	63. 00 65. 00
65. 10	06501 CARDI AC STRESS LAB	2, 384		1		Ö	65. 10
65. 20	06502 CARDI AC REHAB	719	l e	0	111, 732		65. 20
66.00	06600 PHYSI CAL THERAPY	9, 050 2, 688	l e	1			66. 00 67. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	2, 688		87 65	313, 310 232, 793		68.00
69. 00	06900 ELECTROCARDI OLOGY	0	O	0	119, 984	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	4, 378			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0		1		0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 679		1	_		73. 00
76. 00	03610 SLEEP LAB	939	ŀ	343		0	76. 00
76. 01 77. 00	03020 PAIN CLINIC 07700 ALLOGENEIC HSCT ACQUISITION	615	0	4, 536 0		0	76. 01 77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		1			78.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00 88. 01	08800 RURAL HEALTH CLINIC (RHC) 08801 RURAL HEALTH CLINIC (RHC)	14, 327	5, 586			0	88. 00 88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	3, 097	3, 360	12, 237			88. 02
88. 03	08803 RURAL HEALTH CLINIC (RHC)	3, 472	O	1		0	88. 03
88. 04	08804 RURAL HEALTH CLINIC (RHC)	2, 433		1, 781			88. 04
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 142	C	46, 515	3, 610, 750	0	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
118. 00	SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)	252, 793	5, 586	3, 527, 258	41, 191, 920	-21, 905, 399	118. 00
	NONREI MBURSABLE COST CENTERS		ĺ				
	) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN ) 19200 PHYSICIANS' PRIVATE OFFICES	731 37 625	0	1			190. 00 192. 00
	19200 PHYSICIANS PRIVATE OFFICES	37, 625 4, 345		0			192.00
194.00	07950 FOUNDATION AND OTHER	116	0	242	10, 561	0	194. 00
	07951 FI TNESS CENTER	1, 303		0			194. 01
200.00	207952 VACANT SPACE Cross Foot Adjustments	0	332, 992	2 0	161, 192		194. 02 200. 00
201.00	1 1	1					201. 00
						'	

Heal th Fi	nancial Systems	ST. MARY MEDICAL CENTER			In Lieu of Form CMS-2552-10		
COST ALL	OCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 10/01/2022 Fo 09/30/2023		
		CAPI	TAL RELATED CO	OSTS			
	Cost Center Description	BLDG & FLXT	BLDG & FIXT	MVBLE EQUIP		Reconciliation	
		(SQUARE FEET)	(SQUARE FEET)	(DOLLAR VALUE)			
					DEPARTMENT (GROSS		
					SALARI ES)		
		1.00	1. 01	2. 00	4. 00	5A	
202.00	Cost to be allocated (per Wkst. B,	4, 137, 135	406, 335	3, 793, 73	11, 976, 337		202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	13. 933829	1. 200122	1. 07450			203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)				3, 511		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part				0. 000081		205. 00
206. 00	NAME adjustment amount to be allegated						206. 00
200.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						200.00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

| Period: | Worksheet B-1 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0064

					o 09/30/2023	Date/Time Pre 2/28/2024 8:0	
	Cost Center Description	ADMI NI STRATI VE			LAUNDRY &	HOUSEKEEPI NG	Z piii
		& GENERAL (ACCUM. COST)	REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	
		,	, ,	, ,	LAUNDRY)		
	GENERAL SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT						1. 01
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	92, 724, 973					5. 00
6.00	00600 MAINTENANCE & REPAIRS	2, 546, 236	l				6. 00
7. 00 8. 00	OO700   OPERATION OF PLANT   OO800   LAUNDRY & LINEN SERVICE	2, 133, 725 437, 829	1				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	1, 627, 694	1		1	l .	9. 00
10.00	01000 DI ETARY	642, 648					ı
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	891, 204 2, 813, 910	l			2, 881 834	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	153, 733	l e	•			ł
16.00	01600 MEDICAL RECORDS & LIBRARY	258, 592	l			0	16.00
17. 00 19. 00	01700   SOCIAL SERVICE   01900   NONPHYSICIAN ANESTHETISTS	1, 447, 448	l				17. 00 19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,	-				17.00
30.00	03000 ADULTS & PEDI ATRI CS	14, 052, 263			,		30.00
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	2, 855, 816 665, 188	1				31. 00 43. 00
10.00	ANCILLARY SERVICE COST CENTERS	3337.33	2,000				10.00
50.00	05000 OPERATING ROOM	4, 751, 556	l				50.00
51. 00 52. 00	05100  RECOVERY ROOM   05200  DELIVERY ROOM & LABOR ROOM	1, 954, 242 1, 389, 728	l				51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	381, 712					53. 00
54. 00	05400 RADI OLOGY - TUEDADEUTI C	3, 860, 140	1				54.00
55. 00 56. 00	05500  RADI OLOGY - THERAPEUTI C   05600  RADI OI SOTOPE	421, 295	0 551	1		_	55. 00 56. 00
57. 00	05700 CT SCAN	1, 447, 618	ł	•			57. 00
58. 00	05800 MRI	604, 978	1			., ., .	1
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	5, 949, 072 591, 366	l	1		5, 580 0	60. 00 63. 00
65.00	06500 RESPI RATORY THERAPY	1, 101, 118	710	•			65. 00
65. 10 65. 20	06501 CARDI AC STRESS LAB 06502 CARDI AC REHAB	671, 628 112, 661	2, 384 719			_, -,	65. 10 65. 20
66. 00	06600 PHYSI CAL THERAPY	1, 681, 160	ł	•			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	463, 601	2, 688				67. 00
68. 00 69. 00	06800   SPEECH PATHOLOGY   06900   ELECTROCARDI OLOGY	322, 039 153, 065	l e			297 0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	22, 647	Ö				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 958, 745	l e	C		0	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	1, 680, 716 8, 852, 780	l e	0 1, 679		_	72. 00 73. 00
	03610 SLEEP LAB	406, 504	l				76. 00
	03020 PAIN CLINIC	94, 889					
	07700  ALLOGENEIC HSCT ACQUISITION   07800  CAR T-CELL IMMUNOTHERAPY	0	0				77. 00 78. 00
70.00	OUTPATIENT SERVICE COST CENTERS						70.00
88.00	08800 RURAL HEALTH CLINIC (RHC)	5, 511, 012	1				88. 00
88. 01 88. 02	08801   RURAL HEALTH CLINIC (RHC)   08802   RURAL HEALTH CLINIC (RHC)	1, 676, 156 2, 438, 732	l e			_	88. 01 88. 02
88. 03	08803 RURAL HEALTH CLINIC (RHC)	798, 669	3, 472	3, 472	. 0	3, 472	88. 03
88. 04 91. 00	08804   RURAL HEALTH CLINIC (RHC)   09100   EMERGENCY	331, 766	l			_,	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 466, 433	9, 142	9, 142	41, 843	9, 142	91.00
	OTHER REIMBURSABLE COST CENTERS						
102. 00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	C	0	0	102. 00
118. 00		86, 622, 314	174, 183	153, 219	463, 895	150, 528	118. 00
	NONREI MBURSABLE COST CENTERS				1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	207, 927 3, 557, 746	731 37, 625			l	190. 00 192. 00
	19300 NONPAID WORKERS	69, 207					193. 00
	07950 FOUNDATION AND OTHER	182, 377	l e			l .	194. 00
	07951   FI TNESS CENTER   07952   VACANT SPACE	266, 742 1, 818, 660					194. 01 194. 02
200.00		1,575,550	ĺ			l .	200. 00
201.00		24 255 555	0.4/5.5:	0.040.0==	F70		201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	21, 905, 399	3, 147, 761	2, 940, 083	573, 453	2, 058, 926	202.00
203. 00		0. 236241	14. 419229	14. 898641	1. 236170	10. 577689	203. 00

Health Fina	ncial Systems	ST. MARY MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Period: From 10/01/2022	Worksheet B-1		
					To 09/30/2023	Date/Time Pre 2/28/2024 8:0		
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)		
		(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
					LAUNDRY)			
		5. 00	6. 00	7. 00	8. 00	9. 00		
204.00	Cost to be allocated (per Wkst. B,	2, 149, 793	557, 937	486, 89	5 30, 969	79, 043	204. 00	
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	0. 023185	2. 555792	2. 46730	0. 066759	0. 406082	205. 00	
	[1]							
206.00	NAHE adjustment amount to be allocated						206. 00	
	(per Wkst. B-2)							
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00	
	Parts III and IV)							
		•	•	•	•			

Health Financi	al Systems ON - STATISTICAL BASIS	ST. MARY MEDIC	CAL CENTER Provider C	CN: 14-0064 Pe	In Lie	u of Form CMS-   Worksheet B-1	
					om 10/01/2022	Date/Time Pre	pared:
Co	ost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG	CENTRAL SERVI CES & SUPPLY (COSTED	2/28/2024 8:0 MEDI CAL RECORDS & LI BRARY (GROSS REVE	2 pm
		10.00	11 00	HRS) 13. 00	REQUIS.)	NUE) 16. 00	
GENERAL	. SERVICE COST CENTERS	10.00	11. 00	13.00	14. 00	16.00	
1. 01 00101 C/ 2. 00 00200 C/ 4. 00 00400 E1 5. 00 00500 AI 6. 00 00600 M/ 7. 00 00700 01 8. 00 00800 L/ 9. 00 00900 H0 10. 00 01000 D1 11. 00 01100 C/ 13. 00 01300 NI 14. 00 01400 CI 16. 00 01700 SI 19. 00 01900 NI	AP REL COSTS-BLDG & FIXT AP REL COSTS-BLDG & FIXT AP REL COSTS-MVBLE EQUIP MPLOYEE BENEFITS DEPARTMENT DMINISTRATIVE & GENERAL AINTENANCE & REPAIRS PERATION OF PLANT AUNDRY & LINEN SERVICE OUSEKEEPING IETARY AFETERIA URSING ADMINISTRATION ENTRAL SERVICES & SUPPLY EDICAL RECORDS & LIBRARY OCIAL SERVICE ONPHYSICIAN ANESTHETISTS ENT ROUTINE SERVICE COST CENTERS	59, 621 0 0 0 0 0	39, 103 665 406 0 0	19, 337 0 0 0	6, 174, 536 0 0 0	596, 235, 689 0 0	17. 00
30. 00 03000 AI	DULTS & PEDIATRICS	48, 090	10, 996		566, 185	44, 949, 865	
31. 00   03100   I I 43. 00   04300   NI	NTENSIVE CARE UNIT URSERY	6, 567 1, 532	1, 973 535		120, 304 43, 466	6, 839, 763 2, 355, 433	
ANCI LLA	RY SERVICE COST CENTERS						
50. 00   05000   01   05100   R1   05200   D1   05300   A1   05300   A1   05400   D1   05500   A2   05500   A	PERATING ROOM ECOVERY ROOM ELIVERY ROOM & LABOR ROOM NESTHESIOLOGY ADIOLOGY-DIAGNOSTIC ADIOLOGY - THERAPEUTIC ADIOISOTOPE T SCAN	0 0 0 3, 432 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 243 1, 471 1, 119 779 2, 481 0 151 719 405 3, 559 0 803 496 142 1, 169 376 294 166 14 0 0 939 237 78 0 0 0 1, 212 0 0 4, 308	1, 471 1, 119 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 90, 111 97, 403 174, 364 97, 700 0 5, 041 145, 692 53, 227 201, 147 0 150, 328 11, 179 2, 298 941 203 1, 427 0 0 1, 958, 744 1, 680, 716 69, 996 30, 220 49, 763 0 0	49, 589, 361 13, 501, 372 4, 795, 572 16, 324, 265 32, 237, 851 0 6, 984, 303 64, 933, 427 16, 166, 620 100, 599, 043 2, 944, 205 16, 462, 048 14, 825, 631 1, 393, 224 10, 907, 536 2, 563, 962 1, 660, 863 4, 807, 961 112, 652 3, 553, 394 9, 946, 501 84, 959, 689 3, 243, 523 4, 630, 512 0 0 11, 068, 889 4, 301, 195 4, 564, 536 1, 242, 046 642, 439 53, 128, 008	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 63. 00 65. 00 65. 10 65. 20 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 01 77. 00 78. 00 88. 01 88. 01 88. 02 88. 03 88. 04
OTHER R	REIMBURSABLE COST CENTERS PIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	PURPOSE COST CENTERS UBTOTALS (SUM OF LINES 1 through 117)	59, 621	38, 736		6, 174, 147	596, 235, 689	118. 00
NONREI M 190. 00 19000 G 192. 00 19200 P 193. 00 19300 N 194. 00 07950 F 194. 01 07951 F 194. 02 07952 V 200. 00 201. 00	IBURSABLE COST CENTERS  IFT, FLOWER, COFFEE SHOP & CANTEEN HYSICIANS' PRIVATE OFFICES ONPAID WORKERS OUNDATION AND OTHER ITNESS CENTER ACANT SPACE ross Foot Adjustments egative Cost Centers	0 0 0 0 0	100 0 0 14 253 0	0 0 0 0 0	33 356 0 0 0	0 0 0 0 0	190. 00 192. 00 193. 00 194. 00 194. 01 194. 02 200. 00 201. 00
	ost to be allocated (per Wkst. B, art I)	967, 057	1, 216, 682	3, 532, 635	244, 575	319, 682	202.00

Heal th Fi	lealth Financial Systems ST. MARY MEDICAL CENTER In Lieu of Form CMS-2552-10						
COST ALLO	OCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 10/01/2022 To 09/30/2023	Date/Time Pre 2/28/2024 8:0	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	
		(MEALS SERVED)	(FTE' S)	ADMI NI STRATI O		RECORDS &	
					SUPPLY	LI BRARY	
				(DIRECT NRSIN	G (COSTED	(GROSS REVE	
				HRS)	REQUIS.)	NUE)	
		10.00	11.00	13. 00	14.00	16. 00	
203. 00	Unit cost multiplier (Wkst. B, Part I)	16. 220073	31. 114799	182. 68785	2 0. 039610	0. 000536	203. 00
204.00	Cost to be allocated (per Wkst. B,	111, 894	92, 949	314, 96	6 24, 873	5, 995	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	1. 876755	2. 377030	16. 28825	6 0. 004028	0. 000010	205. 00
	[11]						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

ST. MARY MEDICAL CENTER

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: Worksheet B-1 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/28/2024 8:02 pm Provider CCN: 14-0064

				2/28/2024	8: 02 pm
	Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN		
		<u></u>	ANESTHETI STS		
		(TOTAL PATIENT	(ASSI GNED		
		DAYS) 17. 00	TI ME) 19. 00		
	GENERAL SERVICE COST CENTERS	17.00	17.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT				1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL				5. 00
6.00	00600 MAI NTENANCE & REPAI RS				6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE				7. 00 8. 00
9. 00	00900 HOUSEKEEPING				9. 00
10. 00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11. 00
13.00	01300 NURSING ADMINISTRATION				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY				14. 00
	01600 MEDI CAL RECORDS & LI BRARY				16. 00
	01700 SOCIAL SERVICE	15, 782	l		17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		19. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	13, 048	0		30.00
	03100 I NTENSI VE CARE UNI T	1, 729			31.00
	04300 NURSERY	1, 005	o		43. 00
	ANCILLARY SERVICE COST CENTERS	,	-1		
50.00	05000 OPERATING ROOM	0	0		50. 00
51.00	05100 RECOVERY ROOM	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		53. 00
54. 00 55. 00	05400 RADI OLOGY - TUEDADEUTI C	0	0		54.00
56. 00	05500   RADI OLOGY   THERAPEUTI C   05600   RADI OI SOTOPE	0	0		55. 00 56. 00
57. 00	05700 CT SCAN	0	0		57. 00
58. 00	05800 MRI	0	l ol		58. 00
60.00	06000 LABORATORY	0	O		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	o		63. 00
65.00	06500 RESPI RATORY THERAPY	0	0		65. 00
65. 10	06501 CARDI AC STRESS LAB	0	0		65. 10
65. 20	06502 CARDI AC REHAB	0	0		65. 20
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	o		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
	03610 SLEEP LAB	0	0		76. 00
	03020 PAIN CLINIC	0	0		76. 01
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0			77. 00 78. 00
76.00	OUTPATIENT SERVICE COST CENTERS	0	U <sub>I</sub>		78.00
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	0		88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC)	0	o		88. 01
	08802 RURAL HEALTH CLINIC (RHC)	0	o		88. 02
	08803 RURAL HEALTH CLINIC (RHC)	0	0		88. 03
	08804 RURAL HEALTH CLINIC (RHC)	0	0		88. 04
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		91.00
92. 00	OTHER REIMBURSABLE COST CENTERS				92. 00
102 00	10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
102.00	SPECIAL PURPOSE COST CENTERS	0	0		102.00
118.00		15, 782	0		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192. 00
	19300 NONPAI D WORKERS	0	0		193. 00
	07950 FOUNDATION AND OTHER	0	0		194. 00
	07951 FITNESS CENTER 07952 VACANT SPACE	0			194. 01 194. 02
200.00		0			200. 00
201.00					201. 00
202.00		1, 789, 395	О		202. 00
	Part I)				
203. 00	Unit cost multiplier (Wkst. B, Part I)	113. 382017	0. 000000		203. 00

Heal th Fina	ncial Systems	ST. MARY MEDICAL CENTER			In Lieu of Form CMS-2552-10		
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co	CN: 14-0064	Peri od:	Worksheet B-1	
					From 10/01/2022 To 09/30/2023	Date/Time Prepared: 2/28/2024 8:02 pm	
	Cost Center Description	SOCIAL SERVICE					
			ANESTHETI STS				
		(TOTAL PATIENT	(ASSI GNED				
		DAYS)	TIME)				
		17. 00	19. 00				
204.00	Cost to be allocated (per Wkst. B,	33, 559	0	)		204. 00	
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	2. 126410	0. 000000			205. 00	
	11)						
206. 00	NAHE adjustment amount to be allocated					206. 00	
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,					207. 00	
	Parts III and IV)						

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-0064	Peri od: Worksheet C		
		From 10/01/2022   Part I		
		To 00/20/2022 Data/Time Dropared		

				09/30/2023	Date/Time Pre 2/28/2024 8:0	pared: 2 pm
		Title	XVIII	Hospi tal	PPS	_ p
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	<u> </u>		
30. 00 03000 ADULTS & PEDIATRICS	23, 411, 292		23, 411, 292	0	23, 411, 292	30.00
31.00 03100 INTENSIVE CARE UNIT	4, 685, 281		4, 685, 281	o	4, 685, 281	31.00
43. 00 04300 NURSERY	1, 184, 534		1, 184, 534		1, 184, 534	
ANCI LLARY SERVI CE COST CENTERS				-1		
50. 00 05000 OPERATING ROOM	7, 538, 059		7, 538, 059	0	7, 538, 059	50.00
51. 00 05100 RECOVERY ROOM	3, 097, 789		3, 097, 789		3, 097, 789	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 232, 486	B .	2, 232, 486		2, 232, 486	1
53. 00   05300   ANESTHESI OLOGY	518, 127		518, 127		518, 127	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	5, 201, 325		5, 201, 325		5, 201, 325	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0,20.,020		0,201,020	ol ol	0,20.,020	55.00
56. 00   05600   RADI OI SOTOPE	551, 446		551, 446	_	551, 446	
57. 00 05700 CT SCAN	1, 893, 286		1, 893, 286		1, 893, 286	
58. 00   05800   MRI	813, 962	l e	813, 962		813, 962	
60. 00 06000 LABORATORY	7, 749, 830		7, 749, 830		7, 749, 830	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	732, 649		732, 649		732, 649	
65. 00 06500 RESPIRATORY THERAPY	1, 429, 336				1, 429, 336	
65. 10 06501 CARDI AC STRESS LAB	949, 227				949, 227	
65. 20 06502 CARDI AC REHAB	173, 216		, == .		173, 216	
66. 00   06600 PHYSI CAL THERAPY	2, 499, 923		2, 499, 923		2, 499, 923	
67. 00 06700 OCCUPATI ONAL THERAPY					693, 444	1
68. 00   06800   SPEECH PATHOLOGY	693, 444 420, 063		693, 444		420, 063	
69. 00   06900   ELECTROCARDI OLOGY	196, 967		420, 063			1
			196, 967		196, 967	1
70.00   07000   ELECTROENCEPHALOGRAPHY 71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT	28, 493		28, 493		28, 493	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 500, 975 2, 149, 674		2, 500, 975 2, 149, 674		2, 500, 975 2, 149, 674	
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03610   SLEEP LAB	11, 088, 683		11, 088, 683		11, 088, 683	
76. 00   03010   SLEEP LAB 76. 01   03020   PALN CLINIC	550, 309		550, 309		550, 309	
1 1	148, 722	ł .	148, 722		148, 722	
77.00   07700   ALLOGENEIC HSCT ACQUISITION 78.00   07800   CAR T-CELL IMMUNOTHERAPY	C				0	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS				) U	U	78.00
88. 00   08800   RURAL HEALTH CLINIC (RHC)	7, 394, 145	I	7, 394, 145	ol ol	7, 394, 145	88. 00
88.00   08800   RURAL HEALTH CLINIC (RHC)						
88. 02   08802 RURAL HEALTH CLINIC (RHC)	2, 077, 556		2, 077, 556		2, 077, 556	
	3, 178, 845		3, 178, 845		3, 178, 845	
	1, 126, 616	l e	1, 126, 616		1, 126, 616	1
	507, 925		507, 925		507, 925	
91. 00 09100 EMERGENCY	8, 590, 208		8, 590, 208		8, 590, 208	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	4, 446, 226	<u> </u>	4, 446, 226	) <u> </u>	4, 446, 226	92.00
OTHER REIMBURSABLE COST CENTERS  102.00 10200 OPLOLD TREATMENT PROGRAM  O 0 10						
102.00 10200 0PIOLD TREATMENT PROGRAM 200.00  Subtotal (see instructions)	109, 760, 619		1		109, 760, 619	102.00
201.00 Less Observation Beds	4, 446, 226		4, 446, 226		4, 446, 226	1
202.00   Total (see instructions)	105, 314, 393				105, 314, 393	
202.00   Total (See Histi uctions)	100, 314, 393	1	100, 314, 393	'l 이	100, 314, 393	1202.00

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-0064	Period: Worksheet C From 10/01/2022 Part I

					09/30/2023	Date/Time Pre 2/28/2024 8:0	
			Title XVIII		Hospi tal	PPS	2 piii
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
				,		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	38, 807, 782		38, 807, 782			30. 00
31. 00	03100 INTENSIVE CARE UNIT	6, 839, 763		6, 839, 763	3		31. 00
	04300 NURSERY	2, 355, 433		2, 355, 433	3		43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	11, 611, 579	37, 977, 782			0.000000	50. 00
	05100 RECOVERY ROOM	2, 205, 618	11, 295, 754	13, 501, 372		0.000000	ł
	05200 DELIVERY ROOM & LABOR ROOM	4, 394, 951	400, 621	4, 795, 572		0.000000	ł
	05300 ANESTHESI OLOGY	4, 718, 028	11, 606, 237	16, 324, 265		0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	3, 640, 499	28, 597, 352			0.000000	1
	05500 RADI OLOGY - THERAPEUTI C	0	0	C	0.00000	0.000000	1
	05600 RADI OI SOTOPE	522, 492	6, 461, 811	6, 984, 303		0.000000	
	05700 CT SCAN	11, 578, 936	53, 354, 491	64, 933, 427		0. 000000	1
	05800 MRI	1, 345, 895	14, 820, 725	16, 166, 620		0. 000000	58. 00
	06000 LABORATORY	25, 751, 374	74, 847, 669			0. 000000	1
	06300 BLOOD STORING, PROCESSING & TRANS.	1, 066, 007	1, 878, 198			0. 000000	
	06500 RESPI RATORY THERAPY	12, 757, 478	3, 704, 570			0. 000000	1
	06501 CARDI AC STRESS LAB	3, 562, 550	11, 263, 081	14, 825, 631		0. 000000	1
	06502 CARDI AC REHAB	0	1, 393, 224	1, 393, 224		0. 000000	65. 20
	06600 PHYSI CAL THERAPY	1, 357, 078	9, 550, 458			0. 000000	1
	06700 OCCUPATI ONAL THERAPY	733, 383	1, 830, 579			0. 000000	67.00
	06800 SPEECH PATHOLOGY	583, 284	1, 077, 579			0. 000000	1
	06900 ELECTROCARDI OLOGY	1, 240, 370	3, 567, 591	4, 807, 961		0. 000000	l
	07000 ELECTROENCEPHALOGRAPHY	5, 048	107, 604	112, 652		0.000000	l
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 620, 358	1, 933, 036			0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	3, 209, 378	6, 737, 123	9, 946, 501		0.000000	l
		23, 669, 942	61, 289, 747	84, 959, 689		0.000000	•
	03610 SLEEP LAB	2,004	3, 241, 519			0.000000	76. 00
	03020 PALN CLINIC	5, 696	4, 624, 816	1		0.000000	1
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1		0. 000000 0. 000000	1
	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	l d	0		0. 000000	0.000000	78.00
	08800 RURAL HEALTH CLINIC (RHC)	ol	11, 068, 889	11, 068, 889			88. 00
	08801 RURAL HEALTH CLINIC (RHC)		4, 301, 195				88. 01
	08802 RURAL HEALTH CLINIC (RHC)		4, 564, 536				88. 02
	08803 RURAL HEALTH CLINIC (RHC)		1, 242, 046				88. 03
	08804 RURAL HEALTH CLINIC (RHC)		642, 439				88. 04
	09100 EMERGENCY	9, 656, 999	43, 471, 009			0. 000000	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 611, 507	4, 530, 576			0. 000000	1
	OTHER REIMBURSABLE COST CENTERS	1,011,307	4, 330, 370	0, 142, 000	0. 723073	0.000000	72.00
	10200 OPI OI D TREATMENT PROGRAM	0	0		n I		102. 00
200.00	Subtotal (see instructions)	174, 853, 432	421, 382, 257	596, 235, 689			200. 00
201.00	Less Observation Beds	1, 1, 000, 402	121, 302, 237	0,0,200,00			201.00
202.00	Total (see instructions)	174, 853, 432	421, 382, 257	596, 235, 689	,		202.00
50	, , , , , , , , , , , , , , , , , , , ,	, 5557	, 552, 207	1 2.2, 200, 00	'		,

Heal th Financial Systems ST. MARY MEDICAL CENTER In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0064
From 10/01/2022
To 09/30/2023 Date/Time Prepared:

				10 09/30/2023	2/28/2024 8:0	
			Title XVIII	Hospi tal	PPS	2 piii
	Cost Center Description	PPS Inpatient		noopi tui		
		Ratio				
		11.00				
ΙN	PATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03	000 ADULTS & PEDIATRICS					30.00
31.00 03	100 INTENSIVE CARE UNIT					31.00
43. 00 04	300 NURSERY					43.00
AN	CILLARY SERVICE COST CENTERS					
50.00 05	000 OPERATING ROOM	0. 152010				50.00
51.00 05	100 RECOVERY ROOM	0. 229443				51.00
52.00 05	200 DELIVERY ROOM & LABOR ROOM	0. 465531				52.00
53.00 05	300 ANESTHESI OLOGY	0. 031740				53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	0. 161342				54.00
55. 00 05	500 RADI OLOGY - THERAPEUTI C	0. 000000				55. 00
56. 00 05	6600 RADI 0I SOTOPE	0. 078955				56.00
57. 00 05	700 CT SCAN	0. 029157				57. 00
58. 00 05	800 MRI	0. 050348				58. 00
60.00 06	0000 LABORATORY	0. 077037				60.00
63. 00 06	300 BLOOD STORING, PROCESSING & TRANS.	0. 248844				63.00
	500 RESPI RATORY THERAPY	0. 086826				65. 00
65. 10 06	501 CARDI AC STRESS LAB	0. 064026				65. 10
	502 CARDI AC REHAB	0. 124327				65. 20
66. 00 06	600 PHYSI CAL THERAPY	0. 229192				66. 00
67. 00 06	700 OCCUPATIONAL THERAPY	0. 270458				67. 00
68. 00 06	800 SPEECH PATHOLOGY	0. 252919				68. 00
69. 00 06	900 ELECTROCARDI OLOGY	0. 040967				69. 00
70. 00   07	000 ELECTROENCEPHALOGRAPHY	0. 252929				70.00
71. 00   07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 703827				71. 00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENTS	0. 216124				72. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	0. 130517				73. 00
76. 00 03	610 SLEEP LAB	0. 169664				76. 00
76. 01 03	020 PAIN CLINIC	0. 032118				76. 01
77. 00   07	700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77. 00
78. 00   07	800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78. 00
OU <sup>*</sup>	TPATIENT SERVICE COST CENTERS					
88. 00 08	800 RURAL HEALTH CLINIC (RHC)					88. 00
88. 01 08	801 RURAL HEALTH CLINIC (RHC)					88. 01
88. 02 08	802 RURAL HEALTH CLINIC (RHC)					88. 02
88. 03 08	803 RURAL HEALTH CLINIC (RHC)					88. 03
88. 04 08	804 RURAL HEALTH CLINIC (RHC)					88. 04
91.00 09	100 EMERGENCY	0. 161689				91.00
92. 00 09	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 723895				92. 00
	HER REIMBURSABLE COST CENTERS					
102. 00 10	200 OPIOID TREATMENT PROGRAM					102. 00
200.00	Subtotal (see instructions)					200. 00
201.00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-0064	Peri od: Worksheet C From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared:

				Т	o 09/30/2023	Date/Time Pre 2/28/2024 8:0	pared: 2 pm
			Ti tl	e XIX	Hospi tal	Cost	<u> </u>
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	F	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
IN	IPATIENT ROUTINE SERVICE COST CENTERS						
	8000 ADULTS & PEDIATRICS	23, 411, 292		23, 411, 292	ol	23, 411, 292	30.00
	3100 INTENSIVE CARE UNIT	4, 685, 281		4, 685, 281		4, 685, 281	
	1300 NURSERY	1, 184, 534		1, 184, 534		1, 184, 534	1
	ICI LLARY SERVI CE COST CENTERS	1, 101, 001		1, 101, 001	<u> </u>	1, 101, 001	10.00
	5000 OPERATING ROOM	7, 538, 059		7, 538, 059	ol	7, 538, 059	50.00
	5100 RECOVERY ROOM	3, 097, 789		3, 097, 789		3, 097, 789	•
	5200 DELIVERY ROOM & LABOR ROOM	2, 232, 486		2, 232, 486		2, 232, 486	
	5300 ANESTHESI OLOGY	518, 127		518, 127		518, 127	
	5400 RADI OLOGY-DI AGNOSTI C	5, 201, 325		5, 201, 325		5, 201, 325	
	5500 RADI OLOGY - THERAPEUTI C	5, 201, 323		3, 201, 325	0	5, 201, 325	55.00
	6600 RADI OLOGI - MEKAFLUTTO	551, 446		551, 446	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	551, 446	ł
	5700 CT SCAN	1, 893, 286		1, 893, 286		1, 893, 286	
	5800 MRI	813, 962					1
		1		813, 962		813, 962	
	5000 LABORATORY	7, 749, 830		7, 749, 830		7, 749, 830	
	BLOOD STORING, PROCESSING & TRANS.	732, 649		732, 649		732, 649	1
	5500 RESPIRATORY THERAPY	1, 429, 336	0	1, 429, 336		1, 429, 336	
	5501 CARDI AC STRESS LAB	949, 227	0	949, 227		949, 227	65. 10
	5502 CARDI AC REHAB	173, 216	0	173, 216		173, 216	1
	6600 PHYSI CAL THERAPY	2, 499, 923	0	2, 499, 923		2, 499, 923	1
	5700 OCCUPATIONAL THERAPY	693, 444	0	693, 444		693, 444	1
	SPEECH PATHOLOGY	420, 063	0	420, 063		420, 063	•
	900 ELECTROCARDI OLOGY	196, 967		196, 967		196, 967	69. 00
	7000 ELECTROENCEPHALOGRAPHY	28, 493		28, 493		28, 493	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 500, 975		2, 500, 975		2, 500, 975	
	7200 IMPL. DEV. CHARGED TO PATIENTS	2, 149, 674		2, 149, 674		2, 149, 674	72. 00
	7300 DRUGS CHARGED TO PATIENTS	11, 088, 683		11, 088, 683		11, 088, 683	
	3610 SLEEP LAB	550, 309		550, 309	0	550, 309	76. 00
	BO20 PAIN CLINIC	148, 722		148, 722	0	148, 722	76. 01
	7700 ALLOGENEIC HSCT ACQUISITION	0		C	0	0	
	7800 CAR T-CELL IMMUNOTHERAPY	0		C	0	0	78. 00
	ITPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC (RHC)	7, 394, 145		7, 394, 145	0	7, 394, 145	88. 00
	8801 RURAL HEALTH CLINIC (RHC)	2, 077, 556		2, 077, 556	0	2, 077, 556	88. 01
88. 02 08	8802 RURAL HEALTH CLINIC (RHC)	3, 178, 845		3, 178, 845	0	3, 178, 845	88. 02
88. 03 08	8803 RURAL HEALTH CLINIC (RHC)	1, 126, 616		1, 126, 616		1, 126, 616	88. 03
88. 04 08	8804 RURAL HEALTH CLINIC (RHC)	507, 925		507, 925	O	507, 925	88. 04
	P100 EMERGENCY	8, 590, 208		8, 590, 208	o	8, 590, 208	91.00
92.00 09	2200 OBSERVATION BEDS (NON-DISTINCT PART	4, 446, 226		4, 446, 226		4, 446, 226	92.00
OT	THER REIMBURSABLE COST CENTERS						
102.00 10	0200 OPIOID TREATMENT PROGRAM	0		C		0	102. 00
200.00	Subtotal (see instructions)	109, 760, 619	0	109, 760, 619	О	109, 760, 619	1
201.00	Less Observation Beds	4, 446, 226		4, 446, 226		4, 446, 226	
202.00	Total (see instructions)	105, 314, 393	0			105, 314, 393	1
'			,		, -1		

				09/30/2023		pared:
		Ti tl	e XIX	Hospi tal	Cost	2 piii
		Charges	<u> </u>			
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
· ·	· ·	'	+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	38, 807, 782		38, 807, 782			30. 00
31.00  03100   INTENSIVE CARE UNIT	6, 839, 763		6, 839, 763			31. 00
43. 00 04300 NURSERY	2, 355, 433		2, 355, 433			43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	11, 611, 579	37, 977, 782		0. 152010	0.000000	50.00
51. 00   05100   RECOVERY ROOM	2, 205, 618	11, 295, 754			0.000000	51.00
52.00  05200 DELIVERY ROOM & LABOR ROOM	4, 394, 951	400, 621	4, 795, 572	I	0.000000	52. 00
53. 00   05300   ANESTHESI OLOGY	4, 718, 028	11, 606, 237	16, 324, 265	0. 031740	0.000000	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 640, 499	28, 597, 352	32, 237, 851	0. 161342	0.000000	54.00
55. 00  05500  RADI OLOGY - THERAPEUTI C	0	0	0	0.000000	0.000000	55. 00
56. 00  05600  RADI 0I SOTOPE	522, 492	6, 461, 811	6, 984, 303	0. 078955	0.000000	56. 00
57. 00  05700 CT SCAN	11, 578, 936	53, 354, 491	64, 933, 427	0. 029157	0.000000	57. 00
58. 00   05800   MRI	1, 345, 895	14, 820, 725	16, 166, 620	0. 050348	0.000000	58. 00
60. 00   06000   LABORATORY	25, 751, 374	74, 847, 669		0. 077037	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 066, 007	1, 878, 198		0. 248844	0.000000	63. 00
65. 00 06500 RESPIRATORY THERAPY	12, 757, 478	3, 704, 570		I	0.000000	65. 00
65. 10   06501   CARDI AC STRESS LAB	3, 562, 550	11, 263, 081	14, 825, 631	0. 064026	0. 000000	65. 10
65. 20   06502   CARDI AC   REHAB	0	1, 393, 224		0. 124327	0.000000	65. 20
66. 00 06600 PHYSI CAL THERAPY	1, 357, 078	9, 550, 458			0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	733, 383	1, 830, 579		0. 270458	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	583, 284	1, 077, 579		0. 252919	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 240, 370	3, 567, 591	4, 807, 961	0. 040967	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	5, 048	107, 604		I	0. 000000	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 620, 358	1, 933, 036		0. 703827	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 209, 378	6, 737, 123		0. 216124	0. 000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	23, 669, 942	61, 289, 747	84, 959, 689	0. 130517	0. 000000	73. 00
76. 00   03610   SLEEP LAB	2, 004	3, 241, 519		0. 169664	0. 000000	76. 00
76. 01   03020   PAIN CLINIC	5, 696	4, 624, 816		0. 032118	0. 000000	76. 01
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0. 000000	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0. 000000	78. 00
OUTPATIENT SERVICE COST CENTERS		44 0/0 000	11 0/0 000	0.440044		
88. 00   08800   RURAL HEALTH CLINIC (RHC)	0	11, 068, 889			0. 000000	88. 00
88. 01   08801 RURAL HEALTH CLINIC (RHC)	0	4, 301, 195			0. 000000	88. 01
88. 02 08802 RURAL HEALTH CLINIC (RHC)	0	4, 564, 536			0. 000000	88. 02
88. 03   08803   RURAL HEALTH CLINIC (RHC)	0	1, 242, 046			0. 000000	88. 03
88. 04 08804 RURAL HEALTH CLINIC (RHC)	0 (5( 000	642, 439		I	0. 000000	88. 04
91. 00 09100 EMERGENCY	9, 656, 999	43, 471, 009		l .	0. 000000	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	1, 611, 507	4, 530, 576	6, 142, 083	0. 723895	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS	O		1 0	ı		100 00
102.00 10200 OPI OI D TREATMENT PROGRAM	١	421 202 257	1			102. 00 200. 00
200.00 Subtotal (see instructions)	174, 853, 432	421, 382, 257	596, 235, 689			
201.00 Less Observation Beds 202.00 Total (see instructions)	174, 853, 432	421, 382, 257	506 225 400			201. 00 202. 00
202.00   TOTAL (See HISTINGTIONS)	174, 000, 432	421, 302, 231	596, 235, 689			<sub>1</sub> 202.00

Heal th Financial Systems ST. MARY MEDICAL CENTER In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0064
From 10/01/2022
To 09/30/2023 Date/Time Prepared:

Cost Center Description  PPS Inpatient Ratio	рш
Cost Center Description PPS Inpatient Ratio	
Ratio	
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00   03000   ADULTS & PEDI ATRI CS	30.00
	31.00
	43.00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 OPERATING ROOM 0. 000000	50.00
51. 00   05100   RECOVERY ROOM   0.000000	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0.000000	52.00
	53.00
54. 00   05400   RADI 0LOGY - DI AGNOSTI C 0. 000000	54.00
	55.00
	56.00
	57.00
	58. 00
	60.00
	63. 00
	65. 00
	65. 10
	65. 20
	66. 00
	67. 00
	68. 00
	69. 00
	70.00
	71.00
	72.00
	73.00
	76.00
	76. 01
	77. 00
	78.00
OUTPATIENT SERVICE COST CENTERS	
88. 00   08800   RURAL HEALTH CLINIC (RHC)   0. 000000	88. 00
88. 01   08801   RURAL HEALTH CLINIC (RHC) 0. 000000	88. 01
88. 02   08802   RURAL HEALTH CLINIC (RHC) 0. 000000	88. 02
	88. 03
	88. 04
	91.00
	92.00
OTHER REIMBURSABLE COST CENTERS	
	02.00
	200.00
	201.00
202.00 Total (see instructions)	202. 00

Health Financial Systems	ST. MARY MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 10/01/2022 To 09/30/2023		narod:
				10 09/30/2023	2/28/2024 8: 0	
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 386, 553	0	1, 386, 55	3 16, 107	86. 08	30. 00
31.00   INTENSIVE CARE UNIT	359, 835		359, 83	5 1, 729	208. 12	31.00
43. 00 NURSERY	93, 957		93, 95	7 1, 005	93. 49	43.00
200.00 Total (lines 30 through 199)	1, 840, 345		1, 840, 34	5 18, 841		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days					
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDI ATRI CS	5, 006	1	•		l	30. 00
31.00 INTENSIVE CARE UNIT	684	142, 354			ļ	31. 00
43. 00 NURSERY	0	0			ļ	43. 00
200.00 Total (lines 30 through 199)	5, 690	573, 270	1		ļ	200. 00

Health Financial Systems	ST. MARY MEDICAL	L CENTER	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	COSTS	Provider CCN: 14-0064	Peri od:	Worksheet D

	AL COSTS			Period: From 10/01/2022 To 09/30/2023	Date/Time Pre 2/28/2024 8:0	pared: 2 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	·	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS						
50.00   05000   OPERATING ROOM	1, 575, 997					
51.00   05100   RECOVERY ROOM	250, 528	13, 501, 372	0. 01855	66 813, 474	15, 095	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	190, 024	4, 795, 572	0. 03962	.5 65, 199	2, 584	52.00
53. 00   05300   ANESTHESI OLOGY	42, 630	16, 324, 265	0. 00261	1 1, 428, 850	3, 731	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	367, 091					
55. 00   05500 RADI OLOGY - THERAPEUTI C	0	0	0. 00000	0	0	55.00
56. 00   05600 RADI OI SOTOPE	22, 824	6, 984, 303	0. 00326	8 293, 210	958	56.00
57. 00  05700 CT SCAN	260, 726					
58. 00   05800   MRI	105, 956					
60. 00 06000 LABORATORY	357, 981	100, 599, 043				
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	13, 740					
65. 00 06500 RESPIRATORY THERAPY	105, 574					65.00
65. 10   06501   CARDI AC STRESS LAB	118, 770					65. 10
65. 20 06502 CARDI AC REHAB	16, 770					1
66. 00   06600   PHYSI CAL THERAPY	232, 554				13, 557	66.00
57. 00 06700 OCCUPATIONAL THERAPY						
	63, 836 14, 028					
68. 00 06800 SPEECH PATHOLOGY						68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 002		0.00083			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	5, 264				_	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	53, 341					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	45, 836					
73.00 07300 DRUGS CHARGED TO PATIENTS	325, 627					
76. 00   03610   SLEEP LAB	31, 867					
76. 01  03020 PALN CLINIC	19, 418	4, 630, 512				
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0				0	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
B8.00 08800 RURAL HEALTH CLINIC (RHC)	432, 369	11, 068, 889	0. 03906	0	0	88. 00
B8. 01 08801 RURAL HEALTH CLINIC (RHC)	83, 951	4, 301, 195	0. 01951	8 0	0	88. 01
38.02 08802 RURAL HEALTH CLINIC (RHC)	139, 580	4, 564, 536	0. 03057	9 0	0	88. 02
38.03 08803 RURAL HEALTH CLINIC (RHC)	92, 017	1, 242, 046	0. 07408	0	0	88. 03
38. 04   08804 RURAL HEALTH CLINIC (RHC)	57, 129	642, 439	0. 08892	25 0	0	88. 04
91. 00 09100 EMERGENCY	402, 370			4, 095, 588	31, 020	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	263, 332					92.00
200.00 Total (lines 50 through 199)	5, 695, 266			48, 747, 182		

Health Financial Systems	ST. MARY MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	HER PASS THROUGH COST	S Provider C		Period: From 10/01/2022 Fo 09/30/2023		
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown	Ü	Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C	(	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	l ol	0		0	0	31. 00
43. 00   04300 NURSERY	l ol	0	,	0	0	43.00
200.00 Total (lines 30 through 199)	l ol	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		<b>_</b>		
		minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	16, 10 <sup>-</sup>	7 0.00	5, 006	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 729	0.00	684	31. 00
43. 00 04300 NURSERY		0	1, 00!	0.00	0	43. 00
200.00 Total (lines 30 through 199)		0	18, 84	1	5, 690	200. 00
Cost Center Description	Inpati ent			•		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	l ol					31. 00
43. 00   04300 NURSERY	l ol					43. 00
200.00 Total (lines 30 through 199)	ol					200. 00
	-1					

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 14-0064	Peri od: Worksheet D
THROUGH COSTS		From 10/01/2022   Part IV

Through Costs					To 09/30/2023	Date/Time Pre 2/28/2024 8:0	
			Title	XVIII	Hospi tal	PPS	
Cost Center Descri	ption	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST (	CENTERS						
50.00 05000 OPERATING ROOM		0	0	1	0	0	00.00
51.00  05100 RECOVERY ROOM		0	0		0	0	51. 00
52.00  05200   DELI VERY ROOM & LA	ABOR ROOM	0	0		0	0	
53. 00   05300   ANESTHESI OLOGY		0	0		0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOST		0	0		0	0	54. 00
55. 00   05500   RADI OLOGY - THERAF	PEUTI C	0	0		0	0	55. 00
56. 00   05600   RADI 0I SOTOPE		0	0		0	0	56. 00
57.00  05700 CT SCAN		0	0		0	0	57. 00
58. 00  05800 MRI		0	0		0	0	58. 00
60. 00  06000   LABORATORY		0	0		0	0	60.00
63. 00   06300   BLOOD STORING, PRO		0	0	)	0	0	63. 00
65. 00 06500 RESPIRATORY THERAP		0	0	)	0	0	65. 00
65. 10  06501 CARDI AC STRESS LAE	3	0	0	)	0	0	65. 10
65. 20   06502   CARDI AC REHAB		0	0	)	0	0	65. 20
66. 00 06600 PHYSI CAL THERAPY		0	0	)	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERA	APY	0	0	)	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY		0	0	)	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0	0	)	0	0	69. 00
70. 00  07000   ELECTROENCEPHALOGR		0	0	)	0	0	70. 00
71. 00  07100   MEDI CAL SUPPLI ES C		0	0	)	0	0	71. 00
72.00 07200 I MPL. DEV. CHARGED		0	0	1	0	0	72. 00
73.00 07300 DRUGS CHARGED TO F	PATIENTS	0	0	1	0	0	73. 00
76. 00  03610   SLEEP LAB		0	0	1	0	0	76. 00
76. 01   03020   PALN CLINIC		0	0	1	0	0	76. 01
77.00 07700 ALLOGENEIC HSCT AC	CQUISITION	0	0	1	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOT	HERAPY	0	0		0 0	0	78. 00
OUTPATIENT SERVICE COST	CENTERS						
88.00   08800   RURAL HEALTH CLINI	C (RHC)	0	0	1	0	0	88. 00
88. 01   08801   RURAL HEALTH CLINI		0	0	1	0	0	
88. 02   08802   RURAL HEALTH CLINI	C (RHC)	0	0	1	0	0	88. 02
88. 03   08803   RURAL HEALTH CLINI	C (RHC)	0	0	1	0	0	88. 03
88. 04   08804 RURAL HEALTH CLINI	C (RHC)	0	0	)	0	0	88. 04
91.00 09100 EMERGENCY		0	0	)	0	0	
92.00 09200 OBSERVATION BEDS (		0			0	0	72.00
200.00   Total (lines 50 th	rough 199)	0	0	1	0	0	200. 00

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	NCILLARY SERVICE OTHER PASS Provider CCN: 14-0064	Peri od: Worksheet D
THROUGH COSTS		From 10/01/2022   Part IV

THROUGH COSTS				To 09/30/2023		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	( 00	7.00	instructions)	
ANGLILLARY CERVICE COCT CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS  50. 00 05000 OPERATING ROOM		0	Ι ,	49, 589, 361	0.00000	50.00
51. 00   05000   OPERATING ROOM 51. 00   05100   RECOVERY ROOM	0	0				
52. 00   05100   RECOVERY ROOM	0	0		13, 501, 372 4, 795, 572		1
53. 00   05300   ANESTHESI OLOGY	0	0	·			1
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		16, 324, 265 32, 237, 851		1
55. 00   05500   RADI OLOGY - THERAPEUTI C	0	0	· ·	) 32, 237, 631		
56. 00   05600   RADI 01 SOTOPE	0	0	1	-		
57. 00   05700 CT   SCAN	0	0	(			1
	0	0				1
58. 00   05800   MRI 60. 00   06000   LABORATORY	0	0	1			
	0	0	(			
63. 00   06300   BLOOD STORING, PROCESSING & TRANS. 65. 00   06500   RESPIRATORY THERAPY	0	0	1	-,,		
65. 10   06500   RESPIRATORY   THERAPY 65. 10   06501   CARDI AC   STRESS   LAB	0	0	1	16, 462, 048 14, 825, 631		1
65. 20   06502   CARDI AC   STRESS LAB	0	0		14, 825, 631		
66. 00   06600   PHYSI CAL THERAPY	0	0				1
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		2, 563, 962		
68. 00   06800   SPEECH PATHOLOGY	0	0				1
69. 00   06900   SPEECH PATHOLOGY	0	0		4, 807, 961		
70. 00   07000   ELECTROENCEPHALOGRAPHY	0	0		112, 652		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		1	l .	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		9, 946, 501	l	1
73. 00 07300 DRUGS CHARGED TO PATTENTS	0	0	·	84, 959, 689		1
76. 00   03610   SLEEP LAB	0	0		3, 243, 523	l .	
76. 01   03020 PALN CLINIC	0	0		4, 630, 512	l .	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				
78. 00   07800   CAR T-CELL   IMMUNOTHERAPY	0	0				1
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		0	0.000000	70.00
88. 00 08800 RURAL HEALTH CLINIC (RHC)	0	0		11, 068, 889	0.000000	88. 00
88. 01   08801 RURAL HEALTH CLINIC (RHC)	0	0		4, 301, 195		
88. 02 08802 RURAL HEALTH CLINIC (RHC)	0	0	· ·	4, 564, 536		
88. 03 08803 RURAL HEALTH CLINIC (RHC)	0	0		1, 242, 046		1
88. 04   08804 RURAL HEALTH CLINIC (RHC)	0	0	1	642, 439		
91. 00   09100   EMERGENCY	0	0	1	53, 128, 008		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	l o	0	1	6, 142, 083		1
200.00 Total (lines 50 through 199)	l o	0		548, 232, 711		200. 00
(	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	'		1	

Health Financial Systems	ST. MARY MEDICA	L CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN THROUGH COSTS	F ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-0064	Peri od: From 10/01/2022 To 09/30/2023	Worksheet D Part IV Date/Time Prepared:

Tilloodi costs				Го 09/30/2023	Date/Time Pre 2/28/2024 8:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCI LLARY SERVI CE COST CENTERS	T			.1		
50. 00   05000   OPERATI NG ROOM	0. 000000	4, 908, 144		8, 255, 903		50. 00
51. 00   05100   RECOVERY ROOM	0. 000000	813, 474		2, 478, 220		51. 00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	65, 199		2, 444		52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	1, 428, 850		2, 426, 615		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	1, 488, 813	1	5, 842, 318		54. 00
55. 00   05500   RADI OLOGY - THERAPEUTI C	0. 000000	0		0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000	293, 210		1, 964, 911	0	56. 00
57. 00  05700 CT SCAN	0. 000000	4, 879, 900		12, 555, 068	0	57. 00
58. 00   05800   MRI	0. 000000	514, 695		3, 465, 107	0	58. 00
60. 00   06000   LABORATORY	0. 000000	9, 533, 186		6, 512, 929	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	509, 843	(	1, 359, 805	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	4, 982, 698		887, 253	0	65. 00
65. 10   06501   CARDI AC   STRESS   LAB	0. 000000	1, 625, 783	(	3, 396, 012	0	65. 10
65. 20   06502   CARDI AC   REHAB	0. 000000	0		579, 865	0	65. 20
66. 00   06600 PHYSI CAL THERAPY	0. 000000	635, 872		44, 100	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	313, 101		5, 531	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	260, 565		11, 303	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	541, 918		769, 991	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	717, 878		332, 034	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 845, 281		2, 048, 423	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	8, 535, 663		25, 260, 168		73. 00
76. 00   03610   SLEEP LAB	0. 000000	2, 004		613, 416		76. 00
76. 01 03020 PAIN CLINIC	0. 000000	5, 696		1, 503, 556		76. 01
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0		77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0		78. 00
OUTPATIENT SERVICE COST CENTERS				- 1		
88. 00 08800 RURAL HEALTH CLINIC (RHC)	0. 000000	0		0	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC (RHC)	0. 000000	0		0	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC (RHC)	0. 000000	0		0	Ō	88. 02
88. 03 08803 RURAL HEALTH CLINIC (RHC)	0. 000000	0		0	0	88. 03
88. 04   08804 RURAL HEALTH CLINIC (RHC)	0. 000000	0			0	88. 04
91. 00   09100   EMERGENCY	0. 000000	4, 095, 588		8, 820, 593	_	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	749, 821		432, 603		92.00
200.00 Total (lines 50 through 199)	3. 333300	48, 747, 182		89, 568, 168		200.00
200.00   10tal (11105 00 thi oagh 177)	I I	10, 111, 102	'	07, 000, 100	٠	1200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-0064 Peri od: Worksheet D From 10/01/2022 Part V 09/30/2023 Date/Time Prepared: 2/28/2024 8: 02 pm Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 152010 8, 255, 903 1, 254, 980 50.00 51.00 05100 RECOVERY ROOM 0. 229443 2, 478, 220 0 0 568, 610 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1, 138 52 00 0 465531 2, 444 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0.031740 2, 426, 615 77,021 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 161342 5, 842, 318 0 942, 611 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 0.000000 0 0 Ω 55 00 05600 RADI OI SOTOPE 0 56.00 0.078955 1, 964, 911 155, 140 56.00 57.00 05700 CT SCAN 0.029157 12, 555, 068 0 366, 068 57.00 58.00 05800 MRI 0.050348 3, 465, 107 0 0 174, 461 58.00 06000 LABORATORY 26, 597 501, 737 0.077037 6, 512, 929 60 00 60 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 248844 1, 359, 805 0 338, 379 63.00 06500 RESPIRATORY THERAPY 0.086826 887, 253 0 77, 037 65.00 0 0 0 0 65.00 06501 CARDI AC STRESS LAB 0.064026 3, 396, 012 0 217, 433 65.10 65.10 06502 CARDI AC REHAB 0 65 20 0.124327 579.865 72.093 65 20 66.00 06600 PHYSI CAL THERAPY 0. 229192 44, 100 0 10, 107 66.00 06700 OCCUPATIONAL THERAPY 0. 270458 67.00 5, 531 1, 496 67.00 06800 SPEECH PATHOLOGY 0. 252919 11, 303 0 2, 859 68.00 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 0.040967 769, 991 31, 544 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 252929 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 233, 694 71.00 0.703827 332, 034 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0.216124 2,048,423 0 442, 713 72.00 07300 DRUGS CHARGED TO PATIENTS 25, 260, 168 0 3, 296, 881 73.00 0.130517 42, 842 73 00 03610 SLEEP LAB 0.169664 613, 416 0 104, 075 76.00 0 76.00 03020 PAIN CLINIC o 76. 01 0.032118 1, 503, 556 0 48, 291 76.01 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 0.000000 C 77.00 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 Ω 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC) 88.00 88.00 08801 RURAL HEALTH CLINIC (RHC) 88.01 88 01 88. 02 08802 RURAL HEALTH CLINIC (RHC) 88.02

0.161689

0. 723895

8,820,593

89, 568, 168

89, 568, 168

432, 603

0

42, 842

42, 842

26, 597

26, 597

88.03

88.04

91.00

92.00

201.00

1, 426, 193

313, 159

10, 657, 720 200. 00

10, 657, 720 202. 00

08803 RURAL HEALTH CLINIC (RHC)

08804 RURAL HEALTH CLINIC (RHC)

Only Charges

09200 OBSERVATION BEDS (NON-DISTINCT PART

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Subtotal (see instructions)

09100 EMERGENCY

88. 03

88.04

91.00

92.00

200.00

201.00

202.00

Health Financial Systems ST. MARY MEDICAL CENTER In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-0064

Period: From 10/01/2022 Part V

09/30/2023 Date/Time Prepared: 2/28/2024 8: 02 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 55.00 05600 RADI OI SOTOPE 0 56.00 56.00 57.00 05700 CT SCAN 0 57.00 05800 MRI 0 0 58.00 58.00 06000 LABORATORY 2,049 0 60 00 60 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 65.10 06501 CARDI AC STRESS LAB 0000000000000 0 65.10 06502 CARDI AC REHAB 0 65. 20 65 20 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 5.592 73.00 76.00 03610 SLEEP LAB 0 76.00 03020 PAIN CLINIC 76.01 0 76.01 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC) 88.00 88.00 08801 RURAL HEALTH CLINIC (RHC) 88. 01 88.01 88. 02 08802 RURAL HEALTH CLINIC (RHC) 88.02 08803 RURAL HEALTH CLINIC (RHC) 88. 03 88.03 08804 RURAL HEALTH CLINIC (RHC) 88.04 88.04 09100 EMERGENCY 91.00 Ω 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 200.00 Subtotal (see instructions) 2,049 5, 592 200.00 Less PBP Clinic Lab. Services-Program 201. 00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 2,049 5, 592 202.00

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of	Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0	0064 Period: Work From 10/01/2022	ksheet D-1
		To 09/30/2023 Date	e/Time Prepared: 8/2024 8:02 pm
	Title XVIII	Hospi tal	DDS

		Ti +Lo YVIII	Hospi tal	2/28/2024 8: 0 PPS	2 pm	
	Cost Center Description	Title XVIII	Hospi tal	PP5		
	·			1. 00		
	PART I - ALL PROVIDER COMPONENTS				1	
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		16, 107	1.00	
2.00	Inpatient days (including private room days, excluding swing-			16, 107	1	
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00	
4 00	do not complete this line.	40.040	4 00			
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo	13, 048 0	4. 00 5. 00			
5.00	reporting period	on days) through becembe	i si di the cost	0	3.00	
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00	
	reporting period (if calendar year, enter 0 on this line)			_		
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	n days) through December	31 of the cost	0	7. 00	
8. 00	Total swing-bed NF type inpatient days (including private roor	m davs) after December 3	1 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)					
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	5, 006	9. 00	
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including privato r	oom days)	0	10.00	
10.00	through December 31 of the cost reporting period (see instructions)		oom days)	0	10.00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00	
40.00	December 31 of the cost reporting period (if calendar year, er				40.00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	confy (including private	e room days)	0	12. 00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00	
	after December 31 of the cost reporting period (if calendar ye					
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00	
16. 00	Nursery days (title V or XIX only)			0	16.00	
	SWING BED ADJUSTMENT			<u> </u>	10.00	
17. 00						
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	0. 00	18. 00			
18.00	reporting period	0.00	18.00			
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00	
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 21 of t	ho cost	0. 00	20.00	
20.00	reporting period	s arter becember 31 or t	ne cost	0.00	20.00	
21. 00	Total general inpatient routine service cost (see instructions			23, 411, 292		
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00	
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	a period (line 6	0	23. 00	
	x line 18)		9			
24. 00	Swing-bed cost applicable to NF type services through December	1 31 of the cost reporti	ng period (line	0	24. 00	
25. 00	7 x line 19)   Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
	x line 20)		p			
26. 00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		23, 411, 292	27. 00	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)		3,	0		
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0.000000	1	
32.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	1	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	1	
35.00	Average per diem private room cost differential (line 34 x line	0. 00				
36.00	Private room cost differential adjustment (line 3 x line 35)		66 11 1 (1)	0	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	rrentiai (line	23, 411, 292	37. 00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU					
38.00	Adjusted general inpatient routine service cost per diem (see	,		1, 453. 49	1	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	*		7, 276, 171 0		
	Total Program general inpatient routine service cost (line 39)			7, 276, 171		

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	ST. MARY MEDI	Provi der	CCN: 14		Peri od:	worksheet D-1	
						From 10/01/2022 To 09/30/2023	Date/Time Pre 2/28/2024 8:0	pared:
				le XVII		Hospi tal	PPS	2 piii
	Cost Center Description	Total Inpatient Cost	Total npatient Day	ys Di em	rage Per (col. 1 ol. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00		3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0	0.0	0 0	0	42. 00
43. 00	INTENSIVE CARE UNIT	4, 685, 281	1, 72	29	2, 709. 8	2 684	1, 853, 517	43. 00
44.00	CORONARY CARE UNIT							44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)				6, 380, 160	48. 00
48. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	eet D-6, Part			column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0°	1)(see instru	ucti ons	s)		15, 509, 848	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine s	services (fro	om Wksi	t. D, sum	of Parts I and	573, 270	50.00
E4 00				c w			400 740	F4 00
51. 00	Pass through costs applicable to Program inpland IV)	atient anciliary	y services (1	rrom W	KST. D, S	um or Parts II	438, 760	51.00
52.00	Total Program excludable cost (sum of lines						1, 012, 030	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-ph	hysi ci a	an anesth	etist, and	14, 497, 818	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)						1
54.00	Program discharges							54.00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge						0.00	55. 00 55. 01
55. 02	Adjustment amount per discharge (contractor	use only)						55. 02
56.00	Target amount (line 54 x sum of lines 55, 55			/l:	-/!	1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tai	rget amount (	(IIne s	o6 Minus	iine 53)	0 0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	portino	g period	endi ng 1996,		59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	m prior year	cost	coport u	ndated by the	0.00	60.00
00.00	market basket)	of Title 33 Troi	ii piroi yeai	COST	epoi t, u	puared by the	0.00	00.00
61. 00	Continuous improvement bonus payment (if lin						0	61.00
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x							
	enter zero. (see instructions)		J			,,	_	
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)					62.00
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST							30.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decer	mber 31 of th	he cost	reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost r	eporti ng	period (See	0	65. 00
// 00	instructions)(title XVIII only)	+- (1:	(4	/ E	+1 - 10/11			// 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (Tine (	54 prus rine	65)(11	tie xvii	i oniy); ror	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the	cost re	porting period	0	67. 00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	e costs after De	ecember 31 of	f the d	cost reno	rting period	0	68. 00
	(line 13 x line 20)					J F2 34		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						0	69. 00
70. 00	Skilled nursing facility/other nursing facil				(line 37)			70. 00
71.00	Adjusted general inpatient routine service c		ne 70 ÷ line	e 2)				71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x l	line 35	5)			72.00
74. 00	Total Program general inpatient routine serv	ice costs (line	72 + line 73	3)				74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksh	neet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76. 00
77. 00	Program capital-related costs (line 9 x line							77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		covider recor	rds)				78. 00 79. 00
80.00	Total Program routine service costs for comp				ne 78 min	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi		<b>,</b>					81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (							82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)						84. 00
85.00	Utilization review - physician compensation							85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 65)					86. 00
	Total observation bed days (see instructions						3, 059	1
87. 00 88. 00	Adjusted general inpatient routine cost per						1, 453. 49	

Health Financial Systems	ST. MARY MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 10/01/2022	Worksheet D-1	
				To 09/30/2023		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	1, 386, 553	23, 411, 292	0. 05922	4, 446, 226	263, 332	90.00
91.00 Nursing Program cost	0	23, 411, 292	0.00000	4, 446, 226	0	91.00
92.00 Allied health cost	0	23, 411, 292	0.00000	4, 446, 226	0	92.00
93.00 All other Medical Education	0	23, 411, 292	0. 000000	4, 446, 226	0	93. 00

	MEDICAL CENTER	011 14 0077		eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 10/01/2022	Worksheet D-3	
			To 09/30/2023	Date/Time Pre 2/28/2024 8:0	
	Ti tl e	e XVIII	Hospi tal	PPS	-
Cost Center Description		Ratio of Cost	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			11 001 701		
30. 00   03000   ADULTS & PEDI ATRI CS			11, 981, 701		30.00
31. 00 03100 I NTENSI VE CARE UNI T			2, 599, 092		31.00
43. 00 O4300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM		0. 15201	0 4 000 144	746, 087	50.00
50. 00   05000   0PERATI NG ROOM 51. 00   05100   RECOVERY ROOM		0. 15201		l	
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 22944			
53. 00   05300   ANESTHESI OLOGY		0. 40333			
54. 00   05400  RADI OLOGY-DI AGNOSTI C		0. 03174			
55. 00   05500   RADI OLOGY - THERAPEUTI C		0. 00000		240, 200	55.00
56. 00   05600   RADI OI SOTOPE		0. 07895		23, 150	56.00
57. 00   05700 CT   SCAN		0. 02915			
58. 00   05800 MRI		0. 05034			
60. 00 06000 LABORATORY		0. 07703	· ·		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 24884			63.00
65. 00 06500 RESPIRATORY THERAPY		0. 08682	6 4, 982, 698	432, 628	65.00
65. 10   06501   CARDI AC   STRESS   LAB		0.06402	6 1, 625, 783	104, 092	65. 10
65. 20   06502   CARDI AC   REHAB		0. 12432	.7 0	0	65. 20
66. 00   06600   PHYSI CAL THERAPY		0. 22919	2 635, 872	145, 737	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 27045	8 313, 101	84, 681	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 25291	9 260, 565	65, 902	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 04096		22, 201	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 25292	.9	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 70382			71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 21612		398, 810	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 13051			
76. 00   03610   SLEEP LAB		0. 16966		l .	
76. 01   03020   PAIN CLINIC		0. 03211		ł	
77. 00 07700 ALLOGENEI C HSCT ACQUISITION		0.00000		0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		0.00000		0	00 00

0.000000

0.000000

0.000000

0.000000

0.000000

0.161689

0. 723895

4, 095, 588

48, 747, 182

48, 747, 182

749, 821

0 88.00

0 88.02

0

0 88.04

6, 380, 160 200. 00

662, 212

542, 792

88.01

88. 03

91.00

92.00

201. 00

202. 00

88.00

88. 01

88. 02

88. 03

91.00

200.00

201.00

202.00

08800 RURAL HEALTH CLINIC (RHC)

08801 RURAL HEALTH CLINIC (RHC)

08802 RURAL HEALTH CLINIC (RHC)
08803 RURAL HEALTH CLINIC (RHC)

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

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

88. 04 | 08804 | RURAL HEALTH CLINIC (RHC)

09100 EMERGENCY

1.01   160		Title XVIII Ho	spi tal	2/28/2024 8: 0 PPS	2 pm
1.00   1.00				1. 00	
1.01   BiG amounts other than outlier payments for discharges occurring on or ofter October 1 (see   11,741,845   1.05   1.07   1.08   1.09   1.00					
1.02   1.03		DRG amounts other than outlier payments for discharges occurring prior to October 1 (see			1. 00 1. 01
1.00   1.00	1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see		11, 741, 845	1. 02
October 1 (see instructions)   2.00   October 1 (see instructions)   2.01   October 1 (see instructions)   2.02   October 1 (see instructions)   2.03   October 1 (see instructions)   2.04   October 1 (see instructions)   2.04   October 1 (see instructions)   2.04   October 1 (see instructions)   2.05   October 1 (see instructions)	1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior t	to October	0	1. 03
Dutilier reconcilitation amount		October 1 (see instructions)	after	0	1. 04
2.03   Outlier payments for discharges occurring prior to October 1 (see Instructions)	2. 01	Outlier reconciliation amount			2. 00 2. 01
3.00   Managed Carle Simulated Payments   7.2 de   7.00		, , , , , , , , , , , , , , , , , , , ,		0	2. 02 2. 03
Bed days, available of vided by number of days in the cost reporting period (see instructions)   72.62   4.05     Indirect Modical Education Adjustment   File count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1096 (see instructions)   0.00   5.00     File count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1096 (see instructions)   0.00   6.00     File cap adjustment for qualifing hospital programs shall meet the criteria for an add-on to the cap for new programs in accordance with 42 FR 413.796   7.00   7					
FTE count For all opathic and oxteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, See instructions)		Bed days available divided by number of days in the cost reporting period (see instructions)	)	-	4. 00
FIC cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)	5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period	endi ng on	0.00	5. 00
new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track programs FTE cap limit tation adjustment effer the cap-building window closed under \$127 of the CAA 2021 (see instructions) 7.00 MM Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(2) If the cost report stradies July 1, 2011 then see instructions 7.01 AGA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(2) If the cost report stradies July 1, 2011 then see instructions 8.00 Adjustment (increase or decrease) to the hospital's rural track programs FTE limitation(s) for rural and \$47.00 fth \$413.72(b) (a) (b) (b) (c) (c) (c) (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d		FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)			5. 01
the CAA 2021 (see Instructions) 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost cost report straddles July 1, 2011 then see instructions. 7.02 Adjustment (Increase or decrease) to the hospital's rural track programs FTE limitation (s) for rural track programs with a rural track for Medicare OBE affiliated programs in accordance with 413.75(b) and B7 FR 400/B (August 10, 2022) (see Instructions) 8.00 Adjustment (Increase or decrease) to the hospital's rural track programs in accordance with 413.75(b) and B7 FR 400/B (August 10, 2022) (see Instructions) 8.10 Adjustment (Increase or decrease) to the hospital instructions and B7 FR 500/B (August 10, 2022) (see Instructions) 8.11 Instructions and 57 FR 500/B (August 1, 2002). 8.12 The amount of increase if the hospital was awarded FTE cap slots under \$5500 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.12 The amount of increase if the hospital was awarded FTE cap slots under \$5500 of the ACA. If the cost under \$5500 of ACA. (see instructions) 8.21 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see Instructions) 8.22 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see Instructions) 8.23 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see Instructions) 8.24 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see Instructions) 8.25 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see Instructions) 8.26 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see Instructions) 8.27 The count for all opathic and osteopathic programs in the current year from your records 8.28 The Cap start year of the year of year of year of year of		new programs in accordance with 42 CFR 413.79(e)			
		the CAA 2021 (see instructions)			
2.02 Adjustment (Increase or decrease) to the hospital's rural track programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (Increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 413.75(b), and 87 FR 49075 (August 10, 2022) (see instructions) 8.01 Adjustment (Increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1999), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 Inhe amount of increase if the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.21 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA. 2021 (see D.00 of Tecount for all post in the current programs in the current pr		ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2			7. 00
Adjustment (Increase or decrease) to the FTE count for all opathic 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).	7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for track programs with a rural track for Medicare GME affiliated programs in accordance with 41		0.00	7. 02
The amount of increase   fr the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs faffiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May		0.00	8. 00
8.02   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If	the cost	0.00	8. 01
8. 21   The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)	8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hosp	oi tal	0.00	8. 02
9.00   Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus line 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)   10.00   FTE count for allopathic and osteopathic programs in the current year from your records   0.00   10.00   11.00   FTE count for residents in dental and podiatric programs.   0.00   12.00   12.00   13.00   10.00   14.00   15.00   15.00   15.00   16.00	8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021	(see	0.00	8. 21
11.00   FTE count for residents in dental and podiatric programs.   0.00   11.00   12.00   12.00   13.00   10.01   13.00   10.01   14.00   10.01   14.00   10.01   14.00   10.00   15.00   1	9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01,	plus or	0.00	9. 00
12.00   Current year allowable FTE (see instructions)   0.00   12.00   13.00   13.00   10.10					
14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.   15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16.00   Adjustment for residents in initial years of the program (see instructions)   0.00   16.00   16.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for resident to bed ratio (line 18 divided by line 4).   0.000000   19.00   19					
15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.00   18.00   18.00   17.00   18		Total allowable FTE count for the penultimate year if that year ended on or after September	30, 1997,		
16. 00   Adjustment for residents in initial years of the program (see instructions)   0. 00   16. 00   17. 00   Adjustment for residents displaced by program or hospital closure   0. 00   17. 00   18. 00   18. 00   18. 00   19. 00   0. 00   19. 00   0. 00   19. 00   0. 00   0. 00   19. 00   0. 00	15. 00			0.00	15. 00
18. 00       Adjusted rolling average FTE count       0.00       18. 00         19. 00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       20. 00         20. 00       Prior year resident to bed ratio (see instructions)       0.000000       20. 00         21. 00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21. 00         22. 01       IME payment adjustment (see instructions)       0.000000       22. 01         1md rect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.000000       22. 01         23. 00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105       0.00       23. 00         24. 00       IME FTE Resident Count Over Cap (see instructions)       0.00       24. 00         25. 00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25. 00         26. 00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25. 00         27. 00       IME payments adjustment factor. (see instructions)       0.000000       26. 00         28. 01       IME add-on adjustment amount (see instructions)       0.000000       27. 00         28. 01       IME add-on adjustment amount - Managed Care (see instru	16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16. 00
19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adjustment (see instructions)       0.000000       22.01         1 IME payment adjustment - Managed Care (see instructions)       0.00       22.01         23.00       Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.00       23.00         24.00       IME FTE Resident Count Over Cap (see instructions)       0.00       23.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.01       IME add-on adjustment amount (see instructions)       0.000000       27.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.28.00         29.01       Total IME payment (sum of lines 22 and 28)       0.29.00         Total IME payment - Managed Care (sum					•
20.00   Prior year resident to bed ratio (see instructions)   0.000000   20.00   21.00   22.					•
22.00 IME payment adjustment (see instructions)  1 IME payment adjustment - Managed Care (see instructions)  1 IME payment adjustment - Managed Care (see instructions)  2 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see		` ,			
22. 01  IME payment adjustment - Managed Care (see instructions)  Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23. 00  Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105  (f) (1) (iv) (C).  24. 00  IME FTE Resident Count Over Cap (see instructions)  10. 00  25. 00  If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	21.00			0.000000	21.00
Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  24.00 [f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)		IME payment adjustment - Managed Care (see instructions)			22. 00 22. 01
24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  32.01 IME add-on adjustment amount - Managed Care (sum of lines 22.01 and 28.01)  33.00 Allowable disproportionate share percentage (see instructions)  34.02 30.00  35.00 IME add-on adjustment amount - Managed Care (see instructions)  36.00 IME add-on adjustment amount (see instructions)  37.00 IME payment adjustment amount (see instructions)  38.00 IME add-on adjustment amount (see instructions)  39.00 IME add-on adjustment amount (see instructions)  40.00 28.00  40.00 29.00  40.00 29.00  40.00 29.00  40.00 29.00  40.00 20.00  40.00 2	23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.	105	0.00	23. 00
26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0.28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0.28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0.29. 01 29. 01 Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 22. 61 31. 00 31. 00 Percentage of Medicaid patient days (see instructions) 23. 01 32. 00 Sum of lines 30 and 31 27. 63 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 12. 01 33. 00		IME FTE Resident Count Over Cap (see instructions)	ee		
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 Sum of lines 30 and 31  30.00 Allowable disproportionate share percentage (see instructions)  31.00 Allowable disproportionate share percentage (see instructions)  32.00 Sum of lines 30 and 31		Resident to bed ratio (divide line 25 by line 4)			1
28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  31.00 Sum of lines 30 and 31  32.00 Allowable disproportionate share percentage (see instructions)  32.01 Allowable disproportionate share percentage (see instructions)  33.00 Allowable disproportionate share percentage (see instructions)		, , ,			•
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.00 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.02 30.00 31.00 Percentage of Medicaid patient days (see instructions) 23.61 31.00 32.00 Sum of lines 30 and 31 27.63 32.00 Allowable disproportionate share percentage (see instructions) 12.01 33.00		, , ,			•
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  29. 01  4. 02  30. 00  29. 01  30. 00  31. 00  32. 01  33. 00  34. 02  35. 01  36. 02  37. 63  37. 02  38. 00  39. 01  30. 00					29.00
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  4.02 30.00  31.00  22.61 31.00  32.00  32.00 33.00		Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			29. 01
32.00 Sum of lines 30 and 31 27.63 32.00 Allowable disproportionate share percentage (see instructions) 12.01 33.00	30.00			4. 02	30.00
33.00 Allowable disproportionate share percentage (see instructions) 12.01 33.00		, , , , ,			•
34.00   Disproportionate share adjustment (see instructions) 352,549   34.00		Disproportionate share adjustment (see instructions)			1

llool +h	Financial Systems	AL CENTED	المانا	u of Form CMC 1	DEE2 10
	Financial Systems ST. MARY MEDICA ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0064	Peri od:	u of Form CMS-2 Worksheet E	2552-10
CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CCN. 14-0064	From 10/01/2022	Part A	
			To 09/30/2023	Date/Time Pre	
-		T: 11 20/111		2/28/2024 8: 0	2 pm
		Title XVIII	Hospi tal	PPS	
			1.00	0n/After 10/1 2.00	
	Uncompensated Care Payment Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)		0	6, 874, 403, 459	35. 00
35. 01	Factor 3 (see instructions)		0. 00000000	0. 000094679	
35. 02	Hospital UCP, including supplemental UCP (If line 34 is zero,	enter zero on this line	) 0	650, 860	•
	(see instructions)				
35. 03	Pro rata share of the hospital UCP, including supplemental UC	CP (see instructions)	0	650, 860	
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		650, 860		36. 00
40.00	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu			40.00
40.00	Total Medicare discharges (see instructions)		Before 1/1	On/After 1/1	40. 00
			1. 00	1. 01	
41. 00	Total ESRD Medicare discharges (see instructions)		0	0	41. 00
41. 01	Total ESRD Medicare covered and paid discharges (see instruct	i ons)	0	0	41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00	_	42. 00
43.00	Total Medicare ESRD inpatient days (see instructions)	,	0		43. 00
44.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.00
	days)			,	
45. 00	Average weekly cost for dialysis treatments (see instructions		0.00	0. 00	
46. 00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46. 00
47. 00	Subtotal (see instructions)	mall rural baaritala	12, 773, 977 20, 389, 447		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sonly. (see instructions)	silari rurar nosprtars	20, 309, 447		48. 00
	only. (See That detroils)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions	5)		20, 389, 447	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I an			871, 351	50. 00
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		0	52. 00
53. 00	Nursing and Allied Health Managed Care payment			0	53. 00
54.00	Special add-on payments for new technologies			54, 418	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	.0)		0	54. 01 55. 00
55. 01	Cellular therapy acquisition cost (see instructions)	17)		0	55. 01
56. 00	Cost of physicians' services in a teaching hospital (see intr	ructions)		0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	Ö	57. 00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.		,	0	58. 00
59. 00	Total (sum of amounts on lines 49 through 58)			21, 315, 216	59. 00
60.00	Primary payer payments			0	60.00
61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		21, 315, 216	
62. 00	Deductibles billed to program beneficiaries			1, 602, 212	
63.00	Coinsurance billed to program beneficiaries			32, 378	•
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			317, 537 206, 399	•
66. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		310, 770	•
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	i deti ons)		19, 887, 025	67. 00
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0	68. 00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).		,	0	69. 00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	70. 50
70. 75	N95 respirator payment adjustment amount (see instructions)			0	70. 75
70. 87	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)		0	70. 89 70. 90
	70.90 HSP bonus payment HVBP adjustment amount (see instructions)				
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 91 70. 92
70. 92	HVBP payment adjustment amount (see instructions)			0	70. 92
70. 93	, , , , , , , , , , , , , , , , , , , ,			-68, 418	
	Recovery of accelerated depreciation				70. 95
				. '	•

Health Financial Systems	ST.	MARY	MEDI CAI	L CENTER			In Lie	u of Form CMS-	2552	2-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				Provi der	CCN:	14-0064	Peri od: From 10/01/2022 To 09/30/2023			
				Ti t	le X	VIII	Hospi tal	PPS		
						FFY	(уууу)	Amount		
							0	1. 00		
70.96 Low volume adjustment for federal fiscal yea	96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0				0	C	70.	1. 96		
the corresponding federal year for the perior Low volume adjustment for federal fiscal year the perior than the peri	r (yy	yy) (E	nterir				0	C	70.	1. 97

		T: +1 a	N/III	Hooni tol	2/28/2024 8: 02	z piii
		11 (16	XVIII	Hospi tal	PPS	
				(уууу) 0	Amount 1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	col ump 0		0	1.00	70. 96
70. 90	the corresponding federal year for the period prior to 10/1)	cor unii o		U	U	70. 70
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 97
70. 77	the corresponding federal year for the period ending on or after				Ö	70. 77
70. 98	Low Volume Payment-3	,		0	0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	& 70)			19, 818, 607	71. 00
71. 01	Sequestration adjustment (see instructions)	•			396, 372	
71. 02	Demonstration payment adjustment amount after sequestration				0	
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				19, 509, 576	72.00
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	73.00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02,	72, and			-87, 341	74.00
	73)					
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75.00	Protested amounts (nonallowable cost report items) in accordance	e with			395, 141	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	2. 03			0	90. 00
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instruc-				0	92.00
93. 00	Capital outlier reconciliation adjustment amount (see instruction				0	93. 00
94. 00	The rate used to calculate the time value of money (see instruction)	tions)			0. 00	
95.00	Time value of money for operating expenses (see instructions)	>			0	95. 00
96. 00	Time value of money for capital related expenses (see instruction	ons)			0	96. 00
				Dri or to 10/1	On /After 10/1	
				Prior to 10/1		
	USD Popus Payment Amount			Prior to 10/1 1.00	0n/After 10/1 2.00	
100.00	HSP Bonus Payment Amount				2. 00	100.00
100.00	HSP bonus amount (see instructions)				2. 00	100. 00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment				2.00	
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)				2.00 0 0.0000000000	101. 00
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions)				2.00 0 0.0000000000	
101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment				2.00 0 0.0000000000 0	101. 00 102. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)				2.00 0 0.0000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	tion) Adiu	ustment		2.00 0 0.0000000000 0	101. 00 102. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrations)				2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration period				2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrations)				2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration is this the first year of the current 5-year demonstration periodentury Cures Act? Enter "Y" for yes or "N" for no.	od under t			2.00 0.0000000000 0.0000000000 0.0000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrations) Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	od under t			2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line of Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	od under t	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line of Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in file	od under t	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Amedicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fiperiod)	od under t	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (\$410A Demonstrations) Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Amedicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fiperiod) Medicare target amount	od under t	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line of Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fiperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	od under t	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration beautiful to the first year of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line of Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fingeriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	od under t	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instructions)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line of the current o	49)	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (See instructions) Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line of Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fingeriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	49)  rst year  ctions)	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (See instructions) Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Addicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fiperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the \$410A Demonstration (see instruction) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Interpretation (see instructions)	49)  rst year  ctions)	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (\$410A Demonstrat Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Amedicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fiperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the \$410A Demonstration (see instructions) Adjustment to Medicare IPPS payments (see instructions)	49)  rst year  ctions)	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrations) Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line and Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fingeriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the \$410A Demonstration (see instructions) Reserved for future use	49)  rst year  ctions)	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrations) Is this the first year of the current 5-year demonstration periodentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line and Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fixer target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the \$410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	49)  rst year  ctions)	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line of the current	49)  Irst year  ctions)	the 21st	1.00	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instructions)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line of the Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in fingeriod)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see instructions)  Reserved for future use  Total adjustment to Medicare IPPS payments (see instructions)  Comparision of PPS versus Cost Reimbursement  Total adjustment to Medicare Part A IPPS payments (from line 21)	49)  Irst year  ctions)	the 21st	1.00	2.00 0.0000000000 0.0000 0.ration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line of the current	od under t 49)  rst year  ctions) i ne 59)	of the current	1.00	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 10/01/2022 | Part A Exhibit 4 | To 09/30/2023 | Date/Time Prepared: 2/28/2024 8:02 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 14-0064

						077 307 2023	2/28/2024 8: 02	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
1.00	DRG amounts other than outlier	1, 00	1. 00	2. 00	3.00	4. 00	5. 00 0	1. 00
1.00	payments	1.00	U	U	U	U	U	1.00
1. 01	DRG amounts other than outlier	1. 01	0	0	0		0	1. 01
	payments for discharges		Š	· ·			Ü	
	occurring prior to October 1							
1.02	DRG amounts other than outlier	1. 02	11, 741, 845	0		11, 741, 845	11, 741, 845	1. 02
	payments for discharges							
	occurring on or after October							
	1							4 00
1. 03	DRG for Federal specific	1. 03	0	0	0		0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to October 1							
1. 04	DRG for Federal specific	1. 04	0	0		0	0	1. 04
1.01	operating payment for Model 4	1.01	Ğ	O		Ŭ	Ŭ	1.01
	BPCI occurring on or after							
	October 1							
2.00	Outlier payments for	2. 00						2. 00
	discharges (see instructions)							
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
2 02	discharges for Model 4 BPCI	2.02		0				2 02
2. 02	Outlier payments for discharges occurring prior to	2. 03	U	0	0		U	2. 02
	October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	28, 723	0		28, 723	28, 723	2. 03
	di scharges occurring on or	/	_5, , _6	0		_5, .20	_5, .20	
	after October 1 (see							
	instructions)							
3.00	Operating outlier	2. 01	0	0	0	0	0	3. 00
	reconciliation		_	_	_	_	_	
4. 00	Managed care simulated	3. 00	0	0	0	0	0	4. 00
	payments Indirect Medical Education Adj	lictmont						
5. 00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
0.00	A, line 21 (see instructions)	21100	0.00000	0.00000	0.00000	0.00000		0.00
6.00	IME payment adjustment (see	22. 00	0	0	0	0	0	6.00
	instructions)							
6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see							
	instructions)	ustmant for the	Add on for Co	o+: on 400 of +	bs MMA			
7. 00	Indirect Medical Education Adjustment factor	27.00	0. 000000	0. 000000		0. 000000		7. 00
7.00	(see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see	28. 00	o	0	0	0	0	8. 00
	instructions)							
8. 01	IME payment adjustment add on	28. 01	o	0	0	0	0	8. 01
	for managed care (see							
	instructions)		_	_	_	_	_	
9.00	Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed	29. 01	_	0			0	9. 01
7. U I	care (sum of lines 6.01 and	27.01	١	Ü		۷		7. U I
	8. 01)							
	Disproportionate Share Adjustm							
10. 00	Allowable disproportionate	33.00	0. 1201	0. 1201	0. 1201	0. 1201		10. 00
	share percentage (see							
44.00	instructions)	04.00	050 540	•		050 540	252 542	44 00
11. 00	Disproportionate share	34.00	352, 549	0	0	352, 549	352, 549	11.00
11. 01	adjustment (see instructions) Uncompensated care payments	36.00	650, 860	0	0	650, 860	650, 860	11 01
	Additional payment for high pe					030, 000	030, 000	
12. 00	Total ESRD additional payment	46.00	n	0	0	0	n	12. 00
	(see instructions)		Ĭ	0		Ĭ	Ĭ	
13. 00	Subtotal (see instructions)	47. 00	12, 773, 977	0	0	12, 773, 977	12, 773, 977	13. 00
14.00	Hospital specific payments	48. 00	20, 389, 447	0	0	0	0	14.00
	(completed by SCH and MDH,							
	small rural hospitals only.)							
15 00	(see instructions)	40.00	20, 202, 447	_		20 202 447	20 202 417	15 00
15. 00	Total payment for inpatient	49. 00	20, 389, 447	0	0	20, 389, 447	20, 389, 447	15.00
	operating costs (see instructions)							
16. 00	Payment for inpatient program	50.00	871, 351	0	0	871, 351	871, 351	16. 00
	capital (from Wkst. L, Pt. I,		3, 1, 301	0	]	3, 1, 301	3, 1, 301	
	if applicable)							

					rom 10/01/2022 o 09/30/2023	Part A Exhibi Date/Time Pre 2/28/2024 8:0	pared:
			Title	XVIII	Hospi tal	PPS	
	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
	line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	0	1.00	2.00	3. 00	4. 00	5. 00	
17.00 Special add-on payments for	54. 00	54, 418	0	C	54, 418	54, 418	17. 00
new technologies 17.01 Net organ aquisition cost 17.02 Credits received from manufacturers for replaced	68. 00	0	0	C	0	0	17. 01 17. 02
devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see	93. 00	0	0	C	0	0	18. 00
i nstructi ons) 19.00   SUBTOTAL			0	C	21, 315, 216	21, 315, 216	19.00
	W/S L, line	(Amounts from L)					
	0	1.00	2.00	3.00	4. 00	5. 00	
20.00 Capital DRG other than outlier	1. 00	868, 322	0	C	868, 322	868, 322	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	(	0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	3, 029	0	C	3, 029	3, 029	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	(	0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000	0.0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0	0	(	0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0. 0000	0.0000		24. 00
25.00 Disproportionate share adjustment (see instructions)	11. 00	0	0	C	0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	871, 351	0	C	871, 351	871, 351	26. 00
	W/S E, Part A	(Amounts to E,					
	line	Part A)					
	0	1.00	2. 00	3. 00	4. 00	5. 00	
27.00 Low volume adjustment factor				0.000000	0. 000000		27. 00
28.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			C		0	28. 00
29.00 Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
Pt. A, line) 100.00 Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Provider CCN: 14-0064 Peri od: Worksheet E From 10/01/2022 Part A Exhibit 5 09/30/2023 Date/Time Prepared: 2/28/2024 8:02 pm Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 4. 00 0 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 11, 741, 845 11, 741, 845 11, 741, 845 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 Ω 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 28, 723 28, 723 28, 723 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1201 0.1201 0.1201 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 352.549 0 352, 549 352, 549 11.00 instructions) 11.01 0 650, 860 Uncompensated care payments 36 00 650, 860 650, 860 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 O 12.00 instructions) 47.00 13 00 12, 773, 977 0 12, 773, 977 12, 773, 977 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 20, 389, 447 0 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 20, 389, 447 0 20, 389, 447 20, 389, 447 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 871.351 0 871.351 871.351 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 54, 418 54, 418 54, 418 17.00 C 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 0 68.00 17.02 17.02 0 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 18.00 amount (see instructions) 19.00 SUBTOTAL 21, 315, 216 21, 315, 216 19.00

Heal th	Financial Systems	ST. MARY MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA		Provi der CC		Period: From 10/01/2022 To 09/30/2023	Worksheet E Part A Exhibi	t 5 pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	868, 322		0 868, 322	868, 322	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	3, 029		0 3, 029	3, 029	21. 00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0. 000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	871, 351		0 871, 351	871, 351	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	0		0 0	0	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31. 00	HRR adjustment (see instructions)	70. 94	-68, 418		0 -68, 418	-68, 418	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	•
	THISTI GOTI OHS)					(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
22 00	MAC Poduction Program adjustment (see	70.00			0 0	0	22 00

Ν

70. 99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

0 32.00

100. 00

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0064	From 10/01/2022 P To 09/30/2023 D	Worksheet E Part B Date/Time Prepared: 2/28/2024 8:02 pm
	T1 11 \ \0.0111		

		Title XVIII	Hospi tal	2/28/2024 8: 0 PPS	2 pm
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	`		7, 641	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instructions OPPS or REH payments	5)		10, 657, 720 10, 933, 279	2. 00 3. 00
4. 00	Outlier payment (see instructions)			10, 933, 279	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruction	ns)		0. 000	•
6.00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, o	col. 13, line 200		Ö	9. 00
10.00	Organ acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			7, 641	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable charges				
12. 00	Ancillary service charges			69, 439	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6	59)		0	1
14. 00	Total reasonable charges (sum of lines 12 and 13)			69, 439	14. 00
15 00	Customary charges	ont for condition on a	oborgo bool o	0	15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payments that would have been realized from patients liable for payments.			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	yment for services or	i a chai gebasi s	, and the second se	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)		44) (	69, 439	1
19. 00	Excess of customary charges over reasonable cost (complete only if instructions)	fline 18 exceeds lir	ie 11) (see	61, 798	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only if	f line 11 exceeds lir	e 18) (see	0	20. 00
	instructions)		, ,		
21. 00	Lesser of cost or charges (see instructions)			7, 641	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructi	ons)		0 0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0113)		10, 933, 279	•
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	(6 0411		0	
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 24 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			2, 022, 668 8, 918, 252	1
27.00	instructions)	the sum of fiftes 22	and 23] (See	0, 910, 232	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 5	50)		0	28. 00
28. 50	REH facility payment amount				28. 50
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			0 8, 918, 252	29. 00 30. 00
31. 00	Primary payer payments			705	1
32. 00	Subtotal (line 30 minus line 31)			8, 917, 547	•
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 167, 727	
35. 00	Adjusted reimbursable bad debts (see instructions)			107, 727	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)		161, 598	
	Subtotal (see instructions)			9, 026, 570	1
	MSP-LCC reconciliation amount from PS&R			159	•
39. 00 39. 50	OTHER ADJ PER PS&R Pioneer ACO demonstration payment adjustment (see instructions)			51	39. 00 39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced of	devices (see instruct	i ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0 00/ 4/0	39. 99
40. 00 40. 01	Subtotal (see instructions)   Sequestration adjustment (see instructions)			9, 026, 462 180, 529	1
40. 01	Demonstration adjustment (see First detrons)  Demonstration payment adjustment amount after sequestration			100, 327	40. 01
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41. 00	Interim payments			8, 917, 222	
41. 01	Interim payments-PARHM				41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			-71, 289	1
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance w	with CMS Pub. 15-2, c	hapter 1,	1, 144, 872	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92.00	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	93. 00 94. 00
74.00	Total (sum of lines 91 and 93)			<u> </u>	74.00

Health Financial Systems	ST. MARY MEDICA	L CENTER	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0064	Peri od:	Worksheet E	
			From 10/01/2022		
			To 09/30/2023	Date/Time Pr	epared:
				2/28/2024 8:	02 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

| Peri od: | Worksheet E-1 | To 09/30/2023 | Date/Time Prepared: 2/28/2024 8:02 pm Provider CCN: 14-0064

					2/28/2024 8: 02	2 pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4.00	
1.00	Total interim payments paid to provider		19, 415, 276		8, 868, 522	1. 00
2.00	Interim payments payable on individual bills, either		(	)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	05/10/2023	94, 300	05/10/2023	48, 700	3. 01
3. 02	ADJUST MIENTS TO TROVIDER	03/10/2023	74, 300		40, 700	3. 02
3. 03			(		0	3. 03
3. 04			(		0	3. 04
3. 05			(		o	3. 05
	Provider to Program			"		
3.50	ADJUSTMENTS TO PROGRAM		(	)	0	3. 50
3.51			(		0	3. 51
3.52			(	)	0	3. 52
3.53			(	)	0	3. 53
3.54			(	)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		94, 300	)	48, 700	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		19, 509, 576		8, 917, 222	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider				,	
5.01	TENTATI VE TO PROVI DER		(	)	0	5. 01
5.02			(	)	0	5. 02
5.03			(	)	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(		0	5. 50
5. 51			(		0	5. 51
5. 52			(		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(	)	0	5. 99
4 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
6. 00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		(		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		87, 341	1	71, 289	6. 02
7. 00	Total Medicare program liability (see instructions)		19, 422, 235		8, 845, 933	7. 00
	, , , , , , , , , , , , , , , , , , , ,		, .==/200	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8.00	Name of Contractor	(	)	1. 00	2. 00	8. 00

Heal th	Financial Systems ST. MARY MED	CAL CENTER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0064	Peri od:	Worksheet E-1	
			From 10/01/2022 To 09/30/2023		narodi
			10 04/30/2023	2/28/2024 8:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				1.00
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				
	2.00 Medicare days (see instructions)				
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	on (see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30. 00
	Other Adjustment (specify)				31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	lline 31) (see instruction	ns)		32.00

Heal th	Financial Systems ST	. MARY	MEDI CAL	CENTER	In Lie	eu of Form CMS-2	2552-10
		Worksheet E-5					
					From 10/01/2022 To 09/30/2023		pared:
						2/28/2024 8: 02	
				Title XVIII		PPS	
						1.00	
	TO BE COMPLETED BY CONTRACTOR						
1.00	Operating outlier amount from Wkst. E, Pt. A, li	ne 2, o	r sum o	f 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2					0	2.00
3.00	Operating outlier reconciliation adjustment amoun	nt (see	instru	ctions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount	(see in	nstruct	i ons)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00			
6.00	Time value of money for operating expenses (see i	nstruc	tions)			0	6.00
7.00	Time value of money for capital related expenses	(see in	nstruct	i ons)		0	7.00

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

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

Provi der CCN: 14-0064 Peri

————					2/28/2024 8: 0	2 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
'	CURRENT ASSETS	1	1			
1. 00 2. 00	Cash on hand in banks	145, 505, 953	0	0	1	1. 00 2. 00
3.00	Temporary investments Notes receivable		0	0	0	3.00
4.00	Accounts receivable	61, 266, 293	_	0	Ö	4. 00
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-43, 462, 176	1	0	0	6. 00
7.00	Inventory	1, 398, 873	1	0	0	7. 00
8. 00 9. 00	Prepaid expenses Other current assets	38, 271 997, 353		0	0	8. 00 9. 00
10.00	Due from other funds	777, 333	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	165, 744, 567		-	•	11.00
	FIXED ASSETS					
12.00	Land	10, 770, 433		0	_	12. 00
13.00	Land improvements	1, 933, 482	1	0		13.00
14. 00 15. 00	Accumulated depreciation	-1, 166, 502	1	0	1	14.00
16. 00	Buildings Accumulated depreciation	93, 246, 024 -37, 736, 358	1	0	0	15. 00 16. 00
17. 00	Leasehold improvements	12, 520	1	0	Ö	17. 00
18.00	Accumul ated depreciation	-12, 520	1	0	0	18. 00
19. 00	Fi xed equipment	0	0	0	0	19. 00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00 23. 00	Accumulated depreciation Major movable equipment	33, 821, 739	· ·	0	0	22. 00 23. 00
24. 00	Accumulated depreciation	-23, 565, 941	l ő	0	Ö	24.00
25. 00	Mi nor equipment depreciable	0	Ō	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0 010 240	0	0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	2, 819, 348 80, 122, 225	1	0	1	29. 00 30. 00
30.00	OTHER ASSETS	00, 122, 223	0	0		30.00
31.00	Investments	7, 443, 998	0	0	0	31.00
32. 00	Deposits on Leases	0	0	0	_	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	998, 098	1	0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	8, 442, 096 254, 308, 888	1	Ū	1	35. 00 36. 00
00.00	CURRENT LI ABI LI TI ES	201,000,000				00.00
37. 00	Accounts payable	1, 464, 707	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	9, 946, 792	0	0	_	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	1, 108	0	0	0	40. 00 41. 00
42. 00	Accel erated payments	1, 100		0	0	42.00
43. 00	Due to other funds	0	0	0	0	43. 00
44.00	Other current liabilities	5, 810, 110	0	0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	17, 222, 717	0	0	0	45. 00
44 00	LONG TERM LIABILITIES	1 0	0	0	1 0	1 44 00
46. 00 47. 00	Mortgage payable Notes payable	0	0	0	1	46. 00 47. 00
48. 00	Unsecured Loans		Ö	_		48. 00
49. 00	Other long term liabilities	1, 650, 884		0		49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1, 650, 884	0	0		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	18, 873, 601	0	0	0	51.00
E2 00	CAPITAL ACCOUNTS	225 425 207				   E2 00
52. 00 53. 00	General fund balance Specific purpose fund	235, 435, 287	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	235, 435, 287	_	^	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	254, 308, 888	1	0	0	60.00
	59)					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES ST. MARY MEDICAL CENTER

Provider CCN: 14-0064

					To 09/30/2023		
		Genera	l Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		232, 851, 027	l .	(	0	1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		16, 911, 088 249, 762, 115	l .	,		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	0	249, 702, 113		0		4. 00
5. 00	Additions (credit day astiments) (specify)	Ö			0		5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8. 00		0			0	0	8. 00
9.00	T-+-1  -  -	0	0		0	0	9. 00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 249, 762, 115				10. 00 11. 00
12. 00	EQUITY TRANSFER	14, 668, 759	249, 702, 113		0	0	12.00
13. 00	CHANGE IN TRNA AND RNA	-341, 931			0	0	13. 00
14.00		0			0	0	14.00
15. 00		0			0	0	15. 00
16.00		0			0	0	16. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)	0	14, 326, 828		0	0	17. 00 18. 00
19. 00	Fund balance at end of period per balance		235, 435, 287	l .			19. 00
17.00	sheet (line 11 minus line 18)		200, 100, 207		,		17.00
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8.00	_		
1. 00	Fund balances at beginning of period	0.00	7.00	0.00	0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5. 00 6. 00			0				5. 00 6. 00
7. 00			0				7. 00
8. 00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0	•		0		11.00
12. 00 13. 00	EQUITY TRANSFER CHANGE IN TRNA AND RNA		0				12. 00 13. 00
14. 00	CHANGE IN TRNA AND RNA		0				14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00
	Janeer (Time II IIIIIIus IIIIe 10)	1		I	I		

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-0064

		Т	0 09/30/2023	Date/Time Pre 2/28/2024 8:0	
	Cost Center Description	Inpatient	Outpati ent	Total	E piii
		1.00	2. 00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	38, 807, 782		38, 807, 782	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	38, 807, 782		38, 807, 782	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	9, 195, 196		9, 195, 196	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI VE CARE UNI T				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	9, 195, 196		9, 195, 196	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	48, 002, 978		48, 002, 978	17. 00
18. 00	Ancillary services	108, 100, 235	322, 771, 451	430, 871, 686	18. 00
19. 00	Outpati ent servi ces	18, 750, 219	76, 791, 701	95, 541, 920	19.00
20.00	RURAL HEALTH CLINIC (RHC)	0	11, 068, 889	11, 068, 889	20.00
20. 01	RURAL HEALTH CLINIC (RHC)	0	4, 301, 195	4, 301, 195	20. 01
20. 02	RURAL HEALTH CLINIC (RHC)	0	4, 564, 536	4, 564, 536	20. 02
20. 03	RURAL HEALTH CLINIC (RHC)	0	1, 242, 046	1, 242, 046	20. 03
20.04	RURAL HEALTH CLINIC (RHC)	0	642, 439	642, 439	20. 04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26.00	HOSPI CE				26. 00
27.00	PROFESSI ONAL FEES	11, 547	14, 553, 473	14, 565, 020	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	174, 864, 979	435, 935, 730	610, 800, 709	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		128, 680, 383		29. 00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31. 00
32.00		0			32. 00
33.00		0			33. 00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38. 00
39. 00		0			39. 00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		128, 680, 383		43.00
	to Wkst. G-3, line 4)				

111 41-	CT HADY MEDIC	CAL CENTED	1-1:-	£ F CMC 3	NEED 10
	Financial Systems ST. MARY MEDIC ENT OF REVENUES AND EXPENSES	Provider CCN: 14-0064	Peri od:	u of Form CMS-2 Worksheet G-3	2552-10
			From 10/01/2022 To 09/30/2023	Date/Time Prep 2/28/2024 8:02	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, Ii			610, 800, 709	1.00
2.00	Less contractual allowances and discounts on patients' accou	nts		469, 301, 021	2.00
3.00	Net patient revenues (line 1 minus line 2)			141, 499, 688	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		128, 680, 383	4.00
5.00	Net income from service to patients (line 3 minus line 4)			12, 819, 305	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			440, 927	6.00
7.00	Income from investments			314, 919	7.00
8.00	Revenues from telephone and other miscellaneous communicatio	n services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			310, 287	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients	·		0	17.00
18.00	Revenue from sale of medical records and abstracts			200	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			7, 232	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			4, 981	21.00
22. 00	Rental of hospital space			233, 064	22.00
23.00	Governmental appropriations			0	23.00
24. 00	OTHER I NCOME			2, 981, 420	24.00
24. 50	COVI D-19 PHE Fundi ng			0	
25. 00	Total other income (sum of lines 6-24)			4, 293, 030	
26. 00	Total (line 5 plus line 25)			17, 112, 335	
27. 00	PENSI ON AND TAXES			201, 247	
	Total other expenses (sum of line 27 and subscripts)			201, 247	
	Net income (or loss) for the period (line 26 minus line 28)			16, 911, 088	
			'		

	<del>_</del>	EDICAL CENTER		u of Form CMS-2	2552-10
CALCUI	LATION OF CAPITAL PAYMENT	Provi der CCN: 14-0064	Peri od: From 10/01/2022 To 09/30/2023	Worksheet L Parts I-III Date/Time Prep 2/28/2024 8:02	
		Title XVIII	Hospi tal	PPS	Ja
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			11 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			868, 322	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			3, 029	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments	<b>.</b>		0	2. 01
3.00	Total inpatient days divided by number of days in the cos	t reporting period (see inst	ructions)	40. 71	3.00
4. 00 5. 00	Number of interns & residents (see instructions)			0. 00 0. 00	4. 00 5. 00
6. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1 01	columns 1 and	0.00	6.00
	1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)		, part A line	0. 00	7. 00
8. 00	Percentage of Medicaid patient days to total days (see in	structions)		0. 00	8. 00
9. 00	Sum of lines 7 and 8			0. 00	
10. 00		i ons)		0. 00	10.00
11. 00	, , ,			0	11. 00
12. 00	Total prospective capital payments (see instructions)			871, 351	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	1. 00
2. 00	Program inpatient ancillary capital cost (see instruction	,		0	2. 00
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1 0
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums	tancas (saa instructions)		0	1. 00 2. 00
2. 00 3. 00	Net program inpatient capital costs for extraordinary circums	,		0	3. 00
4. 00	Applicable exception percentage (see instructions)			0.00	4. 00
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	5. 00
6. 00	Percentage adjustment for extraordinary circumstances (se			0. 00	
7. 00	Adjustment to capital minimum payment level for extraordi		(line 6)	0.00	7. 00
8. 00	Capital minimum payment level (line 5 plus line 7)	riar y crrediiistances (Trice 2 x	t Title 0)	Ö	8. 00
9. 00	Current year capital payments (from Part I, line 12, as a	pplicable)		0	9. 00
10. 00			less line 9)	0	10.00
11. 00				0	11. 00
12. 00		I payments (line 10 plus lin	ne 11)	0	12. 00
		1 3 1	,	0	13. 00
	1			0	
13. 00			o por 1 ou	٥	50
13. 00 14. 00	(if line 12 is negative, enter the amount on this line)			0	15. 00
13. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	instructions)		0	15. 00 16. 00

Heal th	Financial Systems	ST. MARY MEDI	CAL CENTER		In Lie	eu of Form CMS-	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-0064	Peri od:	Worksheet M-1	
			Component		From 10/01/2022 To 09/30/2023		pared: 2 pm
					RHC I	Cost	2 piii
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati		
		·		+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	1, 521, 733	0	.,,			
2.00	Physician Assistant	90, 152	0				
3.00	Nurse Practitioner	806, 403	0	806, 40	-140, 558	665, 845	3. 00
4.00	Visiting Nurse	0	0		0	0	
5.00	Other Nurse	1, 178, 107	0	1, 178, 10	-298, 848	879, 259	
6.00	Clinical Psychologist	0	0		0	0	6. 00
7.00	Clinical Social Worker	143, 514	0	,	4 -34, 199		
8.00	Laboratory Techni ci an	0	0		0	0	
9.00	Other Facility Health Care Staff Costs	0	0	•	0	0	
10. 00	Subtotal (sum of lines 1 through 9)	3, 739, 909	0	3, 739, 90	-838, 468	2, 901, 441	
11. 00	Physician Services Under Agreement	0	0		0	0	
12. 00	Physician Supervision Under Agreement	0	0		0	0	
13. 00	Other Costs Under Agreement	0	0		0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14. 00
15. 00	Medical Supplies	0	278, 839	278, 83	-50, 181	228, 658	
16. 00	Transportation (Health Care Staff)	0	0		0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	15, 543	1			
18. 00	Professional Liability Insurance	0	4, 393				
19. 00	Other Health Care Costs	0	422, 747	422, 74	-93, 155	329, 592	1
20. 00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	721, 522				1
22. 00	Total Cost of Health Care Services (sum of	3, 739, 909	721, 522	4, 461, 43	-987, 780	3, 473, 651	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
23. 00	Pharmacy	0	0	I	0 0	0	23. 00
24. 00	Dental	0	0	•	0 0	0	
25. 00	Optometry	0	0			0	
25. 00	Tel eheal th	0	0		0 76, 173	_	
25. 01	Chronic Care Management	0	0		0 70, 173	70, 173	1
26. 00	All other nonreimbursable costs	0	0		0	0	
27. 00	Nonallowable GME costs	U					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 76, 173	76, 173	1
20.00	through 27)	U			70, 173	70, 173	20.00
	FACILITY OVERHEAD					1	†
29. 00	Facility Costs	0	121, 855	121, 85	-26, 630	95, 225	29. 00
30. 00	Administrative Costs	285, 369		1			1
	Total Facility Overhead (sum of lines 29 and	285, 369					

121, 855 1, 017, 566 1, 139, 421

1, 860, 943

285, 369

4, 025, 278

1, 424, 790

5, 886, 221

-26, 630 -524, 331 -550, 961

-1, 462, 568

873, 829

4, 423, 653

31.00

32.00

31.00

32.00

and 31)

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0064	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8651	To 09/30/2023 Date/Time Prepared: 2/28/2024 8:02 pm

			Component	3011. 14 00.	1   10	077 307 2023	2/28/2024 8:0	
						RHC I	Cost	
	·	Adjustments	Net Expenses					
			for Allocation					
			(col. 5 + col.					
			6)					
		6.00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	16, 160	1, 195, 526					1.00
2.00	Physician Assistant	0	67, 656					2. 00
3.00	Nurse Practitioner	0	665, 845					3. 00
4.00	Visiting Nurse	0	0					4. 00
5.00	Other Nurse	0	879, 259					5. 00
6.00	Clinical Psychologist	0	0					6. 00
7.00	Clinical Social Worker	0	109, 315					7. 00
8.00	Laboratory Techni ci an	0	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	0					9. 00
10.00	Subtotal (sum of lines 1 through 9)	16, 160	2, 917, 601					10.00
11.00	Physician Services Under Agreement	0	0					11. 00
12.00	Physician Supervision Under Agreement	0	0					12. 00
13.00	Other Costs Under Agreement	0	0					13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0					14.00
15.00	Medical Supplies	0	228, 658					15. 00
16.00	Transportation (Health Care Staff)	0	0					16. 00
17.00	Depreciation-Medical Equipment	0	11, 089					17. 00
18. 00	Professional Liability Insurance	0	2, 871					18. 00
19. 00	Other Health Care Costs	0	329, 592					19. 00
20.00	Allowable GME Costs							20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	572, 210					21. 00
22. 00	Total Cost of Health Care Services (sum of	16, 160	3, 489, 811					22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	0	•				23. 00
24. 00	Dental	0	0	•				24. 00
25. 00	Optometry	0	0	ł				25. 00
25. 01	Tel eheal th	0	76, 173	1				25. 01
25. 02	Chronic Care Management	0	0	•				25. 02
26. 00	All other nonreimbursable costs	0	0					26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	76, 173					28. 00
	through 27)							
	FACILITY OVERHEAD	_1		1				
29. 00	Facility Costs	0	95, 225	ł				29. 00
30. 00	Administrative Costs	-28, 082	750, 522					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-28, 082	845, 747					31. 00
22.00	30)	11 000	4 411 701					22.00
32. 00	Total facility costs (sum of lines 22, 28	-11, 922	4, 411, 731					32. 00
	and 31)	I		I				1

111 41-	Figure in Contract	CT MADY MEDI	LOAL CENTER			£ F CNC :	2552 40
	Financial Systems  SIS OF HOSPITAL-BASED RHC/FQHC COSTS	ST. MARY MEDI	Provi der C	CN: 14-0064 CCN: 14-8646	Period: From 10/01/2022 To 09/30/2023	Worksheet M-1  Date/Time Pre 2/28/2024 8:0	pared:
					RHC II	Cost	<u>_ p</u>
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Reclassi fi ed	
		oomponoatt on	011101 00010	+ col . 2)	ons	Trial Balance	
				,		(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS		•			•	
1.00	Physi ci an	228, 860	C	228, 86	0 -58, 679	170, 181	1.00
2.00	Physician Assistant	31, 479	0	31, 47	-788	30, 691	2. 00
3.00	Nurse Practitioner	474, 629	0	474, 62	-74, 416	400, 213	3. 00
4.00	Visiting Nurse	0	0		0	0	4. 00
5.00	Other Nurse	345, 910	0	345, 91	0 -72, 246	273, 664	5. 00
6.00	Clinical Psychologist	0	0	)	0	0	6.00
7.00	Clinical Social Worker	0	0	)	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	)	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0	)	0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	1, 080, 878	0	1, 080, 87	'8 -206, 129	874, 749	10.00
11.00	Physician Services Under Agreement	0	0	)	0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0	)	0	0	12.00
13.00	Other Costs Under Agreement	0	0	)	0 0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0	)	0	0	14. 00
15.00	Medical Supplies	0	88, 734	88, 73	-24, 883	63, 851	15. 00
16.00	Transportation (Health Care Staff)	0	0	)	0 0	0	16. 00
17.00	Depreciation-Medical Equipment	0	4, 276				
18.00	Professional Liability Insurance	0	1, 568	1, 56		,	
19.00	Other Health Care Costs	0	70, 610	70, 61	0 -15, 984	54, 626	19. 00
20.00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	165, 188		-42, 711	122, 477	21. 00
22. 00	Total Cost of Health Care Services (sum of	1, 080, 878	165, 188	1, 246, 06	-248, 840	997, 226	22. 00
	lines 10, 14, and 21)						1
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0	1	0	0	20.00
24. 00	Dental	0	0	1	0	0	24. 00
25. 00	Optometry	0	0	1	0	0	25. 00
25. 01	Tel eheal th	0	0	1	0	0	
25. 02	Chronic Care Management	0	0	1	0	0	25. 02
26. 00	All other nonreimbursable costs	0	0	1	0	0	26. 00

228, 769

228, 769

1, 309, 647

27. 00

29.00

30.00

31.00

32.00

0 28.00

31, 061 312, 489

343, 550

1, 340, 776

0

117

534, 940

535, 057

1, 781, 123

30, 944

-222, 451

-191, 507

-440, 347

117

306, 171

306, 288

471, 476

27. 00

28.00

31. 00 32. 00 Nonallowable GME costs

through 27) FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0064	Peri od: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8646	To 09/30/2023 Date/Time Prepared:

Adjustments				Component	CCN. 14-0040	10 07/30/2023	2/28/2024 8: 02 pm	
FACILITY HEALTH CARE STAFF COSTS						RHC II		
Cool   5 + col   Cool		·	Adjustments	Net Expenses				
FACILITY HEALTH CARE STAFF COSTS			•	for Allocation				
FACILITY HEALTH CARE STAFF COSTS   1.00   170, 181   1.00   1.0				(col. 5 + col.				
FACILITY HEALTH CARE STAFF COSTS				6)				
1.00   Physician			6. 00	7. 00				
2.00								
3.00	1.00		-				1.	. 00
4.00	2.00	Physician Assistant	502	31, 193			2.	. 00
5.00         Other Nurse         0         273,664         5.00           6.00         Clinical Social Worker         0         0         0           7.00         Clinical Social Worker         0         0         0           8.00         Laboratory Technician         0         0         0           9.00         Other Facility Health Care Staff Costs         0         0         9,00           10.00         Subtotal (sum of lines 1 through 9)         3,009         877,758         10,00           11.00         Physician Services Under Agreement         0         0         11,00           12.00         Physician Supervision Under Agreement         0         0         12,00           13.00         Other Costs Under Agreement         0         0         13,00           14.00         Subtotal (sum of lines 11 through 13)         0         0         12,00           15.00         Medical Supplies         0         63,851         15,00           16.00         Transportation (Health Care Staff)         0         0         16,00           17.00         Depreciation-Medical Equipment         0         2,969         17,00           18.00         Professional Liability Insurance         0	3.00	Nurse Practitioner	2, 507	402, 720			3.	. 00
Clinical Psychologist	4.00	Visiting Nurse	0	0			4.	. 00
7.00	5.00	Other Nurse	0	273, 664			5.	. 00
8.00   Laboratory Technician   0   0   0   0   0   0   0   0   0	6.00	Clinical Psychologist	0	0			6.	. 00
9.00     Other Facility Health Care Staff Costs     0     0       10.00     Subtotal (sum of lines 1 through 9)     3,009     877,758       11.00     Physician Services Under Agreement     0     0       12.00     Physician Supervision Under Agreement     0     0       13.00     Other Costs Under Agreement     0     0       14.00     Subtotal (sum of lines 11 through 13)     0     0       15.00     Medical Supplies     0     63,851       16.00     Transportation (Heal th Care Staff)     0     0       17.00     Depreciation-Medical Equipment     0     2,969       17.00     Depreciation-Medical Equipment     0     2,969       18.00     17.00     18.00       19.00     Other Heal th Care Costs     0     54,626       19.00     Other Heal th Care Costs     0     54,626       20.00     Subtotal (sum of lines 15 through 20)     0     122,477     21.00       21.00     Subtotal (sum of lines 15 through 20)     0     122,477     22.00       22.00     Total Cost of Heal th Care Services (sum of 3,009 1,000,235     23.00       24.00     Depreciation Health Care Services (sum of 1,000,235     24.00       25.01     Total cost of Heal th Care Services     0     0	7.00	Clinical Social Worker	0	0			7.	. 00
10. 00   Subtotal (sum of lines 1 through 9)   3,009   877,758   10. 00	8.00	Laboratory Techni ci an	0	0			8.	. 00
11.00   Physician Services Under Agreement   0   0   0   12.00   Physician Supervision Under Agreement   0   0   0   12.00   13.00   14.00   15.00   16.00	9.00	Other Facility Health Care Staff Costs	0	0			9.	. 00
12. 00	10.00	Subtotal (sum of lines 1 through 9)	3, 009	877, 758			10.	. 00
13. 00   Other Costs Under Agreement   0   0   0   0   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   15. 00   14. 00   15. 00   16. 00   16. 00   17. 00   16. 00   17. 00   16. 00   17. 00   16. 00   17. 00   18. 00   19. 00	11.00	Physician Services Under Agreement	0	0			11.	. 00
14.00   Subtotal (sum of lines 11 through 13)	12.00	Physician Supervision Under Agreement	0	0			12.	. 00
15.00   Medical Supplies   0   63,851   15.00   16.00   Transportation (Health Care Staff)   0   0   0   0   0   16.00   17.00   Depreciation-Medical Equipment   0   2,969   17.00   18.00   19.00   0   0   0   0   19.00   0   0   0   0   0   0   0   0   0	13.00	Other Costs Under Agreement	0	0			13.	. 00
16. 00 Transportation (Health Care Staff) 0 0 17. 00 Depreciation-Medical Equipment 0 2,969 17. 00 1	14.00	Subtotal (sum of lines 11 through 13)	0	0			14.	. 00
17. 00   Depreciation-Medical Equipment   0   2,969   17. 00   18. 00   Professional Liability Insurance   0   1,031   18. 00   19. 00   0   0   0   0   0   0   0   0   0	15.00	Medical Supplies	0	63, 851			15.	. 00
18. 00	16.00	Transportation (Health Care Staff)	0	0			16.	. 00
19. 00 Other Health Care Costs 0 54,626 20. 00 Allowable GME Costs 20. 00 Allowable GME Costs 21. 00 Subtotal (sum of lines 15 through 20) 0 122,477 21. 00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 22. 00 Pharmacy 0 0 0 23. 00 24. 00 Dental 0 0 0 0 24. 00 Dental 0 0 0 0 25. 00 Optometry 0 0 0 0 25. 00 Optometry 0 0 0 0 25. 00 Chronic Care Management 0 0 0 0 25. 00 Chronic Care Management 0 0 0 0 25. 00 26. 00 All other nonreimbursable costs 0 0 0 0 25. 00 Chronic Care Management 0 0 0 0 0 25. 00 Chronic Care Management 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17.00	Depreciation-Medical Equipment	0	2, 969			17.	. 00
20.00   Allowable GME Costs   20.00   21.00   Subtotal (sum of lines 15 through 20)   0   122,477   21.00   22.00	18.00	Professional Liability Insurance	0	1, 031			18.	. 00
21.00   Subtotal (sum of lines 15 through 20)   0   122,477     22.00	19.00	Other Health Care Costs	0	54, 626			19.	. 00
22.00   Total Cost of Health Care Services (sum of lines 10, 14, and 21)   22.00   23.00   24.00   23.00   24.00   25.00   26.00   25.00   25.01   26.00   2	20.00	Allowable GME Costs					20.	. 00
Li nes 10, 14, and 21)	21.00	Subtotal (sum of lines 15 through 20)	0	122, 477			21.	. 00
COSTS OTHER THAN RHC/FOHC SERVICES   23.00   Pharmacy   0   0   0   0   24.00   24.00   Dental   0   0   0   0   24.00   25.00   Optometry   0   0   0   0   25.00   25.01   Tel eheal th   0   0   0   0   25.01   25.02   Chronic Care Management   0   0   0   0   25.02   26.00   All other nonreimbursable costs   0   0   0   0   25.02   26.00   27.00   Nonal lowable GME costs   0   0   0   0   0   27.00   28.00   Total Nonreimbursable Costs (sum of lines 23   0   0   0   0   0   0   0   0   0	22.00		3, 009	1, 000, 235			22.	. 00
COSTS OTHER THAN RHC/FOHC SERVICES   23.00   Pharmacy   0   0   0   0   24.00   24.00   Dental   0   0   0   0   24.00   25.00   Optometry   0   0   0   0   25.00   25.01   Tel eheal th   0   0   0   0   25.01   25.02   Chronic Care Management   0   0   0   0   25.02   26.00   All other nonreimbursable costs   0   0   0   0   25.02   26.00   27.00   Nonal lowable GME costs   0   0   0   0   0   27.00   28.00   Total Nonreimbursable Costs (sum of lines 23   0   0   0   0   0   0   0   0   0		lines 10, 14, and 21)						
24.00   Dental   O		COSTS OTHER THAN RHC/FQHC SERVICES						
25. 00   Optometry   O		Pharmacy	0	0			23.	. 00
25. 01 Tel eheal th	24.00	Dental	0	0				
25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00	Optometry	0	0			25.	. 00
26. 00   All other nonreimbursable costs   0   0   0   26. 00   27. 00   Nonallowable GME costs   27. 00   28. 00   Total Nonreimbursable Costs (sum of lines 23   0   0   29. 00   Facility Costs   0   31, 061   30. 00   Administrative Costs   -900   311, 589   31. 00   Total Facility Overhead (sum of lines 29 and 30)   32. 00   Total facility costs (sum of lines 22, 28   2, 109   1, 342, 885   32. 00   Total facility costs (sum of lines 22, 28   2, 109   1, 342, 885   32. 00   Total facility costs (sum of lines 22, 28   2, 109   1, 342, 885   33. 00   34. 00   34. 00   34. 00   34. 00   34. 00   35. 00   Total facility costs (sum of lines 22, 28   2, 109   1, 342, 885   35. 00   36. 00   36. 00   26. 00   37. 00   27. 00   38. 00   31, 061   39. 00   31, 061   39. 00   31, 061   39. 00   31, 342, 885   39. 00   31, 342, 885   39. 00   31, 342, 885   39. 00   31, 342, 885   39. 00   31, 342, 885   39. 00   31, 342, 885   39. 00   31, 342, 885   39. 00   31, 342, 885   39. 00   31, 342, 885   30. 00   31, 342, 885   30. 00   31, 342, 885   30. 00   31, 342, 885   30. 00   32, 00   30. 00   31, 342, 885   30. 00   32, 00   30. 00   31, 342, 885   30. 00   31, 342, 88	25. 01	Tel eheal th	0	0			25.	. 01
27.00   Nonallowable GME costs   27.00   28.00     Total Nonreimbursable Costs (sum of lines 23   0   0   0   28.00	25. 02	Chronic Care Management	0	0			25.	. 02
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	26.00	All other nonreimbursable costs	0	0			26.	. 00
through 27) FACILITY OVERHEAD  29. 00 Facility Costs 30. 00 Administrative Costs Total Facility Overhead (sum of lines 29 and 30) 31. 00 Total facility costs (sum of lines 22, 28 2, 109 1, 342, 885)  32. 00 Total facility costs (sum of lines 22, 28 2, 109 1, 342, 885)  32. 00 Total facility costs (sum of lines 22, 28 2, 109 1, 342, 885)	27.00	Nonallowable GME costs					27.	. 00
FACILITY OVERHEAD  29. 00 30. 00 Administrative Costs Total Facility Overhead (sum of lines 29 and 30)  30. 00 Total facility costs (sum of lines 22, 28  29. 00 31, 061 29. 00 311, 589 30. 00 312, 650 31. 00 32. 00 32. 00 33. 00 342, 650 31. 00 32. 00	28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0			28.	. 00
29.00   Facility Costs   0   31,061   29.00   30.00   Administrative Costs   -900   311,589   30.00   31.00   30)   Total facility costs (sum of lines 29 and 30)   Total facility costs (sum of lines 22, 28   2,109   1,342,885   32.00   32.00   32.00   33								
30.00 Administrative Costs -900 311,589 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 2,109 1,342,885 32.00								
31.00 Total Facility Overhead (sum of lines 29 and 31.00 31.00 32.00 Total facility costs (sum of lines 22, 28 2, 109 1, 342, 885 32.00		1	Ü					
30) 32.00 Total facility costs (sum of lines 22, 28 2, 109 1, 342, 885 32.00					1			
32.00 Total facility costs (sum of lines 22, 28 2, 109 1, 342, 885 32.00	31. 00		-900	342, 650			31.	. 00
		1 1						
and 31)	32. 00		2, 109	1, 342, 885			32.	. 00
		ana 31)			I			

Heal th	Financial Systems	ST. MARY MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 14-0064	Peri od:	Worksheet M-1	
			Component (	CCN: 14-8645	From 10/01/2022 To 09/30/2023		narod:
			Component	CCN. 14-0045	10 09/30/2023	Date/Time Prep 2/28/2024 8:02	pareu. 2 pm
					RHC III	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	950, 202	0	950, 20	766 - 162, 766	787, 436	1. 00
2.00	Physician Assistant	256, 968	0	256. 90	68 -68, 878	188. 090	2. 00

		Compensation	Other Costs		Recl assi fi cati		1
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	1
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	950, 202	0	950, 202			1. 00
2.00	Physician Assistant	256, 968	0	256, 968			2. 00
3.00	Nurse Practitioner	244, 449	0	244, 449	-30, 560	213, 889	3. 00
4.00	Visiting Nurse	0	0	0	0	0	4. 00
5.00	Other Nurse	575, 843	0	575, 843	-130, 715	445, 128	5. 00
6.00	Clinical Psychologist	0	0	0	0	0	6. 00
7.00	Clinical Social Worker	0	0	0	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	0	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	2, 027, 462	0	2, 027, 462	-392, 919	1, 634, 543	10.00
11. 00	Physician Services Under Agreement	0	0	0	0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12. 00
13.00	Other Costs Under Agreement	0	0	0	0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14. 00
15. 00	Medical Supplies	0	103, 636	103, 636	-31, 991	71, 645	15. 00
16. 00	Transportation (Health Care Staff)	0	0	0	0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	6, 895	6, 895	-4, 597	2, 298	17. 00
18. 00	Professional Liability Insurance	0	4, 559				18. 00
19. 00	Other Health Care Costs	0	37, 631	37, 631			1
20. 00	Allowable GME Costs	, and the second	0,,00.	0,,00.	1,7000	00, 120	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	152, 721	152, 721	-39, 674	113, 047	•
22. 00	Total Cost of Health Care Services (sum of	2, 027, 462	152, 721	2, 180, 183			
22.00	lines 10, 14, and 21)	2,027,102	102, 721	2, 100, 100	102, 070	1, 717, 070	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			ı	I.		
23. 00	Pharmacy	0	0	0	0	0	23. 00
24.00	Dental	0	0	0	0	o	24. 00
25.00	Optometry	0	0	0	0	0	25. 00
25. 01	Tel eheal th	0	0	0	8, 439	8, 439	25. 01
25. 02	Chronic Care Management	0	0	0	0	0	25. 02
26.00	All other nonreimbursable costs	0	0	0	0	0	26. 00
27.00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	0	8, 439	8, 439	28. 00
	through 27)				,		
	FACILITY OVERHEAD			<u>'</u>			
29. 00	Facility Costs	0	31, 836	31, 836	-23, 291	8, 545	29. 00
30.00	Administrative Costs	6, 737	386, 125	392, 862	-246, 036	146, 826	30.00
31.00	Total Facility Overhead (sum of lines 29 and	6, 737	417, 961	424, 698			31.00
	30)						1
32.00	Total facility costs (sum of lines 22, 28	2, 034, 199	570, 682	2, 604, 881	-693, 481	1, 911, 400	32. 00
	and 31)						

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 14-0064	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8645	To 09/30/2023 Date/Time Prepared:

			Component	0014. 11 0010	, 10	04/30/2023	2/28/2024 8:	
						RHC III	Cost	
		Adjustments	Net Expenses		<u> </u>			
			for Allocation	ı				
			(col. 5 + col.					
			6)					
		6. 00	7. 00	1				
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	14, 087	801, 523	s				1. 00
2.00	Physici an Assistant	0	188, 090	)				2. 00
3.00	Nurse Practitioner	0	213, 889					3. 00
4.00	Visiting Nurse	0	0					4. 00
5.00	Other Nurse	0	445, 128	8				5. 00
6.00	Clinical Psychologist	1, 106	1, 106					6. 00
7.00	Clinical Social Worker	0	0					7. 00
8.00	Laboratory Techni ci an	0	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	0					9. 00
10.00	Subtotal (sum of lines 1 through 9)	15, 193	1, 649, 736	,				10.00
11.00	Physician Services Under Agreement	0	O					11. 00
12.00	Physician Supervision Under Agreement	0	l o					12. 00
13.00	Other Costs Under Agreement	0	l	o				13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	l o					14. 00
15.00	Medical Supplies	0	71, 645					15. 00
16.00	Transportation (Health Care Staff)	0	0					16. 00
17. 00		0	2, 298					17. 00
18. 00	·	0	2, 979					18. 00
19.00		0	36, 125					19. 00
20.00								20. 00
21. 00		0	113, 047	,				21. 00
22. 00	Total Cost of Health Care Services (sum of	15, 193		1				22. 00
22.00	lines 10, 14, and 21)	10, 170	1,702,700	1				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES		L	1				
23. 00		0	О					23. 00
24.00	Dental	0	l 0	ol				24.00
25. 00	Optometry	0	0	ol				25. 00
25. 01	Tel eheal th	0	8, 439	o				25. 01
25. 02	Chronic Care Management	0						25. 02
26.00	All other nonreimbursable costs	0	l o					26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	8, 439					28. 00
	through 27)							
	FACILITY OVERHEAD		l	1				
29. 00	Facility Costs	0	8, 545					29. 00
30.00	Administrative Costs	-2, 855						30. 00
31.00	Total Facility Overhead (sum of lines 29 and	-		1				31. 00
	30)	, 555						
32. 00	Total facility costs (sum of lines 22, 28	12, 338	1, 923, 738					32. 00
	and 31)	,						
		'	•	•				•

	Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS	ST. MARY MEDI	Provider Co	CN: 14-0064	Peri od:	eu of Form CMS-2 Worksheet M-1	
,	TO STANDED THE BROCK THIS TO SEE TO				From 10/01/2022		
			Component	CCN: 14-8648	To 09/30/2023	Date/Time Pre 2/28/2024 8:0	
					RHC IV	Cost	z piii
		Compensation	Other Costs	Total (col. 1	Reclassificati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
				<b>'</b>		(col. 3 + col.	
						4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	294, 830	0	294, 83	0 -61, 887	232, 943	1.00
2.00	Physician Assistant	651	0	65	1 -18	633	2.00
3.00	Nurse Practitioner	39, 701	0	39, 70	1 -18, 706	20, 995	
4.00	Visiting Nurse	0	0		0	0	4. 00
5.00	Other Nurse	217, 137	0	217, 13	7 -58, 341	158, 796	
6.00	Clinical Psychologist	0	0		0	0	0.00
7.00	Clinical Social Worker	0	0		0	0	
8.00	Laboratory Techni ci an	0	0		0	0	0.00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	
10.00	Subtotal (sum of lines 1 through 9)	552, 319	0	552, 31	9 -138, 952		10.00
11.00	Physician Services Under Agreement	0	0		0	0	1
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	0	4, 17	0 0	4/ 24/	14.00
15.00	Medical Supplies	0	46, 677	46, 67	7 -431	46, 246	1
16. 00 17. 00	Transportation (Health Care Staff) Depreciation-Medical Equipment	0	2, 068	2, 06	8 -1, 020	1, 048	16. 00 17. 00
18. 00	Professional Liability Insurance	0	1, 568				
19. 00	Other Health Care Costs	0	48, 690	·			
20. 00	Allowable GME Costs	O	40, 070	40, 07	-17, 702	20, 700	20.00
21. 00	Subtotal (sum of lines 15 through 20)	n	99. 003	99, 00	3 -21, 598	77, 405	
22. 00	Total Cost of Health Care Services (sum of	552, 319					•
22.00	lines 10, 14, and 21)	332,317	77,003	031, 32	100, 330	470,772	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES		ļ.		_		1
23. 00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25. 00
25. 01	Tel eheal th	0	0		0 10, 565	10, 565	25. 01
25. 02	Chronic Care Management	0	0		0 0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 10, 565	10, 565	28. 00
	through 27)						1
	FACILITY OVERHEAD			1			
29. 00	Facility Costs	0	14, 706		· ·		
	Administrative Costs	62, 358					
31. U()	Total Facility Overhead (sum of lines 29 and)	62, 358	127, 002	189, 36	0 -76, 432	112, 928	31.00

62, 358

614, 677

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28 and 31)

127, 002

226, 005

-76, 432

-226, 417

189, 360

840, 682

112, 928

614, 265

31.00

32.00

31.00

32.00

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0064	Period: Worksheet M-1 From 10/01/2022
		To 09/30/2023 Date/Time Prepared:

			Component	0011. 14 00	340	10	0 77 307 2023	2/28/2024 8:	
							RHC IV	Cost	
		Adjustments	Net Expenses						
		-	for Allocation	ո					
			(col. 5 + col.						
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	0	232, 943	3					1. 00
2.00	Physician Assistant	0	633	3					2. 00
3.00	Nurse Practitioner	0	20, 99	5					3. 00
4.00	Visiting Nurse	0	(	0					4. 00
5.00	Other Nurse	0	158, 796	6					5. 00
6.00	Clinical Psychologist	0	(	0					6. 00
7.00	Clinical Social Worker	0	(	0					7. 00
8.00	Laboratory Techni ci an	0	(	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	(	o					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	413, 367	7					10. 00
11.00	Physician Services Under Agreement	0	(	o					11. 00
12.00	Physician Supervision Under Agreement	0	(	0					12. 00
13.00	Other Costs Under Agreement	0	(	0					13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	(	0					14. 00
15.00	Medical Supplies	0	46, 246	6					15. 00
16.00	Transportation (Health Care Staff)	0	(	0					16. 00
17. 00	Depreciation-Medical Equipment	0	1, 048	8					17. 00
18.00	Professional Liability Insurance	0	1, 403						18. 00
19. 00	Other Health Care Costs	0	28, 708	8					19. 00
20.00	Allowable GME Costs								20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	77, 40						21. 00
22. 00	Total Cost of Health Care Services (sum of	0	490, 772	2					22. 00
	lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES								
23. 00	1 -	0		0					23. 00
24. 00	Dental	0		0					24. 00
25. 00	Optometry	0	,	0					25. 00
25. 01	Tel eheal th	0	10, 56	1					25. 01
25. 02	Chronic Care Management	0		0					25. 02
26. 00	All other nonreimbursable costs	0	(	0					26. 00
27. 00	Nonallowable GME costs								27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	10, 56	5					28. 00
	through 27)								
	FACILITY OVERHEAD	-1		.1					
29. 00	Facility Costs	0	-3, 386						29. 00
30.00	Administrative Costs	0	116, 314						30.00
31. 00	Total Facility Overhead (sum of lines 29 and	O	112, 928	3					31. 00
22.00	30)		(14.0/	_					22.00
32. 00	Total facility costs (sum of lines 22, 28 and 31)	o	614, 26	٥					32. 00
	lana 31)	ı		1					ı

	Financial Systems	ST. MARY MEDI				eu of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der CO	JN: 14-0064	Peri od: From 10/01/2022	Worksheet M-1	
			Component (	CCN: 14-8638	To 09/30/2023		
					RHC V	Cost	
		Compensation	Other Costs	`	1 Reclassi fi cati		
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1.00	Physi ci an	648	0	64	-186	462	1.00
2.00	Physi ci an Assi stant	О	0		0 0	0	2. 00
3.00	Nurse Practitioner	38, 835	0	38, 83	-9, 876	28, 959	3.00
4.00	Visiting Nurse	0	0		0	0	
5.00	Other Nurse	107, 003	0	107, 00	-23, 510		
6.00	Clinical Psychologist	0	0		0	0	6. 00
7.00	Clinical Social Worker	0	0		0	0	7. 00
8.00	Laboratory Technician	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	144 404	0	147 40	0 0	112 014	9.00
10. 00 11. 00	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	146, 486	0	146, 48	-33, 572	112, 914 0	1
12.00	Physician Supervision Under Agreement	0	0			0	
13. 00	Other Costs Under Agreement	0	0			0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	o	0			l o	1
15. 00	Medical Supplies	O	29, 751	29, 75	-3, 791	25, 960	15. 00
16.00	Transportation (Health Care Staff)	o	0		0 0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	2, 875	2, 87	-696	2, 179	17. 00
18. 00	Professional Liability Insurance	0	0		0	0	18. 00
19. 00	Other Health Care Costs	0	21, 244	21, 24	-3, 797	17, 447	
20.00	Allowable GME Costs		<del>-</del> -			45 50/	20.00
21. 00	Subtotal (sum of lines 15 through 20)	147 407	53, 870				
22. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	146, 486	53, 870	200, 35	-41, 856	158, 500	22. 00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	О	0		0 0	0	24. 00
25.00	Optometry	o	0		0 0	0	25. 00
25. 01	Tel eheal th	0	0		0 2, 129	2, 129	
25. 02	3	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs	0	0		0 2 120	2 120	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23 through 27)	ا	0		0 2, 129	2, 129	28. 00
	FACILITY OVERHEAD					I	1
29. 00	Facility Costs	0	8, 161	8, 16	-1, 571	6, 590	29. 00
30.00		49, 116					
31 00	Total Facility Overhead (sum of lines 29 and	49 116		108 00	-31 983	76 021	31 00

49, 116

195, 602

58, 888

112, 758

108, 004

308, 360

-31, 983

-71, 710

76, 021

236, 650

31.00

32.00

31.00

32.00

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	ST. MARY MEDICAL CENTER	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS	Provi der CCN: 14-0064	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8638	To 09/30/2023 Date/Time Prepared:

			Component	OCIV. 14 O	,030	10	0 77 307 2023	2/28/2024 8:	
							RHC V	Cost	
	·	Adjustments	Net Expenses						
		•	for Allocation						
			(col. 5 + col.						
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	6, 568							1. 00
2.00	Physician Assistant	3, 385	3, 385						2. 00
3.00	Nurse Practitioner	2, 631	31, 590						3. 00
4.00	Visiting Nurse	0	0						4. 00
5.00	Other Nurse	0	83, 493						5. 00
6.00	Clinical Psychologist	0	0						6. 00
7.00	Clinical Social Worker	0	0						7. 00
8.00	Laboratory Techni ci an	0	0						8. 00
9.00	Other Facility Health Care Staff Costs	0	0						9. 00
10.00	Subtotal (sum of lines 1 through 9)	12, 584	125, 498						10.00
11. 00	Physician Services Under Agreement	0	0						11. 00
12.00	Physician Supervision Under Agreement	0	0						12.00
13.00	Other Costs Under Agreement	0	0						13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0						14. 00
15.00	Medical Supplies	0	25, 960						15. 00
16.00	Transportation (Health Care Staff)	0	0						16. 00
17.00	Depreciation-Medical Equipment	0	2, 179						17. 00
18. 00	Professional Liability Insurance	0	0						18. 00
19. 00	Other Health Care Costs	0	17, 447						19. 00
20.00	Allowable GME Costs								20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	45, 586						21. 00
22. 00	Total Cost of Health Care Services (sum of	12, 584	171, 084						22. 00
	lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES								_
23. 00	Pharmacy	0	0						23. 00
24. 00	Dental	0	0	1					24. 00
25. 00	Optometry	0	0						25. 00
25. 01	Tel eheal th	0	2, 129	1					25. 01
25. 02	Chronic Care Management	0	0	1					25. 02
26. 00	All other nonreimbursable costs	0	0						26. 00
27. 00	Nonallowable GME costs								27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	2, 129						28. 00
	through 27)								_
	FACILITY OVERHEAD	_1	, ===						
29. 00	Facility Costs	0	6, 590						29. 00
30.00	Administrative Costs	0	69, 431						30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	76, 021						31. 00
22.00	30)	10 504	240 224						22.00
32. 00	Total facility costs (sum of lines 22, 28	12, 584	249, 234						32. 00
	and 31)	ı	l	I					1

	Financial Systems	ST. MARY MEDI				eu of Form CMS-	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/28/2024 8:0	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits		
		Personnel		Standard (1)			
					3)	4	
	hu ou to take propulative to	1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						1
4 00	Posi ti ons	0.00	0.44	1 4 00	0 00/	<u> </u>	1 00
1.00	Physi ci an	2. 38	1	•			1.00
2.00	Physician Assistant	0. 31		•			2.00
3.00	Nurse Practitioner	3. 52					3.00
4. 00 5. 00	Subtotal (sum of lines 1 through 3)	6. 21 0. 00			18, 039		1
6.00	Visiting Nurse Clinical Psychologist	0.00	•			0	
7. 00	Clinical Social Worker	0.00		2		2, 165	
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0. 91				2, 105	1
7. 01	Diabetes Self Management Training (FQHC	0.00	<b>.</b>			0	
7.02	only)	0.00		1			7.02
8.00	Total FTEs and Visits (sum of lines 4	7. 12	22, 218	3		22, 218	8.00
	through 7)		,			,,	
9.00	Physician Services Under Agreements			ol		0	9.00
		1		•	<u>'</u>		
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPITAL-BASE	D RHC/FQHC SEF	RVICES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			3, 489, 811	10.00
11. 00						76, 173	
12.00	Cost of all services (excluding overhead) (s					3, 565, 984	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 978639	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		845, 747	
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			2, 982, 414	
16. 00	Total overhead (sum of lines 14 and 15)					3, 828, 161	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16		40 11	• • • •		3, 828, 161	
	Overhead applicable to hospital-based RHC/FQ					3, 746, 388	
20. 00	Total allowable cost of hospital-based RHC/F	UHC SERVICES (S	sum of lines 10	) and 19)		7, 236, 199	20.00

	Financial Systems	ST. MARY MED				eu of Form CMS-2	
ALLOC <i>A</i>	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Period: From 10/01/2022	Worksheet M-2	
			Component		To 09/30/2023		
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
	L	1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons			1		ı	
1.00	Physi ci an	0. 49		·			1.00
2. 00	Physician Assistant	0. 13					2.00
3.00	Nurse Practitioner	1. 78					3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 40			6, 069		
5. 00	Visiting Nurse	0.00				0	5.00
6. 00	Clinical Psychologist	0.00				0	6. 00
7. 00	Clinical Social Worker	0.00	l .			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	O			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	2. 40	10, 503			10, 503	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9.00
	I					1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			VICES		1 200 005	
10.00						1, 000, 235	
11.00	Total nonreimbursable costs (from Wkst. M-1,					1 000 225	
12.00	Cost of all services (excluding overhead) (s					1, 000, 235	
13.00	Ratio of hospital -based RHC/FQHC services (I			21)		1.000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		342, 650	
15. 00 16. 00	Parent provider overhead allocated to facili	ty (see Instruc	Etions)			734, 671	15. 00 16. 00
16.00	Total overhead (sum of lines 14 and 15) Allowable GME overhead (see instructions)					1, 077, 321 0	17.00
	Enter the amount from line 16					1, 077, 321	
	Overhead applicable to hospital-based RHC/FQ	NC sorvices (Li	no 12 v lino 1	0)		1, 077, 321	19.00
	Total allowable cost of hospital-based RHC/FU					2, 077, 556	
20.00	Tional allowable cost of nospital-based kHC/F	unc services (s	sum of ittles to	anu 19)		2,077,556	J 20.00

Heal th	Financial Systems	ST. MARY MEDI	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der Co		Peri od:	Worksheet M-2	
			Component (		From 10/01/2022 To 09/30/2023	Date/Time Prep 2/28/2024 8:03	
					RHC III	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00			3)	4	
	WICH TO AND DECENDED IN THE	1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons	1 20	4.7/0	1 20	0 5 27/		1 00
1.00	Physician	1. 28					1.00
2.00	Physician Assistant	1. 45 0. 84					2. 00 3. 00
3. 00 4. 00	Nurse Practitioner Subtotal (sum of lines 1 through 3)	3. 57			10, 185		
5. 00	Visiting Nurse	0.00		1	10, 163	0	•
6. 00	Clinical Psychologist	0.00		1			•
7. 00	Clinical Social Worker	0.00	l e			20	1
7. 00	Medical Nutrition Therapist (FQHC only)	0.02	l e	•		0	•
7. 02	Di abetes Self Management Training (FQHC	0.00	-			0	7. 02
7.02	only)	0.00				١	7.02
8.00	Total FTEs and Visits (sum of lines 4	3. 59	11, 339			11, 339	8. 00
	through 7)					,	
9.00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VI CES			
	Total costs of health care services (from Wks	·				1, 762, 783	1
11. 00						8, 439	1
12. 00	Cost of all services (excluding overhead) (si					1, 771, 222	
13. 00	Ratio of hospital -based RHC/FQHC services (I			0.43		0. 995235	
14.00	Total hospital-based RHC/FQHC overhead - (fro			ne 31)		152, 516	1
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			1, 255, 107	1
16. 00 17. 00	Total overhead (sum of lines 14 and 15)					1, 407, 623	
	Allowable GME overhead (see instructions) Enter the amount from line 16					1, 407, 623	l
	Overhead applicable to hospital-based RHC/FQ	HC sarvicas (li	no 13 v lino 1	8)		1, 407, 623	
	Total allowable cost of hospital-based RHC/FU					3, 163, 699	
20.00	Total arrowable cost of hospital-based known	ano services (s	idiii or TTTIC3 TO	, and 17)		3, 103, 077	20.00

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	ST. MARY MEDI	CAL CENTER Provider C	°N: 14-0064	In Lie	u of Form CMS-2 Worksheet M-2	
ALLUCA	TION OF OVERHEAD TO HOSFITAL-BASED KIRC/TORC S	LKVICLS	FIOVIDE		From 10/01/2022	WOI KSHEET WI-Z	
			Component		To 09/30/2023	Date/Time Pre 2/28/2024 8:0	
					RHC IV	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 46					1. 00
2.00	Physician Assistant	0. 01		_,			2. 00
3.00	Nurse Practitioner	0. 24					3. 00
4.00	Subtotal (sum of lines 1 through 3)	0. 71			2, 457		4. 00
5.00	Visiting Nurse	0.00				0	5. 00
6.00	Clinical Psychologist	0.00	l e			0	6. 00
7.00	Clinical Social Worker	0.00	l e			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l e			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	0. 71	2, 547			2, 547	8. 00
9.00	Physician Services Under Agreements		0			0	9.00
	<u>, , , , , , , , , , , , , , , , , , , </u>				_		
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			490, 772	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			10, 565	11. 00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			501, 337	12. 00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			0. 978926	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. N	1-1, col. 7, li	ne 31)		112, 928	14. 00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			512, 351	15. 00
16.00	Total overhead (sum of lines 14 and 15)	-				625, 279	16. 00
17.00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Enter the amount from line 16					625, 279	18. 00
19.00	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		612, 102	19. 00
20 00	Total allowable cost of hospital-based RHC/F	OHC sarvicas (s	rum of lines 10	and 10)		1, 102, 874	20 00

	Financial Systems	ST. MARY MED				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Period: From 10/01/2022	Worksheet M-2	
			Component		To 09/30/2023	Date/Time Pre 2/28/2024 8:0	
					RHC V	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physi ci an	0. 02		1			1. 00
2.00	Physician Assistant	0. 03	l .				2. 00
3.00	Nurse Practitioner	0. 29					3. 00
4.00	Subtotal (sum of lines 1 through 3)	0. 34		•	756		
5.00	Visiting Nurse	0.00				0	5. 00
6.00	Clinical Psychologist	0.00	l e			0	6. 00
7.00	Clinical Social Worker	0.00	l e			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l e			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	0. 34	1, 473			1, 473	8. 00
9.00	Physician Services Under Agreements		0			0	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VI CES			
	Total costs of health care services (from Wk:					171, 084	
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			2, 129	11. 00
12.00	Cost of all services (excluding overhead) (s					173, 213	12. 00
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 987709	13. 00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. N	1-1, col. 7, li	ne 31)		76, 021	14. 00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			258, 691	15. 00
16.00	Total overhead (sum of lines 14 and 15)					334, 712	
17.00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					334, 712	18. 00
	Overhead applicable to hospital-based RHC/FQ					330, 598	19. 00
20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		501, 682	20.00

	Financial Systems ST. MARY MEDICA ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0064	Period:	u of Form CMS-2 Worksheet M-3	
SERVI (		Component CCN: 14-8651	From 10/01/2022 To 09/30/2023	Date/Time Pre	
		T: +1 o V/////	RHC I	2/28/2024 8: 0	2 pm
		Title XVIII	KHC I	Cost	
				1. 00	
1 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES	m Wko+ M 2 Line 20)		7 22/ 100	1 00
1. 00 2. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Cost of injections/infusions and their administration (from Williams)	· · · · · · · · · · · · · · · · · · ·		7, 236, 199 197, 934	
3. 00	Total allowable cost excluding injections/infusions (line 1 m	· · · · · · · · · · · · · · · · · · ·		7, 038, 265	
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	•		22, 218	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			22, 218 316. 78	1
7.00	Adjusted Cost per visit (Title 3 divided by Title 6)		Cal cul ati on		7. 00
			Rate Period 1		
			(10/01/2022	(01/01/2023 through	
			through 12/31/2022)	09/30/2023)	
			1. 00	2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	113.00	126. 00	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		113. 00	126. 00	9.00
10. 00	Program covered visits excluding mental health services (from	contractor records)	O	3, 968	10.00
11. 00	Program cost excluding costs for mental health services (line		0	499, 968	
12. 00	Program covered visits for mental health services (from contra	•	0	68	
13.00	Program covered cost from mental health services (line 9 x line)	•	0	8, 568	
14. 00 15. 00	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instructions		0	8, 568	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	508, 536	
16. 01	Total program charges (see instructions) (from contractor's re-			1, 193, 463	
16. 02	Total program preventive charges (see instructions)(from provi			13, 463	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			5, 737	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0) (Titles V and XIX see instructions.)	3 and 18) times .80)		346, 689	16. 04
16. 05	Total program cost (see instructions)		0	352, 426	16. 05
17. 00	Primary payer amounts			349	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		69, 438	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		222, 112	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			352, 077	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		46, 531	
22. 00	, ,	•		398, 608	22.00
23. 00	Allowable bad debts (see instructions)			0	
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	rueti enc)		0	
25. 00	,	i de ti ons)		0	
25. 50		s)		0	
25. 99	Demonstration payment adjustment amount before sequestration			0	25. 99
26. 00	Net reimbursable amount (see instructions)			398, 608	
26. 01 26. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			7, 972 0	1
27. 00	Interim payments			339, 943	
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.01)			50, 693	
30.00	Protested amounts (nonallowable cost report items) in accordanchapter I, §115.2	nce with CMS Pub. 15-II,		0	30.00

	Financial Systems ST. MARY MEDICA TION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	L CENTER Provider CCN: 14-0064	In Lie	u of Form CMS-2 Worksheet M-3	
SERVI CE			From 10/01/2022		
		Component CCN: 14-8646	To 09/30/2023	Date/Time Pre 2/28/2024 8:0	
		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
- 1	Total Allowable Cost of hospital-based RHC/FQHC Services (from			2, 077, 556	
	Cost of injections/infusions and their administration (from W Total allowable cost excluding injections/infusions (line 1 m			345 2, 077, 211	2. 00 3. 00
	Total Visits (from Wkst. M-2, column 5, line 8)	rius i i ile 2)		10, 503	
- 1	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
	Total adjusted visits (line 4 plus line 5)			10, 503	
7.00	Adjusted cost per visit (line 3 divided by line 6)			197. 77	7. 00
			Cal cul ati on	of Limit (1)	
			Rate Period 1		
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1.00	2. 00	
8. 00 F	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	113.00	126. 00	8. 00
	Rate for Program covered visits (see instructions)		113.00	126. 00	9.00
_	CALCULATION OF SETTLEMENT			004	10.00
- 1	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line	•	0	994 125, 244	
- 1	Program covered visits for mental health services (from contra	•	o	123, 244	l l
- 1	Program covered cost from mental health services (line 9 x li		0	0	13.00
14. 00   I	Limit adjustment for mental health services (see instructions)	)	0	0	14.00
	Graduate Medical Education Pass Through Cost (see instruction				15. 00
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	125, 244	
- 1	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	•		245, 682 2, 246	
	Total program preventive energes (see instructions) (from proving total program preventive costs ((line 16.02/line 16.01) times	•		1, 145	1
	Total Program non-preventive costs ((line 16 minus lines 16.0)			89, 498	
- 1	(Titles V and XIX see instructions.)				
	Total program cost (see instructions)		0	90, 643	
	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		83 12, 227	
	records)	(11 oiii coitti actoi		12, 221	10.00
	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		46, 242	19. 00
- 1	records)			90, 560	20.00
4	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		90, 380	1
- 1	Total reimbursable Program cost (line 20 plus line 21)	m 1, 11116 10)		90, 646	
- 1	Allowable bad debts (see instructions)			0	1
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction:	e)		0	
	Demonstration payment adjustment amount before sequestration	5)		0	
	Net reimbursable amount (see instructions)			90, 646	
	Sequestration adjustment (see instructions)			1, 813	
- 1	Demonstration payment adjustment amount after sequestration			0	
- 1	Interim payments Tentative settlement (for contractor use only)			88, 016	
- 1	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.0	02 27 and 28)		0 817	
	Protested amounts (nonallowable cost report items) in accorda			0	
	chapter I, §115.2				

	Financial Systems ST. MARY MEDICA ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	L CENTER Provider CCN: 14-0064	In Lie	u of Form CMS-2 Worksheet M-3	
SERVI (			From 10/01/2022		
		Component CCN: 14-8645	To 09/30/2023	Date/Time Prep 2/28/2024 8:03	
		Title XVIII	RHC III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			3, 163, 699	
2.00	Cost of injections/infusions and their administration (from W			160, 427	1
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		3, 003, 272	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	lino (l)		11, 339 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	11116 9)		11, 339	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			264. 86	
			Cal cul ati on		
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023)	
0.00	D 111 1 6 000 D 1 100 04 1 1 0 000		1.00	2. 00	0.00
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	.6 or your contractor)	113. 00 113. 00	126. 00 126. 00	
9.00	CALCULATION OF SETTLEMENT		113.00	120.00	9.00
10. 00	Program covered visits excluding mental health services (from	contractor records)	0	3, 166	10. 00
11.00	Program cost excluding costs for mental health services (line		0	398, 916	
12.00	Program covered visits for mental health services (from contra	actor records)	0	2	12. 00
13.00	Program covered cost from mental health services (line 9 x li	*	0	252	
14.00	Limit adjustment for mental health services (see instructions		0	252	
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	399, 168	15. 00 16. 00
16. 00	Total program charges (see instructions) (from contractor's re		٩	912, 802	
16. 02	Total program preventive charges (see instructions)(from prov	*		1, 918	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		839	1
16.04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		284, 927	16. 04
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	285, 766	
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		403 42, 170	
16.00	records)	(110m contractor		42, 170	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		173, 743	19. 00
20.00	records)			205 242	20.00
20.00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		285, 363 50, 887	
22. 00	, ,	W-4, 1111e 10)		336, 250	
23. 00	Allowable bad debts (see instructions)			0	1
23. 01	Adjusted reimbursable bad debts (see instructions)			0	ı
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24. 00
25. 00				0	
25. 50		S)		0	
25. 99 26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 336, 250	
26. 00	Sequestration adjustment (see instructions)			6, 725	
26. 02	1 '			0, 723	
27. 00	Interim payments			276, 895	
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00		•		52, 630	
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II,		0	30.00

	Financial Systems ST. MARY MEDICA ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0064	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (		Component CCN: 14-8648	From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
		Title XVIII	RHC IV	2/28/2024 8: 0: Cost	2 μιι
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2. line 20)		1, 102, 874	1.00
2. 00	Cost of injections/infusions and their administration (from W			33, 656	1
3. 00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		1, 069, 218	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 0)		2, 547 0	4. 00 5. 00
5. 00	Total adjusted visits (line 4 plus line 5)	11116 7)		2, 547	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			419. 80	
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023) 2. 00	
3. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	113.00	126. 00	8. 00
9. 00	Rate for Program covered visits (see instructions)		113.00	126. 00	9.00
10 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from	contractor records)	O	413	   10.00
10. 00 11. 00	Program cost excluding costs for mental health services (line		0	52, 038	
12. 00	Program covered visits for mental health services (from contra	•	0	0	l l
13. 00	Program covered cost from mental health services (line 9 x li	•	0	0	
14. 00 15. 00	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instructions		0	0	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		o	52, 038	
16. 01	Total program charges (see instructions) (from contractor's re-			142, 511	
16. 02	Total program preventive charges (see instructions)(from prov	-		11, 788	1
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0)			4, 304 31, 097	
10. 04	(Titles V and XIX see instructions.)	3 and 10) trilles .00)		31,077	10.04
16. 05	Total program cost (see instructions)		0	35, 401	16. 05
17.00	Primary payer amounts	(6		0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		8, 863	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		24, 372	19.00
20. 00	records)			25 401	20.00
21. 00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		35, 401 10, 568	
22. 00	, ,	,		45, 969	
23. 00	Allowable bad debts (see instructions)			0	
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	munti ana)		0	
25. 00	,	ructions)		0	
	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
25. 99	Demonstration payment adjustment amount before sequestration			0	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			45, 969 919	
26. 01 26. 02	, ,			919	1
27. 00	Interim payments			33, 388	
28. 00	Tentative settlement (for contractor use only)	00 07 1		0	28. 00
29. 00				11, 662	
30. 00	Protested amounts (nonallowable cost report items) in accordanchapter I, §115.2	ilice with two Pub. 15-11,		0	30.00

CALCULATION SERVICES	ncial Systems ST. MARY MEDICA I OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0064	Peri od:	u of Form CMS-2	
DETER				Worksheet M-3	
		Component CCN: 14-8638	From 10/01/2022 To 09/30/2023	Date/Time Prep 2/28/2024 8:02	
		Title XVIII	RHC V	Cost	
				1. 00	
	RMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
1.00   Total	I Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		501, 682	1.00
	of injections/infusions and their administration (from W			42, 199	1
1	I allowable cost excluding injections/infusions (line 1 m	inus line 2)		459, 483	•
	I Visits (from Wkst. M-2, column 5, line 8) icians visits under agreement (from Wkst. M-2, column 5,	line (1)		1, 473 0	4. 00 5. 00
1 7	I adjusted visits (line 4 plus line 5)	Title 9)		1, 473	6.00
1	sted cost per visit (line 3 divided by line 6)			311. 94	7. 00
			Cal cul ati on		
			Rate Period 1		
			(10/01/2022 through	(01/01/2023 through	
			12/31/2022)	09/30/2023)	
			1. 00	2.00	
1	visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	113.00	126. 00	
	for Program covered visits (see instructions)		113.00	126. 00	9. 00
	JLATION OF SETTLEMENT ram covered visits excluding mental health services (from	contractor records)	ol	273	10.00
	ram cost excluding costs for mental health services (line			34, 398	1
	ram covered visits for mental health services (from contra		o	0 1, 0 70	12.00
0	ram covered cost from mental health services (line 9 x li	•	o	0	13. 00
14.00 Li mi	t adjustment for mental health services (see instructions	)	0	0	14. 00
1	uate Medical Education Pass Through Cost (see instruction	•			15. 00
	Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	34, 398	1
1	I program charges (see instructions)(from contractor's re I program preventive charges (see instructions)(from prov	•		75, 004 741	16. 01 16. 02
	I program preventive costs ((line 16.02/line 16.01) times			340	16. 02
	I Program non-preventive costs ((line 16 minus lines 16.0			24, 618	
	les V and XIX see instructions.)	,			l
1	I program cost (see instructions)		0	24, 958	•
	ary payer amounts	(6		67	17.00
18. 00 Less:	: Beneficiary deductible for RHC only (see instructions)	(from contractor		3, 285	18. 00
1	ficiary coinsurance for RHC/FQHC services (see instructio	ns) (from contractor		14, 196	19. 00
1	Medicare cost excluding vaccines (see instructions)			24, 891	20.00
	ram cost of vaccines and their administration (from Wkst.	M-4, line 16)		10, 777	21.00
22. 00 Total	l reimbursable Program cost (line 20 plus line 21)			35, 668	22. 00
	wable bad debts (see instructions)			0	23. 00
1 -	sted reimbursable bad debts (see instructions)			0	23. 01
1	wable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24. 00
1	R ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) eer ACO demonstration payment adjustment (see instruction	s)		0	1 .
	nstration payment adjustment amount before sequestration	<u>.</u> ,		0	1
	reimbursable amount (see instructions)			35, 668	
	estration adjustment (see instructions)			713	
1	nstration payment adjustment amount after sequestration			0	
	rim payments			24, 195	1
	ative settlement (for contractor use only) nce due component/program (line 26 minus lines 26.01, 26.	02 27 and 201		0 10, 760	28. 00 29. 00
	ested amounts (nonallowable cost report items) in accorda			10, 760	1
	ter I, §115.2	WELL ONG TUD. 10-11,			

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC Component C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-4 Date/Time Preple 2/28/2024 8:03	
		Title	XVIII	RHC I	Cost	2 piii
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2, 917, 601	2, 917, 60	2, 917, 601	2, 917, 601	1. 00
2.00	Ratio of injection/infusion staff time to total health care staff time	0. 001764	0. 00221	0. 000285	0. 000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	5, 147	6, 45	51 832	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	72, 301	10, 72		0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	77, 448			0	
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3, 489, 811	3, 489, 81	3, 489, 811	3, 489, 811	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	3, 746, 388				
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 022193			0. 000000	8. 0
9.00	Overhead cost - injection/infusion (line 7 x line 8)	83, 144	18, 44		0	
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	160, 592	35, 61	1, 724	0	10. 0
11. 00	Total number of injections/infusions (from your records)	347	43		0	
12.00	Cost per injection/infusion (line 10/line 11)	462. 80	81. 8		0. 00	12. 0
13. 00	Number of injection/infusion administered to Program beneficiaries	84	3	39 12	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	38, 875	7, 28	369	0	14.00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
15 05				1. 00	2. 00	4
15. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			197, 934	
16.00	Total Program cost of injections/infusions and their admini	stration costs	(sum of		46, 531	16.0

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CO	CN: 14-0064 CCN: 14-8646	Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-4 Date/Time Prep 2/28/2024 8:02	pared:
		Title	XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	877, 758 0. 000000			877, 758 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	0	6	57 0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	0		99 0	0	
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 000, 235	1, 000, 23		0 1, 000, 235	0.0
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	1, 077, 321 0. 000000	1, 077, 32 0. 0001 <i>6</i>		1, 077, 321 0. 000000	7. 00 8. 00
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	17 34		0 0	
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	0 0.00 0	86. 2	4 0 25 0.00 1 0		11. 0 12. 0 13. 0
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	8	36 0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		345	15. 00
16 00	Total Program cost of injections/infusions and their admini		(sum of		86	16.0

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC Component C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-4 Date/Time Prep 2/28/2024 8:02	pared:
		Title	XVIII	RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 649, 736 0. 002949	1, 649, 73 0. 00537		1, 649, 736 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	4, 865	8, 87	2, 181	0	3.00
1.00	Injections/infusions and related medical supplies costs (from your records)	60, 424	13, 04	45 0	0	4.00
5. 00 5. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	65, 289 1, 762, 783	21, 9 <sup>2</sup> 1, 762, 78		0 1, 762, 783	5. 00 6. 00
7. 00 3. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	1, 400, 916 0. 037037	1, 400, 91 0. 01243		1, 400, 916 0. 000000	
0. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	51, 886 117, 175	17, 4° 39, 33			
1. 00 2. 00 3. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	290 404. 05 92	52 74. 3 16	30. 11		11. 00 12. 00 13. 00
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0°
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	37, 173	12, 26	1, 445	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
5. 00	Total cost of injections/infusions and their administration	n costs (sum of	col umns 1	1. 00	2. 00 160, 427	15. 00
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. Total Program cost of injections/infusions and their admini	M-3, line 2)			50, 887	

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC Component C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-4 Date/Time Prep 2/28/2024 8:02	pared:
		Title	XVIII	RHC IV	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	413, 367	413, 36	413, 367	413, 367	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 001916	0. 00309	0. 000000	0. 000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	792	1, 27	0	0	3.00
1.00	Injections/infusions and related medical supplies costs (from your records)	10, 835	2, 07	71 0	0	4.00
. 00	Direct cost of injections/infusions (line 3 plus line 4)	11, 627	3, 35	50 0	0	5.00
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	490, 772	490, 77	490, 772	490, 772	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	612, 102	612, 10	02 612, 102	612, 102	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 023691	0. 00682	0. 000000	0. 000000	8.00
0.00	Overhead cost - injection/infusion (line 7 x line 8)	14, 501	4, 17	78 0	0	9.00
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	26, 128	7, 52	0	0	10.00
1.00	Total number of injections/infusions (from your records)	52	8	34 0	ol	11.00
2.00	Cost per injection/infusion (line 10/line 11)	502. 46	89. 6	0.00	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	18	1	0	0	13.00
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0°
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	9, 044	1, 52	24 0	0	14.00
					COST OF INJECTIONS /	
					INFUSIONS AND ADMINISTRATION	
				1. 00	2.00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		col umns 1,		33, 656	15. 00
	Total Program cost of injections/infusions and their admini			1	10, 568	1

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC Component C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-4 Date/Time Prep 2/28/2024 8:02	pared:
		Title	XVIII	RHC V	Cost	<u> </u>
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	125, 498	125, 49	98 125, 498	125, 498	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 003675	0. 00938	0. 000000	0.000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	461	1, 17		0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	9, 793	2, 95		0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10, 254	4, 13		0	
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	171, 084	171, 08			6.00
7. 00	Total overhead (from Wkst. M-2, line 19)	330, 598	330, 59	330, 598	330, 598	7.0
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 059935	0. 02418		0.000000	8.00
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	19, 814	7, 99		0	
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	30, 068	12, 13	0	0	10.0
11. 00	Total number of injections/infusions (from your records)	47	12		0	
12. 00	Cost per injection/infusion (line 10/line 11)	639. 74	101.0		0.00	12. 0
13. 00	Number of injection/infusion administered to Program beneficiaries	11	3	0	0	13. 0
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	7, 037	3, 74	10 0	0	14.00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
15.00	T			1. 00	2. 00	45.0
15. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			42, 199	
16. 00					10, 777	16.0

Health Financial Systems	ST. MARY MEDI	CAL CENTER	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 14-0064 Component CCN: 14-8651	Peri od: From 10/01/2022 To 09/30/2023	

		Component con. 14-8031	10 097 307 2023	2/28/2024 8: 02	
			RHC I	Cost	- Je
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			339, 943	1. 00
2.00	Interim payments payable on individual bills, either submitte	ed or to be submitted to		0	2. 00
	the contractor for services rendered in the cost reporting pe				
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount h				3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3. 01
3.02				0	3. 02
3.03				0	3. 03
3.04				0	3. 04
3.05				0	3. 05
	Provider to Program				
3.50				0	3. 50
3. 51				0	3. 5
3.52				0	3. 52
3.53				0	3. 53
3.54				0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98			0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfe	er to Worksheet M-3, line		339, 943	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR		-		
5.00	List separately each tentative settlement payment after desk	review. Also show date of	f		5. 00
	each payment. If none, write "NONE" or enter a zero. (1)				
F 01	Program to Provider				F 0
5. 01				0	5. 0
5. 02 5. 03				0 0	5. 02 5. 03
5.03	Provider to Program			0	5. 03
5. 50	Provider to Program			0	5. 50
5. 51					5. 51
5. 52					5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98	0)		0	5. 99
6.00	Determined net settlement amount (balance due) based on the	*		١	6. 00
6. 01	SETTLEMENT TO PROVIDER	cost report. (1)		50, 693	6. 0
6. 02	SETTLEMENT TO PROGRAM			30, 043	6. 02
7. 00	Total Medicare program liability (see instructions)			390, 636	7. 00
7.00	Total medicale program frability (see instructions)		Contractor	NPR Date	7.0
			Number	(Mo/Day/Yr)	
			Nullipel	( WU/ Day/ II )	
		0	1. 00	2.00	

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES  Provider CCN: 14-0064 Component CCN: 14-8646  Period: From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/28/2024 8:02 pm	Health Financial Systems	ST. MARY MEDICA	L CENTER	In Lie	u of Form CMS-2552-10
				From 10/01/2022	Date/Time Prepared:

		Component CCN: 14-8646	10 09/30/2023	2/28/2024 8: 02	
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			88, 016	1. 00
2. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2. 00
3. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)  Program to Provider				3. 00
3. 01	Flogialii to Flovidei			0	3. 0
3. 02				0	3. 0
3. 02				0	3. 0.
				- 1	
3. 04				0	3. 0
3. 05				0	3. 0
	Provider to Program				0 5
. 50				0	3. 5
. 51				0	3. 5
. 52				0	3. 5
. 53				0	3. 5
. 54				0	3. 5
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3. 9
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	fer to Worksheet M-3, line		88, 016	4. 0
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5. C
	Program to Provider				
. 01				0	5. C
. 02				0	5. C
. 03				0	5. C
	Provider to Program				
. 50				0	5. 5
51				0	5. 5
. 52				0	5. 5
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5. 9
. 00	Determined net settlement amount (balance due) based on the	cost report. (1)			6. 0
. 01	SETTLEMENT TO PROVIDER	•		817	6. (
. 02	SETTLEMENT TO PROGRAM			0	6. C
. 00	Total Medicare program liability (see instructions)			88, 833	7. C
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
			IVAIIIDCI	(WO, Day, II)	
		0	1. 00	2.00	

Health Financial Systems	ST. MARY MEDICA	L CENTER	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVI DER FOR	Provider CCN: 14-0064 Component CCN: 14-8645	Peri od: From 10/01/2022 To 09/30/2023	

		Component Con. 14-8045	10 07/30/2023	2/28/2024 8: 02	
			RHC III	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC	-		276, 895	1. 00
2. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2. 00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	, , , , , , , , , , , , , , , , , , , ,			
3. 00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3.0
3. 02				0	3. 02
3. 03				0	3. 03
3. 04				0	3.0
3. 05				0	3. 05
	Provider to Program				
3. 50				0	3. 50
3. 51				0	3. 5
3. 52				0	3. 5
3. 53				0	3. 5
3. 54				0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		276, 895	4. 0
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5. 0
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5. 0
5. 02				0	5. 02
5. 03				0	5. 0
	Provider to Program				
5. 50				0	5. 5
5. 51				0	5. 5
5. 52				0	5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5. 9
5. 00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6. 0
5. 01	SETTLEMENT TO PROVIDER			52, 630	6. 0
5. 02	SETTLEMENT TO PROGRAM			0	6. 0
7. 00	Total Medicare program liability (see instructions)			329, 525	7. 0
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
3. 00	Name of Contractor				8. 0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES  Provider CCN: 14-0064 From 10/01/2022 To 09/30/2023 Worksheet M-5 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/28/2024 8:02 pm	Health Financial Systems	ST. MARY MEDI	CAL CENTER	In Lie	u of Form CMS-2552-10
				From 10/01/2022	Date/Time Prepared:

2.00   I t 3.00   L r	Total interim payments paid to hospital-based RHC/FQHC Interim payments payable on individual bills, either submitthe contractor for services rendered in the cost reporting particular and the cost reporting particular services reparately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. Dayment. If none, write "NONE" or enter a zero. (1)	period. If none, write	RHC IV Par mm/dd/yyyy 1.00	2/28/2024 8: 02	1. 0
2.00   I t 3.00   L r p	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting p "NONE" or enter a zero List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period.	period. If none, write	mm/dd/yyyy	Amount 2. 00 33, 388	
2.00   I t 3.00   L r p	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting p "NONE" or enter a zero List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period.	period. If none, write	mm/dd/yyyy	Amount 2. 00 33, 388	
2.00   I t 3.00   L r p	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting p "NONE" or enter a zero List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period.	period. If none, write	1.00	33, 388	
2.00   I t 3.00   L r p	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting p "NONE" or enter a zero List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period.	period. If none, write			
t " 3. 00 L r p	the contractor for services rendered in the cost reporting proving of the cost reporting province of the cost reporting province of the cost reporting period.	period. If none, write		0	
r p P	revision of the interim rate for the cost reporting period.	based on subsequent			2. 0
_	Program to Provider	Also show date of each			3. 0
	Togram to Frovider			0	3. 0
. 02					3. 0
. 03					3. 0
. 04					3. 0
. 05					3. (
	Provider to Program			0	J. (
. 50	Tovider to Trogram			0	3. !
51					3.
52					3.
53					3.
. 54					3.
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.4	98)			3.
. 00 T	Total interim payments (sum of lines 1, 2, and 3.99) (transi 27)			33, 388	4. (
T	O BE COMPLETED BY CONTRACTOR				
	List separately each tentative settlement payment after desl each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5. (
Р	Program to Provider				
. 01				0	5. (
. 02				0	5. (
03				0	5.
	Provider to Program			_	_
50				0	5.
51				0	5.
52		>		0	5.
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.49			0	5.
	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
	SETTLEMENT TO PROVIDER			11, 662	6.
-	SETTLEMENT TO PROGRAM			0	6.
. 00 T	Total Medicare program liability (see instructions)			45, 050	7.
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
8. 00 N	Name of Contractor	0	1. 00	2. 00	8. 0

Health Financial Systems	ST. MARY MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0064 Component CCN: 14-8638	Peri od: From 10/01/2022 To 09/30/2023	
			DUO 1/	0 1

		Component con. 14-8038	10 097 307 2023	2/28/2024 8: 02	
			RHC V	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			24, 195	1. 00
2. 00	Interim payments payable on individual bills, either submitte	ed or to be submitted to		0	2. 00
	the contractor for services rendered in the cost reporting po				
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount I	based on subsequent			3. 00
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01	_ v			0	3. 01
3. 02				l ol	3. 02
3. 03				0	3. 03
3. 04				l ol	3. 04
3. 05				0	3. 05
3.03	Provider to Program			0	5. 00
3.50	1 TOVI del 10 1 Togi dill			0	3. 50
3. 51				0	3. 5
3. 52				l ől	3. 52
3. 53					3. 53
3. 54					3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.96	0)			3. 99
3. 99 4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer			·	
4.00	27)	er to worksheet M-3, iine		24, 195	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk	roviow Also show data o	F		5. 00
5.00	each payment. If none, write "NONE" or enter a zero. (1)	Teview. Also show date o	!		5.00
	Program to Provider				
5. 01	i rogram to rrovider			0	5. 01
5. 02				0	5. 02
5. 02					5. 03
3.03	Provider to Program			0	3. 00
5. 50	i rovi dei 16 i rogi aiii			0	5. 50
5. 51					5. 5
5. 52					5. 52
5. 99	Subtatal (sum of lines E O1 E 40 minus sum of lines E E0 E O	0)			5. 99
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9)			١	
6.00	Determined net settlement amount (balance due) based on the distribution of the distri	cost report. (1)		10 7/0	6. 00
6. 01				10, 760	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)		2 1 1	34, 955	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
0.00		0	1. 00	2. 00	0.60
8.00	Name of Contractor			1	8.00