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: 14-0034 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/21/2024 9:54 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/21/2024 9:54 am ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "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

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM HEALTH ST. MARYS HOSPITAL (14-0034) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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 FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Eile	en Lamm	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Eileen Lamm			2
3	Signatory Title	REGIONAL VP FINANCE			3
4	Date	(Dated when report is electronica			4

	·		Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-147, 124	-3, 321	0	0	1.00
2.00	SUBPROVIDER - IPF	0	26, 606	0		0	2. 00
3.00	SUBPROVIDER - IRF	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
12. 30	00T I	0		0		0	12. 30
200.00	TOTAL	0	-120, 518	-3, 321	0	0	200.00
The ab	pove amounts represent "due to" or "due from"	the applicable	program for th	a alament of t	he above compl	av indicated	

from" the applicable program for the element of the above complex indic 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.

use only

Health Financial Systems SSM HEALTH ST. MARYS HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0034 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 9:54 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 400 NORTH PLEASANT AVENUE 1.00 PO Box: 1.00 2.00 City: CENTRALIA State: IL Zi p Code: 62801-County: MARION 2.00 Payment System (P, Component Name CCN CBSA Provi der Date T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal SSM HEALTH ST. MARYS 140034 99914 07/01/1966 Ν Р Р 3.00 1 HOSPI TAL SSM HEALTH ST. MARYS Subprovider - IPF 99914 Р Р 4.00 14S034 4 01/01/2002 N 4.00 **PSYCH** 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF Swing Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 Hospital-Based (CMHC) I 17.00 17.00 Hospital-Based (00T) I ST MARYS WORK SAFETY 99914 N 03/08/2000 0 17.30 17.30 146668 N I NSTI TUTE 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) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 1 3. 00 1. 00 2. 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22. 01 22 01 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 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, 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 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 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 22.04 for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 3 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

61. 20	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.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0. 00	0. 00	61. 20
	,					
	T				1. 00	
	ACA Provisions Affecting the Health Resources and Ser					
62. 00	Enter the number of FTE residents that your hospital		reporting peri	od for which	0. 00	62.00
	your hospital received HRSA PCRE funding (see instruc					
62. 01	Enter the number of FTE residents that rotated from a			your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC prog		is)			
	Teaching Hospitals that Claim Residents in Nonprovide			. 10 5 .	• •	,, ,,
63. 00	Has your facility trained residents in nonprovider se	3	1 9 1		N	63. 00
	"Y" for yes or "N" for no in column 1. If yes, comple	ete iines 64 through 6	7. (See Instru	ctions)		l

Heal th	n Financial Systems	SSM HFALT	H ST. MAR	YS HOSPITAL		In Lie	eu of Form CMS	2552-10
	TAL AND HOSPITAL HEALTH CARE COMP			Provi der Co		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I	pared:
					Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Yea	ar FTE Residents in N	onprovi der	Settings	1.00 This base vea	2.00 ar is vour cost	3.00 reporting	
64. 00	period that begins on or after July 1, 2009 and before June 30, 2010.  Enter in column 1, if line 63 is yes, or your facility trained resider in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the rat of (column 1 divided by (column 1 + column 2)). (see instructions)				0.			64.00
	of (column 1 divided by (column	1 + column 2)). (see Program Name		ons) ram Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	,
		Trogram Name	, , , og.	am oode	FTEs Nonprovi der Si te	FTEs in	(col. 3 + col. 4))	
<b></b>		1.00	2	2. 00	3. 00	4.00	5.00	15.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				O.		0 0.00000C	
					Unwei ghted FTEs Nonprovi der Si te	FTEs in	(col. 1 + col. 2))	
					1. 00	2.00	3.00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovi	der Setting	sEffective	for cost report	ing periods	
66. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima occurring in all nonpo unweighted non-prima cal. Enter in column 3	rovider se ry care re 3 the rati	ettings. esident o of	0.	0. 0	0. 000000	66. 00
		Program Name		ram Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	,
67 00	Enter in column 1, the program	1.00	2	2. 00	3. 00	4. 00 00 0. 0	5. 00 0. 000000	67 00
	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)							

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Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the

If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

applicable column.

applicable column.

94.00

95.00

96.00

aslumn 1 for title V and in aslumn 2 for title VIV	for yes or "N"	idents post for no in	Y	Y	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	concerting of ch	argos on Wkst	Υ	Y	98. 01
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for			T T	T T	90.01
title XIX.		-1	V		00.00
98.02 Does title V or XIX follow Medicare (title XVIII) for the bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes			Y	Y	98. 02
for title V, and in column 2 for title XIX.					
98.03 Does title V or XIX follow Medicare (title XVIII) for a cr reimbursed 101% of inpatient services cost? Enter "Y" for			N	N	98. 03
for title V, and in column 2 for title XIX.	yes or in ror i	no in corumn i			
98.04 Does title V or XIX follow Medicare (title XVIII) for a CA			N	N	98. 04
outpatient services cost? Enter "Y" for yes or "N" for no in column 2 for title XIX.	n column 1 for	title V, and			
98.05 Does title V or XIX follow Medicare (title XVIII) and add	back the RCE dis	sallowance on	Υ	Y	98. 05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in					
column 2 for title XIX.  98.06 Does title V or XIX follow Medicare (title XVIII) when cos	t reimbursed for	r Wkst. D.	Υ	Y	98. 06
Pts. I through IV? Enter "Y" for yes or "N" for no in colu					
column 2 for title XIX. Rural Providers					
105.00 Does this hospital qualify as a CAH?			N		105. 00
106.00 If this facility qualifies as a CAH, has it elected the al	-inclusive meth	hod of payment			106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for	cost raimhursama	ent for I&P			107. 00
training programs? Enter "Y" for yes or "N" for no in colu					107.00
Column 2: If column 1 is Y and line 70 or line 75 is Y, d	,				
approved medical education program in the CAH's excluded Enter "Y" for yes or "N" for no in column 2. (see instruc	PF and/or TRF ( tions)	uni t(s)?			
107.01 If this facility is a REH (line 3, column 4, is "12"), is		cost			107. 01
reimbursement for I&R training programs? Enter "Y" for yes	or "N" for no.	(see			
instructions) 108.00 s this a rural hospital qualifying for an exception to th	e CRNA fee sched	dul e? See 42	N		108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	D				
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respirator	У
109.00 If this hospital qualifies as a CAH or a cost provider, ar		N N	N	N	109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
				1.00	
110.00 Did this hospital participate in the Rural Community Hospi	tal Demonstratio	on project (§41 "N" for no. If	OA Ves	1. 00 N	110. 00
110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W	"Y" for yes or	"N" for no. If	yes,		110. 00
Demonstration) for the current cost reporting period? Enter	"Y" for yes or	"N" for no. If	yes,		110. 00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W	"Y" for yes or	"N" for no. If	yes, h 215, as	N	110.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in	"Y" for yes or orksheet E-2, li the Frontier Co	"N" for no. If ines 200 throug	yes,		110.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this	"Y" for yes or orksheet E-2, li the Frontier Co cost reporting p	"N" for no. If ines 200 throug	yes, h 215, as	N	
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in	"Y" for yes or orksheet E-2, li the Frontier Cocost reporting poolumn 1 is Y, e	"N" for no. If ines 200 throug community period? Enter enter the	yes, h 215, as	N	
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for	"Y" for yes or orksheet E-2, li the Frontier Cocost reporting poolumn 1 is Y, earticipating in	"N" for no. If ines 200 througommunity period? Enter the column 2.	yes, h 215, as	N	
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p	"Y" for yes or orksheet E-2, li the Frontier Cocost reporting poolumn 1 is Y, earticipating in	"N" for no. If ines 200 througommunity period? Enter the column 2.	yes, h 215, as	N	
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Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.	"Y" for yes or prksheet E-2, li the Frontier Cost reporting polumn 1 is Y, carticipating in additional beds;	"N" for no. If ines 200 througon typeriod? Enter enter the column 2.; and/or "C"	1.00 N	N 2. 00	
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Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participate demonstration. In column 3, enter the date the hospital column 2.	"Y" for yes or orksheet E-2, li the Frontier Cocost reporting polumn 1 is Y, earticipating in additional beds; alth Model reporting column 1 is pating in the	ommunity period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic	"Y" for yes or orksheet E-2, li the Frontier Cocost reporting polumn 1 is Y, earticipating in additional beds; alth Model reporting column 1 is pating in the	ommunity period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes	"Y" for yes or orksheet E-2, li  the Frontier Cocost reporting polumn 1 is Y, earticipating in additional beds;  alth Model reporting column 1 is pating in the eased	ommunity period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A,	"Y" for yes or orksheet E-2, li the Frontier Cocost reporting polumn 1 is Y, earticipating in additional beds; alth Model reporting column 1 is pating in the eased or "N" for no B, or E only)	ommunity period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes	"Y" for yes or orksheet E-2, li the Frontier Cocost reporting polumn 1 is Y, earticipating in additional beds; alth Model reporting column 1 is pating in the eased  or "N" for no B, or E only)	ommunity period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided.	"Y" for yes or orksheet E-2, li the Frontier Cocost reporting polumn 1 is Y, earticipating in additional beds; alth Model reporting column 1 is pating in the beased  or "N" for no B, or E only) '93" percent (includes	ommunity period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provid the definition in CMS Pub. 15-1, chapter 22, §2208.1.	"Y" for yes or orksheet E-2, li  the Frontier Cocost reporting polumn 1 is Y, earticipating in additional beds;  alth Model reporting column 1 is pating in the eased  or "N" for no B, or E only) 193" percent (includes ers) based on	ommunity period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provid the definition in CMS Pub. 15-1, chapter 22, §2208.1.  116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	"Y" for yes or orksheet E-2, li the Frontier Coost reporting polumn 1 is Y, earticipating in additional beds; alth Model reporting column 1 is pating in the eased  or "N" for no B, or E only) '93" percent (includes ers) based on	"N" for no. If ines 200 throug  community period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111. 00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provid the definition in CMS Pub. 15-1, chapter 22, §2208. 1.  116.00 Is this facility legally-required to carry mal practice ins	"Y" for yes or orksheet E-2, li the Frontier Coost reporting polumn 1 is Y, earticipating in additional beds; alth Model reporting column 1 is pating in the eased  or "N" for no B, or E only) '93" percent (includes ers) based on	ommunity period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsyl vania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provid the definition in CMS Pub. 15-1, chapter 22, §2208.1.  116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	"Y" for yes or orksheet E-2, li the Frontier Coost reporting polumn 1 is Y, earticipating in additional beds; alth Model reporting column 1 is pating in the eased  or "N" for no B, or E only) '93" percent (includes ers) based on	"N" for no. If ines 200 throug  community period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111. 00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provid the definition in CMS Pub. 15-1, chapter 22, §2208. 1.  116.00 Is this facility legally-required to carry malpractice ins "Y" for yes or "N" for no.	"Y" for yes or orksheet E-2, li  the Frontier Cocost reporting polumn 1 is Y, earticipating in additional beds;  alth Model reporting column 1 is pating in the eased  or "N" for no B, or E only) '93" percent (includes ers) based on 'for yes or urance? Enter olicy? Enter 1	"N" for no. If ines 200 throug  community period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111. 00 1112. 00 1115. 00 116. 00 117. 00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partic demonstration. In column 3, enter the date the hospital c participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provid the definition in CMS Pub. 15-1, chapter 22, §2208. 1.  116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.  117.00 Is this facility legally-required to carry malpractice ins "Y" for yes or "N" for no.	"Y" for yes or orksheet E-2, li  the Frontier Cocost reporting polumn 1 is Y, earticipating in additional beds;  alth Model reporting column 1 is pating in the eased  or "N" for no B, or E only) '93" percent (includes ers) based on 'for yes or urance? Enter olicy? Enter 1	"N" for no. If ines 200 throug  community period? Enter enter the column 2. and/or "C"	1.00 N	N 2. 00	111. 00 1112. 00 1115. 00 116. 00 117. 00

146, 00

Ν

146.00 Has the cost allocation methodology changed from the previously filed cost report?

yes, enter the approval date (mm/dd/yyyy) in column 2.

Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If

Health Financial Systems		ST. MARYS HOSPITA	<b>AL</b>		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der			riod: om 01/01/2023 12/31/2023		epared:
		<u>'</u>		'			
147.00 Was there a change in the statisti	cal basis? Enter "Y" 1	for ves or "N" fo	or no.			1. 00 Y	147. 00
148.00 Was there a change in the order of	allocation? Enter "Y	' for yes or "N"	for no.			N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method					N	149. 00
		Part A	Part		Title V	Title XIX	
Does this facility contain a prov	dor that qualifies for	1.00	2.00		3.00	4.00	
or charges? Enter "Y" for yes or							
155. 00 Hospi tal		N	N N	<u> </u>	N	N	155. 00
156. 00 Subprovi der - IPF		N	N		N	N	156. 00
157.00 Subprovi der - I RF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N		N	N	160. 00
161. 00 CMHC			N		N	N	161. 00
161. 01 161. 3000T			N N		N N	N N	161. 01 161. 30
161. 30 001			I IN		IN	IN	101. 30
						1.00	
Multicampus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	s one or more car	mpuses in di	fferer	nt CBSAs?	N	165. 00
	Name	County	State			FTE/Campus	
	0	1. 00	2. 00	3.0	00 4.00	5. 00	
166.00 If line 165 is yes, for each						0.0	166. 00
campus enter the name in column O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
· ·			·				
					-	1.00	
Health Information Technology (HI					Act	T	
167.00 Is this provider a meaningful user					ntor the	Y	167. 00 168. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the l			THE 107 IS	Y ), E	enter the		168.00
168.01 If this provider is a CAH and is i			der qualify	for a	hardshi n	•	168. 01
exception under §413.70(a)(6)(ii)					nar asın p		100.01
169.00 If this provider is a meaningful u		and is not a CA	H (line 105	iś"N"	), enter the	9.1	99169.00
transition factor. (see instruction	ons)				Begi nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	oegi nni ng date and endi	ng date for the	reporti ng				170. 00
period respectively (min/dd/yyyy)							
					1. 00	2. 00	
171.00 If line 167 is "Y", does this pro- section 1876 Medicare cost plans i "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I, line 2, o	col. 6? Ente		N		0 171. 00

	Financial Systems SSM HEALTH ST.  AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 14-0034	Peri od:	u of Form CMS- Worksheet S-2	
00111	THE THE THE TENETH STATE RETAINED TO SEE THE THE TENETH COLOR OF T	Trovider o		From 01/01/2023 To 12/31/2023	Part II	epared:
				Y/N	Date	34 aiii
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					4
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Ente	er all dates in t	the	
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions) Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare F		N			2. 0
	yes, enter in column 2 the date of termination and in column	mn 3, "V" for				
00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including	na management	Y			3.0
. 00	contracts, with individuals or entities (e.g., chain home of		'			] 3.0
	or medical supply companies) that are related to the provide	der or its				
	officers, medical staff, management personnel, or members					
	of directors through ownership, control, or family and other relationships? (see instructions)	er similar				
	rerationships: (see Thati detrois)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
00	Financial Data and Reports			Δ.		
00	Column 1: Were the financial statements prepared by a Ceraccountant? Column 2: If yes, enter "A" for Audited, "C" to		Y	A		4. 0
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
. 00	Are the cost report total expenses and total revenues diffe		N			5. 0
	those on the filed financial statements? If yes, submit red	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	+
	Approved Educational Activities			1 11 00	2.00	
00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	s the provider	- N		6.0
00	the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see in	actructions		N		7.0
. 00	Were nursing programs and/or allied health programs approve		wed during the	N N		8. 0
00	cost reporting period? If yes, see instructions.	sa ana, or renew	rea adiring the	"		0.0
00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the current	N		10.0
J. UU	cost reporting period? If yes, see instructions.	Ji renewed in t	the current	IN		10.0
1. 00	Are GME cost directly assigned to cost centers other than I	I & R in an App	proved	N		11.0
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N 1. 00	
	Bad Debts				1.00	
2. 00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	tions.		Y	12. 0
3. 00	If line 12 is yes, did the provider's bad debt collection ;	policy change c	during this co	ost reporting	N	13. 0
4 00	period? If yes, submit copy.				, ,	14.0
4. 00	If line 12 is yes, were patient deductibles and/or coinsural instructions.	ance amounts wa	arvea? ir yes,	see	N	14.0
	Bed Complement					
5. 00	Did total beds available change from the prior cost reporti				N	15. 0
		Y/N	t A Date	Y/N Par	t B Date	
		1.00	2.00	3.00	4. 00	
	PS&R Data	11.00	2.00	0.00		
. 00	Was the cost report prepared using the PS&R Report only?	N		N		16. 0
	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)					
7. 00	Was the cost report prepared using the PS&R Report for	Υ	03/28/2024	Υ	03/28/2024	17. 0
	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)					
	LLD COLUMNIC / SDD /L LCGG LDCTFHCTLODG)	N		N		18. 0
8 NN			1	IN		1 10.0
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R	.,,				
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
8. 00 9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		19. 00

HOSPITAL AND HOSPITAL HEALTH CARE RELINGUISEMENT QUESTIONNAIRE    Provider COI 14-0034   Period   Peri	Heal th	Financial Systems SSM HEALTH ST. !	MARYS HOSPITAL		In Lie	u of Form CMS-2	2552-10
20.00   If   Fine 16 or 17 is yes, were adjustments made to PSSR   N N N   20.00	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	CN: 14-0034	From 01/01/2023	Part II Date/Time Pre	pared:
1.00   Report data for Other? Describe the other adjustments:   Y/N   Date   Y/N						Y/N	
Report data for Other? Describe the other adjustments:	20.00	If line 1/ or 17 is use were adjustments made to DCOD	(	)			20.00
21.00   Was the cost report prepared only using the provider's   N   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   2.00   3.00   4.00   2	20.00				IN	IN	20.00
21.00   Precords? If yes, see instructions.   1.00   1.00		,	Y/N	Date	Y/N	Date	
COMPLETED BY COST RETIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)  22.00 Have assured been real if fed for Medicare purposes? If yes, see instructions  23.00 Issue changes occurred in the Medicare depreciation expense due to appraisals made during the cost  23.00 Have there been new capitalized leases entered into during this cost reporting period?  24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period?  25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see  26.00 Instructions.  27.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see  28.00 Instructions.  29.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit to the provider have a funded depreciation account and/or bond funds (Nebt Service Reserve Fund)  29.00 Did the provider have a funded depreciation account and/or bond funds (Nebt Service Reserve Fund)  29.00 Has existing debt been recalled before scheduled maturity without issuance of new debt? If yes, see  30.00 Has existing debt been recalled before scheduled maturity without issuance of new debt? If yes, see  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see  32.00 Has existing debt been recalled maturity without issuance of new debt? If yes, see  33.00 If I in a 3 Li yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  34.00 Were home office costs claimed on the cost reporting agreements with the provider-based physicians?  35.00 If I in a 3 Li yes, where the requirements of sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  36.00 Were home office costs claimed on the cost report?  37.00 If I in a 3 Li yes, where the requirements of manded existing agreements with the provider-based physicians?  38.00 If I in a 3 Li yes, what a home of		The state of the s		2. 00		4. 00	
COMPLETED BY COST REINBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Capital Re	21. 00		N		N		21. 00
COMPLETED BY COST REINBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Capital Re						1. 00	
22.00   lave assets been relifed for Medicare purposes? If yes, see instructions   22.00   lave changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.   24.00   Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions   24.00   Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions   25.00   Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions   27.00   Last the provider's capitalization policy changed during the cost reporting period? If yes, submit coopy   27.00		COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			
23.00   Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.   24.00   Were new leases and/or amendments to existing leases entered into during this cost reporting period?   24.00   If yes, see instructions.   25.00   Have there been new capitalized leases entered into during the cost reporting period? If yes, see   1.00							
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39.00   If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00   If line 36 is yes, did the provider render services to the home office? If yes, see   N   40.00	38. 00	If line 36 is yes , was the fiscal year end of the home off			N		38. 00
see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N  1.00 2.00  Cost Report Preparer Contact Information  41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 314-989-3939  JENNI FER. COHEN®SSMHEALTH. COM 43.00	20.00				V		20.00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions.  1.00 2.00  Cost Report Preparer Contact Information  41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 314-989-3939  JENNI FER. COHEN®SSMHEALTH. COM 43.00	39.00		er chain compon	ents? IT yes	, Y		39.00
instructions.  1.00 2.00  Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 314-989-3939  JENNI FER. COHEN®SSMHEALTH. COM 43.00	40. 00		home office?	If yes, see	N		40. 00
Cost Report Preparer Contact Information  41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 314-989-3939  COHEN 41.00 COHEN 41.00 42.00 JENNI FER. COHEN®SSMHEALTH. COM 43.00							
Cost Report Preparer Contact Information  41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 314-989-3939  COHEN 41.00 COHEN 41.00 42.00 JENNI FER. COHEN®SSMHEALTH. COM 43.00			1	00	2	00	-
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 314-989-3939  JENNI FER. COHEN 41.00 42.00 43.00		Cost Report Preparer Contact Information	1.	00			
respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 314-989-3939  JENNI FER. COHEN@SSMHEALTH. COM 43.00	41. 00	Enter the first name, last name and the title/position	JENNI FER	COHEN		41. 00	
42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 314-989-3939  SSM HEALTH  JENNI FER. COHEN@SSMHEALTH. COM 43.00							
preparer.  43.00 Enter the telephone number and email address of the cost 314-989-3939 JENNI FER. COHEN@SSMHEALTH. COM 43.00	42 00		SSM HEALTH				42 00
43.00 Enter the telephone number and email address of the cost 314-989-3939 JENNIFER. COHEN®SSMHEALTH. COM 43.00	12.00		JOSM TIEVETTI				12.00
report preparer in columns 1 and 2, respectively.	43.00	Enter the telephone number and email address of the cost	314-989-3939		JENNI FER. COHEN	®SSMHEALTH. COM	43. 00
		report preparer in columns 1 and 2, respectively.	I			l	II

Health Financial Systems	SSM HEALTH ST.	MARYS HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der CCN:	F	Period: From 01/01/2023 o 12/31/2023	Worksheet S-2 Part II Date/Time Pro 5/21/2024 9:	epared:
					3/21/2024 7.	74 aiii
		3.00				
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the		REGIONAL DIR GOV				41. 00
held by the cost report preparer in colur	nns 1, 2, and 3,	REIMBURSEMENT				
respecti vel y.						
42.00 Enter the employer/company name of the co	ost report					42. 00
preparer.						
43.00 Enter the telephone number and email addr	ress of the cost					43.00
report preparer in columns 1 and 2, respe	ecti vel y.					

Health Financial Systems SSM HEALTH ST. MARYS HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0034
From 01/01/2023
To 12/31/2023
Date/Time Prepared:

					'	12/31/2023	5/21/2024 9:5	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
		Line No.			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		80	29, 200	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			80	29, 200	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		12	4, 380	0.00	0	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	43. 00					0	13. 00
14. 00	Total (see instructions)			92	33, 580	0.00	0	14.00
15. 00	CAH visits						0	15. 00
15. 10	REH hours and visits					0.00	0	15. 10
16. 00	SUBPROVI DER - I PF	40. 00		24	8, 760		0	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)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
25. 30	CMHC - OOT	99. 30					0	
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			116			_	27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF			_	_			31. 00
32.00	Labor & delivery days (see instructions)			0	(	ון		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges	20.00			,		_	33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	l	0	(	기	0	34. 00

Provider CCN: 14-0034

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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/21/2024 9:54 am

						5/21/2024 9: 5	4 am
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	II tie XVIII	TI LIE XIX	Patients	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 526	91	7, 986			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 465	1, 271				2.00
3.00	HMO IPF Subprovider	30	0				3.00
4.00	HMO I RF Subprovi der	0	0	0			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00 6. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	4, 526	91	7, 986			7. 00
7.00	beds) (see instructions)	4, 320	91	7, 900			7.00
8. 00	INTENSIVE CARE UNIT	464	6	936			8. 00
9. 00	CORONARY CARE UNIT	404	٩	730			9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		o	0			13. 00
14. 00	Total (see instructions)	4, 990	97	8, 922	0.00	384. 77	14.00
15. 00	CAH visits	0	o	0			15. 00
15. 10	REH hours and visits	0	o	0			15. 10
16.00	SUBPROVI DER - I PF	975	23	5, 472	0.00	34. 01	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)			0			24. 10
25. 00	CMHC - CMHC	_	_	_			25. 00
25. 30	CMHC - OOT	0	0	0	0.00	0. 00	25. 30
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0.00	26. 25
27. 00	Total (sum of lines 14-26)		20	(0)	0.00	418. 78	27. 00
28. 00	Observation Bed Days	0	30	696			28. 00
29. 00	Ambul ance Trips	0		F.1			29. 00
30.00	Employee discount days (see instruction)			51 0			30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)	0	0	0			31. 00 32. 00
32. 00	Total ancillary labor & delivery room	٥	٩	0			32. 00
32. UI	outpatient days (see instructions)			U	1		32.01
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 00
34. 00		o	o	0			34. 00
	, , , , , , , , , , , , , , , , , , , ,	-1	-1	_	1	'	

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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 14-0034

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/21/2024 9:54 am Peri od:

						5/21/2024 9: 5	4 am
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	1, 204	31	3, 321	1. 00
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			405	454		2. 00
3.00	HMO IPF Subprovider				492		3. 00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12. 00 13. 00
14. 00	Total (see instructions)	0.00	0	1, 204	31	3, 321	14. 00
15. 00	CAH visits	0.00	U	1, 204	31	3, 321	15. 00
15. 10	REH hours and visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00	0	115	57	885	16. 00
17. 00	SUBPROVI DER - I RF	0.00	· ·	110	0,	000	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)						24. 10
25. 00	CMHC - CMHC						25. 00
25. 30	CMHC - OOT	0. 00					25. 30
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambulance Trips						29. 00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. U1	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			0	ļ		33. 00
33. 01	LTCH site neutral days and discharges			Ō			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

In Lieu of Form CMS-2552-10
Period: Worksheet S-3
From 01/01/2023 Part II Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0034

					17	rom 01/01/2023 o 12/31/2023		
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	4 dili
		1. 00	2.00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	33, 186, 805	0	33, 186, 805	871, 073. 92	38. 10	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4.00	Physician-Part A - Administrative		189, 896	1, 252	191, 148	1, 252. 00	152. 67	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00		1
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		1, 153, 191	0	1, 153, 191	12, 360. 95	93. 29	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	0 3, 317, 397	-119, 606	Ŭ	0. 00 82, 015. 47		
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		3, 144, 896	0	3, 144, 896	30, 748. 06	102. 28	11. 00
12. 00	Care Contract Labor: Top Level		0, 144, 070	0		0.00		12.00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		96, 600	0	96, 600	496. 33	194. 63	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14. 00
14. 01	Home office salaries		4, 668, 671	0	4, 668, 671	76, 245. 21		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0. 00		
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0.00	16. 01
16. 02	- Teaching Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		13, 778, 389	0	13, 778, 389			17. 00
18. 00	instructions) Wage-related costs (other)		,,,,					18. 00
19. 00	(see instructions) Excluded areas		1, 434, 414	0	1, 434, 414			19. 00
20. 00	Non-physician anesthetist Part A Non-physician anesthetist Part		0	0	0			20.00
21.00	B Physician Part A -		21, 897		21, 897			21.00
	Administrative Physician Part A - Teaching		21,377	0	 			22. 00
23. 00	Physician Part B		0	Ö	ő			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		1, 653, 257	0	1, 653, 257			25. 50
25. 51	(core) Related organization wage-related (core)		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

Provider CCN: 14-0034

In Lieu of Form CMS-2552-10
Period: Worksheet S-3
From 01/01/2023 Part II

					T	0 12/31/2023	Date/Time Pre 5/21/2024 9:5	
		Wkst. A Line		Recl assi fi cati		Paid Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
0, 00	OVERHEAD COSTS - DI RECT SALARI E		400.000		400.000	40.005.00	44.04	0, 00
26. 00	Employee Benefits Department	4. 00	180, 008		180, 008	·		26. 00
27. 00	Administrative & General	5. 00	3, 300, 906		3, 300, 906	·		
28. 00	Administrative & General under		453, 251	0	453, 251	2, 408. 44	188. 19	28. 00
20.00	contract (see inst.)	6. 00	0		_	0.00	0.00	29. 00
29. 00	Maintenance & Repairs Operation of Plant	7.00	834, 133	0	834, 133		l .	
30.00	•	7. 00 8. 00	91, 574		91, 574			31.00
31. 00 32. 00	Laundry & Linen Service Housekeeping	9. 00	942, 714		942, 714	·		32.00
32.00	Housekeeping under contract	9.00	942, 714	0	942, / 14	0.00	l .	
33.00	(see instructions)		U	0	0	0.00	0.00	33.00
34. 00	Di etary	10. 00	465, 118	-322, 544	142, 574	7, 382. 07	10 21	34. 00
35. 00	Dietary under contract (see	10.00	66, 970		66, 970	·		
33.00	instructions)		00, 970	0	00, 970	2, 120.00	31.39	33.00
36. 00	Cafeteri a	11. 00	0	322, 544	322, 544	16, 700. 38	19 31	36. 00
37. 00	Maintenance of Personnel	12. 00	0	022,011	0.22,011	0.00		
38. 00	Nursing Administration	13. 00	818, 917	0	818, 917			38. 00
39. 00	Central Services and Supply	14. 00	294, 588		294, 588	·		
40. 00	Pharmacy	15. 00	1, 156, 462		1, 156, 462	·		
41. 00	Medical Records & Medical	16. 00	.,,	0	0	0.00		
00	Records Library		· ·			0.00	0.00	111.00
42.00	Social Service	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

SSM HEALTH ST. MARYS HOSPITAL

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | Part | To 12/31/2024 | Part | Par Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0034

							5/21/2024 9: 54	4 am
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		32, 553, 835	0	32, 553, 835	863, 241. 41	37. 71	1. 00
	instructions)							
2.00	Excluded area salaries (see		3, 317, 397	-119, 606	3, 197, 791	82, 015. 47	38. 99	2.00
	instructions)							
3.00	Subtotal salaries (line 1		29, 236, 438	119, 606	29, 356, 044	781, 225. 94	37. 58	3.00
	minus line 2)							
4.00	Subtotal other wages & related		7, 910, 167	0	7, 910, 167	107, 489. 60	73. 59	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		15, 453, 543	0	15, 453, 543	0.00	52. 64	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		52, 600, 148	119, 606	52, 719, 754	888, 715. 54	59. 32	6.00
7.00	Total overhead cost (see		8, 604, 641	0	8, 604, 641	255, 514. 16	33. 68	7.00
	instructions)							

HUSPII	AL WAGE RELATED COSTS	Provider CCN: 14-0034	From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre 5/21/2024 9:5	pared: 4 am
				Amount	
				Reported	
				1. 00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution Nongualified Defined Benefit Plan Cost (see instructions)			0	2. 00
3.00		773, 893	3. 00		
4.00 Qualified Defined Benefit Plan Cost (see instructions)					4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			997, 392	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 Administr	ator)		9, 177, 822	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrato	r)		0	8. 02
8.03	Health Insurance (Purchased)			0	8. 03
9.00	Prescription Drug Plan			469, 716	9. 00
10.00	Dental, Hearing and Vision Plan			658, 542	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)			31, 848	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)			5, 780	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)			66, 289	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary	)		417, 735	14. 00
15. 00	'Workers' Compensation Insurance			0	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extra	ordinary accrual require	ed by FASB 106.	0	16. 00
	Noncumulative portion)				
	TAXES				
	FICA-Employers Portion Only			2, 475, 939	17. 00
	Medicare Taxes - Employers Portion Only			0	
19. 00	Unemployment Insurance			154, 861	19. 00

Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see

0 20.00

4, 883

15, 234, 700

0 21.00

22.00

23. 00

24. 0025. 00

20.00 State or Federal Unemployment Taxes

Day Care Cost and Allowances

23.00 Tuition Reimbursement

24.00 Tuition Reimbursement

Total Wage Related cost (Sum of Lines 1 -23)

Part B - Other than Core Related Cost

25.00 OTHER WAGE RELATED COSTS (SPECIFY)

OTHER

instructions))

21.00

22.00

Health Financial Systems	SSM HEALTH ST. MARYS HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 14-0034	Peri od: Worksheet S-3
		From 01/01/2023   Part V

		F	1011 01/01/2023	Part V	
		Т	0 12/31/2023	Date/Time Prep 5/21/2024 9:54	
	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		3, 144, 896	15, 234, 700	1.00
2.00	Hospi tal		3, 144, 896	13, 778, 389	2.00
3.00	SUBPROVI DER - I PF		0	1, 362, 986	3.00
4.00	SUBPROVI DER - I RF				4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	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				14.00
15. 00	Hospital-Based Health Clinic FQHC				15.00
16. 00	Hospi tal -Based-CMHC				16.00
16. 30	Hospi tal -Based-CMHC 30		0	0	16. 30
17.00	RENAL DIALYSIS I		0	0	17.00
18. 00	Other		0	93, 325	18.00

	Financial Systems	SSM HEALTH ST. MARYS H				u of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Pro	rovider CCN:	F	Period: From 01/01/2023 To 12/31/2023		pared:
						1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DAT	ΓΑ				1.00	
	Uncompensated and Indigent Care Cost-to-Ch	narge Ratio					1
1.00	Cost to charge ratio (see instructions)					0. 233676	1.00
	Medicaid (see instructions for each line)						
2.00						13, 456, 860	2. 00
3.00	Did you receive DSH or supplemental paymer						3. 00
4.00	If line 3 is yes, does line 2 include all			from Medicai	d?		4. 00
5.00	If line 4 is no, then enter DSH and/or sup	pplemental payments from	m Medicaid			0 104, 826, 828	5. 00
							6. 00
7.00						24, 495, 514	7. 00 8. 00
8. 00	00 Difference between net revenue and costs for Medicaid program (see instructions)  Children's Health Insurance Program (CHIP) (see instructions for each line)						8.00
9. 00							9.00
	Stand-alone CHIP charges					0	
	Stand-alone CHIP cost (line 1 times line 1	10)				0	
	Difference between net revenue and costs 1		ee instructi	ions)		0	
	Other state or local government indigent of	care program (see instru	uctions for	each line)			1
13.00	Net revenue from state or local indigent of					0	13. 00
14.00	Charges for patients covered under state of	or local indigent care p	program (Not	t included i	n lines 6 or	0	14. 00
	10)					_	
15.00	State or local indigent care program cost			,		0	
	Difference between net revenue and costs 1 Grants, donations and total unreimbursed of					0	16. 00
	instructions for each line)	LOST FOI MEDICALD, CHIP	and State/i	ocai indige	iit care program	is (see	
	Private grants, donations, or endowment in	ncome restricted to fund	ding charity	v care		0	17. 00
	Government grants, appropriations or trans					0	
19.00					(sum of lines	11, 038, 654	19. 00
	8, 12 and 16)						
				Uni nsured	Insured	Total (col. 1	
			_	pati ents	pati ents	+ col . 2)	
				1. 00	2. 00	3. 00	
	Uncompensated care cost (see instructions Charity care charges and uninsured discour			4, 185, 906	479, 736	4, 665, 642	20.00
21. 00	Cost of patients approved for charity care		ts (soo	978, 146			
21.00	linstructions)	c and animoured arscount	13 (300	770, 140	477,730	1, 457, 002	21.00
22. 00		ts previously written of	ff as	1, 022, 730	479, 736	1, 502, 466	22. 00
	charity care						
23.00	Cost of charity care (see instructions)			(	0	0	23. 00

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00  $\mid$ Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

Bad debt amount (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

1.00

3, 408, 661

2, 527, 307

572, 881

881, 354

899, 044

899, 044

11, 937, 698 31. 00

24.00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

0 25.00

25.00

25. 01

27. 00

27.01

28.00

stay limit

Hool +b	Financial Systems	SSM HEALTH ST. MARY	'S LIOSDI TAI		Inlia	u of Form CMS (	DEED 10	
	Financial Systems AL UNCOMPENSATED AND INDIGENT CARE DAT.		Provider CCN: 14-C		eriod: rom 01/01/2023		0 pared:	
						1. 00		
	PART II - HOSPITAL DATA							
	Uncompensated and Indigent Care Cost-t							
	the state of the state (and the state of the						1.00	
	Medicaid (see instructions for each li	ne)						
2.00	Net revenue from Medicaid						2. 00	
3. 00							3. 00	
4.00	If line 3 is yes, does line 2 include			Medi cai d	d?		4. 00	
5.00	If line 4 is no, then enter DSH and/or	supplemental payments f	rom Medicaid				5. 00 6. 00	
							7.00	
							8.00	
	Children's Health Insurance Program (CHIP) (see instructions for each line)							
	Stand-alone CHIP charges						10.00	
	Stand-alone CHIP cost (line 1 times li	ne 10)					11. 00	
12.00	Difference between net revenue and cos	sts for stand-alone CHIP	(see instructions)	)			12. 00	
	Other state or local government indige	nt care program (see ins	tructions for each	ı line)				
	Net revenue from state or local indige						13. 00	
14. 00	Charges for patients covered under sta	ite or local indigent car	e program (Not ind	oluded in	n lines 6 or		14. 00	
45.00	10)						45.00	
				/ :			15.00	
	Difference between net revenue and cos Grants, donations and total unreimburs					ns (soo	16. 00	
	instructions for each line)	ed Cost for Medicard, Chi	ir and State/Tocal	i nui gei	it care program	is (see		
17. 00	Private grants, donations, or endowmer	nt income restricted to f	unding charity car	re			17. 00	
	Government grants, appropriations or						18. 00	
	Total unreimbursed cost for Medicaid,				(sum of lines		19. 00	
	8, 12 and 16)		J 1		`			
				sured	Insured	Total (col. 1		
				ients	pati ents	+ col . 2)		
				. 00	2. 00	3. 00		
	Uncompensated care cost (see instructi		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	000 747	4/5 200	4 255 127	20.00	
	Charity care charges and uninsured dis Cost of patients approved for charity			, 889, 747	465, 389 465, 389			
∠1.00	instructions)	care and unitisured disco	uiits (See	847, 568	400, 389	1, 312, 957	21.00	
		nounts previously written	off as	946, 494	465, 389	1, 411, 883	22. 00	
22 00	readments received from patrents for an							
22. 00	charity care	.ounte proviouery miritian				.,,	22.00	

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00  $\mid$ Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

Bad debt amount (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

1.00

3, 208, 247

2, 368, 660

545, 732

839, 587

809, 981

809, 981

809, 981 31. 00

24.00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

0 25.00

25.00

25. 01

27. 00

27.01

28. 00

stay limit

Health Financial Systems In Lieu of Form CMS-2552-10 RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 14-0034 Peri od: Worksheet A From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 9:54 am 1 Reclassi fi cati Cost Center Description 0ther Sal ari es Total (col. Reclassi fied + col . 2) ons (See A-6) Trial Balance (col. 3 +-col. 4) 1.00 4.00 2.00 3.00 5.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1, 455, 300 1, 455, 300 1, 455, 300 1.00 2, 404, 490 2, 404, 490 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2, 404, 490 2.00 0 00400 EMPLOYEE BENEFITS DEPARTMENT -295 4.00 180 008 13, 156, 311 13, 336, 319 13, 336, 024 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 3, 300, 906 21, 335, 651 24, 636, 557 -35, 578 24, 600, 979 5.00 7.00 00700 OPERATION OF PLANT 834, 133 3, 576, 417 4, 410, 550 61, 106 4, 471, 656 7.00 00800 LAUNDRY & LINEN SERVICE 91.574 313, 848 405, 422 -774 404, 648 8.00 8.00 00900 HOUSEKEEPI NG 9.00 942, 714 341,007 1, 283, 721 -23, 445 1, 260, 276 9.00 381, 180 10.00 01000 DI ETARY 465, 118 779, 011 1, 244, 129 862, 949 10.00 01100 CAFETERI A 862, 762 862, 762 11.00 11.00 01300 NURSING ADMINISTRATION 905, 268 1, 724, 185 818 917 -353 1, 723, 832 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 294, 588 105, 261 399, 849 -130, 913 268, 936 14.00 15.00 01500 PHARMACY 1, 156, 462 4, 254, 888 5, 411, 350 -4, 019, 833 1, 391, 517 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 657 657 657 16.00 01700 SOCIAL SERVICE 10, 263 10, 263 17.00 -54 10, 209 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 320, 895 2, 644, 926 7, 965, 821 90, 581 8, 056, 402 30.00 03100 INTENSIVE CARE UNIT 31 00 1 403 387 516, 332 1 919 719 -496 569 1, 423, 150 31 00 40.00 04000 SUBPROVIDER - IPF 2, 969, 087 120, 983 3, 090, 070 20, 162 3, 110, 232 40.00 04300 NURSERY 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 2 019 007 4 486 590 6, 505, 597 -3, 480, 666 3 024 931 50 00 51.00 05100 RECOVERY ROOM 938, 139 138, 849 1,076,988 -102, 448 974, 540 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 53 00 05300 ANESTHESI OLOGY 3, 646, 794 3, 646, 794 -93 735 3, 553, 059 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 133, 523 119, 736 1, 253, 259 -70, 184 1, 183, 075 54.00 05500 RADI OLOGY-THERAPEUTI C 550, 174 123, 145 673, 319 -2, 241 671, 078 55.00 55.00 56.00 05600 RADI 0I SOTOPE 106, 212 344, 396 450, 608 -2, 354 448, 254 56.00 57 00 05700 CT SCAN 339, 469 279, 231 618 700 -55, 132 563, 568 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 171, 719 43, 358 215, 077 -10, 275 204, 802 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 0 60.00 06000 LABORATORY 1, 376, 262 2, 329, 707 3, 705, 969 -1, 042, 386 2, 663, 583 60.00 06400 I NTRAVENOUS THERAPY -26, 291 305, 688 279, 397 64.00 270, 439 35, 249 64 00 65.00 06500 RESPIRATORY THERAPY 1, 151, 014 523, 955 1, 674, 969 -96, 571 1, 578, 398 65.00 06600 PHYSI CAL THERAPY 1, 568, 699 66.00 1, 404, 876 163, 823 82, 185 1, 650, 884 66.00 66, 01 03340 CLINICAL NUTRITION 122, 264 476 122, 740 122, 740 66.01 10, 977 06700 OCCUPATIONAL THERAPY 172, 525 67.00 159, 747 1.801 161, 548 67 00 68.00 06800 SPEECH PATHOLOGY 125, 091 778 125, 869 8, 117 133, 986 68.00 69 00 06900 ELECTROCARDI OLOGY 906, 338 398, 750 1, 305, 088 -66, 069 1, 239, 019 69 00 03140 CARDIAC REHABILITATION 114, 388 69.01 69.01 112.349 114, 518 2. 169 -130 07000 ELECTROENCEPHALOGRAPHY 70.00 63, 639 139, 086 202, 725 -8, 102 194, 623 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 C 4, 421, 575 4, 421, 575 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 1, 675, 798 1, 675, 798 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 992, 997 73.00 0 C 0 3, 992, 997 73.00 74.00 07400 RENAL DIALYSIS 111 111 -104 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2, 065, 960 1, 299, 377 3, 365, 337 -105, 905 3, 259, 432 90.00 09100 EMERGENCY 91.00 2.044.484 2, 178, 289 4, 222, 773 -348, 530 3, 874, 243 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.30 99.30 09930 00T 119,606 119,606 -128.438-8.832 102.00 10200 OPIOID TREATMENT PROGRAM 0 102. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 15, 936 32, 958, 101 68, 176, 283 101, 134, 384 101, 150, 320 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 6,770 994 7, 764 190. 00 7,764 191. 00 19100 RESEARCH 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES ol 159, 501 192, 00 164, 619 -5. 118 159, 501 192. 01 19201 PHYSI CI ANS' PRI VATE OFFI CES 0 0 192. 01 194. 00 07950 NON-REI MBURSABLE 57, 315 237, 062 294, 377 -15, 936 278, 441 194. 00 194. 01 07951 NON-REI MBURSABLE 0 0 194. 01 0 C 194. 02 07952 NON-REI MBURSABLE 0 0 0 194 02 0 194. 03 07953 CONTRACT PHARMACY 25, 664 25, 664 0 25, 664 194. 03 200.00 TOTAL (SUM OF LINES 118 through 199) 33, 186, 805 101, 621, 690 0 101, 621, 690 200. 00 68, 434, 885

SSM HEALTH ST. MARYS HOSPITAL In Lieu of Form CMS-2552-10

 
 Health Financial
 Systems
 SSM HEALTH S

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 | Period: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/21/2024 9:54 am | Provider CCN: 14-0034

				5/21/2024 9:5	54 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
	OFNEDAL CEDIUSE COCT OFNEDO	6. 00	7.00		
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	856, 948	2, 312, 248		1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT	490, 229		•	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 725, 162		•	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-10, 324, 152		1	5. 00
7.00	00700 OPERATION OF PLANT	-80, 101		•	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	404, 648		8. 00
9.00	00900 HOUSEKEEPI NG	-46, 535		•	9. 00
10. 00	01000 DI ETARY	0	381, 180	•	10. 00
11.00	01100 CAFETERI A	-258, 444		•	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	-217, 555		1	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-45, 661		l .	14. 00
15. 00 16. 00	01500   PHARMACY   01600   MEDICAL RECORDS & LIBRARY	-19, 775 -1, 797		1	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	-1, 747			17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS		10, 207		17.00
30.00	03000 ADULTS & PEDI ATRI CS	-1, 840, 916	6, 215, 486		30.00
31.00	03100 INTENSIVE CARE UNIT	7, 719	1, 430, 869		31. 00
40.00	04000 SUBPROVI DER - I PF	-62, 969	3, 047, 263		40.00
43.00	04300 NURSERY	0	0		43. 00
	ANCILLARY SERVICE COST CENTERS				4
50.00	05000 OPERATI NG ROOM	-185, 648		•	50.00
51.00	05100 RECOVERY ROOM	0		l .	51.00
52. 00 53. 00	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	-3, 457, 683	0 95, 376	l .	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-3, 457, 663		•	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	-19, 720		•	55. 00
56. 00	05600 RADI OI SOTOPE	0		•	56.00
57. 00	05700 CT SCAN	-3		•	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	204, 802		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	l .	59. 00
60.00	06000 LABORATORY	-217, 205		•	60. 00
64. 00	06400 I NTRAVENOUS THERAPY	-1	279, 396	•	64. 00
65. 00	06500 RESPI RATORY THERAPY	-30, 233		•	65. 00
66.00	06600 PHYSI CAL THERAPY	-86, 385 0		•	66.00
66. 01 67. 00	03340  CLINICAL NUTRITION   06700  OCCUPATIONAL THERAPY	0	122, 740 172, 525	•	66. 01 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	133, 986	1	68. 00
69. 00	06900 ELECTROCARDI OLOGY	-231, 832		1	69. 00
69. 01	03140 CARDI AC REHABI LI TATI ON	0	114, 388		69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	-120, 879		•	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-527, 543	3, 894, 032		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 675, 798		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	3, 992, 997	•	73. 00
74. 00	07400 RENAL DIALYSIS	0	7		74. 00
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	-742, 467	2 514 045		90.00
	09100 EMERGENCY	-742, 467 -753, 684		•	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-733,004	3, 120, 337		92.00
72.00	OTHER REIMBURSABLE COST CENTERS				72.00
99. 30	09930 00T	0	-8, 832		99. 30
102.00	10200 OPIOID TREATMENT PROGRAM	0		•	102. 00
	SPECIAL PURPOSE COST CENTERS				
118.00		-13, 194, 776	87, 955, 544		118. 00
400.5	NONREI MBURSABLE COST CENTERS	1 =			100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
	19100  RESEARCH  19200  PHYSI CI ANS' PRI VATE OFFI CES		150 501	l control of the cont	191. 00 192. 00
	19200  PHYSICIANS   PRIVATE OFFICES   19201  PHYSICIANS'   PRIVATE OFFICES		159, 501		192. 00
	07950 NON-REI MBURSABLE		278, 441		194. 00
	07951 NON-REI MBURSABLE	0	270, 441	1	194. 00
	07952 NON-REI MBURSABLE	0	Ö	•	194. 02
	07953 CONTRACT PHARMACY	0	25, 664	l control of the cont	194. 03
200.00		-13, 194, 776		1	200. 00

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 14-0034

Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/21/2024 9:54 am

COCK CENTER**   Increases						/2024 9:54 am
			Increases			
A - DRUG SUPPLY IMPLANT IV, AND BLOOD 1.00		Cost Center	Li ne #	Sal ary	0ther	
1.00   MEDICAL SUPPLIES CHARGED TO   71.00   0   4.471,575   2.00   NATL DEV. CHARGED TO   72.00   0   1.675,796   2.00   NATL DEV. CHARGED TO   72.00   0   1.675,796   2.00   NATL DEV. CHARGED TO   ATTENTS   73.00   0   0   0   0   0   0   0   0   0		2. 00	3.00	4.00	5. 00	
1.00   PATIENTS   1.00   1.07   1.00   1.4.21,575   1.00   1.07   1.00   1.07   1.00   1.07   1.00   1.07   1.00   1.07   1.00   1.07   1.00   1.07   1.00   1.07   1.00   1.07   1.00   1.07   1.00		A - DRUG, SUPPLY, IMPLANT, IN	/, AND BLOOD			
2.00   MPL DLY. CHARGED TO   72.00   0   1,675,798   2   20	1.00	MEDICAL SUPPLIES CHARGED TO		0	4, 421, 575	1. 00
3.00 4.00 5.00 6.00 6.00 7.00 7.00 7.00 7.00 7.00 7	2. 00	IMPL. DEV. CHARGED TO	72. 00	0	1, 675, 798	2. 00
5.00		I				
Color			· •		-	
7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9			· •		-	•
8.00 9.00 10.00 9.00 10.00 0.00 0.00 0.00					-	
9,00 10,00 10,00 11,00 10,00 11,00 1			· •		J	
10.00			· · · · · · · · · · · · · · · · · · ·		_	•
11.00			· •		-	•
12,00			· · · · · · · · · · · · · · · · · · ·		_	
13.00					-	
14.00   0.00   0   0   0   14.00   15.00   16.00   16.00   16.00   17.00   0.00   0   0   0   17.00   18.00   17.00   0.00   0   0   0   0   18.00   19.00			· •		_	
15.00					-	
16.00					-	
17. 00					-	
18. 00			· · · · · · · · · · · · · · · · · · ·		-	
19,00			· · · · · · · · · · · · · · · · · · ·		-	
20.00					-	
21.00					-	
22.00			l .		-	
23.00 24.00 24.00 25.00 26.00 0.00 0.00 0.00 0.00 0.00 0.00			· · · · · · · · · · · · · · · · · · ·		-	
24. 00 25. 00 26. 00 26. 00 26. 00 27. 00 28. 00 28. 00 29. 00 30. 00 30. 00 30. 00 31. 00 31. 00 31. 00 31. 00 31. 00 32. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 36. 00 37. 00 38					-	
25. 00					-	
26. 00 27. 00 28. 00 27. 00 28. 00 29. 00 30. 00 30. 00 31. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					-	
27,00			· •		-	
28. 00 29. 00 30. 00 30. 00 31. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			· · · · · · · · · · · · · · · · · · ·		_	
29,00					0	
30.00 31.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	
31.00				1	_	
1.00				- 1	-	•
B - DI ETARY	31.00					31.00
1.00 CAFETERIA 11.00 322,544 540,218 0		D DIETADV		- υ	10, 090, 370	
C - IMPATIENT L&D   C - IMPATIENT L&D	1 00		11 00	322 544	540 218	1 00
C - IMPATIENT L&D   ADULTS & PEDIATRICS   30.00   254,087   123,373   1.00	1.00	0				1.00
1. 00   ADULTS & PEDI ATRI CS   30. 00   254, 087   123, 373   254, 087   123, 373   123, 373   120		C _ IMPATIENT I&D	1	322, 344	340, 210	
Correction   Cor	1 00		30.00	254 087	123 373	1 00
E - UTILITIES	1.00				123 373	1.00
1. 00 OPERATI ON OF PLANT 7. 00 0 61, 430 1. 00 2. 00 3. 00 0. 00 0 0 0 0 3. 00 4. 00 0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0		E - UTILITIES		== ., ==.,	120, 51.5	
2.00 3.00 4.00 5.00 6.00  D THENSIVE CARE UNIT 31.00 SUBPROVI DER - I PF DO D THENSIVE CARE UNIT 1.00 D THENSIVE CARE THENSIVE C	1.00		7. 00	0	61, 430	1.00
3.00 4.00 5.00 6.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
4.00 5.00 6.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00		0.00	o	О	
6. 00    0	4.00		0.00	О	0	4. 00
1.00   ADULTS & PEDIATRICS   30.00   0   72,427   1.00	5.00		0.00	0	0	5. 00
F - PUMP RECLASS   30.00   0   72,427   1.00	6.00		0.00	0	0	6. 00
1. 00 ADULTS & PEDI ATRI CS 30. 00 0 72, 427 1. 00 2. 00 I NTENSI VE CARE UNI T 31. 00 0 8, 459 2. 00 3. 00 SUBPROVI DER - I PF 40. 00 0 49, 661 0 3. 00 H - REHAB ADMI N 1. 00 PHYSI CAL THERAPY 66. 00 102, 467 6, 340 1. 00 2. 00 OCCUPATI ONAL THERAPY 67. 00 9, 249 2, 265 2. 00 3. 00 SPEECH PATHOLOGY 68. 00 7, 890 227 0 3. 00 0 119, 606 8, 832				0	61, 430	
2. 00   INTENSIVE CARE UNIT   31. 00   0   8, 459   2. 00   3. 00   0   49, 661   0   0   130, 547						
3. 00 SUBPROVI DER - I PF 40. 00 0 49, 661 0 130, 547 H - REHAB ADMI N  1. 00 PHYSI CAL THERAPY 66. 00 102, 467 6, 340 1. 00 0 CCUPATI ONAL THERAPY 67. 00 9, 249 2, 265 2. 00 3. 00 SPEECH PATHOLOGY 68. 00 7, 890 227 0 119, 606 8, 832						
O						
H - REHAB ADMIN	3.00	SUBPROVI DER - I PF	40.00			3.00
1. 00     PHYSI CAL THERAPY     66. 00     102, 467     6, 340       2. 00     OCCUPATI ONAL THERAPY     67. 00     9, 249     2, 265       3. 00     SPEECH PATHOLOGY     68. 00     7, 890     227       0     119, 606     8, 832		0		0	130, 547	
2. 00     OCCUPATI ONAL THERAPY     67. 00     9, 249     2, 265       3. 00     SPEECH PATHOLOGY     68. 00     7, 890     227       0     119, 606     8, 832						
3. 00 <u>SPEECH_PATHOLOGY</u>						
0 119, 606 8, 832						
	3. 00	SPEECH PAIHOLOGY				3.00
300. 00 pi anu 10 tai . Trici eases     090, 237  10, 954, 770    500. 00	E00.00	Crand Tatal: Imanages				F00 00
	500. 00	priand rotal: increases	ı l	090, 237	10, 954, 770	500.00

Provider CCN: 14-0034

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/21/2024 9:54 am

						5/21/2024 9:	54 alli
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9.00	10. 00		
	A - DRUG, SUPPLY, IMPLANT, IN	/, AND BLOOD					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	295	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	o	8, 195			2. 00
							1
3. 00	OPERATION OF PLANT	7. 00	0	324			3. 00
4.00	LAUNDRY & LINEN SERVICE	8. 00	0	774	0		4. 00
5.00	HOUSEKEEPI NG	9. 00	0	22, 475	0		5. 00
6.00	DI ETARY	10.00	0	187	0		6. 00
7.00	NURSING ADMINISTRATION	13.00	ol	353	ol		7. 00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	366	o		8. 00
9. 00	PHARMACY	15.00	ő	4, 019, 833			9. 00
					1		1
10. 00	ADULTS & PEDIATRICS	30.00	0	359, 266	1		10. 00
11. 00	INTENSIVE CARE UNIT	31.00	0	127, 568			11.00
12.00	SUBPROVI DER - I PF	40.00	0	29, 499	0		12. 00
13.00	OPERATING ROOM	50.00	0	3, 480, 666	0		13.00
14.00	RECOVERY ROOM	51.00	o	102, 448			14.00
15. 00	ANESTHESI OLOGY	53. 00	o	93, 735			15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54.00	o				16. 00
	I		-	70, 184			
17. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	2, 241			17. 00
18. 00	RADI OI SOTOPE	56.00	0	2, 354	0		18. 00
19.00	CT SCAN	57.00	0	55, 132	0		19. 00
20.00	MAGNETIC RESONANCE IMAGING	58.00	ol	10, 275	ol		20.00
	(MRI)						
21. 00	LABORATORY	60.00	o	1, 042, 386	o		21. 00
	1			· · ·			
22. 00	INTRAVENOUS THERAPY	64.00	0	26, 291	0		22. 00
23. 00	RESPIRATORY THERAPY	65. 00	0	96, 571	0		23. 00
24. 00	PHYSI CAL THERAPY	66.00	0	9, 575	0		24. 00
25.00	OCCUPATI ONAL THERAPY	67.00	0	537	0		25. 00
26.00	ELECTROCARDI OLOGY	69.00	ol	66, 069	ol		26. 00
27. 00	CARDIAC REHABILITATION	69. 01	o	130			27. 00
28. 00	ELECTROENCEPHALOGRAPHY	70.00	Ö	8, 102	o		28. 00
			ĭ				
29. 00	RENAL DI ALYSI S	74. 00	0	104			29. 00
30.00	CLINIC	90.00	0	105, 905			30. 00
31. 00	EMERGENCY	91.00	0	348, 530	0		31.00
		- $  -$	o	10, 090, 370			
	B - DIETARY						1
1.00	DI ETARY	10.00	322, 544	540, 218	0		1.00
1.00		— <del>10.00</del>		540, 218			1.00
	O LMDATIENT LOD		322, 544	540, 218			_
	C - IMPATIENT L&D				1		4
1. 00	INTENSIVE CARE UNIT	31.00	25 <u>4, 0</u> 87	12 <u>3, 3</u> 73			1.00
	0		254, 087	123, 373			
	E - UTILITIES						Ī
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	27, 383	0		1.00
2. 00	HOUSEKEEPI NG	9.00	o	970			2. 00
	•						1
3.00	SOCI AL SERVI CE	17. 00	0	54			3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	40			4. 00
5.00	PHYSI CAL THERAPY	66.00	0	17, 047	0		5. 00
6.00	NON-REI MBURSABLE	194.00	0	15, 936	0		6. 00
				61, 430			İ
	F - PUMP RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	130, 547	0		1. 00
	CLIVINAL SERVICES & SUFFEI			130, 547			
2.00		0.00	0	0	0		2. 00
3.00			0	0	0		3. 00
	0		0	130, 547			
	H - REHAB ADMIN						
1.00	ООТ	99. 30	119, 606	8, 832	0		1.00
2. 00		0.00	0	0, 002			2. 00
3. 00		0.00	0	0			3. 00
3.00		— — <u>-0.</u> 00		— — <u>—                                 </u>	— — Ч		3.00
	U		119, 606	8, 832			
500.00	Grand Total: Decreases		696, 237	10, 954, 770			500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 14-0034 Peri od: Worksheet A-7 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/21/2024 9:54 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 301, 090 1, 060 1, 060 0 1.00 714, 463 72, 847 2.00 Land Improvements 72, 847 0 0 2.00 209, 521 3.00 47, 128, 193 -43, 796 165, 725 3.00 Buildings and Fixtures 0 4.00 Building Improvements 648, 846 131, 903 -592, 636 -460, 733 0 4.00 5.00 Fixed Equipment 5, 561, 439 658, 319 658, 319 703, 650 5.00 34, 369, 271 6.00 Movable Equipment 2, 209, 288 636, 432 2, 845, 720 109, 221 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 89, 723, 302 3, 282, 938 0 3, 282, 938 812, 871 8.00 9.00 Reconciling Items 0 9.00 3<u>, 282, 938</u> 812, 871 Total (line 8 minus line 9) 89, 723, 302 10.00 0 3, 282, 938 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 302, 150 0 1.00 2.00 Land Improvements 787, 310 0 2.00 47, 293, 918 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 188, 113 4.00 5.00 Fi xed Equipment 5, 516, 108 0 5.00 6.00 Movable Equipment 37, 105, 770 0 6.00 7. 00 7.00 HIT designated Assets 0

92, 193, 369

92, 193, 369

0

0

Health Financial Systems	SSM HEALTH ST. MARYS HOSPITAL	In Lieu	u of Form CMS-2552-1
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 14-0034	From 01/01/2023 To 12/31/2023	Worksheet A-7 Part II Date/Time Prepared: 5/21/2024 9:54 am
	SUMMARY OF CAR	PLTAL	

				'	0 12/01/2020	5/21/2024 9:5	
			SL	JMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	,	
					instructions)	instructions)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	1, 726, 703	0	-271, 403	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 404, 490	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4, 131, 193	0	-271, 403	0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 455, 300				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	o	2, 404, 490				2. 00
3.00	Total (sum of lines 1-2)	o	3, 859, 790				3. 00

Heal th	n Financial Systems	SSM HEALTH ST. I	MARYS HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part III Date/Time Prep 5/21/2024 9:54	pared: 4 am
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)		Insurance	
	DART III DECONOLILATION OF CARLTAL COCTO	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	49, 571, 490	1 0	49, 571, 49	0. 537690	0	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	49, 571, 490		49, 571, 49			2.00
3.00	Total (sum of lines 1-2)	92, 193, 367		92, 193, 36			3. 00
0.00	Trotal (sam or rines i 2)	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITA			0.00		
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			_		
1.00	CAP REL COSTS-BLDG & FLXT	0	0	1	1, 975, 332		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1	2, 894, 719		2. 00
3.00	Total (sum of lines 1-2)	0	0	JMMARY OF CAPI	4, 870, 051	0	3. 00
	Cost Center Description	Interest	Insurance (see instructions)	,	Other Capital -Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	336, 916	0		0 0	2, 312, 248	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	2, 894, 719	2. 00
3. 00	Total (sum of lines 1-2)	336, 916	0	1	0	5, 206, 967	3. 00

| Period: | Worksheet A-8 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

Cost Center Description   Sesis/Code (2)   Anount   Cost Center   Using # Most A-7 Ref					T	0 12/31/2023	Date/Time Prep 5/21/2024 9:54	
Cost Center Description   Desis SrCode (2)   Amount   Cost Center   Line #   Mist A-7 B0F							3/21/2024 9.32	+ alli
1.00   Investment   Income					To/From Which the Amount is	to be Adjusted		
1.00   Investment Income								
1.00   Investment   Income								
1.00   COSTS-BLDG & FIXT   1.00   0   1.00		Cost Center Description						
Investment Income - CAP REL   OCAP REL COSTS-MBLE FOUIP   2.00   0.200   0.300   0.300   0.000   0.300   0.000   0.300   0.000   0.300   0.0	1.00	Investment income - CAP REL	1.00					1. 00
COSTS-MVELE EQUIP (chapter 2) 3. 00   Investment income - other (chapter 2) 4. 00   Trade greater 1 income - other (chapter 2) 5. 00   Refunds and rehates of expenses (chapter 8) 5. 00   Refunds and rehates of expenses (chapter 9) 6. 00   Refunds and rehates of expenses (chapter 9) 7. 00   Suppliers (Chapter 9) 7. 00   Suppliers (Chapter 10) 7. 00   Stations excluded) (chapter 2) 7. 01   Tolevision and radio service (chapter 2) 7. 01   Tolevision and radio service (chapter 1) 7. 02   Tolevision and radio service (chapter 1) 7. 03   Tolevision and radio service (chapter 1) 7. 04   Tolevision and radio service (chapter 1) 7. 05   Tolevision and radio service (chapter 1) 7. 06   Tolevision and radio service (chapter 1) 7. 07   Tolevision and radio service (chapter 1) 7. 08   Tolevision and radio service (chapter 1) 7. 09   Tolevision and radio service (chapter 1) 7. 00   Chapter 1) 7. 00   Tolevision and radio service (chapter 1) 7. 00   Tolevision and surgical suppliers to other than patients (chapter 1) 7. 05   Tolevision and surgical suppliers to other than patients (chapter 1) 7. 07   Tolevision and surgical suppliers to other than patients (chapter 1) 7. 08   Tolevision and surgical suppliers to other than patients (chapter 2) 7. 00   Tolevision and surgical suppliers to other than patients (chapter 2) 7. 00   Tolevision and surgical suppliers to other than patients (chapter 2) 7. 00   Tolevision and surgical suppliers to other than patients (chapter 2) 7. 00   Tolevision and surgical suppliers to other than patients (chapter 2) 7. 00   Tolevision and surgical suppliers (chapter 2) 7. 00   Tolevision and s	2.00			0	CAD DEL COSTS MADLE FOLLID	2 00	0	2 00
Chapter 2)	2.00			Ü	CAP REL COSTS-WVBLE EQUIP	2.00		
1.00   1.00	3. 00			0		0. 00	0	3. 00
Section   Sect	4.00	Trade, quantity, and time		0		0.00	О	4. 00
0.00   0.00	5. 00			0		0. 00	О	5. 00
Suppliers (chapter 8)   7.00   Telephone services (pay stations excluded) (chapter 2)   8.00   Television and radio service (chapter 2)   0.00   Television and radio service (chapter 2)   0.00   0	4 00			0		0.00		4 00
Stations excluded)   Chapter   20	6.00			U		0.00	o o	6.00
210	7. 00		A	0	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
Chapter 21)		21)						
9.00   Parking I of (chapter 21)   0   0.00   0   9.00   0   0.00   0   9.00   0   10.00   10.	8. 00			0		0.00	0	8. 00
adjustment		Parking Lot (chapter 21)	4.0.2	0		0. 00		
Cchapter 23   Chapter 23   Chapter 23   Chapter 10   12 00   Retail of organization (helpter 10)   13 00   Laundry and line service   0	10.00		A-8-2	-8, 098, 036				10.00
12.00   Related organization   Chapter 10	11. 00			0		0. 00	0	11. 00
13. 00   Laundry and linen service   0   0.00   0.13. 00     14. 00   Cafterria -employees and guests   B   -258, 444 (AFETERIA   11. 00   0.00   0.14. 00     15. 00   Rental of quarters to employee and others   0.00   0.00   0.00   0.15. 00     16. 00   Sale of medical and surgical supplies to other than patients   0   0.00   0.00   0.16. 00     17. 00   Datients   0.00   0.00   0.17. 00     18. 00   Sale of medical records and abstracts   0   0.00   0.17. 00     18. 00   Sale of medical records and abstracts   0   0.00   0.00   0.18. 00     19. 00   Varing and allied health   0   0.00   0.00   0.00   0.00     19. 00   Varing and allied health   0   0.00   0.00   0.00   0.00     10. 00   Income from imposition of interest, finance or penalty charges (chapter 21)   0.00     22. 00   Income from imposition of interest, finance or penalty charges (chapter 21)   0.00     24. 00   Adjustment for respiratory therapy costs in excess of limitation (chapter 14)   0.00     25. 00   Utilization review   0   0.00   0.00   0.00     26. 00   0.00   0.00   0.00   0.00   0.00     27. 00   0.00   0.00   0.00   0.00   0.00     28. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00   0.00     29. 00   0.00   0.00   0.00   0.00	12. 00	Related organization	A-8-1	-1, 975, 996			О	12. 00
14. 00   Cafeterial-employees and guests   B   -258, 444 (AFETERIA   11. 00   0   14. 00   0   15. 00   0   15. 00   0   15. 00   0   16. 00   16.	13. 00			0		0.00	o	13. 00
16.00   Sale of medical and surgical supplies to other than patients   0   0.00   0   16.00		. , ,		-258, 444	CAFETERI A			
Supplies to other than	15.00			Ü		0.00	U	15.00
Datients   Date of drugs to other than   Date of Dat	16. 00			0		0.00	0	16. 00
Datients   Sale of medical records and abstracts   Sale of medical records   Sale of med		pati ents	_					
abstracts   Nursing and allied health   education (tuition, fees, books, etc.)	17. 00		В	-19, 371	PHARMACY	15.00	0	17. 00
19.00   Nursing and allied health education (tuition, fees, books, etc.)   20.00   Vending machines   0   0.00	18. 00		В	-1, 797	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
books, etc.	19. 00			0		0.00	О	19. 00
20.00   Vending machines   0   10.00   0   20.00   21.00   10.00   10.00   0   21.00   10.00   10.00   0   21.00   10.00   10.00   0   21.00   10.00   10.00   0   21.00   10.00   1								
Interest, finance or penal ty charges (chapter 21)		Vending machines		0				
22.00   Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	21.00			0		0.00	0	21. 00
overpayments and borrowings to repay Medicare overpayments 23.00 Adj ustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT COSTS-BLDG & FIXT Depreciation - CAP REL A 106, 628 CAP REL COSTS-MVBLE EQUIP 2.00 9 27.00 COSTS-MVBLE EQUIP 2.00 Physicians' assistant 0 0 0 0 0 29.00 30.00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 0 0 0 ADULTS & PEDIATRICS 30.00 30.00 30.99	22.00			0		0.00	0	22.00
23. 00	22.00			Ü		0.00		22.00
therapy costs in excess of limitation (chapter 14)  24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14)  25. 00 Utilization review - physicians' compensation (chapter 21)  26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT  27. 00 Depreciation - CAP REL A 145, 548 CAP REL COSTS-BLDG & FIXT  27. 00 Depreciation - CAP REL A 106, 628 CAP REL COSTS-MVBLE EQUIP  28. 00 Non-physician Anesthetist  0 Non-physicians' assistant  0 O*** Cost Center Deleted ***  114. 00  25. 00  9 26. 00  9 27. 00  9 27. 00  28. 00  9 27. 00  29. 00  Adjustment for occupational therapy costs in excess of limitation (chapter 14)  30. 99 Hospice (non-distinct) (see	23 00		A-8-3	0	RESPIRATORY THERAPY	65 00		23 00
24. 00	20.00	therapy costs in excess of	7. 0 0	J		33. 33		20.00
1 imitation (chapter 14)   Utilization review -	24. 00		A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
25. 00   Utilization review -								
Chapter 21)   Chapter 21)   Depreciation - CAP REL   A   145,548 CAP REL COSTS-BLDG & FIXT   1.00   9 26.00	25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
26.00 Depreciation - CAP REL								
27. 00 Depreciation - CAP REL A 106, 628 CAP REL COSTS-MVBLE EQUIP 2. 00 9 27. 00 COSTS-MVBLE EQUIP 0. Non-physician Anesthetist 0. 0 *** Cost Center Deleted *** 19. 00 28. 00 Physicians' assistant 0. 00 0. 00 0. 29. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 1. Mospice (non-distinct) (see 0. Adjustment for occupations) 0. 00 ADULTS & PEDIATRICS 30. 00 30. 99	26. 00	Depreciation - CAP REL	А	145, 548	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
28. 00 Non-physician Anesthetist	27. 00		А	106, 628	CAP REL COSTS-MVBLE EQUIP	2.00	9	27. 00
29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	28 00			0	*** Cost Center Deleted ***	19 00		28 00
therapy costs in excess of   I imitation (chapter 14) 30.99   Hospice (non-distinct) (see	29. 00	Physicians' assistant		0		0.00	О	29. 00
limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99	30. 00		A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30. 00
	20.00	limitation (chapter 14)		0	ADULTO A DEDI ATRICO	20.00		20.00
	3U. 99	instructions)		0	MUULIS & PEDIATKICS	30.00		30. 99
31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00	31. 00		A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
limitation (chapter 14)	00.00	limitation (chapter 14)		_			_	00.00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	32.00	,		0		0.00	O	32.00
33. 00 MI SCELLANEOUS REVENUE B -2, 709, 325 ADMINISTRATIVE & GENERAL 5. 00 0 33. 00	33. 00	MI SCELLANEOUS REVENUE	В	-2, 709, 325	ADMINISTRATIVE & GENERAL	5. 00	o	33. 00

Peri od: Provider CCN: 14-0034 Worksheet A-8 From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				T	o 12/31/2023	Date/Time Prep	
				Expense Classification on	Workshoot A	5/21/2024 9: 54	4 am
				To/From Which the Amount is			
				TOTT OIL WITCH THE AMOUNT IS	to be Aujusteu		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	oost deriter beserretron	1.00	2. 00	3.00	4. 00	5. 00	
33. 01	MI SCELLANEOUS REVENUE	В		OPERATION OF PLANT	7.00	0.00	33. 01
33. 02	MI SCELLANEOUS REVENUE	В		HOUSEKEEPI NG	9. 00	0	33. 02
33. 03	MI SCELLANEOUS REVENUE	В		NURSING ADMINISTRATION	13. 00	0	33. 03
33. 04	MI SCELLANEOUS REVENUE	В		CENTRAL SERVICES & SUPPLY	14. 00	0	33. 04
33. 05	MI SCELLANEOUS REVENUE	В		INTENSIVE CARE UNIT	31.00	0	33. 05
33. 06	MI SCELLANEOUS REVENUE	В		SUBPROVI DER - I PF	40.00	0	33. 06
33. 07	MI SCELLANEOUS REVENUE	В		OPERATING ROOM	50.00	0	33. 07
33. 08	MI SCELLANEOUS REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 08
33. 09	MI SCELLANEOUS REVENUE	В	·	RADI OLOGY-THERAPEUTI C	55.00	0	33. 09
33. 10	MI SCELLANEOUS REVENUE	В		CT SCAN	57.00	0	33. 10
33. 11	MI SCELLANEOUS REVENUE	B		LABORATORY	60.00	0	33. 11
33. 12	MI SCELLANEOUS REVENUE	В		I NTRAVENOUS THERAPY	64.00	0	33. 12
33. 13	MI SCELLANEOUS REVENUE	В		RESPIRATORY THERAPY	65.00	0	33. 13
33. 14	MI SCELLANEOUS REVENUE	В		PHYSICAL THERAPY	66.00	0	33. 14
33. 15	MI SCELLANEOUS REVENUE	В		ELECTROCARDI OLOGY	69.00	0	33. 15
33. 16	MI SCELLANEOUS REVENUE	B		ELECTROEARDFOLOGF	70.00	0	33. 16
33. 10	MI SCELLANEOUS REVENUE	В		CLINIC	90.00	0	33. 10
33. 17	MARKETI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 19	MARKETING	A		NURSING ADMINISTRATION	13. 00	0	33. 19
33. 20	MARKETING	A		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 19
33. 20	MARKETING	A		RADI OLOGY-THERAPEUTI C	55.00	0	33. 20
33. 22	MARKETING	Ä		RESPIRATORY THERAPY	65.00	0	33. 22
33. 23	MARKETING	A		CLINIC	90.00	0	33. 23
33. 24	RECRUI TMENT	A	•	NURSING ADMINISTRATION	13.00	0	33. 24
33. 25	GIFT	В	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
33. 26	GIFT	В	•	NURSING ADMINISTRATION	13. 00	0	33. 26
33. 27	GIFT	B		PHARMACY	15.00	0	33. 27
33. 28	GIFT	В		ADULTS & PEDIATRICS	30.00	0	33. 28
34. 00	GIFT	В		RADI OLOGY-THERAPEUTI C	55.00	0	34. 00
34. 01	GIFT	В		PHYSI CAL THERAPY	66.00	0	34. 00
34. 02	GIFT	В		CLINIC	90.00	0	34. 02
34. 02	ENTERTAL NMENT	В		ADMINISTRATIVE & GENERAL	5. 00	0	34. 02
34. 03	INTEREST	A		CAP REL COSTS-BLDG & FIXT	1.00	11	34. 03
34. 05	WSI RENT	A		PHYSICAL THERAPY	66.00	0	34. 04
	1 -	1	•	1		0	
34. 06 38. 00	PHYSICAN PART B BENEFITS OTHER ADJUSTMENTS (SPECIFY)	A	-2/1,411	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	0	34. 06 38. 00
38.00			Ü		0.00	U	38.00
39. 00	(3)		0		0.00	0	39. 00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		Ü		0.00	١	39.00
40. 00	OTHER ADJUSTMENTS (SPECIFY)		^		0.00	0	40. 00
40.00	(3)		Ü		0.00	١	40.00
41. 00	OTHER ADJUSTMENTS (SPECIFY)		^		0.00	0	41. 00
41.00	(3)		U		0.00	l 4	41.00
50. 00	TOTAL (sum of lines 1 thru 49)		-13, 194, 776				50. 00
55. 55	(Transfer to Worksheet A,		15, 174, 770				00.00
	column 6, line 200.)						
	122. 2 0, 11110 2001,			l .	1		

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

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Provider CCN: 14-0034

Worksheet A-8-1

17, 248, 035

5.00

15, 272, 039

From 01/01/2023 OFFICE COSTS 12/31/2023 Date/Time Prepared: 5/21/2024 9:54 am Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 1.00 3.00 4.00 5.00 2.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 HOME OFFICE 103, 081 1.00 2. 00 CAP REL COSTS-MVBLE EQUIP HOME OFFICE 2.00 470.822 87.221 2.00 1.00 CAP REL COSTS-BLDG & FIXT HOME OFFICE - INTEREST -271, 152 3.00 3.00 4.00 4.00 EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE 5, 011, 116 14, 543 4.00 4.01 5. 00 ADMINISTRATIVE & GENERAL HOME OFFICE 10, 214, 563 17, 302, 645 4.01 7. OO OPERATION OF PLANT 4 02 HOME OFFICE 69, 112 C 4 02 14.00 CENTRAL SERVICES & SUPPLY 4.03 HOME OFFICE 45,666 4.03 4.04 71. 00 MEDICAL SUPPLIES CHARGED TO HOME OFFICE -527, 543 4.04

\* 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	
			norated organization(e) and	0 0 00	
0 1 1 (1)				5	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownership		Ownarahi n	
		Owner Sni p		Ownershi p	
1. 00	2.00	3.00	4. 00	5. 00	
1.00	2.00	3.00	4.00	3.00	
R INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			
B. THIERRELATIONSHIT TO RELAT	LD ORGANIZATION(3) AND OR THE	WL OITTOL.			d .

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	G	SSM HEALTH	100.00	FRAN SISTERS	100. 00	6. 00
7.00	G	SSM HEALTH	100.00	FRAN SISTERS	100.00	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	CHURCH				100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- 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.
- 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

5 00

line 12.

TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2,

Heal th	Financial Syste	ems		SSM HEALT	H ST. MARY	YS HOSPITA	۱L			In Lie	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANIZATIONS A	ND HOME	Provi der	CCN:	14-0034	Peri od	:	Worksheet A-	3-1
OFFI CE	COSTS									1/01/2023		
									To 1	2/31/2023		
											5/21/2024 9:	24 am
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REG	QUI RED AS A RESU	ILT OF TRAI	NSACTI ONS	WI TH	RELATED C	RGANI ZA	ATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:										
1.00	103, 081	9										1.00
2.00	383, 601	9										2.00
3.00	271, 152	11										3.00
4.00	4, 996, 573	0										4. 00
4.01	-7, 088, 082	0										4. 01
4 02	_60_112	1										1 1 02

\* 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.

4.03

4.04

5.00

nas not	been posted to worksheet A,	corumns i and/or	z, the amount	arrowable should b	Je Tharcated Th Corumn 4 Or	tili 3 pai t.	
	Related Organization(s)						
	and/or Home Office						
	Type of Business						
	31						
	6, 00						
	B. INTERRELATIONSHIP TO RELAT	FD ORGANIZATION(S	S) AND/OR HOME	OFFI CF:			

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	Schieffe dilact title XVIII.	
6.00	HOME OFFICE	6. 00
7.00	SSM HOSPITALS	7.00
8.00		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:

0

4.03

4.04

5.00

-45,666

-527, 543

-1, 975, 996

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0034

Peri od: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/21/2024 9:54 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7.00 5. OO ADMINISTRATIVE & GENERAL 457, 019 1. 00 1.00 145, 176 1.052 602, 195 211, 500 2.00 30.00 ADULTS & PEDIATRICS 1, 840, 866 1, 840, 866 197, 500 2.00 0 3.00 31.00 INTENSIVE CARE UNIT -8, 775 211, 500 3.00 -8, 775 0 62, 970 4.00 40. 00 SUBPROVIDER - IPF 62, 970 181, 300 0 4.00 50. 00 OPERATI NG ROOM 5.00 178,060 133, 339 44, 720 246, 400 200 5.00 6.00 53. 00 ANESTHESI OLOGY 3, 457, 683 3, 457, 683 239, 400 6.00 7.00 55. 00 RADI OLOGY-THERAPEUTI C 18, 734 18, 734 0 271, 900 0 7.00 60. 00 LABORATORY 217, 202 217, 202 260, 300 0 8.00 Ω 8 00 9.00 65. 00 RESPIRATORY THERAPY 24, 162 14, 812 9, 350 211, 500 47 9.00 10.00 69. 00 ELECTROCARDI OLOGY 245, 205 221, 205 24,000 211, 500 133 10.00 70. 00 ELECTROENCEPHALOGRAPHY 125, 657 116, 307 211, 500 11.00 11.00 9, 350 47 90. 00 CLI NI C 197, 500 12.00 734, 137 734, 137 0 12.00 13.00 91. 00 EMERGENCY 779, 321 725, 421 53,900 197, 500 270 13.00 200.00 8, 277, 417 7, 990, 920 286, 496 1, 749 200.00 5 Percent of Cost Center/Physician Physician Cost Cost of Provi der Wkst. A Line # Unadjusted RCE of Malpractice Unadjusted RCE I denti fi er Li mi t Memberships & Component Limit Conti nui ng Share of col Insurance Educati on 2.00 8.00 9.00 13.00 14.00 1.00 12.00 5. OO ADMINISTRATIVE & GENERAL 1.00 5, 349 106, 970 1. 00 2.00 30.00 ADULTS & PEDIATRICS O 0 0 0 2 00 0 3.00 31. 00 INTENSIVE CARE UNIT 0 0 3.00 4.00 40. 00 SUBPROVIDER - IPF 0 0 4.00 0 0 50. 00 OPERATING ROOM 0 5.00 5.00 23, 692 1, 185 53. 00 ANESTHESI OLOGY 0 6.00 0 6.00 7.00 55. 00 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 7.00 0 0 0 8.00 60. 00 LABORATORY 0 8.00 0 9.00 65. 00 RESPIRATORY THERAPY 4,779 0 9.00 239 10.00 69. 00 ELECTROCARDI OLOGY 13, 524 676 0 0 10.00 70. 00 ELECTROENCEPHALOGRAPHY 0 0 11.00 4,779 239 11.00 0 0 12.00 90. 00 CLI NI C 0 0 12.00 0 13.00 91. OO EMERGENCY 25, 637 1, 282 13.00 <u>8, 9</u>70 179, 381 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment Di sal I owance Identi fi er Component limit Share of col. 14 1.00 2.00 15.00 16. 00 17.00 18.00 1.00 5. OO ADMINISTRATIVE & GENERAL 106, 970 38, 206 495, 225 1.00 30. 00 ADULTS & PEDIATRICS 0 1, 840, 866 2.00 2.00 0 0 31.00 INTENSIVE CARE UNIT 3.00 0 O 0 -8, 775 3.00 4.00 40.00 SUBPROVIDER - IPF 0 62,970 4.00 50. 00 OPERATING ROOM 0 5.00 23, 692 21,028 154, 368 5.00 6.00 53. 00 ANESTHESI OLOGY 0 6.00 0 0 3, 457, 683 7.00 55. 00 RADI OLOGY-THERAPEUTI C 0 0 0 18, 734 7.00 8.00 60. 00 LABORATORY 0 217, 202 8.00 9.00 65. 00 RESPIRATORY THERAPY 0 4, 779 4,571 19, 383 9.00 69. 00 ELECTROCARDI OLOGY 0 10.00 13, 524 10, 476 231, 681 10.00 11.00 70. 00 ELECTROENCEPHALOGRAPHY 0 4, 779 4,571 120,878 11.00 90. 00 CLI NI C 0 12.00 734, 137 12.00 0 91. OO EMERGENCY 28. 263 13.00 25.637 753.684 13.00 200.00 179, 381 107, 115 8, 098, 036 200.00

| Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0034

				Τ̈́	o 12/31/2023	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		5/21/2024 9:5	4 am
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center bescription	for Cost	BLDG & TIXI	WVBLL LQUIF	BENEFI TS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2.00	4. 00	4A	
	NERAL SERVICE COST CENTERS OTOO CAP REL COSTS-BLDG & FIXT	2, 312, 248	2, 312, 248				1.00
	200 CAP REL COSTS-MVBLE EQUIP	2, 894, 719		2, 894, 719			2. 00
	0400 EMPLOYEE BENEFITS DEPARTMENT	18, 061, 186				47 /57 504	4. 00
	0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT	14, 276, 827 4, 391, 555	697, 907 174, 676	1		17, 657, 531 5, 242, 061	5. 00 7. 00
	0800 LAUNDRY & LINEN SERVICE	404, 648				562, 859	8. 00
	1990 HOUSEKEEPI NG	1, 213, 741	30, 466	1		1, 799, 007	1
	000 DI ETARY 100 CAFETERI A	381, 180 604, 318		1		497, 813 879, 784	1
13. 00 01	300 NURSING ADMINISTRATION	1, 506, 277	4, 310	5, 396	448, 812	1, 964, 795	13. 00
	400 CENTRAL SERVICES & SUPPLY 500 PHARMACY	223, 275		1		391, 095	1
	600 MEDI CAL RECORDS & LI BRARY	1, 371, 742 -1, 140		_		2, 005, 548 57, 518	1
	700 SOCIAL SERVICE	10, 209				34, 595	
	IPATIENT ROUTINE SERVICE COST CENTERS  SOOO ADULTS & PEDIATRICS	6, 215, 486	351, 405	439, 927	3, 055, 414	10, 062, 232	30. 00
	100 INTENSIVE CARE UNIT	1, 430, 869		1		2, 131, 104	1
	000 SUBPROVI DER - I PF	3, 047, 263		1			1
	300 NURSERY  CLLLARY SERVICE COST CENTERS	0	0	0	0	0	43. 00
50.00 05	000 OPERATING ROOM	2, 839, 283	246, 200	308, 219	1, 106, 529	4, 500, 231	50. 00
	5100 RECOVERY ROOM	974, 540	0	_		1, 488, 693	
	3200 DELIVERY ROOM & LABOR ROOM 3300 ANESTHESIOLOGY	95, 376	0 2, 241	_	_	0 100, 423	52. 00 53. 00
54. 00 05	400 RADI OLOGY-DI AGNOSTI C	1, 179, 429	69, 417	l		1, 956, 983	1
	5500 RADI OLOGY-THERAPEUTI C	651, 358	0			952, 884	55. 00
	6600 RADIOI SOTOPE 6700 CT SCAN	448, 254 563, 565				548, 149 752, 452	1
	MAGNETIC RESONANCE IMAGING (MRI)	204, 802				303, 864	58. 00
	5900 CARDI AC CATHETERI ZATI ON	0	0	· ·		0	59.00
	0000 LABORATORY 0400 INTRAVENOUS THERAPY	2, 446, 378 279, 396		1		3, 272, 771 440, 484	60. 00 64. 00
65. 00 06	500 RESPI RATORY THERAPY	1, 548, 165	6, 740	1		2, 194, 162	1
	6600 PHYSI CAL THERAPY 8340 CLINI CAL NUTRITION	1, 564, 499		1			1
	5700 OCCUPATIONAL THERAPY	122, 740 172, 525	0   0		. ,	189, 748 265, 144	1
68. 00 06	800 SPEECH PATHOLOGY	133, 986			72, 881	215, 638	
	9900 ELECTROCARDI OLOGY	1, 007, 187	32, 319	1	496, 724	1, 576, 691	69.00
	8140 CARDIAC REHABILITATION 1000 ELECTROENCEPHALOGRAPHY	114, 388 73, 744	11, 879	0 14, 872		175, 962 135, 373	1
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 894, 032		1		3, 894, 032	1
	/200 IMPL. DEV. CHARGED TO PATIENTS /300 DRUGS CHARGED TO PATIENTS	1, 675, 798 3, 992, 997		l .		1, 675, 798 3, 992, 997	
	7400 RENAL DIALYSIS	7	0			3, 772, 771 7	1
	TPATIENT SERVICE COST CENTERS						
	2000 CLINIC 2100 EMERGENCY	2, 516, 965 3, 120, 559				3, 783, 152 4, 372, 720	
	2200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 120, 337	30, 470	73, 177	1, 120, 472	4, 372, 720	
	HER REIMBURSABLE COST CENTERS	0.022		1		0.022	00.00
99. 30   09 102. 00 10	0200 OPLOID TREATMENT PROGRAM	-8, 832 0					99. 30 102. 00
	ECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	87, 955, 544	2, 065, 806	2, 586, 197	17, 964, 245	87, 275, 238	118. 00
	NREIMBURSABLE COST CENTERS OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 764	1, 767	2, 212	3, 710	15. 453	190. 00
191. 00 19	2100 RESEARCH	0	0	· o	0	0	191. 00
	2200 PHYSICIANS' PRIVATE OFFICES 2201 PHYSICIANS' PRIVATE OFFICES	159, 501	0	0	90, 220	249, 721	192. 00 192. 01
	7950 NON-REI MBURSABLE	278, 441	244, 675	306, 310	31, 412	860, 838	
194. 01 07	951 NON-REI MBURSABLE	0	0	0	0	0	194. 01
	7952 NON-REIMBURSABLE 7953 CONTRACT PHARMACY	0 25, 664	0	0			194. 02 194. 03
200.00	Cross Foot Adjustments	25, 004					200. 00
201.00	Negative Cost Centers	00 101 51	0 212 5	0 221 - 1	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	88, 426, 914	2, 312, 248	2, 894, 719	18, 089, 587	88, 426, 914	J202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/21/2024 9:54 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 17, 657, 531 5 00 5 00 7.00 00700 OPERATION OF PLANT 1, 307, 774 6, 549, 835 7.00 220, 169 00800 LAUNDRY & LINEN SERVICE 140, 420 8.00 923, 448 8.00 9.00 00900 HOUSEKEEPI NG 448, 811 139, 831 0 2, 387, 649 9.00 01000 DI ETARY 0 730, 729 10.00 10.00 124, 193 78. 459 30, 264 01100 CAFETERI A 219, 486 201, 154 0 77, 593 0 11.00 11.00 13 00 01300 NURSING ADMINISTRATION 490, 171 19, 782 0 7,630 0 13.00 01400 CENTRAL SERVICES & SUPPLY 97.569 0 5,008 14 00 14 00 12, 982 0 15.00 01500 PHARMACY 500, 338 0 0 15.00 119, 555 16.00 01600 MEDICAL RECORDS & LIBRARY 14, 349 0 46, 117 0 16.00 01700 SOCIAL SERVICE 17.00 49, 701 17.00 8, 631 0 19, 172 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 510, 291 1, 612, 870 512, 342 622, 141 405, 419 30.00 03100 INTENSIVE CARE UNIT 47, 517 31.00 531, 661 143, 392 60,049 55, 312 31.00 04000 SUBPROVIDER - IPF 1, 187, 860 68, 331 351, 057 277, 793 40.00 40.00 177, 144 04300 NURSERY 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 1, 122, 704 1, 129, 999 0 435, 883 n 50.00 0 0 05100 RECOVERY ROOM 371, 395 51.00 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 53.00 05300 ANESTHESI OLOGY 25,053 10, 286 0 3.968 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 488, 222 0 54.00 54.00 318, 607 122, 899 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 237, 723 Λ 55.00 56.00 05600 RADI 0I S0T0PE 136, 751 84, 962 0 32, 773 0 56.00 05700 CT SCAN 187, 719 5, 786 2, 232 57.00 0 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 75.807 10, 089 3.892 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 59.00 60.00 06000 LABORATORY 816, 481 147, 002 56, 704 0 60.00 06400 INTRAVENOUS THERAPY 0 64.00 109, 891 26, 235 10, 120 0 64.00 65 00 06500 RESPIRATORY THERAPY 547 393 30 933 0 11 932 0 65 00 0 06600 PHYSI CAL THERAPY 66.00 610, 812 117, 725 45, 411 0 66.00 03340 CLINICAL NUTRITION 47, 338 0 0 66.01 66.01 67.00 06700 OCCUPATIONAL THERAPY 66.147 0 0 67.00 0 53, 797 0 06800 SPEECH PATHOLOGY 68.00 17,878 6, 896 0 68.00 69.00 06900 ELECTROCARDI OLOGY 393, 348 148, 337 0 57, 219 0 69.00 69.01 03140 CARDIAC REHABILITATION 43, 898 0 69.01 70 00 07000 ELECTROENCEPHALOGRAPHY 33.772 54 523 0 21 032 Ω 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 971, 471 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 418,073 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 996, 161 0 o 0 73.00 07400 RENAL DIALYSIS 0 74 00 74.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 943, 809 272, 961 0 105, 291 0 90.00 91.00 09100 EMERGENCY 0 91.00 1.090.893 268, 362 103.517 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.30 99.30 09930 00T 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 17, 370, 214 5, 418, 724 923, 448 1, 951, 337 730, 729 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 8, 110 3,855 3, 129 191. 00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 62,300 0 192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES 0 0 192. 01 194. 00 07950 NON-REI MBURSABLE 0 194, 00 214, 759 1, 123, 001 0 433, 183 194. 01 07951 NON-REI MBURSABLE 0 0 194. 01 194. 02 07952 NON-REI MBURSABLE 0 0 0 194. 02 194. 03 07953 CONTRACT PHARMACY 0 194. 03 6, 403 C 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 17, 657, 531 6, 549, 835 923, 448 2, 387, 649 730, 729 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | Part | Prepared: | Part | Par

			То	12/31/2023	Date/Time Pre 5/21/2024 9:5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVI CE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL						5. 00
7.00   00700   0PERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00   01100   CAFETERI A	1, 378, 017	·				11. 00
13.00 O1300 NURSING ADMINISTRATION	41, 227					13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	14, 830	1	521, 484	0 5/4 40/		14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	58, 220 0	1	0	2, 564, 106	227 520	15. 00 16. 00
17. 00 O1700 SOCIAL SERVICE	0	1	0	0	237, 539 0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS		<u>′I                                    </u>	o <sub>l</sub>	<u>o</u> լ		17.00
30. 00 03000 ADULTS & PEDIATRICS	280, 672	737, 291	55, 092	120, 393	12, 430	30. 00
31.00 03100 INTENSIVE CARE UNIT	57, 859	1	21, 327	33, 945	1, 711	31. 00
40. 00   04000   SUBPROVI DER - I PF	149, 473		4, 085	4, 679	4, 842	40. 00
43. 00 04300 NURSERY	0	)  0	0	0	0	43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00   05000   OPERATI NG ROOM	101, 643	288, 848	212, 047	342, 274	29, 341	50.00
51. 00   05100   RECOVERY   ROOM	47, 229		1, 157	10, 268	7, 714	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	1	9, 337	778, 564	9, 054	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	57, 065		8, 960	40, 947	10, 637	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C 56. 00   05600   RADI OI SOTOPE	27, 697		1, 440	152 042	4, 688	55. 00 56. 00
57. 00   05700 CT SCAN	5, 347 17, 090	1	248 6, 495	152, 862 628, 780	4, 742 36, 418	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	8, 645		666	9, 515	6, 356	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1	0	0	0	59. 00
60. 00   06000   LABORATORY	69, 285	0	140, 928	1, 915	31, 055	60.00
64. 00 06400 I NTRAVENOUS THERAPY	13, 615		2, 827	18, 527	1, 199	64. 00
65. 00 06500 RESPI RATORY THERAPY	57, 945	1	9, 456	659	6, 951	65. 00
66. 00   06600   PHYSI CAL THERAPY 66. 01   03340   CLI NI CAL NUTRI TI ON	75, 884 6, 155	1	972 0	785	6, 069 19	66. 00 66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	8, 508	1	23	0	865	67. 00
68.00 06800 SPEECH PATHOLOGY	6, 695	1	0	Ö	407	68. 00
69. 00 06900 ELECTROCARDI OLOGY	45, 628	55, 611	2, 967	6, 940	9, 343	69. 00
69. 01 03140 CARDI AC REHABI LI TATI ON	5, 656	1	93	4, 773	412	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 204	1	385	21, 259	1, 548	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	1	0	0	3, 069 2, 093	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1	0	0	14, 413	73. 00
74. 00 07400 RENAL DIALYSIS	0	1	0	Ö	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	104, 007		3, 438	329, 839		
91. 00 09100 EMERGENCY	102, 925	295, 114	39, 541	57, 182	25, 611	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
99. 30 09930 00T	0	O	0	o	0	99. 30
102.00 10200 OPI OI D TREATMENT PROGRAM	0	1	0	Ö		102. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 366, 504	2, 503, 707	521, 484	2, 564, 106	237, 539	118. 00
NONREI MBURSABLE COST CENTERS	2.4.1		0	ام		100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	341		0	ol Ol		190. 00 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	8, 287	19, 898	0	0		192. 00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0,	0	0	Ö		192. 01
194. 00 07950 NON-REI MBURSABLE	2, 885	0	0	O		194. 00
194. 01 07951 NON-REI MBURSABLE	0	이	0	0		194. 01
194. 02 07952 NON-REI MBURSABLE 194. 03 07953 CONTRACT PHARMACY	0		0	0		194. 02 194. 03
200.00 Cross Foot Adjustments	U	ή		٥	0	200. 00
201.00 Negative Cost Centers	0	ol	О	o	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	1, 378, 017	2, 523, 605	521, 484	2, 564, 106	237, 539	

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0034 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 9:54 am Cost Center Description SOCIAL SERVICE Total Subtotal Intern & Residents Cost & Post Stepdown Adjustments 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 112,099 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 16, 993, 368 30.00 03000 ADULTS & PEDIATRICS 16, 993, 368 30.00 62 195 0 0 31.00 03100 INTENSIVE CARE UNIT 7, 289 3, 276, 400 3, 276, 400 31.00 40.00 04000 SUBPROVIDER - IPF 42, 615 7, 389, 535 0 7, 389, 535 40.00 43.00 04300 NURSERY 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8, 162, 970 0 8, 162, 970 50.00 05100 RECOVERY ROOM 0 2, 124, 164 51.00 2, 124, 164 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 00000000000000000000000 52.00 0 05300 ANESTHESI OLOGY 936, 685 936, 685 53 00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 020, 183 3, 020, 183 54.00 05500 RADI OLOGY-THERAPEUTI C 1, 244, 282 0 1, 244, 282 55.00 55.00 05600 RADI OI SOTOPE 0 966, 268 56, 00 966, 268 56, 00 05700 CT SCAN 0 1, 638, 092 1, 638, 092 57.00 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 421, 209 0 421, 209 58.00 05900 CARDIAC CATHETERIZATION 59 00 59.00 60.00 06000 LABORATORY 4, 536, 141 0 4, 536, 141 60.00 06400 INTRAVENOUS THERAPY 0 64.00 677, 012 677.012 64 00 06500 RESPIRATORY THERAPY 2, 859, 431 2, 859, 431 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 3, 306, 026 3, 306, 026 66.00 03340 CLINICAL NUTRITION 0 243, 260 243, 260 66.01 66, 01 06700 OCCUPATI ONAL THERAPY 67.00 340, 687 340, 687 67.00 301, 311 68.00 06800 SPEECH PATHOLOGY 301, 311 68.00 06900 ELECTROCARDI OLOGY 2, 296, 084 2, 296, 084 69.00 69.00 03140 CARDIAC REHABILITATION 258, 319 0 258, 319 69.01 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 271, 096 0 271, 096 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 868, 572 0 4, 868, 572 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 2, 095, 964 0 2, 095, 964 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 5,003,571 5, 003, 571 73.00 74.00 07400 RENAL DIALYSIS 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 5. 811. 415 5. 811. 415 90.00 09000 CLI NI C 0 0 91.00 09100 EMERGENCY 0 6, 355, 865 0 6, 355, 865 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 99 30 09930 00T 0 -8, 832 0 -8,832 99.30 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 112, 099 85, 389, 087 0 85, 389, 087 118 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 30, 888 0 30.888 0 0 191. 00 19100 RESEARCH 191.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 340, 206 340, 206 192 00 0 192. 01 19201 PHYSICIANS' PRIVATE OFFICES 0 192. 01 194. 00 07950 NON-REI MBURSABLE 0 194.00 2, 634, 666 2, 634, 666 0 194. 01 07951 NON-REI MBURSABLE 0 194.01 0 194. 02 07952 NON-REI MBURSABLE 0 194. 02 0 194. 03 07953 CONTRACT PHARMACY 0 32, 067 32, 067 194.03 0 200.00 Cross Foot Adjustments 200. 00 0 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 112,099 88, 426, 914 88, 426, 914 202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0034

					То	12/31/2023	Date/Time Pre 5/21/2024 9:5	
				CAPI TAL REI	ATED COSTS		1 37 2 17 202 4 7. 3	T GIII
		Cook Cooks December 1	D:+1	DIDC & FLVT	M/DLE FOLLD	Ch.tt1	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs	1.00	2.00	24	4.00	
	GENER	AL SERVICE COST CENTERS	0	1. 00	2. 00	2A	4. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP		40 (40	45 700	00.404	00.404	2.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	0 49, 668	12, 612 697, 907		28, 401 1, 621, 291	28, 401 2, 839	4. 00 5. 00
7. 00		OPERATION OF PLANT	669	174, 676		394, 023	717	7. 00
8.00		LAUNDRY & LINEN SERVICE	O	47, 970		108, 023	79	8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	0	30, 466 17, 094		68, 606 38, 494	811 123	9. 00 10. 00
11. 00	1	CAFETERI A	0	43, 827		98, 694	277	11.00
13. 00	1	NURSING ADMINISTRATION	14, 642	4, 310		24, 348	704	
14.00		CENTRAL SERVICES & SUPPLY	2, 094	2, 828	1	8, 463	253	
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	130, 548 0	0 26, 048		130, 548 58, 658	995 0	15. 00 16. 00
17. 00		SOCIAL SERVICE	0	10, 829		24, 386	0	17. 00
20.00		ENT ROUTINE SERVICE COST CENTERS		054 405	400 007	705 77/	4 040	00.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	4, 444 1, 004	351, 405 31, 242		795, 776 71, 358	4, 810 988	30. 00 31. 00
40. 00		SUBPROVI DER - I PF	0	38, 595		86, 913	2, 553	
43. 00		NURSERY	0	0	0	0	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	86, 790	246, 200	308, 219	641, 209	1, 736	50. 00
51. 00		RECOVERY ROOM	00,770	240, 200	1	041, 209	807	51.00
52. 00	1	DELIVERY ROOM & LABOR ROOM	0	0	0	o	0	52. 00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	2, 241 69, 417	2, 806 86, 903	5, 047 156, 320	0 975	53. 00 54. 00
55. 00	1	RADI OLOGY-THERAPEUTI C	0	09, 417		150, 320	473	
56.00	05600	RADI OI SOTOPE	0	18, 511		41, 685	91	56. 00
57. 00		CT SCAN	0	1, 261		2, 839	292	
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0	2, 198 0		4, 950 0	148 0	58. 00 59. 00
60. 00		LABORATORY	0	32, 028	40, 096	72, 124	1, 184	
64. 00	1	I NTRAVENOUS THERAPY	0	5, 716		12, 872	233	
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	114, 231 80, 120	6, 740 25, 650		129, 408 137, 881	990 1, 296	65. 00 66. 00
66. 01	1	CLINICAL NUTRITION	00, 120	25, 050		137, 001	105	66. 01
67. 00		OCCUPATIONAL THERAPY	o	0		0	145	
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	3, 895 32, 319		8, 771 72, 780	114 779	
69. 00		CARDI AC REHABI LI TATI ON	0	32, 319	40, 461	72, 780	97	69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY	O	11, 879	14, 872	26, 751	55	70. 00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
		DRUGS CHARGED TO PATTENTS	0	0		o	0	
74. 00	07400	RENAL DIALYSIS	0	0	0	0	0	
90. 00		TIENT SERVICE COST CENTERS CLINIC	62, 476	59, 472	74, 453	196, 401	1, 777	90. 00
91. 00		EMERGENCY	02,470	58, 472 58, 470		131, 669	1, 777	
		OBSERVATION BEDS (NON-DISTINCT PART)		•	·	0		92. 00
00.20	0THER 09930	REI MBURSABLE COST CENTERS		0		ما	0	00.20
		OPIOID TREATMENT PROGRAM	0	0	1	0		99. 30 102. 00
	SPECIA	AL PURPOSE COST CENTERS				-		
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	546, 686	2, 065, 806	2, 586, 197	5, 198, 689	28, 204	118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 767	2, 212	3, 979	6	190. 00
191.00	19100	RESEARCH	0	0	0	0	0	191. 00
		PHYSICIANS' PRIVATE OFFICES	127	0	0	127		192. 00
		PHYSI CI ANS' PRI VATE OFFI CES NON-REI MBURSABLE	18, 180	0 244, 675	306, 310	569, 165		192. 01 194. 00
	1	NON-REI MBURSABLE	0	244, 373	0	0		194. 01
		NON-REI MBURSABLE	0	0	0	О		194. 02
194. 03 200. 00		CONTRACT PHARMACY Cross Foot Adjustments	0	0	0	0	0	194. 03 200. 00
200.00		Negative Cost Centers		0	О	ol	0	200. 00
202.00	1	TOTAL (sum lines 118 through 201)	564, 993	2, 312, 248	2, 894, 719	5, 771, 960	28, 401	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/21/2024 9:54 am

						5/21/2024 9:5	4 am
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10. 00	
	ERAL SERVICE COST CENTERS	Т		T			
	00 CAP REL COSTS-BLDG & FIXT						1.00
	OO CAP REL COSTS-MVBLE EQUIP						2. 00
	OO EMPLOYEE BENEFITS DEPARTMENT						4. 00
	OO ADMINISTRATIVE & GENERAL	1, 624, 130					5. 00
	OO OPERATION OF PLANT	120, 290	515, 030				7. 00
	00 LAUNDRY & LINEN SERVICE	12, 916	17, 312		404 (0)		8. 00
	00 HOUSEKEEPI NG	41, 282	10, 995		121, 694	F7 7F0	9.00
	OO DI ETARY	11, 423	6, 169		1, 543	57, 752	
	OO CAFETERIA	20, 188	15, 817		3, 955	0	11.00
	OO NURSI NG ADMI NI STRATI ON	45, 086	1, 555		389	0	1
	00 CENTRAL SERVI CES & SUPPLY	8, 974	1, 021	0	255	0	14.00
	OO PHARMACY	46, 021	0 401	_	2 250	0	15.00
	00 MEDICAL RECORDS & LIBRARY	1, 320	9, 401	0	2, 350	0	16.00
	OO SOCIAL SERVICE	794	3, 908	0	977	0	17. 00
	ATIENT ROUTINE SERVICE COST CENTERS	220 002	10/ 00/	7/ 7/0	21 711	22.042	20.00
	OO ADULTS & PEDIATRICS OO INTENSIVE CARE UNIT	230, 882 48, 902	126, 826 11, 275			32, 042 3, 755	30. 00 31. 00
1	00  SUBPROVI DER - I PF	109, 260	11, 275		2, 819 3, 483	21, 955	
	OO NURSERY	109, 280	13, 929	1	3, 463	21, 955	
	I LLARY SERVI CE COST CENTERS	U U		ıl O	U U	0	43.00
	OO OPERATING ROOM	103, 267	88, 855	0	22, 216	0	50.00
	OO RECOVERY ROOM	34, 161	00, 000			0	51.00
	OO DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
-	00 ANESTHESI OLOGY	2, 304	809	_	202	0	53.00
-	00 RADI OLOGY-DI AGNOSTI C	44, 907	25, 053		6, 264	0	54.00
	00 RADI OLOGY-THERAPEUTI C	21, 866	25, 055		0, 204	0	55.00
-	OO RADI OI SOTOPE	12, 578	6, 681	j o	1, 670	0	56.00
	00 CT SCAN	17, 267	455	_	114	0	57.00
	OO MAGNETIC RESONANCE IMAGING (MRI)	6, 973	793		198	0	58.00
	OO CARDI AC CATHETERI ZATI ON	0,770	0		0	0	59.00
	OO LABORATORY	75, 100	11, 559	Ō	2, 890	0	60.00
	00 I NTRAVENOUS THERAPY	10, 108	2, 063		516	0	64. 00
	OO RESPIRATORY THERAPY	50, 349	2, 432		608	0	65. 00
	00 PHYSI CAL THERAPY	56, 183	9, 257		2, 315	0	66.00
	40 CLINICAL NUTRITION	4, 354	0	1	0	0	66. 01
	OO OCCUPATI ONAL THERAPY	6, 084	0	o	0	0	67. 00
	00 SPEECH PATHOLOGY	4, 948	1, 406	0	351	0	68. 00
69. 00 069	OO ELECTROCARDI OLOGY	36, 180	11, 664	1	2, 916	0	69. 00
69. 01 031	40 CARDI AC REHABI LI TATI ON	4, 038	0	1	0	0	69. 01
70.00 070	OO ELECTROENCEPHALOGRAPHY	3, 106	4, 287	0	1, 072	0	70. 00
	OO MEDICAL SUPPLIES CHARGED TO PATIENTS	89, 356	0	О	0	0	71. 00
72. 00 072	00 IMPL. DEV. CHARGED TO PATIENTS	38, 455	0	o	0	0	72. 00
	OO DRUGS CHARGED TO PATIENTS	91, 627	0	0	0	0	73. 00
74. 00   074	00 RENAL DIALYSIS	0	0	0	0	0	74. 00
OUT	PATIENT SERVICE COST CENTERS						
90.00 090	OO CLI NI C	86, 812	21, 464	0	5, 366	0	90. 00
91.00 091	OO EMERGENCY	100, 341	21, 102	0	5, 276	0	91.00
92. 00 092	OO OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTH	ER REIMBURSABLE COST CENTERS						
99. 30 099		0	0	0	0	0	99. 30
	OO OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPE	CLAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 597, 702	426, 088	138, 330	99, 456	57, 752	118. 00
	REIMBURSABLE COST CENTERS						
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	355	638	0	159		190. 00
	00 RESEARCH	0	0	0	0		191. 00
	00 PHYSICIANS' PRIVATE OFFICES	5, 730	0	0	0		192. 00
	01 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 01
	50 NON-REI MBURSABLE	19, 754	88, 304	0	22, 079		194. 00
	51 NON-REI MBURSABLE	0	0	9	0		194. 01
	52 NON-REI MBURSABLE	0	0	9	0		194. 02
	53 CONTRACT PHARMACY	589	0	9	0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 624, 130	515, 030	138, 330	121, 694	57, 752	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0034

			To	12/31/2023	Date/Time Pre	pared:
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/21/2024 9: 5 MEDI CAL	4 am
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVI CE COST CENTERS	11.00	13.00	14.00	15.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00   00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL						4. 00 5. 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	120 021					10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG ADMI NI STRATI ON	138, 931 4, 157	76, 239				11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	1, 495	l	20, 461			14. 00
15. 00 01500 PHARMACY	5, 870	0	0	183, 434		15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	1	0	0	71, 386	16.00
17. 00 O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	O	0	17. 00
30. 00 03000 ADULTS & PEDIATRICS	28, 286	22, 273	2, 162	8, 613	3, 729	30.00
31.00 03100 INTENSIVE CARE UNIT	5, 834		837	2, 428	513	31. 00
40. 00   04000   SUBPROVI DER - I PF	15, 071	10, 883	160	335	1, 453	40. 00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43. 00
50. 00 05000 OPERATING ROOM	10, 248	8, 726	8, 320	24, 486	8, 802	50.00
51. 00   05100   RECOVERY ROOM	4, 762	5, 973	45	735	2, 314	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	366	55, 699	2, 716	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C	5, 754 2, 793	479 600	352 57	2, 929	3, 191 1, 407	54. 00 55. 00
56. 00   05600 RADI OI SOTOPE	539		10	10, 936	1, 423	56. 00
57. 00  05700   CT   SCAN	1, 723	34	255	44, 982	11, 047	57. 00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	872		26	681	1, 907	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON 60. 00   06000   LABORATORY	0 6, 986	-	0 5, 529	0 137	0 9, 317	59. 00 60. 00
64. 00   06400   INTRAVENOUS THERAPY	1, 373	1	5, 529 111	1, 325	360	64. 00
65. 00 06500 RESPI RATORY THERAPY	5, 843		371	47	2, 085	65. 00
66. 00 06600 PHYSI CAL THERAPY	7, 651	0	38	56	1, 821	66. 00
66. 01   03340   CLI NI CAL NUTRI TI ON	621	0	0	0	6	66. 01
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	858 675		0	0	260 122	67. 00 68. 00
69. 00   06900   ELECTROCARDI OLOGY	4, 601	1, 680	116	496	2, 803	69. 00
69. 01 03140 CARDI AC REHABI LI TATI ON	570		4	341	124	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	323	0	15	1, 521	464	70.00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   72. 00   07200   MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	921 628	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0	o	4, 324	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
OUTPATIENT SERVICE COST CENTERS	40.407	7.00/	405	00.50/	4.0//	
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	10, 487 10, 378		135 1, 551	23, 596 4, 091	1, 966 7, 683	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 370	0, 910	1, 331	4, 071	7,003	92.00
OTHER REIMBURSABLE COST CENTERS						
99. 30   09930   00T	0		0	0	0	99. 30
102.00 10200 OPI OI D TREATMENT PROGRAM  SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	137, 770	75, 638	20, 461	183, 434	71, 386	118.00
NONREI MBURSABLE COST CENTERS					,	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	34	1	0	0		190. 00
191. 00 19100  RESEARCH 192. 00 19200  PHYSI CLANS'   PRI VATE   OFFI CES	0	1	0	0		191. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	836 0	601	0	0		192. 00
194. 00 07950 NON-REI MBURSABLE	291	l o	0	o		194. 00
194. 01 07951 NON-REI MBURSABLE	0	1	0	О		194. 01
194. 02 07952 NON-REI MBURSABLE	0		0	o		194. 02
194.03 07953  CONTRACT PHARMACY 200.00  Cross Foot Adjustments	0		0	O	0	194. 03 200. 00
201.00 Negative Cost Centers	0	0	О	o	343	201.00
202.00 TOTAL (sum lines 118 through 201)	138, 931	76, 239	20, 461	183, 434	71, 729	202. 00

ALLOCATION OF CAPITAL RELATED COSTS  Disti Center Description  SOCIAL SERVICE  Social Interest Service	Health Financial Systems	SSM HEALTH ST. M.				u of Form CMS-2552-10
Part	ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	Fr	om 01/01/2023	Date/Time Prepared:
CEMERAL SERVICE COST CENTERS	Cost Center Description	SOCI AL SERVI CE		Residents Cost & Post	Total	
SEREPAL SERVICE COST CENTERS     1.00   0.0000 CAP SEL COSTS SERVICE AS FLYXT   2.00   0.0000 CAP SEL COSTS SERVICE AS FLYXT   2.00		17.00	24.00		24 00	
1.00   00000  CAP RET COSTS-MURG & FIXT   2.00	GENERAL SERVICE COST CENTERS	17.00	24.00	25.00	26.00	
4.00   00400  EMPLOYUS BENEFITS DEPARTMENT	1.00 O0100 CAP REL COSTS-BLDG & FIXT					
5.00   0.0000   D.0000   D.00000   D.0000   D.0000   D.0000   D.0000   D.0000   D.0000   D.00000   D.0000   D.00000   D.0000   D.00000   D.00000   D.00000   D.00000   D.00000   D.00000000   D.0000000000						
8.00   000000   LAURDORY & LINEN SERVICE	ł ł					
9.00   00000  DI TERRY						
10.00   01000   DETARY						
13.00   10300   NURSING ABUNIN STRATION     14.00   10400   CHRINAL SERVICES & SUPPLY     15.00   15.00   15.00   PLARMACY   15.00   15.00   15.00   15.00   PLARMACY   15.00   15.0						
14.00						
15.00						
17. 00						
IMPATI ENT ROUTINE SERVICE COST CENTERS						
0.000   0.0000   ADULTS & PEDIATRICS   16, 681   1, 380, 539   0   1, 380, 539   30, 00   3	- '	30, 065				17.00
40.00   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000000		16, 681	1, 380, 539	0	1, 380, 539	30.00
43. 00   0300   NURSERY   0   0   0   0   0   0   43. 00		1 1				
ANCILL ARY SERVICE COST CENTERS		1				
51.00   05100   RECOVERY ROOM   LABOR ROOM   0   48.797   0   48.797   51.00   52.00   05200   05200   DELYCEPY ROOM & LABOR ROOM   0   0   0   0   0   52.00   05300   DELYCEPY ROOM & LABOR ROOM   0   0   0   0   0   52.00   05400   ANSTHESI OLOGY   0   0   67.143   0   67.143   53.00   0   0   0   0   0   0   0   0   0			<u> </u>	<u> </u>		10.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   52.00		1				
53.00   05300   ANESTHESI OLOGY   0   67, 143   0   67, 143   53.00		-1				
55.00   05500   RADI OLOGY-THERAPEUTIC   0   27, 196   0   27, 196   55.00   05700   CT SCAN   0   75, 626   56.00   05700   CT SCAN   0   75, 626   0   75, 626   56.00   05700   CT SCAN   0   79, 008   0   79, 008   57, 00   05700   CT SCAN   0   79, 008   0   79,	53. 00 05300 ANESTHESI OLOGY	0		0		53. 00
56. 00   05600   RADIO I SOTOPE   0   75, 626   0   75, 626   56. 00		0				
58. 00   05800   MAGNETIC RESONANCE I INAGI NG (MRI )						
59.00   0.65900   CARDIAC CATHETERI ZATION   0   0   0   0   0   0   0   0   0	57. 00  05700 CT SCAN	0	79, 008	0	79, 008	57. 00
60.00   0.0000   LABORATORY   0   184, 826   0   184, 826   0.0.00		0				
64.00		0	ŭ		- 1	
66.00   06600   PHYSICAL THERAPY   0   216,498   0   216,498   66.00		1			30, 596	
66 01   0340   CLI NI CAL NUTRI TI ON   0   5,086   0   5,086   66 01		-1				
68. 00   06800   SPEECH PATHOLOGY   0   16, 387   0   16, 387   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   134, 015   0   134, 015   69. 00   69. 01   03140   CARDI AC REHABI LITATI ON   0   0, 006   0   0, 006   69. 01   03140   CARDI AC REHABI LITATI ON   0   0, 006   0   0, 006   70. 00   07000   ELECTROCEPHALOGRAPHY   0   37, 594   0   37, 594   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   90, 277   0   90, 277   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   39, 083   0   39, 083   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   95, 951   0   95, 951   73. 00   74. 00   07400   RENALD IN LAYSIS   0   0   0   0   0   0   74. 00   07400   ENALD IN LAYSIS   0   0   0   0   0   74. 00   07400   ENALD IN LAYSIS   0   0   0   0   0   75. 00   09000   CLI NI C   0   355, 930   0   355, 930   90. 00   76. 00   09000   09000   09000   0   0   0		0				
69. 00   06900   ELECTROCARDIOLOGY   0   134, 015   0   134, 015   69. 00   69. 01   03140   CARDIAC REHABILITATION   0   0   0,006   0   6,006   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   37,594   0   37,594   70. 00   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   90,277   0   90,277   71. 00   72. 00   072.00   IMPL. DEV. CHARGED TO PATIENTS   0   39,083   0   39,083   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   95,951   0   95,951   73. 00   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   0   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   0   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   74. 00   09100   EMERGENCY   0   355,930   0   355,930   90,00   75. 00   09100   EMERGENCY   0   292,765   0   292,765   91. 00   76. 00   09100   EMERGENCY   0   292,765   0   292,765   91. 00   76. 00   09100   EMERGENCY   0   0   0   0   0   0   77. 00   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   09100   78. 00   09100   09100   09100   09100   09100   09100   09100   78. 00   09100   09		0				
69. 01 03140 CARDIAC REHABILITATION 0 6,006 0 6,006 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 37,594 0 37,594 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 90,277 0 99. 277 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 39,083 0 39,083 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 95,951 0 95,951 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 95,951 73. 00 000 000 CLINIC 0 0 355,930 0 355,930 90. 00 000 CLINIC 0 0 355,930 0 355,930 90. 00 0010 EMERGENCY 0 292,765 0 292,765 91. 00 00 09000 DBSERVATION BEDS (NON-DISTINCT PART) 0 292,765 0 292,765 91. 00 00 0930 DOT DOT TREATMENT PROGRAM 0 0 0 0 0 0 99. 30 102. 00 10200   0PI OI D TREATMENT PROGRAM 0 0 0 0 0 0 99. 30 102. 00 10200   0PI OI D TREATMENT PROGRAM 0 0 0 0 0 5,058,779 118. 00 00 10200   0PI OI D TREATMENT PROGRAM 0 0 0 0 0 5,058,779 118. 00 00 1000   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0				
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   90, 277   0   90, 277   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   39, 083   72. 00   73. 00   73.00   DRUGS CHARGED TO PATIENTS   0   95, 951   0   95, 951   73. 00   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   0		0				
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   39, 083   0   39, 083   72. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   95, 951   0   95, 951   73. 00   74. 00   0   0   0   0   0   0   0   0   0		-1				
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   95, 951   0   95, 951   73. 00   74. 00   0   0   0   0   0   0   0   0   0		1				l
OUTPATIENT SERVICE COST CENTERS   90.00   09000   CLINIC   0   355, 930   0   355, 930   90.00	73.00 07300 DRUGS CHARGED TO PATIENTS	1				
90. 00   09000   CLINIC   0   355, 930   0   355, 930   90. 00   91.00   MERGENCY   0   292, 765   0   292, 765   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0   92. 00   0   0   0   0   0   92. 00   00   0   0   0   0   0   0   0		0	0	0	0	74. 00
91. 00   09100   EMERGENCY   0   292, 765   0   292, 765   0   292, 765   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   292, 765   0   292, 765   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   0   0   0   0   0		0	355, 930	0	355, 930	90.00
OTHER REIMBURSABLE COST CENTERS   OP930 OOT		0	292, 765		292, 765	
99. 30				0		92.00
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   30,065   5,058,779   0   5,058,779   118.00	99. 30 09930 00T	1 1				
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   30,065   5,058,779   0   5,058,779   118.00		0	0	0	0	102. 00
191. 00       19100       RESEARCH       0       0       0       0       191. 00         192. 00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       7, 436       0       7, 436       192. 00         192. 01       19201       PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       192. 01         194. 00       07950       NON-REI MBURSABLE       0       699, 642       0       699, 642       194. 00         194. 01       07952       NON-REI MBURSABLE       0       0       0       0       194. 01         194. 02       07952       NON-REI MBURSABLE       0       0       0       0       194. 02         194. 03       07953       CONTRACT PHARMACY       0       589       0       589       194. 03         200. 00       Cross Foot Adj ustments       0       0       0       0       200. 00         201. 00       Negati ve Cost Centers       0       343       0       343       201. 00	118.00 SUBTOTALS (SUM OF LINES 1 through 117	) 30, 065	5, 058, 779	0	5, 058, 779	118. 00
192.00     19200     PHYSI CI ANS' PRI VATE OFFI CES     0     7, 436     0     7, 436     192.00       192.01     19201     PHYSI CI ANS' PRI VATE OFFI CES     0     0     0     0     0     192.01       194.00     07950     NON-REI MBURSABLE     0     699, 642     0     699, 642     194.00       194.02     07952     NON-REI MBURSABLE     0     0     0     0     194.01       194.02     07952     NON-REI MBURSABLE     0     0     0     0     194.02       194.03     07953     CONTRACT PHARMACY     0     589     0     589     194.03       200.00     Cross Foot Adjustments     0     0     0     0     200.00       201.00     Negative Cost Centers     0     343     0     343     201.00		0	5, 171		5, 171	
192.01     19201     PHYSI CI ANS' PRI VATE OFFI CES     0     0     0     0     192.01       194.00     07950     NON-REI MBURSABLE     0     699, 642     0     699, 642     194.00       194.01     07951     NON-REI MBURSABLE     0     0     0     0     194.01       194.02     07952     NON-REI MBURSABLE     0     0     0     0     194.02       194.03     07953     CONTRACT PHARMACY     0     589     0     589     194.03       200.00     Cross Foot Adjustments     0     0     0     0     200.00       201.00     Negative Cost Centers     0     343     0     343     201.00		0	7 436		7 436	
194. 01 07951     NON-REI MBURSABLE     0     0     0     0     194. 01       194. 02 07952     NON-REI MBURSABLE     0     0     0     0     194. 02       194. 03 07953     CONTRACT PHARMACY     0     589     0     589     194. 03       200. 00 0     Cross Foot Adjustments     0     0     0     0     200. 00       201. 00 Negati ve Cost Centers     0     343     0     343     201. 00	192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192. 01
194. 02 07952     NON-REI MBURSABLE     0     0     0     0     194. 02       194. 03 07953     CONTRACT PHARMACY     0     589     0     589     194. 03       200. 00 cross Foot Adjustments     0     0     0     0     200. 00       201. 00 Negati ve Cost Centers     0     343     0     343     201. 00		0	699, 642	0	699, 642	
194.03 07953 CONTRACT PHARMACY     0     589     0     589     194.03       200.00 Cross Foot Adjustments     0     0     0     0     200.00       201.00 Negative Cost Centers     0     343     0     343     201.00			0	0	0	
201.00   Negative Cost Centers   0 343 0 343 201.00	194.03 07953 CONTRACT PHARMACY		589	-	589	194. 03
			0	0	0	
, , , , , , , , , , , , , , , , , , , ,		30.065				
		, , , , , , , , , , , , , , , , , , , ,				,

Heal th	Financial Systems	SSM HEALTH ST. !	MARYS HOSPITAL		In Li€	eu of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC		eri od:	Worksheet B-1	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre	pared:
		1				5/21/2024 9:5	4 am
		CAPITAL REI	_ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	·	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4.00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT	429, 194	429, 194				1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 341	2, 341	33, 006, 797			2. 00 4. 00
	00500 ADMINISTRATIVE & GENERAL	129, 544		3, 300, 906		70, 778, 215	5. 00
7.00	00700 OPERATION OF PLANT	32, 423	32, 423	834, 133	0	5, 242, 061	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	8, 904		91, 574		562, 859	8. 00
	00900 HOUSEKEEPI NG 01000 DI ETARY	5, 655 3, 173		942, 714 142, 574		1, 799, 007 497, 813	9. 00 10. 00
	01100 CAFETERI A	8, 135		322, 544		879, 784	11. 00
	01300 NURSING ADMINISTRATION	800		818, 917		1, 964, 795	13. 00
	01400 CENTRAL SERVICES & SUPPLY	525	1	294, 588		391, 095	14. 00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	4, 835	0 4, 835	1, 156, 462 0		2, 005, 548	15. 00 16. 00
	01700 SOCIAL SERVICE	2, 010		0	-	57, 518 34, 595	17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,010	2,010			01,070	17.00
	03000 ADULTS & PEDIATRICS	65, 227		5, 574, 982			30. 00
	03100 I NTENSI VE CARE UNI T	5, 799		1, 149, 300		_,,	31.00
	04000 SUBPROVI DER - I PF 04300 NURSERY	7, 164	7, 164 0	2, 969, 087 0			40. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS		<u> </u>				43.00
	05000 OPERATING ROOM	45, 699	45, 699	2, 019, 007	0	4, 500, 231	50. 00
	05100 RECOVERY ROOM	0	0	938, 139		1, 488, 693	51.00
	O5200   DELIVERY ROOM & LABOR ROOM   O5300   ANESTHESI OLOGY	416	0 416	0	0	0 100, 423	52. 00 53. 00
	05400 RADI OLOGY-DI AGNOSTI C	12, 885	l	1, 133, 523	0	1, 956, 983	54. 00
	05500 RADI OLOGY-THERAPEUTI C	0	0	550, 174		952, 884	55. 00
	05600 RADI OI SOTOPE	3, 436		106, 212		548, 149	56. 00
	05700 CT SCAN	234	1	339, 469		752, 452	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	408	408	171, 719 0		303, 864 0	58. 00 59. 00
	06000 LABORATORY	5, 945	1 -1	1, 376, 262	-	3, 272, 771	60.00
	06400 I NTRAVENOUS THERAPY	1, 061	1, 061	270, 439		440, 484	64. 00
	06500 RESPI RATORY THERAPY	1, 251	1, 251	1, 151, 014		2, 194, 162	65. 00
	06600 PHYSI CAL THERAPY 03340 CLI NI CAL NUTRI TI ON	4, 761	4, 761 0	1, 507, 343 122, 264		2, 448, 368 189, 748	66. 00 66. 01
	06700 OCCUPATIONAL THERAPY			168, 996		265, 144	67. 00
	06800 SPEECH PATHOLOGY	723	723	132, 981			68. 00
	06900 ELECTROCARDI OLOGY	5, 999	5, 999	906, 338		.,	
	03140 CARDI AC REHABI LI TATI ON	0	0	112, 349		175, 962	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 205	2, 205	63, 639 0	0	135, 373 3, 894, 032	70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	o	0	0	1, 675, 798	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	o	0	0	3, 992, 997	73. 00
74. 00	07400 RENAL DI ALYSI S	0	0	0	0	7	74. 00
90 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	11, 039	11, 039	2, 065, 960	0	3, 783, 152	90.00
	09100 EMERGENCY	10, 853		2, 044, 484		4, 372, 720	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	·					92. 00
	OTHER REIMBURSABLE COST CENTERS	1				1	
	09930 00T 10200 0PL0LD TREATMENT PROGRAM	0	0	0	· ·		99. 30 102. 00
102.00	SPECIAL PURPOSE COST CENTERS		<u> </u>			0	102.00
118.00		383, 450	383, 450	32, 778, 093	-17, 648, 699	69, 626, 539	118. 00
	NONREI MBURSABLE COST CENTERS	1			1	1	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	1	6, 770	0	15, 453	
191.00	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	164, 619	0	249, 721	191.00
192.01	19201 PHYSI CLANS' PRI VATE OFFI CES	0	o o	0	Ö		192. 01
194.00	07950 NON-REI MBURSABLE	45, 416	45, 416	57, 315	0	860, 838	194. 00
	07951 NON-REI MBURSABLE	0	0	0	0	l .	194. 01
	07952 NON-REI MBURSABLE 07953 CONTRACT PHARMACY	0	0	0	0	0 25, 664	194. 02 194. 03
200.00	Cross Foot Adjustments			U		25, 004	200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	2, 312, 248	2, 894, 719	18, 089, 587		17, 657, 531	202. 00
203. 00	Part       Unit cost multiplier (Wkst. B, Part   )	5. 387419	6. 744547	0. 548056		0. 249477	303 00
_55.00	1 10 1 3331 mai (1 pi 1 31 (m/31. b, 1 di t 1 )	0. 307717	0. , 4404/	5. 546656	1	0.247477	

Heal th Finar	ncial Systems	SSM HEALTH ST. N	MARYS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS			Peri od:	Worksheet B-1		
		_			From 01/01/2023 To 12/31/2023		
		CAPITAL REL	_ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
				DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)	
		1.00	2. 00	4. 00	5A	5. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)			28, 40	1	1, 624, 130	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00086	D	0. 022947	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0034 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 9:54 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE PLANT (SQUARE FEET) (TOTAL PATIENT (GROSS (SQUARE FEET) (TOTAL PATIENT DAYS) SALARI ES) DAYS) 7.00 10.00 11.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 264, 886 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.904 14, 394 8.00 00900 HOUSEKEEPI NG 9.00 5,655 250, 327 9.00 10.00 01000 DI ETARY 3, 173 3, 173 14, 394 10.00 01100 CAFETERI A 27, 372, 352 11.00 8.135 8.135 11.00 01300 NURSING ADMINISTRATION 800 800 818, 917 13.00 C 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 525 C 525 0 294, 588 14.00 15.00 01500 PHARMACY 1, 156, 462 15.00 01600 MEDICAL RECORDS & LIBRARY 4,835 4,835 0 16.00 C 0 16.00 01700 SOCIAL SERVICE 17.00 2,010 C 2, 010 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 65, 227 7, 986 65, 227 7, 986 5, 574, 982 30.00 03100 INTENSIVE CARE UNIT 1, 149, 300 31 00 5 799 936 5 799 936 31 00 04000 SUBPROVIDER - IPF 40.00 7, 164 5, 472 7, 164 5, 472 2, 969, 087 40.00 04300 NURSERY 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 45, 699 2 019 007 50 00 45, 699 Ω 51.00 05100 RECOVERY ROOM 0 0 C 0 938, 139 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 0 52.00 0 53 00 05300 ANESTHESI OLOGY Ω 53 00 416 416 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 12,885 C 12,885 1, 133, 523 54.00 05500 RADI OLOGY-THERAPEUTI C 550, 174 55.00 55.00 56.00 05600 RADI 0I SOTOPE 3, 436 0 3, 436 0 0 0 0 0 0 0 0 0 106, 212 56.00 57 00 05700 CT SCAN Ω 339, 469 57 00 234 234 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 408 0 408 171, 719 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 1, 376, 262 60.00 06000 LABORATORY 5,945 5, 945 60.00 06400 I NTRAVENOUS THERAPY 1,061 1, 061 270, 439 0 64.00 64 00 65.00 06500 RESPIRATORY THERAPY 1, 251 0 1, 251 1, 151, 014 65.00 06600 PHYSI CAL THERAPY 1, 507, 343 66.00 4,761 4, 761 66.00 66, 01 03340 CLINICAL NUTRITION 122, 264 66.01 C 0 |06700| OCCUPATI ONAL THERAPY 168, 996 67.00 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 723 723 132, 981 68.00 69 00 06900 ELECTROCARDI OLOGY 5, 999 5, 999 0 906, 338 69 00 03140 CARDIAC REHABILITATION 112, 349 69.01 69.01 0 C 07000 ELECTROENCEPHALOGRAPHY 70.00 2.205 C 2, 205 63, 639 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 11, 039 0 11, 039 0 2, 065, 960 90.00 09000 CLI NI C 09100 EMERGENCY 91.00 10.853 C 10,853 0 2.044.484 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.30 99.30 09930 00T 0 0 0 0 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 102. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 219, 142 14, 394 204, 583 14, 394 27, 143, 648 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 328 328 6, 770 190. 00 191. 00 19100 RESEARCH 0 191.00 C 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19201 PHYSICIANS' PRIVATE OFFICES 0 0 0 164, 619 192, 00 0 0 Ω C  $\cap$ 0 192. 01 194. 00 07950 NON-REI MBURSABLE 45, 416 45, 416 57, 315 194. 00 194. 01 07951 NON-REI MBURSABLE 0 0 0 194. 01 0 C 194. 02 07952 NON-REI MBURSABLE 0 Ω 0 0 0 194.02 194. 03 07953 CONTRACT PHARMACY 0 C 0 0 194. 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 1, 378, 017 202. 00 202.00 Cost to be allocated (per Wkst. B, 6, 549, 835 923, 448 2.387.649 730, 729 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 24. 726996 64. 155065 9.538120 50. 766222 0. 050343 203. 00 204.00 Cost to be allocated (per Wkst. B, 515, 030 138, 330 121, 694 57, 752 138, 931 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 1 944346 9 610254 0 486140 4 012227 0.005076 205.00 11)

Health Financial Systems	SSM HEALTH ST.	MARYS HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS				Peri od:	Worksheet B-1		
	,			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 9:5		
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A		
	PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL PATIENT	(GROSS		
	(SQUARE FEET)	(TOTAL PATIENT		DAYS)	SALARI ES)		
		DAYS)					
	7. 00	8. 00	9. 00	10.00	11. 00		
206.00 NAHE adjustment amount to be allocated						206. 00	
(per Wkst. B-2)							
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00	
Parts III and IV)							

		SSM HEALIH SI. M		N 44 0004		u or form CMS	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2023 To 12/31/2023	Worksheet B-1 Date/Time Pre 5/21/2024 9:5	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	(TOTAL PATIENT	
		(DI RECT NURS.	(COSTED	REGUI 3. )	(GROSS	DAYS)	
		HRS. )	REQUIS.)	45.00	CHARGES)	17.00	
	GENERAL SERVICE COST CENTERS	13.00	14. 00	15. 00	16. 00	17. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 00	OO400						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSING ADMINISTRATION	261, 387					13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	4, 507, 708	81, 65	4		14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	o		365, 453, 719		16. 00
17. 00	01700 SOCIAL SERVICE	0	0	(	0	14, 394	17. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	76, 366	476, 217	2 02	19, 123, 508	7 004	30.00
30.00	03100   NTENSIVE CARE UNIT	19, 186	184, 352	3, 83 <sup>,</sup> 1, 08 <sup>,</sup>		7, 986 936	1
40. 00	04000 SUBPROVI DER - I PF	37, 314	35, 315	149		5, 472	
43.00	04300 NURSERY	0	0	(	0 0	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	29, 918	1, 832, 928	10, 90	45, 139, 523	0	50.00
51. 00	05100 RECOVERY ROOM	20, 478	10, 001	32		Ö	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	
53. 00 54. 00	05300  ANESTHESI OLOGY   05400  RADI OLOGY-DI AGNOSTI C	1, 643	80, 709 77, 447	24, 79 1, 30		0	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 056	12, 449		7, 213, 009	0	55. 00
56. 00	05600 RADI OI SOTOPE	45	2, 142	4, 86		0	
57. 00 58. 00	05700 CT SCAN   05800 MAGNETIC RESONANCE IMAGING (MRI)	116 246	56, 147 5, 760	20, 02, 30;		0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	3, 700		0 9,776,131	0	1
60.00	06000 LABORATORY	0	1, 218, 181	6	1	0	60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	5, 605	24, 438 81, 742	590 21		0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	8, 400	2!		0	66.00
66. 01	03340 CLINICAL NUTRITION	0	0		28, 930	0	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	196		1, 330, 887 626, 728	0	
69. 00	06900 ELECTROCARDI OLOGY	5, 760	25, 646	22		0	1
69. 01	03140 CARDI AC REHABI LI TATI ON	2, 851	800	15:		0	
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 329 0	67	7 2, 381, 431 0 4, 722, 024	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o		3, 219, 491	0	
	07300 DRUGS CHARGED TO PATIENTS	O	O	(	22, 174, 184	0	
74. 00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0	(	0	0	74.00
90. 00	09000 CLINIC	27, 175	29, 719	10, 50	10, 080, 042	0	90.00
91.00	09100 EMERGENCY	30, 567	341, 790	1, 82	39, 400, 989	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	09930 00T	0	0	(	0	0	99. 30
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	(	0	0	102. 00
118. 00	SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)	259, 326	4, 507, 708	81, 65	365, 453, 719	1/ 30/	118. 00
110.00	NONREI MBURSABLE COST CENTERS	237, 320	4, 307, 700	01, 03	5 303, 433, 717	14, 374	] 110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19100  RESEARCH   19200  PHYSI CLANS'   PRI VATE OFFI CES	2, 061	0		0 0		191. 00 192. 00
	19201 PHYSI CLANS' PRI VATE OFFI CES	2,001	o	·			192. 01
	07950 NON-REI MBURSABLE	0	o	(	0		194. 00
	07951   NON-REI MBURSABLE   07952   NON-REI MBURSABLE	0	0	(	0		194. 01 194. 02
	07953 CONTRACT PHARMACY	0	o	,			194. 02
200.00	1 1						200. 00
201. 00 202. 00		2 522 405	521 404	2 544 10	227 520	112, 099	201. 00
202.00	Part I)	2, 523, 605	521, 484	2, 564, 10	237, 539	112,099	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0. 115687	31. 40131			
204.00	Cost to be allocated (per Wkst. B, Part II)	76, 239	20, 461	183, 43	71, 729	30, 065	204. 00
	lartii)	1 1	ı		T	ı	I
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Health Financial Systems	SSM HEALTH ST. MA	ARYS HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der CO	CN: 14-0034	Peri od: From 01/01/2023	Worksheet B-1		
				To 12/31/2023	Date/Time Pre 5/21/2024 9:5		
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &			
		SUPPLY	REQUI S. )	LI BRARY	(TOTAL PATIENT		
	(DI RECT NURS.	(COSTED		(GROSS	DAYS)		
	HRS. )	REQUIS.)		CHARGES)			
	13. 00	14.00	15. 00	16.00	17. 00		
205.00 Unit cost multiplier (Wkst. B, Part	0. 291671	0. 004539	2. 24642	0. 000195	2. 088718	205. 00	
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Title XVIII

			litle	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	, raj .		Di Sai i Gwanee		
		26)					
			2.00	2.00	4.00	Г 00	
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDI ATRI CS	16, 993, 368		16, 993, 368		16, 993, 368	
31.00	03100 INTENSIVE CARE UNIT	3, 276, 400		3, 276, 400	0	3, 276, 400	31.00
40.00	04000 SUBPROVI DER - I PF	7, 389, 535		7, 389, 535	0	7, 389, 535	40.00
43.00	04300 NURSERY	0		0		0	43.00
	ANCILLARY SERVICE COST CENTERS			-	-		
50.00	05000 OPERATI NG ROOM	8, 162, 970		8, 162, 970	21, 028	8, 183, 998	50.00
51. 00	05100 RECOVERY ROOM	2, 124, 164		2, 124, 164	21, 020	2, 124, 164	
		2, 124, 104			-		
52.00	05200 DELIVERY ROOM & LABOR ROOM	00, (05		0	0	0	
53.00	05300 ANESTHESI OLOGY	936, 685		936, 685	0	936, 685	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 020, 183		3, 020, 183	0	3, 020, 183	
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 244, 282		1, 244, 282	0	1, 244, 282	55. 00
56.00	05600 RADI 0I SOTOPE	966, 268		966, 268	0	966, 268	56.00
57.00	05700 CT SCAN	1, 638, 092		1, 638, 092	ol	1, 638, 092	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	421, 209		421, 209		421, 209	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	12.7207		0		0	1
60.00	06000 LABORATORY	4, 536, 141		4, 536, 141	0	4, 536, 141	1
					U o		
64.00	06400 I NTRAVENOUS THERAPY	677, 012		677, 012		677, 012	
65.00	06500 RESPI RATORY THERAPY	2, 859, 431	0	_, _,		2, 864, 002	
66. 00	06600 PHYSI CAL THERAPY	3, 306, 026	0	3, 306, 026	0	3, 306, 026	
66. 01	03340 CLINICAL NUTRITION	243, 260	0	243, 260	0	243, 260	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	340, 687	0	340, 687	o	340, 687	67. 00
68. 00	06800 SPEECH PATHOLOGY	301, 311	1 0	301, 311	0	301, 311	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 296, 084		2, 296, 084	10, 476	2, 306, 560	
69. 01	03140 CARDI AC REHABI LI TATI ON	258, 319		258, 319		258, 319	
70. 00	07000 ELECTROENCEPHALOGRAPHY	271, 096		271, 096		275, 667	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 868, 572		4, 868, 572		4, 868, 572	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 095, 964		2, 095, 964	0	2, 095, 964	
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 003, 571		5, 003, 571	0	5, 003, 571	
74.00	07400 RENAL DI ALYSI S	9		9	0	9	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	5, 811, 415		5, 811, 415	0	5, 811, 415	90.00
91.00	09100 EMERGENCY	6, 355, 865		6, 355, 865	28, 263	6, 384, 128	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 362, 288		1, 362, 288		1, 362, 288	
72.00	OTHER REIMBURSABLE COST CENTERS	1, 302, 200		1, 302, 200	l	1, 302, 200	72.00
00.20	09930 OOT					0	99. 30
				0		_	
	10200 OPIOID TREATMENT PROGRAM	0 7/0	_	0			102. 00
200.00		86, 760, 207		,,		86, 829, 116	
201.00		1, 362, 288		1, 362, 288		1, 362, 288	
202.00	Total (see instructions)	85, 397, 919	0	85, 397, 919	68, 909	85, 466, 828	202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0034 Title XVIII

			Title	XVIII	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'		·	+ col. 7)	Ratio	I npati ent	
				<b>_</b>		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	'					
	03000 ADULTS & PEDIATRICS	18, 088, 951		18, 088, 951			30.00
	03100 INTENSIVE CARE UNIT	2, 632, 841		2, 632, 841			31. 00
	04000 SUBPROVI DER - I PF	7, 449, 785		7, 449, 785			40. 00
	04300 NURSERY	0		0	l .		43. 00
	ANCILLARY SERVICE COST CENTERS	<u> </u>					10.00
	05000 OPERATING ROOM	14, 142, 319	30, 997, 204	45, 139, 523	0. 180839	0. 000000	50. 00
	05100 RECOVERY ROOM	1, 437, 416	10, 430, 969			0. 000000	1
	05200 DELIVERY ROOM & LABOR ROOM	1, 437, 410	10, 430, 707			0. 000000	
	05300 ANESTHESI OLOGY	3, 993, 360	9, 936, 428			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	1, 871, 921	14, 493, 401			0. 000000	
	05500 RADI OLOGY-THERAPEUTI C	45, 435	7, 167, 574			0. 000000	
	05600 RADI OLOGI - THERAPEUTI C		6, 980, 996			0. 000000	
	05700 CT SCAN	314, 176 10, 590, 471				0. 000000	
			45, 443, 194				
	05800 MAGNETIC RESONANCE IMAGING (MRI)	763, 758	9, 014, 393			0.000000	
	05900 CARDI AC CATHETERI ZATI ON	0	0			0.000000	
	06000 LABORATORY	12, 497, 465	35, 279, 545			0. 000000	
	06400 I NTRAVENOUS THERAPY	20, 695	1, 823, 450			0. 000000	
	06500 RESPI RATORY THERAPY	3, 923, 862	6, 769, 693			0. 000000	
	06600 PHYSI CAL THERAPY	1, 220, 072	8, 116, 624			0. 000000	
	03340 CLI NI CAL NUTRI TI ON	0	28, 930			0. 000000	
	06700 OCCUPATI ONAL THERAPY	292, 723	1, 038, 164			0. 000000	
	06800 SPEECH PATHOLOGY	131, 110	495, 618			0. 000000	
	06900 ELECTROCARDI OLOGY	3, 576, 292	10, 797, 682			0. 000000	
	03140 CARDIAC REHABILITATION	672	633, 812			0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	61, 019	2, 320, 412	2, 381, 431		0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 262, 921	1, 459, 103	4, 722, 024	1. 031035	0.000000	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 892, 525	1, 326, 966	3, 219, 491	0. 651023	0.000000	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 447, 856	13, 726, 328	22, 174, 184	0. 225648	0.000000	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	431, 734	9, 648, 308	10, 080, 042	0. 576527	0.000000	90.00
91. 00	09100 EMERGENCY	8, 192, 277	31, 208, 712	39, 400, 989	0. 161312	0. 000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	202, 515	832, 042		1. 316784	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
	09930 00T	0	0	0			99. 30
	10200 OPI OI D TREATMENT PROGRAM	0	0	Ö			102. 00
200.00	Subtotal (see instructions)	105, 484, 171	259, 969, 548	_			200.00
201.00			,, 0.10				201. 00
202.00		105, 484, 171	259, 969, 548	365, 453, 719			202. 00
_0 00	(333 1.131 331 3.13)	1 .00, .0., ., .,	_0,,,0,,010	300, .00, 717			1-32.00

Health Financial Systems SSM HEALTH ST. MARYS HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: From 01/01/2023 | Date/Time Prepared: From 01/01/

				10 12/31/2023	5/21/2024 9:5	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
	T	11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	T				
	03000 ADULTS & PEDIATRICS					30.00
31. 00	03100 INTENSIVE CARE UNIT					31.00
40. 00	04000 SUBPROVI DER - I PF					40.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 181304				50.00
51.00	05100 RECOVERY ROOM	0. 178977				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
53.00	05300 ANESTHESI OLOGY	0. 067243				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 184548				54.00
55. 00	05500  RADI OLOGY-THERAPEUTI C	0. 172505				55.00
56.00	05600 RADI 0I SOTOPE	0. 132453				56.00
57.00	05700 CT SCAN	0. 029234				57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 043077				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60. 00	06000 LABORATORY	0. 094944				60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 367114				64.00
65. 00	06500 RESPI RATORY THERAPY	0. 267825				65.00
66. 00	06600 PHYSI CAL THERAPY	0. 354089				66.00
66. 01	03340 CLINICAL NUTRITION	8. 408572				66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0. 255985				67.00
68. 00	06800 SPEECH PATHOLOGY	0. 480768				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 160468				69.00
69. 01	03140 CARDI AC REHABI LI TATI ON	0. 407132				69. 01
	07000 ELECTROENCEPHALOGRAPHY	0. 115757				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 031035				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 651023				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 225648				73.00
74.00	07400 RENAL DIALYSIS	0. 000000				74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 576527				90.00
91. 00	09100 EMERGENCY	0. 162030				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 316784				92.00
	OTHER REIMBURSABLE COST CENTERS					
99. 30	09930 00T					99. 30
102.00	10200 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

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-0034	Peri od:	Worksheet C
		From 01/01/2023	
			Date/Time Prepared:
			5/21/2024 9:54 am

					To 12/31/2023	Date/Time Pre 5/21/2024 9:5	
			Ti tl	e XIX	Hospi tal	PPS	<del>1</del> aiii
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	16, 993, 368		16, 993, 36	3 0	16, 993, 368	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 276, 400		3, 276, 40	ol ol	3, 276, 400	31.00
40.00	04000 SUBPROVI DER - I PF	7, 389, 535		7, 389, 53		7, 389, 535	
43.00	04300 NURSERY	0			ol	0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	8, 162, 970		8, 162, 97	21, 028	8, 183, 998	50.00
51.00	05100 RECOVERY ROOM	2, 124, 164		2, 124, 16	1 0	2, 124, 164	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			ol ol	0	52.00
53.00	05300 ANESTHESI OLOGY	936, 685		936, 68	5 0	936, 685	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 020, 183		3, 020, 18	3 0	3, 020, 183	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 244, 282		1, 244, 28	2 0	1, 244, 282	1
56.00	05600 RADI OI SOTOPE	966, 268		966, 26		966, 268	
57.00	05700 CT SCAN	1, 638, 092		1, 638, 09	2 0	1, 638, 092	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	421, 209		421, 20	el ol	421, 209	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			ol ol	0	59.00
60.00	06000 LABORATORY	4, 536, 141		4, 536, 14	1 0	4, 536, 141	60.00
64.00	06400 I NTRAVENOUS THERAPY	677, 012		677, 01	2 0	677, 012	64. 00
65.00	06500 RESPIRATORY THERAPY	2, 859, 431	0			2, 864, 002	65. 00
66.00	06600 PHYSI CAL THERAPY	3, 306, 026	0	3, 306, 02		3, 306, 026	66.00
66, 01	03340 CLINICAL NUTRITION	243, 260	0	243, 26	ol ol	243, 260	66, 01
67. 00	06700 OCCUPATI ONAL THERAPY	340, 687	0	340, 68		340, 687	67.00
68. 00	06800 SPEECH PATHOLOGY	301, 311	0	301, 31		301, 311	68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 296, 084		2, 296, 08	10, 476	2, 306, 560	69. 00
69. 01	03140 CARDI AC REHABI LI TATI ON	258, 319		258, 31	el o	258, 319	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	271, 096		271, 09		275, 667	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 868, 572		4, 868, 57		4, 868, 572	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 095, 964		2, 095, 96	4 o	2, 095, 964	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 003, 571		5, 003, 57	ı o	5, 003, 571	73. 00
74.00	07400 RENAL DIALYSIS	9			e o	9	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	5, 811, 415		5, 811, 41	5 0	5, 811, 415	90. 00
91.00	09100 EMERGENCY	6, 355, 865		6, 355, 86	28, 263	6, 384, 128	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 362, 288		1, 362, 28	3	1, 362, 288	92.00
	OTHER REIMBURSABLE COST CENTERS						
99. 30	09930 00T	0				0	99. 30
102.00	10200 OPIOID TREATMENT PROGRAM	0				0	102. 00
200.00	Subtotal (see instructions)	86, 760, 207	0	86, 760, 20	68, 909	86, 829, 116	200. 00
201.00		1, 362, 288		1, 362, 28	3	1, 362, 288	
202.00	Total (see instructions)	85, 397, 919	0	85, 397, 91	68, 909	85, 466, 828	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0034 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 9:54 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 18, 088, 951 18, 088, 951 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 632, 841 2, 632, 841 31.00 04000 SUBPROVIDER - IPF 7, 449, 785 7, 449, 785 40.00 40.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 14, 142, 319 30, 997, 204 45, 139, 523 0. 180839 0.000000 50.00 51.00 05100 RECOVERY ROOM 1, 437, 416 10, 430, 969 11, 868, 385 0.178977 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 52.00 3, 993, 360 05300 ANESTHESI OLOGY 9, 936, 428 13, 929, 788 0.000000 53.00 0.067243 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,871,921 14, 493, 401 16, 365, 322 0.184548 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 45, 435 7, 167, 574 7, 213, 009 0.172505 0.000000 55.00 6, 980, 996 05600 RADI OI SOTOPE 0.000000 56.00 56,00 314, 176 7, 295, 172 0.132453 57.00 05700 CT SCAN 10, 590, 471 45, 443, 194 56, 033, 665 0.029234 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 763, 758 9,014,393 9, 778, 151 0.043077 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 12, 497, 465 06000 LABORATORY 35, 279, 545 47, 777, 010 0 094944 60.00 0.000000 60 00 64.00 06400 I NTRAVENOUS THERAPY 20, 695 1,823,450 1, 844, 145 0.367114 0.000000 64.00 06500 RESPIRATORY THERAPY 3, 923, 862 6, 769, 693 10, 693, 555 0.000000 65.00 0. 267398 65.00 06600 PHYSI CAL THERAPY 8, 116, 624 0.354089 0.000000 66.00 1, 220, 072 9, 336, 696 66.00 03340 CLINICAL NUTRITION 28, 930 28, 930 66.01 8.408572 0.000000 66.01 67.00 06700 OCCUPATIONAL THERAPY 292, 723 1, 038, 164 1, 330, 887 0.255985 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 131, 110 495, 618 626, 728 0.480768 0.000000 68.00 10, 797, 682 69 00 06900 ELECTROCARDI OLOGY 3, 576, 292 14 373 974 0 159739 0 000000 69 00 69.01 03140 CARDIAC REHABILITATION 672 633, 812 634, 484 0.407132 0.000000 69.01 07000 ELECTROENCEPHALOGRAPHY 61, 019 2, 320, 412 2, 381, 431 0.113837 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 262, 921 1, 459, 103 4, 722, 024 1.031035 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 219, 491 72.00 72.00 1, 892, 525 1, 326, 966 0.651023 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 8, 447, 856 13, 726, 328 22, 174, 184 0. 225648 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 431, 734 9, 648, 308 10, 080, 042 0.576527 0.000000 90.00 09100 EMERGENCY 8, 192, 277 31, 208, 712 39, 400, 989 0.161312 0.000000 91.00 91.00 202, 515 832, 042 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 034, 557 1.316784 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 99.30 09930 00T 0 0 99.30

105, 484, 171

105, 484, 171

259, 969, 548

259, 969, 548

365, 453, 719

365, 453, 719

102.00

200. 00

201 00

202.00

102.00 10200 OPI OI D TREATMENT PROGRAM

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

202.00

				To 12/31/2023	Date/Time Prepared: 5/21/2024 9:54 am
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
	<b>'</b>	Ratio			
		11. 00			
IN	PATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03	000 ADULTS & PEDIATRICS				30. 00
31.00 03	100 INTENSIVE CARE UNIT				31.00
40.00 04	000 SUBPROVIDER - IPF				40.00
43.00 04	300 NURSERY				43. 00
AN	CILLARY SERVICE COST CENTERS				
	OOO OPERATING ROOM	0. 181304			50. 00
51.00 05	100 RECOVERY ROOM	0. 178977			51.00
	200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05	300 ANESTHESI OLOGY	0. 067243			53. 00
	400 RADI OLOGY-DI AGNOSTI C	0. 184548			54. 00
55.00 05	500 RADI OLOGY-THERAPEUTI C	0. 172505			55. 00
	6600 RADI OI SOTOPE	0. 132453			56. 00
	700 CT SCAN	0. 029234			57. 00
	800 MAGNETIC RESONANCE IMAGING (MRI)	0. 043077			58. 00
	900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
	000 LABORATORY	0. 094944			60.00
64. 00   06	400 I NTRAVENOUS THERAPY	0. 367114			64. 00
	500 RESPI RATORY THERAPY	0. 267825			65. 00
	600 PHYSI CAL THERAPY	0. 354089			66. 00
	340 CLINICAL NUTRITION	8. 408572			66. 01
	700 OCCUPATIONAL THERAPY	0. 255985			67. 00
	800 SPEECH PATHOLOGY	0. 480768			68. 00
	900 ELECTROCARDI OLOGY	0. 160468			69. 00
	140 CARDI AC REHABI LI TATI ON	0. 407132			69. 01
	000 ELECTROENCEPHALOGRAPHY	0. 115757			70.00
1	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 031035			71.00
	200 I MPL. DEV. CHARGED TO PATIENTS	0. 651023			72. 00
	300 DRUGS CHARGED TO PATIENTS	0. 225648			73. 00
	400 RENAL DI ALYSI S	0. 000000			74. 00
	TPATIENT SERVICE COST CENTERS	0.57/507			
	0000 CLINIC	0. 576527			90.00
	2100 EMERGENCY	0. 162030			91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 316784			92. 00
	HER REIMBURSABLE COST CENTERS				
99. 30 09					99. 30
	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 SSM HEALTH ST CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0034

Title XIX   Hospital   PPS   Cost Center Description   Total Cost   (Wkst. B, Part I, col. 26)   Cost Center Description   Total Cost   (Wkst. B, Part I, col. 26)   Cost Col. 1   Col. 26)   Cost Col. 2   C						10 12/31/2023	5/21/2024 9: 54	
Wilst B, Part Net of Capital Cost (col 1 col 26)				Ti tl	e XIX	Hospi tal		
1, col. 26)   11 col. 26)   Cost (col. 1 - col. 2)   Amount		Cost Center Description	Total Cost	Capital Cost	Operating Cos	t Capi tal	Operating Cost	
ANCILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00			(Wkst. B, Part					
ANCILLARY SERVICE COST CENTERS			I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
ANCILLARY SERVICE COST CENTERS								
SOLOD    OSDOO    O			1.00	2. 00	3. 00	4. 00	5. 00	
51.00   05100   RECOVERY ROOM   2.124, 164   48, 797   2,075, 367   0   0   51.00								
S2.00   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   0540			8, 162, 970				0	
53.00   05300   AMESTHESI OLOGY   936, 685   67, 143   869, 542   0   0   53.00			2, 124, 164	48, 797	2, 075, 36	7 0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C   3, 020, 183   246, 224   2, 773, 959   0   0   54. 00   55. 00   05500   RADI OLOGY-THERAPEUTI C   1, 244, 282   27, 196   1, 217, 086   0   0   56. 00   55. 00   05600   RADI OLOGY-THERAPEUTI C   1, 244, 282   27, 196   1, 217, 086   0   0   56. 00   57. 00   05600   RADI OLOGY-THERAPEUTI C   1, 244, 282   27, 196   1, 217, 086   0   0   0   0   57. 00   05600   RADIOLOGY-THERAPEUTI C   1, 244, 282   27, 196   1, 217, 086   0   0   0   0   58. 00   05600   RADIOLOGY-THERAPEUTI C   1, 241, 282   27, 196   1, 217, 086   0   0   0   0   58. 00   05800   MAGNETI C RESONANCE I IMAGI NG (MRI )   421, 209   16, 620   404, 589   0   0   58. 00   59. 00   05900   CARDIA C CATHETERI ZATI ON   0   0   0   0   0   0   0   60. 00   06900   LABORATORY   4, 536, 141   184, 826   4, 351, 315   0   0   60. 00   60. 00   06600   RESPI RATORY THERAPY   2, 859, 431   192, 133   2, 667, 298   0   0   65. 00   66. 00   06600   RESPI RATORY THERAPY   3, 306, 026   216, 498   3, 899, 528   0   0   65. 00   66. 01   03340   CLINIT CLA NUTRI TION   243, 260   238, 174   0   0   66. 01   67. 00   06700   0CCUPATI ONAL THERAPY   340, 687   7, 348   333, 339   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   301, 311   16, 387   284, 924   0   0   68. 00   69. 01   03140   CARDIA C REHABI LITATI ON   258, 319   6, 006   252, 313   0   0   69. 01   69. 01   03140   CARDIA C REHABI LITATI ON   258, 319   6, 006   252, 313   0   0   69. 01   71. 00   07000   ELECTROCROEPHALOGRAPHY   271, 096   37, 594   233, 502   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   2, 095, 964   39, 083   2, 056, 881   0   0   72. 00   71. 00   07400   RENAL DI ALYSIS   9   0   74, 00   71. 00   07400   RENAL DI ALYSIS   5   0   0   0   0   0   0   71. 00   09200   OSERVATI ON BEDS (NON-DISTINCT PART)   1, 362, 288   110, 672   1, 251, 616   0   0   0   0   0   71. 00   09000   10   00   00   00   00   0	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
55.00   05500   RADI OLOGY-THERAPEUTI C			936, 685			2 0	0	
56.00   05600   RADI OI SOTOPE   966, 268   75, 626   890, 642   0   0   56.00   57.00   05700   CT SCAN   1,638, 092   79, 008   1,559, 084   0   0   57.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   421, 209   16, 620   404, 589   0   0   58.00   59.00   0   0   0   0   0   0   0   0   0			3, 020, 183	246, 224			0	
57. 00   05700   CT SCAN   1,638,092   79,008   1,559,084   0   0   57.00   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   421,209   16,620   404,589   0   0   58. 00   59. 00   05900   CARDI AC CATHETER I ZATI ON   0   0   0   0   0   60. 00   05900   CARDI AC CATHETER I ZATI ON   0   0   0   0   60. 00   05900   CARDI AC CATHETER I ZATI ON   0   0   0   0   60. 00   06000   LABORATORY   4,536,141   184,826   4,351,315   0   0   60.00   64. 00   06400   I NTRAVENOUS THERAPY   677. 012   30,596   646,416   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   2,2859,431   192,133   2,667,298   0   0   65. 00   66. 01   03340   CALI THERAPY   3,306,026   216,498   3,089,528   0   0   66. 00   66. 01   03340   CALI NI CAL NUTRI TI ON   243,260   5,086   238,174   0   0   66. 01   67. 00   06700   0CCUPATI ONAL THERAPY   340,687   7,348   333,339   0   0   67,00   68. 00   06800   SPEECH PATHOLOGY   301,311   16,387   284,924   0   0   68.00   69. 00   06900   ELECTROCARDI OLOGY   2,296,084   134,015   2,162,069   0   0   69.00   69. 01   03140   CARDI AC REHABI LITATI ON   258,319   6,006   252,313   0   0   69,01   70. 00   07000   ELECTROCARDI OLOGY   271,096   37,594   233,502   0   0   70.00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   2,095,964   39,083   2,056,881   0   0   72.00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   2,095,964   39,083   2,056,881   0   0   72.00   74. 00   07400   RENAL DI ALYSI S   9   0   9   0   0   74. 00   07400   RENAL DI ALYSI S   9   0   9   0   0   74. 00   09000   CLI NI C   5,811,415   355,930   5,455,485   0   0   90.00   74. 00   09000   CLI NI C   5,811,415   355,865   292,765   6,063,100   0   91.00   792. 00   09000   DERREGENCY   6,355,865   292,765   6,063,100   0   91.00   793. 00   09000   CLI REATMENT PROGRAM   0   0   0   0   0   0   702. 00   09000   DI TREATMENT PROGRAM   0   0   0   0   0   702. 00   09000   Subtotal (sum of lines 50 thru 199)   59,100,904   3,293,646   55,807,258   0   0   702. 00   00000   Subtotal (sum o	55.00		1, 244, 282	27, 196	1, 217, 08	6 0	0	55. 00
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   421, 209   16, 620   404, 589   0   0   59. 00   659. 00   659. 00   600   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   59. 00   60. 00			966, 268			2 0	0	
59. 00         05900         CARDI AC CATHETERI ZATI ON         0			1, 638, 092	79, 008	1, 559, 08	4 0	0	
60. 00   06000   LABORATORY   4,536,141   184,826   4,351,315   0   0   60. 00   64. 00   06400   INTRAVENOUS THERAPY   677,012   30,596   646,416   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   2,859,431   192,133   2,667,298   0   0   65. 00   06600   PHYSI CAL THERAPY   3,306,026   216,498   3,089,528   0   0   66. 01   03340   CLI NI CAL NUTRI TION   243,260   5,086   238,174   0   0   66. 01   0340   CLI NI CAL NUTRI TION   243,260   5,086   238,174   0   0   66. 01   0340   CLI NI CAL DITRI THERAPY   340,687   7,348   333,339   0   0   67. 00   06900   CEUPATI ONAL THERAPY   340,687   7,348   333,339   0   0   67. 00   06900   ELECTROCARDI OLOGY   2,296,084   134,015   2,162,069   0   0   68.00   69. 00   69. 01   03140   CARDI AC REHABI LI TATI ON   258,319   6,006   252,313   0   0   69. 01   03140   CARDI AC REHABI LI TATI ON   258,319   6,006   252,313   0   0   69. 01   07.00   07000   ELECTROENCEPHALOGRAPHY   271,096   37,594   233,502   0   0   70. 00   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   4,868,572   90,277   4,778,295   0   0   71. 00   72. 00   73.00   07300   DRUGS CHARGED TO PATI ENTS   5,003,571   95,951   4,907,620   0   73. 00   74. 00   00   00   00   00   00   00   00	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	421, 209	16, 620	404, 58	9 0	0	58. 00
64. 00   06400   INTRAVENOUS THERAPY   677, 012   30, 596   646, 416   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   2, 859, 431   192, 133   2, 667, 298   0   0   65. 00   06500   RESPI RATORY THERAPY   2, 859, 431   192, 133   2, 667, 298   0   0   65. 00   06. 00   06500   PMSI CAL THERAPY   3, 306, 026   216, 498   3, 089, 528   0   0   66. 00   06. 00   0340   CLI NI CAL NUTRI TI ON   243, 260   5, 086   238, 174   0   0   66. 01   07. 00   06700   0CCUPATI ONAL THERAPY   340, 687   7, 348   333, 339   0   0   67. 00   06900   SPEECH PATHOLOGY   301, 311   16, 387   284, 924   0   0   68. 00   06900   SPEECH PATHOLOGY   2, 296, 084   134, 015   2, 162, 069   0   0   0   0   0   0   0   0   0	59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
65. 00   06500   RESPI RATORY THERAPY   2, 859, 431   192, 133   2, 667, 298   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   3, 306, 026   216, 498   3, 089, 528   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   340, 687   7, 348   333, 339   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   301, 311   16, 387   284, 924   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   2, 296, 084   134, 015   2, 162, 069   0   0   69. 00   69. 01   03140   CARDI AC REHABI LI TATI ON   258, 319   6, 006   252, 313   0   0   69. 01   69. 01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   4, 868, 572   90, 277   4, 778, 295   0   0   71. 00   67. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   2, 095, 964   39, 083   2, 056, 881   0   0   72. 00   67. 00   07400   RENAL DI ALYSI S   9   0   9, 90   0   0   68. 00   09000   CLI NI C   5, 811, 415   355, 930   5, 455, 485   0   0   90. 00   69. 00   09000   CLI NI C   5, 811, 415   355, 930   5, 455, 485   0   0   99. 30   69. 00   09000   DOPI OI TREATMENT PROGRAM   0   0   0   0   0   69. 00   09000   Subtotal (sum of lines 50 thru 199)   59, 100, 904   3, 293, 646   55, 807, 258   0   0   00. 00   69. 00   0   00   00   0   0   0   69. 00   00   00   00   00   00   69. 00   00   00   00   00   69. 00   00   00   00   00   69. 00   00   00   00   00   69. 00   00   0	60.00	06000 LABORATORY	4, 536, 141	184, 826	4, 351, 31	5 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY 3, 306, 026 210, 498 3, 089, 528 0 0 66. 00 66. 00 66. 01 03340 CLI NI CAL NUTRI TI ON 243, 260 5, 086 238, 174 0 0 66. 01 67. 00 06700 0CCUPATI ONAL THERAPY 340, 687 7, 348 333, 339 0 0 67. 00 680 SPECCH PATHOLOGY 301, 311 16, 387 284, 924 0 0 680 0 SPECCH PATHOLOGY 2, 296, 084 134, 015 2, 162, 069 0 0 69. 00 69. 01 03140 CARDI AC REHABI LI TATI ON 258, 319 6, 006 252, 313 0 0 69. 01 70. 00 07000 ELECTROCARDI OLOGY 271, 096 37, 594 233, 502 0 0 70. 00 71. 00 07000 ELECTROCEPHALOGRAPHY 271, 096 37, 594 233, 502 0 0 70. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 4, 868, 572 90, 277 4, 778, 295 0 0 71. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 095, 964 39, 083 2, 056, 881 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 5, 003, 571 95, 951 4, 907, 620 0 0 73. 00 07400 RENAL DI ALYSI S 9 0 9 0 9 0 0 74. 00 00 00 00 00 00 00 00 00 00 00 00 00	64.00	06400 I NTRAVENOUS THERAPY	677, 012	30, 596	646, 41	6 0	0	64. 00
66. 01 03340 CLINICAL NUTRITION 243, 260 5, 086 238, 174 0 0 66. 01 67. 00 6700 0CCUPATI ONAL THERAPY 340, 687 7, 348 333, 339 0 0 67. 00 680. 0 680. 0 5PEECH PATHOLOGY 301, 311 16, 387 284, 924 0 0 68. 00 690. 0	65.00	06500 RESPI RATORY THERAPY	2, 859, 431	192, 133	2, 667, 29	8 0	0	65. 00
67. 00	66.00	06600 PHYSI CAL THERAPY	3, 306, 026	216, 498	3, 089, 52	8 0	0	66. 00
68. 00	66. 01	03340 CLINICAL NUTRITION	243, 260	5, 086	238, 17	4 0	0	66. 01
69. 00	67.00	06700 OCCUPATI ONAL THERAPY	340, 687	7, 348	333, 33	9 0	0	67. 00
69. 01	68.00	06800 SPEECH PATHOLOGY	301, 311	16, 387	284, 92	4 0	0	68. 00
70. 00	69. 00	06900 ELECTROCARDI OLOGY	2, 296, 084	134, 015	2, 162, 06	9 0	0	69. 00
71. 00	69. 01	03140 CARDI AC REHABI LI TATI ON	258, 319	6, 006	252, 31	3 0	0	69. 01
72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	271, 096	37, 594	233, 50	2 0	0	70. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   5,003,571   95,951   4,907,620   0   0   73.00   74. 00   07400   RENAL DI ALYSIS   9   0   9   0   0    OUTPATIENT SERVICE COST CENTERS  90. 00   09000   CLI NI C   5,811,415   355,930   5,455,485   0   0   0   0    91. 00   09100   EMERGENCY   6,355,865   292,765   6,063,100   0   0   0    92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   1,362,288   110,672   1,251,616   0   0    99. 30   09930   OOT   0   0   0   0   0    102. 00   10200   OPI OID TREATMENT PROGRAM   0   0   0   0    200. 00   Subtotal (sum of lines 50 thru 199)   59,100,904   3,293,646   55,807,258   0    0   0   0   0   0    0   0   0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 868, 572	90, 277	4, 778, 29	5 0	0	71. 00
74. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 095, 964	39, 083	2, 056, 88	1 0	0	72. 00
OUTPATIENT SERVICE COST CENTERS   OUTP	73.00	07300 DRUGS CHARGED TO PATIENTS	5, 003, 571	95, 951	4, 907, 62	o o	0	73. 00
90. 00	74.00	07400 RENAL DIALYSIS	9	0		9 0	0	74. 00
91. 00		OUTPATIENT SERVICE COST CENTERS						
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   1,362,288   110,672   1,251,616   0   0   92. 00	90.00	09000 CLI NI C	5, 811, 415	355, 930	5, 455, 48	5 0	0	90. 00
OTHER REIMBURSABLE COST CENTERS           99. 30         09930 00T         0         0         0         0         99. 30           102. 00 10200 0PI 0I D TREATMENT PROGRAM 200. 00         0         0         0         0         0         0         0         102. 00           200. 00 Subtotal (sum of lines 50 thru 199)         59, 100, 904         3, 293, 646         55, 807, 258         0         0         200. 00	91.00	09100 EMERGENCY	6, 355, 865	292, 765	6, 063, 10	o o	0	91. 00
99. 30	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 362, 288	110, 672	1, 251, 61	6 0	0	92. 00
102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 102.00 200.00 Subtotal (sum of lines 50 thru 199) 59,100,904 3,293,646 55,807,258 0 0 200.00		OTHER REIMBURSABLE COST CENTERS						
200.00   Subtotal (sum of lines 50 thru 199)   59,100,904   3,293,646   55,807,258   0   0   200.00	99. 30	09930 00T	0	0		0 0	0	99. 30
	102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0	0	102. 00
004 00	200.00	Subtotal (sum of lines 50 thru 199)	59, 100, 904	3, 293, 646	55, 807, 25	8 0	0	200. 00
201.00    Less Observation Beds   1,362,288  110,672  1,251,616  0  0 201.00	201.00	Less Observation Beds	1, 362, 288	110, 672	1, 251, 61	6 0	0	201. 00
202.00   Total (line 200 minus line 201)   57,738,616   3,182,974   54,555,642   0   0   202.00	202.00	Total (line 200 minus line 201)	57, 738, 616	3, 182, 974	54, 555, 64	2 0	0	202. 00

Peri od: Worksheet C From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/21/2024 9:54 am REDUCTIONS FOR MEDICALD ONLY

						5/21/2024 9:5	4 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges				
		Capital and		Cost to Charge			
		Operating Cost		Ratio (col. 6			
		Reducti on	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	8, 162, 970	45, 139, 523	0. 180839			50. 00
51.00	05100 RECOVERY ROOM	2, 124, 164	11, 868, 385	0. 178977			51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000			52.00
53.00	05300 ANESTHESI OLOGY	936, 685	13, 929, 788	0.067243			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 020, 183	16, 365, 322	0. 184548			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 244, 282	7, 213, 009	0. 172505			55. 00
56.00	05600 RADI 0I SOTOPE	966, 268	7, 295, 172	0. 132453			56. 00
57.00	05700 CT SCAN	1, 638, 092	56, 033, 665	0. 029234			57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	421, 209	9, 778, 151	0. 043077			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.000000			59. 00
60.00	06000 LABORATORY	4, 536, 141	47, 777, 010	0. 094944			60.00
64.00	06400 I NTRAVENOUS THERAPY	677, 012	1, 844, 145				64.00
65.00	06500 RESPI RATORY THERAPY	2, 859, 431	10, 693, 555	0. 267398			65. 00
66.00	06600 PHYSI CAL THERAPY	3, 306, 026	9, 336, 696	0. 354089			66. 00
66. 01	03340 CLINICAL NUTRITION	243, 260	28, 930	8. 408572			66. 01
67.00	06700 OCCUPATI ONAL THERAPY	340, 687	1, 330, 887	0. 255985			67.00
68.00	06800 SPEECH PATHOLOGY	301, 311	626, 728	0. 480768			68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 296, 084	14, 373, 974	0. 159739			69. 00
69. 01	03140 CARDI AC REHABI LI TATI ON	258, 319	634, 484	0. 407132			69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	271, 096	2, 381, 431	0. 113837			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 868, 572	4, 722, 024	1. 031035			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 095, 964	3, 219, 491	0. 651023			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 003, 571	22, 174, 184	0. 225648			73. 00
74.00	07400 RENAL DIALYSIS	9	0	1			74.00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
90.00	09000 CLI NI C	5, 811, 415	10, 080, 042	0. 576527			90.00
91.00	09100 EMERGENCY	6, 355, 865					91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 362, 288	1, 034, 557	1. 316784			92.00
	OTHER REIMBURSABLE COST CENTERS		, ,				
99. 30	09930 00T	0	C	0.000000			99. 30
	10200 OPI OI D TREATMENT PROGRAM	0	O	1			102. 00
200.00		59, 100, 904	337, 282, 142				200. 00
201.00		1, 362, 288		1			201. 00
202.00	l	57, 738, 616					202.00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		, ,,	1			

Health Financial Systems	SSM HEALTH ST. I	MARYS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	AL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 9:5	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 380, 539		1, 380, 53			1
31.00 INTENSIVE CARE UNIT	165, 255		165, 25			1
40. 00   SUBPROVI DER - I PF	330, 011	0	330, 01	1 5, 472		
43. 00 NURSERY	0			0	0.00	
200.00 Total (lines 30 through 199)	1, 875, 805		1, 875, 80	5 15, 090		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	4, 526		•			30. 00
31. 00 INTENSIVE CARE UNIT	464					31. 00
40. 00 SUBPROVI DER - I PF	975		1			40. 00
43. 00 NURSERY	0	0	1			43. 00
200.00 Total (lines 30 through 199)	5, 965	860, 400	0			200. 00

Health Financial Systems	SSM HEALTH ST.	MARYS HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023	Part II	nanad.
				To 12/31/2023	Date/Time Pre 5/21/2024 9:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T	1		.1		
50. 00   05000   OPERATI NG ROOM	917, 865				71, 123	1
51. 00   05100   RECOVERY ROOM	48, 797			· ·	1, 396	1
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	_	1 0.0000		0	52.00
53. 00   05300   ANESTHESI OLOGY	67, 143			· ·	2, 655	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	246, 224					54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	27, 196			· ·	11	55. 00
56. 00   05600   RADI OI SOTOPE	75, 626			· ·	1, 088	56. 00
57. 00   05700   CT   SCAN	79, 008				7, 441	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	16, 620			· ·	541	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	_	1 0.0000		0	59. 00
60. 00   06000   LABORATORY	184, 826				23, 279	60.00
64.00 06400 INTRAVENOUS THERAPY	30, 596			· ·	116	1
65. 00 06500 RESPI RATORY THERAPY	192, 133				37, 536	•
66. 00   06600   PHYSI CAL THERAPY	216, 498			· ·	16, 731	
66. 01   03340   CLI NI CAL NUTRI TI ON	5, 086				0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	7, 348			· ·	795	67. 00
68. 00 06800 SPEECH PATHOLOGY	16, 387				2, 756	
69. 00 06900 ELECTROCARDI OLOGY	134, 015				14, 068	
69. 01 03140 CARDI AC REHABI LI TATI ON	6, 006				0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	37, 594			· ·	633	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	90, 277				25, 522	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	39, 083			· ·	7, 173	
73.00 07300 DRUGS CHARGED TO PATIENTS	95, 951				18, 978	
74. 00 07400 RENAL DI ALYSI S	0	0	0.00000	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS		1		_1		
90. 00   09000   CLI NI C	355, 930				0	90.00
91. 00   09100   EMERGENCY	292, 765				28, 341	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	110, 672			· ·	10, 925	1
200.00   Total (lines 50 through 199)	3, 293, 646	337, 282, 142	l	32, 263, 910	290, 835	J200. 00

Health Financial Systems SSM HEALTH ST. MARYS HOSPITAL In Lieu of Form CMS-2552-							
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		TS Provider CO	F	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/21/2024 9:5	pared:	
			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		Adjustments		Education Cost		
	Adjustments						
	1A	1.00	2A	2. 00	3. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS	0	0	C	0	0	30.00	
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31. 00	
40. 00   04000   SUBPROVI DER - 1 PF	0	0	l	0	0	40.00	
43. 00 04300 NURSERY	0	0	1	0	0	43.00	
200.00 Total (lines 30 through 199)	0	0	1	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,					
	instructions)	minus col. 4)					
	4.00	5. 00	6.00	7. 00	8. 00		
INPATIENT ROUTINE SERVICE COST CENTERS				"			
30. 00 03000 ADULTS & PEDIATRICS	0	0	8, 682	0.00	4, 526	30.00	
31.00 03100 INTENSIVE CARE UNIT		0	936	0.00	464	31. 00	
40. 00   04000   SUBPROVI DER - I PF	0	0	5, 472	0.00	975	40.00	
43. 00 04300 NURSERY		0	1	0.00	0	43.00	
200.00 Total (lines 30 through 199)		0	15, 090		5. 965	200.00	
Cost Center Description	Inpatient						
p	Program						
	Pass-Through						
	Cost (col. 7 x						
	col. 8)						
	9. 00						

30.00

31. 00 40. 00 43. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF

43. 00 | 04300 | NURSERY 200. 00 | Total (lines 30 through 199)

12/31/2023 Date/Time Prepared: 5/21/2024 9:54 am Title XVIII Hospi tal Non Physician Nursi ng Allied Health Allied Health Cost Center Description Nursi ng Anestheti st Post-Stepdown Program Program Cost Post-Stepdown Adi ustments Adjustments 1.00 3. 00 2A 2.00 ЗА ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 0 0000000000000000000000000 0 05100 RECOVERY ROOM 51.00 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 0 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 57.00 05700 CT SCAN 0 0 57.00 01 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 59.00 60.00 06000 LABORATORY 60.00 0 0 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 0 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 03340 CLINICAL NUTRITION 0 66.01 0 66.01 06700 OCCUPATIONAL THERAPY 0 0 67.00 67 00 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 03140 CARDIAC REHABILITATION 0 69. 01 69.01 0 07000 ELECTROENCEPHALOGRAPHY 0 70 00 Ω 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 Ω 73.00 07400 RENAL DIALYSIS 0 0 74.00 0 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0 0 0 0 0 0 90.00 0 91. 00 09100 EMERGENCY 91.00 Ω 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00

0

0 200. 00

Total (lines 50 through 199)

Health Financial Systems	SSM HEALTH ST. MAR	RYS HOSPITAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT AND THROUGH COSTS	CILLARY SERVICE OTHER PASS	Provider CCN: 14-0034	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepa 5/21/2024 9:54	
		Title XVIII	Hospi tal	PPS	
Cost Center Description		Total Cost Total	Total Charges	Ratio of Cost	

THROUGH GOOTS			1	o 12/31/2023	Date/Time Pre 5/21/2024 9:5	
		Titl∈	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		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			1		I	
50.00   05000   OPERATING ROOM	0	0	,			
51.00 05100 RECOVERY ROOM	0	0	(	11, 868, 385		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0	(	13, 929, 788		
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	16, 365, 322		
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	(	7, 213, 009		1
56. 00   05600   RADI OI SOTOPE	0	0	(	7, 295, 172		
57. 00  05700 CT SCAN	0	0	(	56, 033, 665		
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	(	9, 778, 151	0.000000	58. 00
59. 00  05900  CARDI AC CATHETERI ZATI ON	0	0	(	0	0.000000	59. 00
60. 00  06000  LABORATORY	0	0	(	47, 777, 010		
64.00   06400   I NTRAVENOUS THERAPY	0	0	(	1, 844, 145		
65. 00  06500 RESPIRATORY THERAPY	0	0	(	10, 693, 555	0.000000	65. 00
66. 00  06600 PHYSI CAL THERAPY	0	0	(	9, 336, 696	0.000000	66. 00
66. 01   03340   CLI NI CAL NUTRI TI ON	0	0	(	28, 930		
67. 00  06700 OCCUPATI ONAL THERAPY	0	0	(	1, 330, 887	0.000000	67. 00
68.00   06800   SPEECH PATHOLOGY	0	0	(	626, 728	0.000000	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0	(	14, 373, 974	0.000000	69. 00
69. 01   03140   CARDI AC REHABI LI TATI ON	0	0	(	634, 484	0.000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(	2, 381, 431	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	4, 722, 024	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	3, 219, 491	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	22, 174, 184	0.000000	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0	(	0	0.000000	74. 00
OUTPATIENT SERVICE COST CENTERS				·		
90. 00 09000 CLI NI C	0	C	(	10, 080, 042	0.000000	90. 00
91. 00 09100 EMERGENCY	0	0	(	39, 400, 989	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(	1, 034, 557	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	(	337, 282, 142		200. 00

Health Financial Systems	SSM HEALTH ST. MARYS HOSPITAL			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIEN	F ANCILLARY SERV	VICE OTHER PASS	Provider Co	CN: 14-0034	Peri od:	Worksheet D	
THROUGH COSTS					From 01/01/2023	Part IV	
					To 12/31/2023	Date/Time Pre	pared:
						5/21/2024 9:5	4 am
			Title	: XVIII	Hospi tal	PPS	
Cost Center Description		Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Dass_Through	Charges	Dass_Through	

						5/21/2024 9:5	<u>4 alli</u>
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS	T		T			
50.00	05000 OPERATI NG ROOM	0. 000000	3, 497, 755		9, 081, 095		50. 00
51. 00	05100 RECOVERY ROOM	0. 000000	339, 600		0 2, 803, 618		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	550, 770		0 1, 298, 917	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 311, 210		0 5, 509, 231	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	2, 977		0 1, 810, 498	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	104, 950		0 1, 033, 174	0	56. 00
57.00	05700 CT SCAN	0. 000000	5, 277, 477		0 12, 792, 406	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	318, 158		0 2, 711, 270	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60.00	06000 LABORATORY	0. 000000	6, 016, 708		0 4, 189, 800	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	6, 970		0 636, 545	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	2, 089, 139		0 1, 285, 342	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	721, 518		0 1, 490	0	66. 00
66. 01	03340 CLINICAL NUTRITION	0. 000000	0		0 0	0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	143, 977		0 1, 100	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	105, 398		0 36, 866	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	1, 508, 925		0 3, 244, 033	0	69. 00
69. 01	03140 CARDIAC REHABILITATION	0. 000000	0		0 0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	40, 090		0 1, 409, 685	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 334, 963		0 343, 991	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	590, 910		0 265, 078	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 385, 856		0 6, 160, 507	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0		o o	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 376, 743	0	90. 00
91.00	09100 EMERGENCY	0. 000000	3, 814, 437		0 7, 297, 855	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	102, 122		0 200, 008	0	92. 00
200.00	Total (lines 50 through 199)		32, 263, 910		0 62, 489, 252	0	200. 00
	•			•	•	•	•

APPORTI ONWENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST   Provider CON: 14-0034   Provider CON: 14-0034   Provider CON: 12-002-75   Prov	Health Financial Systems	SSM HEALTH ST. I	MARYS HOSPITAL		In Lie	u of Form CMS-2	2552-10
To   12/31/2002   Date/Time Prepared:   S/21/2024 9:54 am   Title   XVII   Title   XVII   Hospital   PPS   From   Services   Cost   C	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C				
Title   XVIII   Hospital   Formal Ratio   From Worksheet   C.   Part   Cost   Reimbursed   Cost   Reimbursed   Cost   C					From 01/01/2023	Part V	
Cost Center Description					10 12/31/2023	Date/lime Pre	pared:
Cost Center Description			Ti +Lo	V// I I	Hocni tal		4 alli
Cost Center Description			11116		поѕрі таі		
Ratio From Worksheet C, Part I, col. 9	Coot Contar Deparintion	Coot to Change	DDC Doimburgood		Coot		
North-Sheet C, Part I, col. 9   Services Subject To Ded. & Coins. (see inst.)   Subject To Ded. & Coins. (see inst.)	cost center bescription						
Part I, col. 9						(See Hist.)	
Ded. & Col ns. (see inst.)   Ded. & Col ns. (see inst.)							
1.00   2.00   3.00   4.00   5.00		rait i, coi. 9					
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS   ST. 00   0   0   0   0   1,642,216   50.00   0   0   0   0   0   0   0   0   0		1 00	2 00			5.00	
SOLO   05000	ANCILLADY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
S1-00   05100   RECOVERY ROOM & LABOR ROOM   0.178977   2,803,618   0   0   0   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000		0 180839	9 081 095	:	n n	1 642 216	50.00
52.00   05200   05200   05200   05200   05200   053000   053000   053000   053000   053000   053000   053000   05300					0		
53.00   05300   AMESTHESI OLOGY   0.067243   1,298,917   0 0   0.87,343   53.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   0.184548   5,509,231   0 0   0.1016,718   54.00   55.00   05500   RADI OLOGY-THERAPEUTI C   0.172505   1,810,498   0   0   312,320   55.00   05500   RADI OLOGY-THERAPEUTI C   0.132453   1,033,174   0   0   136,847   56.00   57.00   05700   CT SCAN   0.029234   12,792,406   0   0   373,973   57.00   58.00   05800   MAGNETI C RESONANCE   IMAGI NG (MRI)   0.043077   2,711,270   0   0   0   116,793   58.00   59.00   05800   MAGNETI C RESONANCE   IMAGI NG (MRI)   0.043077   2,711,270   0   0   0   0   0   59.00   60.00   06000   LABDRATORY   0.094944   4,189,800   0   0   0   397,796   60.00   60.00   06000   LABDRATORY   0.267398   1,285,342   0   0   343,698   65.00   65.00   06500   RESPI RATORY THERAPY   0.354089   1,490   0   0   0   528   66.00   66.00   06600   PHYSI CAL THERAPY   0.354089   1,490   0   0   0   528   66.00   66.01   03340   CLI NI CAL NUTRI TI ON   8.408572   0   0   0   0   0   528   66.00   67.00   06000   06000   06000   06000   0					-		
54.00   05400   RADI OLOGY-THERAPEUTI C   0.184548   5.509, 231   0   0   0   1,016,718   54.00				,	-		
55.00   05500   RADI OLOGY-THERAPEUTI C   0.172505   1,810,498   0   0   312,320   55.00   56.00   05600   RADI OI SOTOPE   0.132453   1,033,174   0   0   0   136,847   56.00   05700   CT SCAN   0.029234   12,792,406   0   0   0   373,973   57.00   05700   CT SCAN   0.029234   12,792,406   0   0   0   0   0   116,793   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0.043077   2,711,270   0   0   0   0   0   116,793   58.00   05900   CARDI AC CATHETERI ZATI ON   0.000000   0   0   0   0   0   0   0				II.	0		
56.00   05600   RADIOISOTOPE   0.132453   1,033,174   0   0   136,847   56.00   57.00   05700   CT SCAN   0.029234   12,792,406   0   0   373,973   57.00   05900   CARDIAC CATHETERIZATION   0.043077   2,711,270   0   0   0   0   0   59.00   05900   CARDIAC CATHETERIZATION   0.000000   0   0   0   0   0   0   59.00   05900   CARDIAC CATHETERIZATION   0.000000   0   0   0   0   0   0   0		l .			٦		1
57. 00   05700   CT SCAN   0.029234   12,792,406   0   0   373,973   57.00				1	0		1
58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0.043077   2,711,270   0   0   0   116,793   58.00					-		1
59.00   05900   CARDI AC CATHETERI ZATI ON   0.000000   0   0   0   0   0   59.00					-		
60. 00   06000   LABORATORY   0. 094944   4, 189, 800   0   0   397, 796   60. 00   0   64. 00   06400   INTRAVENOUS THERAPY   0. 367114   636, 545   0   0   0   233, 685   64. 00   06500   RESPI RATORY THERAPY   0. 267398   1, 285, 342   0   0   0   0   343, 698   65. 00   066. 01   03340   CLI NI CAL NUTRI TI ON   8   408572   0   0   0   0   0   0   0   0   0					9	· ·	
64. 00   06400   INTRAVENOUS THERAPY   0. 367114   636, 545   0   0   233, 685   64. 00   65. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   06600   PHYSI CAL THERAPY   0. 354089   1, 285, 342   0   0   343, 698   65. 00   66. 00   0343   CLI NI CAL NUTRI TI ON   8. 408572   0   0   0   0   0   0. 60. 01   67. 00   06700   0CCUPATI ONAL THERAPY   0. 255985   1, 100   0   0   0   282   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 480768   36, 866   0   0   17, 724   68. 00   69. 00   0900   ELECTROCARDI OLOGY   0. 159739   3, 244, 033   0   0   518, 199   69. 00   69. 01   03140   CARDI AC REHABI LITATI ON   0. 407132   0   0   0   0   0   0   0   0   0					-	-	
65. 00 06500 RESPIRATORY THERAPY					-		
66. 00 06600 PHYSI CAL THERAPY 0. 354089 1, 490 0 0 0 528 66. 00 66. 01 03340 CLINI CAL NUTRITION 8. 408572 0 0 0 0 0 0 66. 01 67. 00 0600 0CCUPATIONAL THERAPY 0. 255985 1, 100 0 0 0 282 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 480768 36, 866 0 0 0 17, 724 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 159739 3, 244, 033 0 0 518, 199 69. 00 69. 01 03140 CARDI AC REHABI LI TATI ON 0. 407132 0 0 0 0 0 0 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 113837 1, 409, 685 0 0 0 160, 474 70. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1. 031035 343, 991 0 0 0 354, 667 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 651023 265, 078 0 0 172, 572 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 225648 6, 160, 507 0 15, 516 1, 390, 106 73. 00 07400 RENAL DI ALYSI S 0. 0000000 0 0 0 0 0 0 74. 00 00000 CLINI C 0. 09000 CLINI C 0. 09100 EMERGENCY 0. 161312 7, 297, 855 0 0 0 17, 177, 232 91. 00 09100 EMERGENCY 0. 161312 7, 297, 855 0 0 0 17, 177, 232 91. 00 09100 ELESS PBP CLI INI C 0. 576527 376, 743 0 0 0 263, 367 92. 00 09100 CLESS PBP CLI INI C 0. 0576527 0. 00 15, 516 9, 435, 526 200. 00 00 00 00 00 00 00 00 00 00 00 00					-		1
66. 01 03340 CLINICAL NUTRITION 8. 408572 0 0 0 0 0 66. 01 67. 00 06700 OCCUPATIONAL THERAPY 0. 255985 1, 100 0 0 282 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 480768 36, 866 0 0 17, 724 68. 00 69. 00 69. 00 ELECTROCARDIOLOGY 0. 159739 3, 244, 033 0 0 518, 199 69. 00 07000 ELECTROENCEPHALOGRAPHY 0. 113837 1, 409, 685 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·	1			0	· ·	
67. 00		1		<u>'</u>	-		
68. 00   06800   SPEECH PATHOLOGY   0. 480768   36, 866   0   0   17, 724   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 159739   3, 244, 033   0   0   518, 199   69. 00   69. 01   03140   CARDI AC REHABI LITATI ON   0. 407132   0   0   0   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 113837   1, 409, 685   0   0   160, 474   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   1. 031035   343, 991   0   0   354, 667   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 651023   265, 078   0   0   172, 572   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 225648   6, 160, 507   0   15, 516   1, 390, 106   73. 00   74. 00   07400   RENAL DI ALYSI S   0. 000000   0   0   0   74. 00   007400   EMERGENCY   0. 161312   7, 297, 855   0   0   1, 177, 232   91. 00   792. 00   09200   DRUGS CHARGED TO PATI ENTS   1. 316784   200, 008   0   0   263, 367   92. 00   792. 00   09200   DRUGS CHARGED TO PATI ENTS   1. 316784   200, 008   0   0   263, 367   92. 00   792. 00   09200   DRUGS CHARGED TO PATI ENTS   1. 316784   200, 008   0   0   263, 367   92. 00   792. 00   09200   DRUGS CHARGED TO PATI ENTS   1. 316784   200, 008   0   0   263, 367   92. 00   792. 00   09200   DRUGS CHARGED TO PATI ENTS   1. 316784   200, 008   0   0   263, 367   92. 00   792. 00   09200   DRUGS CHARGED TO PATI ENTS   1. 316784   200, 008   0   0   263, 367   92. 00   792. 00   09200   DRUGS CHARGED TO PATI ENTS   1. 316784   200, 008   0   0   263, 367   92. 00   792. 00   09200   DRUGS CHARGED TO PATI ENTS   1. 316784   200, 008   0   0   0   263, 367   92. 00   793. 00   00				<u>'</u>	-	-	
69. 00					-		1
69. 01				•	-		
70. 00	· ·	1			0	· ·	
71. 00				)	٩		
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 651023   265, 078   0   0   172, 572   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 225648   6, 160, 507   0   15, 516   1, 390, 106   73. 00   07400   RENAL DI ALYSIS   0. 000000   0   0   0   0   0   0   0		1		1	0		
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 225648   6, 160, 507   0   15, 516   1, 390, 106   73. 00   74. 00   07400   RENAL DIALYSIS   0. 0000000   0   0   0   0    OUTPATIENT SERVICE COST CENTERS  90. 00   09100   O9100   EMERGENCY   0. 161312   7, 297, 855   0   0   1, 177, 232   91. 00    92. 00   09200   OSERVATION BEDS (NON-DISTINCT PART)   1. 316784   200, 008   0   0   263, 367   92. 00    200. 00   Subtotal (see instructions)   Cess PBP Clinic Lab. Services-Program   0   0   0   0    Only Charges					0		
74. 00 07400 RENAL DIALYSIS 0.000000 0 0 0 0 0 74.00 OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0.576527 376, 743 0 0 217, 203 90.00 91.00 EMERGENCY 0.161312 7, 297, 855 0 0 1, 177, 232 91.00 09200 08SERVATION BEDS (NON-DISTINCT PART) 1.316784 200, 008 0 0 263, 367 92.00 200.00 Subtotal (see instructions) 62, 489, 252 0 15, 516 9, 435, 526 200.00 01 y Charges		1			-		
90. 00   09000   CLINIC   0. 576527   376, 743   0   0   217, 203   90. 00   91. 00   09100   EMERGENCY   0. 161312   7, 297, 855   0   0   1, 177, 232   91. 00   92.00   09200   08SERVATION BEDS (NON-DISTINCT PART)   1. 316784   200, 008   0   0   263, 367   92. 00   200. 00   Subtotal (see instructions)   62, 489, 252   0   15, 516   9, 435, 526   200. 00   201. 00   001 y Charges				1			
90. 00		0.000000	0	)	0 0	0	74.00
91. 00   09100   EMERGENCY   0. 161312   7, 297, 855   0   0   0   1, 177, 232   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   1. 316784   200, 008   0   0   263, 367   92. 00   201. 00   Less PBP Clinic Lab. Services-Program   0   0   0   201. 00   0   0   0   0   0   0   0   0   0							
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   1.316784   200,008   0   0   263,367   92.00   200.00   Subtotal (see instructions)   Less PBP Clinic Lab. Services-Program   0   0   0   201.00   0   0   0   0   0   0   0   0   0					-		
200.00   Subtotal (see instructions)   62,489,252   0   15,516   9,435,526   200.00   201.00   0   0   0   0   0   0   0   0   0		l .			-		
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges		1. 316784			-		
Only Charges			62, 489, 252	2	0 15, 516	9, 435, 526	
					0		201. 00
202.00   Net Charges (line 200 - line 201)   62,489,252  0  15,516  9,435,526 202.00							
	202.00   Net Charges (line 200 - line 201)		62, 489, 252	2	0 15, 516	9, 435, 526	202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	P	rovi der CC	JN: 14-0034	From 01/01/2023 To 12/31/2023	Part V Date/Time Pro 5/21/2024 9:	
			Title	XVIII	Hospi tal	PPS	
	Cos	sts					
Cost Center Description	Cost		Cost				
	Rei mbursed	Rei	mbursed				
	Servi ces		vices Not				
	Subject To		ject To				
	Ded. & Coins.		& Coins.				
	(see inst.)		e inst.)				
	6. 00		7. 00				
ANCILLARY SERVICE COST CENTERS							
50. 00   05000   OPERATI NG   ROOM	0	1	0				50.00
51. 00   05100   RECOVERY ROOM	0	l	0				51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0		0				52. 00
53. 00   05300   ANESTHESI OLOGY	0		0				53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	1	0				54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	1	0				55. 00
56. 00   05600   RADI 0I SOTOPE	0	1	0				56. 00
57. 00   05700   CT   SCAN	0	1	0				57. 00
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0	1	0				58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	1	0				59. 00
60. 00   06000   LABORATORY	0		0				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0		0				64. 00
65. 00 06500 RESPI RATORY THERAPY	0		0				65. 00
66. 00   06600   PHYSI CAL THERAPY	0		0				66.00
66. 01   03340   CLI NI CAL NUTRI TI ON	0		0				66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0		0				67. 00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	0		0				68. 00 69. 00
1 I	0		0				69. 00
69. 01   03140   CARDI AC REHABI LI TATI ON 70. 00   07000   ELECTROENCEPHALOGRAPHY	0		0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0				70.00
72. 00   07200   MPL. DEV. CHARGED TO PATTENTS			0				72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS			3, 501				73.00
74. 00   07400   RENAL DI ALYSI S		1	3, 301				74.00
OUTPATIENT SERVICE COST CENTERS	ı o	1					74.00
90. 00 09000 CLINIC	O		0				90.00
91. 00   09100   EMERGENCY	0	l	0				91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)			0				92.00
200.00 Subtotal (see instructions)	0		3, 501				200. 00
201.00 Less PBP Clinic Lab. Services-Program			3, 301				201.00
Only Charges							
202.00   Net Charges (line 200 - line 201)	o		3, 501				202. 00

	SSM HEALTH ST.				eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 14-0034	Peri od: From 01/01/2023	Worksheet D Part II	
		Component	CCN: 14-S034	To 12/31/2023		pared: 4 am
		Titl∈	e XVIII	Subprovi der – I PF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOLILARY OFFICE OF SOUT OFFICE	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	047.0/5	45 400 500	0.0000	4		F0.00
50. 00   05000   OPERATING ROOM	917, 865		1		0	
51. 00 05100 RECOVERY ROOM	48, 797				0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		0.00000		0	52. 00
53. 00 05300 ANESTHESI OLOGY	67, 143		1		0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	246, 224				l e	1
55. 00   05500   RADI OLOGY-THERAPEUTI C	27, 196				0	55. 00
56. 00   05600   RADI OI SOTOPE	75, 626				0	56.00
57. 00   05700   CT   SCAN	79, 008					
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	16, 620				7	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	104 024	_			0	
	184, 826				900	
64. 00 06400 I NTRAVENOUS THERAPY	30, 596				0	64. 00 65. 00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	192, 133 216, 498				1, 229 369	
66. 01   03340   CLI NI CAL NUTRI TI ON	5, 086		1		0	66. 01
67. 00 06700 OCCUPATIONAL THERAPY	7, 348				41	
68. 00   06800   SPEECH PATHOLOGY	16, 387				10	1
69. 00   06900   ELECTROCARDI OLOGY	134, 015		1		171	1
69. 01   03140   CARDI AC   REHABI LI TATI ON	6, 006				1/1	
70. 00 07000 ELECTROENCEPHALOGRAPHY	37, 594				0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	90, 277				270	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	39, 083		1		4	
73. 00 07300 DRUGS CHARGED TO PATIENTS	95, 951				330	
74. 00   07400   RENAL DI ALYSI S	75, 751		1		0	74.00
OUTPATIENT SERVICE COST CENTERS		1	0.00000	<u> </u>		1 74.00
90. 00   09000   CLI NI C	355, 930	10, 080, 042	0. 03531	0 0	0	90.00
91. 00   09100   EMERGENCY	292, 765				984	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	272, 703				0	
200.00 Total (lines 50 through 199)	3, 182, 974			641, 885		200. 00
200.00   10tal (11100 00 th ough 177)	0,102,777	1 007, 202, 142	1	011,000	1, 307	1-30.00

Health Financial Systems	SSM HEALTH ST. I	MARYS HOSPITAL		In Li	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	ERVICE OTHER PASS	Provider CO	CN: 14-0034	Peri od: From 01/01/2023	Worksheet D Part IV	
THROUGH COSTS		Component (	CCN: 14-S034	To 12/31/2023		
		Title	XVIII	Subprovi der -	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments 2A	2. 00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	ZA ZA	2.00	) JA	3.00	
50. 00 05000 OPERATING ROOM	0	0		0 (	0	50.00
51. 00   05100   RECOVERY ROOM	0	0		0	l .	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		o d	ol o	
53. 00   05300   ANESTHESI OLOGY	0	0		0	0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0	0		0	0	56. 00
57. 00 05700 CT SCAN	0	0		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	
60. 00   06000   LABORATORY	0	0		0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 (	0	
66. 00   06600   PHYSI CAL THERAPY	0	0		0	0	
66. 01   03340   CLINICAL NUTRITION	0	0		0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 (	0	
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	0	0			0	
69. 01 03140 CARDI AC REHABI LI TATI ON	0	0				
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			1	
74. 00   07400   RENAL DI ALYSI S	0	0		o o		
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0		0 (	0	90.00
91. 00 09100 EMERGENCY	0	0		0 (	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	1
200.00 Total (lines 50 through 199)	0	0		ol d		200.00

APPORT I OMMENT OF INPATI ENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS   Component CCN: 14-0034   From 10/10/12/023   From 10/10/12/0233   To 12/31/2023   From 10/10/12/0234   Part I V   Date/Time Prepared: 572/12/024   Part I V   Date/Time	Heal th	Financial Systems S	SSM HEALTH ST. 1	MARYS HOSPITAL		In Lie	eu of Form CMS-:	2552-10
Component CCN: 14-S034   To 12/31/203   Date/Time Prepared			RVICE OTHER PASS	S Provider C	CN: 14-0034			
Title XVIII   Subprovider   PPS   S721/2024 9:54 am   PPS   S721/2						From 01/01/2023	Part IV	
Cost Center Description				· ·			5/21/2024 9:5	
Medical Education Cost				Titl∈	e XVIII		PPS	
Education Cost		Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
ANCILLARY SERVICE COST CENTERS			Medi cal	(sum of cols.	Outpati ent			
ANCILLARY SERVICE COST CENTERS			Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
ANCILLARY SERVICE COST CENTERS				4)	col s. 2, 3,	8)	7)	
A.00   5.00   6.00   7.00   8.00					and 4)			
ANCI LLARY SERVICE COST CENTERS							instructions)	
50.00			4.00	5. 00	6. 00	7. 00	8. 00	
51.00   05100   RECOVERY ROOM   0   0   0   0   0   11, 868, 385   0.000000   51.00   52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   0								
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   0	50.00	05000  OPERATI NG ROOM	0	0	)	0 45, 139, 523	0.000000	50.00
53. 00   05300   ANESTHESI OLOGY   0   0   0   13, 929, 788   0.000000   53. 00   54. 00   05500   RADI OLOGY-DIAGNOSTI C   0   0   0   16, 365, 322   0.000000   54. 00   55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   7, 213, 009   0.000000   55. 00   55. 00   05600   RADI OLOGY-THERAPEUTI C   0   0   0   7, 213, 009   0.000000   55. 00   56. 00   05600   RADI OLOGY-THERAPEUTI C   0   0   0   7, 295, 172   0.000000   56. 00   57. 00   05700   CT SCAN   0   0   0   0   56, 033, 665   0.000000   57. 00   58. 00   05800   MAGNETI C RESONANCE   IMAGI NG (MRI )   0   0   0   0   0   0   0.000000   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0.000000   59. 00   60. 00   06000   LABORATORY   0   0   0   0   0   0.000000   59. 00   60. 00   06000   LABORATORY   0   0   0   0   0   0.000000   64. 00   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   10, 693, 555   0.000000   65. 00   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   9, 336, 696   0.000000   65. 00   66. 01   03340   CLI II I CAL NUTRI TI ON   0   0   0   0   28, 930   0.000000   66. 01   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   28, 930   0.000000   66. 01   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   43, 373, 974   0.000000   69. 01   69. 01   03140   CARDI AC REHABI LI TATI ON   0   0   0   0   47, 373, 974   0.000000   69. 01   70. 00   07000   ELECTROCARDI OLOGY   0   0   0   0   3, 219, 491   0.000000   72. 00   71. 00   07000   BRUGS CHARGED TO PATI ENTS   0   0   0   0   2, 381, 431   0.000000   72. 00   71. 00   07000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   2, 174, 184   0.000000   74. 00   71. 00   07000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0   71. 00   07000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   71. 00   07000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   71. 00   07000   0   0   0   0   0   0   0	51.00	05100 RECOVERY ROOM	0	0	)	0 11, 868, 385	0.000000	51.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   16, 365, 322   0.000000   54. 00   55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   7, 213, 009   0.000000   55. 00   0.000000   55. 00   0.000000   55. 00   0.000000   55. 00   0.000000   56. 00   0.000000   55. 00   0.000000   56. 00   0.000000   56. 00   0.000000   56. 00   0.000000   56. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000   0.000000   0.0000000   0.0000000   0.00000000	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0 0	0.000000	52.00
55. 00         05500 RADI OLOGY-THERAPEUTI C         0         0         7, 213, 009         0, 000000         55. 00           56. 00         05600 RADI OLOGY-THERAPEUTI C         0         0         0         7, 295, 172         0, 000000         56. 00           57. 00         05700 CT SCAN         0         0         0         56, 033, 665         0, 000000         57. 00         58. 00         0         0         56, 033, 665         0, 000000         57. 00         0         0         56, 033, 665         0, 000000         57. 00         0         0         0, 000000         58. 00         0         0         0, 000000         58. 00         0         0         0, 000000         58. 00         0         0         0, 000000         58. 00         0         0         0, 000000         58. 00         0         0         0, 000000         58. 00         0         0         0         0, 000000         58. 00         <	53.00	05300 ANESTHESI OLOGY	0	0	)	0 13, 929, 788	0.000000	53.00
56. 00   05600   RADI OI SOTOPE   0   0   0   7, 295, 172   0.000000   56. 00   57. 00   57. 00   57. 00   57. 00   57. 00   57. 00   58. 00   0.000000   57. 00   58. 00   0.000000   57. 00   58. 00   0.000000   57. 00   0.0000000   57. 00   0.00000000   57. 00   0.000000000   57. 00   0.0000000000   57. 00   0.0000000000000	54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0	)	0 16, 365, 322	0.000000	54. 00
57. 00   05700   CT SCAN   0   0   0   56,033,665   0.000000   57. 00   58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI ) 0   0   0   9,778,151   0.000000   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0.00000   60. 00   06000   LABORATORY   0   0   0   0   47,777,010   0.000000   60. 00   06400   INTRAVENOUS THERAPY   0   0   0   1,844,145   0.000000   64. 00   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   1,844,145   0.000000   65. 00   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   9,336,696   0.000000   66. 00   66. 01   03340   CLI NI CAL NUTRI TI ON   0   0   0   28,930   0.000000   66. 01   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   28,930   0.000000   66. 01   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   626,728   0.000000   69. 01   69. 01   03140   CARDI AC REHABI LI TATI ON   0   0   0   634,484   0.000000   69. 01   70. 00   07000   ELECTROCARDI OLOGY   0   0   0   0   33,40   34,431   0.000000   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   2,381,431   0.000000   70. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   2,381,431   0.000000   72. 00   73. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   0   0.00000   74. 00   91. 00   09000   CLI NI C   0   0   0   0   0   0   0   0   0.00000   91. 00   09000   CLI NI C   0   0   0   0   0   0   0   0   0	55.00	05500   RADI OLOGY-THERAPEUTI C	0	0	)	0 7, 213, 009	0.000000	55. 00
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)   0   0   0   9, 778, 151   0.000000   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0.000000   60. 00   06000   LABORATORY   0   0   0   47, 777, 010   0.000000   64. 00   06400   I NTRAVENOUS THERAPY   0   0   0   1, 844, 145   0.000000   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   10, 693, 555   0.000000   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   28, 930   0.000000   66. 01   03340   CLI NITRAI TI ON   0   0   0   28, 930   0.000000   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   28, 930   0.000000   68. 00   06900   SPEECH PATHOLOGY   0   0   0   0   626, 728   0.000000   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   634, 484   0.000000   69. 01   03140   CARDI AC REHABI LI TATI ON   0   0   0   0   634, 484   0.000000   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   3, 219, 491   0.000000   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0, 22, 174, 184   0.000000   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0, 22, 174, 184   0.000000   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0, 20, 21, 41, 41, 41, 41, 41, 41, 41, 41, 41, 4	56.00	05600  RADI 0I SOTOPE	0	0	)	0 7, 295, 172	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0.000000 59. 00 60. 00	57.00	05700  CT SCAN	0	0	)	0 56, 033, 665	0.000000	57. 00
60. 00 06000 LABORATORY 0 0 0 0 47, 777, 010 0.000000 60. 00 64. 00 06400   INTRAVENOUS THERAPY 0 0 0 0 1, 844, 145 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 10, 693, 555 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0, 336, 696 0.000000 66. 00 66. 01 03340 CLI NI CAL NUTRI TI ON 0 0 0 28, 930 0.000000 66. 01 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 1, 330, 887 0.000000 66. 01 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 1, 330, 887 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 1, 330, 887 0.000000 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 14, 373, 974 0.000000 69. 00 69. 01 03140 CARDI AC REHABI LI TATI ON 0 0 0 0 634, 484 0.000000 69. 01 07. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 2, 381, 431 0.000000 69. 01 07. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 4, 722, 024 0.000000 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 2, 381, 431 0.000000 73. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0, 3, 219, 491 0.000000 73. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0, 000000 73. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0, 000000 074. 00 09100 EMERGENCY 0 0 0 0 0, 39, 400, 989 0.000000 91. 00 092. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 1, 034, 557 0.000000 92. 00	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	)	0 9, 778, 151	0.000000	58. 00
64. 00	59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	)	0	0.000000	59. 00
65. 00	60.00	06000 LABORATORY	0	0	)	0 47, 777, 010	0.000000	60.00
66. 00	64.00	06400 I NTRAVENOUS THERAPY	0	0	)	0 1, 844, 145	0.000000	64.00
66. 01	65.00	06500 RESPI RATORY THERAPY	0	0	)	0 10, 693, 555	0.000000	65.00
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   1,330,887   0.000000   67. 00   68. 00   06800   SPECH PATHOLOGY   0   0   0   0   626,728   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   14,373,974   0.000000   69. 00   69. 00   03140   CARDI AC REHABI LI TATI ON   0   0   0   0   0   634,484   0.000000   69. 01   07000   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0	66.00	06600 PHYSI CAL THERAPY	0	0	)	0 9, 336, 696	0.000000	66. 00
68. 00   06800   SPEECH PATHOLOGY   0   0   0   626, 728   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   14, 373, 974   0.000000   69. 00   69. 01   03140   CARDI AC REHABI LI TATI ON   0   0   0   0   634, 484   0.000000   69. 01   071. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   2, 381, 431   0.000000   70. 00   71. 00   07200   MPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   3, 219, 491   0.000000   72. 00   73. 00   07300   RUGS CHARGED TO PATI ENTS   0   0   0   0   0.000000   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0.000000   74. 00   00TPATI ENT SERVI CE COST CENTERS   0   0   0   0.000000   74. 00   09000   CLI NI C   0   0   0   0.000000   90. 00   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   0, 0000000   92. 00   92. 00   0000000   92. 00   00000000000000000000000000000000	66. 01	03340 CLINICAL NUTRITION	0	0	)	0 28, 930	0.000000	66. 01
69. 00	67.00	06700 OCCUPATI ONAL THERAPY	0	0	)	0 1, 330, 887	0.000000	67. 00
69. 01	68.00	06800 SPEECH PATHOLOGY	0	0	)	0 626, 728	0.000000	68. 00
70. 00	69.00	06900 ELECTROCARDI OLOGY	0	0	)	0 14, 373, 974	0.000000	69. 00
71. 00	69. 01	03140 CARDI AC REHABI LI TATI ON	0	0	)	0 634, 484	0.000000	69. 01
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   3, 219, 491   0.000000   72. 00   73. 00   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0.000000   74. 00   0000000   74. 00   000000   0000000   0000000000000	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	)	0 2, 381, 431	0.000000	70. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   22, 174, 184   0.000000   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0.000000   74. 00   0   0   0   0   0   0   0   0   0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	)	0 4, 722, 024	0.000000	71. 00
74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0.000000   74. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0 3, 219, 491	0.000000	72. 00
OUTPATI ENT SERVI CE COST CENTERS         OUTPATI ENT SERVI CE COST CENTERS           90. 00         09000 CLI NI C         0         0         10, 080, 042         0.000000         90.00           91. 00         09100 EMERGENCY         0         0         0         39, 400, 989         0.000000         91.00           92. 00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         0         1, 034, 557         0.000000         92.00	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	)	0 22, 174, 184	0.000000	73. 00
90. 00	74.00	07400 RENAL DIALYSIS	0	0	)	0 0	0.000000	74. 00
91. 00   09100   EMERGENCY		OUTPATIENT SERVICE COST CENTERS						
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0 0 1,034,557 0.000000   92.00	90.00		0	0		0 10, 080, 042	0.000000	90. 00
	91.00	09100 EMERGENCY	0	0	)	0 39, 400, 989	0.000000	91.00
200.00   Total (lines 50 through 199)   0  0  337, 282, 142   200.00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	)	0 1, 034, 557	0.000000	92.00
	200.00	Total (lines 50 through 199)	0	0		0 337, 282, 142		200. 00

	Financial Systems  FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	SSM HEALTH ST. MA	Provi der Co	N. 14 0024	Peri od:	u of Form CMS-2 Worksheet D	2552-10
	GH COSTS	WICE UINER PASS	3   110VI del CON. 14-0034		From 01/01/2023	Part IV	
TTIKOU	00313		Component (	CCN: 14-S034	To 12/31/2023	Date/Time Pre 5/21/2024 9:5	pared: 4 am
			Title	XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	cost center bescription	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	charges	Costs (col.		Costs (col. 9	
		7)		x col . 10)	0	x col . 12)	
		9, 00	10. 00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	10.00	
0.00	05000 OPERATING ROOM	0.000000	0		0 0	0	50.00
1. 00	05100 RECOVERY ROOM	0. 000000	0		0	0	
2. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
3. 00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	
4. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	11, 249		0 0	0	54.00
5. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
6. 00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	
7. 00	05700 CT SCAN	0. 000000	59. 936		0 0	0	
8. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	4, 370		0 0	0	
9. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	
0.00	06000 LABORATORY	0. 000000	232, 536		0 0	0	60.00
4. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	1
5. 00	06500 RESPIRATORY THERAPY	0. 000000	68, 390		0 0	0	65. 0
6. 00	06600 PHYSI CAL THERAPY	0. 000000	15, 906		0 0	0	66.0
6. 01	03340 CLINICAL NUTRITION	0. 000000	0		0 0	0	66.0
7. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	7, 483		0 0	0	67.00
8. 00	06800 SPEECH PATHOLOGY	0. 000000	400		0 0	0	68.00
9. 00	06900 ELECTROCARDI OLOGY	0. 000000	18, 300		0 0	0	69.00
9. 01	03140 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	69. 0°
0.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	14, 144		0 0	0	71.00
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	309		0 0	0	72.00
3. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	76, 369		0 0	0	73.00
4. 00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						1
0.00	09000 CLI NI C	0. 000000	0		0 90, 113	0	90.00
1. 00	09100 EMERGENCY	0. 000000	132, 493		0 0	0	91.00
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00	Total (lines 50 through 199)		641, 885		0 90, 113	0	200. 00

Health Financial Systems	MARYS HOSPITAL		In Lie	u of Form CMS-2	2552-10	
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	S AND VACCINE COST	Provi der Co		Peri od: From 01/01/2023	Worksheet D Part V	
		Component (		To 12/31/2023		pared: 4 am
		Title	XVIII	Subprovi der -	PPS	
				I PF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2 00	3 00	4 00	5.00	

				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 180839	0	0	0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 178977	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 067243	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 184548	0	0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 172505	0	0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 132453	0	0	0	0	56. 00
57.00	05700 CT SCAN	0. 029234	0	0	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 043077	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0.000000	0	0	0	0	59. 00
60. 00	06000 LABORATORY	0. 094944	0	0	0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 367114	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 267398	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 354089	0	0	0	0	66. 00
66. 01		8. 408572	0	0	0	0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0. 255985	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 480768	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 159739	0	0	0	0	69. 00
69. 01	03140 CARDI AC REHABI LI TATI ON	0. 407132	0	0	0	0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 113837	0	0	0	0	70.00
71. 00		1. 031035	0	0	0	0	71. 00
72. 00		0. 651023	0	0	0	0	72. 00
73. 00		0. 225648	0	Ö	0	0	73. 00
	07400 RENAL DIALYSIS	0. 000000		0		0	74. 00
, ,, ,,	OUTPATIENT SERVICE COST CENTERS	0.00000					7 00
90. 00	09000 CLI NI C	0. 576527	90, 113	0	0	51, 953	90.00
91. 00	1	0. 161312		0		0	91.00
92. 00	1	1. 316784		Ö	o o	Ö	92.00
200. 0			90, 113		0	51, 953	200. 00
201. 0			, , , , , ,	n n	n		201. 00
200	Only Charges						
202. 0			90, 113	О	0	51, 953	202. 00
		I		'	'	2.,,00	

Health Financial Systems S	systems SSM HEALTH ST. MA				In Lieu of Form CMS-2552-10		
			CN: 14-0034 CCN: 14-S034	Peri od: From 01/01/2023 To 12/31/2023		pared: 4 am	
		Title	e XVIII	Subprovi der - I PF	PPS		
	Cos	sts					
Cost Center Description	Cost Reimbursed	Cost Reimbursed					

				 I PF	
		Cos	sts	<u>.                                    </u>	
	Cost Center Description	Cost	Cost		
	·	Reimbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
		Ded. & Coins.	Ded. & Coins.		
		(see inst.)	(see inst.)		
		6. 00	7. 00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000  OPERATI NG 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	05400  RADI OLOGY-DI AGNOSTI C	0	0		54.00
55.00	05500  RADI OLOGY-THERAPEUTI C	0	0		55. 00
56.00	05600 RADI OI SOTOPE	0	0		56. 00
57.00	05700 CT SCAN	0	0		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60.00	06000 LABORATORY	0	0		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		64. 00
65.00	06500 RESPI RATORY THERAPY	0	0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		66. 00
66. 01	03340 CLINICAL NUTRITION	0	0		66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0	0		67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		69. 00
69. 01	03140 CARDI AC REHABI LI TATI ON	0	0		69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		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
74.00	07400 RENAL DIALYSIS	0	0		74. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	0		90.00
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Subtotal (see instructions)	0	0		200. 00
201.00	Less PBP Clinic Lab. Services-Program	0			201. 00
	Only Charges				
202.00	Net Charges (line 200 - line 201)	0	0		202. 00

Health Financial Systems	SSM HEALTH ST.	MARYS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 380, 539		1,000,00			
31.00 INTENSIVE CARE UNIT	165, 255		165, 25			
40. 00   SUBPROVI DER - I PF	330, 011	C	330, 01			
43. 00 NURSERY	0		1	0	0.00	
200.00 Total (lines 30 through 199)	1, 875, 805		1, 875, 80	5 15, 090		200. 00
Cost Center Description	Inpatient	I npati ent				
	Program days	Program				
		Capital Cost (col. 5 x col.				
		6)				
	6, 00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	1			
30. 00 ADULTS & PEDIATRICS	91	14, 470				30.00
31.00 INTENSIVE CARE UNIT	6	1, 059			ļ	31.00
40. 00 SUBPROVI DER - I PF	23	1, 387	,			40.00
43. 00 NURSERY	0	c c			ļ	43.00
200.00 Total (lines 30 through 199)	120	16, 916	o			200. 00

Health Financial Systems	SSM HEALTH ST. MAR	SSM HEALTH ST. MARYS HOSPITAL		
ADDODEL ONMENT OF LADATICAL	ANCILLARY CERVICE CARLEAL COCTO	D	D!I	Wassissian D

Health Financial Systems SSM HEALTH ST. MARYS HOSPITAL In Lieu of Form CMS-2552-10								
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		L COSTS	Provi der C	Provider CCN: 14-0034		Worksheet D		
					From 01/01/2023	Part II		
					To 12/31/2023	Date/Time Pre 5/21/2024 9:5	parea:	
			Ti tl	e XIX	Hospi tal	PPS	4 (111)	
Cost Center Description		Capi tal	Total Charges			Capital Costs		
oust defiter beschiptron			(from Wkst. C,			(column 3 x		
			Part I, col.			column 4)		
		(from Wkst. B, Part II, col.	8)	2)	3.1			
			ĺ					
			2.00	3.00	4. 00	5. 00		
<u> </u>	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	917, 865	45, 139, 523	0. 0203	34 0	0	50. 00	
51.00	05100 RECOVERY ROOM	48, 797	11, 868, 385	0. 0041	12 0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C	0. 00000	00	0	52. 00	
53.00	05300 ANESTHESI OLOGY	67, 143	13, 929, 788	0. 00482	20 0	0	53. 00	
54.00	05400   RADI OLOGY-DI AGNOSTI C	246, 224	16, 365, 322	0. 0150	45 0	0	54.00	
55.00	05500 RADI OLOGY-THERAPEUTI C	27, 196	7, 213, 009	0.0037	70 0	0	55. 00	
56.00	05600 RADI OI SOTOPE	75, 626	7, 295, 172	0. 0103	67 0	0	56. 00	
57.00	05700 CT SCAN	79, 008	56, 033, 665	0.0014	10 0	0	57. 00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	16, 620	9, 778, 151	0. 00170	00	0	58. 00	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C	0. 00000	00	0	59. 00	
60.00	06000 LABORATORY	184, 826	47, 777, 010	0. 0038	69 0	0	60.00	
64.00	06400 I NTRAVENOUS THERAPY	30, 596	1, 844, 145	0. 01659	91 0	0	64. 00	
65.00	06500 RESPI RATORY THERAPY	192, 133	10, 693, 555	0. 0179	67 0	0	65. 00	
66.00	06600 PHYSI CAL THERAPY	216, 498	9, 336, 696	0. 02318	38 0	0	66. 00	
66. 01	03340 CLINICAL NUTRITION	5, 086	28, 930	0. 17580	04	0	66. 01	
67.00	06700 OCCUPATI ONAL THERAPY	7, 348	1, 330, 887	0. 0055	21 0	0	67. 00	
68.00	06800 SPEECH PATHOLOGY	16, 387	626, 728	0. 02614	47 0	0	68. 00	
69.00	06900 ELECTROCARDI OLOGY	134, 015	14, 373, 974	0.0093	23 0	0	69. 00	
69. 01	03140 CARDI AC REHABI LI TATI ON	6, 006	634, 484	0.0094	66 0	0	69. 01	
70.00	07000 ELECTROENCEPHALOGRAPHY	37, 594	2, 381, 431	0. 01578	36 0	0	70. 00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	90, 277	4, 722, 024	0. 0191	18 0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	39, 083	3, 219, 491	0. 0121:	39 0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	95, 951	22, 174, 184	0.0043	27 0	0	73. 00	
74.00			C	0. 00000	00	0	74. 00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLI NI C	355, 930	10, 080, 042	0. 0353	10 0	0	90.00	
91.00	91. 00   09100   EMERGENCY		39, 400, 989	0. 0074	30 0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	110, 672	1, 034, 557	0. 1069	75 0	0	92.00	
200.00 Total (lines 50 through 199)		3, 293, 646	337, 282, 142		0	0	200. 00	

	SSM HEALTH ST. I				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider Co		Period: From 01/01/2023	Worksheet D	
				From 01/01/2023 Fo 12/31/2023		nared·
			'	12/31/2023	5/21/2024 9: 5	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown		Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	_	1	_	.1	-	
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	C	0	0	
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0	0	
40. 00   04000   SUBPROVI DER - I PF	0	0		0	0	
43.00   04300   NURSERY 200.00   Total (lines 30 through 199)	0	0			0	43. 00 200. 00
200.00 Total (lines 30 through 199)  Cost Center Description	Curi na Dod	Total Costs	Total Dotiont	Per Diem (col.	Inpatient	200.00
cost center bescription	Swing-Bed Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Days	5 ÷ COI . 0)	Frogram Days	
	instructions)					
	4. 00	5.00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	8, 682	0.00	91	30.00
31.00 03100 INTENSIVE CARE UNIT		0	936	0.00	6	31. 00
40. 00   04000   SUBPROVI DER - 1 PF	0	0	5, 472	0.00	23	40.00
43. 00   04300   NURSERY		0	C	0.00	0	43.00
200.00 Total (lines 30 through 199)		0	15, 090		120	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					

30.00

31. 00 40. 00 43. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04400 SUBPROVI DER - I PF 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199)

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | Part IV | Par THROUGH COSTS

					10 12/31/2023	5/21/2024 9: 5	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	T	1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATI NG ROOM	0	0		0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0		0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
66. 01	03340 CLI NI CAL NUTRI TI ON	0	0		0 0	0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
69. 01	03140 CARDI AC REHABI LI TATI ON	0	0		0	0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	0		0	0	90. 00
91. 00	09100 EMERGENCY	0	0		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems	SSM HEALTH ST. MARYS HOSPITAL In Lieu			u of Form CMS-2552-	-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-0034	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared 5/21/2024 9:54 am	
		Title XIX	Hospi tal	PPS	

Inkough COSTS				o 12/31/2023	Date/Time Pre 5/21/2024 9:5	
		Ti tl	e XIX	Hospi tal	PPS	4 4111
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
, , , , , , , , , , , , , , , , , , ,	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
			·		instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	(	45, 139, 523	0. 000000	50. 00
51.00   05100   RECOVERY ROOM	0	0	(	11, 868, 385	0. 000000	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	(	0	0. 000000	
53. 00   05300   ANESTHESI OLOGY	0	0	(	13, 929, 788		
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	16, 365, 322		
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	(	7, 213, 009	0. 000000	55. 00
56. 00   05600   RADI 0I SOTOPE	0	0	(	7, 295, 172	0.000000	56. 00
57. 00   05700   CT   SCAN	0	0	(	56, 033, 665	0. 000000	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	(	9, 778, 151	0.000000	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0	(	0	0. 000000	59. 00
60. 00   06000   LABORATORY	0	0	(	47, 777, 010	0. 000000	60.00
64. 00   06400   I NTRAVENOUS THERAPY	0	0	(	1, 844, 145	0. 000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	(	10, 693, 555	0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(	9, 336, 696	0.000000	66. 00
66.01 03340 CLINICAL NUTRITION	0	0	(	28, 930	0.000000	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(	1, 330, 887	0.000000	
68. 00 06800 SPEECH PATHOLOGY	0	0	(	626, 728	0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(	14, 373, 974	0.000000	69. 00
69. 01   03140   CARDI AC   REHABI LI TATI ON	0	0	(	634, 484	0.000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(	2, 381, 431	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	4, 722, 024	0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	3, 219, 491	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	22, 174, 184	0.000000	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0	(	0	0.000000	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(	10, 080, 042	0. 000000	90. 00
91. 00 09100 EMERGENCY	0	0	(	39, 400, 989	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(	1, 034, 557	0. 000000	92.00
200.00   Total (lines 50 through 199)	0	0	(	337, 282, 142		200. 00

Health Financial Systems	In lie	u of Form CMS-2	2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT A THROUGH COSTS	SSM HEALTH ST. MA NCILLARY SERVICE OTHER PASS	Provi der Co		Period: From 01/01/2023	Worksheet D	1002 10
THROUGH COSTS					Date/Time Prep 5/21/2024 9:54	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	

					3/21/2024 9.3	4 am
		Titl	e XIX	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	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	C	0	0	0	50.00
51.00   05100   RECOVERY ROOM	0. 000000	C	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	C	0	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	C	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	C	0	0	0	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	C	0	0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000	C	0	0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	C	o	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	C	o	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	C	ol o	0	0	59.00
60. 00   06000   LABORATORY	0. 000000	C	ol o	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	C	ol o	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	C	ol o	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	C	ol o	0	0	66. 00
66. 01 03340 CLINI CAL NUTRI TI ON	0. 000000	Ċ		0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	Ċ		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	Ċ		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	Ċ		0	0	69. 00
69. 01 03140 CARDI AC REHABI LI TATI ON	0. 000000	Ċ		0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	Ċ		0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	Č	ol o	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	Č	ol o	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	C	ol o	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	Č	-	0	o o	
OUTPATIENT SERVICE COST CENTERS	0.00000		ή			7 1. 00
90. 00 09000 CLINIC	0. 000000	C	0	0	0	90.00
91. 00 09100 EMERGENCY	0.000000	C	-	0	0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	C	_	0	0	
200.00 Total (lines 50 through 199)	0.000000	C	-	0	1	200. 00
200. 00   Total (Triles 00 till ough 177)	1		,	O		1200.00

	CM LIENTIL CT. I	MADVC HOODI TAL			6.5	0550 40
Health Financial Systems S APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	SM HEALTH ST. I	Provider C	CN: 14 0024	Period:	eu of Form CMS-2 Worksheet D	2552-10
APPORTIONMENT OF INPATTENT ANCILLARY SERVICE CAPITA	L 00313	Provider C	CN. 14-0034	From 01/01/2023	Part II	
		Component	CCN: 14-S034	To 12/31/2023	Date/Time Pre	pared:
		T: ±1	- VIV	Code and a state of	5/21/2024 9: 5 PPS	4 am
		11 (1	e XIX	Subprovi der  - I PF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
, , , , , , , , , , , , , , , , , , ,		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)		ŕ	
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	917, 865					
51.00   05100   RECOVERY ROOM	48, 797					
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0.0000		0	52. 00
53. 00   05300   ANESTHESI OLOGY	67, 143				0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	246, 224				0	
55. 00   05500   RADI OLOGY-THERAPEUTI C	27, 196				0	55. 00
56. 00   05600   RADI 0I SOTOPE	75, 626				0	
57. 00   05700   CT   SCAN	79, 008				0	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	16, 620				0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				0	
60. 00   06000   LABORATORY	184, 826				0	
64. 00 06400 I NTRAVENOUS THERAPY	30, 596				0	64.00
65. 00 06500 RESPI RATORY THERAPY	192, 133				0	
66. 00 06600 PHYSI CAL THERAPY	216, 498				0	66. 00
66. 01 03340 CLINI CAL NUTRITION	5, 086			٥. ١	0	66. 01
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	7, 348				0	
68. 00   06800  SPEECH PATHOLOGY 69. 00   06900  ELECTROCARDI OLOGY	16, 387 134, 015		l .		0	69.00
69. 00   00900  ELECTROCARDI OLOGT 69. 01   03140  CARDI AC REHABI LI TATI ON	6,006		l .			
70. 00   07000   ELECTROENCEPHALOGRAPHY	37, 594		l .			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	90, 277		l .		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	39, 083		l .			
73. 00 07300 DRUGS CHARGED TO PATTENTS	95, 951		l .			
74. 00   07400   RENAL DI ALYSI S	95, 951					
OUTPATIENT SERVICE COST CENTERS			0.00000	50  0	0	1 /4.00
90. 00 09000 CLINIC	355, 930	10, 080, 042	0. 0353	10 0	0	90.00
91. 00   09100  EMERGENCY	292, 765		l .			1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					
200.00 Total (Lines 50 through 199)	3, 182, 974			0		200. 00
			1	'		

APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	SM HEALTH ST. I		CN: 14-0034		ri od:	worksheet D	2002 10
THROUG	H COSTS		Component	CCN: 14-S034	To	om 01/01/2023 12/31/2023	Part IV Date/Time Pre 5/21/2024 9:5	pared: 4 am
			Titl	e XIX	S	ubprovi der - I PF	PPS	
	Cost Center Description	Non Physician		Nursi ng		Allied Health	Allied Health	
		Anesthetist	Program	Program		Post-Stepdown		
		Cost	Post-Stepdown			Adjustments		
		1.00	Adjustments 2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	_ ZM	2.00		JA	3.00	
50. 00	05000 OPERATING ROOM	0	0		0	O	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	l o		0	o	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	o	0	55.00
56.00	05600 RADI 0I SOTOPE	0	0		0	O	0	56.00
57.00	05700 CT SCAN	0	0		0	o	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	O	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	o	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
66. 01	03340 CLINICAL NUTRITION	0	0		0	0	0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
69. 01	03140 CARDIAC REHABILITATION	0	0		0	o	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	1
74.00	07400 RENAL DIALYSIS	0	0		0	0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	0	-		0	0	0	
	100100 EMEDCENCY		1		0		0	1 01 00

0

0 90.00 0 91.00 0 92.00 0 200.00

0

90.00 | 09000 | CLINIC 91.00 | 09100 | EMERGENCY 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 200.00 | Total (lines 50 through 199)

APPORT I OMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS   Component CCN: 14-0034   Peri od: From 01/01/2023   To 12/31/2023   To 12/31/2023   From 01/01/2023   Part I V Date/Time Prepared: 52/12/2024 9.54 art I V Date/Time Prepa	Heal th	Financial Systems S	SSM HEALTH ST. I	MARYS HOSPITAL		In Lie	eu of Form CMS-:	2552-10
Component CN: 14-S034   To 12/31/203   Date/Time Preparents	APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 14-0034			
Title XIX   Subprovider   PPS   PR	THROUG	H COSTS				From 01/01/2023	Part IV	
Cost Center Description				Component	CCN: 14-S034	10 12/31/2023		
Cost Center Description				Ti tl	e XIX	Subprovi der -		4 (111)
Medical Education Cost   1, 2, 3, and   Cost (sum of cols.   Cost   Cost (sum of cols.   Cost (sum of cols.   Cost   Cost (sum of cols.   Cost   Co					·			
Education Cost		Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
ANCILLARY SERVICE COST CENTERS			Medi cal	(sum of cols.				
ANCILLARY SERVICE COST CENTERS			Education Cost	1, 2, 3, and				
ANCILLARY SERVICE COST CENTERS				4)		8)		
A.00   5.00   6.00   7.00   8.00					and 4)			
ANCI LLARY SERVICE COST CENTERS				5.00		7.00		
50.00		ANOULLARY CERVI OF COCT OFNITERS	4.00	5.00	6.00	7.00	8.00	
51.00   05100   RECOVERY ROOM   0   0   0   0   0   11, 868, 385   0.000000   51.00   52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   0	FO 00			1 0	ı	0 45 120 522	0.000000	F0 00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   0					l .			
53.00         05300         ANESTHESI OLGY         0         0         0         13, 929, 788         0.000000         53.00           54.00         05400         RADI OLGY-DIAGNOSTI C         0         0         0         16, 365, 322         0.000000         55.00           55.00         05500         RADI OLGY-THERAPEUTI C         0         0         0         7, 213, 3099         0.000000         55.00           56.00         05500         RADI OLGY-THERAPEUTI C         0         0         0         7, 295, 172         0.000000         56.00           57.00         05700         CT SCAN         0         0         0         56, 033, 665         0.000000         56.00           58.00         05800         MAGRITI C         RESONANCE IMAGING (MRI)         0         0         0         9,778,151         0.00000         56.00           59.00         05900         CARDI AC CATHETERI ZATI ON         0         0         0         47,777,010         0.000000         59.00           60.00         06000         LABORATORY         0         0         47,777,010         0.000000         60.00           64.00         OAGORATORY         0         0         47,777,010         0.000000 </td <td></td> <td></td> <td>1</td> <td>1</td> <td></td> <td></td> <td></td> <td></td>			1	1				
54. 00   05400   RADI OLOGY - DI AGNOSTI C   0   0   0   16, 365, 322   0.000000   54. 00   55. 00   05500   RADI OLOGY - THERAPEUTI C   0   0   0   0   7, 213, 009   0.000000   55. 00   0.000000   55. 00   0.000000   55. 00   0.000000   55. 00   0.000000   56. 00   0.000000   55. 00   0.000000   56. 00   0.000000   55. 00   0.000000   56. 00   0.000000   56. 00   0.000000   55. 00   0.000000   56. 00   0.000000   56. 00   0.000000   56. 00   0.000000   56. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   57. 00   0.000000   0.000000   0.000000   0.000000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000000			0			-		
55. 00         05500 RADI OLOGY-THERAPEUTI C         0         0         7, 213, 009         0.000000         55. 00           56. 00         05600 RADI OLOGY-THERAPEUTI C         0         0         0         7, 295, 172         0.000000         56. 00           57. 00         05700 CT SCAN         0         0         56. 03, 365         0.000000         57. 00         58.00         56. 03, 365         0.000000         57. 00         58.00         56. 03, 365         0.000000         57. 00         0         0         56. 03, 365         0.000000         58.00         58.00         56. 03, 365         0.000000         58.00         0         0         0         0.00000         58.00         58.00         69.00         0.00000         0         0         0.00000         58.00         69.00         0.00000         0         0         0.00000         58.00         69.00         0         0.00000         0         0.000000         58.00         69.00         0         0.00000         64.00         0         0.00000         64.00         0         0.00000         64.00         0         0.00000         64.00         0         0.00000         65.00         0         0.000000         65.00         0         0.00000			0					1
56. 00   05600   RADI OI SOTOPE   0   0   0   7, 295, 172   0.000000   56. 00   57. 00   57. 00   57. 00   57. 00   57. 00   57. 00   58. 00   0.000000   57. 00   58. 00   0.000000   57. 00   58. 00   0.000000   57. 00   0.0000000   57. 00   0.00000000   57. 00   0.000000000   57. 00   0.0000000000   57. 00   0.0000000000000			0			· · · · · ·	•	1
57. 00   05700   CT SCAN			0					
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)   0   0   0   9, 778, 151   0.000000   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0.000000   60. 00   06000   LABORATORY   0   0   0   47, 777, 010   0.000000   60. 00   64. 00   06400   I NTRAVENOUS THERAPY   0   0   0   1, 844, 145   0.000000   64. 00   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   10, 693, 555   0.000000   65. 00   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   9, 336, 696   0.000000   66. 00   66. 01   03340   CLI NIT CAL NUTRI TI ON   0   0   0   28, 930   0.000000   66. 01   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   1, 330, 887   0.000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   626, 728   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   634, 484   0.000000   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0, 331, 431   0.000000   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0, 32, 19, 491   0.000000   71. 00   71. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0, 22, 174, 184   0.000000   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0, 000000   74. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0, 000000   74. 00   75. 00   07900   CLINIC   0   0   0   0, 39, 400, 989   0.000000   74. 00   75. 00   07900   CLINIC   0   0   0   0, 39, 400, 989   0.000000   74. 00   75. 00   07900   CLINIC   0   0   0   0, 000000   74. 00   75. 00   07900   CLINIC   0   0   0   0, 000000   0, 000000   75. 00   07900   CLINIC   0   0   0   0, 000000   0, 000000   75. 00   07900   CLINIC   0   0   0   0, 000000   0, 000000   75. 00   07900   CLINIC   0   0   0   0, 000000   0, 000000   75. 00   07900   CLINIC   0   0   0   0, 000000   75. 00   07900   CLINIC   0   0   0   0, 000000   75. 00   07900   CLINIC   0   0   0   0, 000000   75. 00   07900   CLINIC   0   0   0, 000000   75. 00   07900   CLINIC   0   0   0   0, 000000   75. 00   07900   CLINIC   0   0   0   0, 000000   7								
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0.000000 59. 00 60. 00								
60. 00 06000 LABORATORY 0 0 0 0 47, 777, 010 0.000000 60. 00 64. 00 06400   INTRAVENOUS THERAPY 0 0 0 0 1, 844, 145 0.000000 64. 00 0 0 1, 844, 145 0.000000 64. 00 0 0 1, 844, 145 0.000000 64. 00 0 0 0 1, 844, 145 0.000000 64. 00 0 0 0 10, 693, 555 0.000000 64. 00 0 0 0.000000 64. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
64. 00						-		1
65. 00								
66. 00						· · · · ·		1
66. 01					1	, ,		
67. 00		1		,				1
68. 00   06800   SPEECH PATHOLOGY   0   0   0   626, 728   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   14, 373, 974   0.000000   69. 00   69. 01   03140   CARDI AC REHABI LI TATI ON   0   0   0   634, 484   0.000000   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   2, 381, 431   0.000000   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   4, 722, 024   0.000000   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   3, 219, 491   0.000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0.000000   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0.000000   74. 00    90. 00   09000   CLI NI C   0   0   0   0.000000   90. 00   91. 00   09100   EMERGENCY   0   0   0   39, 400, 989   0.000000   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   1, 034, 557   0.000000   92. 00				ı				1
69. 00			0		1			
69. 01			0					1
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   2, 381, 431   0.000000   70.00   71.00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   4, 722, 024   0.000000   71.00   72.00   07200   MPL. DEV. CHARGED TO PATI ENTS   0   0   0   3, 219, 491   0.000000   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   22, 174, 184   0.000000   73.00   74.00   07400   RENAL DI ALYSI S   0   0   0   0   0.000000   74.00   00TPATI ENT SERVI CE COST CENTERS   0   0   0   0   0.000000   74.00   09000   CLI NI C   0   0   0   0   0, 000000   90.00   91.00   92.00   09200   DSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   1, 034, 557   0.000000   92.00   92.00   000000000000000000000000000000000			0					
71. 00			0			· ·		1
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   3, 219, 491   0.000000   72. 00   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   22, 174, 184   0.000000   73. 00   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0.000000   74. 00   00000   00000   000000   000000   000000			0					1
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   22, 174, 184   0.000000   73. 00   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   0.000000   74. 00   0   0   0   0   0   0   0   0   0			0					
74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0.000000   74. 00			0		,	· · · · · ·		
OUTPATIENT SERVICE COST CENTERS           90. 00         09000 CLINIC         0         0         10,080,042         0.000000         90.00           91. 00         09100 EMERGENCY         0         0         0         39,400,989         0.000000         91.00           92. 00         09200 OBSERVATI ON BEDS (NON-DISTINCT PART)         0         0         1,034,557         0.000000         92.00			0					
90. 00					'			
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   1,034,557   0.000000   92.00	90.00		0	C		0 10, 080, 042	0.000000	90.00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   1,034,557   0.000000   92.00			0		1			
200.00   Total (lines 50 through 199)   0   0   337, 282, 142   200.00	92.00		0	0	)	0 1, 034, 557	0.000000	92. 00
	200.00	Total (lines 50 through 199)	0	0	)	0 337, 282, 142		200.00

	CON LIE AL TILL CT. MA	IDVC HOCDLEAL			6.5	0550 40
Health Financial Systems S APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	SSM HEALTH ST. MA	Provider C	CN: 14 0024	Period:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	WIGE OTHER TASS		CCN: 14-S034	From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre 5/21/2024 9:5	pared: 4 am
		Ti tl	e XIX	Subprovi der – I PF	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	0. 000000	C	1	0	0	
51.00   05100   RECOVERY ROOM	0. 000000	C		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	C		0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000	C		0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	C		0	0	
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000	C		0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000	C		0	0	
57. 00   05700   CT   SCAN	0. 000000	C	1	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	C	1	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	C	1	0	0	
60. 00   06000   LABORATORY	0. 000000	C	1	0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	C		0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	C	1	0	0	
66. 00   06600   PHYSI CAL THERAPY	0. 000000	C	1	0	0	66. 00
66. 01 03340 CLINI CAL NUTRITION	0. 000000	C	1	0 0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	C	1	0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 000000	C	1	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	C		0 0	0	69.00
69. 01 03140 CARDI AC REHABI LI TATI ON	0. 000000	C		0 0	0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	C	1	0	0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0.000000	C	1	0 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	C		0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	C		0 0	0	
74. 00 07400 RENAL DIALYSIS	0. 000000	C		0 0	0	74. 00
OUTPATIENT SERVICE COST CENTERS	0.000000		ı	0 0		00.00
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	0. 000000 0. 000000	C	1	0 0	0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	C	1	0 0	0	
200.00 Total (lines 50 through 199)	0.000000	C	1	0 0	-	200.00
200.00   Total (Titles 50 till ough 199)	1	C	1	0	ı	1200.00

Health Financial Systems	SSM HEALTH ST. MAR	YS HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034	Peri od: From 01/01/2023	Worksheet D-1	
				Date/Time Pre 5/21/2024 9:5	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					

		Ti +1 o V/////	Haani tal	5/21/2024 9: 5	4 am	
	Cost Center Description	Title XVIII	Hospi tal	PPS		
				1. 00		
	PART I - ALL PROVIDER COMPONENTS					
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	oveluding nowborn)		8, 682	1. 00	
2.00	Inpatient days (including private room days, excluding swing-lead days)			8, 682	2.00	
3.00	Private room days (excluding swing-bed and observation bed day	<i>3</i> ,	vate room days,	0	3. 00	
4 00	do not complete this line.			7.00/	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 room		21 of the cost	7, 986 0	4. 00 5. 00	
3.00	reporting period	om days) trii ough becember	31 Of the cost	O	3.00	
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00	
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	21 of the cost	0	7. 00		
7.00	reporting period	ii days) tiii ougii beceiibei	31 Of the Cost	U	7.00	
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3°	1 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)	5				
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	4, 526	9. 00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10.00	
	through December 31 of the cost reporting period (see instructions)			_		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11. 00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00	
	through December 31 of the cost reporting period					
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year)			0	13. 00	
14. 00	Medically necessary private room days applicable to the Progra	0	14. 00			
15. 00	Total nursery days (title V or XIX only)	0	15. 00			
16. 00	Nursery days (title V or XIX only)			0	16. 00	
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 o	f the cost	0.00	17. 00	
17.00	reporting period	es thi dugit becember 31 of	the cost	0.00	17.00	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00	
10.00	reporting period	0.00	10.00			
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	0.00	19. 00			
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00	
04 00	reporting period	`		47,000,070	04.00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		na period (line	16, 993, 368 0	1	
22.00	5 x line 17)	or or the dost report.	ng perrod (rrne	· ·	22.00	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00	
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	c 31 of the cost reportion	ng period (line	0	24. 00	
24.00	7 x line 19)	31 of the cost reportin	ig perrou (Trie	O	24.00	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
26. 00	x line 20)  Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		16, 993, 368	1	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	•	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00	
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	1	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 22) ( :+	h!>	0.00	1	
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		tions)	0. 00 0. 00	1	
36. 00	, , , , , , , , , , , , , , , , , , ,				36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost a	16, 993, 368	37. 00			
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 957. 31	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line	-		8, 858, 785	39. 00	
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 20)	,		0 050 705	40.00	
41.00	Total Program general inpatient routine service cost (line 39	+ ITTIC 40)	l	8, 858, 785	41.00	

Intensive Care Type Inpatient Hospital Units  43.00 INTENSIVE CARE UNIT  45.00 BURN INTENSIVE CARE UNIT  46.00 SURGICAL INTENSIVE CARE UNIT  46.00 SURGICAL INTENSIVE CARE UNIT  47.00 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description  48.00 Program Inpatient ancillary service cost (Wist. D-3, col. 3, line 200)  48.00 Program Inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)  48.01 Program Inpatient costs (sum of lines 41 through 49.01)(see instructions)  6.382,750  7.50 OI Total Program inpatient costs (sum of lines 41 through 49.01)(see instructions)  7.50 OI Total Program excludable to Program inpatient routine services (from Wist. D, sum of Parts II and IV)  7.50 Pass through costs applicable to Program inpatient routine services (from Wist. D, sum of Parts II and IV)  7.50 OI Total Program excludable cost (sum of lines 50 and 51)  7.50 OI Total Program excludable cost (sum of lines 50 and 51)  7.50 OI Total Program excludable cost (sum of lines 50 and 51)  7.50 OI Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and II, 1092, 433  7.50 OT Total Program discharges  7.50 OI Total Program discharges  8.00 OI Total Program discharges  8.00 OI Total Program discharges  9.0 OO OI Total P	52-10
Cost Center Description  Total Inpatient Cost Inpatient Dost   Dost    Total Inpatient Cost   Dost    Total Inpatient Dost   Dos	
Impatient Cost   Impatient Days   Diem (Col. 1   col. 2)   col.	alli
1.00	
Intensive Care Type Inpatient Hospital Units	12.00
43.00   INTERSIVE CARE UNIT	42. 00
45.00 BURN INTENIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY)  88.00 Program inpatient ancillary service cost (Wst. D-3, col. 3, line 200)  88.00 Program inpatient ancillary service cost (Wst. D-3, col. 3, line 200)  88.00 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)  99.00 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions)  10.00 Pass through costs applicable to Program inpatient routine services (from Wsst. D, sum of Parts I and 101, 598  1111)  151.00 Pass through costs applicable to Program inpatient ancillary services (from Wsst. D, sum of Parts I and 101, 598  1111)  151.00 Pass through costs applicable to Program inpatient ancillary services (from Wsst. D, sum of Parts I and 101, 598  1111)  151.00 Pass through costs applicable to Program inpatient ancillary services (from Wsst. D, sum of Parts I and 101, 598  1111)  151.00 Pass through costs applicable to Program inpatient ancillary services (from Wsst. D, sum of Parts I and 101, 598  1111)  151.00 Pass through costs applicable to Program inpatient ancillary services (from Wsst. D, sum of Parts I and 101, 598  1111)  151.00 Pass through costs applicable to Program inpatient ancillary services (from Wsst. D, sum of Parts I and 101, 598  1111)  1111  1111  1111  1111  1111  1111  1111	
48.00   Program inpatient cellular therapy acquisition cost (Wist. D-3, col. 3, line 200)   6, 382, 750   48.01   Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)   6, 865, 735   PASS THROUGH COST ADJUSTMENTS   16, 865, 735   PASS THROUGH COST ADJUSTMENTS   290, 835   111   151, 00   Program excludable to Program inpatient ancillary services (from Wkst. D, sum of Parts I and line of the pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II   290, 835   111   290, 835   111   15, 200   Total Program excludable cost (sum of lines 50 and 51)   1, 092, 433   15, 200   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)   1, 773, 302   15, 200   Total Program discharge   0	44. 00 45. 00
Cost Center Description    1.00	46. 00
48. 01   Program Inpatient ancillary service cost (Wist. D-3, col. 3, line 200)   49. 00   Total Program Inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)   16, 885, 735   PASS THROUGH COST ADJUSTMENTS   16, 865, 735   PASS THROUGH COST ADJUSTMENTS   16, 865, 735   PASS THROUGH COST ADJUSTMENTS   111)   111)   111   1	47. 00
48. 01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 16, 865,735  50. 00 Part III patient costs (sum of lines 41 through 48.01) (see instructions) 16, 865,735  50. 00 Part INBOUGH COST ADJUSTMENTS  50. 00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts II and III) 290, 835  50. 00 Target amount per accludable cost (sum of lines 50 and 51) 1,092, 433  50. 00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and endical education costs (line 49 minus line 52)  50. 00 Target amount per discharge 0,000  50. 01 Target amount per discharge 0,000  50. 02 Adjustment amount per discharge (contractor use only) 0,000  50. 02 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0,000  50. 00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0,000  50. 00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0,000  50. 00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0,000  60. 00 Expected costs (lines 53 + line 54, or line 55 from the cost reporting period ending 1996, 0.000  60. 00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 0,000  60. 00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 0,000  60. 00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 0,000  60. 00 Expected costs (lesser of line 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 0,000  60. 00 Expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 0,000  60. 00 Expected costs (lines 54 x 60), or 1 % of the cost reporting period (See Instructions) 0,000  60. 00 Expected costs (lines 54 x 60), or 1 % of the cost reporting period (See Instructions) 0,000  60. 00 Expected costs (lines 50 x 1000	48. 00
PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 11.59 and 11.50 pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 290, 835 and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 15,773,302 medical education costs (line 49 minus line 52)  74.00 Program discharges  50.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 15,773,302 medical education costs (line 49 minus line 52)  74.00 Program discharges  60.00  75.00 Program discharges  70.00 Program discharges  80.00  75.00 Program discharges  80.00  75.00 Program discharges  80.00  75.00 Program adjustment amount per discharge  80.00  75.00 Program discharges   48. 01	
50.0 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 290,835 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program excludable cost (sum of lines 50 and 51) 54.00 Program excludable cost (sum of lines 50 and 51) 55.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 55.00 Target amount per discharge 56.00 Target amount per discharge 57.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 58.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 58.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Ternaded costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (lif line 54 ilne 54 ils less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 63.00 All Alwable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (Lite XVIII only) 65.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (Lite XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Ince 12 x line 19) 67.00 Total Medicare swing-bed SNF inpatient ro	49. 00
551.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program excludable cost (sum of lines 50 and 51)  54.00 Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  55.00 Target amount per discharges  0.00  55.01 Permanent adjustment amount per discharge  0.00  55.01 Permanent adjustment amount per discharge  0.00  56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  0.01 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  0.02 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  0.03 Bonus payment (see instructions)  0.04 Bonus payment (see instructions)  0.05 Bonus payment (see instructions)  0.06 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  0.00 Expected costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  0.00 Expected costs (lesser of line 53 + line 54 or line 55 from prior year cost report, updated by the market basket)  0.00 Expected costs (lesser of line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lenes 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  0.00 Allowable Inpatient cost plus incentive payment (see instructions)  0.01 Allowable Inpatient Proutine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  0.01 Allowable Inpatient Proutine costs after December 31 of the cost reporting period (See instructions) (title VVIII only)  0.01 Allowable Inpatient Proutine costs after December 31 of the	50. 00
53.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  54.00 Program discharges  54.00 Target amount per discharge  55.01 Promanent adjustment amount per discharge  55.01 Premanent adjustment amount per discharge  56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  59.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (Litle XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (Litle VVIII X swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37)  71.00 Aljusted general inpatient routine routine service	51. 00
total Program inpatient operating cost excluding capital related, non-physician anesthetist, and total program inpatient operating cost excluding capital related, non-physician anesthetist, and total related and costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges 0.00  55.00 Program discharges 0.00  55.01 Permanent adjustment amount per discharge 0.00  55.02 Adjustment amount per discharge (contractor use only) 0.00  56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.00  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.00  58.00 Bonus payment (see instructions) 0.00  59.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (fitle XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (fitle V XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Ine 12 x line 19)  67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Ine 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting	52 00
TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges 0.00  55.01 Permanent adjustment amount per discharge 0.00  55.02 Adjustment amount per discharge (contractor use only) 0.00  55.02 Adjustment amount per discharge (contractor use only) 0.00  56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.00  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.00  58.00 Bonus payment (see instructions) 0.00  Trended costs (lesser of line 53 * line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  60.00 Expected costs (lesser of line 53 * line 54, or line 55 from prior year cost report, updated by the market basket)  61.00 Continuous improvement bonus payment (if line 53 * line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (tile XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	
54.00 Program discharges 55.01 Target amount per discharge 55.01 Praget amount per discharge 55.01 Praget amount per discharge (contractor use only) 55.02 Adjustment amount per discharge (contractor use only) 56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 63.00 All Jowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00	
55.01 Permanent adjustment amount per discharge 55.02 Adjustment amount per discharge (contractor use only) 56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 63.01 Allowable Inpatient cost plus incentive payment (see instructions) 63.02 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Ine 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILIT	54. 00
55. 02 Adjustment amount per discharge (contractor use only) 56. 00 Target amount (line 54 xs um of lines 55, 55. 01, and 55. 02) 57. 00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58. 00 Bonus payment (see instructions) 59. 00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 60. 00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61. 00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55. 01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62. 00 Relief payment (see instructions) 63. 00 Allowable Inpatient cost plus incentive payment (see instructions) 64. 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65. 00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67. 00 Title V or XIX swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60 OT Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60 OT Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60 OT Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 61 ON OT Skilled nursing facility/other nursing facility/ICF/IID onley.	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  8.00 Bonus payment (see instructions)  9.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  69.00 Total litle V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)	55. 02
58.00 Bonus payment (see instructions)  59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)  61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total Itile V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)	56. 00 57. 00
updated and compounded by the market basket)  60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)  61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)	58. 00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine costs per diem (line 70 + line 2)	59. 00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  67.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	50. 00
Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	61. 00
Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0 CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 0 (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0 (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)	62. 00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)	63. 00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 + line 2)	64. 00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 + line 2)	65. 00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0 (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 + line 2)	66. 00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	67. 00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)	68. 00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	70. 00
72.00 Program routine service cost (line 9 x line 71)	71. 00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)	72. 00 73. 00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)	74. 00
75.00   Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column   26, line 45)	75. 00
76.00 Per diem capital related costs (line 75 ÷ line 2)	76. 00
77.00   Program capital-related costs (line 9 x line 76) 78.00   Inpatient routine service cost (line 74 minus line 77)	77. 00 78. 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	79. 00 80. 00
81.00 Inpatient routine service cost per diem limitation	81. 00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions)	82. 00 83. 00
84.00 Program inpatient ancillary services (see instructions)	84. 00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	85. 00 86. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	
	87. 00 88. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions)  1,362,288	39. 00

Health Financial Systems S	SM HEALTH ST. 1	MARYS HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/21/2024 9:54	
		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, 380, 539	16, 993, 368	0. 08124	0 1, 362, 288	110, 672	90.00
91.00 Nursing Program cost	0	16, 993, 368	0.00000	0 1, 362, 288	0	91.00
92.00 Allied health cost	0	16, 993, 368	0.00000	0 1, 362, 288	0	92.00
93.00 All other Medical Education	0	16, 993, 368	0. 00000	1, 362, 288	0	93. 00

Health Financial Systems	SSM HEALTH ST. MARYS HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0034	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 14-S03	To 12/31/2023	Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Subprovider -	PPS

		II the Aviii	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		5, 472	1.00
2.00	Inpatient days (including private room days, excluding swing-b			5, 472	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		5, 472	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	975	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	Join days) arter	Ö	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	/ only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ve			U	13.00
14.00	Medically necessary private room days applicable to the Progra	•	, I	0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period	· · · · · · · · · · · · · · · · · · ·			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
17.00	reporting period	o tili dagii becellibei di di	110 0031	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		7, 389, 535	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportir	na period (line	0	24. 00
	7 x line 19)		.9		
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25.00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		7, 389, 535	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	22) (	-!>	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x line	, ,	.1 0115)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	:= = :/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	7, 389, 535	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 350. 43	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 316, 669	
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 30)	•		1 216 660	40.00
41. 00	Total Program general inpatient routine service cost (line 39	T IIIIC 40)	I	1, 316, 669	41.00

		SM HEALTH ST. MA				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 14-0 Component CCN: 14-	i	Period: From 01/01/2023 Fo 12/31/2023	Worksheet D-1 Date/Time Pre	
			Title XVIII		Subprovi der -	5/21/2024 9: 5 PPS	
	Cost Center Description	Total Inpatient CostIr	patient Days Diem (	ige Per col. 1 - . 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00		. 2) . 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0. 00	0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	O	0. 00	0	0	43.00
44. 00	CORONARY CARE UNIT		Š,	0.00		Ü	44. 00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
10.00						1. 00	10.00
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisition			ne 10	column 1)	108, 573 0	1
49. 00	Total Program inpatient costs (sum of lines			THE TO,	corumir 1)	1, 425, 242	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>	,				
50. 00	Pass through costs applicable to Program inp.	atient routine se	ervices (from Wkst.	D, sum	of Parts I and	58, 802	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (from Wks	t. D, sı	um of Parts II	4, 569	51.00
	and IV)	,	•				
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		atod non nhysician	apostho	atist and	63, 371 1, 361, 871	
JJ. UU	medical education costs (line 49 minus line			ancs tile	anu	1, 301, 6/1	] 33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						1
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor					0.00	1
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55		ust amount (line E/	mi nua l	ino [2)	0	
58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	jet amount (Tine 56	IIII Hus I	THE 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from t	he cost reporting p	period 6	endi ng 1996,	0.00	
60. 00	updated and compounded by the market basket)	or line 55 from	nrior year cost re	oort ur	ndated by the	0.00	60.00
61. 00	market basket)						61. 00
	$55.01$ , or line $59$ , or line $60$ , enter the les $53$ ) are less than expected costs (lines $54 \times 10^{-2}$						
(2.00	enter zero. (see instructions)					0	(2.00
63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	·					
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decemb	er 31 of the cost i	reportir	ng period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cost re	oorting	period (See	0	65. 00
	instructions)(title XVIII only)		(5) (1)			0	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (IINe 64	+ prus rine 65)(titi	e XVIII	on y); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through [	ecember 31 of the	cost rep	oorting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of the co	st renor	rting period	0	68. 00
	(line 13 x line 20)						
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			ne 37)			70.00
71. 00	Adjusted general inpatient routine service c	ost per diem (lir	•	/			71.00
72.00	Program routine service cost (line 9 x line		lino 14 v li== 25\				72.00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv						73.00
75. 00	Capital -related cost allocated to inpatient		· ·	et B, Pa	art II, column		75. 00
74 00	26, line 45)	2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76.00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces			70 m!	is line 70)		79.00
	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		st Timitation (IINe	/o mini	ıs IIIIe /9)		80.00
82. 00	Inpatient routine service cost limitation (						82. 00
83. 00	Reasonable inpatient routine service costs (						83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		:)				84. 00 85. 00
55.00	Total Program inpatient operating costs (sum	•	•				86.00
86. 00	Total III girling to the Committee of th						
86. 00 87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions	S THROUGH COST	<u>-</u>			0	   87. 00

Health Financial Systems S	SM HEALTH ST. N	MARYS HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (		From 01/01/2023 To 12/31/2023		
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
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	330, 011	7, 389, 535	0. 04465	9 0	0	90. 00
91.00 Nursing Program cost	0	7, 389, 535	0.00000	0	0	91.00
92.00 Allied health cost	0	7, 389, 535	0.00000	0	0	92. 00
93.00 All other Medical Education	0	7, 389, 535	0.00000	0 0	0	93. 00

Health Financial Systems	SSM HEALTH ST. MARYS H	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Pro		Peri od: From 01/01/2023	Worksheet D-1	
				Date/Time Prep 5/21/2024 9:54	
		Title XIX	Hospi tal	PPS	
Cost Center Description					

		Ti +Lo VIV	Hoopi tal	5/21/2024 9: 5	4 am
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s. excluding newborn)		8, 682	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			8, 682	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	od days)		7, 986	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	7, 400	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private room	om days) after December :	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	aays) tiii sagii bessiiibsi	0. 0. 1 0001	· ·	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3 <sup>-</sup>	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing_bed_and	91	9. 00
7. 00	newborn days) (see instructions)	o the mogram (exchaining	swifig-bed and	71	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom dave) after	0	11. 00
11. 00	December 31 of the cost reporting period (if calendar year, en		Joil days) arter	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT	0	16. 00		
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period	oo en ough becombe. O. o	5551	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	0. 00	18. 00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00		
17.00	reporting period	0.00	19.00		
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		16, 993, 368	21. 00
21.00	Swing-bed cost applicable to SNF type services through December		na period (line	10, 993, 300	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	and 31 of the cost reportion	na period (line	0	24. 00
2 00	7 x line 19)	or or the edet report.	.g po ou (	· ·	2 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	, , ,				27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nue lino 22)(soo instruc	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin			0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00		
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	16, 993, 368	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 957. 31	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	-		178, 115	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 178, 115	40. 00 41. 00
11.00	1.0ta. 1.0gram general impatreme routine service cost (Time 37			170, 113	1 00

		HEALTH ST. MA	ARYS HOSPITAL			u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC	CN: 14-0034	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre	pared:
				e XIX	Hospi tal	5/21/2024 9: 5 PPS	4 diii
	Cost Center Description	Total atient Cost	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3. 00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>	O O	0.1	50  0	0	42.00
43.00	INTENSIVE CARE UNIT	3, 276, 400	936	3, 500.	43 6	21, 003	1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
48. 00	Program inpatient ancillary service cost (Wkst.	D 2 col 2	Line 200)			1.00	48. 00
48. 01	Program inpatient cellular therapy acquisition c			III, line 10,	column 1)	0	
49. 00	Total Program inpatient costs (sum of lines 41 t	hrough 48.01	)(see instruc	tions)	,	199, 118	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpatie	nt routine s	ervices (from	Wkst. D. sur	n of Parts I and	15, 529	50.00
			•				
51. 00	Pass through costs applicable to Program inpatie and IV)	nt ancillary	services (Tr	OM WKST. D, S	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines 50 a					15, 529	
53. 00	Total Program inpatient operating cost excluding medical education costs (line 49 minus line 52)	capital rel	ated, non-phy	sician anesth	netist, and	183, 589	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION						į
54. 00 55. 00	Program discharges Target amount per discharge						54. 00 55. 00
55. 01	Permanent adjustment amount per discharge						55. 01
55. 02	, ,						55. 02 56. 00
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55.01, Difference between adjusted inpatient operating		get amount (I	ine 56 minus	line 53)	0	57.00
58.00	Bonus payment (see instructions)				,	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54, or lupdated and compounded by the market basket)	ine 55 from	the cost repo	rting period	ending 1996,	0.00	59. 00
60.00	Expected costs (lesser of line 53 ÷ line 54, or	line 55 from	prior year c	ost report, ι	updated by the	0.00	60. 00
61. 00	market basket) Continuous improvement bonus payment (if line 53 55.01, or line 59, or line 60, enter the lesser 53) are less than expected costs (lines 54 x 60)	of 50% of th	e amount by w	hich operatir	ng costs (line	0	61. 00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00
	Allowable Inpatient cost plus incentive payment	(see instruc	tions)				63. 00
64 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs t	hrough Decem	her 31 of the	cost renorti	ng period (See	0	64. 00
	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine costs a instructions)(title XVIII only)	fter Decembe	er 31 of the c	ost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine c	osts (line 6	4 plus line 6	5)(title XVII	I only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine co	sts through	December 31 o	f the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine co	sts after Do	combor 21 of	the cost rone	orting poriod	0	68. 00
	(line 13 x line 20)			•	or tring period		
69. 00	Total title V or XIX swing-bed NF inpatient rout PART III - SKILLED NURSING FACILITY, OTHER NURSI					0	69.00
70.00	Skilled nursing facility/other nursing facility/	ICF/IID rout	ine service c	ost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service cost Program routine service cost (line 9 x line 71)	per diem (li	ne 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applicable		•	ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine service Capital-related cost allocated to inpatient rout		,	orksheet R [	Part II column		74. 00 75. 00
73.00	26, line 45)	THE 3ET VICE	COSTS (TIOII W	orksneet b, i	art II, corumii		75.00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2 Program capital-related costs (line 9 x line 76)	)					76. 00 77. 00
78. 00		ne 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess co Total Program routine service costs for comparis				nue lino 70)		79. 00 80. 00
81.00			ociimi tati UII	(11116 10 IIII1	IGS TITE 17)		81.00
82.00	Inpatient routine service cost limitation (line						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (see Program inpatient ancillary services (see instru		•)				83. 00 84. 00
85.00	Utilization review - physician compensation (see	instruction					85. 00
86. 00	Total Program inpatient operating costs (sum of PART IV - COMPUTATION OF OBSERVATION BED PASS TH		ougn 85)				86. 00
87.00	Total observation bed days (see instructions)		lino 2)				87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per diem Observation bed cost (line 87 x line 88) (see in		111le 2)			1, 957. 31 1, 362, 288	1

Health Financial Systems S	SM HEALTH ST. 1	MARYS HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/21/2024 9:54	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	1, 380, 539	16, 993, 368	0. 08124	0 1, 362, 288	110, 672	90.00
91.00 Nursing Program cost	0	16, 993, 368	0.00000	0 1, 362, 288	0	91.00
92.00 Allied health cost	0	16, 993, 368	0.00000	0 1, 362, 288	0	92.00
93.00 All other Medical Education	0	16, 993, 368	0. 00000	1, 362, 288	0	93. 00

Health Financial Systems	SSM HEALTH ST. MARYS HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-003	4 Period: From 01/01/2023	Worksheet D-1
	Component CCN: 14-SO:		Date/Time Prepared: 5/21/2024 9:54 am
	Title XIX	Subprovi der -	PPS
		I PF	

			I PF		
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		5, 472	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			5, 472	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	vs). If you have only private	e room days,	0	3. 00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation be	ad days)		5, 472	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		of the cost	0,472	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 31 o	f the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through Docombor 21	of the cost	0	7. 00
7.00	reporting period	ruays) tili ougii becember 31	or the cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31 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 swi	ng-bed and	23	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private room	days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruct		days)	G	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		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	conly (including private ro	om days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private ro	om days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter 0 on this line)	,		
14.00	Medically necessary private room days applicable to the Progra	m (excluding swing-bed days	)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of the	e cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of the	cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of the	cost	0.00	19. 00
17.00	reporting period	through becember 31 of the	COST	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of the c	ost	0.00	20.00
	reporting period			7 000 505	
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		poriod (lipo	7, 389, 535 0	
22.00	5 x line 17)	s 31 of the cost reporting	perrou (Trile	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting pe	riod (line 6	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reporting p	eriod (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting per	iod (line 8	0	25. 00
	x line 20)			_	
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)		7, 389, 535	27. 00
28 00	General inpatient routine service charges (excluding swing-bed	l and observation bed charge	5)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed enarge.		0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus line 33)(see instruction	s)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line)	, .	3)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost differ	ential (line	7, 389, 535	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 350. 43	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	· · · · · · · · · · · · · · · · · · ·		31, 060	
40. 00	Medically necessary private room cost applicable to the Progra			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)	ļ	31, 060	41. 00

		SM HEALTH ST. MA			eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 14-003 Component CCN: 14-SC	From 01/01/202		
			Title XIX	Subprovi der -	5/21/2024 9: 5 PPS	i <u>4 am</u>
	Cost Center Description	Total Inpatient Costlr	Total Average	. 1 ÷	(col. 3 x col.	
		1.00	2.00 3.00		4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0.00	0 0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0. 00	0 0	43.00
44. 00	CORONARY CARE UNIT			0.00		44. 00
	BURN INTENSIVE CARE UNIT					45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)					46. 00 47. 00
47.00	Cost Center Description					47.00
	·				1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisition			10 column 1)	0 0	
49. 00	Total Program inpatient costs (sum of lines			e 10, Corumin 1)	31, 060	
	PASS THROUGH COST ADJUSTMENTS	· · · · · · · · · · · · · · · · · · ·	(000 1110 11 00 01 0110)		1 2.7 222	]
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from Wkst. D,	sum of Parts I and	1, 387	50.00
51. 00		atient ancillary	services (from Wkst	D sum of Parts II	0	51.00
, 50	and IV)	,		, 0		3 50
52.00	Total Program excludable cost (sum of lines				1, 387	•
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ited, non-physician ar	nesthetist, and	29, 673	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	<i>52</i>				
	Program di scharges				0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge				0.00	
	Adjustment amount per discharge (contractor	use only)			0.00	•
56. 00	Target amount (line 54 x sum of lines 55, 55			==>	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (line 56 mi	nus line 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from t	he cost reporting per	iod ending 1996,	0.00	
	updated and compounded by the market basket)					
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)				0.00	
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of the	e amount by which oper	rating costs (İine	0	61.00
(2.00	enter zero. (see instructions)					(2.00
63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)		0 0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	(00000000000000000000000000000000000000			<u> </u>	
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	oer 31 of the cost rep	porting period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the cost repor	ting period (See	0	65. 00
	instructions)(title XVIII only)					
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line 64	plus line 65)(title	xvIII only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through [	December 31 of the cos	st reporting period	0	67. 00
/O CC	(line 12 x line 19)	-			_	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Dec	cemper 31 of the cost	reporting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient		·		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NI			27)		70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	•	•	; o/)		70.00
72. 00	Program routine service cost (line 9 x line					72.00
73.00	Medically necessary private room cost applic					73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient		•	B Part II column	1	74. 00 75. 00
73.00	26, line 45)	routine service (	costs (110m worksheet	b, rait ii, corumii		75.00
76.00	Per diem capital-related costs (line 75 ÷ li					76. 00
	Program capital-related costs (line 9 x line   Inpatient routine service cost (line 74 minu					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		ovi der records)			79.00
	Total Program routine service costs for comp		st limitation (line 78	3 minus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I					81.00
83. 00	Reasonable inpatient routine service cost in itation (	· · · · · · · · · · · · · · · · · · ·				83.00
84. 00	Program inpatient ancillary services (see in	structions)				84.00
85.00	Utilization review - physician compensation	•				85.00
oo. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		agri oo)			86.00
87. 00	Total observation bed days (see instructions	)			0	•
88. 00	Adjusted general inpatient routine cost per					88.00

Health Financial Systems	SSM HEALTH ST. M	ARYS HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (		From 01/01/2023 To 12/31/2023		pared: 4 am
		Titl	e XIX	Subprovi der  - I PF	PPS	
Cost Center Description		,	,			
· ·					1.00	
89.00 Observation bed cost (line 87 x line 88	<pre>8) (see instructions)</pre>				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THE	OUGH COST					
90.00 Capital -related cost	330, 011	7, 389, 535	0. 04465	9 0	0	90.00
91.00 Nursing Program cost	0	7, 389, 535	0.00000	0	0	91.00
92.00 Allied health cost	0	7, 389, 535	0.00000	0	0	92.00
93.00 All other Medical Education	0	7, 389, 535	0.00000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN	N: 14-0034	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/21/2024 9:5	pared:
	Title	XVIII	Hospi tal	PPS	
Cost Center Description	F	Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVIDER - IPF 43. 00   04300   NURSERY			7, 745, 514 1, 222, 640 0		30. 00 31. 00 40. 00 43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   0PERATING ROOM 51. 00   05100   RECOVERY ROOM		0. 18130 0. 17897		634, 157 60, 781	50. 00 51. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 00000		00,701	52.0
53. 00   05300   ANESTHESI OLOGY		0. 06724		37, 035	53. 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 18454			54.0
55. 00   05500 RADI OLOGY-THERAPEUTI C		0. 17250		514	55. C
56. 00   05600   RADI 0I SOTOPE		0. 13245	104, 950	13, 901	56.0
57.00   05700   CT SCAN		0. 02923	5, 277, 477	154, 282	57. C
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 04307			58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000	0 0	0	59.0
50. 00   06000   LABORATORY		0. 09494	6, 016, 708	571, 250	60. C
04.00   06400   I NTRAVENOUS THERAPY		0. 36711	6, 970	2, 559	64.0
55. 00 06500 RESPI RATORY THERAPY		0. 26782			65. C
66. 00 06600 PHYSI CAL THERAPY		0. 35408		255, 482	66.0
66. 01 03340 CLINICAL NUTRITION		8. 40857		0	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 25598	•	36, 856	
58. 00 O6800 SPEECH PATHOLOGY		0. 48076	•	50, 672	
59. 00 06900 ELECTROCARDI OLOGY		0. 16046		242, 134	
69. 01 03140 CARDI AC REHABI LITATI ON		0. 40713		0	69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 11575	•	4, 641	70.0
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 03103			
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 65102	•	· ·	
73. 00   07300   DRUGS CHARGED TO PATIENTS		0. 22564			
74. 00   07400  RENAL DI ALYSI S   0UTPATI ENT SERVI CE COST CENTERS		0. 00000	00 0	0	74.0
20. 00 09000 CLINIC		0. 57652	27 0	0	90.0

0. 576527

0. 162030

1. 316784

3, 814, 437 102, 122

32, 263, 910

32, 263, 910

6, 382, 750 200. 00

618, 053

134, 473

90.00

91.00

92.00

201. 00

202. 00

90.00

91.00

200.00

201.00

202.00

09000 CLI NI C

09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

<del>_</del>	MARYS HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-0034	Peri od: From 01/01/2023	Worksheet D-3	3
	Component	CCN: 14-S034	To 12/31/2023	Date/Time Pre 5/21/2024 9:5	
	Title	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00   03000   ADULTS & PEDI ATRI CS					30.00
31. 00   03100   INTENSIVE CARE UNIT					31.00
40. 00   04000   SUBPROVI DER - 1 PF			1, 192, 574		40.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50.00   05000   OPERATING ROOM		0. 18130		0	
51. 00   05100   RECOVERY ROOM		0. 17897		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
53. 00   05300   ANESTHESI OLOGY		0. 06724		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 18454	•	2, 076	
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 17250		0	
56. 00   05600   RADI OI SOTOPE		0. 13245		1 752	
57.00  05700 CT SCAN 58.00  05800 MAGNETIC RESONANCE IMAGING (MRI)		0.02923		1, 752	
58.00   05800   MAGNETIC RESONANCE IMAGING (MRI) 59.00   05900   CARDIAC CATHETERIZATION		0. 04307 0. 00000		188 0	
60. 00   06000   LABORATORY		0. 09494		22, 078	
64. 00   06400   I NTRAVENOUS THERAPY		0. 36711		22,078	1
65. 00 06500 RESPI RATORY THERAPY		0. 26782		18, 317	
66. 00   06600   PHYSI CAL THERAPY		0. 35408	•	5, 632	
66. 01   03340   CLI NI CAL   NUTRI TI ON		8. 40857		0	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 25598		1, 916	
68. 00 06800 SPEECH PATHOLOGY		0. 48076	400	192	68.00
69. 00   06900   ELECTROCARDI OLOGY		0. 16046	18, 300	2, 937	69.00
69. 01 03140 CARDIAC REHABILITATION		0. 40713	32 0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 11575	57 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 03103	14, 144	14, 583	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 65102		201	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 22564		17, 233	
74. 00 07400 RENAL DIALYSIS		0.00000	00 0	0	74. 00
OUTPATIENT SERVICE COST CENTERS			.=  -	_	
90. 00   09000   CLI NI C		0. 57652		0	
91. 00   09100   EMERGENCY		0. 16203		21, 468	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		1. 31678		100 573	
200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only cha			641, 885	108, 573	200.00
ALL THE TERS PRE LITHER LANDESTORY SERVICES PROGRAM ONLY ON	armes illine 611				1/(11 ()()

Health Financial Systems	SSM HEALTH ST. MARYS HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0034	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/21/2024 9:54 am

	T' II WILL		5/21/2024 9: 5	4 am
	Title XVIII Hospita	tl	PPS	
			1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see		0 7, 605, 743	1. 00 1. 01
1. 02	instructions)  DRG amounts other than outlier payments for discharges occurring on or after October 1 (see		2, 662, 512	1. 02
1. 03	instructions)  [DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Oc-	toher	0	1. 03
1. 03	1 (see instructions)  DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	lobei	0	1. 03
	October 1 (see instructions)		O	
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)		70 543	2. 02
2. 03 2. 04	Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)		70, 543 39, 617	2. 03 2. 04
3. 00	Managed Care Simulated Payments		0	3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)		90. 09	4. 00
	Indirect Medical Education Adjustment			
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period endiror before 12/31/1996. (see instructions)	ng on	0. 00	5. 00
5. 01 6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap	p for	0. 00 0. 00	5. 01 6. 00
6. 26	new programs in accordance with 42 CFR 413.79(e) Rural track program FTE cap limitation adjustment after the cap-building window closed under §12	7 of	0. 00	6. 26
7. 00	the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(		0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If cost report straddles July 1, 2011 then see instructions.		0. 00	7. 01
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for ru track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75		0. 00	7. 02
8. 00	and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1202)		0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). 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. 02	report straddles July 1, 2011, see instructions.  The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital		0. 00	8. 02
8. 21	under § 5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0. 00	8. 21
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 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	or	0. 00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records FTE count for residents in dental and podiatric programs.		0.00	10. 00 11. 00
12. 00	Current year allowable FTE (see instructions)	ł		12. 00
13. 00	Total allowable FTE count for the prior year.	İ		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, otherwise enter zero.	1997,	0. 00	14. 00
	Sum of lines 12 through 14 divided by 3.			15. 00
	Adjustment for residents in initial years of the program (see instructions)		0.00	
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	-	0.00	17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).	1	0.000000	
20. 00	Prior year resident to bed ratio (see instructions)	İ	0. 000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)	İ	0.000000	
22. 00	IME payment adjustment (see instructions)		0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)		0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		0.00	22.00
	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$ .		0.00	
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see		0. 00 0. 00	
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)		0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)		0. 000000	
	IME add-on adjustment amount (see instructions)		0.000000	28. 00
	IME add-on adjustment amount - Managed Care (see instructions)		0	
29. 00	Total IME payment ( sum of lines 22 and 28)		0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment		0	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4. 16	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)		15. 25	
32.00	Sum of lines 30 and 31		19. 41	
33. 00	Allowable disproportionate share percentage (see instructions)		5. 39	
34. 00	Disproportionate share adjustment (see instructions)		138, 365	34.00

CALCUL	Financial Systems SSM HEALTH ST. MAR' ATION OF REIMBURSEMENT SETTLEMENT	YS HOSPITAL Provider CCN: 14-0034	Peri od:	u of Form CMS-2 Worksheet E	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	The second secon		From 01/01/2023 To 12/31/2023	Part A Date/Time Pre	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompared Care Downert Adjustment		1. 00	2. 00	
5. 00	Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions)		6 874 403 459	5, 938, 006, 757	35.00
5. 01	Factor 3 (see instructions)		0. 000076569	0. 000076537	35. 0°
5. 02	Hospital UCP, including supplemental UCP (see instructions)		526, 366	454, 477	35. 0
5. 03	Pro rata share of the hospital UCP, including supplemental UCF	P (see instructions)	393, 693	114, 240	35. 0
6. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		507, 933		36.0
0 00	Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throu			40.0
0. 00	Total Medicare discharges (see instructions)		0		40. 0 41. 0
1. 00	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instructi	ons)	0		41.0
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qualit		0.00		42.0
3. 00	Total Medicare ESRD inpatient days (see instructions)		0		43.0
4. 00	Ratio of average length of stay to one week (line 43 divided by	by line 41 divided by 7	0. 000000		44.0
	days)				
5. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.0
6. 00 7. 00	Total additional payment (line 45 times line 44 times line 41. Subtotal (see instructions)	.01)	11, 024, 713		46. 0 47. 0
8. 00	Hospital specific payments (to be completed by SCH and MDH, sm	mall rural hospitals	11, 940, 484		48. 0
0.00	only. (see instructions)	.a a. a	1177107101		10.0
				Amount	
9. 00	Total payment for inpatient operating costs (see instructions)			1. 00 11, 711, 541	49. 0
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and			780, 255	
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	
2. 00	Direct graduate medical education payment (from Wkst. E-4, lir			0	52.0
3. 00	Nursing and Allied Health Managed Care payment			0	53.0
4. 00	Special add-on payments for new technologies			35, 724	54.0
4. 01	Islet isolation add-on payment	2)		0	54.0
5. 00 5. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cellular therapy acquisition cost (see instructions)	<del>7</del> )		0	55. C
6. 00	Cost of physicians' services in a teaching hospital (see intru	ictions)		0	56.0
7. 00	Routine service other pass through costs (from Wkst. D, Pt. II	•	hrough 35).	0	57.0
3. 00	Ancillary service other pass through costs from Wkst. D, Pt. I		g / .	0	58. (
9. 00	Total (sum of amounts on lines 49 through 58)			12, 527, 520	59. (
0. 00	Primary payer payments			13, 010	
1.00	Total amount payable for program beneficiaries (line 59 minus	line 60)		12, 514, 510	•
2.00	Deductibles billed to program beneficiaries			1, 321, 028	1
3. 00 4. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			15, 200 535, 824	
5. 00	Adjusted reimbursable bad debts (see instructions)			348, 286	1
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		499, 704	•
	Subtotal (line 61 plus line 65 minus lines 62 and 63)	•		11, 526, 568	•
3. 00	Credits received from manufacturers for replaced devices for a		′	0	
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	s)	0	69. (
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	notion) odiust		0	70.0
). 50 ). 75	Rural Community Hospital Demonstration Project (§410A Demonstr N95 respirator payment adjustment amount (see instructions)	ation) adjustment (see	instructions)	0	70. 5 70. 7
). 73 ). 87	Demonstration payment adjustment amount (see Instructions)			0	70. 7
0. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 8
0. 89	Pioneer ACO demonstration payment adjustment amount (see instr	ructions)			70. 8
0. 90	HSP bonus payment HVBP adjustment amount (see instructions)	•		371	70. 9
). 91	HSP bonus payment HRR adjustment amount (see instructions)			-918	
	Bundled Model 1 discount amount (see instructions)			0	70. 9
	,				
0. 92	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			5, 710 -14, 111	70. °

Health Financial Systems	SSM HEALTH ST. MARYS HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0034	Peri od:	Worksheet E
		From 01/01/2023	

CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider C	F	From 01/01/2023 To 12/31/2023	5/21/2024 9:5	
	<u> </u>	Titl∈	XVIII	Hospi tal	PPS	
				(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
	the corresponding federal year for the period ending on or aft	ter 10/1)		_	_	
70. 98	Low Volume Payment-3			0	0	
70. 99	HAC adjustment amount (see instructions)				0	70. 99
	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			11, 517, 620	1
	Sequestration adjustment (see instructions)				230, 352	
	Demonstration payment adjustment amount after sequestration				0	1
	Sequestration adjustment-PARHM pass-throughs					71.03
72. 00	Interim payments				11, 434, 392	
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	2, 72, and			-147, 124	74.00
	73)					
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			363, 167	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	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruct	tions)			0	93.00
94.00	The rate used to calculate the time value of money (see instru	ucti ons)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)				0	95.00
96.00	Time value of money for capital related expenses (see instruct	tions)		-	0	96. 00
					On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount				170 110	
100.00	HSP bonus amount (see instructions)			513, 710	173, 118	1100.00
404 00	HVBP Adjustment for HSP Bonus Payment			4 000000000	4 000444/00/	101 00
	HVBP adjustment factor (see instructions)	- >		1.0000000000	1. 0021446006	1
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	5)		0	3/1	102. 00
102.00	HRR Adjustment for HSP Bonus Payment			1 0000	0.0047	102 00
	HRR adjustment factor (see instructions)			1.0000	0. 9947	
104.00	HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr		ictmont	0	-918	104. 00
200 00	Is this the first year of the current 5-year demonstration per					200 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	rou unuer t	THE ZIST			200. 00
	Cost Reimbursement					ł
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	49)				201. 00
	Medicare discharges (see instructions)	, 47)				202.00
	Case-mix adjustment factor (see instructions)					203. 00
200.00	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the current	5-vear demonst	ration	200.00
	peri od)	iiist yeur	or the current	. o year demonst	1 4 1 0 1 1	
204 00	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement					1
207.00	Program reimbursement under the §410A Demonstration (see instr	uctions)				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	,				208.00
	Adjustment to Medicare IPPS payments (see instructions)	,				209.00
	Reserved for future use					210. 00
	Total adjustment to Medicare IPPS payments (see instructions)					211. 00
	Comparision of PPS versus Cost Reimbursement					1
212. 00	Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212. 00
	Low-volume adjustment (see instructions)	•				213. 00
	Net Medicare Part A IPPS adjustment (difference between PPS ar	nd cost reim	mbursement)			218. 00
	(line 212 minus line 213) (see instructions)		•			
				•		

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 14-0034

					1	0 12/31/2023	Date/lime Pre 5/21/2024 9:5	
				Title		Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	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. 01	payments DRG amounts other than outlier	1. 01	7, 605, 743	0	7, 605, 743		7, 605, 743	
1 00	payments for discharges occurring prior to October 1	1.00	2 //2 512	O		2 //2 512	2 //2 512	1 00
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	2, 662, 512	U		2, 662, 512	2, 662, 512	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	O O	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	O O		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	70, 543	0	70, 543		70, 543	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	39, 617	O		39, 617	39, 617	2. 03
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
5. 00	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
5.00	A, line 21 (see instructions)	21.00	0.000000	0.000000	0.00000	0.000000		3.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	O	0	0	0	6. 01
	Indirect Medical Education Adju	ustment for th	e Add-on for Sec	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	O	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	O	0	0	0	9. 01
	Disproportionate Share Adjustme	ent						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0539	0. 0539	0. 0539	0. 0539		10. 00
11. 00	instructions) Disproportionate share adjustment (see instructions)	34.00	138, 365	O	102, 488	35, 877	138, 365	11. 00
11. 01	Uncompensated care payments  Additional payment for high per	36.00	507, 933 RD beneficiary (	0 di scharges	393, 693	114, 240	507, 933	11. 01
12. 00	Total ESRD additional payment	46. 00	0	0	0	0	0	12. 00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	11, 024, 713 11, 940, 484	0	8, 172, 467 0	2, 852, 246 0	11, 024, 713 0	
15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see	49. 00	11, 711, 541	0	8, 859, 295	2, 852, 246	11, 711, 541	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	780, 255	0	572, 260	207, 995	780, 255	16. 00
			•			·		

LOW VO	LUME CALCULATION EXHIBIT 4			Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi Date/Time Pre 5/21/2024 9:5	pared:
					XVIII	Hospi tal	PPS	
		· ·	Amounts (from	Pre/Post	Peri od Pri or		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
47.00		0	1.00	2. 00	3.00	4. 00	5. 00	47.00
17.00	Special add-on payments for	54. 00	35, 724	0	35, 72	4 0	35, 724	17. 00
17 01	new technologies							17.01
17. 01	Net organ aquisition cost	(0.00	0	_			0	17. 01
17. 02	Credits received from manufacturers for replaced	68. 00	Ü	0		0 0	0	17. 02
	devices for applicable MS-DRGs							
18. 00		93. 00	0	^		0	0	18. 00
10.00	adjustment amount (see	73.00	O	0			O	10.00
	instructions)							
19 00	SUBTOTAL			0	9, 467, 27	9 3, 060, 241	12, 527, 520	19 00
		W/S L, line	(Amounts from	-	1, 101, 21		12/02//020	
		,	L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	774, 208	0	568, 10	3 206, 105	774, 208	20. 00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0		0 0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	6, 047	0	4, 15	7 1, 890	6, 047	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0		0 0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0. 000	0.0000		22. 00
	percentage (see instructions)							
23. 00	Indirect medical education	6. 00	0	0		0 0	0	23. 00
	adjustment (see instructions)	40.00						
24.00	Allowable disproportionate	10. 00	0. 0000	0. 0000	0.000	0.0000		24. 00
	share percentage (see							
25. 00	instructions) Disproportionate share	11. 00	0	_		0	0	25. 00
25.00	adjustment (see instructions)	11.00	U	0		U U	U	25.00
26. 00	Total prospective capital	12.00	780, 255	0	572, 26	0 207, 995	780, 255	26 00
20.00	payments (see instructions)	12.00	700, 233	0	372, 20	201, 773	700, 233	20.00
	payments (see Tristi deti ons)	W/S E, Part A	(Amounts to F					
		line	Part A)					
		0	1.00	2. 00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 06962	1 0. 069621		27. 00
28.00	Low volume adjustment	70. 96			659, 12	1	659, 121	28. 00
	(transfer amount to Wkst. E,				·			
	Pt. A, line)							
29.00		70. 97				213, 057	213, 057	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Υ					100. 00
	adjustments to Wkst. E, Pt. A.							

Provider CCN: 14-0034

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 01/01/2023 Part A Exhibit 5 Date/Time Prepared: 5/21/2024 9:54 am 12/31/2023 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 0 4.00 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 7, 605, 743 7, 605, 743 7, 605, 743 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 2, 662, 512 2, 662, 512 2, 662, 512 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 0 1.03 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 70.543 70 543 70 543 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 39, 617 39, 617 39, 617 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 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 C 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 0.0539 0.0539 0.0539 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 138.365 102.488 35, 877 138, 365 11.00 instructions) 11.01 507. 933 <u>393, 69</u>3 507, 933 Uncompensated care payments 36, 00 114, 240 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 12.00 instructions) 47.00 13 00 11, 024, 713 8, 172, 467 Subtotal (see instructions) 2.852.246 11, 024, 713 13 00 14.00 Hospital specific payments (completed by SCH 48.00 11, 940, 484 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 11, 711, 541 8, 859, 295 2, 852, 246 11, 711, 541 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 780, 255 572, 260 207 995 780, 255 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 35, 724 35, 724 35, 724 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 C 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 0 amount (see instructions) 19.00 **SUBTOTAL** 9, 467, 279 3, 060, 241 12, 527, 520 19.00

Heal th	Financial Systems S	SM HEALTH ST. M	MARYS HOSPITAL		In Li€	eu of Form CMS-:	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 9:5	pared:
				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	774, 208	568, 10	206, 105	774, 208	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
	Capital DRG outlier payments	2. 00	6, 047	4, 15	1, 890	6, 047	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	780, 255	572, 20	207, 995	780, 255	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	5, 710		0 5, 710	5, 710	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	371		0 371	371	30. 01
31. 00	HRR adjustment (see instructions)	70. 94	-14, 111		0 -14, 111	-14, 111	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	-918		0 -918		
	instructions)					(	
						(Amt. to Wkst. E, Pt. A)	
		0	1. 00	2. 00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99			0	0	32. 00
	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	SSM HEALTH ST. MAR	YS HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	From 01/01/2023	Worksheet E Part B Date/Time Prepared: 5/21/2024 9:54 am
		T: +1 - \/\/\	11: 4-1	DDC

	T:+Lo VVIII		Haani tal	5/21/2024 9: 5	4 am
	Title XVIII		Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3, 501	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instructions) OPPS or REH payments			9, 435, 526 8, 139, 540	2. 00 3. 00
4. 00	Outlier payment (see instructions)			7, 567	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7. 00
8.00	Transitional corridor payment (see instructions)	aduaa+1	an aceta from	0	8.00
9. 00	Ancillary service other pass through costs including REH direct graduate medical Wkst. D, Pt. IV, col. 13, line 200	educati	on costs from	0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			3, 501	•
	COMPUTATION OF LESSER OF COST OR CHARGES			·	
	Reasonabl e charges				
12.00	Ancillary service charges			15, 516	•
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			15 51/	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			15, 516	14.00
15. 00	Aggregate amount actually collected from patients liable for payment for services	s on a c	harge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for payment for service		9	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)		J		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			15, 516	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceed	ds line	11) (see	12, 015	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceed</pre>	ds line	18) (see	0	20.00
20.00	instructions)	us iiiic	10) (300	O	20.00
21. 00	Lesser of cost or charges (see instructions)			3, 501	21.00
22.00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			8, 147, 107	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 25 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see i	i netruct	ions)	0 1, 619, 797	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines			6, 530, 811	
27.00	instructions)	00 <b>LL</b> u	20] (000	0,000,011	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 00
28. 50	REH facility payment amount (see instructions)				28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30. 00 31. 00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments			6, 530, 811 0	30. 00 31. 00
32. 00	Subtotal (line 30 minus line 31)			6, 530, 811	•
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			0,000,011	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			303, 763	
35. 00	Adjusted reimbursable bad debts (see instructions)			197, 446	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)			262, 360 6, 728, 257	
38. 00	Subtotal (see instructions)   MSP-LCC reconciliation amount from PS&R			0, 720, 237	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			Ö	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 devices (see ins	structio	ns)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			6, 728, 257 134, 565	40. 00 40. 01
40. 01	Demonstration payment adjustment amount after sequestration			134, 303	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			Ü	40. 03
41.00	Interim payments			6, 597, 013	1
41. 01	Interim payments-PARHM				41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)			0.001	42. 01
43.00	Balance due provider/program (see instructions)			-3, 321	•
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15	5-2 cha	nter 1	0	43. 01 44. 00
44.00	§115. 2	∪ -∠, UIId	pter i,	U	44.00
	TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00	92. 00 93. 00
73. UU	Time variae of money (see firstructions)		l	U	73.00

Health Financial Systems	SSM HEALTH ST. MAR	YS HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Peri od: From 01/01/2023 To 12/31/2023		
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems	SSM HEALTH ST. MARYS HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0034	Peri od: From 01/01/2023	Worksheet E
	Component CCN: 14-S034		
	Title XVIII	Subprovi der -	PPS

Medical and other services relimbursed under OPPS (see instructions)   51,85,860			litle XVIII	Subprovi der - I PF	PPS	
PART B - MEDICAL AND OTHER HEALTH SERVICES   1.00   Medical and other services (see instructions)   5.1, 55. 1, 55. 1, 55. 1, 56. 10   Payments of this payments of this payments of this payments of this payments of this payments of this payments of this payments of this payments of this payments of this payments of this payments of this payments of this payments of this payments of this payments of this payments of this payments of the paym					1 00	
Medical and other services (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
OPPS or RFII payments (see instructions)  Outlier payment (see instructions)  Outlier payment (see instructions)  OUT on a time in payment (see instructions)  OUT on a time in the hospital specific payment to cost ratio (see instructions)  OUT on a time in the hospital specific payment to cost ratio (see instructions)  OUT on a time in of 4.01, divided by line 6  OUT on a time in of 4.01, divided by line 6  OUT on a time in of 4.01, divided by line 6  OUT on a time in of 4.01, divided by line 6  OUT on a time in of 4.01, divided by line 6  OUT on a time in one of 4.01, divided by line 6  OUT on a time in one of 4.01, divided by line 6  OUT on a time in one of 4.01, divided by line 6  OUT on a time in one of 4.01, divided by line 6  OUT on a time in one of 4.01, divided by line 6  OUT on time in one of 4.01, divided by line 6  OUT on time in one of 4.01, divided by line 6  OUT on the line of 4.01, divided by line 6  OUT on time in one of 4.01, divided					0	1. 00
0.00 Uniter payment (see instructions) (0.00 or instructions) (0.00 or instruction amount (see instructions) (0.00 or instructions) (0.00			tions)		51, 953	2. 00
Output/ATION OF LESSER OF COST OR CHARGES  COMPUTATION OF LESSER OF COST		1 3			28, 496	3. 00
Enter the hospit all specific payment to cost ratio (see instructions)    Computational Corridor Payment (see Instructions)   Computational Corridor Payment (see Instructions						4. 00 4. 01
Line 2 times line 5  Control lines 3, 4, and 4, 01, divided by line 6  Control lines 3, 4, and 4, 01, divided by line 6  Control lines 3, 4, and 4, 01, divided by line 6  Control lines 3, 4, and 4, 01, divided by line 6  Control lines 3, 4, and 4, 01, divided by line 6  Control lines 3, 4, and 4, 01, divided by line 6  Control lines 3, 4, and 4, 01, divided by line 6  Control lines 3, 4, and 4, 01, divided by line 6  Control lines 3, 4, and 4, 01, divided by line 6  Control lines 3, 4, and 4, 01, divided by line 6  Control lines 4, and 10, and		· · · · · · · · · · · · · · · · · · ·	rtions)			5. 00
5.00 Sum of lines 3, 4, and 4,01, divided by line 6 00 Transitional corridor payment (see Instructions) 5.00 Transitional corridor payment (see Instructions) 6.00 Transitional corridor payment (see Instructions) 7.00 Despin acquisitions 7.00 Despin acquisitions 7.00 Despin acquisitions 7.00 Total cost (sum of lines 1 and 10) (see Instructions) 7.00 Despin acquisitions 7.00 Transitional corridor (see Instructions) 7.00 Despin acquisitions 7.00 Despin acquisition charges (Sum of lines 1 and 13) (see Instructions) 7.00 Despin acquisition charges (Sum of lines 1 and 13) 8.00 Despin acquisition charges (Sum of lines 1 and 13) 8.00 Despin acquisition charges (Sum of lines 1 and 13) 8.00 Despin acquisition charges (Sum of lines 1 and 13) 8.00 Despin acquisition charges (Sum of lines 1 and 13) 8.00 Despin acquisition charges (From Wast. 0-4, Pt. III, col. 4, line 69) 8.00 Despin acquisition charges (Sum of lines 1 and 13) 8.00 Despin acquisition charges (See Instructions) 8.00 Despin acquisition			211 0113)		0.000	6. 00
Ancillary service other pass through costs including REH direct graduate medical education costs from Wasts D. Pt. IV. col. 13, line 20, 13, line 20, 13, line 20, 13, line 20, 13, line 20, 13, line 20, 13, line 20, 13, line 20, 13, line 20, 13, line 20, 20, 20, 20, 20, 20, 20, 20, 20, 20,					0.00	7. 00
Wist D, Pt. IV, col. 13, line 200  Total cost (sum of lines 1 and 10) (see instructions)  ComPUTATION OF LESSER OF COST OR CHARGES  Reasonable charges  12.00 Ancillary service charges  Computation of Lesses of Cost of Charges  13.00 organ acquisition charges (from Wist. D-4, Pt. III., col. 4, line 69)  Cryptal acquisition charges (from Wist. D-4, Pt. III., col. 4, line 69)  Cryptal acquisition charges (sum of lines 12 and 13)  Cost of Cost of Cost of Charges  Aggregate amount actually collected from patients liable for payment for services on a charge basis and such payment been made in accordance with 42 CFR 9413.13(e)  17.00 Ratio of line 15 to line 16 (not to exceed 1.000000)  18.00 Total customary charges (see Instructions)  18.00 Excess of customary charges (see Instructions)  20.00 Excess of customary charges (see Instructions)  20.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see Instructions)  21.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)  22.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)  23.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)  24.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)  25.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)  26.01 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)  27.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)  28.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)  28.01 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)  28.02 Excess of rea	3. 00	Transitional corridor payment (see instructions)			0	8. 00
10.00   Organ acquisitions   COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges   Reasonable charges   Cost of Charges   Cost	<del>7</del> . 00		ct graduate medical educa	ation costs from	0	9. 00
1.0 D Total cost (sum of lines 1 and 10) (see instructions)  COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable charges  Reasonable charges  Reasonable charges  Control or charges  Con						40.00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancil lary service charges 12.00 Ancil lary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR \$413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.00000) 18.00 Intal customary charges (see instructions) 18.00 Intal customary charges (see instructions) 19.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 21.00 Lesser of cost or charges (see instructions) 22.00 Interns and residents (see instructions) 23.00 Cost of physiclans's services in a teaching hospital (see instructions) 24.00 Total prospective payment (sum of lines 2, 4, 4.01, 8 and 9) 25.00 Deductibles and colnsurance amounts (for CAH, see instructions) 26.00 Deductibles and colnsurance amounts (for CAH, see instructions) 27.00 Subtotal ([lines 21 and 24 finus the sum of lines 22 and 23] (see Instructions) 28.00 Expensive the medical education payments (from Wkst. E-4, line 50) 29.01 EXID (Instructions) 29.02 EXID (Instructions) 29.03 EXID (Instructions) 29.04 EXID (Instructions) 29.05 EXID direct medical education costs (from Wkst. E-4, line 36) 29.06 EXID direct medical education and expensive the instructions) 29.07 EXID (Instructions) 29.08 EXID (Instructions) 29.09 EXID (Instructions) 29.00 EXID (Instructions) 29.01 EXID (Instructions) 29.01 EXID (Instructions) 29.02 EXID (Instructions) 29.03 EXID (Instructions) 29.04 EXID (Instructions)					0	10.00
Reasonable charges 13.00 Actilitary service charges 17.00 Actilitary service charges 18.10.00 Actilitary service charges 18.10.00 Actilitary service charges 18.10.00 Agreed the charges (grow Wkst. D-4, Pt. III, col. 4, line 69) 18.10.00 Agreed the charges (grow of lines 12 and 13) 18.10.00 Aggreed the amount actually collected from patients liable for payment for services on a charge basis of the control of	11.00				U	11. 00
12.00 Ancil lary service charges 14.00 Total reasonable charges (Sum of Ilnes 12 and 13) 15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis of Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CPR §413. 13(e) 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CPR §413. 13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (See instructions) 18.00 Excess of customary charges (See instructions) 20.00 Excess of customary charges (see instructions) 21.00 Lesses of customary charges (see instructions) 22.00 Interns and residents (see instructions) 22.00 Interns and residents (see instructions) 23.00 Cost of physic dark services in a teaching hospital (see instructions) 24.00 Interns and residents (see instructions) 25.00 Deductibles and colinsurance amounts (for CMI, see instructions) 26.00 Deductibles and colinsurance amounts (for CMI, see instructions) 27.00 Deductibles and colinsurance amounts (for CMI, see instructions) 28.26 Deductibles and colinsurance amounts relating to amount on line 24 (for CAH, see instructions) 28.27 Described and colonsurance amounts (for CMI, see instructions) 28.28 Described in the sum of lines 22 and 26) plus the sum of lines 22 and 23] (see instructions) 29.00 ESD direct medical education coasts (from Wast. E-4, line 50) 20.01 Extractions (sum of lines 27, 28, 28.50 and 29) 20.02 Significance (sum of lines 27, 28, 28.50 and 29) 20.03 Subtotal (sum of lines 27, 28, 28.50 and 29) 20.03 Subtotal (sum of lines 27, 28, 28.50 and 29) 20.04 Significance (sum of lines 27, 28, 28.50 and 29) 20.05 Significance (sum of lines 27, 28, 28.50 and 29) 20.06 Significance (sum of lines 27, 28, 28.50 and 29) 20.07 Significance (sum of lines 28, 28, 28, 28, 28, 28, 28, 28, 28, 28,						
13.00   Organ acquist it on charges (from Wisst. D-4, Pt. IIII, col. 4, line 69)   Costomary charges	12. 00				0	12. 00
Customary charges  16.00 Agroupt a amount actually collected from patients liable for payment for services on a charge basis of Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e)  17.00 Ratio of line 15 to line 16 (not to exceed 1.000000 CFR \$413.13(e)  18.00 Total customary charges (see instructions)  19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)  10.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see instructions)  10.00 Excess of cost or charges (see instructions)  10.00 Lesser of cost or charges (see instructions)  11.00 Lesser of cost or charges (see instructions)  12.00 Lesser of cost or charges (see instructions)  12.00 Ocst of physicians' services in a teaching hospital (see instructions)  12.00 Ocst of physicians' services in a teaching hospital (see instructions)  12.00 Ocst of physicians' services in a teaching hospital (see instructions)  12.00 Deductibles and coin surrance amounts FETTLEWIN  12.00 Deductibles and coin survance amounts relating to amount on line 24 (for CAH, see instructions)  12.00 Deductibles and coin survance amounts relating to amount on line 24 (for CAH, see instructions)  12.00 Deductibles and coin survance amounts relating to amount on line 24 (for CAH, see instructions)  12.00 Deductibles and coin survance amounts relating to amount on line 25 and 26) plus the sum of lines 22 and 23 (see instructions)  12.00 Deductibles and coin survance amounts relating to amount on line 24 (for CAH, see instructions)  12.00 Deductibles and coin survance amounts relating to amount on line 24 (for CAH, see instructions)  12.00 Defuncting and the survance of lines 22 and 23 (see instructions)  12.00 Defuncting and the survance of lines 22 and 24 in lust be sum of lines 22 and 23 (see instructions)  12.00 Defuncting and the survance of lines 22 and 24 in lust be s			ne 69)		0	13.00
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis of the collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) and 10 file 15 to line 16 (not to exceed 1.000000) total customery charges (see instructions) total customery charges (see instructions) total customery charges (see instructions) total customery charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) total customery charges over reasonable cost (complete only if line 11 exceeds line 18) (see instructions) total customery charges (see instructions) total customery charges (see instructions) total customery charges (see instructions) total customery charges (see instructions) total customery charges (see instructions) total customery charges (see instructions) total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) total prospective payment (sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) total prospective payment (sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) to consume amounts relating to amount on line 24 (for CAH, see instructions) to consume the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) to consume the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) to consume the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) to consume the sum of lines 27, 28, 28 50 and 29) to compare the sum of lines 27, 28, 28 50 and 29) to compare the sum of lines 27, 28, 28 50 and 29) to compare the sum of lines 27, 28, 28 50 and 29) to compare the sum of lines 27, 28, 28 50 and 29) to compare the sum of lines 27 and 28 to compare the sum of lines 27, 28, 28 50 and 29) to compare the sum of lines 27 and 28 to compare the sum of lines	14. 00	Total reasonable charges (sum of lines 12 and 13)	•		0	14. 00
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR \$413.13(e)  17.00 Ratio of line 15 to line 16 (not to exceed 1.000000)  19.00 Excess of customary charges (see instructions)  20.00 Excess of customary charges (see instructions)  20.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions)  21.00 Lesser of cost or charges (see instructions)  22.00 Interns and residents (see instructions)  22.00 Interns and residents (see instructions)  23.00 Cost of physicians' services in a teaching hospital (see instructions)  24.00 Interns and residents (see instructions)  25.00 Deductible sand coinsurance amounts (For CAH, see instructions)  26.00 Deductible sand coinsurance amounts (For CAH, see instructions)  27.00 Subtotal ([(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)  28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)  29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)  20.00 Subtotal ([suin of lines 27, 28, 28, 50 and 29)  20.01 ESRD direct medical education costs (from Wkst. E-4, line 36)  20.02 Primary payer payments  20.03 Composite rate ESRD (from Wkst. E-1, line 11)  30.00 Autotal (sum of lines 27, 28, 28, 50 and 29)  30.00 Subtotal (sum of lines 27, 28, 28, 50 and 29)  30.00 Subtotal (sum of lines 27, 28, 28, 50 and 29)  30.00 Allowable bad debts (see instructions)  30.00 Allowable bad debts (see instructions)  30.00 Allowable bad debts (see instructions)  30.00 Allowable bad debts (see instructions)  30.00 Allowable and consumer and payment amount feore sequestration  30.01 Allowable bad debts (see instructions)  30.02 Allowable and consumer and payment amount see instructions)  30.03 Allowable and consumer and payment amount feore sequestration  30.04 Allowable and consumer and payment amount services explained to the first payment amount feore seque						
had such payment been made in accordance with 42 CFR §413.13(e) 0  17. 00 Ratio of Iline 15 to Iline 16 (not to exceed 1.000000) 0  18. 00 Total customary charges (see instructions) 0  19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0  20. 00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see instructions) 0  21. 00 Lesser of cost or charges (see instructions) 0  22. 00 Interns and residents (see instructions) 0  23. 00 Cost of physic icans' services in a teaching hospital (see instructions) 0  24. 00 Total prospective payment (sum of lines 3, 4, 4. 01, 8 and 9) 26, 496  25. 00 PUTATION OF REIMBURSEMENT SETILEMENT 0  26. 00 Deductible sand coinsurance amounts (for CAH, see instructions) 0  27. 00 Subtotal [(Ilines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0  28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0  29. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0  29. 00 ESRO direct medical education costs (from Wkst. E-4, line 36) 0  29. 00 Subtotal (sum of lines 27, 28, 28.50 and 29) 0  29. 01 ESRO direct medical education costs (from Wkst. E-4, line 36) 0  29. 02. 233  20. 03					0	15. 00
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 19.00 Excess of customary charges (see instructions) 19.00 Excess of customary charges (see instructions) 20.00 Excess of customary charges (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 21.00 Lesser of cost or charges (see instructions) 22.00 Interns and residents (see instructions) 23.00 Cost of physicians' services in a teaching hospital (see instructions) 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 28.496 COMPUTATION OF REIMBURSEMENT SETTLEMENT 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 27.00 Subtotal ([(in es 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 Direct graduate medical education payments (from West. E-4, line 36) 30.00 Subtotal ([(in es 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 31.00 Direct graduate medical education payments (from West. E-4, line 36) 31.00 Direct graduate medical education costs (from West. E-4, line 36) 31.00 Direct graduate medical education costs (from West. E-4, line 36) 32.00 Subtotal ((sum of lines 27, 28, 28, 50 and 29) 32.00 Primary payer payments 32.00 Subtotal (sum of lines 27, 28, 28, 50 and 29) 33.00 Cost of physical and sum of lines 27, 28, 28, 50 and 29) 34.00 Allowable bad debts (see instructions) 35.00 Allowable bad debts (see instructions) 36.00 Allowable bad debts (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.70 Demonstration payment adjustment dee instructions) 39.71 Demonstration payment adjustment sequestration 39.72 Primary payments adjustment amount before sequestration 39.73 Primary payments adjustment amount seter sequestration 39.74 Demonstration payment adjustment amount seter sequestration 39.75 Primary payments adjustment amount after sequestration 39.76 Primary payments adjustment amount after	16.00	·	. 3	n a chargebasis	١	16. 00
Total customary charges (see instructions)   Complete only if line 18 exceeds line 11) (see instructions)   Complete only if line 18 exceeds line 11) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 11 exceeds line 18) (see instructions)   Complete only if line 12 exceeds line 18) (see instructions)   Complete only if line 18 exceeds line 18) (see instructions)   Complete only if line 18 exceeds line 18) (see instructions)   Complete only if line 18 exceeds line 18) (see instructions)   Complete only if line 18 exceeds line 18) (see instructions)   Complete only if line 18 exceeds line 18) (see instructions)   Complete only if line 18 exceeds line 18) (see instructions)   Complete only if line 18 exceeds line 18)   Complete only if line 18 exceeds line 18) (see instructions)   Complete only if line 18 exceeds line 18) (see instructions)   Complete only if line 18 exceeds line 18) (see instructions)   Complete only if line 18 exceeds line 18) (see instructions)   Co	17 00		=)		0 000000	17. 00
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)   Composite cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   Composite cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   Composite cost or charges (see instructions)   Composite cost or charges (see instructions)   Composite cost of physicians' services in a teaching hospital (see instructions)   Composite cost of physicians' services in a teaching hospital (see instructions)   Composite cost of physicians' services in a teaching hospital (see instructions)   Composite cost of physicians' services in a teaching hospital (see instructions)   Composite cost of physicians' services and colors and of lines 2, 4, 4, 01, 8 and 9)   Composite cost of physicians' services and colors and colors instructions   Composite cost of physicians' services and colors a					0.000000	18. 00
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 21. 00 Lesser of cost or charges (see instructions) 22. 00 Interns and residents (see instructions) 22. 00 Cost of physicians' services in a teaching hospital (see instructions) 22. 00 Converted to the physicians' services in a teaching hospital (see instructions) 22. 00 Deductible sand coinsurance amounts (for CAH, see instructions) 25. 00 Deductible sand coinsurance amounts (for CAH, see instructions) 27. 00 Subtotal ([(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30. 00 Subtotal (sum of lines 27, 28, 28, 50 and 29) 31. 00 Primary payer payments 32. 00 Subtotal (sum of lines 27, 28, 28, 50 and 29) 32. 00 Composite rate ESRD (from Wkst. I-5, line 11) 34. 00 Allowable bad debts (see instructions) 35. 00 Adjusted reimbursable bad debts (see instructions) 36. 00 Allowable bad debts (see instructions) 37. 00 Subtotal (see instructions) 38. 00 MPS-LOC reconcilitation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Ploneer AcO demonstration payment adjustment (see instructions) 39. 99 Recovery of AcCellerated bustment amount (see instructions) 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment amount fore resquestration 40. 02 Sequestration adjustment amount after sequestration 40. 03 Sequestration adjustment face instructions) 40. 04 Sequestration adjustment face instructions 40. 05 Sequestration adjustment fore instructions 40. 06 Subtotal (see instructions) 40. 07 Sequestration adjustment face instructions) 40. 08 Sequestration adjustment face instructions 40. 09 Sequestration adjustment face instructions 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment face ins			y if line 18 exceeds lin	ne 11) (see	0	19. 00
instructions)  21 00 Isses of cost or charges (see instructions)  22 00 Interns and residents (see instructions)  23 00 Cost of physicians' services in a teaching hospital (see instructions)  24 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)  25 00 Deductible sand coinsurance amounts (for CAH, see instructions)  26 00 Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  27 00 Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  28 00 Direct graduate medical education payments (from Wkst. E-4, line 50)  29 00 ESRO direct medical education payments (from Wkst. E-4, line 50)  20 00 ESRO direct medical education costs (from Wkst. E-4, line 36)  20 00 Direct graduate medical education costs (from Wkst. E-4, line 36)  20 00 Direct graduate medical education costs (from Wkst. E-4, line 36)  20 00 Direct graduate medical education costs (from Wkst. E-4, line 36)  21 00 Direct graduate medical education costs (from Wkst. E-4, line 36)  22 00 Subtotal (sum of lines 27, 28, 28.50 and 29)  23 10 00 Composite rate ESRD (from Wkst. Isonates)  30 00 Composite rate ESRD (from Wkst. Isonates)  31 00 Composite rate ESRD (from Wkst. Isonates)  32 00 Allowable bad debts (see instructions)  33 00 Composite rate ESRD (from Wkst. Isonates)  34 00 Allowable bad debts (see instructions)  35 00 Adjusted relimbursable bad debts (see instructions)  37 00 Subtotal (see instructions)  38 00 MSP-LCC reconcilitation amount from PS&R  39 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39 0F Demonstration payment adjustment amount (see instructions)  39 0F Pomonstration payment adjustment amount before sequestration  39 0F Pomonstration payment adjustment amount feore sequestration  40 07 Subtotal (see instructions)  40 Sequestration adjustment (see instructions)  40 Sequestration adjustment (see instructions)  40 Sequestration adjustment from payment adjustment amount after sequestration  40 Sequestration adjustment for contractor use only)		instructions)				
21.00   Lesser of cost or charges (see instructions)   Cost of physicians' (see instructions)   Cost of physicians' services in a teaching hospital (see instructions)   Cost of physicians' services in a teaching hospital (see instructions)   Cost of physicians' services in a teaching hospital (see instructions)   Cost of physicians' services in a teaching hospital (see instructions)   Computation to feel industriant of the physicians of t	20. 00		y if line 11 exceeds lin	ne 18) (see	0	20. 00
22.00   Interns and residents (see instructions)   C   C   C   C   C   C   C   C   C	21 00	•				21 00
Cast of physicians' services in a teaching hospital (see instructions)  Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)  ComPUTATION OF REIMBURSEMENT SETTLEMENT  Deductibles and coinsurance amounts (for CAH, see instructions)  8, 264  27, 00  Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)  10  11  12  12  13  14  15  15  16  17  17  18  18  18  18  18  19  19  19  10  10  10  10  10  10  10		9 ,			0	21. 00 22. 00
Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  Deductibles and coinsurance amounts (for CAH, see instructions)  Eductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  Eductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  Eductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  Eductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  Eductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  Eductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  Eductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  Eductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  Eductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  Eductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  Eductions and 25 and 26) plus the sum of lines 22 and 23] (see instructions)  Eductions and 26 and 26) plus the sum of lines 22 and 23] (see instructions)  Eductions and 27 and 28 an		· · · · · · · · · · · · · · · · · · ·	ructions)		0	23. 00
COMPUTATION OF RELIMBURSEMENT SETTLEMENT  Deductibles and coinsurance amounts (for CAH, see instructions)  26.00 Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)  8, 264  27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)  28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)  28.50 Reh facility payment amount (see instructions)  29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)  30.00 Subtotal (sum of lines 27, 28, 28, 50 and 29)  20.23  21.00 Subtotal [(line 30 minus line 31)  ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  Composite rate ESRD (from Wkst. I-5, line 11)  34.00 Allowable bad debts (see instructions)  35.00 Adjusted reimbursable bad debts (see instructions)  36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  37.00 Subtotal (see instructions)  38.00 MSP-LCC reconciliation amount from PS&R  9.01 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39.50 Pioneer ACO demonstration payment adjustment (see instructions)  39.75 Py5 respirator payment adjustment amount (see instructions)  39.79 Pomonstration payment adjustment amount (see instructions)  39.79 Pomonstration payment adjustment amount before sequestration  40.00 Subtotal (see instructions)  40.01 Sequestration adjustment (see instructions)  40.02 Demonstration payment adjustment amount before sequestration  40.03 Sequestration adjustment (see instructions)  40.04 Subtotal (see instructions)  40.05 Subtotal (see instructions)  40.06 Subtotal (see instructions)  40.07 Sequestration adjustment (see instructions)  40.08 Demonstration payment adjustment amount after sequestration  40.09 Subtotal (see instructions)  40.00 Tentative settlement-PARHM (for contractors use only)  40.01 Tentative settlement-PARHM (for contractor use only)		, ,	,		28, 496	24. 00
26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   8,264   27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   28.51   REH facility payment amount (see instructions)   29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   20.01   Outlier of lines 27, 28, 28, 50 and 29)   20.02   Subtotal (sum of lines 27, 28, 28, 50 and 29)   20.03   Subtotal (line 30 minus line 31)   20.04   Subtotal (line 30 minus line 31)   20.05   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   20.07   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   20.08   Allowable bad debts (see instructions)   20.09   Allowable bad debts (see instructions)   20.01   Allowable bad debts (see instructions)   20.02   Subtotal (see instructions)   20.03   Subtotal (see instructions)   20.04   Outlier of the subtored bad bad bad seed to see instructions)   20.05   Outlier of the subtored bad debts (see instructions)   20.07   Outlier of the subtored bad debts (see instructions)   20.08   Outlier of the subtored bad debts (see instructions)   20.09   Outlier of the subtored bad debts (see instructions)   20.00   Outlier of the subtored bad debts (see instructions)   20.01   Outlier of the subtored bad debts (see instructions)   20.02   Outlier of the subtored bad bad subtored bad bad subtored						
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.50 REH facility payment amount (see instructions) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 31.00 Primary payer payments 32.00 Subtotal (ine 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.57 NP5 respirator payment adjustment amount (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.90 Demonstration payment adjustment amount after sequestration 39.90 Sequestration adjustment (see instructions) 39.91 Sequestration adjustment amount after sequestration 39.92 Sequestration adjustment (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.90 Demonstration payment adjustment amount after sequestration 39.91 Sequestration adjustment (see instructions) 39.92 Sequestration adjustment (see instructions) 39.92 Sequestration adjustment (see instructions) 39.93 Interim payments 39.94 Interim payments 39.95 Interim payments (for contractors use only) 39.80 Tentative settlement (for contractor use only) 39.80 Tentative settlement (for contractor use only)		· · · · · · · · · · · · · · · · · · ·	•		0	25. 00
instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)  28.50 REH facility payment amount (see instructions) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  33.00 Composite rate ESRD (from Wkst. I-5, line 11) 34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment (see instructions) 40.04 Sequestration adjustment (for contractors use only) 42.01 Tentative settlement (for contractor use only)						
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.50 REH facility payment amount (see instructions) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 20, 232 31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31) 20, 233 200 EVALUDIABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 20, 233 200 Allowable bad debts (see instructions) 31.00 Allowable bad debts (see instructions) 32.00 Adjusted reimbursable bad debts (see instructions) 33.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 33.00 MSP-LCC reconciliation amount from PS&R 33.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment (see instructions) 40.04 Sequestration adjustment (see instructions) 40.05 Sequestration adjustment (see instructions) 40.06 Demonstration payment adjustment amount after sequestration 40.07 Sequestration adjustment (see instructions) 40.08 Interim payments 40.09 Tentative settlement (for contractors use only) 40.10 Tentative settlement (for contractors use only) 40.10 Tentative settlement (for contractor use only)	27.00	- · · · · · · · · · · · · · · · · · · ·	olus the sum of lines 22	and 23] (see	20, 232	27. 00
28.50 REH facility payment amount (see instructions) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31) 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  33.00 Composite rate ESRD (from Wkst. I-5, line 11) 34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Nor respirator payment adjustment amount (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment (see instructions) 40.03 Sequestration adjustment amount after sequestration 40.03 Sequestration adjustment Apart amount after sequestration 40.03 Sequestration adjustment Apart amount after sequestration 40.04 Interim payments 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement -PARHM (for contractor use only)	28 NN	•	ne 50)		0	28. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  32.00 Composite rate ESRD (from Wkst. I-5, line 11) 34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 Nys respirator payment adjustment amount (see instructions) 39.79 Pertial or full credits received from manufacturers for replaced devices (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment (see instructions) 40.04 Sequestration adjustment famount after sequestration 40.05 Interim payments 41.00 Interim payments 41.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (For contractor use only)			55)		ı	28. 50
31.00   Primary payer payments   20,233   Subtotal (line 30 minus line 31)   20,233   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		, , ,			0	29. 00
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  33.00 Composite rate ESRD (from Wkst. I-5, line 11) 34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.57 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 Perspirator payment adjustment amount (see instructions) 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 50 Sequestration adjustment (see instructions) 51 Sequestration adjustment (see instructions) 52 Sequestration adjustment (see instructions) 53 Sequestration adjustment (see instructions) 54 Sequestration adjustment (see instructions) 55 Sequestration adjustment (see instructions) 56 Sequestration adjustment Apart Apa					20, 232	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  33.00 Composite rate ESRD (from Wkst. I -5, line 11)  34.00 Allowable bad debts (see instructions)  35.00 Adjusted reimbursable bad debts (see instructions)  36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  37.00 Subtotal (see instructions)  38.00 MSP-LCC reconciliation amount from PS&R  39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pioneer ACO demonstration payment adjustment (see instructions)  39.75 N9.77 N9.77 respirator payment adjustment amount (see instructions)  99.99 Partial or full credits received from manufacturers for replaced devices (see instructions)  80.90 Subtotal (see instructions)  90.00 Subtotal (see instructions)  90.00 Subtotal (see instructions)  90.00 Subtotal (see instructions)  90.00 Subtotal (see instructions)  90.00 Subtotal (see instructions)  90.00 Subtotal (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment amount after sequestration  90.00 Sequestration adjustment amount after sequestration  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration adjustment (see instructions)  90.00 Sequestration (see instructions)  90.00 Sequestration (see instructions)  90.00 S					0	31.00
33.00 Composite rate ESRD (from Wkst. I-5, line 11)  34.00 Allowable bad debts (see instructions)  35.00 Adjusted reimbursable bad debts (see instructions)  36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  37.00 Subtotal (see instructions)  38.00 MSP-LCC reconciliation amount from PS&R  39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39.50 Pioneer ACO demonstration payment adjustment (see instructions)  39.75 Demonstration payment adjustment amount (see instructions)  39.97 Demonstration payment adjustment amount before sequestration  39.98 RECOVERY OF ACCELERATED DEPRECIATION  40.00 Subtotal (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Sequestration adjustment (see instructions)  10.03 Sequestration adjustment (see instructions)  10.04			YEC)		20, 232	32. 00
34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment (see instructions) 40.04 Demonstration payment adjustment amount after sequestration 40.05 Interim payments 41.01 Interim payments 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only)		· · · · · · · · · · · · · · · · · · ·	,E3)		0	33. 00
35. 00 Adjusted reimbursable bad debts (see instructions) 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 75 N95 respirator payment adjustment amount (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 30 Sequestration adjustment (see instructions) 30 Demonstration payment adjustment amount after sequestration 30 Sequestration adjustment (see instructions) 30 Demonstration payment adjustment amount after sequestration 30 Demonstration payment adjustment amount after sequestration 31 Demonstration payment adjustment amount after sequestration 32 Sequestration adjustment (see instructions) 39 Demonstration payment adjustment amount after sequestration 30 Demonstration payment adjustment amount after sequestration 30 Demonstration payment adjustment amount after sequestration 31 Demonstration payment adjustment amount after sequestration 30 Demonstration payment adjustment amount after sequestration 31 Demonstration payment adjustment amount after sequestration 32 Demonstration payment adjustment amount after sequestration 32 Demonstration payment adjustment amount after sequestration 33 Demonstration payment adjustment amount after sequestration 34 Demonstration payment adjustment amount after sequestration 35 Demonstration payment adjustment amount after sequestration 36 Demonstration adjustment amount after sequestration 37 Demonstration and full credits received from manufacturers for replaced devices (see instructions) 39 Demonstration payment adjustment amount sequestration 39 Demonstration payment adjustment amount sequestration 39 Demonstration payment amount s					0	34. 00
37. 00 Subtotal (see instructions)  38. 00 MSP-LCC reconciliation amount from PS&R  39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39. 50 Pioneer ACO demonstration payment adjustment (see instructions)  39. 75 N95 respirator payment adjustment amount (see instructions)  39. 97 Demonstration payment adjustment amount before sequestration  39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  40. 01 Sequestration adjustment (see instructions)  40. 02 Demonstration payment adjustment amount after sequestration  40. 03 Sequestration adjustment-PARHM pass-throughs  41. 00 Interim payments  41. 01 Interim payments  42. 00 Tentative settlement (for contractors use only)  Tentative settlement-PARHM (for contractor use only)	35. 00				0	35. 00
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments 42.00 Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)	36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	36. 00
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 75 N95 respirator payment adjustment amount (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)					20, 232	37. 00
39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 75 N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration 40. 02 Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs 11. 1 Interim payments 11. 1 Interim payments-PARHM 12. 00 Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)					0	38. 00
39. 75 N95 respirator payment adjustment amount (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only)			- >		0	39. 00
39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Demonstration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only)			>)		0	39. 50 39. 75
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Demonstration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only)		, , ,			0	39. 73
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only)			ced devices (see instruc	tions)	0	39. 98
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only)			, , , , , , , , ,	-	0	39. 99
40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only)		· · · · · · · · · · · · · · · · · · ·			20, 232	40. 00
40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only)					405	40. 01
41.00 Interim payments  41.01 Interim payments-PARHM  42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM (for contractor use only)					0	40. 02
41.01   Interim payments-PARHM 42.00   Tentative settlement (for contractors use only) 42.01   Tentative settlement-PARHM (for contractor use only)		· · · · · · · · · · · · · · · · · · ·			10 027	40. 03 41. 00
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only)		. 3			17, 02/	41. 00
42.01 Tentative settlement-PARHM (for contractor use only)		· ·			0	42. 00
į vardo ir daras daras daras daras daras daras daras daras daras daras daras daras daras daras daras daras dar						42. 01
43.00 Balance due provider/program (see instructions)		,			0	43.00
43.01 Balance due provider/program-PARHM (see instructions)				_		43. 01
	14. 00		nce with CMS Pub. 15-2, o	chapter 1,	0	44. 00
§115. 2 TO BE COMPLETED BY CONTRACTOR						
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)					0	90. 00
		· · · · · · · · · · · · · · · · · · ·			0	91.00
	<del>7</del> 2. 00	· · · · · · · · · · · · · · · · · · ·			0. 00	92. 00

Health Financial Systems	SSM HEALTH ST. MARYS HOSPITAL In Lieu o				2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Peri od:	Worksheet E	
		C CON 14 CO24	From 01/01/2023		
		Component CCN: 14-S034	To 12/31/2023	Date/Time Pre 5/21/2024 9:5	pared: <u>4 am                                    </u>
		Title XVIII	Subprovi der -	PPS	
			IPF		
				1. 00	
93.00 Time Value of Money (see instructions)				0	93. 00
94.00 Total (sum of lines 91 and 93)				0	94. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

Health Financial Systems SSM HEANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0034

			'	0 12/31/2023	5/21/2024 9:54	
		Ti tl e	xVIII	Hospi tal	PPS	
		Inpatient Part A		Part 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		11, 402, 818		6, 652, 689	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		0		0	2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					3. 00
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	08/21/2023	31, 574		0	3. 01
3.02					0	3. 02
3.03			1 0		l ol	3. 03
3.04			1 0		l ol	3. 04
3. 05			0		0	3. 05
	Provider to Program			<u>'</u>		
3.50	ADJUSTMENTS TO PROGRAM		0	08/21/2023	55, 676	3. 50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		31, 574		-55, 676	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		11, 434, 392		6, 597, 013	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		1 0		0	5. 01
5.02			1 0		l ol	5. 02
5.03			1 0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER				0	6. 01
6. 02	SETTLEMENT TO PROGRAM		147, 124		3. 321	6. 02
7.00	Total Medicare program liability (see instructions)		11, 287, 268		6, 593, 692	7. 00
7.00	Total medicale program frability (see instructions)		11, 201, 200	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	The state of the s	•		t .		

Component CCN: 14-S034

		Title	XVIII	Subprovider -	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 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		913, 64	0	19, 827 0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3. 05	Drawi dan ta Drawan			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 50	ADJUSTIVILNTS TO FROGRAW			0		3. 50
3. 52				Ö	l ől	3. 52
3. 53				o	Ö	3. 53
3. 54				o	l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			O	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		913, 64	0	19, 827	4. 00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01 5. 02	TENTATIVE TO PROVIDER			0	0 0	5. 01 5. 02
5. 02 5. 03				0		5. 02
5.05	Provider to Program			<u> </u>	0	5.05
5. 50	TENTATI VE TO PROGRAM			ol	0	5. 50
5. 51				Ö	o	5. 51
5.52				O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		26, 60		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		940, 24		19, 827	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
8. 00	Name of Contractor	(	J	1. 00	2.00	8. 00
6.00	Inallie of Collet actor			1	ı l	0.00

Heal th	Financial Systems SSM HEALTH ST. N	MARYS HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL					epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	ON			
1.00	Total hospital discharges as defined in AARA §4102 from Wks	t. S-3, Pt. I col. 15 line	e 14		1. 00
2.00	Medicare days (see instructions)				2.00
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	line 20			6.00
7. 00					
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	31.00 Utilet Aujustiliett (specify)				

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	SSM HEALTH ST. N	MARYS HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Peri od:	Worksheet E-3
			From 01/01/2023	
		Component CCN: 14-S034	To 12/31/2023	Date/Time Prepared:
		·		5/21/2024 9:54 am
		Title XVIII	Subprovi der -	PPS
			IPF	

	I PF		
		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 037, 754	1
00	Net IPF PPS Outlier Payments	0	2
0	Net IPF PPS ECT Payments	0	1
00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0. 00	١.
	15, 2004. (see instructions)		
)1	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
00	New Teaching program adjustment. (see instructions)	0.00	
00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	
00	teaching program" (see instuctions)	0.00	
00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new tasking program" (see instructions)	0. 00	
00	teaching program" (see instructions)	0.00	ŀ
00 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 00 14. 991781	
00	Average Daily Census (see instructions)  Teaching Adjustment Factor (((1 + (line 9)) raised to the newer of F150 1)		
00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000 0	1
00	Teaching Adjustment (line 1 multiplied by line 10).  Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 037, 754	
00	Nursing and Allied Health Managed Care payment (see instruction)	1, 037, 734	1
	Organ acquisition (DO NOT USE THIS LINE)	U	1
00	Cost of physicians' services in a teaching hospital (see instructions)	0	1
00	Subtotal (see instructions)	1, 037, 754	
00	Primary payer payments	1, 037, 734	1
00	Subtotal (line 16 less line 17).	1, 037, 754	
00	Deductibles	105, 468	
00	Subtotal (line 18 minus line 19)	932, 286	
	Coi nsurance	0	
00	Subtotal (line 20 minus line 21)	932, 286	
	Allowable bad debts (exclude bad debts for professional services) (see instructions)	41, 767	
	Adjusted reimbursable bad debts (see instructions)	27, 149	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	40, 122	
00	Subtotal (sum of lines 22 and 24)	959, 435	
00	Direct graduate medical education payments (see instructions)	0	
00	Other pass through costs (see instructions)	0	1
00	Outlier payments reconciliation	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
98	Recovery of accelerated depreciation.	0	1
99	Demonstration payment adjustment amount before sequestration	0	3
00	Total amount payable to the provider (see instructions)	959, 435	3
01	Sequestration adjustment (see instructions)	19, 189	
02	Demonstration payment adjustment amount after sequestration	0	3
00	Interim payments	913, 640	3
00	Tentative settlement (for contractor use only)	0	3
00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	26, 606	3
00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	3
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
00	Original outlier amount from Worksheet E-3, Part II, line 2	0	5
00	Outlier reconciliation adjustment amount (see instructions)	0	5
00	The rate used to calculate the Time Value of Money	0.00	5
00	Time Value of Money (see instructions)	0	5
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE	END OF	
	THE COVID-19 PHE)		
00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	9
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	

Health Financial Systems SSM HEALTH ST. MARYS HOSPITAL In Lieu o					u of Form CMS-2	552-10
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 14-0034	Peri od:	Worksheet E-5	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/21/2024 9:54	
			Title XVIII		PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, Pt. A, lin	ne 2, or sum c	of 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	ıcti ons)		0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)					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 instructions)					0	6.00
7.00	Time value of money for capital related expenses	(see instruct	i ons)		o	7.00

In Lieu of Form CMS-2552-10

Health Financial Systems SSM HEALTH ST BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/21/2024 9:54 am Provider CCN: 14-0034 onl y)

OH y)					5/21/2024 9:5	4 am
	<u> </u>	General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1. 00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	101, 946	0	0	0	1. 00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	44, 131, 453	0	ol	0	4. 00
5.00	Other recei vabl e	313, 192		ol	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-19, 948, 859		Ö	0	6. 00
7. 00	Inventory	1, 953, 230		ol	0	7. 00
8. 00	Prepaid expenses	395, 075		ő	0	8. 00
9. 00	Other current assets	171, 801	0	0	0	9. 00
10. 00	Due from other funds	171,801		0	0	10.00
				-		
11. 00	Total current assets (sum of lines 1-10)	27, 117, 838	0	0	0	11. 00
40.00	FI XED ASSETS	1 000 150		اء		40.00
12. 00	Land	1, 302, 150		0	0	12.00
13. 00	Land improvements	787, 310		0	0	13. 00
14. 00	Accumulated depreciation	-677, 522		0	0	14. 00
15. 00	Bui I di ngs	47, 293, 918		0	0	15. 00
16. 00	Accumul ated depreciation	-23, 979, 040	0	0	0	16. 00
17.00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumul ated depreciation	0	0	0	0	18. 00
19.00	Fi xed equipment	5, 516, 108	0	0	0	19. 00
20.00	Accumulated depreciation	-3, 347, 507	0	ol	0	20. 00
21.00	Automobiles and trucks	237, 182		ol	0	21. 00
22. 00	Accumulated depreciation	-221, 569		ol	0	22. 00
23. 00	Major movable equipment	35, 956, 160		ő	0	23. 00
24. 00	Accumulated depreciation	-26, 428, 634		0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	-20, 420, 034		o	0	25. 00
				o o		
26. 00	Accumulated depreciation	0	0	U	0	26. 00
27. 00	HIT designated Assets	0	0	U O	0	27. 00
28. 00	Accumulated depreciation	0	0	O <sub>1</sub>	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	36, 438, 556	0	0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	1, 153, 383	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	384, 965	587, 005	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1, 538, 348	587, 005	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	65, 094, 742	587, 005	ol	0	36. 00
	CURRENT LIABILITIES			<u> </u>		
37.00	Accounts payable	-62, 828, 076	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	2, 889, 143		ol	0	38. 00
39. 00	Payroll taxes payable	2,007,110	Ŏ	ő	0	39. 00
40. 00	Notes and Loans payable (short term)	279, 490		o O	0	40.00
		279,490	0	0	0	41.00
41. 00	Deferred income	0	0	Ч	U	
42.00	Accel erated payments	0			•	42.00
43.00	Due to other funds	050 454	0	U <sub>0</sub>	0	43. 00
44.00	Other current liabilities	359, 451		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	-59, 299, 992	0	0	0	45. 00
	LONG TERM LIABILITIES	T	T			
46. 00	Mortgage payable	0		0	0	
47. 00	Notes payable	0	0	0	0	
48. 00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	29, 981, 670	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29, 981, 670	0	0	0	50. 00
51.00	Total liabilities (sum of lines 45 and 50)	-29, 318, 322	0	o	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	94, 413, 064				52.00
53.00	Specific purpose fund		587, 005			53. 00
54.00	Donor created - endowment fund balance - restricted			ol		54.00
55. 00	Donor created - endowment fund balance - unrestricted			ő		55. 00
56. 00	Governing body created - endowment fund balance			o		56.00
57. 00	Plant fund balance - invested in plant			4	0	57.00
	· ·				0	58.00
58. 00	Plant fund balance - reserve for plant improvement,				0	JO. UU
59. 00	replacement, and expansion	94, 413, 064	E07 00E	o	0	59. 00
	Total fund balances (sum of lines 52 thru 58)			0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	65, 094, 742	587, 005	٩	0	60. 00
	[59]	I	ı	ı		I

Health Financial Systems In Lieu of Form CMS-2552-10 SSM HEALTH ST. MARYS HOSPITAL STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 14-0034 Peri od: Worksheet G-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/21/2024 9:54 am General Fund Special Purpose Fund Endowment Fund 2.00 1.00 3.00 4. 00 5. 00 Fund balances at beginning of period 1.00 57, 294, 104 510, 584 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 28, 426, 713 2.00 3.00 Total (sum of line 1 and line 2) 85, 720, 817 510, 584 3.00 4.00 CREDIT ADDITIONS 7, 598, 635 4.00 76, 421 5.00 0 5.00 0 0 0 0 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9. 00 10.00 Total additions (sum of line 4-9) 7, 598, 635 76, 421 10.00 Subtotal (line 3 plus line 10) 93, 319, 452 587, 005 11.00 11.00 Deductions (debit adjustments) (specify) 12.00 0 0 0 0 0 0 12.00 13.00 13.00 14.00 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 93, 319, 452 587, 005 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund

		6. 00	7. 00	8. 00	
1.00	Fund balances at beginning of period	0		0	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	CREDIT ADDITIONS		0		4. 00
5.00			0		5. 00
6.00			0		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	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			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	0		0	19. 00

sheet (line 11 minus line 18)

Health Financial Systems SSM STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-0034

			To 12/31/2023	Date/lime Prep   5/21/2024 9:54			
	Cost Center Description	Inpati ent	Outpati ent	Total	ı diii		
		1.00	2. 00	3. 00			
	PART I - PATIENT REVENUES	<u> </u>					
	General Inpatient Routine Services						
1.00	Hospi tal	18, 088, 9	51	18, 088, 951	1.00		
2.00	SUBPROVI DER - I PF	7, 449, 7	35	7, 449, 785	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	NURSI NG FACILITY				8. 00		
9.00	OTHER LONG TERM CARE				9. 00		
10. 00	Total general inpatient care services (sum of lines 1-9)	25, 538, 7	36	25, 538, 736	10. 00		
44 00	Intensive Care Type Inpatient Hospital Services	2 (22 2	4.4	0 (00 044	44.00		
11.00	INTENSIVE CARE UNIT	2, 632, 8	41	2, 632, 841	11. 00		
12.00	CORONARY CARE UNIT				12.00		
13.00	BURN INTENSIVE CARE UNIT				13. 00 14. 00		
14. 00 15. 00	SURGI CAL INTENSIVE CARE UNIT				15. 00		
16. 00	OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of I	i nos 2 422 9	11	2, 632, 841	16. 00		
16.00	111-15)	i nes 2, 632, 8	+ 1	2, 032, 841	16.00		
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	28, 171, 5	77	28, 171, 577	17. 00		
18. 00	Ancillary services	68, 486, 0		286, 766, 553			
19. 00	Outpati ent servi ces	8, 826, 5		50, 515, 586	19. 00		
20. 00	RURAL HEALTH CLINIC	0, 020, 3	0 41,007,001	0	20. 00		
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	21. 00		
22. 00	HOME HEALTH AGENCY				22. 00		
23. 00	AMBULANCE SERVICES				23. 00		
24. 00	CMHC				24. 00		
24. 30	00T		0 0	0	24. 30		
25.00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00		
26.00	HOSPI CE				26. 00		
27.00	NON-REI MBURSABLE	2	36 163, 451	163, 687	27. 00		
27. 01	ORGAN ACQUISITION CHARGES		0 0	0	27. 01		
27. 02	PROFESSI ONAL FEES		0 0	0	27. 02		
27. 03	EMPLOYEE CHARGES	770, 8		6, 200, 047	27. 03		
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst. 106, 255, 2	19 265, 562, 231	371, 817, 450	28. 00		
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		101, 621, 690		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		
34. 00 35. 00			0		34. 00 35. 00		
36. 00	Total additions (sum of lines 30-35)	+	0		36. 00		
37. 00	DEDUCT (SPECIFY)				37. 00		
38. 00	DEDUCT (SI ECTIT)		0		38. 00		
39. 00			o		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	101, 621, 690		43. 00		
	to Wkst. G-3, line 4)	(3. 2.3. 3. )	.5.,52.,676		.0.00		
		'	•	. '			

	<del>-</del>		eu of Form CMS-2552-10			
STATEM	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 14-0034 Period:			Worksheet G-3		
	From 01/01/2023 To 12/31/2023				pared:	
	10 12/31/2023					
				1. 00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column	3, line 28)		371, 817, 450	1. 00	
2.00	Less contractual allowances and discounts on patients'	accounts		248, 131, 834	2.00	
3.00	Net patient revenues (line 1 minus line 2)			123, 685, 616	3. 00	
4.00	Less total operating expenses (from Wkst. G-2, Part II	, line 43)		101, 621, 690	4.00	
5.00	Net income from service to patients (line 3 minus line	4)		22, 063, 926	5. 00	
	OTHER I NCOME					
6.00	6.00 Contributions, donations, bequests, etc				6. 00	
7.00	7.00   Income from investments			0	7. 00	
8.00				0	8. 00	
9.00				0	9. 00	
10.00	Purchase di scounts			195	10.00	
11.00	Rebates and refunds of expenses			0	11. 00	
12.00				0	12. 00	
13.00	13.00 Revenue from Laundry and Linen service			0	13. 00	
14.00	14.00 Revenue from meals sold to employees and guests			258, 394	14. 00	
15. 00	5.00 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	.00 Revenue from sale of medical records and abstracts			0	18. 00	
19.00	00 Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00	
21. 00	Rental of vending machines			0	21. 00	
22. 00	Rental of hospital space			226, 984	22. 00	
23. 00	Governmental appropriations			0	23. 00	
24. 00	OTHER INCOME			3, 315, 122	24. 00	
04 50	, , , , , ,			/	1	

0 24.50

966, 057 966, 057 28, 426, 713 29, 00

25. 00

26.00

7, 328, 844 29, 392, 770

24. 50 COVID-19 PHE Funding
25. 00 Total other income (sum of lines 6-24)

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

26.00 Total (line 5 plus line 25)

27. 00 OTHER EXPENSES

	Financial Systems SSM HEALTH ST. MA	_		u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 14-0034	Peri od: From 01/01/2023	Worksheet L Parts I-III	
			To 12/31/2023		pared:
	5/21/2024 9:5				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			774, 208	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			6, 047	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructi ons)	24. 58	3. 00
4.00	Number of interns & residents (see instructions)			0.00	4.00
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, columns 1 and	0	6. 00
	1.01)(see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A	patient days (Worksheet E	, part A line	0.00	7. 00
8. 00	30) (see instructions)   Percentage of Medicaid patient days to total days (see instructions)				8. 00
9. 00	Sum of lines 7 and 8	uctions)		0. 00 0. 00	
10.00				0.00	
11. 00	3. (			0.00	
	12.00   Total prospective capital payments (see instructions)			780, 255	
12.00	prospective dapital payments (see thetraetrens)			7007200	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			0	
1.00					
2.00				0	2.00
3.00					
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)				2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)				3. 00
4.00	Applicable exception percentage (see instructions)				4. 00
5.00	Capital cost for comparison to payments (line 3 x line 4)				5. 00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)				6. 00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as applicable)			0	
10.00	Current year comparison of capital minimum payment level to			0	10.00
11. 00	Carryover of accumulated capital minimum payment level over	capital payment (from pri	or year	0	11. 00
12.00	Worksheet L, Part III, line 14)	numente (line 10 plus lis	o 11)	0	12.00
12. 00 13. 00					12. 00 13. 00
14. 00					
14.00	(if line 12 is negative, enter the amount on this line)	capital payment for the f	orrowing period	ı	14.00

15.00 0 16.00 0 17.00

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

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