

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

**WORKSHEET S
PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only		1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 11/28/2018	Time: 08:04
		2. <input type="checkbox"/> Manually submitted cost report		
		3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report		
		4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status	6. Date Received: _____	10. NPR Date: _____	
	(1) As Submitted	7. Contractor No.: _____	11. Contractor's Vendor Code: ____	
	(2) Settled without audit	8. <input type="checkbox"/> Initial Report for this Provider CCN	12. <input type="checkbox"/> If line 5, column 1 is 4:	
	(3) Settled with audit	9. <input type="checkbox"/> Final Report for this Provider CCN	Enter number of times reopened = 0-9.	
	(4) Reopened			
	(5) Amended			

PART II - CERTIFICATION

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

CERTIFICATION BY 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 the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY MEDICAL CENTER, INC. (15-0034) ((Provider Name(s) and Number(s)) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, 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.

I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

ECR Encryption: 11/28/2018 08:04
OD1SkgKit4aqhBMIH.25rKaB6feSr0
poNJD0chqSqMtnJp86pwuKyxy5RW12
NMuo1po:n30Myydn

(Signed)

Mary J. Andic
Chief Financial Officer or Administrator of Provider(s)
VP Finance/CFO

Title

11/28/2018 08:04
Date

PI Encryption: 11/28/2018 08:04
YA4Nf9MlatAi0GZbFqrKfk50-bP6F0
Zrflh0NKNGrENkaHax2YkTl15yjk8
Drm00ZW-y40SISMv

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		202,216	151,377			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		39,659	-57			3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		241,875	151,320			200

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2017	To: 06 / 30 / 2018	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
	1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	580	3,054		182	2,911	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	16	160			179	25

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
	Prospective Payment System (PPS)-Capital	V	XVIII	XIX
		1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

		1	2	3	
Teaching Hospitals					
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	Y			60
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23	1	60.01
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63
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**WORKSHEET S-2
PART I**

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

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
	1	2	3	4	5		
65							65

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
	1	2	3	4	5		
67							67

Inpatient Psychiatric Facility PPS

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

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**WORKSHEET S-2
PART I**

Title V and XIX Services		V	XIX	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	Y	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06

Rural Providers

		1	2		
105	Does this hospital qualify as a CAH?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions)			107	
108	If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		108	
109	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			109	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.				111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:		1		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

All Providers

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

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

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

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

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

Multicampus

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

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

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

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

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

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	160	58,400			18,218	496	39,627	1
2	HMO and other (see instructions)						10,305	5,990		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider						732	339		4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		160	58,400			18,218	496	39,627	7
8	Intensive Care Unit	31	20	7,300			1,695	46	4,728	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						38	1,928	13
14	Total (see instructions)		180	65,700			19,913	580	46,283	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41	20	7,300			3,996	16	5,992	17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					18,316		28,811	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		200							27
28	Observation Bed Days								4,867	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							157	279	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					4,102	108	9,513	1
2	HMO and other (see instructions)					1,743	1,194		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider						30		4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		1,064.22			4,102	108	9,513	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF		28.55			375		545	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		23.12						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		1,115.89						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION

**WORKSHEET S-3
PARTS II-III**

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	Total salaries (see instructions)	200	69,457,139	69,457,139	2,457,740.00	28.26	1
2	Non-physician anesthetist Part A						2
3	Non-physician anesthetest Part B						3
4	Physician-Part A - Administrative						4
4.01	Physician-Part A - Teaching						4.01
5	Physician-Part B		459,995	459,995	7,791.00	59.04	5
6	Non-physician-Part B						6
7	Interns & residents (in an approved program)	21					7
7.01	Contracted interns & residents (in an approved program)						7.01
8	Home office and/or related organization personnel						8
9	SNF	44					9
10	Excluded area salaries (see instructions)		3,964,693	249,277	4,213,970	129,340.00	32.58
OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		3,483,181		3,483,181	75,533.00	46.11
12	Contract management and administrative services						12
13	Contract labor: Physician-Part A - Administrative		377,651		377,651	2,425.00	155.73
14	Home office salaries & wage-related costs						14
14.01	Home office salaries		9,499,975		9,499,975	301,018.00	31.56
14.02	Related organization salaries						14.02
15	Home office: Physician Part A - Administrative						15
16	Home office & Contract Physicians Part A - Teaching						16
WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		16,614,839		16,614,839		17
18	Wage-related costs (other)(see instructions)						18
19	Excluded areas		996,356		996,356		19
20	Non-physician anesthetist Part A						20
21	Non-physician anesthetist Part B						21
22	Physician Part A - Administrative						22
22.01	Physician Part A - Teaching						22.01
23	Physician Part B		84,050		84,050		23
24	Wage-related costs (RHC/FQHC)						24
25	Interns & residents (in an approved program)						25
25.50	Home office wage-related		2,291,612		2,291,612		25.50
25.51	Related organization wage-related						25.51
25.52	Home office: Physician Part A - Administrative - wage-related						25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related						25.53
OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		1,046,509		1,046,509	31,505.00	33.22
27	Administrative & General		6,339,287	-219,000	6,120,287	226,805.00	26.98
28	Administrative & General under contract (see instructions)		1,500,496		1,500,496	10,415.00	144.07
29	Maintenance & Repairs		1,556,006		1,556,006	49,910.00	31.18
30	Operation of Plant		976,432		976,432	51,650.00	18.90
31	Laundry & Linen Service		89,847		89,847	6,800.00	13.21
32	Housekeeping		1,784,856		1,784,856	118,260.00	15.09
33	Housekeeping under contract (see instructions)						33
34	Dietary		1,988,246	-1,280,066	708,180	43,999.00	16.10
35	Dietary under contract (see instructions)						35
36	Cafeteria			1,280,066	1,280,066	79,530.00	16.10
37	Maintenance of Personnel						37
38	Nursing Administration		2,713,437		2,713,437	79,837.00	33.99
39	Central Services and Supply		472,306		472,306	22,746.00	20.76
40	Pharmacy		2,694,897	-446,417	2,248,480	59,100.00	38.05
41	Medical Records & Medical Records Library		38,374		38,374	1,298.00	29.56
42	Social Service						42
43	Other General Service						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		70,497,640		70,497,640	2,460,364.00	28.65	1
2	Excluded area salaries (see instructions)		3,964,693	249,277	4,213,970	129,340.00	32.58	2
3	Subtotal salaries (line 1 minus line 2)		66,532,947	-249,277	66,283,670	2,331,024.00	28.44	3
4	Subtotal other wages & related costs (see instructions)		13,360,807		13,360,807	378,976.00	35.26	4
5	Subtotal wage-related costs (see instructions)		18,906,451		18,906,451		28.52%	5
6	Total (sum of lines 3 through 5)		98,800,205	-249,277	98,550,928	2,710,000.00	36.37	6
7	Total overhead cost (see instructions)		21,200,693	-665,417	20,535,276	781,855.00	26.26	7

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HOSPITAL WAGE RELATED COSTS

**WORKSHEET S-3
PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution	2,428,982	2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	8,880,005	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	718,526	10
11	Life Insurance (If employee is owner or beneficiary)	65,035	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	57,921	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	474,699	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	4,073,706	17
18	Medicare Taxes - Employers Portion Only	963,214	18
19	Unemployment Insurance	33,157	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	17,695,245	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor 1	Benefit Cost 2	
	0			
1	Total facility contract labor and benefit cost	3,483,181	17,695,245	1
2	Hospital	3,483,181	17,695,245	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

KPMG LLP Compu-Max 2552-10

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 15-7313

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

County:

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		2,550		960	3,510	1
2	Unduplicated Census Count (see instructions)		591.00		537.00	1,128.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week 40.00	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)	0.90		0.90	3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel	10.73		10.73	5
6	Direct Nursing Service	7.36		7.36	6
7	Nursing Supervisor				7
8	Physical Therapy Service	2.52	0.47	2.99	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service	1.07	0.83	1.90	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service	0.12	0.19	0.31	12
13	Speech Pathology Supervisor				13
14	Medical Social Service	0.11		0.11	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	3.86		3.86	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	1	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	23844	20

PPS ACTIVITY

		Full Episodes				Total (columns 1 through 4)	
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes		
		1	2	3	4		
21	Skilled Nursing Visits	6,544	2,015	129	126	8,814	21
22	Skilled Nursing Visit Charges	1,146,692	351,565	22,637	21,870	1,542,764	22
23	Physical Therapy Visits	3,717	708	9	70	4,504	23
24	Physical Therapy Visit Charges	763,357	144,868	1,839	14,378	924,442	24
25	Occupational Therapy Visits	1,535	394	1	31	1,961	25
26	Occupational Therapy Visit Charges	316,207	80,828	209	6,293	403,537	26
27	Speech Pathology Visits	270	97		9	376	27
28	Speech Pathology Visit Charges	55,264	19,349		1,782	76,395	28
29	Medical Social Service Visits	64	42		5	111	29
30	Medical Social Service Visit Charges	14,965	9,716		1,150	25,831	30
31	Home Health Aide Visits	1,539	966	1	44	2,550	31
32	Home Health Aide Visit Charges	201,187	125,770	129	5,704	332,790	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	13,669	4,222	140	285	18,316	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,497,672	732,096	24,814	51,177	3,305,759	35
36	Total Number of Episodes (standard/non-outlier)	668		61	11	740	36
37	Total Number of Outlier Episodes		92		4	96	37
38	Total Non-Routine Medical Supply Charges	152,176	77,485	3,685	1,472	234,818	38

KPMG LLP Compu-Max 2552-10

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.209076	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		9,691,873	2
3	Did you receive DSH or supplemental payments from Medicaid?		N	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid			5
6	Medicaid charges		121,081,064	6
7	Medicaid cost (line 1 times line 6)		25,315,145	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		15,623,272	8

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

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

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

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		93	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		1,123	14
15	State or local indigent care program cost (line 1 times line 14)		235	15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		142	16

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

17	Private grants, donations, or endowment income restricted to funding charity care			17
18	Government grants, appropriations of transfers for support of hospital operations			18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		15,623,413	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	10,189,895	2,244,228	12,434,123	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,130,462	2,244,228	4,374,690	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	2,130,462	2,244,228	4,374,690	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit				25
26	Total bad debt expense for the entire hospital complex (see instructions)			8,635,216	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,009,519	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,553,106	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			7,082,110	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			2,024,286	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			6,398,976	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			22,022,389	31

KPMG LLP Compu-Max 2552-10

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				9,807,316	9,807,316	-1,348,211	8,459,105	1
2	00200	Cap Rel Costs-Mvble Equip				8,538,670	8,538,670	1,113,999	9,652,669	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	108,348	-2,020,365	-1,912,017	12,439,750	10,527,733	-6,261	10,521,472	4
4.01	00401	MAINTENANCE OF PERSONNEL	938,161	1,011,485	1,949,646	-700,585	1,249,061		1,249,061	4.01
5.01	00540	NON-PATIENT TELEPHONES						561,913	561,913	5.01
5.02	00560	PURCHASING, RECEIVING & STORES	362,503	316,953	679,456		679,456		679,456	5.02
5.03	00570	PATIENT REGISTRATION	1,497,490	644,754	2,142,244	-395,122	1,747,122		1,747,122	5.03
5.04	00580	PATIENT ACCOUNTING		108	108		108	2,836,991	2,837,099	5.04
5.05	00590	ADMINISTRATIVE & GENERAL	4,479,294	66,826,953	71,306,247	-7,920,001	63,386,246	-40,111,570	23,274,676	5.05
6	00600	Maintenance & Repairs	1,556,006	6,992,130	8,548,136	-621,301	7,926,835		7,926,835	6
7	00700	Operation of Plant	976,432	1,311,098	2,287,530	108,601	2,396,131		2,396,131	7
8	00800	Laundry & Linen Service	89,847	684,367	774,214	-45,851	728,363		728,363	8
9	00900	Housekeeping	1,784,856	1,280,907	3,065,763	-534,222	2,531,541		2,531,541	9
10	01000	Dietary	1,988,246	2,310,116	4,298,362	-3,298,931	999,431	-3,797	995,634	10
11	01100	Cafeteria				2,767,357	2,767,357	-1,060,605	1,706,752	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	2,713,437	2,987,793	5,701,230	-407,273	5,293,957	-1,656,169	3,637,788	13
14	01400	Central Services & Supply	472,306	508,537	980,843	-418,252	562,591		562,591	14
15	01500	Pharmacy	2,694,897	11,334,012	14,028,909	-11,055,532	2,973,377		2,973,377	15
16	01600	Medical Records & Library	38,374	103,081	141,455	-12,406	129,049	2,632,135	2,761,184	16
17	01700	Social Service		56	56	-56				17
19	01900	Nonphysician Anesthetists								19
23	02300	PARAMED ED PRGM-(SPECIFY)				298,805	298,805	-82,071	216,734	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	15,830,978	7,183,628	23,014,606	-5,713,195	17,301,411	-352,551	16,948,860	30
31	03100	Intensive Care Unit	3,348,812	2,184,385	5,533,197	-1,231,774	4,301,423	-13,956	4,287,467	31
41	04100	Subprovider - IRF	1,693,438	1,370,847	3,064,285	-414,032	2,650,253		2,650,253	41
43	04300	Nursery				1,504,017	1,504,017		1,504,017	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	4,532,361	26,753,258	31,285,619	-17,978,938	13,306,681	-8,330	13,298,351	50
51	05100	Recovery Room	1,603,961	685,955	2,289,916	-282,511	2,007,405		2,007,405	51
52	05200	Delivery Room & Labor Room				1,333,727	1,333,727		1,333,727	52
53	05300	Anesthesiology		4,062,410	4,062,410	-68,158	3,994,252	-3,472,451	521,801	53
54	05400	Radiology-Diagnostic	3,365,085	4,997,478	8,362,563	-3,454,266	4,908,297	-17,926	4,890,371	54
54.01	03630	RADIOLOGY - ULTRASOUND	785,823	550,673	1,336,496	-233,228	1,103,268		1,103,268	54.01
56	05600	Radioisotope	495,679	1,116,199	1,611,878	-242,135	1,369,743		1,369,743	56
57	05700	CT Scan	863,584	1,235,122	2,098,706	-426,297	1,672,409	-2,966	1,669,443	57
59	05900	Cardiac Catheterization	1,908,493	7,827,743	9,736,236	-6,567,564	3,168,672	-6,817	3,161,855	59
60	06000	Laboratory	3,531,044	5,682,635	9,213,679	-822,082	8,391,597	-121,029	8,270,568	60
62	06200	Whole Blood & Packed Red Blood Cells	163,804	1,154,518	1,318,322	-52,918	1,265,404		1,265,404	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,982,501	952,980	2,935,481	-391,871	2,543,610	-45,235	2,498,375	65
66	06600	Physical Therapy		2,933,506	2,933,506	-27,984	2,905,522	-5,300	2,900,222	66
67	06700	Occupational Therapy		947,893	947,893	-23,313	924,580	-95	924,485	67
68	06800	Speech Pathology		426,237	426,237	-1,116	425,121		425,121	68
70	07000	Electroencephalography	525,160	3,885,692	4,410,852	-3,997,544	413,308	-5,636	407,672	70
71	07100	Medical Supplies Charged to Patients				10,115,697	10,115,697		10,115,697	71
72	07200	Impl. Dev. Charged to Patients				14,264,070	14,264,070		14,264,070	72
73	07300	Drugs Charged to Patients				9,738,649	9,738,649		9,738,649	73
74	07400	Renal Dialysis		774,079	774,079	-1,608	772,471		772,471	74
76.97	07697	CARDIAC REHABILITATION	596,573	256,493	853,066	-102,297	750,769	-88,694	662,075	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	2,797,733	2,268,182	5,065,915	-1,209,400	3,856,515	-603,877	3,252,638	90
91	09100	Emergency	3,460,658	2,621,503	6,082,161	-1,200,682	4,881,479	-233	4,881,246	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	2,212,660	1,112,561	3,325,221	-350,441	2,974,780	-325	2,974,455	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	69,398,544	175,275,962	244,674,506	713,773	245,388,279	-41,869,067	203,519,212	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	5,578	15,347	20,925	-2,136	18,789		18,789	192
194	07950	OTHER NON-REIMBURSEABLE COST CENTERS	53,017	1,177,984	1,231,001	-711,637	519,364		519,364	194
194.01	07951	OTHER NONREIMBURSABLE								194.01
200		TOTAL (sum of lines 118-199)	69,457,139	176,469,293	245,926,432		245,926,432	-41,869,067	204,057,365	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	MEDICAL SUPPLY RECLASS	A	Medical Supplies Charged to P	71		9,722,550	1
2			Impl. Dev. Charged to Patient	72		14,264,070	2
3			Medical Supplies Charged to P	71		393,147	3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
500	Total reclassifications					24,379,767	500
	Code Letter - A						
1	RECLASSI DEPRECIATION EXPENSE	B	Cap Rel Costs-Bldg & Fixt	1		7,841,343	1
2			Cap Rel Costs-Mvble Equip	2		7,069,658	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36							36
500	Total reclassifications					14,911,001	500
	Code Letter - B						
1	RECLASS SOCIAL SERVICE COSTS	C	ADMINISTRATIVE & GENERAL	5.05		56	1
2	RECLASS PATIENT ACCT	C					2
500	Total reclassifications					56	500
	Code Letter - C						
1	RECLASS LDRP COSTS	D	Nursery	43	856,083	647,934	1
2			Delivery Room & Labor Room	52	759,154	574,573	2
500	Total reclassifications				1,615,237	1,222,507	500
	Code Letter - D						
1	RECLASS EMS PARAMEDICAL ED COSTS	E	PARAMED ED PRGM-(SPECIFY)	23	219,000	50,703	1
2	RECLASS FICA	E	PARAMED ED PRGM-(SPECIFY)	23		15,342	2
3			PARAMED ED PRGM-(SPECIFY)	23	13,760		3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications				232,760	66,045	500
	Code Letter - E						

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	INCREASES			
				LINE #	SALARY	OTHER	
1	CAFETERIA EXPENSES RECLASS	F	Cafeteria	11	1,280,066	1,487,291	1
500	Total reclassifications Code Letter - F				1,280,066	1,487,291	500
1	BENEFITS RECLASS	G	Employee Benefits Department	4		9,904,173	1
2			Employee Benefits Department	4		2,535,936	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
500	Total reclassifications Code Letter - G					12,440,109	500
1	UTILITIES EXPENSE RECLASS	H	Operation of Plant	7		848,834	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications Code Letter - H					848,834	500
1	INTEREST EXPENSE RECLASS	I	Cap Rel Costs-Bldg & Fixt	1		1,383,634	1
500	Total reclassifications Code Letter - I					1,383,634	500
1	RECLASS DRUG COSTS	J	Drugs Charged to Patients	73		9,738,649	1
500	Total reclassifications Code Letter - J					9,738,649	500
1	BUILDING RENT EXPENSE RECLASS	L	Cap Rel Costs-Bldg & Fixt	1		387,273	1
2							2
3							3
500	Total reclassifications Code Letter - L					387,273	500
1	EQUIPMENT RENT EXPENSE RECLASS	M	Cap Rel Costs-Mvble Equip	2		1,469,012	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
500	Total reclassifications					1,469,012	500
	Code Letter - M						
1	RECLASS PROPERTY INSURANCE	O	Cap Rel Costs-Bldg & Fixt	1		195,066	1
500	Total reclassifications					195,066	500
	Code Letter - O						
1	RECLASS IV COSTS	P	Adults & Pediatrics	30	288,007	184,450	1
2			Intensive Care Unit	31	35,758	22,901	2
3			Subprovider - IRF	41	16,517	10,578	3
4			Recovery Room	51	19,374	12,408	4
5			Radiology-Diagnostic	54	4,688	3,002	5
6			Radioisotope	56	1,250	801	6
7			Clinic	90	54,618	34,979	7
8			Emergency	91	26,205	16,782	8
500	Total reclassifications				446,417	285,901	500
	Code Letter - P						
	GRAND TOTAL (Increases)				3,574,480	68,815,145	

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	MEDICAL SUPPLY RECLASS	A	Pharmacy	15		3,033	1	
2							2	
3			Adults & Pediatrics	30		222,735	3	
4			Intensive Care Unit	31		134,116	4	
5			Subprovider - IRF	41		14,974	5	
6			Operating Room	50		14,385,180	6	
7			Recovery Room	51		9,828	7	
8			Anesthesiology	53		56,797	8	
9			Electroencephalography	70		3,782,477	9	
10			Clinic	90		76,904	10	
11			Emergency	91		18,288	11	
12			Cardiac Catheterization	59		5,583,491	12	
13			Radiology-Diagnostic	54		91,944	13	
500	Total reclassifications					24,379,767	500	
	Code letter - A							
1	RECLASSI DEPRECIATION EXPENSE	B	Employee Benefits Department	4		359	9	
2			MAINTENANCE OF PERSONNEL	4.01		3,789	9	
3			PATIENT REGISTRATION	5.03		83,687	3	
4			ADMINISTRATIVE & GENERAL	5.05		4,423,330	4	
5			Maintenance & Repairs	6		337,801	5	
6			Operation of Plant	7		262,940	6	
7			Laundry & Linen Service	8		3,010	7	
8			Housekeeping	9		5,312	8	
9			Dietary	10		58,643	9	
10			Nursing Administration	13		112	10	
11			Central Services & Supply	14		98,697	11	
12			Pharmacy	15		200,100	12	
13			Medical Records & Library	16		4,136	13	
14			Adults & Pediatrics	30		541,104	14	
15			Intensive Care Unit	31		646,983	15	
16			Subprovider - IRF	41		55,833	16	
17			Operating Room	50		2,301,275	17	
18			Recovery Room	51		27,020	18	
19			Anesthesiology	53		11,361	19	
20			Radiology-Diagnostic	54		2,412,811	20	
21			RADIOLOGY - ULTRASOUND	54.01		93,736	21	
22			Radioisotope	56		150,468	22	
23			CT Scan	57		229,843	23	
24			Cardiac Catheterization	59		675,301	24	
25			Laboratory	60		204,019	25	
26			Whole Blood & Packed Red Bloo	62		17,496	26	
27			Respiratory Therapy	65		70,803	27	
28			Physical Therapy	66		25,646	28	
29			Occupational Therapy	67		1,816	29	
30			Speech Pathology	68		1,116	30	
31			Electroencephalography	70		117,568	31	
32			CARDIAC REHABILITATION	76.97		1,075	32	
33			Clinic	90		710,794	33	
34			Emergency	91		617,573	34	
35			Home Health Agency	101		24,375	35	
36			OTHER NON-REIMBURSEABLE COST	194		491,069	36	
500	Total reclassifications					14,911,001	500	
	Code letter - B							
1	RECLASS SOCIAL SERVICE COSTS	C	Social Service	17		56	1	
2	RECLASS PATIENT ACCT	C					2	
500	Total reclassifications					56	500	
	Code letter - C							
1	RECLASS LDRP COSTS	D	Adults & Pediatrics	30	856,083	647,934	1	
2			Adults & Pediatrics	30	759,154	574,573	2	
500	Total reclassifications				1,615,237	1,222,507	500	
	Code letter - D							
1	RECLASS EMS PARAMEDICAL ED COSTS	E	ADMINISTRATIVE & GENERAL	5.05	219,000	50,703	1	
2	RECLASS FICA	E	ADMINISTRATIVE & GENERAL	5.05		15,342	2	
3			Adults & Pediatrics	30	1,920		3	
4			Intensive Care Unit	31	960		4	
5			Operating Room	50	960		5	
6			Respiratory Therapy	65	640		6	
7			Laboratory	60	320		7	
8			Emergency	91	8,960		8	
500	Total reclassifications				232,760	66,045	500	
	Code letter - E							

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	CAFETERIA EXPENSES RECLASS	F	Dietary	10	1,280,066	1,487,291	1	
500	Total reclassifications				1,280,066	1,487,291	500	
	Code letter - F							
1	BENEFITS RECLASS	G					1	
2			MAINTENANCE OF PERSONNEL	4.01		695,609	2	
3			PATIENT REGISTRATION	5.03		311,435	3	
4			ADMINISTRATIVE & GENERAL	5.05		619,102	4	
5			Maintenance & Repairs	6		277,956	5	
6			Operation of Plant	7		272,089	6	
7			Laundry & Linen Service	8		42,841	7	
8			Housekeeping	9		528,910	8	
9			Dietary	10		459,319	9	
10			Nursing Administration	13		407,161	10	
11			Central Services & Supply	14		180,239	11	
12			Pharmacy	15		374,413	12	
13			Medical Records & Library	16		8,270	13	
14			Adults & Pediatrics	30		2,582,149	14	
15			Intensive Care Unit	31		508,374	15	
16			Subprovider - IRF	41		368,320	16	
17			Operating Room	50		810,594	17	
18			Recovery Room	51		277,445	18	
19			Radiology-Diagnostic	54		693,914	19	
20			RADIOLOGY - ULTRASOUND	54.01		83,447	20	
21			Radioisotope	56		78,976	21	
22			CT Scan	57		118,638	22	
23			Cardiac Catheterization	59		276,899	23	
24			Laboratory	60		584,800	24	
25			Whole Blood & Packed Red Bloo	62		35,422	25	
26			Respiratory Therapy	65		301,094	26	
27			Occupational Therapy	67		21,497	27	
28			Electroencephalography	70		96,261	28	
29			CARDIAC REHABILITATION	76.97		97,687	29	
30			Clinic	90		437,276	30	
31			Emergency	91		598,848	31	
32			Home Health Agency	101		280,149	32	
33			Physicians' Private Offices	192		2,136	33	
34			OTHER NON-REIMBURSEABLE COST	194		8,839	34	
500	Total reclassifications					12,440,109	500	
	Code letter - G							
1	UTILITIES EXPENSE RECLASS	H					1	
2			ADMINISTRATIVE & GENERAL	5.05		413,298	2	
3			Operation of Plant	7		197,097	3	
4			Operating Room	50		3,471	4	
5			Laboratory	60		3,708	5	
6			Respiratory Therapy	65		3,295	6	
7			CARDIAC REHABILITATION	76.97		3,395	7	
8			Clinic	90		9,986	8	
9			Home Health Agency	101		12,027	9	
10			OTHER NON-REIMBURSEABLE COST	194		202,557	10	
500	Total reclassifications					848,834	500	
	Code letter - H							
1	INTEREST EXPENSE RECLASS	I	ADMINISTRATIVE & GENERAL	5.05		1,383,634	11	
500	Total reclassifications					1,383,634	500	
	Code letter - I							
1	RECLASS DRUG COSTS	J	Pharmacy	15		9,738,649	1	
500	Total reclassifications					9,738,649	500	
	Code letter - J							
1	BUILDING RENT EXPENSE RECLASS	L	ADMINISTRATIVE & GENERAL	5.05		347,583	10	
2			OTHER NON-REIMBURSEABLE COST	194		5,800	2	
3			Home Health Agency	101		33,890	3	
500	Total reclassifications					387,273	500	
	Code letter - L							
1	EQUIPMENT RENT EXPENSE RECLASS	M	MAINTENANCE OF PERSONNEL	4.01		1,187	10	
2			ADMINISTRATIVE & GENERAL	5.05		252,999	2	
3			Maintenance & Repairs	6		5,544	3	
4			Operation of Plant	7		8,107	4	
5			Dietary	10		13,612	5	
6			Central Services & Supply	14		139,316	6	

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
7			Pharmacy	15		7,019	7	
8			Subprovider - IRF	41		2,000	8	
9			Operating Room	50		477,458	9	
10			Radiology-Diagnostic	54		263,287	10	
11			RADIOLOGY - ULTRASOUND	54.01		56,045	11	
12			Radioisotope	56		14,742	12	
13			CT Scan	57		77,816	13	
14			Cardiac Catheterization	59		31,873	14	
15			Laboratory	60		29,235	15	
16			Respiratory Therapy	65		16,039	16	
17			Physical Therapy	66		2,338	17	
18			Electroencephalography	70		1,238	18	
19			Renal Dialysis	74		1,608	19	
20			CARDIAC REHABILITATION	76.97		140	20	
21			Clinic	90		64,037	21	
22			OTHER NON-REIMBURSEABLE COST	194		3,372	22	
500	Total reclassifications					1,469,012	500	
	Code letter - M							
1	RECLASS PROPERTY INSURANCE	O	ADMINISTRATIVE & GENERAL	5.05		195,066	12	
500	Total reclassifications					195,066	500	
	Code letter - O							
1	RECLASS IV COSTS	P	Pharmacy	15	446,417	285,901	1	
2							2	
3							3	
4							4	
5							5	
6							6	
7							7	
8							8	
500	Total reclassifications				446,417	285,901	500	
	Code letter - P							
	GRAND TOTAL (Decreases)				3,574,480	68,815,145		

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

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RECONCILIATION OF CAPITAL COST CENTERS

**WORKSHEET A-7
PARTS I, II & III**

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	11,292,789	44,621		44,621	1,094,825	10,242,585		2
3	Buildings and Fixtures	159,070,729	5,544,673		5,544,673	1,102,614	163,512,788		3
4	Building Improvements	498,412	226,714		226,714	31,213	693,913		4
5	Fixed Equipment								5
6	Movable Equipment	113,489,850	5,022,444		5,022,444	7,772,635	110,739,659		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	284,351,780	10,838,452		10,838,452	10,001,287	285,188,945		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	284,351,780	10,838,452		10,838,452	10,001,287	285,188,945		10

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

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

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				Total (sum of cols. 5 through 7)	
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs			
*		1	2	3	4	5	6	7	8		
1	Cap Rel Costs-Bldg & Fi	174,449,286		174,449,286	0.611697					1	
2	Cap Rel Costs-Mvble Equip	110,739,659		110,739,659	0.388303					2	
3	Total (sum of lines 1-2)	285,188,945		285,188,945	1.000000					3	

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	7,876,766	387,273		195,066			8,459,105	1	
2	Cap Rel Costs-Mvble Equip	8,183,657	1,469,012					9,652,669	2	
3	Total (sum of lines 1-2)	16,060,423	1,856,285		195,066			18,111,774	3	

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref.
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-78	Cap Rel Costs-Mvble Equip	2	9	7
8	Television and radio service (chapter 21)	A	-22,680	Cap Rel Costs-Mvble Equip	2	9	8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-440,513				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-1,844,890				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-1,060,605	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines	B	-3,338	Dietary	10		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures	A	-120,310	Cap Rel Costs-Bldg & Fixt	1	9	26
27	Depreciation--movable equipment	A	59,243	Cap Rel Costs-Mvble Equip	2	9	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	OFFSET CRNA/ANESTHESIOLOGIST FEES	A	-3,472,451	Anesthesiology	53		33
33.01	AHA LIFE 1991 PHILLIPS EQ	A	5,750	Cap Rel Costs-Mvble Equip	2	9	33.01
33.07	1990 ASSETS-INSTALLMENTS	A	-1,397	Cap Rel Costs-Mvble Equip	2	9	33.07
34	PHOTOGRAPHIC FEES	B	-1,533	Radiology-Diagnostic	54		34
34.03	OFFSET OTHER OP REV	B	-82,071	PARAMED ED PRGM-(SPECIFY)	23		34.03
34.04	OFFSET OTHER INCOME	B	-334	Adults & Pediatrics	30		34.04
35	ADVERTISING OFFSET	A	-972,342	ADMINISTRATIVE & GENERAL	5.05		35
35.03	OFFSET NP SALARIES	A	-287,085	Clinic	90		35.03
35.06	OFFSET PHYSICIAN SALARIES	A	-172,910	Clinic	90		35.06
35.09	OFFSET PHYSICIAN FEES	A	-341,250	Adults & Pediatrics	30		35.09
35.10	OFFSET HOSPITALISTS	A	-1,632,924	Nursing Administration	13		35.10
35.11	OFFSET PHYSICIAN FEES	A	-3,825	Employee Benefits Department	4		35.11
36	OFFSET OTHER INCOME	B	-8	Operating Room	50		36
37	OTHER OP REV/EP	B	-2,745	Electroencephalography	70		37
38	OFFSET LAB INCOME	B	-105,652	Laboratory	60		38
39	OFFSET HHA PR COSTS	A	-325	Home Health Agency	101		39
40	OTHER INCOME OFFSET	B	-20,900	ADMINISTRATIVE & GENERAL	5.05		40
41	OTHER REVENUE	B	-684	Clinic	90		41
41.03	OFFSET OTHER INCOME	B	-1,707	Employee Benefits Department	4		41.03
42	OFFSET OTHER INCOME	B	-5,300	Physical Therapy	66		42
42.01	OFFSET PHO REVENUE	B	-40,600	ADMINISTRATIVE & GENERAL	5.05		42.01
42.03	OTHER INCOME	B	-23,975	ADMINISTRATIVE & GENERAL	5.05		42.03
42.04	OTHER INCOME	B	-25	Intensive Care Unit	31		42.04
42.05	OFFSET DIETARY INCOME	B	-459	Dietary	10		42.05
43	OFFSET OTHER INCOME	B	-233	Emergency	91		43
43.03	OFFSET CONTRIBUTION EXPENSE	A	-87,596	ADMINISTRATIVE & GENERAL	5.05		43.03
43.04	OFFSET CONTRIBUTION EXPENSE	A	-729	Employee Benefits Department	4		43.04
43.05	OFFSET CONTRIBUTION EXPENSE	A	-20	Clinic	90		43.05
44	PHONE OFFSET	A	-54,947	NON-PATIENT TELEPHONES	5.01		44
45							45
46	OTHER INCOME RESP THERAPY	B	-43,572	Respiratory Therapy	65		46
46.01	OFFSET CARDIAC INCOME	B	-58,382	CARDIAC REHABILITATION	76.97		46.01
47	OFFSET INTEREST EXPENSE	A	-1,383,634	Cap Rel Costs-Bldg & Fixt	1	11	47

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref. 5
				COST CENTER	LINE#		
		1	2	3	4		
47.01	BARIATRIC COSTS/DEPT 4266	A	-79,284	Clinic	90		47.01
47.02	OFFSET PHYSICIAN FEES	A	-30,312	CARDIAC REHABILITATION	76.97		47.02
47.03	OFFSET PHYSICIAN FEES	A	-5,400	Radiology-Diagnostic	54		47.03
47.04	OFFSET PHYSICIAN FEES	A	-2,966	CT Scan	57		47.04
47.05	OFFSET PHYSICIAN FEES	A	-1,018	Clinic	90		47.05
48	OTHER INCOME	B	-95	Occupational Therapy	67		48
49	PROVIDER TAX	A	-17,264,678	ADMINISTRATIVE & GENERAL	5.05		49
49.01	OFFSET PHYSICIAN CORP ALLOCATIONS	A	-12,258,278	ADMINISTRATIVE & GENERAL	5.05		49.01
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-41,869,067				50

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

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

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ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
1	2	3	4	5	6	7	
1	5.05	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE	14,992,993	24,152,763	-9,159,770	1
2	1	Cap Rel Costs-Bldg & Fixt	BLDG DEPR	155,733		155,733	9
3	2	Cap Rel Costs-Mvble Equip	EQ DEPR	1,073,161		1,073,161	9
3.01	5.01	NON-PATIENT TELEPHONES	TELECOMMUNICATIONS	616,860		616,860	3.01
3.02	16	Medical Records & Library	MEDICAL RECORDS	2,632,135		2,632,135	3.02
3.03	5.04	PATIENT ACCOUNTING	PATIENT ACCTING	2,836,991		2,836,991	3.03
4							4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			22,307,873	24,152,763	-1,844,890	5

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

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5.05	ADMINISTRATIVE & GEN AGGREGATE	318,206	279,909	38,297	211,500	342	34,775	1,739	1
2	13	Nursing Administrati	60,258		60,258	211,500	364	37,013	1,851	2
3	30	Adults & Pediatrics	19,915		19,915	211,500	88	8,948	447	3
4	31	Intensive Care Unit AGGREGATE	28,573	9,313	19,260	211,500	144	14,642	732	4
5	50	Operating Room	21,353		21,353	246,400	110	13,031	652	5
6	54	Radiology-Diagnostic	24,326		24,326	271,900	102	13,333	667	6
7	59	Cardiac Catheterizat	18,330		18,330	260,300	92	11,513	576	7
8	60	Laboratory	45,170		45,170	211,500	293	29,793	1,490	8
9	65	Respiratory Therapy	27,185		27,185	211,500	251	25,522	1,276	9
10	4.01	MAINTENANCE OF PERSO	3,033		3,033	211,500	30	3,050	153	10
11	70	Electroencephalograp	15,500		15,500	211,500	124	12,609	630	11
12	90	Clinic AGGREGATE	112,192	27,168	85,024	211,500	485	49,316	2,466	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	694,041	316,390	377,651		2,425	253,545	12,679	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5.05	ADMINISTRATIVE & GEN AGGREGATE					34,775	3,522	283,431	1
2	13	Nursing Administrati					37,013	23,245	23,245	2
3	30	Adults & Pediatrics					8,948	10,967	10,967	3
4	31	Intensive Care Unit AGGREGATE					14,642	4,618	13,931	4
5	50	Operating Room					13,031	8,322	8,322	5
6	54	Radiology-Diagnostic					13,333	10,993	10,993	6
7	59	Cardiac Catheterizat					11,513	6,817	6,817	7
8	60	Laboratory					29,793	15,377	15,377	8
9	65	Respiratory Therapy					25,522	1,663	1,663	9
10	4.01	MAINTENANCE OF PERSO					3,050			10
11	70	Electroencephalograp					12,609	2,891	2,891	11
12	90	Clinic AGGREGATE					49,316	35,708	62,876	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					253,545	124,123	440,513	200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINTENANCE OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	8,459,105	8,459,105					1
2	Cap Rel Costs-Mvble Equip	9,652,669		9,652,669				2
4	Employee Benefits Department	10,521,472	6,275	7,558	10,535,305			4
4.01	MAINTENANCE OF PERSONNEL	1,249,061	37,868	45,610	142,524	1,475,063		4.01
5.01	NON-PATIENT TELEPHONES	561,913	30,538	36,781			629,232	5.01
5.02	PURCHASING, RECEIVING & STORES	679,456	66,193	79,725	55,071	13,266		5.02
5.03	PATIENT REGISTRATION	1,747,122	43,513	52,408	227,496	50,495	15,009	5.03
5.04	PATIENT ACCOUNTING	2,837,099	6,055	7,293				5.04
5.05	ADMINISTRATIVE & GENERAL	23,274,676	908,901	1,094,711	647,215	74,130	162,792	5.05
6	Maintenance & Repairs	7,926,835	699,459	842,452	236,385	30,350	14,432	6
7	Operation of Plant	2,396,131	366,047	440,879	148,338	31,400	6,350	7
8	Laundry & Linen Service	728,363	14,294	17,216	13,649	4,135	577	8
9	Housekeeping	2,531,541	63,217	76,140	271,152	71,904	18,473	9
10	Dietary	995,634	110,834	133,493	107,585	26,746	9,236	10
11	Cafeteria	1,706,752	131,975	158,955	194,465	48,358		11
12	Maintenance of Personnel							12
13	Nursing Administration	3,637,788	35,743	43,050	412,220	48,535	4,618	13
14	Central Services & Supply	562,591	58,496	70,454	71,752	13,835	6,350	14
15	Pharmacy	2,973,377	57,675	69,466	341,585	35,927	12,123	15
16	Medical Records & Library	2,761,184	38,660	46,564	5,830	784	1,155	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)	216,734			35,360	4,527		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	16,948,860	1,172,355	1,412,020	2,203,066	320,686	102,178	30
31	Intensive Care Unit	4,287,467	192,626	232,005	514,031	61,939	14,432	31
41	Subprovider - IRF	2,650,253	160,827	193,706	259,773	38,254	10,968	41
43	Nursery	1,504,017	54,670	65,846	130,054	15,858		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	13,298,351	458,996	552,829	688,401	92,795	42,719	50
51	Recovery Room	2,007,405	93,168	112,215	246,614	28,554	5,195	51
52	Delivery Room & Labor Room	1,333,727	48,483	58,394	115,329	14,378		52
53	Anesthesiology	521,801	4,867	5,862			1,155	53
54	Radiology-Diagnostic	4,890,371	259,068	312,030	511,929	68,642	29,441	54
54.01	RADIOLOGY - ULTRASOUND	1,103,268	35,449	42,696	119,381	12,380	4,618	54.01
56	Radioisotope	1,369,743	78,860	94,981	75,492	7,069	12,700	56
57	CT Scan	1,669,443	46,709	56,258	131,194	15,453	5,773	57
59	Cardiac Catheterization	3,161,855	122,915	148,043	289,934	33,208	16,164	59
60	Laboratory	8,270,568	161,502	194,518	536,381	87,522	16,741	60
62	Whole Blood & Packed Red Blood Cells	1,265,404	13,077	15,751	24,885	3,313	2,309	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,498,375	50,858	61,255	301,080	39,253	1,155	65
66	Physical Therapy	2,900,222	228,897	275,691			11,546	66
67	Occupational Therapy	924,485	29,629	35,686		3,958	6,927	67
68	Speech Pathology	425,121	3,240	3,902			1,732	68
70	Electroencephalography	407,672	25,348	30,530	79,781	10,559	8,659	70
71	Medical Supplies Charged to Patients	10,115,697						71
72	Impl. Dev. Charged to Patients	14,264,070						72
73	Drugs Charged to Patients	9,738,649						73
74	Renal Dialysis	772,471						74
76.97	CARDIAC REHABILITATION	662,075	99,282	119,578	90,630	11,432	9,814	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	3,252,638	354,626	427,124	433,323	50,571	42,141	90
91	Emergency	4,881,246	219,015	263,789	528,356	69,211	16,164	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,974,455			336,143	34,106	15,586	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	203,519,212	6,590,210	7,937,464	10,526,404	1,473,533	629,232	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		10,438	12,572				190
192	Physicians' Private Offices	18,789	466,047	561,323	847	215		192
194	OTHER NON-REIMBURSABLE COST CENTERS	519,364	962,252	1,141,310	8,054	1,315		194
194.01	OTHER NONREIMBURSABLE		430,158					194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	204,057,365	8,459,105	9,652,669	10,535,305	1,475,063	629,232	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING & STORES 5.02	PATIENT REGISTRATN 5.03	PATIENT ACCOUNTING 5.04	SUBTOTAL (cols.0-4) 4A	ADMINI- STRATIVE & GENERAL 5.05	MAIN- TENANCE & REPAIRS 6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES	893,711						5.02
5.03	PATIENT REGISTRATION	875	2,136,918					5.03
5.04	PATIENT ACCOUNTING			2,850,447				5.04
5.05	ADMINISTRATIVE & GENERAL	2,091			26,164,516	26,164,516		5.05
6	Maintenance & Repairs	1,136			9,751,049	1,434,184	11,185,233	6
7	Operation of Plant	84			3,389,229	498,488	712,126	7
8	Laundry & Linen Service	2			778,236	114,463	27,808	8
9	Housekeeping	2,103			3,034,530	446,319	122,985	9
10	Dietary	7,901			1,391,429	204,651	215,623	10
11	Cafeteria				2,240,505	329,533	256,751	11
12	Maintenance of Personnel							12
13	Nursing Administration	275			4,182,229	615,122	69,535	13
14	Central Services & Supply	8,138			791,616	116,431	113,801	14
15	Pharmacy	11,346			3,501,499	515,000	112,204	15
16	Medical Records & Library	8			2,854,185	419,794	75,211	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)				256,621	37,744		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	63,466	146,828	195,899	22,565,358	3,318,950	2,280,755	30
31	Intensive Care Unit	19,671	23,916	31,909	5,377,996	790,996	374,744	31
41	Subprovider - IRF	4,963	14,813	19,763	3,353,320	493,206	312,881	41
43	Nursery		10,166	13,564	1,794,175	263,887	106,357	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	355,449	252,445	336,814	16,078,799	2,364,870	892,952	50
51	Recovery Room	6,910	28,587	38,141	2,566,789	377,523	181,254	51
52	Delivery Room & Labor Room		9,032	12,050	1,591,393	234,062	94,321	52
53	Anesthesiology	18,565	50,479	67,350	670,079	98,555	9,469	53
54	Radiology-Diagnostic	12,919	190,534	254,212	6,529,146	960,307	504,004	54
54.01	RADIOLOGY - ULTRASOUND	5,383	41,611	55,517	1,420,303	208,898	68,965	54.01
56	Radioisotope	1,383	36,155	48,238	1,724,621	253,657	153,417	56
57	CT Scan	8,154	150,975	201,432	2,285,391	336,135	90,870	57
59	Cardiac Catheterization	148,932	164,229	219,116	4,304,396	633,091	239,125	59
60	Laboratory	99,662	269,230	358,565	9,994,689	1,470,019	314,193	60
62	Whole Blood & Packed Red Blood Cells	5,657	11,495	15,336	1,357,227	199,621	25,441	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	11,520	47,279	63,080	3,073,855	452,103	98,941	65
66	Physical Therapy	2,395	38,878	51,872	3,509,501	516,177	445,307	66
67	Occupational Therapy	1,323	14,839	19,798	1,036,645	152,470	57,642	67
68	Speech Pathology	79	2,842	3,791	440,707	64,819	6,303	68
70	Electroencephalography	31,898	41,966	55,992	692,405	101,839	49,314	70
71	Medical Supplies Charged to Patients		62,219	83,013	10,260,929	1,509,177		71
72	Impl. Dev. Charged to Patients		73,742	98,387	14,436,199	2,123,276		72
73	Drugs Charged to Patients		202,647	270,373	10,211,669	1,501,932		73
74	Renal Dialysis		8,219	10,966	791,656	116,437		74
76.97	CARDIAC REHABILITATION	351	4,839	6,456	1,004,457	147,736	193,148	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	16,412	35,588	47,482	4,659,905	685,379	689,907	90
91	Emergency	39,481	193,185	257,749	6,468,196	951,342	426,083	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	4,856	10,180	13,582	3,388,908	498,441		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	893,388	2,136,918	2,850,447	199,924,358	25,556,634	9,321,437	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				23,010	3,384	20,307	190
192	Physicians' Private Offices				1,047,221	154,025		192
194	OTHER NON-REIMBURSEABLE COST CENTERS	323			2,632,618	387,205	1,843,489	194
194.01	OTHER NONREIMBURSABLE				430,158	63,268		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	893,711	2,136,918	2,850,447	204,057,365	26,164,516	11,185,233	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant	4,599,843						7
8	Laundry & Linen Service	11,241	931,748					8
9	Housekeeping	49,712		3,653,546				9
10	Dietary	87,157		70,157	1,969,017			10
11	Cafeteria	103,782		83,538		3,014,109		11
12	Maintenance of Personnel							12
13	Nursing Administration	28,107		22,625		134,189	5,051,807	13
14	Central Services & Supply	46,000		37,027		38,250		14
15	Pharmacy	45,354		36,507		99,330		15
16	Medical Records & Library	30,401		24,471		2,168		16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)					12,517		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	921,907	387,178	742,085	1,622,245	886,634	2,480,519	30
31	Intensive Care Unit	151,476	40,514	121,930	110,822	171,250	479,097	31
41	Subprovider - IRF	126,470	41,611	101,801	205,444	105,764	295,938	41
43	Nursery	42,991	10,969	34,605		43,844	122,692	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	360,942	105,459	290,538		256,560	717,743	50
51	Recovery Room	73,265		58,974		78,947	220,874	51
52	Delivery Room & Labor Room	38,126	7,090	30,689		39,753	111,194	52
53	Anesthesiology	3,828		3,081				53
54	Radiology-Diagnostic	203,724	59,629	163,986		189,780		54
54.01	RADIOLOGY - ULTRASOUND	27,877	14,522	22,439		34,229		54.01
56	Radioisotope	62,013	8,274	49,917		19,544		56
57	CT Scan	36,731	19,677	29,566		42,725		57
59	Cardiac Catheterization	96,657	23,257	77,803		91,813		59
60	Laboratory	127,001	4,754	102,228		241,980		60
62	Whole Blood & Packed Red Blood Cells	10,284		8,278		9,160		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	39,993		32,192		108,526		65
66	Physical Therapy	179,998	21,462	144,888				66
67	Occupational Therapy	23,300	5,683	18,755		10,943		67
68	Speech Pathology	2,548	705	2,051				68
70	Electroencephalography	19,933	41	16,045		29,194		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION	78,073	1,829	62,844		31,607	88,386	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	278,869	21,611	224,473		139,818		90
91	Emergency	172,228	154,874	138,634	30,506	191,354	535,364	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,479,988	929,139	2,752,127	1,969,017	3,009,879	5,051,807	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	8,208		6,607				190
192	Physicians' Private Offices	366,487	2,609	295,001		594		192
194	OTHER NON-REIMBURSABLE COST CENTERS	745,160		599,811		3,636		194
194.01	OTHER NONREIMBURSABLE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,599,843	931,748	3,653,546	1,969,017	3,014,109	5,051,807	202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	23	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	1,143,125						14
15	Pharmacy		4,309,894					15
16	Medical Records & Library			3,406,230				16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)				306,882			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			234,052	41,684	35,481,367		30
31	Intensive Care Unit			38,124	22,998	7,679,947		31
41	Subprovider - IRF			23,612		5,060,047		41
43	Nursery			16,206		2,435,726		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			402,410		21,470,273		50
51	Recovery Room			45,569		3,603,195		51
52	Delivery Room & Labor Room			14,397		2,161,025		52
53	Anesthesiology			80,467	25,154	890,633		53
54	Radiology-Diagnostic			303,721		8,914,297		54
54.01	RADIOLOGY - ULTRASOUND			66,330		1,863,563		54.01
56	Radioisotope			57,633		2,329,076		56
57	CT Scan			240,662		3,081,757		57
59	Cardiac Catheterization			261,789		5,727,931		59
60	Laboratory			429,040	7,666	12,691,570		60
62	Whole Blood & Packed Red Blood Cells			18,323		1,628,334		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			75,366	13,416	3,894,392		65
66	Physical Therapy			61,974		4,879,307		66
67	Occupational Therapy			23,654		1,329,092		67
68	Speech Pathology			4,530		521,663		68
70	Electroencephalography			66,896		975,667		70
71	Medical Supplies Charged to Patients	463,348		99,181		12,332,635		71
72	Impl. Dev. Charged to Patients	679,777		117,548		17,356,800		72
73	Drugs Charged to Patients		4,309,894	323,029		16,346,524		73
74	Renal Dialysis			13,101		921,194		74
76.97	CARDIAC REHABILITATION			7,713		1,615,793		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			56,729		6,756,691		90
91	Emergency			307,947	195,964	9,572,492		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			16,227		3,903,576		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,143,125	4,309,894	3,406,230	306,882	195,424,567		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					61,516		190
192	Physicians' Private Offices					1,865,937		192
194	OTHER NON-REIMBURSABLE COST CENTERS					6,211,919		194
194.01	OTHER NONREIMBURSABLE					493,426		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,143,125	4,309,894	3,406,230	306,882	204,057,365		202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	MAINTENANCE OF PERSONNEL						4.01
5.01	NON-PATIENT TELEPHONES						5.01
5.02	PURCHASING, RECEIVING & STORES						5.02
5.03	PATIENT REGISTRATION						5.03
5.04	PATIENT ACCOUNTING						5.04
5.05	ADMINISTRATIVE & GENERAL						5.05
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	35,481,367					30
31	Intensive Care Unit	7,679,947					31
41	Subprovider - IRF	5,060,047					41
43	Nursery	2,435,726					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	21,470,273					50
51	Recovery Room	3,603,195					51
52	Delivery Room & Labor Room	2,161,025					52
53	Anesthesiology	890,633					53
54	Radiology-Diagnostic	8,914,297					54
54.01	RADIOLOGY - ULTRASOUND	1,863,563					54.01
56	Radioisotope	2,329,076					56
57	CT Scan	3,081,757					57
59	Cardiac Catheterization	5,727,931					59
60	Laboratory	12,691,570					60
62	Whole Blood & Packed Red Blood Cells	1,628,334					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	3,894,392					65
66	Physical Therapy	4,879,307					66
67	Occupational Therapy	1,329,092					67
68	Speech Pathology	521,663					68
70	Electroencephalography	975,667					70
71	Medical Supplies Charged to Patients	12,332,635					71
72	Impl. Dev. Charged to Patients	17,356,800					72
73	Drugs Charged to Patients	16,346,524					73
74	Renal Dialysis	921,194					74
76.97	CARDIAC REHABILITATION	1,615,793					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	6,756,691					90
91	Emergency	9,572,492					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	3,903,576					101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	195,424,567					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	61,516					190
192	Physicians' Private Offices	1,865,937					192
194	OTHER NON-REIMBURSABLE COST CENTERS	6,211,919					194
194.01	OTHER NONREIMBURSABLE	493,426					194.01
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	204,057,365					202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	MAINTENANCE OF PERSONNEL	
		0	1	2	2A	4	4.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		6,275	7,558	13,833	13,833		4
4.01	MAINTENANCE OF PERSONNEL		37,868	45,610	83,478	187	83,665	4.01
5.01	NON-PATIENT TELEPHONES		30,538	36,781	67,319			5.01
5.02	PURCHASING, RECEIVING & STORES		66,193	79,725	145,918	72	752	5.02
5.03	PATIENT REGISTRATION		43,513	52,408	95,921	298	2,864	5.03
5.04	PATIENT ACCOUNTING		6,055	7,293	13,348			5.04
5.05	ADMINISTRATIVE & GENERAL		908,901	1,094,711	2,003,612	848	4,205	5.05
6	Maintenance & Repairs		699,459	842,452	1,541,911	310	1,721	6
7	Operation of Plant		366,047	440,879	806,926	194	1,781	7
8	Laundry & Linen Service		14,294	17,216	31,510	18	235	8
9	Housekeeping		63,217	76,140	139,357	355	4,078	9
10	Dietary		110,834	133,493	244,327	141	1,517	10
11	Cafeteria		131,975	158,955	290,930	255	2,743	11
12	Maintenance of Personnel							12
13	Nursing Administration		35,743	43,050	78,793	540	2,753	13
14	Central Services & Supply		58,496	70,454	128,950	94	785	14
15	Pharmacy		57,675	69,466	127,141	447	2,038	15
16	Medical Records & Library		38,660	46,564	85,224	8	44	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)					46	257	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,172,355	1,412,020	2,584,375	2,917	18,189	30
31	Intensive Care Unit		192,626	232,005	424,631	673	3,513	31
41	Subprovider - IRF		160,827	193,706	354,533	340	2,170	41
43	Nursery		54,670	65,846	120,516	170	899	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		458,996	552,829	1,011,825	902	5,263	50
51	Recovery Room		93,168	112,215	205,383	323	1,620	51
52	Delivery Room & Labor Room		48,483	58,394	106,877	151	816	52
53	Anesthesiology		4,867	5,862	10,729			53
54	Radiology-Diagnostic		259,068	312,030	571,098	671	3,893	54
54.01	RADIOLOGY - ULTRASOUND		35,449	42,696	78,145	156	702	54.01
56	Radioisotope		78,860	94,981	173,841	99	401	56
57	CT Scan		46,709	56,258	102,967	172	877	57
59	Cardiac Catheterization		122,915	148,043	270,958	380	1,884	59
60	Laboratory		161,502	194,518	356,020	703	4,964	60
62	Whole Blood & Packed Red Blood Cells		13,077	15,751	28,828	33	188	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		50,858	61,255	112,113	394	2,226	65
66	Physical Therapy		228,897	275,691	504,588			66
67	Occupational Therapy		29,629	35,686	65,315		225	67
68	Speech Pathology		3,240	3,902	7,142			68
70	Electroencephalography		25,348	30,530	55,878	105	599	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION		99,282	119,578	218,860	119	648	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		354,626	427,124	781,750	568	2,868	90
91	Emergency		219,015	263,789	482,804	692	3,926	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency					440	1,934	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		6,590,210	7,937,464	14,527,674	13,821	83,578	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		10,438	12,572	23,010			190
192	Physicians' Private Offices		466,047	561,323	1,027,370	1	12	192
194	OTHER NON-REIMBURSEABLE COST CENTERS		962,252	1,141,310	2,103,562	11	75	194
194.01	OTHER NONREIMBURSABLE		430,158		430,158			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		8,459,105	9,652,669	18,111,774	13,833	83,665	202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	NONPATIENT TELEPHONES	PURCHASING RECEIVING & STORES	PATIENT REGISTRATN	PATIENT ACCOUNTING	ADMINI- STRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	
		5.01	5.02	5.03	5.04	5.05	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES	67,319						5.01
5.02	PURCHASING, RECEIVING & STORES		146,742					5.02
5.03	PATIENT REGISTRATION	1,606	144	100,833				5.03
5.04	PATIENT ACCOUNTING				13,348			5.04
5.05	ADMINISTRATIVE & GENERAL	17,416	343			2,026,424		5.05
6	Maintenance & Repairs	1,544	187			111,074	1,656,747	6
7	Operation of Plant	679	14			38,607	105,479	7
8	Laundry & Linen Service	62				8,865	4,119	8
9	Housekeeping	1,976	345			34,566	18,216	9
10	Dietary	988	1,297			15,850	31,938	10
11	Cafeteria					25,522	38,030	11
12	Maintenance of Personnel							12
13	Nursing Administration	494	45			47,640	10,300	13
14	Central Services & Supply	679	1,336			9,017	16,856	14
15	Pharmacy	1,297	1,863			39,886	16,620	15
16	Medical Records & Library	124	1			32,512	11,140	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)					2,923		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	10,932	10,421	6,937	899	257,087	337,823	30
31	Intensive Care Unit	1,544	3,230	1,130	146	61,261	55,507	31
41	Subprovider - IRF	1,173	815	700	91	38,198	46,344	41
43	Nursery			480	62	20,437	15,753	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,570	58,362	11,927	1,546	183,154	132,263	50
51	Recovery Room	556	1,135	1,351	175	29,238	26,847	51
52	Delivery Room & Labor Room			427	55	18,128	13,971	52
53	Anesthesiology	124	3,048	2,385	309	7,633	1,403	53
54	Radiology-Diagnostic	3,150	2,121	9,002	1,167	74,374	74,653	54
54.01	RADIOLOGY - ULTRASOUND	494	884	1,966	255	16,179	10,215	54.01
56	Radioisotope	1,359	227	1,708	221	19,645	22,724	56
57	CT Scan	618	1,339	7,133	925	26,033	13,460	57
59	Cardiac Catheterization	1,729	24,454	7,759	1,006	49,031	35,419	59
60	Laboratory	1,791	16,364	12,593	1,911	113,850	46,538	60
62	Whole Blood & Packed Red Blood Cells	247	929	543	70	15,460	3,768	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	124	1,892	2,234	290	35,014	14,655	65
66	Physical Therapy	1,235	393	1,837	238	39,977	65,958	66
67	Occupational Therapy	741	217	701	91	11,808	8,538	67
68	Speech Pathology	185	13	134	17	5,020	934	68
70	Electroencephalography	926	5,237	1,983	257	7,887	7,304	70
71	Medical Supplies Charged to Patients			2,939	381	116,882		71
72	Impl. Dev. Charged to Patients			3,484	452	164,443		72
73	Drugs Charged to Patients			9,574	1,241	116,321		73
74	Renal Dialysis			388	50	9,018		74
76.97	CARDIAC REHABILITATION	1,050	58	229	30	11,442	28,609	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	4,509	2,695	1,681	218	53,081	102,188	90
91	Emergency	1,729	6,483	9,127	1,183	73,679	63,111	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,668	797	481	62	38,603		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	67,319	146,689	100,833	13,348	1,979,345	1,380,683	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					262	3,008	190
192	Physicians' Private Offices					11,929		192
194	OTHER NON-REIMBURSABLE COST CENTERS		53			29,988	273,056	194
194.01	OTHER NONREIMBURSABLE					4,900		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	67,319	146,742	100,833	13,348	2,026,424	1,656,747	202

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant	953,680						7
8	Laundry & Linen Service	2,330	47,139					8
9	Housekeeping	10,307		209,200				9
10	Dietary	18,070		4,017	318,145			10
11	Cafeteria	21,517		4,783		383,780		11
12	Maintenance of Personnel							12
13	Nursing Administration	5,827		1,295		17,086	164,773	13
14	Central Services & Supply	9,537		2,120		4,870		14
15	Pharmacy	9,403		2,090		12,648		15
16	Medical Records & Library	6,303		1,401		276		16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)					1,594		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	191,137	19,585	42,494	262,115	112,893	80,905	30
31	Intensive Care Unit	31,405	2,050	6,982	17,906	21,805	15,627	31
41	Subprovider - IRF	26,221	2,105	5,829	33,195	13,467	9,653	41
43	Nursery	8,913	555	1,981		5,583	4,002	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	74,834	5,335	16,636		32,667	23,410	50
51	Recovery Room	15,190		3,377		10,052	7,204	51
52	Delivery Room & Labor Room	7,905	359	1,757		5,062	3,627	52
53	Anesthesiology	794		176				53
54	Radiology-Diagnostic	42,238	3,017	9,390		24,164		54
54.01	RADIOLOGY - ULTRASOUND	5,780	735	1,285		4,358		54.01
56	Radioisotope	12,857	419	2,858		2,489		56
57	CT Scan	7,615	996	1,693		5,440		57
59	Cardiac Catheterization	20,040	1,177	4,455		11,690		59
60	Laboratory	26,331	241	5,854		30,811		60
62	Whole Blood & Packed Red Blood Cells	2,132		474		1,166		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	8,292		1,843		13,818		65
66	Physical Therapy	37,319	1,086	8,296				66
67	Occupational Therapy	4,831	288	1,074		1,393		67
68	Speech Pathology	528	36	117				68
70	Electroencephalography	4,133	2	919		3,717		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION	16,187	93	3,598		4,024	2,883	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	57,818	1,093	12,853		17,803		90
91	Emergency	35,708	7,835	7,938	4,929	24,365	17,462	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	721,502	47,007	157,585	318,145	383,241	164,773	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,702		378				190
192	Physicians' Private Offices	75,983	132	16,892		76		192
194	OTHER NON-REIMBURSABLE COST CENTERS	154,493		34,345		463		194
194.01	OTHER NONREIMBURSABLE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	953,680	47,139	209,200	318,145	383,780	164,773	202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS
		14	15	16	23	24	25
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	MAINTENANCE OF PERSONNEL						4.01
5.01	NON-PATIENT TELEPHONES						5.01
5.02	PURCHASING, RECEIVING & STORES						5.02
5.03	PATIENT REGISTRATION						5.03
5.04	PATIENT ACCOUNTING						5.04
5.05	ADMINISTRATIVE & GENERAL						5.05
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply	174,244					14
15	Pharmacy		213,433				15
16	Medical Records & Library			137,033			16
17	Social Service						17
19	Nonphysician Anesthetists						19
23	PARAMED ED PRGM-(SPECIFY)				4,820		23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics			9,442		3,948,151	30
31	Intensive Care Unit			1,538		648,948	31
41	Subprovider - IRF			953		535,787	41
43	Nursery			654		180,005	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room			16,233		1,578,927	50
51	Recovery Room			1,838		304,289	51
52	Delivery Room & Labor Room			581		159,716	52
53	Anesthesiology			3,246		29,847	53
54	Radiology-Diagnostic			12,252		831,190	54
54.01	RADIOLOGY - ULTRASOUND			2,676		123,830	54.01
56	Radioisotope			2,325		241,173	56
57	CT Scan			9,708		178,976	57
59	Cardiac Catheterization			10,561		440,543	59
60	Laboratory			16,931		634,902	60
62	Whole Blood & Packed Red Blood Cells			739		54,577	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy			3,040		195,935	65
66	Physical Therapy			2,500		663,427	66
67	Occupational Therapy			954		96,176	67
68	Speech Pathology			183		14,309	68
70	Electroencephalography			2,699		91,646	70
71	Medical Supplies Charged to Patients	70,625		4,001		194,828	71
72	Impl. Dev. Charged to Patients	103,619		4,742		276,740	72
73	Drugs Charged to Patients		213,433	13,031		353,600	73
74	Renal Dialysis			529		9,985	74
76.97	CARDIAC REHABILITATION			311		288,141	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic			2,288		1,041,413	90
91	Emergency			12,423		753,394	91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency			655		44,640	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	174,244	213,433	137,033		13,915,095	118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen					28,360	190
192	Physicians' Private Offices					1,132,395	192
194	OTHER NON-REIMBURSEABLE COST CENTERS					2,596,046	194
194.01	OTHER NONREIMBURSABLE					435,058	194.01
200	Cross Foot Adjustments				4,820	4,820	200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	174,244	213,433	137,033	4,820	18,111,774	202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	MAINTENANCE OF PERSONNEL						4.01
5.01	NON-PATIENT TELEPHONES						5.01
5.02	PURCHASING, RECEIVING & STORES						5.02
5.03	PATIENT REGISTRATION						5.03
5.04	PATIENT ACCOUNTING						5.04
5.05	ADMINISTRATIVE & GENERAL						5.05
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	3,948,151					30
31	Intensive Care Unit	648,948					31
41	Subprovider - IRF	535,787					41
43	Nursery	180,005					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,578,927					50
51	Recovery Room	304,289					51
52	Delivery Room & Labor Room	159,716					52
53	Anesthesiology	29,847					53
54	Radiology-Diagnostic	831,190					54
54.01	RADIOLOGY - ULTRASOUND	123,830					54.01
56	Radioisotope	241,173					56
57	CT Scan	178,976					57
59	Cardiac Catheterization	440,543					59
60	Laboratory	634,902					60
62	Whole Blood & Packed Red Blood Cells	54,577					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	195,935					65
66	Physical Therapy	663,427					66
67	Occupational Therapy	96,176					67
68	Speech Pathology	14,309					68
70	Electroencephalography	91,646					70
71	Medical Supplies Charged to Patients	194,828					71
72	Impl. Dev. Charged to Patients	276,740					72
73	Drugs Charged to Patients	353,600					73
74	Renal Dialysis	9,985					74
76.97	CARDIAC REHABILITATION	288,141					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,041,413					90
91	Emergency	753,394					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	44,640					101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	13,915,095					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	28,360					190
192	Physicians' Private Offices	1,132,395					192
194	OTHER NON-REIMBURSABLE COST CENTERS	2,596,046					194
194.01	OTHER NONREIMBURSABLE	435,058					194.01
200	Cross Foot Adjustments	4,820					200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	18,111,774					202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINTENANCE OF PERSONNEL NUMBER OF FTES	NONPATIENT TELEPHONES NUMBER OF PHONES	PURCHASING RECEIVING & STORES SUPPLY EXPENSE	
		1	2	4	4.01	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	576,994						1
2	Cap Rel Costs-Mvble Equip		546,653					2
4	Employee Benefits Department	428	428	69,348,791				4
4.01	MAINTENANCE OF PERSONNEL	2,583	2,583	938,161	116,644			4.01
5.01	NON-PATIENT TELEPHONES	2,083	2,083			1,090		5.01
5.02	PURCHASING, RECEIVING & STORES	4,515	4,515	362,503	1,049		1,786,577	5.02
5.03	PATIENT REGISTRATION	2,968	2,968	1,497,490	3,993	26	1,749	5.03
5.04	PATIENT ACCOUNTING	413	413					5.04
5.05	ADMINISTRATIVE & GENERAL	61,996	61,996	4,260,294	5,862	282	4,180	5.05
6	Maintenance & Repairs	47,710	47,710	1,556,006	2,400	25	2,271	6
7	Operation of Plant	24,968	24,968	976,432	2,483	11	168	7
8	Laundry & Linen Service	975	975	89,847	327	1	3	8
9	Housekeeping	4,312	4,312	1,784,856	5,686	32	4,205	9
10	Dietary	7,560	7,560	708,180	2,115	16	15,795	10
11	Cafeteria	9,002	9,002	1,280,066	3,824			11
12	Maintenance of Personnel							12
13	Nursing Administration	2,438	2,438	2,713,437	3,838	8	550	13
14	Central Services & Supply	3,990	3,990	472,306	1,094	11	16,269	14
15	Pharmacy	3,934	3,934	2,248,480	2,841	21	22,682	15
16	Medical Records & Library	2,637	2,637	38,374	62	2	16	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)			232,760	358			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	79,966	79,966	14,501,828	25,359	177	126,873	30
31	Intensive Care Unit	13,139	13,139	3,383,610	4,898	25	39,323	31
41	Subprovider - IRF	10,970	10,970	1,709,955	3,025	19	9,922	41
43	Nursery	3,729	3,729	856,083	1,254			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	31,308	31,308	4,531,401	7,338	74	710,561	50
51	Recovery Room	6,355	6,355	1,623,335	2,258	9	13,813	51
52	Delivery Room & Labor Room	3,307	3,307	759,154	1,137			52
53	Anesthesiology	332	332			2	37,113	53
54	Radiology-Diagnostic	17,671	17,671	3,369,773	5,428	51	25,826	54
54.01	RADIOLOGY - ULTRASOUND	2,418	2,418	785,823	979	8	10,760	54.01
56	Radioisotope	5,379	5,379	496,929	559	22	2,764	56
57	CT Scan	3,186	3,186	863,584	1,222	10	16,301	57
59	Cardiac Catheterization	8,384	8,384	1,908,493	2,626	28	297,723	59
60	Laboratory	11,016	11,016	3,530,724	6,921	29	199,229	60
62	Whole Blood & Packed Red Blood Cells	892	892	163,804	262	4	11,308	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,469	3,469	1,981,861	3,104	2	23,030	65
66	Physical Therapy	15,613	15,613			20	4,788	66
67	Occupational Therapy	2,021	2,021		313	12	2,645	67
68	Speech Pathology	221	221			3	157	68
70	Electroencephalography	1,729	1,729	525,160	835	15	63,765	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION	6,772	6,772	596,573	904	17	701	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	24,189	24,189	2,852,351	3,999	73	32,809	90
91	Emergency	14,939	14,939	3,477,903	5,473	28	78,925	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			2,212,660	2,697	27	9,708	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	449,517	449,517	69,290,196	116,523	1,090	1,785,932	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	712	712					190
192	Physicians' Private Offices	31,789	31,789	5,578	17			192
194	OTHER NON-REIMBURSEABLE COST CENTERS	65,635	64,635	53,017	104		645	194
194.01	OTHER NONREIMBURSABLE	29,341						194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	8,459,105	9,652,669	10,535,305	1,475,063	629,232	893,711	202
203	Unit Cost Multiplier (Wkst. B, Part I)	14.660646	17.657763	0.151918	12.645854	577.277064	0.500236	203
204	Cost to be allocated (Per Wkst. B, Part II)			13,833	83,665	67,319	146,742	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000199	0.717268	61.760550	0.082136	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINTENACE OF PERSONNEL NUMBER OF FTES	NONPATIENT TELEPHONES NUMBER OF PHONES	PURCHASING RECEIVING & STORES SUPPLY EXPENSE	
		1	2	4	4.01	5.01	5.02	
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PATIENT REGISTRATN GROSS REVENUE	PATIENT ACCOUNTING GROSS REVENUE	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.03	5.04	5A.05	5.05	6	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION	934,705,912						5.03
5.04	PATIENT ACCOUNTING		934,705,912					5.04
5.05	ADMINISTRATIVE & GENERAL			-26,164,516	177,892,849			5.05
6	Maintenance & Repairs				9,751,049	392,168		6
7	Operation of Plant				3,389,229	24,968	398,989	7
8	Laundry & Linen Service				778,236		975	8
9	Housekeeping				3,034,530	4,312	4,312	9
10	Dietary				1,391,429	7,560	7,560	10
11	Cafeteria				2,240,505	9,002	9,002	11
12	Maintenance of Personnel							12
13	Nursing Administration				4,182,229	2,438	2,438	13
14	Central Services & Supply				791,616	3,990	3,990	14
15	Pharmacy				3,501,499	3,934	3,934	15
16	Medical Records & Library				2,854,185	2,637	2,637	16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)				256,621			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	64,229,333	64,229,333		22,565,358	79,966	79,966	30
31	Intensive Care Unit	10,462,065	10,462,065		5,377,996	13,139	13,139	31
41	Subprovider - IRF	6,479,717	6,479,717		3,353,320	10,970	10,970	41
43	Nursery	4,447,222	4,447,222		1,794,175	3,729	3,729	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	110,430,895	110,430,895		16,078,799	31,308	31,308	50
51	Recovery Room	12,505,186	12,505,186		2,566,789	6,355	6,355	51
52	Delivery Room & Labor Room	3,950,928	3,950,928		1,591,393	3,307	3,307	52
53	Anesthesiology	22,082,019	22,082,019		670,079	332	332	53
54	Radiology-Diagnostic	83,348,115	83,348,115		6,529,146	17,671	17,671	54
54.01	RADIOLOGY - ULTRASOUND	18,202,449	18,202,449		1,420,303	2,418	2,418	54.01
56	Radioisotope	15,815,801	15,815,801		1,724,621	5,379	5,379	56
57	CT Scan	66,043,361	66,043,361		2,285,391	3,186	3,186	57
59	Cardiac Catheterization	71,841,197	71,841,197		4,304,396	8,384	8,384	59
60	Laboratory	117,694,963	117,694,963		9,994,689	11,016	11,016	60
62	Whole Blood & Packed Red Blood Cells	5,028,358	5,028,358		1,357,227	892	892	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	20,682,085	20,682,085		3,073,855	3,469	3,469	65
66	Physical Therapy	17,007,087	17,007,087		3,509,501	15,613	15,613	66
67	Occupational Therapy	6,491,112	6,491,112		1,036,645	2,021	2,021	67
68	Speech Pathology	1,243,086	1,243,086		440,707	221	221	68
70	Electroencephalography	18,357,950	18,357,950		692,405	1,729	1,729	70
71	Medical Supplies Charged to Patients	27,217,521	27,217,521		10,260,929			71
72	Impl. Dev. Charged to Patients	32,258,085	32,258,085		14,436,199			72
73	Drugs Charged to Patients	88,646,774	88,646,774		10,211,669			73
74	Renal Dialysis	3,595,255	3,595,255		791,656			74
76.97	CARDIAC REHABILITATION	2,116,710	2,116,710		1,004,457	6,772	6,772	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	15,567,718	15,567,718		4,659,905	24,189	24,189	90
91	Emergency	84,507,934	84,507,934		6,468,196	14,939	14,939	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	4,452,986	4,452,986		3,388,908			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	934,705,912	934,705,912	-26,164,516	173,759,842	326,821	301,853	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				23,010	712	712	190
192	Physicians' Private Offices				1,047,221		31,789	192
194	OTHER NON-REIMBURSEABLE COST CENTERS				2,632,618	64,635	64,635	194
194.01	OTHER NONREIMBURSABLE				430,158			194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,136,918	2,850,447		26,164,516	11,185,233	4,599,843	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.002286	0.003050		0.147080	28.521534	11.528746	203
204	Cost to be allocated (Per Wkst. B, Part II)	100,833	13,348		2,026,424	1,656,747	953,680	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000108	0.000014		0.011391	4.224585	2.390241	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PATIENT REGISTRATN GROSS REVENUE	PATIENT ACCOUNTING GROSS REVENUE	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.03	5.04	5A.05	5.05	6	7	
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA NUMBER OF FTES	NURSING ADMINISTRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY EXPENSE	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NON-PATIENT TELEPHONES							5.01
5.02	PURCHASING, RECEIVING & STORES							5.02
5.03	PATIENT REGISTRATION							5.03
5.04	PATIENT ACCOUNTING							5.04
5.05	ADMINISTRATIVE & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	1,535,273						8
9	Housekeeping		393,702					9
10	Dietary		7,560	178,793				10
11	Cafeteria		9,002		86,208			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,438		3,838	1,074,246		13
14	Central Services & Supply		3,990		1,094		23,986,620	14
15	Pharmacy		3,934		2,841			15
16	Medical Records & Library		2,637		62			16
17	Social Service							17
19	Nonphysician Anesthetists							19
23	PARAMED ED PRGM-(SPECIFY)				358			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	637,965	79,966	147,305	25,359	527,472		30
31	Intensive Care Unit	66,757	13,139	10,063	4,898	101,878		31
41	Subprovider - IRF	68,564	10,970	18,655	3,025	62,930		41
43	Nursery	18,074	3,729		1,254	26,090		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	173,768	31,308		7,338	152,625		50
51	Recovery Room		6,355		2,258	46,968		51
52	Delivery Room & Labor Room	11,682	3,307		1,137	23,645		52
53	Anesthesiology		332					53
54	Radiology-Diagnostic	98,253	17,671		5,428			54
54.01	RADIOLOGY - ULTRASOUND	23,928	2,418		979			54.01
56	Radioisotope	13,633	5,379		559			56
57	CT Scan	32,423	3,186		1,222			57
59	Cardiac Catheterization	38,321	8,384		2,626			59
60	Laboratory	7,833	11,016		6,921			60
62	Whole Blood & Packed Red Blood Cells		892		262			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,469		3,104			65
66	Physical Therapy	35,363	15,613					66
67	Occupational Therapy	9,364	2,021		313			67
68	Speech Pathology	1,162	221					68
70	Electroencephalography	68	1,729		835			70
71	Medical Supplies Charged to Patients						9,722,550	71
72	Impl. Dev. Charged to Patients						14,264,070	72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION	3,014	6,772		904	18,795		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	35,610	24,189		3,999			90
91	Emergency	255,192	14,939	2,770	5,473	113,843		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,530,974	296,566	178,793	86,087	1,074,246	23,986,620	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		712					190
192	Physicians' Private Offices	4,299	31,789		17			192
194	OTHER NON-REIMBURSEABLE COST CENTERS		64,635		104			194
194.01	OTHER NONREIMBURSABLE							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	931,748	3,653,546	1,969,017	3,014,109	5,051,807	1,143,125	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.606894	9.279978	11.012830	34.963217	4.702654	0.047657	203
204	Cost to be allocated (Per Wkst. B, Part II)	47,139	209,200	318,145	383,780	164,773	174,244	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.030704	0.531366	1.779404	4.451791	0.153385	0.007264	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA NUMBER OF FTES	NURSING ADMINISTRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY SUPPLY EXPENSE	
		8	9	10	11	13	14	
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	PARAMED EDUCATION ASSIGNED TIME				
	15	16	23				

GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	MAINTENANCE OF PERSONNEL						4.01
5.01	NON-PATIENT TELEPHONES						5.01
5.02	PURCHASING, RECEIVING & STORES						5.02
5.03	PATIENT REGISTRATION						5.03
5.04	PATIENT ACCOUNTING						5.04
5.05	ADMINISTRATIVE & GENERAL						5.05
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy	10,000					15
16	Medical Records & Library		934,705,912				16
17	Social Service						17
19	Nonphysician Anesthetists						19
23	PARAMED ED PRGM-(SPECIFY)			2,562			23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		64,229,333	348			30
31	Intensive Care Unit		10,462,065	192			31
41	Subprovider - IRF		6,479,717				41
43	Nursery		4,447,222				43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room		110,430,895				50
51	Recovery Room		12,505,186				51
52	Delivery Room & Labor Room		3,950,928				52
53	Anesthesiology		22,082,019	210			53
54	Radiology-Diagnostic		83,348,115				54
54.01	RADIOLOGY - ULTRASOUND		18,202,449				54.01
56	Radioisotope		15,815,801				56
57	CT Scan		66,043,361				57
59	Cardiac Catheterization		71,841,197				59
60	Laboratory		117,694,963	64			60
62	Whole Blood & Packed Red Blood Cells		5,028,358				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		20,682,085	112			65
66	Physical Therapy		17,007,087				66
67	Occupational Therapy		6,491,112				67
68	Speech Pathology		1,243,086				68
70	Electroencephalography		18,357,950				70
71	Medical Supplies Charged to Patients		27,217,521				71
72	Impl. Dev. Charged to Patients		32,258,085				72
73	Drugs Charged to Patients	10,000	88,646,774				73
74	Renal Dialysis		3,595,255				74
76.97	CARDIAC REHABILITATION		2,116,710				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	Clinic		15,567,718				90
91	Emergency		84,507,934	1,636			91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		4,452,986				101
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,000	934,705,912	2,562			118
NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
194	OTHER NON-REIMBURSABLE COST CENTERS						194
194.01	OTHER NONREIMBURSABLE						194.01
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	4,309,894	3,406,230	306,882			202
203	Unit Cost Multiplier (Wkst. B, Part I)	430,989,400	0.003644	119,782,201			203
204	Cost to be allocated (Per Wkst. B, Part II)	213,433	137,033	4,820			204

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	PARAMED EDUCATION ASSIGNED TIME				
		15	16	23				
205	Unit Cost Multiplier (Wkst. B, Part II)	21.343300	0.000147	1.881343				205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		CODE	LINE NO.	AMOUNT
	1	2	3	4

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	35,481,367		35,481,367	10,967	35,492,334	30
31	Intensive Care Unit	7,679,947		7,679,947	4,618	7,684,565	31
41	Subprovider - IRF	5,060,047		5,060,047		5,060,047	41
43	Nursery	2,435,726		2,435,726		2,435,726	43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	21,470,273		21,470,273	8,322	21,478,595	50
51	Recovery Room	3,603,195		3,603,195		3,603,195	51
52	Delivery Room & Labor Room	2,161,025		2,161,025		2,161,025	52
53	Anesthesiology	890,633		890,633		890,633	53
54	Radiology-Diagnostic	8,914,297		8,914,297	10,993	8,925,290	54
54.01	RADIOLOGY - ULTRASOUND	1,863,563		1,863,563		1,863,563	54.01
56	Radioisotope	2,329,076		2,329,076		2,329,076	56
57	CT Scan	3,081,757		3,081,757		3,081,757	57
59	Cardiac Catheterization	5,727,931		5,727,931	6,817	5,734,748	59
60	Laboratory	12,691,570		12,691,570	15,377	12,706,947	60
62	Whole Blood & Packed Red Blood Cells	1,628,334		1,628,334		1,628,334	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	3,894,392		3,894,392	1,663	3,896,055	65
66	Physical Therapy	4,879,307		4,879,307		4,879,307	66
67	Occupational Therapy	1,329,092		1,329,092		1,329,092	67
68	Speech Pathology	521,663		521,663		521,663	68
70	Electroencephalography	975,667		975,667	2,891	978,558	70
71	Medical Supplies Charged to Patients	12,332,635		12,332,635		12,332,635	71
72	Impl. Dev. Charged to Patients	17,356,800		17,356,800		17,356,800	72
73	Drugs Charged to Patients	16,346,524		16,346,524		16,346,524	73
74	Renal Dialysis	921,194		921,194		921,194	74
76.97	CARDIAC REHABILITATION	1,615,793		1,615,793		1,615,793	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	Clinic	6,756,691		6,756,691	35,708	6,792,399	90
91	Emergency	9,572,492		9,572,492		9,572,492	91
92	Observation Beds (Non-Distinct Part)	3,882,357		3,882,357		3,882,357	92
OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,903,576		3,903,576		3,903,576	101
200	Subtotal (sum of lines 30 thru 199)	199,306,924		199,306,924	97,356	199,404,280	200
201	Less Observation Beds	3,882,357		3,882,357		3,882,357	201
202	Total (line 200 minus line 201)	195,424,567		195,424,567		195,521,923	202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8				
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	53,216,477		53,216,477				30
31	Intensive Care Unit	10,462,065		10,462,065				31
41	Subprovider - IRF	6,479,717		6,479,717				41
43	Nursery	4,447,222		4,447,222				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	35,620,259	74,810,636	110,430,895	0.194423	0.194423	0.194498	50
51	Recovery Room	3,996,687	8,508,499	12,505,186	0.288136	0.288136	0.288136	51
52	Delivery Room & Labor Room	2,874,349	1,076,579	3,950,928	0.546966	0.546966	0.546966	52
53	Anesthesiology	7,118,474	14,963,545	22,082,019	0.040333	0.040333	0.040333	53
54	Radiology-Diagnostic	12,569,538	70,778,577	83,348,115	0.106953	0.106953	0.107084	54
54.01	RADIOLOGY - ULTRASOUND	3,111,634	15,090,815	18,202,449	0.102380	0.102380	0.102380	54.01
56	Radioisotope	3,462,515	12,353,286	15,815,801	0.147263	0.147263	0.147263	56
57	CT Scan	19,376,523	46,666,838	66,043,361	0.046663	0.046663	0.046663	57
59	Cardiac Catheterization	28,263,064	43,578,133	71,841,197	0.079730	0.079730	0.079825	59
60	Laboratory	37,988,438	79,706,525	117,694,963	0.107834	0.107834	0.107965	60
62	Whole Blood & Packed Red Blood Cells	3,237,836	1,790,522	5,028,358	0.323830	0.323830	0.323830	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	19,002,335	1,679,750	20,682,085	0.188298	0.188298	0.188378	65
66	Physical Therapy	6,467,312	10,539,775	17,007,087	0.286898	0.286898	0.286898	66
67	Occupational Therapy	4,452,242	2,038,870	6,491,112	0.204756	0.204756	0.204756	67
68	Speech Pathology	915,849	327,237	1,243,086	0.419652	0.419652	0.419652	68
70	Electroencephalography	4,224,648	14,133,302	18,357,950	0.053147	0.053147	0.053304	70
71	Medical Supplies Charged to Patients	12,370,752	14,846,769	27,217,521	0.453114	0.453114	0.453114	71
72	Impl. Dev. Charged to Patients	20,119,324	12,138,761	32,258,085	0.538060	0.538060	0.538060	72
73	Drugs Charged to Patients	46,552,645	42,094,129	88,646,774	0.184401	0.184401	0.184401	73
74	Renal Dialysis	3,467,455	127,800	3,595,255	0.256225	0.256225	0.256225	74
76.97	CARDIAC REHABILITATION	413,406	1,703,304	2,116,710	0.763351	0.763351	0.763351	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	640,714	14,927,004	15,567,718	0.434019	0.434019	0.436313	90
91	Emergency	25,483,590	59,024,344	84,507,934	0.113273	0.113273	0.113273	91
92	Observation Beds (Non-Distinct Part)	2,082,936	8,929,920	11,012,856	0.352530	0.352530	0.352530	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		4,452,986	4,452,986				101
200	Subtotal (sum of lines 30 thru 199)	378,418,006	556,287,906	934,705,912				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	378,418,006	556,287,906	934,705,912				202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	35,481,367		35,481,367		35,481,367	30
31	Intensive Care Unit	7,679,947		7,679,947		7,679,947	31
41	Subprovider - IRF	5,060,047		5,060,047		5,060,047	41
43	Nursery	2,435,726		2,435,726		2,435,726	43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	21,470,273		21,470,273		21,470,273	50
51	Recovery Room	3,603,195		3,603,195		3,603,195	51
52	Delivery Room & Labor Room	2,161,025		2,161,025		2,161,025	52
53	Anesthesiology	890,633		890,633		890,633	53
54	Radiology-Diagnostic	8,914,297		8,914,297		8,914,297	54
54.01	RADIOLOGY - ULTRASOUND	1,863,563		1,863,563		1,863,563	54.01
56	Radioisotope	2,329,076		2,329,076		2,329,076	56
57	CT Scan	3,081,757		3,081,757		3,081,757	57
59	Cardiac Catheterization	5,727,931		5,727,931		5,727,931	59
60	Laboratory	12,691,570		12,691,570		12,691,570	60
62	Whole Blood & Packed Red Blood Cells	1,628,334		1,628,334		1,628,334	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	3,894,392		3,894,392		3,894,392	65
66	Physical Therapy	4,879,307		4,879,307		4,879,307	66
67	Occupational Therapy	1,329,092		1,329,092		1,329,092	67
68	Speech Pathology	521,663		521,663		521,663	68
70	Electroencephalography	975,667		975,667		975,667	70
71	Medical Supplies Charged to Patients	12,332,635		12,332,635		12,332,635	71
72	Impl. Dev. Charged to Patients	17,356,800		17,356,800		17,356,800	72
73	Drugs Charged to Patients	16,346,524		16,346,524		16,346,524	73
74	Renal Dialysis	921,194		921,194		921,194	74
76.97	CARDIAC REHABILITATION	1,615,793		1,615,793		1,615,793	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	Clinic	6,756,691		6,756,691		6,756,691	90
91	Emergency	9,572,492		9,572,492		9,572,492	91
92	Observation Beds (Non-Distinct Part)	3,882,357		3,882,357		3,882,357	92
OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,903,576		3,903,576		3,903,576	101
200	Subtotal (sum of lines 30 thru 199)	199,306,924		199,306,924		199,306,924	200
201	Less Observation Beds	3,882,357		3,882,357		3,882,357	201
202	Total (line 200 minus line 201)	195,424,567		195,424,567		195,424,567	202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8				
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	53,216,477		53,216,477				30
31	Intensive Care Unit	10,462,065		10,462,065				31
41	Subprovider - IRF	6,479,717		6,479,717				41
43	Nursery	4,447,222		4,447,222				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	35,620,259	74,810,636	110,430,895	0.194423	0.194423	0.194423	50
51	Recovery Room	3,996,687	8,508,499	12,505,186	0.288136	0.288136	0.288136	51
52	Delivery Room & Labor Room	2,874,349	1,076,579	3,950,928	0.546966	0.546966	0.546966	52
53	Anesthesiology	7,118,474	14,963,545	22,082,019	0.040333	0.040333	0.040333	53
54	Radiology-Diagnostic	12,569,538	70,778,577	83,348,115	0.106953	0.106953	0.106953	54
54.01	RADIOLOGY - ULTRASOUND	3,111,634	15,090,815	18,202,449	0.102380	0.102380	0.102380	54.01
56	Radioisotope	3,462,515	12,353,286	15,815,801	0.147263	0.147263	0.147263	56
57	CT Scan	19,376,523	46,666,838	66,043,361	0.046663	0.046663	0.046663	57
59	Cardiac Catheterization	28,263,064	43,578,133	71,841,197	0.079730	0.079730	0.079730	59
60	Laboratory	37,988,438	79,706,525	117,694,963	0.107834	0.107834	0.107834	60
62	Whole Blood & Packed Red Blood Cells	3,237,836	1,790,522	5,028,358	0.323830	0.323830	0.323830	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	19,002,335	1,679,750	20,682,085	0.188298	0.188298	0.188298	65
66	Physical Therapy	6,467,312	10,539,775	17,007,087	0.286898	0.286898	0.286898	66
67	Occupational Therapy	4,452,242	2,038,870	6,491,112	0.204756	0.204756	0.204756	67
68	Speech Pathology	915,849	327,237	1,243,086	0.419652	0.419652	0.419652	68
70	Electroencephalography	4,224,648	14,133,302	18,357,950	0.053147	0.053147	0.053147	70
71	Medical Supplies Charged to Patients	12,370,752	14,846,769	27,217,521	0.453114	0.453114	0.453114	71
72	Impl. Dev. Charged to Patients	20,119,324	12,138,761	32,258,085	0.538060	0.538060	0.538060	72
73	Drugs Charged to Patients	46,552,645	42,094,129	88,646,774	0.184401	0.184401	0.184401	73
74	Renal Dialysis	3,467,455	127,800	3,595,255	0.256225	0.256225	0.256225	74
76.97	CARDIAC REHABILITATION	413,406	1,703,304	2,116,710	0.763351	0.763351	0.763351	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	640,714	14,927,004	15,567,718	0.434019	0.434019	0.434019	90
91	Emergency	25,483,590	59,024,344	84,507,934	0.113273	0.113273	0.113273	91
92	Observation Beds (Non-Distinct Part)	2,082,936	8,929,920	11,012,856	0.352530	0.352530	0.352530	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		4,452,986	4,452,986				101
200	Subtotal (sum of lines 30 thru 199)	378,418,006	556,287,906	934,705,912				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	378,418,006	556,287,906	934,705,912				202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

**WORKSHEET C
PART II**

[] Title V

[XX] Title XIX

COST CENTER DESCRIPTIONS		Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction
		1	2	3	4
ANCILLARY SERVICE COST CENTERS					
50	Operating Room	21,470,273	1,578,927	19,891,346	50
51	Recovery Room	3,603,195	304,289	3,298,906	51
52	Delivery Room & Labor Room	2,161,025	159,716	2,001,309	52
53	Anesthesiology	890,633	29,847	860,786	53
54	Radiology-Diagnostic	8,914,297	831,190	8,083,107	54
54.01	RADIOLOGY - ULTRASOUND	1,863,563	123,830	1,739,733	54.01
56	Radioisotope	2,329,076	241,173	2,087,903	56
57	CT Scan	3,081,757	178,976	2,902,781	57
59	Cardiac Catheterization	5,727,931	440,543	5,287,388	59
60	Laboratory	12,691,570	634,902	12,056,668	60
62	Whole Blood & Packed Red Blood Cells	1,628,334	54,577	1,573,757	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	3,894,392	195,935	3,698,457	65
66	Physical Therapy	4,879,307	663,427	4,215,880	66
67	Occupational Therapy	1,329,092	96,176	1,232,916	67
68	Speech Pathology	521,663	14,309	507,354	68
70	Electroencephalography	975,667	91,646	884,021	70
71	Medical Supplies Charged to Patients	12,332,635	194,828	12,137,807	71
72	Impl. Dev. Charged to Patients	17,356,800	276,740	17,080,060	72
73	Drugs Charged to Patients	16,346,524	353,600	15,992,924	73
74	Renal Dialysis	921,194	9,985	911,209	74
76.97	CARDIAC REHABILITATION	1,615,793	288,141	1,327,652	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
90	Clinic	6,756,691	1,041,413	5,715,278	90
91	Emergency	9,572,492	753,394	8,819,098	91
92	Observation Beds (Non-Distinct Part)	3,882,357	431,873	3,450,484	92
OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency	3,903,576	44,640	3,858,936	101
200	Subtotal	148,649,837	9,034,077	139,615,760	200
201	Less Observation Beds	3,882,357	431,873	3,450,484	201
202	Total	144,767,480	8,602,204	136,165,276	202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

**WORKSHEET C
PART II**

Title V

Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		21,470,273	110,430,895	0.194423	50
51	Recovery Room		3,603,195	12,505,186	0.288136	51
52	Delivery Room & Labor Room		2,161,025	3,950,928	0.546966	52
53	Anesthesiology		890,633	22,082,019	0.040333	53
54	Radiology-Diagnostic		8,914,297	83,348,115	0.106953	54
54.01	RADIOLOGY - ULTRASOUND		1,863,563	18,202,449	0.102380	54.01
56	Radioisotope		2,329,076	15,815,801	0.147263	56
57	CT Scan		3,081,757	66,043,361	0.046663	57
59	Cardiac Catheterization		5,727,931	71,841,197	0.079730	59
60	Laboratory		12,691,570	117,694,963	0.107834	60
62	Whole Blood & Packed Red Blood Cells		1,628,334	5,028,358	0.323830	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		3,894,392	20,682,085	0.188298	65
66	Physical Therapy		4,879,307	17,007,087	0.286898	66
67	Occupational Therapy		1,329,092	6,491,112	0.204756	67
68	Speech Pathology		521,663	1,243,086	0.419652	68
70	Electroencephalography		975,667	18,357,950	0.053147	70
71	Medical Supplies Charged to Patients		12,332,635	27,217,521	0.453114	71
72	Impl. Dev. Charged to Patients		17,356,800	32,258,085	0.538060	72
73	Drugs Charged to Patients		16,346,524	88,646,774	0.184401	73
74	Renal Dialysis		921,194	3,595,255	0.256225	74
76.97	CARDIAC REHABILITATION		1,615,793	2,116,710	0.763351	76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic		6,756,691	15,567,718	0.434019	90
91	Emergency		9,572,492	84,507,934	0.113273	91
92	Observation Beds (Non-Distinct Part)		3,882,357	11,012,856	0.352530	92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency		3,903,576	4,452,986	0.876620	101
200	Subtotal		148,649,837	860,100,431		200
201	Less Observation Beds		3,882,357	11,012,856		201
202	Total		144,767,480	849,087,575		202

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
1	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,948,151		3,948,151	44,494	88.73	18,218	1,616,483	30
31	Intensive Care Unit	648,948		648,948	4,728	137.26	1,695	232,656	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF	535,787		535,787	5,992	89.42	3,996	357,322	41
42	Subprovider I								42
43	Nursery	180,005		180,005	1,928	93.36			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	5,312,891		5,312,891	57,142		23,909	2,206,461	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0034

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,578,927	110,430,895	0.014298	14,919,510	213,319	50
51	Recovery Room	304,289	12,505,186	0.024333	1,830,226	44,535	51
52	Delivery Room & Labor Room	159,716	3,950,928	0.040425	12,360	500	52
53	Anesthesiology	29,847	22,082,019	0.001352	3,202,785	4,330	53
54	Radiology-Diagnostic	831,190	83,348,115	0.009973	5,296,566	52,823	54
54.01	RADIOLOGY - ULTRASOUND	123,830	18,202,449	0.006803	1,380,944	9,395	54.01
56	Radioisotope	241,173	15,815,801	0.015249	1,547,890	23,604	56
57	CT Scan	178,976	66,043,361	0.002710	8,434,285	22,857	57
59	Cardiac Catheterization	440,543	71,841,197	0.006132	12,399,826	76,036	59
60	Laboratory	634,902	117,694,963	0.005394	16,411,850	88,526	60
62	Whole Blood & Packed Red Blood	54,577	5,028,358	0.010854	1,420,297	15,416	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	195,935	20,682,085	0.009474	8,179,015	77,488	65
66	Physical Therapy	663,427	17,007,087	0.039009	1,862,284	72,646	66
67	Occupational Therapy	96,176	6,491,112	0.014817	782,593	11,596	67
68	Speech Pathology	14,309	1,243,086	0.011511	225,615	2,597	68
70	Electroencephalography	91,646	18,357,950	0.004992	2,050,940	10,238	70
71	Medical Supplies Charged to Pat	194,828	27,217,521	0.007158	5,279,347	37,790	71
72	Impl. Dev. Charged to Patients	276,740	32,258,085	0.008579	9,844,958	84,460	72
73	Drugs Charged to Patients	353,600	88,646,774	0.003989	18,706,179	74,619	73
74	Renal Dialysis	9,985	3,595,255	0.002777	1,806,571	5,017	74
76.97	CARDIAC REHABILITATION	288,141	2,116,710	0.136127	176,703	24,054	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,041,413	15,567,718	0.066896	149,472	9,999	90
91	Emergency	753,394	84,507,934	0.008915	11,191,794	99,775	91
92	Observation Beds (Non-Distinct	431,873	11,012,856	0.039215	1,073,340	42,091	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	8,989,437	855,647,445		128,185,350	1,103,711	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Nursing School Post-Stepdown Adjustments 1A	Nursing School 1	Allied Health Post-Stepdown Adjustments 2A	Allied Health Cost 2	All Other Medical Education Cost 3	Swing-Bed Adjustment Amount (see instructions) 4	Total Costs (sum of cols. 1 through 3 minus col 4.) 5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)				41,684			41,684	30
31	Intensive Care Unit				22,998			22,998	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)				64,682			64,682	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	44,494	0.94	18,218	17,125	30
31	Intensive Care Unit	4,728	4.86	1,695	8,238	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF	5,992		3,996		41
42	Subprovider I					42
43	Nursery	1,928				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	57,142		23,909	25,363	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0034

**WORKSHEET D
PART IV**

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology					25,154		25,154	25,154	53
54	Radiology-Diagnostic									54
54.01	RADIOLOGY - ULTRASOUND									54.01
56	Radioisotope									56
57	CT Scan									57
59	Cardiac Catheterization									59
60	Laboratory					7,666		7,666	7,666	60
62	Whole Blood & Packed Red Blood									62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy					13,416		13,416	13,416	65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90	Clinic									90
91	Emergency					195,964		195,964	195,964	91
92	Observation Beds (Non-Distinct					4,558		4,558	4,558	92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					246,758		246,758	246,758	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0034

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	110,430,895			14,919,510		20,259,051		50
51	Recovery Room	12,505,186			1,830,226		2,083,503		51
52	Delivery Room & Labor Room	3,950,928			12,360		2,325		52
53	Anesthesiology	22,082,019	0.001139	0.001139	3,202,785	3,648	4,236,049	4,825	53
54	Radiology-Diagnostic	83,348,115			5,296,566		21,056,671		54
54.01	RADIOLOGY - ULTRASOUND	18,202,449			1,380,944		3,525,428		54.01
56	Radioisotope	15,815,801			1,547,890		4,312,772		56
57	CT Scan	66,043,361			8,434,285		13,913,252		57
59	Cardiac Catheterization	71,841,197			12,399,826		17,778,896		59
60	Laboratory	117,694,963	0.000065	0.000065	16,411,850	1,067	8,976,474	583	60
62	Whole Blood & Packed Red Blood	5,028,358			1,420,297		389,480		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,682,085	0.000649	0.000649	8,179,015	5,308	566,352	368	65
66	Physical Therapy	17,007,087			1,862,284		46,308		66
67	Occupational Therapy	6,491,112			782,593		17,430		67
68	Speech Pathology	1,243,086			225,615		6,431		68
70	Electroencephalography	18,357,950			2,050,940		5,467,403		70
71	Medical Supplies Charged to Pat	27,217,521			5,279,347		5,579,996		71
72	Impl. Dev. Charged to Patients	32,258,085			9,844,958		4,231,825		72
73	Drugs Charged to Patients	88,646,774			18,706,179		16,684,259		73
74	Renal Dialysis	3,595,255			1,806,571		116,675		74
76.97	CARDIAC REHABILITATION	2,116,710			176,703		754,890		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90	Clinic	15,567,718			149,472		5,286,730		90
91	Emergency	84,507,934	0.002319	0.002319	11,191,794	25,954	11,004,350	25,519	91
92	Observation Beds (Non-Distinct	11,012,856	0.000414	0.000414	1,073,340	444	2,641,933	1,094	92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	855,647,445			128,185,350	36,421	148,938,483	32,389	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0034

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.194423	20,259,051		51,240	3,938,825		9,962	50
51	Recovery Room	0.288136	2,083,503			600,332			51
52	Delivery Room & Labor Room	0.546966	2,325			1,272			52
53	Anesthesiology	0.040333	4,236,049			170,853			53
54	Radiology-Diagnostic	0.106953	21,056,671			2,252,074			54
54.01	RADIOLOGY - ULTRASOUND	0.102380	3,525,428			360,933			54.01
56	Radioisotope	0.147263	4,312,772			635,112			56
57	CT Scan	0.046663	13,913,252			649,234			57
59	Cardiac Catheterization	0.079730	17,778,896			1,417,511			59
60	Laboratory	0.107834	8,976,474			967,969			60
62	Whole Blood & Packed Red Blood	0.323830	389,480			126,125			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.188298	566,352			106,643			65
66	Physical Therapy	0.286898	46,308			13,286			66
67	Occupational Therapy	0.204756	17,430			3,569			67
68	Speech Pathology	0.419652	6,431			2,699			68
70	Electroencephalography	0.053147	5,467,403			290,576			70
71	Medical Supplies Charged to Pat	0.453114	5,579,996			2,528,374			71
72	Impl. Dev. Charged to Patients	0.538060	4,231,825			2,276,976			72
73	Drugs Charged to Patients	0.184401	16,684,259		105,305	3,076,594		19,418	73
74	Renal Dialysis	0.256225	116,675			29,895			74
76.97	CARDIAC REHABILITATION	0.763351	754,890			576,246			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.434019	5,286,730			2,294,541			90
91	Emergency	0.113273	11,004,350			1,246,496			91
92	Observation Beds (Non-Distinct	0.352530	2,641,933			931,361			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		148,938,483		156,545	24,497,496		29,380	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		148,938,483		156,545	24,497,496		29,380	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T034

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,578,927	110,430,895	0.014298	148,805	2,128	50
51	Recovery Room	304,289	12,505,186	0.024333	17,064	415	51
52	Delivery Room & Labor Room	159,716	3,950,928	0.040425			52
53	Anesthesiology	29,847	22,082,019	0.001352	29,063	39	53
54	Radiology-Diagnostic	831,190	83,348,115	0.009973	204,021	2,035	54
54.01	RADIOLOGY - ULTRASOUND	123,830	18,202,449	0.006803	13,519	92	54.01
56	Radioisotope	241,173	15,815,801	0.015249	19,876	303	56
57	CT Scan	178,976	66,043,361	0.002710	165,372	448	57
59	Cardiac Catheterization	440,543	71,841,197	0.006132	67,693	415	59
60	Laboratory	634,902	117,694,963	0.005394	801,768	4,325	60
62	Whole Blood & Packed Red Blood	54,577	5,028,358	0.010854	54,954	596	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	195,935	20,682,085	0.009474	517,295	4,901	65
66	Physical Therapy	663,427	17,007,087	0.039009	1,833,880	71,538	66
67	Occupational Therapy	96,176	6,491,112	0.014817	1,871,669	27,733	67
68	Speech Pathology	14,309	1,243,086	0.011511	268,255	3,088	68
70	Electroencephalography	91,646	18,357,950	0.004992	882	4	70
71	Medical Supplies Charged to Pat	194,828	27,217,521	0.007158	509,929	3,650	71
72	Impl. Dev. Charged to Patients	276,740	32,258,085	0.008579	62,598	537	72
73	Drugs Charged to Patients	353,600	88,646,774	0.003989	1,938,271	7,732	73
74	Renal Dialysis	9,985	3,595,255	0.002777	416,715	1,157	74
76.97	CARDIAC REHABILITATION	288,141	2,116,710	0.136127			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,041,413	15,567,718	0.066896	740	50	90
91	Emergency	753,394	84,507,934	0.008915			91
92	Observation Beds (Non-Distinct)		11,012,856				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	8,557,564	855,647,445		8,942,369	131,186	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T034

**WORKSHEET D
PART IV**

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology					25,154		25,154	25,154	53
54	Radiology-Diagnostic									54
54.01	RADIOLOGY - ULTRASOUND									54.01
56	Radioisotope									56
57	CT Scan									57
59	Cardiac Catheterization									59
60	Laboratory					7,666		7,666	7,666	60
62	Whole Blood & Packed Red Blood									62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy					13,416		13,416	13,416	65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90	Clinic									90
91	Emergency					195,964		195,964	195,964	91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					242,200		242,200	242,200	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T034

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	110,430,895			148,805				50
51	Recovery Room	12,505,186			17,064				51
52	Delivery Room & Labor Room	3,950,928							52
53	Anesthesiology	22,082,019	0.001139	0.001139	29,063	33			53
54	Radiology-Diagnostic	83,348,115			204,021		339		54
54.01	RADIOLOGY - ULTRASOUND	18,202,449			13,519				54.01
56	Radioisotope	15,815,801			19,876				56
57	CT Scan	66,043,361			165,372				57
59	Cardiac Catheterization	71,841,197			67,693				59
60	Laboratory	117,694,963	0.000065	0.000065	801,768	52			60
62	Whole Blood & Packed Red Blood	5,028,358			54,954				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,682,085	0.000649	0.000649	517,295	336			65
66	Physical Therapy	17,007,087			1,833,880				66
67	Occupational Therapy	6,491,112			1,871,669				67
68	Speech Pathology	1,243,086			268,255				68
70	Electroencephalography	18,357,950			882				70
71	Medical Supplies Charged to Pat	27,217,521			509,929		146		71
72	Impl. Dev. Charged to Patients	32,258,085			62,598				72
73	Drugs Charged to Patients	88,646,774			1,938,271		2,057		73
74	Renal Dialysis	3,595,255			416,715				74
76.97	CARDIAC REHABILITATION	2,116,710							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	15,567,718			740				90
91	Emergency	84,507,934	0.002319	0.002319					91
92	Observation Beds (Non-Distinct	11,012,856							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	855,647,445			8,942,369	421	2,542		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T034

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.194423							50
51	Recovery Room	0.288136							51
52	Delivery Room & Labor Room	0.546966							52
53	Anesthesiology	0.040333							53
54	Radiology-Diagnostic	0.106953	339			36			54
54.01	RADIOLOGY - ULTRASOUND	0.102380							54.01
56	Radioisotope	0.147263							56
57	CT Scan	0.046663							57
59	Cardiac Catheterization	0.079730							59
60	Laboratory	0.107834							60
62	Whole Blood & Packed Red Blood	0.323830							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.188298							65
66	Physical Therapy	0.286898							66
67	Occupational Therapy	0.204756							67
68	Speech Pathology	0.419652							68
70	Electroencephalography	0.053147							70
71	Medical Supplies Charged to Pat	0.453114	146			66			71
72	Impl. Dev. Charged to Patients	0.538060							72
73	Drugs Charged to Patients	0.184401	2,057		3,724	379		687	73
74	Renal Dialysis	0.256225							74
76.97	CARDIAC REHABILITATION	0.763351							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.434019							90
91	Emergency	0.113273							91
92	Observation Beds (Non-Distinct	0.352530							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		2,542		3,724	481		687	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		2,542		3,724	481		687	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,948,151		3,948,151	44,494	88.73	496	44,010	30
31	Intensive Care Unit	648,948		648,948	4,728	137.26	46	6,314	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF	535,787		535,787	5,992	89.42	16	1,431	41
42	Subprovider I								42
43	Nursery	180,005		180,005	1,928	93.36	38	3,548	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	5,312,891		5,312,891	57,142		596	55,303	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0034

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,578,927	110,430,895	0.014298	210,201	3,005	50
51	Recovery Room	304,289	12,505,186	0.024333	21,022	512	51
52	Delivery Room & Labor Room	159,716	3,950,928	0.040425	74,772	3,023	52
53	Anesthesiology	29,847	22,082,019	0.001352	44,995	61	53
54	Radiology-Diagnostic	831,190	83,348,115	0.009973	72,031	718	54
54.01	RADIOLOGY - ULTRASOUND	123,830	18,202,449	0.006803	36,025	245	54.01
56	Radioisotope	241,173	15,815,801	0.015249	32,427	494	56
57	CT Scan	178,976	66,043,361	0.002710	188,681	511	57
59	Cardiac Catheterization	440,543	71,841,197	0.006132	55,455	340	59
60	Laboratory	634,902	117,694,963	0.005394	401,734	2,167	60
62	Whole Blood & Packed Red Blood	54,577	5,028,358	0.010854	14,378	156	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	195,935	20,682,085	0.009474	195,615	1,853	65
66	Physical Therapy	663,427	17,007,087	0.039009	26,252	1,024	66
67	Occupational Therapy	96,176	6,491,112	0.014817	10,826	160	67
68	Speech Pathology	14,309	1,243,086	0.011511	8,127	94	68
70	Electroencephalography	91,646	18,357,950	0.004992	1,722	9	70
71	Medical Supplies Charged to Pat	194,828	27,217,521	0.007158	161,011	1,153	71
72	Impl. Dev. Charged to Patients	276,740	32,258,085	0.008579	18,652	160	72
73	Drugs Charged to Patients	353,600	88,646,774	0.003989	675,230	2,693	73
74	Renal Dialysis	9,985	3,595,255	0.002777	42,660	118	74
76.97	CARDIAC REHABILITATION	288,141	2,116,710	0.136127			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,041,413	15,567,718	0.066896	366	24	90
91	Emergency	753,394	84,507,934	0.008915	199,447	1,778	91
92	Observation Beds (Non-Distinct	431,873	11,012,856	0.039215	9,138	358	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	8,989,437	855,647,445		2,500,767	20,656	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Nursing School Post-Stepdown Adjustments 1A	Nursing School 1	Allied Health Post-Stepdown Adjustments 2A	Allied Health Cost 2	All Other Medical Education Cost 3	Swing-Bed Adjustment Amount (see instructions) 4	Total Costs (sum of cols. 1 through 3 minus col 4.) 5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)				41,684			41,684	30
31	Intensive Care Unit				22,998			22,998	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)				64,682			64,682	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	44,494	0.94	496	466	30
31	Intensive Care Unit	4,728	4.86	46	224	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF	5,992		16		41
42	Subprovider I					42
43	Nursery	1,928		38		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	57,142		596	690	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0034

**WORKSHEET D
PART IV**

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology					25,154		25,154	25,154	53
54	Radiology-Diagnostic									54
54.01	RADIOLOGY - ULTRASOUND									54.01
56	Radioisotope									56
57	CT Scan									57
59	Cardiac Catheterization									59
60	Laboratory					7,666		7,666	7,666	60
62	Whole Blood & Packed Red Blood									62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy					13,416		13,416	13,416	65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90	Clinic									90
91	Emergency					195,964		195,964	195,964	91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					242,200		242,200	242,200	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0034

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	110,430,895			210,201				50
51	Recovery Room	12,505,186			21,022				51
52	Delivery Room & Labor Room	3,950,928			74,772				52
53	Anesthesiology	22,082,019	0.001139	0.001139	44,995	51			53
54	Radiology-Diagnostic	83,348,115			72,031				54
54.01	RADIOLOGY - ULTRASOUND	18,202,449			36,025				54.01
56	Radioisotope	15,815,801			32,427				56
57	CT Scan	66,043,361			188,681				57
59	Cardiac Catheterization	71,841,197			55,455				59
60	Laboratory	117,694,963	0.000065	0.000065	401,734	26			60
62	Whole Blood & Packed Red Blood	5,028,358			14,378				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,682,085	0.000649	0.000649	195,615	127			65
66	Physical Therapy	17,007,087			26,252				66
67	Occupational Therapy	6,491,112			10,826				67
68	Speech Pathology	1,243,086			8,127				68
70	Electroencephalography	18,357,950			1,722				70
71	Medical Supplies Charged to Pat	27,217,521			161,011				71
72	Impl. Dev. Charged to Patients	32,258,085			18,652				72
73	Drugs Charged to Patients	88,646,774			675,230				73
74	Renal Dialysis	3,595,255			42,660				74
76.97	CARDIAC REHABILITATION	2,116,710							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	15,567,718			366				90
91	Emergency	84,507,934	0.002319	0.002319	199,447	463			91
92	Observation Beds (Non-Distinct	11,012,856			9,138				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	855,647,445			2,500,767	667			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0034

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.194423							50
51	Recovery Room	0.288136							51
52	Delivery Room & Labor Room	0.546966							52
53	Anesthesiology	0.040333							53
54	Radiology-Diagnostic	0.106953							54
54.01	RADIOLOGY - ULTRASOUND	0.102380							54.01
56	Radioisotope	0.147263							56
57	CT Scan	0.046663							57
59	Cardiac Catheterization	0.079730							59
60	Laboratory	0.107834							60
62	Whole Blood & Packed Red Blood	0.323830							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.188298							65
66	Physical Therapy	0.286898							66
67	Occupational Therapy	0.204756							67
68	Speech Pathology	0.419652							68
70	Electroencephalography	0.053147							70
71	Medical Supplies Charged to Pat	0.453114							71
72	Impl. Dev. Charged to Patients	0.538060							72
73	Drugs Charged to Patients	0.184401							73
74	Renal Dialysis	0.256225							74
76.97	CARDIAC REHABILITATION	0.763351							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.434019							90
91	Emergency	0.113273							91
92	Observation Beds (Non-Distinct	0.352530							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T034

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,578,927	110,430,895	0.014298	15,162	217	50
51	Recovery Room	304,289	12,505,186	0.024333			51
52	Delivery Room & Labor Room	159,716	3,950,928	0.040425			52
53	Anesthesiology	29,847	22,082,019	0.001352			53
54	Radiology-Diagnostic	831,190	83,348,115	0.009973			54
54.01	RADIOLOGY - ULTRASOUND	123,830	18,202,449	0.006803	913	6	54.01
56	Radioisotope	241,173	15,815,801	0.015249			56
57	CT Scan	178,976	66,043,361	0.002710			57
59	Cardiac Catheterization	440,543	71,841,197	0.006132			59
60	Laboratory	634,902	117,694,963	0.005394	5,326	29	60
62	Whole Blood & Packed Red Blood	54,577	5,028,358	0.010854			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	195,935	20,682,085	0.009474	3,276	31	65
66	Physical Therapy	663,427	17,007,087	0.039009	8,515	332	66
67	Occupational Therapy	96,176	6,491,112	0.014817	8,402	124	67
68	Speech Pathology	14,309	1,243,086	0.011511			68
70	Electroencephalography	91,646	18,357,950	0.004992			70
71	Medical Supplies Charged to Pat	194,828	27,217,521	0.007158	4,244	30	71
72	Impl. Dev. Charged to Patients	276,740	32,258,085	0.008579			72
73	Drugs Charged to Patients	353,600	88,646,774	0.003989	25,399	101	73
74	Renal Dialysis	9,985	3,595,255	0.002777	11,340	31	74
76.97	CARDIAC REHABILITATION	288,141	2,116,710	0.136127			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,041,413	15,567,718	0.066896			90
91	Emergency	753,394	84,507,934	0.008915			91
92	Observation Beds (Non-Distinct		11,012,856				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	8,557,564	855,647,445		82,577	901	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T034

**WORKSHEET D
PART IV**

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology					25,154		25,154	25,154	53
54	Radiology-Diagnostic									54
54.01	RADIOLOGY - ULTRASOUND									54.01
56	Radioisotope									56
57	CT Scan									57
59	Cardiac Catheterization									59
60	Laboratory					7,666		7,666	7,666	60
62	Whole Blood & Packed Red Blood									62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy					13,416		13,416	13,416	65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90	Clinic									90
91	Emergency					195,964		195,964	195,964	91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					242,200		242,200	242,200	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T034

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	110,430,895			15,162				50
51	Recovery Room	12,505,186							51
52	Delivery Room & Labor Room	3,950,928							52
53	Anesthesiology	22,082,019	0.001139	0.001139					53
54	Radiology-Diagnostic	83,348,115							54
54.01	RADIOLOGY - ULTRASOUND	18,202,449			913				54.01
56	Radioisotope	15,815,801							56
57	CT Scan	66,043,361							57
59	Cardiac Catheterization	71,841,197							59
60	Laboratory	117,694,963	0.000065	0.000065	5,326				60
62	Whole Blood & Packed Red Blood	5,028,358							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,682,085	0.000649	0.000649	3,276	2			65
66	Physical Therapy	17,007,087			8,515				66
67	Occupational Therapy	6,491,112			8,402				67
68	Speech Pathology	1,243,086							68
70	Electroencephalography	18,357,950							70
71	Medical Supplies Charged to Pat	27,217,521			4,244				71
72	Impl. Dev. Charged to Patients	32,258,085							72
73	Drugs Charged to Patients	88,646,774			25,399				73
74	Renal Dialysis	3,595,255			11,340				74
76.97	CARDIAC REHABILITATION	2,116,710							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	15,567,718							90
91	Emergency	84,507,934	0.002319	0.002319					91
92	Observation Beds (Non-Distinct	11,012,856							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	855,647,445			82,577	2			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T034

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.194423							50
51	Recovery Room	0.288136							51
52	Delivery Room & Labor Room	0.546966							52
53	Anesthesiology	0.040333							53
54	Radiology-Diagnostic	0.106953							54
54.01	RADIOLOGY - ULTRASOUND	0.102380							54.01
56	Radioisotope	0.147263							56
57	CT Scan	0.046663							57
59	Cardiac Catheterization	0.079730							59
60	Laboratory	0.107834							60
62	Whole Blood & Packed Red Blood	0.323830							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.188298							65
66	Physical Therapy	0.286898							66
67	Occupational Therapy	0.204756							67
68	Speech Pathology	0.419652							68
70	Electroencephalography	0.053147							70
71	Medical Supplies Charged to Pat	0.453114							71
72	Impl. Dev. Charged to Patients	0.538060							72
73	Drugs Charged to Patients	0.184401							73
74	Renal Dialysis	0.256225							74
76.97	CARDIAC REHABILITATION	0.763351							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.434019							90
91	Emergency	0.113273							91
92	Observation Beds (Non-Distinct	0.352530							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0034

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	44,494	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	44,494	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	39,627	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	18,218	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	35,492,334	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	35,492,334	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	35,492,334	37

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0034

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					797.69	38	
39	Program general inpatient routine service cost (line 9 x line 38)					14,532,316	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40	
41	Total Program general inpatient routine service cost (line 39 + line 40)					14,532,316	41	
42	Nursery (Titles V and XIX only)						42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	7,684,565	4,728	1,625.33	1,695	2,754,934	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					24,003,980	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					41,291,230	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,874,502	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,140,132	51
52	Total Program excludable cost (sum of lines 50 and 51)					3,014,634	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					38,276,596	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0034

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					4,867	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					797.69	88
89	Observation bed cost (line 87 x line 88) (see instructions)					3,882,357	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	3,948,151	35,492,334	0.111240	3,882,357	431,873	90
91	Nursing School						91
92	Allied Health	41,684	35,492,334	0.001174	3,882,357	4,558	92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T034

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,992	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,992	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	5,992	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,996	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	5,060,047	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,060,047	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,060,047	37

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T034

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)	844.47	38
39	Program general inpatient routine service cost (line 9 x line 38)	3,374,502	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	3,374,502	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,027,361	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	5,401,863	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	357,322	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	131,607	51
52	Total Program excludable cost (sum of lines 50 and 51)	488,929	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	4,912,934	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0034

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	44,494	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	44,494	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	39,627	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	496	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	1,928	15
16	Nursery days (title V or XIX only)	38	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	35,481,367	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	35,481,367	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	35,481,367	37

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0034

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					797.44	38	
39	Program general inpatient routine service cost (line 9 x line 38)					395,530	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40	
41	Total Program general inpatient routine service cost (line 39 + line 40)					395,530	41	
42	Nursery (Titles V and XIX only)	2,435,726	1,928	1,263.34	38	48,007	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	7,679,947	4,728	1,624.35	46	74,720	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					461,501	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					979,758	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					54,562	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					21,323	51
52	Total Program excludable cost (sum of lines 50 and 51)					75,885	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					903,873	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0034

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					4.867	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T034

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,992	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,992	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	5,992	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	16	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	5,060,047	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,060,047	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,060,047	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T034

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)	844.47	38
39	Program general inpatient routine service cost (line 9 x line 38)	13,512	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	13,512	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	17,908	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	31,420	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,431	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	903	51
52	Total Program excludable cost (sum of lines 50 and 51)	2,334	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	29,086	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

KPMG LLP Compu-Max 2552-10

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0034

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		23,701,395		30
31	Intensive Care Unit		4,481,968		31
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.194498	14,919,510	2,901,815	50
51	Recovery Room	0.288136	1,830,226	527,354	51
52	Delivery Room & Labor Room	0.546966	12,360	6,760	52
53	Anesthesiology	0.040333	3,202,785	129,178	53
54	Radiology-Diagnostic	0.107084	5,296,566	567,177	54
54.01	RADIOLOGY - ULTRASOUND	0.102380	1,380,944	141,381	54.01
56	Radioisotope	0.147263	1,547,890	227,947	56
57	CT Scan	0.046663	8,434,285	393,569	57
59	Cardiac Catheterization	0.079825	12,399,826	989,816	59
60	Laboratory	0.107965	16,411,850	1,771,905	60
62	Whole Blood & Packed Red Blood Cells	0.323830	1,420,297	459,935	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.188378	8,179,015	1,540,746	65
66	Physical Therapy	0.286898	1,862,284	534,286	66
67	Occupational Therapy	0.204756	782,593	160,241	67
68	Speech Pathology	0.419652	225,615	94,680	68
70	Electroencephalography	0.053304	2,050,940	109,323	70
71	Medical Supplies Charged to Patients	0.453114	5,279,347	2,392,146	71
72	Impl. Dev. Charged to Patients	0.538060	9,844,958	5,297,178	72
73	Drugs Charged to Patients	0.184401	18,706,179	3,449,438	73
74	Renal Dialysis	0.256225	1,806,571	462,889	74
76.97	CARDIAC REHABILITATION	0.763351	176,703	134,886	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.436313	149,472	65,217	90
91	Emergency	0.113273	11,191,794	1,267,728	91
92	Observation Beds (Non-Distinct Part)	0.352530	1,073,340	378,385	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		128,185,350	24,003,980	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		128,185,350		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T034

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
41	Subprovider - IRF		4,183,610		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.194498	148,805	28,942	50
51	Recovery Room	0.288136	17,064	4,917	51
52	Delivery Room & Labor Room	0.546966			52
53	Anesthesiology	0.040333	29,063	1,172	53
54	Radiology-Diagnostic	0.107084	204,021	21,847	54
54.01	RADIOLOGY - ULTRASOUND	0.102380	13,519	1,384	54.01
56	Radioisotope	0.147263	19,876	2,927	56
57	CT Scan	0.046663	165,372	7,717	57
59	Cardiac Catheterization	0.079825	67,693	5,404	59
60	Laboratory	0.107965	801,768	86,563	60
62	Whole Blood & Packed Red Blood Cells	0.323830	54,954	17,796	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.188378	517,295	97,447	65
66	Physical Therapy	0.286898	1,833,880	526,137	66
67	Occupational Therapy	0.204756	1,871,669	383,235	67
68	Speech Pathology	0.419652	268,255	112,574	68
70	Electroencephalography	0.053304	882	47	70
71	Medical Supplies Charged to Patients	0.453114	509,929	231,056	71
72	Impl. Dev. Charged to Patients	0.538060	62,598	33,681	72
73	Drugs Charged to Patients	0.184401	1,938,271	357,419	73
74	Renal Dialysis	0.256225	416,715	106,773	74
76.97	CARDIAC REHABILITATION	0.763351			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.436313	740	323	90
91	Emergency	0.113273			91
92	Observation Beds (Non-Distinct Part)	0.352530			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		8,942,369	2,027,361	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		8,942,369		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0034

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		632,946		30
31	Intensive Care Unit		75,360		31
41	Subprovider - IRF				41
43	Nursery		106,859		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.194423	210,201	40,868	50
51	Recovery Room	0.288136	21,022	6,057	51
52	Delivery Room & Labor Room	0.546966	74,772	40,898	52
53	Anesthesiology	0.040333	44,995	1,815	53
54	Radiology-Diagnostic	0.106953	72,031	7,704	54
54.01	RADIOLOGY - ULTRASOUND	0.102380	36,025	3,688	54.01
56	Radioisotope	0.147263	32,427	4,775	56
57	CT Scan	0.046663	188,681	8,804	57
59	Cardiac Catheterization	0.079730	55,455	4,421	59
60	Laboratory	0.107834	401,734	43,321	60
62	Whole Blood & Packed Red Blood Cells	0.323830	14,378	4,656	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.188298	195,615	36,834	65
66	Physical Therapy	0.286898	26,252	7,532	66
67	Occupational Therapy	0.204756	10,826	2,217	67
68	Speech Pathology	0.419652	8,127	3,411	68
70	Electroencephalography	0.053147	1,722	92	70
71	Medical Supplies Charged to Patients	0.453114	161,011	72,956	71
72	Impl. Dev. Charged to Patients	0.538060	18,652	10,036	72
73	Drugs Charged to Patients	0.184401	675,230	124,513	73
74	Renal Dialysis	0.256225	42,660	10,931	74
76.97	CARDIAC REHABILITATION	0.763351			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.434019	366	159	90
91	Emergency	0.113273	199,447	22,592	91
92	Observation Beds (Non-Distinct Part)	0.352530	9,138	3,221	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,500,767	461,501	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,500,767		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T034

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
41	Subprovider - IRF		17,280		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.194423	15,162	2,948	50
51	Recovery Room	0.288136			51
52	Delivery Room & Labor Room	0.546966			52
53	Anesthesiology	0.040333			53
54	Radiology-Diagnostic	0.106953			54
54.01	RADIOLOGY - ULTRASOUND	0.102380	913	93	54.01
56	Radioisotope	0.147263			56
57	CT Scan	0.046663			57
59	Cardiac Catheterization	0.079730			59
60	Laboratory	0.107834	5,326	574	60
62	Whole Blood & Packed Red Blood Cells	0.323830			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.188298	3,276	617	65
66	Physical Therapy	0.286898	8,515	2,443	66
67	Occupational Therapy	0.204756	8,402	1,720	67
68	Speech Pathology	0.419652			68
70	Electroencephalography	0.053147			70
71	Medical Supplies Charged to Patients	0.453114	4,244	1,923	71
72	Impl. Dev. Charged to Patients	0.538060			72
73	Drugs Charged to Patients	0.184401	25,399	4,684	73
74	Renal Dialysis	0.256225	11,340	2,906	74
76.97	CARDIAC REHABILITATION	0.763351			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.434019			90
91	Emergency	0.113273			91
92	Observation Beds (Non-Distinct Part)	0.352530			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		82,577	17,908	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		82,577		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	8,848,499			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	29,181,866			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	344,683			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	166.67			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0397			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1445			31
32	Sum of lines 30 and 31	0.1842			32
33	Allowable disproportionate share percentage (see instructions)	0.0472			33
34	Disproportionate share adjustment (see instructions)	448,758			34
		Prior to		On or after	
		October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000208307	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,219,956		1,409,550	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	307,496		1,054,266	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,361,762			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	40,185,568			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	40,185,568			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	3,230,010			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	5,171			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).	25,363			57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	36,421			58
59	Total (sum of amounts on lines 49 through 58)	43,482,533			59
60	Primary payer payments	3,660			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	43,478,873			61
62	Deductibles billed to program beneficiaries	3,774,700			62
63	Coinsurance billed to program beneficiaries	274,609			63
64	Allowable bad debts (see instructions)	614,903			64
65	Adjusted reimbursable bad debts (see instructions)	399,687			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	96,779			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	39,829,251			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (ADD BACK GME REIMBURSEMENT)				70
70.01	OTHER ADJ (NO DESC ENTERED)				70.01
70.02	OTHER ADJUSTMENTS PER PSR				70.02
70.93	HVBP payment adjustment amount (see instructions)	325,320			70.93
70.94	HRR adjustment amount (see instructions)	-721,147			70.94
71	Amount due provider (see instructions)	39,433,424			71
71.01	Sequestration adjustment (see instructions)	788,668			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	38,442,540			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	202,216			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	604,000			75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1		
100	HSP bonus amount (see instructions)				100
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0034

**WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	29,380			1
2	Medical and other services reimbursed under OPPS (see instructions)	24,465,107			2
3	OPPS payments	25,340,449			3
4	Outlier payment (see instructions)	13,406			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	32,389			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	29,380			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	156,545			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	156,545			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	156,545			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	127,165			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	29,380			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	25,386,244			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	4,707,118			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	20,708,506			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	20,708,506			30
31	Primary payer payments	13,518			31
32	Subtotal (line 30 minus line 31)	20,694,988			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	890,368			34
35	Adjusted reimbursable bad debts (see instructions)	578,739			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	480,366			36
37	Subtotal (see instructions)	21,273,727			37
38	MSP-LCC reconciliation amount from PS&R	278			38
39	Other adjustments (FDO LOSS)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	21,273,449			40
40.01	Sequestration adjustment (see instructions)	425,469			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	20,696,603			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	151,377			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T034

**WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	687			1
2	Medical and other services reimbursed under OPPS (see instructions)	481			2
3	OPPS payments	506			3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	687			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	3,724			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	3,724			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	3,724			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	3,037			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	687			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	506			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	12			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,181			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	1,181			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	1,181			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	1,181			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	1,181			40
40.01	Sequestration adjustment (see instructions)	24			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	1,214			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-57			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0034

**WORKSHEET E-1
PART I**

Check Hospital SUB (Other)
Applicable IPF SNF
Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		38,029,640		20,249,704
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero		412,900		446,899
3	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)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		38,442,540		20,696,603
	TO BE COMPLETED BY CONTRACTOR				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.02			6.02
7	Total Medicare program liability (see instructions)				7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)
					8

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

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-T034

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
Applicable IPF SNF
Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		6,973,183		1,214
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				1
3	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)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,973,183		1,214
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.02			6.02
7	Total Medicare program liability (see instructions)				7
8	Name of Contractor		Contractor Number	NPR Date (Month/Day/Year)	8

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

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T034

**WORKSHEET E-3
PART III**

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	6,989,307		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.020000		2
3	Inpatient Rehabilitation LIP payments (see instructions)	171,238		3
4	Outlier payments	44,909		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	16,416,438		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	7,205,454		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	7,205,454		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	7,205,454		19
20	Deductibles	27,732		20
21	Subtotal (line 19 minus line 20)	7,177,722		21
22	Coinsurance	53,275		22
23	Subtotal (line 21 minus line 22)	7,124,447		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	47,835		24
25	Adjusted reimbursable bad debts (see instructions)	31,093		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	32,214		26
27	Subtotal (sum of lines 23 and 25)	7,155,540		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)	421		29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	7,155,961		32
32.01	Sequestration adjustment (see instructions)	143,119		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	6,973,183		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	39,659		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	49,399		36

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0034

WORKSHEET E-3
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	1,436,775		8
9	2,500,767		9
10			10
11			11
12	3,937,542		12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	3,937,542		16
17	3,937,542		17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26	1,357		26
27	1,357		27
28			28
29	1,357		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	1,357		31
32			32
33			33
34			34
35			35
36	1,357		36
37	-1,357		37
38			38
39			39
40			40
41			41
42			42
43			43

KPMG LLP Compu-Max 2552-10

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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	2,598				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	30,864,644				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	7,093,511				7
8	Prepaid expenses	1,818,617				8
9	Other current assets					9
10	Due from other funds	1,407,035				10
11	Total current assets (sum of lines 1-10)	41,186,405				11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	141,516,597				15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	141,516,597				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	6,706,274				34
35	Total other assets (sum of lines 31-34)	6,706,274				35
36	Total assets (sum of lines 11, 30 and 35)	189,409,276				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	977,598				37
38	Salaries, wages and fees payable	6,870,592				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	365,178				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	2,447,908				44
45	Total current liabilities (sum of lines 37 thru 44)	10,661,276				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	168,301				47
48	Unsecured loans					48
49	Other long term liabilities	16,405,890				49
50	Total long term liabilities (sum of lines 46 thru 49)	16,574,191				50
51	Total liabilities (sum of lines 45 and 50)	27,235,467				51
CAPITAL ACCOUNTS						
52	General fund balance	162,173,809				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	162,173,809				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	189,409,276				60

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		156,771,614			1
2	Net income (loss) (from Worksheet G-3, line 29)		25,304,076			2
3	Total (sum of line 1 and line 2)		182,075,690			3
4	Additions (credit adjustments) (specify)					4
5	TRANSFER OF FUNDS					5
6	CONTRIBUTIONS	131,119				6
7	RELEASE RESTRICTED ASSETS	98,000				7
8						8
9						9
10	Total additions (sum of lines 4-9)		229,119			10
11	Subtotal (line 3 plus line 10)		182,304,809			11
12	Deductions (debit adjustments) (specify)					12
13	TRANSFER FUNDS	19,975,000				13
14	ASSETS RELEASED	156,000				14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		20,131,000			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		162,173,809			19

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

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	63,448,684		63,448,684	1
2	Subprovider IPF				2
3	Subprovider IRF	6,552,988		6,552,988	3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	70,001,672		70,001,672	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	10,995,542		10,995,542	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	10,995,542		10,995,542	16
17	Total inpatient routine care services (sum of lines 10 and 16)	80,997,214		80,997,214	17
18	Ancillary services	297,421,178		297,421,178	18
19	Outpatient services		552,611,337	552,611,337	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		4,452,986	4,452,986	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	378,418,392	557,064,323	935,482,715	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		245,926,432	29
30	Add (specify)			30
31	BAD DEBTS			31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		245,926,432	43

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	935,482,715	1
2	Less contractual allowances and discounts on patients' accounts	666,910,825	2
3	Net patient revenues (line 1 minus line 2)	268,571,890	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	245,926,432	4
5	Net income from service to patients (line 3 minus line 4)	22,645,458	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	2,855	6
7	Income from investments	137,576	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	1,061,064	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	3,388	21
22	Rental of hospitial space	999,252	22
23	Governmental appropriations	1,439	23
24	Other (OTHER OPERATING INCOME)	146,708	24
24.01	Other (CARDIO INCOME)		24.01
24.02	Other (RELEASED TEMP ASSETS)	47,814	24.02
24.03	Other (LAB INCOME)	105,652	24.03
24.04	Other (THERAPY INCOME)	48,872	24.04
24.05	Other (CLASSES)	90,377	24.05
24.06	Other (PHOTOGRAPHIC FEES)	1,420	24.06
24.07	Other (GAIN ON SALE OF ASSETS)	12,201	24.07
24.08	Other (ROUNDING)		24.08
25	Total other income (sum of lines 6-24)	2,658,618	25
26	Total (line 5 plus line 25)	25,304,076	26
29	Net income (or loss) for the period (line 26 minus line 28)	25,304,076	29

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7313

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	694,637	494,075			151,616	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	818,081		77,127		101,288	6
7	Physical Therapy	434,376			71,920		7
8	Occupational Therapy	128,574			132,299		8
9	Speech Pathology	14,047			28,935		9
10	Medical Social Services	14,379					10
11	Home Health Aide	108,566		18,766			11
12	Supplies (see instructions)					36,535	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	2,212,660	494,075	95,893	233,154	289,439	24

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7313

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	1,340,328	-350,441	989,887	-325	989,562	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	996,496		996,496		996,496	6
7	Physical Therapy	506,296		506,296		506,296	7
8	Occupational Therapy	260,873		260,873		260,873	8
9	Speech Pathology	42,982		42,982		42,982	9
10	Medical Social Services	14,379		14,379		14,379	10
11	Home Health Aide	127,332		127,332		127,332	11
12	Supplies (see instructions)	36,535		36,535		36,535	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	3,325,221	-350,441	2,974,780	-325	2,974,455	24

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

KPMG LLP Compu-Max 2552-10

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7313

**WORKSHEET H-1
PART I**

		CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE
		0	1	2	3
GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures				1
2	Capital Related-Movable Equipment				2
3	Plant Operation & Maintenance				3
4	Transportation (see instructions)				4
5	Administrative and General	989,562			5
HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	996,496			6
7	Physical Therapy	506,296			7
8	Occupational Therapy	260,873			8
9	Speech Pathology	42,982			9
10	Medical Social Services	14,379			10
11	Home Health Aide	127,332			11
12	Supplies (see instructions)	36,535			12
13	Drugs				13
14	DME				14
HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services				15
16	Respiratory Therapy				16
17	Private Duty Nursing				17
18	Clinic				18
19	Health Promotion Activities				19
20	Day Care Program				20
21	Home Delivered Means Program				21
22	Homemaker Service				22
23	All Others				23
23.50	Telemedicine				23.50
24	Totals (sum of lines 1-23)	2,974,455			24

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7313

**WORKSHEET H-1
PART I**

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		989,562	989,562		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		996,496	493,816	1,490,312	6
7	Physical Therapy		506,296	250,897	757,193	7
8	Occupational Therapy		260,873	129,276	390,149	8
9	Speech Pathology		42,982	21,300	64,282	9
10	Medical Social Services		14,379	7,126	21,505	10
11	Home Health Aide		127,332	63,100	190,432	11
12	Supplies (see instructions)		36,535	24,047	60,582	12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		2,974,455		2,974,455	24

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 15-7313

**WORKSHEET H-1
PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
GENERAL SERVICE COST CENTERS								
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-989,562	1,996,884	5
HHA REIMBURSABLE SERVICES								
6	Skilled Nursing Care						996,496	6
7	Physical Therapy						506,296	7
8	Occupational Therapy						260,873	8
9	Speech Pathology						42,982	9
10	Medical Social Services						14,379	10
11	Home Health Aide						127,332	11
12	Supplies (see instructions)					11,991	48,526	12
13	Drugs							13
14	DME							14
HHA NONREIMBURSABLE SERVICES								
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-977,571	1,996,884	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						989,562	25
26	Unit Cost Multiplier						0.495553	26

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7313

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINTENACE OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
1	Administrative and General				336,143	34,106	15,586	1
2	Skilled Nursing Care	1,490,312						2
3	Physical Therapy	757,193						3
4	Occupational Therapy	390,149						4
5	Speech Pathology	64,282						5
6	Medical Social Services	21,505						6
7	Home Health Aide	190,432						7
8	Supplies	60,582						8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	2,974,455			336,143	34,106	15,586	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7313

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	PURCHASING RECEIVING & STORES 5.02	PATIENT REGISTRATN 5.03	PATIENT ACCOUNTING 5.04	SUBTOTAL (cols.0-4) 4A	ADMINI- STRATIVE & GENERAL 5.05	MAIN- TENANCE & REPAIRS 6	
1	Administrative and General	4,856	10,180	13,582	414,453	60,958		1
2	Skilled Nursing Care				1,490,312	219,195		2
3	Physical Therapy				757,193	111,368		3
4	Occupational Therapy				390,149	57,383		4
5	Speech Pathology				64,282	9,455		5
6	Medical Social Services				21,505	3,163		6
7	Home Health Aide				190,432	28,009		7
8	Supplies				60,582	8,910		8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	4,856	10,180	13,582	3,388,908	498,441		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7313

**WORKSHEET H-2
PART I**

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

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7313

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	NONPHYSIC. ANESTHET. 19	
1	Administrative and General				16,227			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)				16,227			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7313

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS	
		23	24	25	26	27	28	
1	Administrative and General		491,638		491,638			1
2	Skilled Nursing Care		1,709,507		1,709,507	246,330	1,955,837	2
3	Physical Therapy		868,561		868,561	125,154	993,715	3
4	Occupational Therapy		447,532		447,532	64,486	512,018	4
5	Speech Pathology		73,737		73,737	10,625	84,362	5
6	Medical Social Services		24,668		24,668	3,554	28,222	6
7	Home Health Aide		218,441		218,441	31,476	249,917	7
8	Supplies		69,492		69,492	10,013	79,505	8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		3,903,576		3,903,576	491,638	3,903,576	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.144093		21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7313

**WORKSHEET H-2
PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINTENACE OF PERSONNEL NUMBER OF FTES	NONPATIENT TELEPHONES NUMBER OF PHONES	PURCHASING RECEIVING & STORES SUPPLY EXPENSE	
		1	2	4	4.01	5.01	5.02	
1	Administrative and General			2,212,660	2,697	27	9,708	1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)			2,212,660	2,697	27	9,708	20
21	Total cost to be allocated			336,143	34,106	15,586	4,856	21
22	Unit Cost Multiplier			0.151918		577.259259		22
22	Unit Cost Multiplier				12.645903		0.500206	22

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ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7313

**WORKSHEET H-2
PART II**

	HHA COST CENTER	PATIENT REGISTRATN GROSS REVENUE	PATIENT ACCOUNTING GROSS REVENUE	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.03	5.04	4A.05	5.05	6	7	
1	Administrative and General	4,452,986	4,452,986		414,453			1
2	Skilled Nursing Care				1,490,312			2
3	Physical Therapy				757,193			3
4	Occupational Therapy				390,149			4
5	Speech Pathology				64,282			5
6	Medical Social Services				21,505			6
7	Home Health Aide				190,432			7
8	Supplies				60,582			8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	4,452,986	4,452,986		3,388,908			20
21	Total cost to be allocated	10,180	13,582		498,441			21
22	Unit Cost Multiplier	0.002286						22
22	Unit Cost Multiplier		0.003050		0.147080			22

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ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7313

WORKSHEET H-2
PART II

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

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7313

**WORKSHEET H-2
PART II**

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY SUPPLY EXPENSE	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	
		14	15	16	17	19	23	
1	Administrative and General			4,452,986				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)			4,452,986				20
21	Total cost to be allocated			16,227				21
22	Unit Cost Multiplier			0.003644				22
22	Unit Cost Multiplier							22

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ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 15-7313

**WORKSHEET H-3
PARTS I & II**

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	1,955,837		1,955,837	14,424	135.60	1
2	Physical Therapy	3	993,715		993,715	7,238	137.29	2
3	Occupational Therapy	4	512,018		512,018	2,960	172.98	3
4	Speech Pathology	5	84,362		84,362	523	161.30	4
5	Medical Social Services	6	28,222		28,222	156	180.91	5
6	Home Health Aide	7	249,917		249,917	3,510	71.20	6
7	Total (sum of lines 1-6)		3,824,071		3,824,071	28,811		7

Limitation Cost Computation						
				Program Visits		
				PART B		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	23844		8,814		8
9	Physical Therapy	23844		4,504		9
10	Occupational Therapy	23844		1,961		10
11	Speech Pathology	23844		376		11
12	Medical Social Services	23844		111		12
13	Home Health Aide	23844		2,550		13
14	Total (sum of lines 8-13)			18,316		14

Supplies and Drugs Cost Computations								
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8	79,505		79,505	260,351	0.305376	15
16	Cost of Drugs	9						16

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.286898			col. 2, line 2	1
2	Occupational Therapy	67	0.204756			col. 2, line 3	2
3	Speech Pathology	68	0.419652			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.453114			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.184401			col. 2, line 16	5

KPMG LLP Compu-Max 2552-10

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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 15-7313

**WORKSHEET H-3
PARTS I & II**

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
		Part B			Part B			Total	
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		8,814			1,195,178		1,195,178	1
2	Physical Therapy		4,504			618,354		618,354	2
3	Occupational Therapy		1,961			339,214		339,214	3
4	Speech Pathology		376			60,649		60,649	4
5	Medical Social Services		111			20,081		20,081	5
6	Home Health Aide		2,550			181,560		181,560	6
7	Total (sum of lines 1-6)		18,316			2,415,036		2,415,036	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services				
		Part B			Part B				
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6	7	8	9	10	11		
15	Cost of Medical Supplies			234,817			71,707		15
16	Cost of Drugs								16

KPMG LLP Compu-Max 2552-10

ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 15-7313

**WORKSHEET H-4
PARTS I & II**

Check applicable box: Title V Title XVIII Title XIX

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		2,073,362	11
12	Total PPS Reimbursement - Full Episodes with Outliers		432,088	12
13	Total PPS Reimbursement - LUPA Episodes		23,648	13
14	Total PPS Reimbursement - PEP Episodes		11,198	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		13,178	15
16	Total PPS Outlier Reimbursement - PSP Episodes		1,999	16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		2,555,473	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		2,555,473	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		2,555,473	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		2,555,473	29
30	Other adjustments (see instructions) (specify)		984	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		2,556,457	31
31.01	Sequestration adjustment (see instructions)		51,129	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		2,505,328	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

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ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES HHA CCN: 15-7313

WORKSHEET H-5

	DESCRIPTION	Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1	2	3	4	
1	Total interim payments paid to provider				2,505,328	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.					2
3	List separately each retroactive lump sum adjustment 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)	.01				3.01
		.02				3.02
	Program	.03				3.03
	To	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	To	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				2,505,328	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01				5.01
		.02				5.02
	Program	.03				5.03
	To	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01				6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	Name of Contractor	Contractor Number		NPR Date: Month, Day, Year		8

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

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0034

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	3,093,458	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	19,001	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	122.28	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0397	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1445	8
9	Sum of lines 7 and 8	0.1842	9
10	Allowable disproportionate share percentage (see instructions)	0.0380	10
11	Disproportionate share adjustment (see instructions)	117,551	11
12	Total prospective capital payments (see instructions)	3,230,010	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ST. MARY MEDICAL CENTER, INC. Provider CCN: 15-0034	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 08:04 Version: 2018.04 (09/26/2018)
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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0034

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

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