ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/20/2015 Time: 11:20 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-70,497	30,362	-37,206		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						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		-70,497	30,362	-37,206		200

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

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control
number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,
search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions
for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence

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: 111 E. SPRING ST.	P.O. Box:			1
2	City: STREATOR	State: IL	ZIP Code: 61364	County: LASALLE	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'S HOSPITAL	14-0026	99914	1	05 / 23 / 1966	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 06 / 30 / 2015							20
21	Type of control (see instructions)	1								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)	N	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.	551				20	193	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.							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.	2		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.	2		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		37
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: 07 / 01 / 2014	Ending: 06 / 30 / 2015	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

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

Inpatient Psychiatric Faciltiy PPS

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118

		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	51,845	403,750	343,076	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	Y	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

Transplant Center Information

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

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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		140

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

141	Name: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name:	Contractor's Number:	141
142	Street: 4936 LAVERNA RD.	P.O. Box: 19456		142
143	City: SPRINGFIELD	State: IL	ZIP Code: 62794	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.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			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.	Y			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 transitional factor. (see instructions)	0.50			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10 / 01 / 2012	09 / 30 / 2013	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. (see instructions)			N	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/16/2015	Y	09/16/2015	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

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

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

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

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

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

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

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

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render servcies 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: JOSH	Last name: WIRTH	Title: ACCOUNTING	41
42	Employer: HSHS ST MARY'S			42
43	Phone number: 815-673-2311	E-mail Address: JOSHUA.WIRTH@HSHS.ORG		43

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	86	32,850			2,987	663	4,455	1
2	HMO and other (see instructions)						344	8		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									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)		86	32,850			2,987	663	4,455	7
8	Intensive Care Unit	31	8	2,920			492	93	884	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								13
14	Total (see instructions)		94	35,770			3,479	756	5,339	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								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								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)		94							27
28	Observation Bed Days							163	1,065	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								38	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					810	135	1,332	1
2	HMO and other (see instructions)					77			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								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)		263.13			810	135	1,332	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								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)		263.13						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	12,775,966	83,907	12,859,873	541,312.00	23.76	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							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 personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)			34,648	34,648	915.00	37.87	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		75,706		75,706	1,035.00	73.15	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		192,400		192,400	1,040.00	185.00	13
14	Home office salaries & wage-related costs		1,939,101		1,939,101	24,931.00	77.78	14
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)		5,494,351		5,494,351			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		14,843		14,843			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		138,225		138,225	5,176.00	26.70	26
27	Administrative & General		1,908,704	83,907	1,992,611	83,159.00	23.96	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs		450,882		450,882	17,407.00	25.90	29
30	Operation of Plant		137,527		137,527	9,167.00	15.00	30
31	Laundry & Linen Service		29,385		29,385	2,660.00	11.05	31
32	Housekeeping		409,524		409,524	34,614.00	11.83	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		336,355		336,355	24,758.00	13.59	34
35	Dietary under contract (see instructions)							35
36	Cafeteria		20,895		20,895	1,185.00	17.63	36
37	Maintenance of Personnel							37
38	Nursing Administration		704,757		704,757	23,112.00	30.49	38
39	Central Services and Supply		90,691		90,691	5,332.00	17.01	39
40	Pharmacy		502,092		502,092	11,025.00	45.54	40
41	Medical Records & Medical Records Library		400,217		400,217	23,777.00	16.83	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	12,775,966	83,907	12,859,873	541,312.00	23.76	1
2	Excluded area salaries (see instructions)		34,648	34,648	915.00	37.87	2
3	Subtotal salarles (line 1 minus line 2)	12,775,966	49,259	12,825,225	540,397.00	23.73	3
4	Subtotal other wages & related costs (see instructions)	2,207,207		2,207,207	27,006.00	81.73	4
5	Subtotal wage-related costs (see instructions)	5,494,351		5,494,351		42.84%	5
6	Total (sum of lines 3 through 5)	20,477,524	49,259	20,526,783	567,403.00	36.18	6
7	Total overhead cost (see instructions)	5,129,254	83,907	5,213,161	241,372.00	21.60	7

HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	4,356	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)	1,496,883	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	9,586	7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	2,584,788	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	26,421	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	281,589	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	943,294	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	141,636	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	20,641	23
24	Total Wage Related cost (Sum of lines 1-23)	5,509,194	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	Wage Index Fiscal Year Ending Date			1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)			2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month			3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)			4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	Effective Date of Pension Plan			6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date			7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable			9
10	Ending Date of Averaging Period from Line 5			10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)			12
13	Total Contributions Made During Averaging Period			13
14	Average Monthly Contribution (Line 13 divided by Line 12)			14
15	Number of MOnths in Provider Cost Reporting Period on Line 2			15
16	Average Pension Contributions (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)			17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)			18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

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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	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			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

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
	DESCRIPTION	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable mrthod(s))

21	MCP	INITIAL METHOD	

	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

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)	0.259992	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	5,548,942	2
3	Did you receive DSH or supplemental payments from Medicaid?	N	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	23,875,900	6
7	Medicaid cost (line 1 times line 6)	6,207,543	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.	658,601	8

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

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

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

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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	658,601	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,822,087	1,260,866	4,082,953	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	733,720	327,815	1,061,535	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	733,720	327,815	1,061,535	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?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	320,524	26
27	Medicare bad debts for the entire hospital complex (see instructions)	222,529	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	97,995	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	25,478	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,087,013	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,745,614	31

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		1,452,961	1,452,961	101,053	1,554,014	27,987	1,582,001	1
2	00200	Cap Rel Costs-Mvble Equip		1,330,945	1,330,945		1,330,945	715,612	2,046,557	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	138,225	5,377,746	5,515,971		5,515,971	-916,127	4,599,844	4
5	00500	Administrative & General	1,908,704	9,301,346	11,210,050	-1,108,766	10,101,284	-2,551,644	7,549,640	5
6	00600	Maintenance & Repairs	450,882	441,786	892,668		892,668		892,668	6
7	00700	Operation of Plant	137,527	1,049,363	1,186,890		1,186,890	-89	1,186,801	7
8	00800	Laundry & Linen Service	29,385	212,516	241,901		241,901		241,901	8
9	00900	Housekeeping	409,524	203,765	613,289		613,289		613,289	9
10	01000	Dietary	336,355	232,830	569,185		569,185	-5,120	564,065	10
11	01100	Cafeteria	20,895	552	21,447		21,447		21,447	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	704,757	2,593	707,350		707,350		707,350	13
14	01400	Central Services & Supply	90,691	236,142	326,833	-191,297	135,536		135,536	14
15	01500	Pharmacy	502,092	824,793	1,326,885	-770,998	555,887	-1,882	554,005	15
16	01600	Medical Records & Library	400,217	264,681	664,898		664,898	-26,008	638,890	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,516,302	70,063	1,586,365		1,586,365	17,706	1,604,071	30
31	03100	Intensive Care Unit	617,516	22,706	640,222		640,222		640,222	31
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	980,299	1,437,880	2,418,179	-1,027,370	1,390,809		1,390,809	50
53	05300	Anesthesiology		72,208	72,208	1,108,766	1,180,974	-1,108,766	72,208	53
54	05400	Radiology-Diagnostic	813,441	570,159	1,383,600		1,383,600	-1,338	1,382,262	54
57	05700	CT Scan	119,352	220,633	339,985		339,985		339,985	57
58	05800	MRI	56,644	181,704	238,348		238,348		238,348	58
60	06000	Laboratory	962,124	1,505,845	2,467,969		2,467,969	-25,375	2,442,594	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	258,297	106,458	364,755	-71,838	292,917		292,917	65
66	06600	Physical Therapy	664,049	8,391	672,440	-66	672,374	-88	672,286	66
67	06700	Occupational Therapy	133,616	124,143	257,759	-980	256,779	-74,763	182,016	67
68	06800	Speech Pathology	36,288	230	36,518		36,518		36,518	68
68.01	03040	AUDIOLOGY								68.01
69	06900	Electrocardiology	22,655	42,077	64,732		64,732	-33,839	30,893	69
70	07000	Electroencephalography	633	138,349	138,982		138,982	-34,459	104,523	70
71	07100	Medical Supplies Charged to Patients				876,186	876,186		876,186	71
72	07200	Impl. Dev. Charged to Patients				462,256	462,256		462,256	72
73	07300	Drugs Charged to Patients				770,998	770,998		770,998	73
76.97	07697	CARDIAC REHABILITATION	65,470	4,688	70,158		70,158		70,158	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	42,075	919	42,994		42,994		42,994	90
90.01	09001	OTTAWA CLINIC	498,859	480,975	979,834	-47,220	932,614	-263,625	668,989	90.01
91	09100	Emergency	859,092	759,520	1,618,612	-46,891	1,571,721	-687,952	883,769	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		178,365	178,365	-178,365				113
118		SUBTOTALS (sum of lines 1-117)	12,775,966	26,857,332	39,633,298	-124,532	39,508,766	-4,969,770	34,538,996	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		21,644	21,644		21,644		21,644	190
192	19200	Physicians' Private Offices		2,762,124	2,762,124	124,532	2,886,656	-1,965,103	921,553	192
194	07950	OTHER NONREIMBURSABLE COST		6,439	6,439		6,439		6,439	194
200		TOTAL (sum of lines 118-199)	12,775,966	29,647,539	42,423,505		42,423,505	-6,934,873	35,488,632	200

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	SUPPLIES CHARGED PATIENTS	A	Medical Supplies Charged to P	71		191,297	1
500	Total reclassifications					191,297	500
	Code Letter - A						
1	DRUGS CHARGED TO PATIENTS	B	Drugs Charged to Patients	73		770,998	1
500	Total reclassifications					770,998	500
	Code Letter - B						
1	MEDICAL AND SURGICAL SUPPLIES	C	Medical Supplies Charged to P	71		684,889	1
2			Impl. Dev. Charged to Patient	72		462,256	2
3							3
4							4
5							5
500	Total reclassifications					1,147,145	500
	Code Letter - C						
1	ELIMNATE SALARY CREDITS	D	Administrative & General	5	83,907		1
500	Total reclassifications				83,907		500
	Code Letter - D						
1	PHYSICIAN EXPENSES	G	Physicians' Private Offices	192		87,228	1
500	Total reclassifications					87,228	500
	Code Letter - G						
1	CLINIC DEPRECIATION EXP	H	OTTAWA CLINIC	90.01		75,030	1
2			Physicians' Private Offices	192		2,282	2
500	Total reclassifications					77,312	500
	Code Letter - H						
1	PHYSICIAN UTILITIES EXP	I	Physicians' Private Offices	192		374	1
500	Total reclassifications					374	500
	Code Letter - I						
1	PHYSICIAN STAFF EXPENSE	J	Physicians' Private Offices	192	34,648		1
500	Total reclassifications				34,648		500
	Code Letter - J						
1	ANESTHESIA PHYSICIAN COST	K	Anesthesiology	53		1,108,766	1
500	Total reclassifications					1,108,766	500
	Code Letter - K						
1	INTEREST EXPENSE	L	Cap Rel Costs-Bldg & Fixt	1		178,365	1
500	Total reclassifications					178,365	500
	Code Letter - L						
	GRAND TOTAL (Increases)				118,555	3,561,485	

(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.

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	SUPPLIES CHARGED PATIENTS	A	Central Services & Supply	14		191,297		1
500	Total reclassifications					191,297		500
	Code letter - A							
1	DRUGS CHARGED TO PATIENTS	B	Pharmacy	15		770,998		1
500	Total reclassifications					770,998		500
	Code letter - B							
1	MEDICAL AND SURGICAL SUPPLIES	C	Emergency	91		46,891		1
2			Operating Room	50		1,027,370		2
3			Respiratory Therapy	65		71,838		3
4			Physical Therapy	66		66		4
5			Occupational Therapy	67		980		5
500	Total reclassifications					1,147,145		500
	Code letter - C							
1	ELIMNATE SALARY CREDITS	D	Administrative & General	5		83,907		1
500	Total reclassifications					83,907		500
	Code letter - D							
1	PHYSICIAN EXPENSES	G	OTTAWA CLINIC	90.01		87,228		1
500	Total reclassifications					87,228		500
	Code letter - G							
1	CLINIC DEPRECIATION EXP	H	Cap Rel Costs-Bldg & Fixt	1		77,312	9	1
2							9	2
500	Total reclassifications					77,312		500
	Code letter - H							
1	PHYSICIAN UTILITIES EXP	I	OTTAWA CLINIC	90.01		374		1
500	Total reclassifications					374		500
	Code letter - I							
1	PHYSICIAN STAFF EXPENSE	J	OTTAWA CLINIC	90.01	34,648			1
500	Total reclassifications				34,648			500
	Code letter - J							
1	ANESTHESIA PHYSICIAN COST	K	Administrative & General	5		1,108,766		1
500	Total reclassifications					1,108,766		500
	Code letter - K							
1	INTEREST EXPENSE	L	Interest Expense	113		178,365	11	1
500	Total reclassifications					178,365		500
	Code letter - L							
	GRAND TOTAL (Decreases)				34,648	3,645,392		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	1,259,924					1,259,924		1
2	Land Improvements	1,011,302					1,011,302		2
3	Buildings and Fixtures	51,898,358					51,898,358		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	25,195,353		44,158	44,158	2,377,343	22,862,168		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	79,364,937		44,158	44,158	2,377,343	77,031,752		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	79,364,937		44,158	44,158	2,377,343	77,031,752		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,158,017		294,944				1,452,961	1
2	Cap Rel Costs-Mvble Equip	1,330,945						1,330,945	2
3	Total (sum of lines 1-2)	2,488,962		294,944				2,783,906	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may
have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	19,392,249		19,392,249	0.437207					1
2	Cap Rel Costs-Mvble Equ	24,962,643		24,962,643	0.562793					2
3	Total (sum of lines 1-2)	44,354,892		44,354,892	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,108,692		473,309				1,582,001	1
2	Cap Rel Costs-Mvble Equip	2,046,557						2,046,557	2
3	Total (sum of lines 1-2)	3,155,249		473,309				3,628,558	3

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

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-2,228,404				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-415,342				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						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	B	-26,008	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						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			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		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							33
33.01	X-RAY DEPT INC	B	-1,338	Radiology-Diagnostic	54		33.01
33.03	DIETARY INCOME	B	-5,120	Dietary	10		33.03
33.06	OTHER INCOME	B	-89	Operation of Plant	7		33.06
33.07	OTHER INCOME	B	-3,621	Administrative & General	5		33.07
33.08	NON ALLOWABLE ADVERTISING	A	-104,565	Administrative & General	5		33.08
33.10	ASSOC DUE LOBBY	A	-24,675	Administrative & General	5		33.10
33.11	EDUCATION	B	-1,732	Administrative & General	5		33.11
34	OTHER INCOME	B	-3,227	Administrative & General	5		34
35							35
36	HSHS SELF IND EXP	B	-916,127	Employee Benefits Department	4		36
37	OTHER INCOME	B	-4,700	Administrative & General	5		37
38	MEDICAID TAX	A	-1,250,183	Administrative & General	5		38
39	OTHER INCOME	B	-1,882	Pharmacy	15		39
40	OTHER INCOME	B	-88	Physical Therapy	66		40
41	OTHER INCOME	B	-50	Adults & Pediatrics	30		41
42	OTHER INCOME	B	-375	Laboratory	60		42
43	MEDICAL GROUP ASSESSMENT	A	-1,965,103	Physicians' Private Offices	192		43
44	HHA & SNF COST ADD-ON TO ZEROOUT T	A	17,756	Adults & Pediatrics	30		44
45							45
46							46
47							47
48							48
49							49

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-6,934,873				50

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

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

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	CENTRAL MANAGEMENT SERVIC	1,083,871	3,968,933	-2,885,062		1
2	5	Administrative & General	CENTRAL MANAGEMENT SERVIC	1,726,121		1,726,121		2
3	1	Cap Rel Costs-Bldg & Fixt	HOME OFFICE	27,987		27,987	9	3
3.01	2	Cap Rel Costs-Mvble Equip	HOME OFFICE	715,612		715,612	9	3.01
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			3,553,591	3,968,933	-415,342		5

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

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

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

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

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

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

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

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

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	69	Electrocardiology AGGREGATE	33,839	33,839		159,800				1
2	91	Emergency AGGREGATE	687,952	687,952		159,800				2
3	60	Laboratory AGGREGATE	25,000	25,000		208,000				3
4	67	Occupational Therapy AGGREGATE	74,763	74,763		159,800				4
5	53	Anesthesiology AGGREGATE	1,108,766	1,108,766		159,800				5
6	90.01	OTTAWA CLINIC AGGREGATE	263,625	263,625		159,800				6
7	70	Electroencephalograp AGGREGATE	34,459	34,459		159,800				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
200		TOTAL	2,228,404	2,228,404						200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	69	Electrocardiology AGGREGATE							33,839	1
2	91	Emergency AGGREGATE							687,952	2
3	60	Laboratory AGGREGATE							25,000	3
4	67	Occupational Therapy AGGREGATE							74,763	4
5	53	Anesthesiology AGGREGATE							1,108,766	5
6	90.01	OTTAWA CLINIC AGGREGATE							263,625	6
7	70	Electroencephalograp AGGREGATE							34,459	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
200		TOTAL							2,228,404	200

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,582,001	1,582,001					1
2	Cap Rel Costs-Mvble Equip	2,046,557		2,046,557				2
4	Employee Benefits Department	4,599,844	7,521	405	4,607,770			4
5	Administrative & General	7,549,640	319,853	296,453	721,726	8,887,672	8,887,672	5
6	Maintenance & Repairs	892,668	43,636	15,053	163,309	1,114,666	372,422	6
7	Operation of Plant	1,186,801	382,098	3,313	49,812	1,622,024	541,936	7
8	Laundry & Linen Service	241,901	15,556	896	10,643	268,996	89,875	8
9	Housekeeping	613,289	21,399	1,243	148,329	784,260	262,030	9
10	Dietary	564,065	57,107	19,647	121,827	762,646	254,808	10
11	Cafeteria	21,447	14,088	365	7,568	43,468	14,523	11
12	Maintenance of Personnel							12
13	Nursing Administration	707,350	12,168		255,262	974,780	325,685	13
14	Central Services & Supply	135,536	24,297	78,886	32,848	271,567	90,734	14
15	Pharmacy	554,005	18,652	105,892	181,857	860,406	287,471	15
16	Medical Records & Library	638,890	24,285	2,431	144,958	810,564	270,818	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,604,071	178,989	115,834	549,203	2,448,097	817,936	30
31	Intensive Care Unit	640,222	32,600	25,309	223,664	921,795	307,982	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,390,809	108,894	270,164	355,063	2,124,930	709,962	50
53	Anesthesiology	72,208	3,280	14,728		90,216	30,142	53
54	Radiology-Diagnostic	1,382,262	92,613	495,001	294,628	2,264,504	756,596	54
57	CT Scan	339,985	8,163	1,839	43,229	393,216	131,378	57
58	MRI	238,348	9,504	393,718	20,516	662,086	221,210	58
60	Laboratory	2,442,594	50,350	57,569	348,480	2,898,993	968,585	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	292,917	9,987	15,356	93,555	411,815	137,592	65
66	Physical Therapy	672,286	31,475	5,547	240,518	949,826	317,347	66
67	Occupational Therapy	182,016	25,900	5,788	48,396	262,100	87,570	67
68	Speech Pathology	36,518	4,450	43	13,143	54,154	18,093	68
68.01	AUDIOLOGY							68.01
69	Electrocardiology	30,893	2,715	27,443	8,206	69,257	23,140	69
70	Electroencephalography	104,523	712		229	105,464	35,237	70
71	Medical Supplies Charged to Patients	876,186				876,186	292,743	71
72	Impl. Dev. Charged to Patients	462,256				462,256	154,445	72
73	Drugs Charged to Patients	770,998				770,998	257,599	73
76.97	CARDIAC REHABILITATION	70,158	16,790	4,772	23,713	115,433	38,567	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	42,994	10,311		15,240	68,545	22,902	90
90.01	OTTAWA CLINIC	668,989		9,804	168,137	846,930	282,969	90.01
91	Emergency	883,769	50,311	36,907	311,162	1,282,149	428,380	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	34,538,996	1,577,704	2,004,406	4,595,221	34,479,999	8,550,677	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	21,644	2,390			24,034	8,030	190
192	Physicians' Private Offices	921,553		28,226	12,549	962,328	321,524	192
194	OTHER NONREIMBURSABLE COST	6,439	1,907	13,925		22,271	7,441	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	35,488,632	1,582,001	2,046,557	4,607,770	35,488,632	8,887,672	202

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

	COST CENTER DESCRIPTIONS	MAIN-TENANCE + REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs	1,487,088						6
7	Operation of Plant	553,271	2,717,231					7
8	Laundry & Linen Service	2,807	50,996	412,674				8
9	Housekeeping	611	70,148		1,117,049			9
10	Dietary	49,794	187,206	668		1,255,122		10
11	Cafeteria	4,981	46,182		16,017		125,171	11
12	Maintenance of Personnel							12
13	Nursing Administration	17,217	39,888				7,692	13
14	Central Services & Supply	133,456	79,651	1,828	68,201		2,098	14
15	Pharmacy	7,041	61,145				10,489	15
16	Medical Records & Library	623	79,609		5,683		7,692	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	91,846	586,750	125,641	346,687	1,047,983	20,279	30
31	Intensive Care Unit	73,723	106,868	33,656	38,234	161,272	6,993	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	207,016	356,969	130,870	51,151	19,959	11,888	50
53	Anesthesiology		10,753		17,050			53
54	Radiology-Diagnostic	60,978	303,598	22,722	96,618		9,091	54
57	CT Scan	10,210	26,759	4,937	21,700		1,399	57
58	MRI	9,135	31,156				699	58
60	Laboratory	89,457	165,053	422	25,317		13,986	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	15,677	32,740		17,567		2,797	65
66	Physical Therapy	15,111	103,179	8,877	16,017		6,993	66
67	Occupational Therapy	9,440	84,902	3,816	13,434		699	67
68	Speech Pathology		14,588		12,917		699	68
68.01	AUDIOLOGY							68.01
69	Electrocardiology	6,871	8,899					69
70	Electroencephalography	441	2,334	1,229	36,684		699	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION	18,700	55,039	1,236	44,951		699	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	3,645	33,803				699	90
90.01	OTTAWA CLINIC	36,539		4,991	100,235		6,993	90.01
91	Emergency	61,759	164,928	71,781	87,318	25,908	11,888	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,480,349	2,703,143	412,674	1,015,781	1,255,122	124,472	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		7,836					190
192	Physicians' Private Offices	5,234			101,268			192
194	OTHER NONREIMBURSABLE COST	1,505	6,252				699	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,487,088	2,717,231	412,674	1,117,049	1,255,122	125,171	202

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		13	14	15	16	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
5	Administrative & General							5
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	1,365,262						13
14	Central Services & Supply	80,310	727,845					14
15	Pharmacy	133,849	392	1,360,793				15
16	Medical Records & Library		3		1,174,992			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		21,594		575,746	6,082,559		30
31	Intensive Care Unit	294,468	4,247		47,000	1,996,238		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	267,698	164,577		129,249	4,174,269		50
53	Anesthesiology		15,689			163,850		53
54	Radiology-Diagnostic		1,999			3,516,106		54
57	CT Scan		34			589,633		57
58	MRI		27			924,313		58
60	Laboratory					4,161,813		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	107,079				725,267		65
66	Physical Therapy		85			1,417,435		66
67	Occupational Therapy		11			461,972		67
68	Speech Pathology					100,451		68
68.01	AUDIOLOGY							68.01
69	Electrocardiology					108,167		69
70	Electroencephalography		7			182,095		70
71	Medical Supplies Charged to Patients		337,754			1,506,683		71
72	Impl. Dev. Charged to Patients		178,190			794,891		72
73	Drugs Charged to Patients			1,359,428		2,388,025		73
76.97	CARDIAC REHABILITATION	26,770	410			301,805		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		354			129,948		90
90.01	OTTAWA CLINIC		2,462	517		1,281,636		90.01
91	Emergency	455,088			422,997	3,012,196		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,365,262	727,835	1,359,945	1,174,992	34,019,352		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		3			39,903		190
192	Physicians' Private Offices					1,390,354		192
194	OTHER NONREIMBURSABLE COST		7	848		39,023		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,365,262	727,845	1,360,793	1,174,992	35,488,632		202

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
5	Administrative & General							5
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
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,082,559						30
31	Intensive Care Unit	1,996,238						31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,174,269						50
53	Anesthesiology	163,850						53
54	Radiology-Diagnostic	3,516,106						54
57	CT Scan	589,633						57
58	MRI	924,313						58
60	Laboratory	4,161,813						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	725,267						65
66	Physical Therapy	1,417,435						66
67	Occupational Therapy	461,972						67
68	Speech Pathology	100,451						68
68.01	AUDIOLOGY							68.01
69	Electrocardiology	108,167						69
70	Electroencephalography	182,095						70
71	Medical Supplies Charged to Patients	1,506,683						71
72	Impl. Dev. Charged to Patients	794,891						72
73	Drugs Charged to Patients	2,388,025						73
76.97	CARDIAC REHABILITATION	301,805						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	129,948						90
90.01	OTTAWA CLINIC	1,281,636						90.01
91	Emergency	3,012,196						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	34,019,352						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	39,903						190
192	Physicians' Private Offices	1,390,354						192
194	OTHER NONREIMBURSABLE COST	39,023						194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	35,488,632						202

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		7,521	405	7,926	7,926		4
5	Administrative & General		319,853	296,453	616,306	1,241	617,547	5
6	Maintenance & Repairs		43,636	15,053	58,689	281	25,877	6
7	Operation of Plant		382,098	3,313	385,411	86	37,655	7
8	Laundry & Linen Service		15,556	896	16,452	18	6,245	8
9	Housekeeping		21,399	1,243	22,642	255	18,207	9
10	Dietary		57,107	19,647	76,754	210	17,705	10
11	Cafeteria		14,088	365	14,453	13	1,009	11
12	Maintenance of Personnel							12
13	Nursing Administration		12,168		12,168	439	22,630	13
14	Central Services & Supply		24,297	78,886	103,183	57	6,304	14
15	Pharmacy		18,652	105,892	124,544	313	19,974	15
16	Medical Records & Library		24,285	2,431	26,716	249	18,817	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		178,989	115,834	294,823	945	56,833	30
31	Intensive Care Unit		32,600	25,309	57,909	385	21,399	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		108,894	270,164	379,058	611	49,330	50
53	Anesthesiology		3,280	14,728	18,008		2,094	53
54	Radiology-Diagnostic		92,613	495,001	587,614	507	52,570	54
57	CT Scan		8,163	1,839	10,002	74	9,129	57
58	MRI		9,504	393,718	403,222	35	15,370	58
60	Laboratory		50,350	57,569	107,919	599	67,308	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		9,987	15,356	25,343	161	9,560	65
66	Physical Therapy		31,475	5,547	37,022	414	22,050	66
67	Occupational Therapy		25,900	5,788	31,688	83	6,085	67
68	Speech Pathology		4,450	43	4,493	23	1,257	68
68.01	AUDIOLOGY							68.01
69	Electrocardiology		2,715	27,443	30,158	14	1,608	69
70	Electroencephalography		712		712		2,448	70
71	Medical Supplies Charged to Patients						20,341	71
72	Impl. Dev. Charged to Patients						10,731	72
73	Drugs Charged to Patients						17,899	73
76.97	CARDIAC REHABILITATION		16,790	4,772	21,562	41	2,680	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		10,311		10,311	26	1,591	90
90.01	OTTAWA CLINIC			9,804	9,804	289	19,661	90.01
91	Emergency		50,311	36,907	87,218	535	29,765	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,577,704	2,004,406	3,582,110	7,904	594,132	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,390		2,390		558	190
192	Physicians' Private Offices			28,226	28,226	22	22,340	192
194	OTHER NONREIMBURSABLE COST		1,907	13,925	15,832		517	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,582,001	2,046,557	3,628,558	7,926	617,547	202

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MAIN-TENANCE + REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs	84,847						6
7	Operation of Plant	31,567	454,719					7
8	Laundry & Linen Service	160	8,534	31,409				8
9	Housekeeping	35	11,739		52,878			9
10	Dietary	2,841	31,328	51		128,889		10
11	Cafeteria	284	7,728		758		24,245	11
12	Maintenance of Personnel							12
13	Nursing Administration	982	6,675				1,490	13
14	Central Services & Supply	7,614	13,329	139	3,228		406	14
15	Pharmacy	402	10,232				2,032	15
16	Medical Records & Library	36	13,322		269		1,490	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,240	98,191	9,563	16,412	107,617	3,931	30
31	Intensive Care Unit	4,206	17,884	2,562	1,810	16,561	1,354	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,812	59,738	9,960	2,421	2,050	2,303	50
53	Anesthesiology		1,800		807			53
54	Radiology-Diagnostic	3,479	50,806	1,729	4,574		1,761	54
57	CT Scan	583	4,478	376	1,027		271	57
58	MRI	521	5,214				135	58
60	Laboratory	5,104	27,621	32	1,198		2,709	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	894	5,479		832		542	65
66	Physical Therapy	862	17,267	676	758		1,354	66
67	Occupational Therapy	539	14,208	290	636		135	67
68	Speech Pathology		2,441		611		135	68
68.01	AUDIOLOGY							68.01
69	Electrocardiology	392	1,489					69
70	Electroencephalography	25	391	94	1,737		135	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION	1,067	9,211	94	2,128		135	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	208	5,657				135	90
90.01	OTTAWA CLINIC	2,085		380	4,745		1,354	90.01
91	Emergency	3,524	27,600	5,463	4,133	2,661	2,303	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	84,462	452,362	31,409	48,084	128,889	24,110	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1,311					190
192	Physicians' Private Offices	299			4,794			192
194	OTHER NONREIMBURSABLE COST	86	1,046				135	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	84,847	454,719	31,409	52,878	128,889	24,245	202

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		13	14	15	16	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
5	Administrative & General							5
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	44,384						13
14	Central Services & Supply	2,611	136,871					14
15	Pharmacy	4,351	74	161,922				15
16	Medical Records & Library		1		60,900			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		4,061		29,841	627,457		30
31	Intensive Care Unit	9,573	799		2,436	136,878		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,703	30,949		6,699	563,634		50
53	Anesthesiology		2,950			25,659		53
54	Radiology-Diagnostic		376			703,416		54
57	CT Scan		6			25,946		57
58	MRI		5			424,502		58
60	Laboratory					212,490		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,481				46,292		65
66	Physical Therapy		16			80,419		66
67	Occupational Therapy		2			53,666		67
68	Speech Pathology					8,960		68
68.01	AUDIOLOGY							68.01
69	Electrocardiology					33,661		69
70	Electroencephalography		1			5,543		70
71	Medical Supplies Charged to Patients		63,513			83,854		71
72	Impl. Dev. Charged to Patients		33,509			44,240		72
73	Drugs Charged to Patients			161,760		179,659		73
76.97	CARDIAC REHABILITATION	870	77			37,865		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		67			17,995		90
90.01	OTTAWA CLINIC		463	61		38,842		90.01
91	Emergency	14,795			21,924	199,921		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	44,384	136,869	161,821	60,900	3,550,899		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1			4,260		190
192	Physicians' Private Offices					55,681		192
194	OTHER NONREIMBURSABLE COST		1	101		17,718		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	44,384	136,871	161,922	60,900	3,628,558		202

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
5	Administrative & General							5
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
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	627,457						30
31	Intensive Care Unit	136,878						31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	563,634						50
53	Anesthesiology	25,659						53
54	Radiology-Diagnostic	703,416						54
57	CT Scan	25,946						57
58	MRI	424,502						58
60	Laboratory	212,490						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	46,292						65
66	Physical Therapy	80,419						66
67	Occupational Therapy	53,666						67
68	Speech Pathology	8,960						68
68.01	AUDIOLOGY							68.01
69	Electrocardiology	33,661						69
70	Electroencephalography	5,543						70
71	Medical Supplies Charged to Patients	83,854						71
72	Impl. Dev. Charged to Patients	44,240						72
73	Drugs Charged to Patients	179,659						73
76.97	CARDIAC REHABILITATION	37,865						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	17,995						90
90.01	OTTAWA CLINIC	38,842						90.01
91	Emergency	199,921						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	3,550,899						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	4,260						190
192	Physicians' Private Offices	55,681						192
194	OTHER NONREIMBURSABLE COST	17,718						194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,628,558						202

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE + REPAIRS MAINTENANC HOURS	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	248,849						1
2	Cap Rel Costs-Mvble Equip		1,414,454					2
4	Employee Benefits Department	1,183	280	12,721,648				4
5	Administrative & General	50,313	204,890	1,992,611	-8,887,672	26,600,960		5
6	Maintenance & Repairs	6,864	10,404	450,882		1,114,666	656,875	6
7	Operation of Plant	60,104	2,290	137,527		1,622,024	244,390	7
8	Laundry & Linen Service	2,447	619	29,385		268,996	1,240	8
9	Housekeeping	3,366	859	409,524		784,260	270	9
10	Dietary	8,983	13,579	336,355		762,646	21,995	10
11	Cafeteria	2,216	252	20,895		43,468	2,200	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,914		704,757		974,780	7,605	13
14	Central Services & Supply	3,822	54,521	90,691		271,567	58,950	14
15	Pharmacy	2,934	73,186	502,092		860,406	3,110	15
16	Medical Records & Library	3,820	1,680	400,217		810,564	275	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	28,155	80,057	1,516,302		2,448,097	40,570	30
31	Intensive Care Unit	5,128	17,492	617,516		921,795	32,565	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	17,129	186,721	980,299		2,124,930	91,443	50
53	Anesthesiology	516	10,179			90,216		53
54	Radiology-Diagnostic	14,568	342,114	813,441		2,264,504	26,935	54
57	CT Scan	1,284	1,271	119,352		393,216	4,510	57
58	MRI	1,495	272,114	56,644		662,086	4,035	58
60	Laboratory	7,920	39,788	962,124		2,898,993	39,515	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,571	10,613	258,297		411,815	6,925	65
66	Physical Therapy	4,951	3,834	664,049		949,826	6,675	66
67	Occupational Therapy	4,074	4,000	133,616		262,100	4,170	67
68	Speech Pathology	700	30	36,288		54,154		68
68.01	AUDIOLOGY							68.01
69	Electrocardiology	427	18,967	22,655		69,257	3,035	69
70	Electroencephalography	112		633		105,464	195	70
71	Medical Supplies Charged to Patients					876,186		71
72	Impl. Dev. Charged to Patients					462,256		72
73	Drugs Charged to Patients					770,998		73
76.97	CARDIAC REHABILITATION	2,641	3,298	65,470		115,433	8,260	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,622		42,075		68,545	1,610	90
90.01	OTTAWA CLINIC		6,776	464,211		846,930	16,140	90.01
91	Emergency	7,914	25,508	859,092		1,282,149	27,280	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	248,173	1,385,322	12,687,000	-8,887,672	25,592,327	653,898	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	376				24,034		190
192	Physicians' Private Offices		19,508	34,648		962,328	2,312	192
194	OTHER NONREIMBURSABLE COST	300	9,624			22,271	665	194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,582,001	2,046,557	4,607,770		8,887,672	1,487,088	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.357273	1.446888	0.362199		0.334111	2.263883	203
204	Cost to be allocated (Per Wkst. B, Part II)			7,926		617,547	84,847	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000623		0.023215	0.129168	205

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	
		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
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	130,385						7
8	Laundry & Linen Service	2,447	53,742					8
9	Housekeeping	3,366		2,162				9
10	Dietary	8,983	87		19,620			10
11	Cafeteria	2,216		31		179		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,914				11	51	13
14	Central Services & Supply	3,822	238	132		3	3	14
15	Pharmacy	2,934				15	5	15
16	Medical Records & Library	3,820		11		11		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	28,155	16,362	671	16,382	29		30
31	Intensive Care Unit	5,128	4,383	74	2,521	10	11	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	17,129	17,043	99	312	17	10	50
53	Anesthesiology	516		33				53
54	Radiology-Diagnostic	14,568	2,959	187		13		54
57	CT Scan	1,284	643	42		2		57
58	MRI	1,495				1		58
60	Laboratory	7,920	55	49		20		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,571		34		4	4	65
66	Physical Therapy	4,951	1,156	31		10		66
67	Occupational Therapy	4,074	497	26		1		67
68	Speech Pathology	700		25		1		68
68.01	AUDIOLOGY							68.01
69	Electrocardiology	427						69
70	Electroencephalography	112	160	71		1		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION	2,641	161	87		1	1	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,622				1		90
90.01	OTTAWA CLINIC		650	194		10		90.01
91	Emergency	7,914	9,348	169	405	17	17	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	129,709	53,742	1,966	19,620	178	51	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	376						190
192	Physicians' Private Offices			196				192
194	OTHER NONREIMBURSABLE COST	300				1		194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,717,231	412,674	1,117,049	1,255,122	125,171	1,365,262	202
203	Unit Cost Multiplier (Wkst. B, Part I)	20.840058	7.678799	516.673913	63.971560	699.279330	26,769.843137	203
204	Cost to be allocated (Per Wkst. B, Part II)	454,719	31,409	52,878	128,889	24,245	44,384	204
205	Unit Cost Multiplier (Wkst. B, Part II)	3.487510	0.584440	24.457909	6.569266	135.446927	870.274510	205

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT				
		14	15	16				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
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	1,888,142						14
15	Pharmacy	1,018	785,015					15
16	Medical Records & Library	7		100				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	56,017		49				30
31	Intensive Care Unit	11,017		4				31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	426,938		11				50
53	Anesthesiology	40,700						53
54	Radiology-Diagnostic	5,186						54
57	CT Scan	89						57
58	MRI	71						58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy	220						66
67	Occupational Therapy	28						67
68	Speech Pathology							68
68.01	AUDIOLOGY							68.01
69	Electrocardiology							69
70	Electroencephalography	18						70
71	Medical Supplies Charged to Patients	876,186						71
72	Impl. Dev. Charged to Patients	462,252						72
73	Drugs Charged to Patients		784,228					73
76.97	CARDIAC REHABILITATION	1,063						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	919						90
90.01	OTTAWA CLINIC	6,387	298					90.01
91	Emergency			36				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,888,116	784,526	100				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	9						190
192	Physicians' Private Offices							192
194	OTHER NONREIMBURSABLE COST	17	489					194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	727,845	1,360,793	1,174,992				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.385482	1.733461	11,749.920000				203
204	Cost to be allocated (Per Wkst. B, Part II)	136,871	161,922	60,900				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.072490	0.206266	609.000000				205

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C**
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	6,082,559		6,082,559		6,082,559	30
31	Intensive Care Unit	1,996,238		1,996,238		1,996,238	31
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	4,174,269		4,174,269		4,174,269	50
53	Anesthesiology	163,850		163,850		163,850	53
54	Radiology-Diagnostic	3,516,106		3,516,106		3,516,106	54
57	CT Scan	589,633		589,633		589,633	57
58	MRI	924,313		924,313		924,313	58
60	Laboratory	4,161,813		4,161,813		4,161,813	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	725,267		725,267		725,267	65
66	Physical Therapy	1,417,435		1,417,435		1,417,435	66
67	Occupational Therapy	461,972		461,972		461,972	67
68	Speech Pathology	100,451		100,451		100,451	68
68.01	AUDIOLOGY						68.01
69	Electrocardiology	108,167		108,167		108,167	69
70	Electroencephalography	182,095		182,095		182,095	70
71	Medical Supplies Charged to Patients	1,506,683		1,506,683		1,506,683	71
72	Impl. Dev. Charged to Patients	794,891		794,891		794,891	72
73	Drugs Charged to Patients	2,388,025		2,388,025		2,388,025	73
76.97	CARDIAC REHABILITATION	301,805		301,805		301,805	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	129,948		129,948		129,948	90
90.01	OTTAWA CLINIC	1,281,636		1,281,636		1,281,636	90.01
91	Emergency	3,012,196		3,012,196		3,012,196	91
92	Observation Beds (Non-Distinct Part)	1,173,534		1,173,534		1,173,534	92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	35,192,886		35,192,886		35,192,886	200
201	Less Observation Beds	1,173,534		1,173,534		1,173,534	201
202	Total (line 200 minus line 201)	34,019,352		34,019,352		34,019,352	202

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C**
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	7,538,492		7,538,492				30
31	Intensive Care Unit	2,279,918		2,279,918				31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,188,064	14,137,968	17,326,032	0.240925	0.240925	0.240925	50
53	Anesthesiology	991,244	4,884,143	5,875,387	0.027888	0.027888	0.027888	53
54	Radiology-Diagnostic	2,099,519	14,284,387	16,383,906	0.214607	0.214607	0.214607	54
57	CT Scan	2,313,759	13,136,456	15,450,215	0.038163	0.038163	0.038163	57
58	MRI	66,058	3,170,524	3,236,582	0.285583	0.285583	0.285583	58
60	Laboratory	4,755,648	19,111,900	23,867,548	0.174371	0.174371	0.174371	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,681,185	360,177	2,041,362	0.355286	0.355286	0.355286	65
66	Physical Therapy	603,207	2,856,334	3,459,541	0.409718	0.409718	0.409718	66
67	Occupational Therapy	64,794	736,727	801,521	0.576369	0.576369	0.576369	67
68	Speech Pathology	35,893	146,608	182,501	0.550413	0.550413	0.550413	68
68.01	AUDIOLOGY							68.01
69	Electrocardiology	394,979	1,406,817	1,801,796	0.060033	0.060033	0.060033	69
70	Electroencephalography		690,763	690,763	0.263614	0.263614	0.263614	70
71	Medical Supplies Charged to Patients	2,493,671	2,263,866	4,757,537	0.316694	0.316694	0.316694	71
72	Impl. Dev. Charged to Patients	1,118,976	717,717	1,836,693	0.432784	0.432784	0.432784	72
73	Drugs Charged to Patients	3,602,084	3,058,012	6,660,096	0.358557	0.358557	0.358557	73
76.97	CARDIAC REHABILITATION	406	596,855	597,261	0.505315	0.505315	0.505315	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		731,987	731,987	0.177528	0.177528	0.177528	90
90.01	OTTAWA CLINIC		2,113,699	2,113,699	0.606347	0.606347	0.606347	90.01
91	Emergency	2,123,770	9,304,027	11,427,797	0.263585	0.263585	0.263585	91
92	Observation Beds (Non-Distinct Part)	421,875	1,365,014	1,786,889	0.656747	0.656747	0.656747	92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	35,773,542	95,073,981	130,847,523				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	35,773,542	95,073,981	130,847,523				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	627,457		627,457	5,520	113.67	2,987	339,532	30
31	Intensive Care Unit	136,878		136,878	884	154.84	492	76,181	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)	764,335		764,335	6,404		3,479	415,713	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0026** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	563,634	17,326,032	0.032531	1,869,491	60,816	50
53	Anesthesiology	25,659	5,875,387	0.004367	499,649	2,182	53
54	Radiology-Diagnostic	703,416	16,383,906	0.042933	1,562,735	67,093	54
57	CT Scan	25,946	15,450,215	0.001679	1,490,212	2,502	57
58	MRI	424,502	3,236,582	0.131157	30,981	4,063	58
60	Laboratory	212,490	23,867,548	0.008903	3,481,446	30,995	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	46,292	2,041,362	0.022677	1,181,993	26,804	65
66	Physical Therapy	80,419	3,459,541	0.023246	452,416	10,517	66
67	Occupational Therapy	53,666	801,521	0.066955	51,423	3,443	67
68	Speech Pathology	8,960	182,501	0.049096	29,750	1,461	68
68.01	AUDIOLOGY						68.01
69	Electrocardiology	33,661	1,801,796	0.018682	319,363	5,966	69
70	Electroencephalography	5,543	690,763	0.008024			70
71	Medical Supplies Charged to Pat	83,854	4,757,537	0.017626	1,376,631	24,264	71
72	Impl. Dev. Charged to Patients	44,240	1,836,693	0.024087	763,549	18,392	72
73	Drugs Charged to Patients	179,659	6,660,096	0.026975	3,250,000	87,669	73
76.97	CARDIAC REHABILITATION	37,865	597,261	0.063398			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	17,995	731,987	0.024584			90
90.01	OTTAWA CLINIC	38,842	2,113,699	0.018376			90.01
91	Emergency	199,921	11,427,797	0.017494	1,361,227	23,813	91
92	Observation Beds (Non-Distinct	121,058	1,786,889	0.067748	145,558	9,861	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,907,622	121,029,113		17,866,424	379,841	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						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)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	5,520		2,987		30
31	Intensive Care Unit	884		492		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)	6,404		3,479		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0026** **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
68.01	AUDIOLOGY							68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
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
90.01	OTTAWA CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0026** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	17,326,032			1,869,491		6,653,162		50
53	Anesthesiology	5,875,387			499,649		1,146,392		53
54	Radiology-Diagnostic	16,383,906			1,562,735		5,436,627		54
57	CT Scan	15,450,215			1,490,212		4,578,945		57
58	MRI	3,236,582			30,981		1,047,543		58
60	Laboratory	23,867,548			3,481,446		2,670,786		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,041,362			1,181,993		112,177		65
66	Physical Therapy	3,459,541			452,416		60		66
67	Occupational Therapy	801,521			51,423				67
68	Speech Pathology	182,501			29,750				68
68.01	AUDIOLOGY								68.01
69	Electrocardiology	1,801,796			319,363		512,911		69
70	Electroencephalography	690,763					162,616		70
71	Medical Supplies Charged to Pat	4,757,537			1,376,631		1,237,953		71
72	Impl. Dev. Charged to Patients	1,836,693			763,549		405,209		72
73	Drugs Charged to Patients	6,660,096			3,250,000		2,002,767		73
76.97	CARDIAC REHABILITATION	597,261					386,442		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	731,987							90
90.01	OTTAWA CLINIC	2,113,699							90.01
91	Emergency	11,427,797			1,361,227		2,249,655		91
92	Observation Beds (Non-Distinct	1,786,889			145,558		470,966		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	121,029,113			17,866,424		29,074,211		200

(A) Worksheet A line numbers

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0026** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.240925	6,653,162	2,460		1,602,913	593		50
53	Anesthesiology	0.027888	1,146,392	3,017		31,971	84		53
54	Radiology-Diagnostic	0.214607	5,436,627	1,200		1,166,738	258		54
57	CT Scan	0.038163	4,578,945			174,746			57
58	MRI	0.285583	1,047,543			299,160			58
60	Laboratory	0.174371	2,670,786			465,708			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.355286	112,177	15		39,855	5		65
66	Physical Therapy	0.409718	60			25			66
67	Occupational Therapy	0.576369							67
68	Speech Pathology	0.550413							68
68.01	AUDIOLOGY								68.01
69	Electrocardiology	0.060033	512,911			30,792			69
70	Electroencephalography	0.263614	162,616			42,868			70
71	Medical Supplies Charged to Pat	0.316694	1,237,953	2,195		392,052	695		71
72	Impl. Dev. Charged to Patients	0.432784	405,209			175,368			72
73	Drugs Charged to Patients	0.358557	2,002,767		38,451	718,106		13,787	73
76.97	CARDIAC REHABILITATION	0.505315	386,442			195,275			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.177528							90
90.01	OTTAWA CLINIC	0.606347							90.01
91	Emergency	0.263585	2,249,655			592,975			91
92	Observation Beds (Non-Distinct	0.656747	470,966			309,306			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		29,074,211	8,887	38,451	6,237,858	1,635	13,787	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		29,074,211	8,887	38,451	6,237,858	1,635	13,787	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	627,457		627,457	5,520	113.67	663	75,363	30
31	Intensive Care Unit	136,878		136,878	884	154.84	93	14,400	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)	764,335		764,335	6,404		756	89,763	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0026** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	563,634	17,326,032	0.032531			50
53	Anesthesiology	25,659	5,875,387	0.004367			53
54	Radiology-Diagnostic	703,416	16,383,906	0.042933			54
57	CT Scan	25,946	15,450,215	0.001679			57
58	MRI	424,502	3,236,582	0.131157			58
60	Laboratory	212,490	23,867,548	0.008903			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	46,292	2,041,362	0.022677			65
66	Physical Therapy	80,419	3,459,541	0.023246			66
67	Occupational Therapy	53,666	801,521	0.066955			67
68	Speech Pathology	8,960	182,501	0.049096			68
68.01	AUDIOLOGY						68.01
69	Electrocardiology	33,661	1,801,796	0.018682			69
70	Electroencephalography	5,543	690,763	0.008024			70
71	Medical Supplies Charged to Pat	83,854	4,757,537	0.017626			71
72	Impl. Dev. Charged to Patients	44,240	1,836,693	0.024087			72
73	Drugs Charged to Patients	179,659	6,660,096	0.026975			73
76.97	CARDIAC REHABILITATION	37,865	597,261	0.063398			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	17,995	731,987	0.024584			90
90.01	OTTAWA CLINIC	38,842	2,113,699	0.018376			90.01
91	Emergency	199,921	11,427,797	0.017494			91
92	Observation Beds (Non-Distinct	121,058	1,786,889	0.067748			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,907,622	121,029,113				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						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)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	5,520		663		30
31	Intensive Care Unit	884		93		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)	6,404		756		200

(A) Worksheet A line numbers

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0026** **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
68.01	AUDIOLOGY							68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
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
90.01	OTTAWA CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0026** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	17,326,032							50
53	Anesthesiology	5,875,387							53
54	Radiology-Diagnostic	16,383,906							54
57	CT Scan	15,450,215							57
58	MRI	3,236,582							58
60	Laboratory	23,867,548							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,041,362							65
66	Physical Therapy	3,459,541							66
67	Occupational Therapy	801,521							67
68	Speech Pathology	182,501							68
68.01	AUDIOLOGY								68.01
69	Electrocardiology	1,801,796							69
70	Electroencephalography	690,763							70
71	Medical Supplies Charged to Pat	4,757,537							71
72	Impl. Dev. Charged to Patients	1,836,693							72
73	Drugs Charged to Patients	6,660,096							73
76.97	CARDIAC REHABILITATION	597,261							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	731,987							90
90.01	OTTAWA CLINIC	2,113,699							90.01
91	Emergency	11,427,797							91
92	Observation Beds (Non-Distinct	1,786,889							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	121,029,113							200

(A) Worksheet A line numbers

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.240925							50
53	Anesthesiology	0.027888							53
54	Radiology-Diagnostic	0.214607							54
57	CT Scan	0.038163							57
58	MRI	0.285583							58
60	Laboratory	0.174371							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.355286							65
66	Physical Therapy	0.409718							66
67	Occupational Therapy	0.576369							67
68	Speech Pathology	0.550413							68
68.01	AUDIOLOGY								68.01
69	Electrocardiology	0.060033							69
70	Electroencephalography	0.263614							70
71	Medical Supplies Charged to Pat	0.316694							71
72	Impl. Dev. Charged to Patients	0.432784							72
73	Drugs Charged to Patients	0.358557							73
76.97	CARDIAC REHABILITATION	0.505315							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.177528							90
90.01	OTTAWA CLINIC	0.606347							90.01
91	Emergency	0.263585							91
92	Observation Beds (Non-Distinct	0.656747							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0026** **WORKSHEET D-1**
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,520	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,520	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)	4,455	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)	2,987	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)	6,082,559	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)	6,082,559	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)	6,082,559	37

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,101.91	38
39	Program general inpatient routine service cost (line 9 x line 38)	3,291,405	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)	3,291,405	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	1,996,238	884	2,258.19	492	1,111,029	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)	4,529,119	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	8,931,553	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	415,713	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	379,841	51
52	Total Program excludable cost (sum of lines 50 and 51)	795,554	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	8,135,999	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0026** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,065	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,101.91	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,173,534	89
		Cost	Routine Cost (from line 27)	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	627,457	6,082,559	0.103157	1,173,534	121,058	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0026** **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)	5,520	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,520	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)	4,455	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)	663	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)	6,082,559	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)	6,082,559	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)	6,082,559	37

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,101.91	38
39	Program general inpatient routine service cost (line 9 x line 38)					730,566	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)					730,566	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	1,996,238	884	2,258.19	93	210,012	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)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					940,578	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	89,763	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	89,763	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	850,815	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,065	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 27)	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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0026** **WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		4,478,688		30
31	Intensive Care Unit		1,131,262		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.240925	1,869,491	450,407	50
53	Anesthesiology	0.027888	499,649	13,934	53
54	Radiology-Diagnostic	0.214607	1,562,735	335,374	54
57	CT Scan	0.038163	1,490,212	56,871	57
58	MRI	0.285583	30,981	8,848	58
60	Laboratory	0.174371	3,481,446	607,063	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.355286	1,181,993	419,946	65
66	Physical Therapy	0.409718	452,416	185,363	66
67	Occupational Therapy	0.576369	51,423	29,639	67
68	Speech Pathology	0.550413	29,750	16,375	68
68.01	AUDIOLOGY				68.01
69	Electrocardiology	0.060033	319,363	19,172	69
70	Electroencephalography	0.263614			70
71	Medical Supplies Charged to Patients	0.316694	1,376,631	435,971	71
72	Impl. Dev. Charged to Patients	0.432784	763,549	330,452	72
73	Drugs Charged to Patients	0.358557	3,250,000	1,165,310	73
76.97	CARDIAC REHABILITATION	0.505315			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.177528			90
90.01	OTTAWA CLINIC	0.606347			90.01
91	Emergency	0.263585	1,361,227	358,799	91
92	Observation Beds (Non-Distinct Part)	0.656747	145,558	95,595	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		17,866,424	4,529,119	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		17,866,424		202

(A) Worksheet A line numbers

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0026** **WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.240925			50
53	Anesthesiology	0.027888			53
54	Radiology-Diagnostic	0.214607			54
57	CT Scan	0.038163			57
58	MRI	0.285583			58
60	Laboratory	0.174371			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.355286			65
66	Physical Therapy	0.409718			66
67	Occupational Therapy	0.576369			67
68	Speech Pathology	0.550413			68
68.01	AUDIOLOGY				68.01
69	Electrocardiology	0.060033			69
70	Electroencephalography	0.263614			70
71	Medical Supplies Charged to Patients	0.316694			71
72	Impl. Dev. Charged to Patients	0.432784			72
73	Drugs Charged to Patients	0.358557			73
76.97	CARDIAC REHABILITATION	0.505315			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.177528			90
90.01	OTTAWA CLINIC	0.606347			90.01
91	Emergency	0.263585			91
92	Observation Beds (Non-Distinct Part)	0.656747			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

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)	1,321,580			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,916,289			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)	65,902			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	501,980			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	95.08			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)	0.0279			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1421			31
32	Sum of lines 30 and 31	0.1700			32
33	Allowable disproportionate share percentage (see instructions)	0.0380			33
34	Disproportionate share adjustment (see instructions)	49,760			34
		Prior to	**On or after**		
	Uncompensated Care Adjustment	**October 1**	**October 1**		
35	Total uncompensated care amount (see instructions)	9,046,380,143			35
35.01	Factor 3 (see instructions)	0.000036097			35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	326,547	288,846		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	82,308	216,041		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	298,349			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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	5,651,880			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	7,279,631			48
49	Total payment for inpatient operating costs (see instructions)	6,872,693			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	426,008			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				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).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	7,298,701			59
60	Primary payer payments	3,740			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	7,294,961			61
62	Deductibles billed to program beneficiaries	705,776			62
63	Coinsurance billed to program beneficiaries	3,465			63
64	Allowable bad debts (see instructions)	151,213			64
65	Adjusted reimbursable bad debts (see instructions)	98,288			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	83,295			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	6,684,008			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 (specify) (see instructions)				70
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	5,012			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-10,179			70.91
70.93	HVBP payment adjustment amount (see instructions)	21,505			70.93
70.94	HRR adjustment amount (see instructions)	-43,666			70.94
70.96	Low volume adjustment for federal fiscal year (2014)	108,919			70.96
70.97	Low volume adjustment for federal fiscal year (2015)	419,301			70.97
71	Amount due provider (see instructions)	7,184,900			71
71.01	Sequestration adjustment (see instructions)	143,698			71.01
72	Interim payments	7,111,699			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-70,497			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	4,714			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)	307,712	913,101		100

	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	1.0051953207	1.0037380118		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)	1,599	3,413		102

	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
103	HRR adjustment factor (see instructions)	0.9960	0.9902		103
104	HRR adjustment amount for HSP bonus payment (see instructions)	-1,231	-8,948		104

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97) **EXHIBIT 4**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Pre/Post Entitlement	10/01/2013 through 09/30/2014		10/01/2014 through 09/30/2015		Total (col. 2 through 4)	
		1	2	3	3.01	4	4.01	5	
1	DRG Amounts Other Than Outlier Payments								1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1,321,580		1,321,580				1,321,580	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,916,289				3,916,289		3,916,289	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1								1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1								1.04
2	Outlier payments for discharges	65,902		46,027		19,875		65,902	2
2.01	Outlier payment for discharges for Model 4 BPCI								2.01
3	Operating outlier reconciliation								3
4	Managed Care Simulated Payments	501,980		118,443		383,537		501,980	4
	Indirect Medical Education Adjustment								
5	Amount from Worksheet E Part A, line 21								5
6	IME payment adjustment								6
6.01	IME payment adjustment for managed care								6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7	IME payment adjustment factor								7
8	IME add-on adjustment amount								8
8.01	IME payment adjustment add-on for managed care								8.01
9	Total IME payment (sum of lines 6 and 8)								9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)								9.01
	Disproportionate Share Adjustment								
10	Allowable disproportionate share percentage	0.0380	0.0380	0.0380	0.0380	0.0380	0.0380		10
11	Disproportionate share adjustment	49,760		12,555		37,205		49,760	11
11.01	Uncompensated care payments	298,349		82,308		216,041		298,349	11.01
	Additional payment for high percentage of ESRD beneficiary discharges								
12	Total ESRD additional payment								12
13	Subtotal	5,651,880		1,462,470		4,189,410		5,651,880	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	7,279,631		1,878,064		5,401,567		7,279,631	14
15	Total payment for inpatient operating costs SCH and MDH only	6,872,693		1,774,166		5,098,528		6,872,694	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	426,008		114,201		311,807		426,008	16
17	Special add-on payments for new technologies								17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)								17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG								17.02
18	Capital outlier reconciliation adjustment amount								18
19	**SUBTOTAL**			1,888,367		5,410,335		7,298,702	19
20	Capital DRG other than outlier	413,638		104,390		309,248		413,638	20
20.01	Model 4 BPCI Capital DRG other than outlier								20.01
21	Capital DRG outlier payments	12,370		9,811		2,559		12,370	21
21.01	Model 4 BPCI Capital DRG outlier payments								21.01
22	Indirect medical education percentage								22
23	Indirect medical education adjustment								23
24	Allowable disproportionate share percentage								24
25	Disproportionate share adjustment								25
26	Total prospective capital payments	426,008		114,201		311,807		426,008	26
27	**Low volume adjustment factor**			0.057679		0.077500			27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)			108,919				108,919	28

ST. MARY'S HOSPITAL Provider CCN: 14-0026	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97) **EXHIBIT 4**

29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)					419,301		419,301	29

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0026** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	15,422			1
2	Medical and other services reimbursed under OPPS (see instructions)	6,237,858			2
3	PPS payments	4,127,543			3
4	Outlier payment (see instructions)	10,240			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.840			5
6	Line 2 times line 5	5,239,801			6
7	Sum of line 3 and line 4 divided by line 6	0.7897			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)	15,422			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	47,338			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)	47,338			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)	47,338			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	31,916			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	15,422			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,137,783			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	439			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	920,120			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)	3,232,646			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)	3,232,646			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	3,232,646			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)	191,140			34
35	Adjusted reimbursable bad debts (see instructions)	124,241			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	102,075			36
37	Subtotal (see instructions)	3,356,887			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,356,887			40
40.01	Sequestration adjustment (see instructions)	67,138			40.01
41	Interim payments	3,259,387			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	30,362			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				7,111,699		3,269,350	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50			02/27/2014	9,963	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				-9,963	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				7,111,699		3,259,387	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01				30,362	6.01
	based on the cost report (1)		.02		-70,497			6.02
7	Total Medicare program liability (see instructions)				7,041,202		3,289,749	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.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	1,332	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	3,479	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	344	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	5,339	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	130,847,523	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	4,082,953	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	752,626	8
9	Sequestration adjustment amount (see instructions)	15,053	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	737,573	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	774,779	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-37,206	32

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

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0026** **WORKSHEET E-3 PART VII**

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

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

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

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	1,580,704				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	21,809,089				4
5	Other receivables	213,674				5
6	Allowances for uncollectible notes and accounts receivable	-14,548,890				6
7	Inventory	750,231				7
8	Prepaid expenses	581,822				8
9	Other current assets	3,620,695				9
10	Due from other funds	459,383				10
11	Total current assets (sum of lines 1-10)	14,466,708				11
	FIXED ASSETS					
12	Land	1,259,924				12
13	Land improvements	1,011,302				13
14	Accumulated depreciation	-836,404				14
15	Buildings	42,931,598				15
16	Accumulated depreciation	-18,635,085				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	9,363,196				19
20	Accumulated depreciation	-6,432,797				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	22,924,442				23
24	Accumulated depreciation	-18,478,786				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)	33,107,390				30
	OTHER ASSETS					
31	Investments	248,720				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	27,411,366				34
35	Total other assets (sum of lines 31-34)	27,660,086				35
36	Total assets (sum of lines 11, 30 and 35)	75,234,184				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,953,539				37
38	Salaries, wages and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	8,279,135				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	10,232,674				45
	LONG TERM LIABILITIES					
46	Mortgage payable	8,452,064				46
47	Notes payable	2,442,303				47
48	Unsecured loans					48
49	Other long term liabilities	11,115,611				49
50	Total long term liabilities (sum of lines 46 thru 49)	22,009,978				50
51	Total liabilities (sum of lines 45 and 50)	32,242,652				51
	CAPITAL ACCOUNTS					
52	General fund balance	42,991,532				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

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
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)	42,991,532				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	75,234,184				60

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		40,793,753			1
2	Net income (loss) (from Worksheet G-3, line 29)		2,197,779			2
3	Total (sum of line 1 and line 2)		42,991,532			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		42,991,532			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						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)		42,991,532			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						5
6						6
7						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						13
14						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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	7,898,561		7,898,561	1
2	Subprovider IPF				2
3	Subprovider IRF				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)	7,898,561		7,898,561	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	2,195,661		2,195,661	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)	2,195,661		2,195,661	16
17	Total inpatient routine care services (sum of lines 10 and 16)	10,094,222		10,094,222	17
18	Ancillary services	25,442,228	99,857,428	125,299,656	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				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)	35,536,450	99,857,428	135,393,878	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		42,423,505	29
30	Add (specify)			30
31				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)		42,423,505	43

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	135,393,878	1
2	Less contractual allowances and discounts on patients' accounts	91,035,441	2
3	Net patient revenues (line 1 minus line 2)	44,358,437	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	42,423,505	4
5	Net income from service to patients (line 3 minus line 4)	1,934,932	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		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		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		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (MISC)	262,847	24
25	Total other income (sum of lines 6-24)	262,847	25
26	Total (line 5 plus line 25)	2,197,779	26
29	Net income (or loss) for the period (line 26 minus line 28)	2,197,779	29

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0026** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	413,638	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	12,370	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)	14.73	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)	426,008	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

ST. MARY'S HOSPITAL Provider CCN: 14-0026	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/20/2015 Run Time: 11:20 Version: 2015.10 (11/17/2015)

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0026** **WORKSHEET L**

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

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
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
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
68.01	AUDIOLOGY							68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
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
90.01	OTTAWA CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
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 NONREIMBURSABLE COST							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202