Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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: 05/22/2014 TIME: 15:02 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 STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. MARY'S HOSPITAL (14-0034) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(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		144,373	-255,176	-87,095		1
2	SUBPROVIDER - IPF		18,464				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
12.20	OUTPATIENT REHABILITATION PROVIDER - OPT						12.20
200	TOTAL		162,837	-255,176	-87,095		200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD 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.

Optimizer Systems, Inc. **WinLASH** Micro System

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:

1	STREET: 400 NORTH PLEASANT AVENUE	P.O. BOX:		1
2	CITY: CENTRALIA	STATE: IL	ZIP CODE: 62801-	COUNTY: MARION 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV-IDER 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	14-0034	99914	1	07/01/1966	N	P	P	3
4	SUBPROVIDER - IPF	ST. MARY'S PSYCH	14-S034	99914	4	01/01/2002	N	P	P	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
17.20	HOSPITAL-BASED (OPT)	ST MARY'S WORK SAFETY INSTITUTE	14-6668	99914		03/08/2000	N	O	N	17.20
18	RENAL DIALYSIS									18
19	OTHER									19

20	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 01 / 01 / 2013	TO: 12 / 31 / 2013	20
21	TYPE OF CONTROL (see instructions)	1		21

	INPATIENT PPS INFORMATION	1	2	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILTY 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
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.	2	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 COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	3,704	150					24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							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
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.	1		37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING: 01 / 01 / 2013	ENDING: 12 / 31 / 2013	38

	1	2	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		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 WORKSHEET L, PART III AND L-1, PARTS I THROUGH 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 WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART 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 BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT 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 RECEIVED HRSA PCRE FUNDING (see instructions)					62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)					62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS						
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N				63

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER 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 NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER 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 NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				66

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

	INPATIENT PSYCHIATRIC FACILITY PPS	1	2	3	
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			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, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.	N	N		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, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				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
	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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

		V	XIX	
TITLE V AND XIX SERVICES		1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR 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.			106
107	COLUMN 1: 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. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			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.	Y	N	N	N	109

MISCELLANEOUS COST REPORTING INFORMATION					
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 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'	N			115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.		Y		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.		1		118

		PREMIUMS	PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:	519,456			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.		N		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 CERTIFIED 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 CERTIFIED 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

Optimizer Systems, Inc. WinLASH Micro System

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	269020	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: SSM HEALTHCARE	CONTRACTOR'S NAME: A	CONTRACTOR'S NUMBER: 05301	141
142	STREET: 477 N LINDBERGH	P.O. BOX:		142
143	CITY: ST. LOUIS	STATE: MO	ZIP CODE: 63141	143

144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	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, section 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	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N		N	156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)					158
159	SNF	N	N			159
160	HHA	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.		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
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)	1.00		169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	07/03/2013	09/30/2013	170

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	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)	Y			3

		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON 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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	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

		Y/N	
BAD DEBTS			
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.	Y	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	03/31/2014	Y	03/31/2014	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 REPORT 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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

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

CAPITAL RELATED COSTS			
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 CAPITALIZED 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	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?			36
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.			37
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.			38
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.			39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.			40

COST REORT PREPARER INFORMATION				
41	FIRST NAME: MIKE	LAST NAME: HOBBS	TITLE: FINANCIAL REIMBURSEMENT SP	41
42	EMPLOYER: SMGS			42
43	PHONE NUMBER: 6184367566	E-MAIL ADDRESS: MIKE_HOBBS@SSMHC.COM		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA 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	79	30,903			11,372	2,759	15,688	1
2	HMO AND OTHER (see instructions)						50			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)		79	30,903			11,372	2,759	15,688	7
8	INTENSIVE CARE UNIT	31	12	4,380			1,319	515	2,751	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						478	863	13
14	TOTAL (see instructions)		91	35,283			12,691	3,752	19,302	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	12	4,380			463	782	2,233	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
25.20	OPT	99.20								25.20
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		103							27
28	OBSERVATION BED DAYS							516	2,351	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)								258	30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)							102	140	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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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)					2,926	936	4,600	1
2	HMO AND OTHER (see instructions)					11			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)		711.80			2,926	936	4,600	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF		6.00			117	226	636	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
25.20	OPT								25.20
26	RHC								26
27	TOTAL (sum of lines 14-26)		717.80						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

Optimizer Systems, Inc. WinLASH Micro System

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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	35,993,647		35,993,647	1,493,019.00	24.11	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B		194,751		194,751	2,088.00	93.27	3
4	PHYSICIAN-PART A - ADMINISTRATIVE		278,566		278,566	1,728.00	161.21	4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B		37,838		37,838	234.00	161.70	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)		1,352,554	51,570	1,404,124	58,683.00	23.93	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		397,889		397,889	6,891.00	57.74	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		190,110		190,110	1,002.00	189.73	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		8,211,200		8,211,200	165,944.00	49.48	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)		16,293,266		16,293,266			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		616,773		616,773			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B		92,215		92,215			21
22	PHYSICIAN PART A - ADMINISTRATIVE		35,147		35,147			22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B		5,561		5,561			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		407,164		407,164	18,322.00	22.22	26
27	ADMINISTRATIVE & GENERAL		4,890,669	18,593	4,909,262	150,506.00	32.62	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		200,000		200,000	1,000.00	200.00	28
29	MAINTENANCE & REPAIRS		788,690	-631,518	157,172	8,116.00	19.37	29
30	OPERATION OF PLANT			631,518	631,518	32,610.00	19.37	30
31	LAUNDRY & LINEN SERVICE		127,972		127,972	10,784.00	11.87	31
32	HOUSEKEEPING		947,566		947,566	77,884.00	12.17	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		896,765	-602,003	294,762	19,305.00	15.27	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			602,003	602,003	45,309.00	13.29	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		824,146		824,146	20,961.00	39.32	38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,303,839		1,303,839	52,780.00	24.70	41
42	SOCIAL SERVICE		269,279		269,279	12,410.00	21.70	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	35,961,058		35,961,058	1,491,697.00	24.11	1
2	EXCLUDED AREA SALARIES (see instructions)	1,352,554	51,570	1,404,124	58,683.00	23.93	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	34,608,504	-51,570	34,556,934	1,433,014.00	24.11	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	8,799,199		8,799,199	173,837.00	50.62	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	16,328,413		16,328,413		47.25%	5
6	TOTAL (sum of lines 3 through 5)	59,736,116	-51,570	59,684,546	1,606,851.00	37.14	6
7	TOTAL OVERHEAD COST (see instructions)	10,656,090	18,593	10,674,683	449,987.00	23.72	7

Optimizer Systems, Inc. WinLASH Micro System

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

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	287,105	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,313,284	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	11,384,008	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	242,479	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	108,279	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)	8,487	12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	119,318	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	337,679	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	2,259,034	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	41,648	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	191,945	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	16,293,266	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL	110,057	25

Optimizer Systems, Inc. WinLASH Micro System

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

	STEP 2: 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

Optimizer Systems, Inc. WinLASH Micro System

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HOSPITAL CONTRACT LABOR AND BENEFIT COST **WORKSHEET S-3 PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	365,451		1
2	HOSPITAL	365,451		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
16.20	HOSPITAL-BASED (OPT)			16.20
17	RENAL DIALYSIS			17
18	OTHER			18

Optimizer Systems, Inc. WinLASH Micro System

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

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.344016	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	13,197,786	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	53,834,922	6
7	MEDICAID COST (line 1 times line 6)	18,520,075	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.	5,322,289	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 AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	5,322,289	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	8,425,527	1,122,285	9,547,812	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	2,898,516	386,084	3,284,600	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	2,898,516	386,084	3,284,600	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)	10,262,268	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	231,978	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	10,030,290	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	3,450,580	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	6,735,180	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	12,057,469	31

Optimizer Systems, Inc. WinLASH Micro System

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		1,494,956	1,494,956	799,078	2,294,034	7,964	2,301,998	1
2	00200	CAP REL COSTS-MVBLE EQUIP		1,841,112	1,841,112	27,540	1,868,652	705,364	2,574,016	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	407,164	15,450,358	15,857,522		15,857,522	-4,479,388	11,378,134	4
5	00500	ADMINISTRATIVE & GENERAL	4,890,669	19,305,641	24,196,310	-692,212	23,504,098	-220,252	23,283,846	5
6	00600	MAINTENANCE & REPAIRS	788,690	2,242,420	3,031,110	-2,017,442	1,013,668	-7	1,013,661	6
6.01	00601	BIOMEDICAL SERVICES		850,195	850,195		850,195		850,195	6.01
7	00700	OPERATION OF PLANT				2,047,852	2,047,852		2,047,852	7
8	00800	LAUNDRY & LINEN SERVICE	127,972	399,811	527,783	-200	527,583		527,583	8
9	00900	HOUSEKEEPING	947,566	246,597	1,194,163	-89,137	1,105,026	-840	1,104,186	9
10	01000	DIETARY	896,765	791,922	1,688,687	-1,223,970	464,717	-83	464,634	10
11	01100	CAFETERIA				1,223,970	1,223,970	-366,822	857,148	11
13	01300	NURSING ADMINISTRATION	824,146	30,636	854,782		854,782	-1,542	853,240	13
16	01600	MEDICAL RECORDS & LIBRARY	1,303,839	248,902	1,552,741	-146	1,552,595	-93,725	1,458,870	16
17	01700	SOCIAL SERVICE	269,279	27,950	297,229	-1,295	295,934	-246	295,688	17
19	01900	NONPHYSICIAN ANESTHETISTS	194,751		194,751		194,751	-194,751		19
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	7,014,476	1,031,536	8,046,012	-1,056,405	6,989,607	-3,155	6,986,452	30
31	03100	INTENSIVE CARE UNIT	2,288,346	862,737	3,151,083	30,255	3,181,338	-111	3,181,227	31
40	04000	SUBPROVIDER - IPF	904,938	23,203	928,141	-35	928,106	-7,066	921,040	40
43	04300	NURSERY				654,798	654,798	-48	654,750	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	2,272,549	3,125,221	5,397,770	88,512	5,486,282	-27,010	5,459,272	50
52	05200	DELIVERY ROOM & LABOR ROOM				522,628	522,628		522,628	52
53	05300	ANESTHESIOLOGY		2,173,960	2,173,960	-50	2,173,910	-1,992,758	181,152	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,591,198	1,093,803	2,685,001	-900	2,684,101	-910,678	1,773,423	54
54.01	05401	CARDIAC REHABILITATION	95,288	1,451	96,739		96,739	-10,394	86,345	54.01
56.01	03470	NUCLEAR MEDICINE	169,013	648,894	817,907		817,907	-39,293	778,614	56.01
57	05700	CT SCAN	279,679	58,809	338,488		338,488		338,488	57
58	05800	MRI	115,274	54,726	170,000		170,000		170,000	58
59	05900	CARDIAC CATHETERIZATION	312,017	392,127	704,144	32,542	736,686	-18,832	717,854	59
60	06000	LABORATORY	1,760,579	2,228,548	3,989,127	-633	3,988,494	-78,696	3,909,798	60
64	06400	INTRAVENOUS THERAPY	231,615	59,846	291,461		291,461		291,461	64
65	06500	RESPIRATORY THERAPY	731,668	216,275	947,943	9,112	957,055	-32,156	924,899	65
65.98	06501	HYPERBARIC OXYGEN THERAPY				45,717	45,717		45,717	65.98
66	06600	PHYSICAL THERAPY	1,330,382	300,900	1,631,282	34	1,631,316	-144,105	1,487,211	66
68	06800	SPEECH PATHOLOGY	108,468	2,931	111,399		111,399		111,399	68
69	06900	ELECTROCARDIOLOGY	749,706	448,722	1,198,428		1,198,428	-407,052	791,376	69
70.01	07001	NEUROLOGY	306,249	292,861	599,110		599,110	-270,979	328,131	70.01
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,414	179,516	342,930	-342,930				71
73	07300	DRUGS CHARGED TO PATIENTS	1,258,145	4,512,538	5,770,683		5,770,683	-12,518	5,758,165	73
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	303,002	149,190	452,192	-45,717	406,475	-206,837	199,638	90
90.01	09002	DIABETES EDUCATION	32,054	356	32,410		32,410		32,410	90.01
90.02	09001	PSYCH SERVICES	324,985	29,602	354,587	-5	354,582	-46,415	308,167	90.02
90.04	09003	ANTICOAGULATION CLINIC	106,088	212	106,300		106,300		106,300	90.04
91	09100	EMERGENCY	2,446,057	1,312,057	3,758,114		3,758,114	-664,004	3,094,110	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	35,546,031	62,130,521	97,676,552	10,961	97,687,513	-9,516,435	88,171,078	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				-168	-168		-168	190
193.05	19305	OTHER NON-REIMBURSABLE	445,761	556,242	1,002,003	-119,034	882,969	64,984	947,953	193.05
193.06	19306	OUTSIDE ACCOUNTING	1,855	18	1,873		1,873		1,873	193.06
193.07	19307	OUTSIDE PRINTING				108,252	108,252		108,252	193.07
193.08	19308	FOUNDATION				-11	-11	191,620	191,609	193.08
194	07951	AHEC		6,000	6,000		6,000		6,000	194
200		TOTAL (sum of lines 118-199)	35,993,647	62,692,781	98,686,428		98,686,428	-9,259,831	89,426,597	200

Optimizer Systems, Inc. WinLASH Micro System

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS FROM OB TO NURSERY	A	NURSERY	43	574,936	78,349	1
500	TOTAL RECLASSIFICATIONS				574,936	78,349	500
	CODE LETTER - A						
1							1
2	RECLASS FROM OB TO DELIVERY ROOM	B	DELIVERY ROOM & LABOR ROOM	52	459,949	62,679	2
500	TOTAL RECLASSIFICATIONS				459,949	62,679	500
	CODE LETTER -						
1							1
2							2
3	RECLASS FROM DIETARY TO CAFETERIA	C	CAFETERIA	11	602,003	621,967	3
500	TOTAL RECLASSIFICATIONS				602,003	621,967	500
	CODE LETTER -						
1							1
2							2
3							3
4	RECLASS IV PUMP COST	D	ADULTS & PEDIATRICS	30		119,508	4
5	RECLASS IV PUMP COST	D	INTENSIVE CARE UNIT	31		30,255	5
6	RECLASS IV PUMP COST	D	NURSERY	43		1,513	6
500	TOTAL RECLASSIFICATIONS					151,276	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6
7	RECLASS MAILROOM COST	E	ADMINISTRATIVE & GENERAL	5	11,512		7
500	TOTAL RECLASSIFICATIONS				11,512		500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5	RECLASS CENTRAL SERVICE COST	F					5
6	RECLASS CENTRAL SERVICE COST	F					6
7	RECLASS CENTRAL SERVICE COST	F					7
8	RECLASS CENTRAL SERVICE COST	F	ADMINISTRATIVE & GENERAL	5	58,651		8
9	RECLASS CENTRAL SERVICE COST	F	OPERATING ROOM	50	63,410	25,102	9
10	RECLASS CENTRAL SERVICE COST	F	RESPIRATORY THERAPY	65	6,528	2,584	10
11	RECLASS CENTRAL SERVICE COST	F	CARDIAC CATHETERIZATION	59	23,313	9,229	11
500	TOTAL RECLASSIFICATIONS				151,902	36,915	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12	RECLASS INTEREST & FINANCIN	G	CAP REL COSTS-BLDG & FIXT	1		705,501	12
500	TOTAL RECLASSIFICATIONS					705,501	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13	RECLASS PLANT OPERATIONS	H	OPERATION OF PLANT	7	631,518	1,310,983	13

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
500	TOTAL RECLASSIFICATIONS				631,518	1,310,983	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14	RECLASS O/S PRINTING TO NON-REIMBURS	I	OUTSIDE PRINTING	193.07	51,570	56,682	14
500	TOTAL RECLASSIFICATIONS				51,570	56,682	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15	RECLASS INVENTORY COST	J	MEDICAL SUPPLIES CHARGED TO P	71		8,675	15
500	TOTAL RECLASSIFICATIONS					8,675	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16	RECLASS DOCUMENT SHREDDING	K	ADMINISTRATIVE & GENERAL	5		87,361	16
500	TOTAL RECLASSIFICATIONS					87,361	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11	RECLASS UTILITIES	L	OPERATION OF PLANT	7		105,351	11
12	RECLASS UTILITIES	L	PHYSICAL THERAPY	66		34	12
13	RECLASS UTILITIES	L					13
14	RECLASS UTILITIES	L					14
15	RECLASS UTILITIES	L					15
16	RECLASS UTILITIES	L					16
17	RECLASS UTILITIES	L					17
18	RECLASS UTILITIES	L					18
19	RECLASS UTILITIES	L					19

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
20	RECLASS UTILITIES	L					20
21	RECLASS UTILITIES	L					21
22	RECLASS UTILITIES	L					22
23	RECLASS UTILITIES	L					23
24	RECLASS UTILITIES	L					24
25	RECLASS UTILITIES	L					25
26	RECLASS UTILITIES	L					26
27	RECLASS UTILITIES	L					27
500	TOTAL RECLASSIFICATIONS					105,385	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25	RECLASS REAL ESTATE TAXES	M	CAP REL COSTS-BLDG & FIXT	1		46,176	25
26	RECLASS REAL ESTATE TAXES	M	ADMINISTRATIVE & GENERAL	5		8,337	26
500	TOTAL RECLASSIFICATIONS					54,513	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27	RECLASS HYPERBARIC OXYGEN THERAPY	N	HYPERBARIC OXYGEN THERAPY	65.98	37,765	7,952	27
500	TOTAL RECLASSIFICATIONS				37,765	7,952	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28	RECLASS PROP INSUR EXP FROM M&R	O	OTHER CAP REL COSTS	3		74,941	28
500	TOTAL RECLASSIFICATIONS					74,941	500
	CODE LETTER -						
	GRAND TOTAL (INCREASES)				2,521,155	3,363,179	

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

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RECLASS FROM OB TO NURSERY	A	ADULTS & PEDIATRICS	30	574,936	78,349		1
500	TOTAL RECLASSIFICATIONS				574,936	78,349		500
	CODE LETTER - A							
1								1
2	RECLASS FROM OB TO DELIVERY ROOM	B	ADULTS & PEDIATRICS	30	459,949	62,679		2
500	TOTAL RECLASSIFICATIONS				459,949	62,679		500
	CODE LETTER -							
1								1
2								2
3	RECLASS FROM DIETARY TO CAFETERIA	C	DIETARY	10	602,003	621,967		3
500	TOTAL RECLASSIFICATIONS				602,003	621,967		500
	CODE LETTER -							
1								1
2								2
3								3
4	RECLASS IV PUMP COST	D	MEDICAL SUPPLIES CHARGED TO P	71		119,508		4
5	RECLASS IV PUMP COST	D	MEDICAL SUPPLIES CHARGED TO P	71		30,255		5
6	RECLASS IV PUMP COST	D	MEDICAL SUPPLIES CHARGED TO P	71		1,513		6
500	TOTAL RECLASSIFICATIONS					151,276		500
	CODE LETTER -							
1								1
2								2
3								3
4								4
5								5
6								6
7	RECLASS MAILROOM COST	E	MEDICAL SUPPLIES CHARGED TO P	71	11,512			7
500	TOTAL RECLASSIFICATIONS				11,512			500
	CODE LETTER -							
1								1
2								2
3								3
4								4
5	RECLASS CENTRAL SERVICE COST	F						5
6	RECLASS CENTRAL SERVICE COST	F						6
7	RECLASS CENTRAL SERVICE COST	F						7
8	RECLASS CENTRAL SERVICE COST	F	MEDICAL SUPPLIES CHARGED TO P	71	58,651			8
9	RECLASS CENTRAL SERVICE COST	F	MEDICAL SUPPLIES CHARGED TO P	71	63,410	25,102		9
10	RECLASS CENTRAL SERVICE COST	F	MEDICAL SUPPLIES CHARGED TO P	71	6,528	2,584		10
11	RECLASS CENTRAL SERVICE COST	F	MEDICAL SUPPLIES CHARGED TO P	71	23,313	9,229		11
500	TOTAL RECLASSIFICATIONS				151,902	36,915		500
	CODE LETTER -							
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12	RECLASS INTEREST & FINANCIN	G	ADMINISTRATIVE & GENERAL	5		705,501	11	12
500	TOTAL RECLASSIFICATIONS					705,501		500
	CODE LETTER -							
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12

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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	
13	RECLASS PLANT OPERATIONS	H	MAINTENANCE & REPAIRS	6	631,518	1,310,983		13
500	TOTAL RECLASSIFICATIONS				631,518	1,310,983		500
	CODE LETTER -							
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14	RECLASS O/S PRINTING TO NON-REIMBURS	I	ADMINISTRATIVE & GENERAL	5	51,570	56,682		14
500	TOTAL RECLASSIFICATIONS				51,570	56,682		500
	CODE LETTER -							
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15	RECLASS INVENTORY COST	J	ADMINISTRATIVE & GENERAL	5		8,675		15
500	TOTAL RECLASSIFICATIONS					8,675		500
	CODE LETTER -							
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16	RECLASS DOCUMENT SHREDDING	K	HOUSEKEEPING	9		87,361		16
500	TOTAL RECLASSIFICATIONS					87,361		500
	CODE LETTER -							
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11	RECLASS UTILITIES	L	ADMINISTRATIVE & GENERAL	5		35,645		11
12	RECLASS UTILITIES	L	LAUNDRY & LINEN SERVICE	8		200		12
13	RECLASS UTILITIES	L	HOUSEKEEPING	9		1,776		13
14	RECLASS UTILITIES	L	MEDICAL RECORDS & LIBRARY	16		146		14
15	RECLASS UTILITIES	L	SOCIAL SERVICE	17		1,295		15
16	RECLASS UTILITIES	L	SUBPROVIDER - IPF	40		35		16
17	RECLASS UTILITIES	L	ANESTHESIOLOGY	53		50		17

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
18	RECLASS UTILITIES	L	RADIOLOGY-DIAGNOSTIC	54		900		18
19	RECLASS UTILITIES	L	LABORATORY	60		633		19
20	RECLASS UTILITIES	L						20
21	RECLASS UTILITIES	L						21
22	RECLASS UTILITIES	L	PSYCH SERVICES	90.02		5		22
23	RECLASS UTILITIES	L	GIFT, FLOWER, COFFEE SHOP & C	190		168		23
24	RECLASS UTILITIES	L	OTHER NON-REIMBURSABLE	193.05		64,521		24
25	RECLASS UTILITIES	L	FOUNDATION	193.08		11		25
26	RECLASS UTILITIES	L						26
27	RECLASS UTILITIES	L						27
500	TOTAL RECLASSIFICATIONS					105,385		500
	CODE LETTER -							
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25	RECLASS REAL ESTATE TAXES	M	OTHER NON-REIMBURSABLE	193.05		46,176	13	25
26	RECLASS REAL ESTATE TAXES	M	OTHER NON-REIMBURSABLE	193.05		8,337		26
500	TOTAL RECLASSIFICATIONS					54,513		500
	CODE LETTER -							
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27	RECLASS HYPERBARIC OXYGEN THERAPY	N	CLINIC	90	37,765	7,952		27
500	TOTAL RECLASSIFICATIONS				37,765	7,952		500
	CODE LETTER -							
1								1
2								2
3								3

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28	RECLASS PROP INSUR EXP FROM M&R	O	MAINTENANCE & REPAIRS	6		74,941		28
500	TOTAL RECLASSIFICATIONS					74,941		500
	CODE LETTER -							
	GRAND TOTAL (DECREASES)				2,521,155	3,363,179		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	1,259,000					1,259,000		1
2	LAND IMPROVEMENTS	667,527					667,527		2
3	BUILDINGS AND FIXTURES	25,508,643	3,187,788		3,187,788	482,972	28,213,459		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	1,342,093	367,211		367,211		1,709,304		5
6	MOVABLE EQUIPMENT	16,055,655	1,901,304		1,901,304	571,351	17,385,608		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	44,832,918	5,456,303		5,456,303	1,054,323	49,234,898		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	44,832,918	5,456,303		5,456,303	1,054,323	49,234,898		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,494,956						1,494,956	1
2	CAP REL COSTS-MVBLE EQUIP	1,841,112						1,841,112	2
3	TOTAL (sum of lines 1-2)	3,336,068						3,336,068	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	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	29,922,763		29,922,763	0.632505	47,401			47,401	1
2	CAP REL COSTS-MVBLE EQU	17,385,608		17,385,608	0.367495	27,540			27,540	2
3	TOTAL (sum of lines 1-2)	47,308,371		47,308,371	1.000000	74,941			74,941	3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,502,920		705,501	47,401	46,176		2,301,998	1
2	CAP REL COSTS-MVBLE EQUIP	2,546,476			27,540			2,574,016	2
3	TOTAL (sum of lines 1-2)	4,049,396		705,501	74,941	46,176		4,876,014	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				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)	B	-8,688	ADMINISTRATIVE & GENERAL	5		4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	A	-13,165	ADMINISTRATIVE & GENERAL	5		7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-4,873,644				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)	B	-517	RADIOLOGY-DIAGNOSTIC	54		11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-3,127,079				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-363,955	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	A	-30,868	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	A	562,854	CAP REL COSTS-BLDG & FIXT	1	9	26
27	DEPRECIATION--MOVABLE EQUIPMENT	A	80,942	CAP REL COSTS-MVBLE EQUIP	2	9	27
28	NON-PHYSICIAN ANESTHETIST	A	-194,751	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 AND						32
33							33
34	MISC. REVENUE	B	-14,070	ADMINISTRATIVE & GENERAL	5		34
35	MISC. REVENUE	A	-12,518	DRUGS CHARGED TO PATIENTS	73		35
35.02	MISC. REVENUE	B	-270	HOUSEKEEPING	9		35.02
36							36
37	CARDIOLOGY	A	-34,377	ELECTROCARDIOLOGY	69		37
38	BABY PHOTO INCOME	B	-48	NURSERY	43		38
39	MANAGEMENT FEES	B	-36,000	RADIOLOGY-DIAGNOSTIC	54		39
40	GIFTS, CONTRIBUTIONS & ENTERTAINME	A	-82	OPERATING ROOM	50		40
41							41
41.01	CLASS FEES	B	-3,853	RESPIRATORY THERAPY	65		41.01
42	MEDICAL RECORDS & MISC. INCOME	B	-38,702	PHYSICAL THERAPY	66		42
43							43
44	MISC. REVENUE	B	-2,867	CAFETERIA	11		44
45	MISC. REVENUE	B	-62,857	MEDICAL RECORDS & LIBRARY	16		45
45.01	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-31,375	EMPLOYEE BENEFITS DEPARTMENT	4		45.01
45.02	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-120,973	ADMINISTRATIVE & GENERAL	5		45.02
45.03	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-7	MAINTENANCE & REPAIRS	6		45.03
45.04	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-570	HOUSEKEEPING	9		45.04
45.05	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-83	DIETARY	10		45.05
45.06	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-1,542	NURSING ADMINISTRATION	13		45.06
45.08	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-246	SOCIAL SERVICE	17		45.08
45.09	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-3,155	ADULTS & PEDIATRICS	30		45.09
45.10	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-111	INTENSIVE CARE UNIT	31		45.10
45.11	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-68	SUBPROVIDER - IPF	40		45.11
45.12	AMORTIZATION OF GOODWILL	A	-140,151	CAP REL COSTS-MVBLE EQUIP	2	9	45.12
45.15	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-500	LABORATORY	60		45.15
45.21	GIFTS, CONTRIBUTIONS & ENTERTAI	A	-416	EMERGENCY	91		45.21
45.25	PHYSICIAN RECRUITMENT	A	-135,647	ADMINISTRATIVE & GENERAL	5		45.25
45.26	OTHER FINANCE DEPT.	A	6,000	OTHER NON-REIMBURSABLE	193.05		45.26
45.27	UNFUNDED PENSION	A	-206,000	EMPLOYEE BENEFITS DEPARTMENT	4		45.27

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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	
45.28	OTHER FINANCE BENEFITS	A	2,400	EMPLOYEE BENEFITS DEPARTMENT	4	9	45.28
45.29	PATIENT TELEPHONE SERVICE	A	-176	CAP REL COSTS-MVBLE EQUIP	2	9	45.29
45.30	PATIENT TELEPHONE SERVICE BENEF	A	-5,679	EMPLOYEE BENEFITS DEPARTMENT	4		45.30
45.31	MEDICAL RECORDS BENEFITS	A	-11,445	EMPLOYEE BENEFITS DEPARTMENT	4		45.31
45.32	PROF LIAB INS DEDUCTIBLE RESERV	A	184,000	ADMINISTRATIVE & GENERAL	5		45.32
45.35	CANCER CENTER OFFSETS	A	9,570	OTHER NON-REIMBURSABLE	193.05		45.35
45.36	FOUNDATION EXPENSE OFFSETS	A	70,860	FOUNDATION	193.08		45.36
45.37	FOUNDATION SALARY OFFSETS	A	120,760	FOUNDATION	193.08		45.37
45.38	CRNA FEES	A	-2,536	ANESTHESIOLOGY	53		45.38
45.39	CRNA BENEFITS	A	-81,776	EMPLOYEE BENEFITS DEPARTMENT	4		45.39
45.40	WSI RENT EXPENSE	A	-49,414	PHYSICAL THERAPY	66		45.40
45.41	WIS RENT EXPENSE	A	49,414	OTHER NON-REIMBURSABLE	193.05		45.41
45.43	INTEREST EXP. UNNECESSARY BORRO	A	-705,501	CAP REL COSTS-BLDG & FIXT	1	9	45.43
45.46	DUES RELATED TO LOBBYING EXP.	A	-30,790	ADMINISTRATIVE & GENERAL	5		45.46
46	GIFTS, CONTRIBUTIONS & ENTERTAINME	A	-99	PSYCH SERVICES	90.02		46
47	GIFTS, CONTRIBUTIONS & ENTERTAINME	A	-60	CLINIC	90		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-9,259,831				50

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

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

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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 ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	CORPORATE FEES	313,500	313,500			1
2	5	ADMINISTRATIVE & GENERAL	SISTER SERVICES	99,162	99,162			2
3	5	ADMINISTRATIVE & GENERAL	CORPORATE FEES	959,302	945,880	13,422		3
4	5	ADMINISTRATIVE & GENERAL	DATA PROCESSING	6,407,652	6,318,000	89,652		4
4.01	1	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	150,611		150,611	9	4.01
4.02	2	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION	764,749		764,749	9	4.02
4.03	4	EMPLOYEE BENEFITS DEPARTMENT	FLEX BENEFITS	6,204,985	10,350,498	-4,145,513		4.03
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			14,899,961	18,027,040	-3,127,079		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			MOTHERHOUSE		CONVENT	6
7	B			SSM		CORPORATE	7
8	B			FSI		CORPORATE	8
9							9
10							10

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

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

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	5	ADMINISTRATIVE & GEN ADMINISTRATIVE	273,189	113,173	160,016	159,800	1,161	89,196	4,460	1
2	30	ADULTS & PEDIATRICS ADULTS & PEDIAT				159,800				2
3	40	SUBPROVIDER - IPF SUBPROVIDER - I	15,000		15,000	138,700	120	8,002	400	3
4	50	OPERATING ROOM OPERATING ROOM	46,097	121	45,976	182,900	218	19,169	958	4
5	53	ANESTHESIOLOGY ANESTHESIOLOGY	2,005,845	1,970,280	35,565	167,500	194	15,623	781	5
6	54	RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGN	880,438	865,438	15,000	217,600	60	6,277	314	6
7	54.01	CARDIAC REHABILITATI CARDIAC REHABIL	15,695		15,695	159,800	69	5,301	265	7
8	56.01	NUCLEAR MEDICINE NUCLEAR MEDICIN	39,293	39,293		217,600				8
9	60	LABORATORY LABORATORY	119,596	39,596	80,000	208,000	414	41,400	2,070	9
10	65	RESPIRATORY THERAPY RESPIRATORY THE	40,442	19,731	20,710	159,800	158	12,139	607	10
11	66	PHYSICAL THERAPY PHYSICAL THERAP	58,985	50,739	8,246	159,800	39	2,996	150	11
12	69	ELECTROCARDIOLOGY ELECTROCARDIOLO	380,050	358,546	21,504	159,800	96	7,375	369	12
13	59	CARDIAC CATHETERIZAT CARDIAC CATHETE	26,438	1,688	24,750	159,800	99	7,606	380	13
14	70.01	NEUROLOGY NEUROLOGY	279,737	260,357	19,380	159,800	114	8,758	438	14
15	90	CLINIC CLINIC	210,157	204,657	5,500	159,800	44	3,380	169	15
16	90.02	PSYCH SERVICES PSYCH SERVICES	52,846	42,221	10,625	159,800	85	6,530	327	16
17	91	EMERGENCY EMERGENCY	681,796	627,962	53,834	159,800	237	18,208	910	17
200		TOTAL	5,125,604	4,593,802	531,801		3,108	251,960	12,598	200

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	5	ADMINISTRATIVE & GEN ADMINISTRATIVE					89,196	70,820	183,993	1
2	30	ADULTS & PEDIATRICS ADULTS & PEDIAT								2
3	40	SUBPROVIDER - IPF SUBPROVIDER - I					8,002	6,998	6,998	3
4	50	OPERATING ROOM OPERATING ROOM					19,169	26,807	26,928	4
5	53	ANESTHESIOLOGY ANESTHESIOLOGY					15,623	19,942	1,990,222	5
6	54	RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGN					6,277	8,723	874,161	6
7	54.01	CARDIAC REHABILITATI CARDIAC REHABIL					5,301	10,394	10,394	7
8	56.01	NUCLEAR MEDICINE NUCLEAR MEDICIN							39,293	8
9	60	LABORATORY LABORATORY					41,400	38,600	78,196	9
10	65	RESPIRATORY THERAPY RESPIRATORY THE					12,139	8,571	28,303	10
11	66	PHYSICAL THERAPY PHYSICAL THERAP					2,996	5,250	55,989	11
12	69	ELECTROCARDIOLOGY ELECTROCARDIOLO					7,375	14,129	372,675	12
13	59	CARDIAC CATHETERIZAT CARDIAC CATHETE					7,606	17,144	18,832	13
14	70.01	NEUROLOGY NEUROLOGY					8,758	10,622	270,979	14
15	90	CLINIC CLINIC					3,380	2,120	206,777	15
16	90.02	PSYCH SERVICES PSYCH SERVICES					6,530	4,095	46,316	16
17	91	EMERGENCY EMERGENCY					18,208	35,626	663,588	17
200		TOTAL					251,960	279,841	4,873,644	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

Optimizer Systems, Inc. *WinLASH* Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

Optimizer Systems, Inc. *WinLASH* Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

Optimizer Systems, Inc. WinLASH Micro System

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

Optimizer Systems, Inc. *WinLASH* Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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 MOVEABLE 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	2,301,998	2,301,998					1
2	CAP REL COSTS-MVBLE EQUIP	2,574,016		2,574,016				2
4	EMPLOYEE BENEFITS DEPARTMENT	11,378,134	14,796		11,392,930			4
5	ADMINISTRATIVE & GENERAL	23,283,846	800,390	352,704	2,001,444	26,438,384	26,438,384	5
6	MAINTENANCE & REPAIRS	1,013,661	52,091		10,417	1,076,169	451,705	6
6.01	BIOMEDICAL SERVICES	850,195	6,415		25,501	882,111	370,252	6.01
7	OPERATION OF PLANT	2,047,852	134,077	95,175	205,239	2,482,343	1,041,924	7
8	LAUNDRY & LINEN SERVICE	527,583	45,356	5,389	38,603	616,931	258,947	8
9	HOUSEKEEPING	1,104,186	33,114	8,924	57,192	1,203,416	505,115	9
10	DIETARY	464,634	17,338	4,931	3,790	490,693	205,961	10
11	CAFETERIA	857,148	49,460	16,866	195,647	1,119,121	469,733	11
13	NURSING ADMINISTRATION	853,240	4,752	132,253	42,837	1,033,082	433,620	13
16	MEDICAL RECORDS & LIBRARY	1,458,870	38,293	2,685		1,499,848	629,537	16
17	SOCIAL SERVICE	295,688	4,871			300,559	126,155	17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,986,452	330,462	3,441	1,943,325	9,263,680	3,888,299	30
31	INTENSIVE CARE UNIT	3,181,227	34,444	193,451	743,696	4,152,818	1,743,079	31
40	SUBPROVIDER - IPF	921,040	42,552		289,224	1,252,816	525,849	40
43	NURSERY	654,750	25,321	61,944	186,850	928,865	389,876	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,459,272		550,520	402,239	6,412,031	2,691,347	50
52	DELIVERY ROOM & LABOR ROOM	522,628	39,256	49,326	149,480	760,690	319,287	52
53	ANESTHESIOLOGY	181,152	2,471	35,088	239,909	458,620	192,498	53
54	RADIOLOGY-DIAGNOSTIC	1,773,423	79,664	536,295	526,671	2,916,053	1,223,967	54
54.01	CARDIAC REHABILITATION	86,345		7,164	25,867	119,376	50,106	54.01
56.01	NUCLEAR MEDICINE	778,614	5,607	181	323	784,725	329,376	56.01
57	CT SCAN	338,488	4,164	106,972	90,894	540,518	226,874	57
58	MRI	170,000	2,423	15,095	37,463	224,981	94,432	58
59	CARDIAC CATHETERIZATION	717,854	26,248	19,023	100,388	863,513	362,446	59
60	LABORATORY	3,909,798	43,188	89,336	505,663	4,547,985	1,908,944	60
64	INTRAVENOUS THERAPY	291,461	6,302	2,471	75,273	375,507	157,613	64
65	RESPIRATORY THERAPY	924,899	9,290	37,744	45,063	1,016,996	426,868	65
65.98	HYPERBARIC OXYGEN THERAPY	45,717	1,230	6,423	12,273	65,643	27,553	65.98
66	PHYSICAL THERAPY	1,487,211	28,279	17,736	700,862	2,234,088	937,723	66
68	SPEECH PATHOLOGY	111,399	4,294	3,319	4,111	123,123	51,679	68
69	ELECTROCARDIOLOGY	791,376	35,632	66,461	225,155	1,118,624	469,525	69
70.01	NEUROLOGY	328,131	13,097	23,385	95,840	460,453	193,268	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS	5,758,165	17,154	46,744	493,192	6,315,255	2,650,727	73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	199,638	1,812	6,423	84,413	292,286	122,682	90
90.01	DIABETES EDUCATION	32,410	380		6,357	39,147	16,431	90.01
90.02	PSYCH SERVICES	308,167	62,242	1,319	89,395	461,123	193,549	90.02
90.04	ANTICOAGULATION CLINIC	106,300	594		34,478	141,372	59,339	90.04
91	EMERGENCY	3,094,110	35,329	47,162	790,406	3,967,007	1,665,088	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	88,171,078	2,052,388	2,545,950	10,479,480	86,979,952	25,411,374	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-168				-168		190
193.05	OTHER NON-REIMBURSABLE	947,953	248,755	14,275	717,979	1,928,962	809,651	193.05
193.06	OUTSIDE ACCOUNTING	1,873			40,350	42,223	17,722	193.06
193.07	OUTSIDE PRINTING	108,252		13,791	12,863	134,906	56,625	193.07
193.08	FOUNDATION	191,609	855		142,258	334,722	140,494	193.08
194	AHEC	6,000				6,000	2,518	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	89,426,597	2,301,998	2,574,016	11,392,930	89,426,597	26,438,384	202

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		6	6.01	7	8	9	10	
	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	1,527,874						6
6.01	BIOMEDICAL SERVICES	1,749	1,254,112					6.01
7	OPERATION OF PLANT	932,578		4,456,845				7
8	LAUNDRY & LINEN SERVICE	12,960		126,557	1,015,395			8
9	HOUSEKEEPING	3,817		92,399	51,220	1,855,967		9
10	DIETARY	14,153		48,379	2,026	449	761,661	10
11	CAFETERIA	48,263		138,010	6,929	1,796		11
13	NURSING ADMINISTRATION	2,624	47,588	13,259		1,796		13
16	MEDICAL RECORDS & LIBRARY	3,896		106,851		19,847		16
17	SOCIAL SERVICE	1,431		13,590		3,323		17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	115,052	295,972	922,095	326,648	518,884	557,880	30
31	INTENSIVE CARE UNIT	89,529	34,530	96,111	67,364	100,490	57,637	31
40	SUBPROVIDER - IPF	14,948	290	118,734	21,280	140,273	70,389	40
43	NURSERY	11,370	28,437	70,654	4,523	31,252		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	65,358	212,694	841,151	172,130	176,913	14,788	50
52	DELIVERY ROOM & LABOR ROOM	8,667	1,451	109,536	33,387	27,929		52
53	ANESTHESIOLOGY	159	81,247	6,895				53
54	RADIOLOGY-DIAGNOSTIC	20,593	95,176	222,287	78,244	54,331	12,691	54
54.01	CARDIAC REHABILITATION		1,161			24,516		54.01
56.01	NUCLEAR MEDICINE	1,352	13,638	15,646		5,298		56.01
57	CT SCAN	477	22,923	11,618		9,519		57
58	MRI	2,067	33,079	6,762		7,633		58
59	CARDIAC CATHETERIZATION	6,917	57,454	73,239	8,235	27,300	2,786	59
60	LABORATORY	29,101	20,312	120,508	221	41,848		60
64	INTRAVENOUS THERAPY	3,578		17,585	3,646	24,247	3,291	64
65	RESPIRATORY THERAPY	2,385	47,007	25,921		3,413		65
65.98	HYPERBARIC OXYGEN THERAPY		4,353	3,431		9,340		65.98
66	PHYSICAL THERAPY	4,771	33,950	78,908	42,007	60,977		66
68	SPEECH PATHOLOGY	1,829	290	11,983		3,053		68
69	ELECTROCARDIOLOGY	12,165	68,480	99,426	11,222	31,611	3,108	69
70.01	NEUROLOGY	1,988	69,931	36,545	7,548	14,907	1,791	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS	4,612		47,865	789	22,630		73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	21,627		5,055	5,031	29,456		90
90.01	DIABETES EDUCATION			1,061				90.01
90.02	PSYCH SERVICES	5,963	290	173,676		71,843		90.02
90.04	ANTICOAGULATION CLINIC			1,657		2,604		90.04
91	EMERGENCY	28,703	76,024	98,581	121,928	168,471	37,300	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,474,682	1,246,277	3,755,975	964,378	1,635,949	761,661	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
193.05	OTHER NON-REIMBURSABLE	52,556	7,835	700,870	51,017	220,018		193.05
193.06	OUTSIDE ACCOUNTING							193.06
193.07	OUTSIDE PRINTING	636						193.07
193.08	FOUNDATION							193.08
194	AHEC							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,527,874	1,254,112	4,456,845	1,015,395	1,855,967	761,661	202

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		11	13	16	17	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
6.01	BIOMEDICAL SERVICES							6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA	1,783,852						11
13	NURSING ADMINISTRATION	34,357	1,566,326					13
16	MEDICAL RECORDS & LIBRARY	86,403		2,346,382				16
17	SOCIAL SERVICE	20,410			465,468			17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	469,434	821,874	678,262	437,540	18,295,620		30
31	INTENSIVE CARE UNIT	142,191	248,945	112,458	27,928	6,873,080		31
40	SUBPROVIDER - IPF	65,993	115,539	91,840		2,417,951		40
43	NURSERY	31,976	55,983	22,960		1,575,896		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	159,540	279,318	165,406		11,190,676		50
52	DELIVERY ROOM & LABOR ROOM	25,513	44,667	12,183		1,343,310		52
53	ANESTHESIOLOGY			19,680		759,099		53
54	RADIOLOGY-DIAGNOSTIC	103,412		168,452		4,895,206		54
54.01	CARDIAC REHABILITATION	5,783		3,046		203,988		54.01
56.01	NUCLEAR MEDICINE	7,484		57,400		1,214,919		56.01
57	CT SCAN	17,689		263,573		1,093,191		57
58	MRI	7,144		56,229		432,327		58
59	CARDIAC CATHETERIZATION	17,009		18,977		1,437,876		59
60	LABORATORY	136,408		246,938		7,052,265		60
64	INTRAVENOUS THERAPY	15,988		16,400		617,855		64
65	RESPIRATORY THERAPY	56,128		6,091		1,584,809		65
65.98	HYPERBARIC OXYGEN THERAPY	3,062		3,514		116,896		65.98
66	PHYSICAL THERAPY	44,562		15,229		3,452,215		66
68	SPEECH PATHOLOGY	5,783		1,171		198,911		68
69	ELECTROCARDIOLOGY	49,665		54,355		1,918,181		69
70.01	NEUROLOGY	20,410		23,194		830,035		70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS	58,509		128,155		9,228,542		73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	17,689		15,697		509,523		90
90.01	DIABETES EDUCATION	1,701		234		58,574		90.01
90.02	PSYCH SERVICES	20,410		11,714		938,568		90.02
90.04	ANTICOAGULATION CLINIC	4,422		703		210,097		90.04
91	EMERGENCY	146,953		152,521		6,462,576		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,776,028	1,566,326	2,346,382	465,468	84,912,186		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					-168		190
193.05	OTHER NON-REIMBURSABLE					3,770,909		193.05
193.06	OUTSIDE ACCOUNTING	1,021				60,966		193.06
193.07	OUTSIDE PRINTING	6,803				198,970		193.07
193.08	FOUNDATION					475,216		193.08
194	AHEC					8,518		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,783,852	1,566,326	2,346,382	465,468	89,426,597		202

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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
6.01	BIOMEDICAL SERVICES							6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	18,295,620						30
31	INTENSIVE CARE UNIT	6,873,080						31
40	SUBPROVIDER - IPF	2,417,951						40
43	NURSERY	1,575,896						43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,190,676						50
52	DELIVERY ROOM & LABOR ROOM	1,343,310						52
53	ANESTHESIOLOGY	759,099						53
54	RADIOLOGY-DIAGNOSTIC	4,895,206						54
54.01	CARDIAC REHABILITATION	203,988						54.01
56.01	NUCLEAR MEDICINE	1,214,919						56.01
57	CT SCAN	1,093,191						57
58	MRI	432,327						58
59	CARDIAC CATHETERIZATION	1,437,876						59
60	LABORATORY	7,052,265						60
64	INTRAVENOUS THERAPY	617,855						64
65	RESPIRATORY THERAPY	1,584,809						65
65.98	HYPERBARIC OXYGEN THERAPY	116,896						65.98
66	PHYSICAL THERAPY	3,452,215						66
68	SPEECH PATHOLOGY	198,911						68
69	ELECTROCARDIOLOGY	1,918,181						69
70.01	NEUROLOGY	830,035						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS	9,228,542						73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	509,523						90
90.01	DIABETES EDUCATION	58,574						90.01
90.02	PSYCH SERVICES	938,568						90.02
90.04	ANTICOAGULATION CLINIC	210,097						90.04
91	EMERGENCY	6,462,576						91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	84,912,186						118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-168						190
193.05	OTHER NON-REIMBURSABLE	3,770,909						193.05
193.06	OUTSIDE ACCOUNTING	60,966						193.06
193.07	OUTSIDE PRINTING	198,970						193.07
193.08	FOUNDATION	475,216						193.08
194	AHEC	8,518						194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	89,426,597						202

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVEABLE 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		14,796		14,796	14,796		4
5	ADMINISTRATIVE & GENERAL	16,459	800,390	352,704	1,169,553	2,600	1,172,153	5
6	MAINTENANCE & REPAIRS	376	52,091		52,467	14	20,026	6
6.01	BIOMEDICAL SERVICES		6,415		6,415	33	16,415	6.01
7	OPERATION OF PLANT		134,077	95,175	229,252	267	46,194	7
8	LAUNDRY & LINEN SERVICE	85	45,356	5,389	50,830	50	11,480	8
9	HOUSEKEEPING	48,259	33,114	8,924	90,297	74	22,394	9
10	DIETARY		17,338	4,931	22,269	5	9,131	10
11	CAFETERIA		49,460	16,866	66,326	254	20,826	11
13	NURSING ADMINISTRATION		4,752	132,253	137,005	56	19,225	13
16	MEDICAL RECORDS & LIBRARY		38,293	2,685	40,978		27,911	16
17	SOCIAL SERVICE		4,871		4,871		5,593	17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	182,203	330,462	3,441	516,106	2,523	172,392	30
31	INTENSIVE CARE UNIT	32,940	34,444	193,451	260,835	966	77,280	31
40	SUBPROVIDER - IPF		42,552		42,552	376	23,314	40
43	NURSERY	1,513	25,321	61,944	88,778	243	17,285	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	33,451		550,520	583,971	522	119,321	50
52	DELIVERY ROOM & LABOR ROOM		39,256	49,326	88,582	194	14,156	52
53	ANESTHESIOLOGY	2,536	2,471	35,088	40,095	312	8,534	53
54	RADIOLOGY-DIAGNOSTIC	719	79,664	536,295	616,678	684	54,265	54
54.01	CARDIAC REHABILITATION			7,164	7,164	34	2,221	54.01
56.01	NUCLEAR MEDICINE	9	5,607	181	5,797		14,603	56.01
57	CT SCAN		4,164	106,972	111,136	118	10,058	57
58	MRI	10,832	2,423	15,095	28,350	49	4,187	58
59	CARDIAC CATHETERIZATION	1,753	26,248	19,023	47,024	130	16,069	59
60	LABORATORY	90,214	43,188	89,336	222,738	657	84,633	60
64	INTRAVENOUS THERAPY		6,302	2,471	8,773	98	6,988	64
65	RESPIRATORY THERAPY	21,914	9,290	37,744	68,948	59	18,925	65
65.98	HYPERBARIC OXYGEN THERAPY		1,230	6,423	7,653	16	1,222	65.98
66	PHYSICAL THERAPY	45,495	28,279	17,736	91,510	910	41,574	66
68	SPEECH PATHOLOGY		4,294	3,319	7,613	5	2,291	68
69	ELECTROCARDIOLOGY	178	35,632	66,461	102,271	292	20,816	69
70.01	NEUROLOGY		13,097	23,385	36,482	124	8,569	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	865			865			71
73	DRUGS CHARGED TO PATIENTS	129,468	17,154	46,744	193,366	640	117,521	73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		1,812	6,423	8,235	110	5,439	90
90.01	DIABETES EDUCATION		380		380	8	728	90.01
90.02	PSYCH SERVICES	252	62,242	1,319	63,813	116	8,581	90.02
90.04	ANTICOAGULATION CLINIC		594		594	45	2,631	90.04
91	EMERGENCY		35,329	47,162	82,491	1,026	73,822	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	619,521	2,052,388	2,545,950	5,217,859	13,610	1,126,620	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
193.05	OTHER NON-REIMBURSABLE	221,402	248,755	14,275	484,432	932	35,896	193.05
193.06	OUTSIDE ACCOUNTING					52	786	193.06
193.07	OUTSIDE PRINTING			13,791	13,791	17	2,510	193.07
193.08	FOUNDATION	3,690	855		4,545	185	6,229	193.08
194	AHEC						112	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	844,613	2,301,998	2,574,016	5,720,627	14,796	1,172,153	202

Optimizer Systems, Inc. WinLASH Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		6	6.01	7	8	9	10	
	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	72,507						6
6.01	BIOMEDICAL SERVICES	83	22,946					6.01
7	OPERATION OF PLANT	44,257		319,970				7
8	LAUNDRY & LINEN SERVICE	615		9,086	72,061			8
9	HOUSEKEEPING	181		6,634	3,635	123,215		9
10	DIETARY	672		3,473	144	30	35,724	10
11	CAFETERIA	2,290		9,908	492	119		11
13	NURSING ADMINISTRATION	125	871	952		119		13
16	MEDICAL RECORDS & LIBRARY	185		7,671		1,318		16
17	SOCIAL SERVICE	68		976		221		17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,460	5,416	66,201	23,181	34,444	26,167	30
31	INTENSIVE CARE UNIT	4,249	632	6,900	4,781	6,671	2,703	31
40	SUBPROVIDER - IPF	709	5	8,524	1,510	9,313	3,301	40
43	NURSERY	540	520	5,072	321	2,075		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,102	3,892	60,389	12,216	11,745	694	50
52	DELIVERY ROOM & LABOR ROOM	411	27	7,864	2,369	1,854		52
53	ANESTHESIOLOGY	8	1,487	495				53
54	RADIOLOGY-DIAGNOSTIC	977	1,741	15,959	5,553	3,607	595	54
54.01	CARDIAC REHABILITATION		21			1,628		54.01
56.01	NUCLEAR MEDICINE	64	250	1,123		352		56.01
57	CT SCAN	23	419	834		632		57
58	MRI	98	605	485		507		58
59	CARDIAC CATHETERIZATION	328	1,051	5,258	584	1,812	131	59
60	LABORATORY	1,381	372	8,652	16	2,778		60
64	INTRAVENOUS THERAPY	170		1,262	259	1,610	154	64
65	RESPIRATORY THERAPY	113	860	1,861		227		65
65.98	HYPERBARIC OXYGEN THERAPY		80	246		620		65.98
66	PHYSICAL THERAPY	226	621	5,665	2,981	4,048		66
68	SPEECH PATHOLOGY	87	5	860		203		68
69	ELECTROCARDIOLOGY	577	1,253	7,138	796	2,099	146	69
70.01	NEUROLOGY	94	1,279	2,624	536	990	84	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS	219		3,436	56	1,502		73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,026		363	357	1,956		90
90.01	DIABETES EDUCATION			76				90.01
90.02	PSYCH SERVICES	283	5	12,469		4,770		90.02
90.04	ANTICOAGULATION CLINIC			119		173		90.04
91	EMERGENCY	1,362	1,391	7,077	8,653	11,185	1,749	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	69,983	22,803	269,652	68,440	108,608	35,724	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
193.05	OTHER NON-REIMBURSABLE	2,494	143	50,318	3,621	14,607		193.05
193.06	OUTSIDE ACCOUNTING							193.06
193.07	OUTSIDE PRINTING	30						193.07
193.08	FOUNDATION							193.08
194	AHEC							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	72,507	22,946	319,970	72,061	123,215	35,724	202

Optimizer Systems, Inc. WinLASH Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		11	13	16	17	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
6.01	BIOMEDICAL SERVICES							6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA	100,215						11
13	NURSING ADMINISTRATION	1,930	160,283					13
16	MEDICAL RECORDS & LIBRARY	4,854		82,917				16
17	SOCIAL SERVICE	1,147			12,876			17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	26,373	84,102	23,969	12,103	998,437		30
31	INTENSIVE CARE UNIT	7,988	25,475	3,974	773	403,227		31
40	SUBPROVIDER - IPF	3,707	11,823	3,245		108,379		40
43	NURSERY	1,796	5,729	811		123,170		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	8,963	28,583	5,845		839,243		50
52	DELIVERY ROOM & LABOR ROOM	1,433	4,571	431		121,892		52
53	ANESTHESIOLOGY			695		51,626		53
54	RADIOLOGY-DIAGNOSTIC	5,810		5,953		711,822		54
54.01	CARDIAC REHABILITATION	325		108		11,501		54.01
56.01	NUCLEAR MEDICINE	420		2,028		24,637		56.01
57	CT SCAN	994		9,314		133,528		57
58	MRI	401		1,987		36,669		58
59	CARDIAC CATHETERIZATION	956		671		74,014		59
60	LABORATORY	7,663		8,726		337,616		60
64	INTRAVENOUS THERAPY	898		580		20,792		64
65	RESPIRATORY THERAPY	3,153		215		94,361		65
65.98	HYPERBARIC OXYGEN THERAPY	172		124		10,133		65.98
66	PHYSICAL THERAPY	2,503		538		150,576		66
68	SPEECH PATHOLOGY	325		41		11,430		68
69	ELECTROCARDIOLOGY	2,790		1,921		140,099		69
70.01	NEUROLOGY	1,147		820		52,749		70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					865		71
73	DRUGS CHARGED TO PATIENTS	3,287		4,529		324,556		73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	994		555		19,035		90
90.01	DIABETES EDUCATION	96		8		1,296		90.01
90.02	PSYCH SERVICES	1,147		414		91,598		90.02
90.04	ANTICOAGULATION CLINIC	248		25		3,835		90.04
91	EMERGENCY	8,256		5,390		202,402		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	99,776	160,283	82,917	12,876	5,099,488		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
193.05	OTHER NON-REIMBURSABLE					592,443		193.05
193.06	OUTSIDE ACCOUNTING	57				895		193.06
193.07	OUTSIDE PRINTING	382				16,730		193.07
193.08	FOUNDATION					10,959		193.08
194	AHEC					112		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	100,215	160,283	82,917	12,876	5,720,627		202

Optimizer Systems, Inc. WinLASH Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
6.01	BIOMEDICAL SERVICES							6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	998,437						30
31	INTENSIVE CARE UNIT	403,227						31
40	SUBPROVIDER - IPF	108,379						40
43	NURSERY	123,170						43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	839,243						50
52	DELIVERY ROOM & LABOR ROOM	121,892						52
53	ANESTHESIOLOGY	51,626						53
54	RADIOLOGY-DIAGNOSTIC	711,822						54
54.01	CARDIAC REHABILITATION	11,501						54.01
56.01	NUCLEAR MEDICINE	24,637						56.01
57	CT SCAN	133,528						57
58	MRI	36,669						58
59	CARDIAC CATHETERIZATION	74,014						59
60	LABORATORY	337,616						60
64	INTRAVENOUS THERAPY	20,792						64
65	RESPIRATORY THERAPY	94,361						65
65.98	HYPERBARIC OXYGEN THERAPY	10,133						65.98
66	PHYSICAL THERAPY	150,576						66
68	SPEECH PATHOLOGY	11,430						68
69	ELECTROCARDIOLOGY	140,099						69
70.01	NEUROLOGY	52,749						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	865						71
73	DRUGS CHARGED TO PATIENTS	324,556						73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	19,035						90
90.01	DIABETES EDUCATION	1,296						90.01
90.02	PSYCH SERVICES	91,598						90.02
90.04	ANTICOAGULATION CLINIC	3,835						90.04
91	EMERGENCY	202,402						91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,099,488						118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
193.05	OTHER NON-REIMBURSABLE	592,443						193.05
193.06	OUTSIDE ACCOUNTING	895						193.06
193.07	OUTSIDE PRINTING	16,730						193.07
193.08	FOUNDATION	10,959						193.08
194	AHEC	112						194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	5,720,627						202

Optimizer Systems, Inc. WinLASH Micro System

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS HOURS OF SERVICE	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	387,560						1
2	CAP REL COSTS-MVBLE EQUIP		1,892,444					2
4	EMPLOYEE BENEFITS DEPARTMENT	2,491		35,055,935				4
5	ADMINISTRATIVE & GENERAL	134,752	259,312	6,158,437	-26,438,384	62,988,381		5
6	MAINTENANCE & REPAIRS	8,770		32,054		1,076,169	19,216	6
6.01	BIOMEDICAL SERVICES	1,080		78,466		882,111	22	6.01
7	OPERATION OF PLANT	22,573	69,974	631,518		2,482,343	11,729	7
8	LAUNDRY & LINEN SERVICE	7,636	3,962	118,782		616,931	163	8
9	HOUSEKEEPING	5,575	6,561	175,980		1,203,416	48	9
10	DIETARY	2,919	3,625	11,661		490,693	178	10
11	CAFETERIA	8,327	12,400	602,003		1,119,121	607	11
13	NURSING ADMINISTRATION	800	97,234	131,808		1,033,082	33	13
16	MEDICAL RECORDS & LIBRARY	6,447	1,974			1,499,848	49	16
17	SOCIAL SERVICE	820				300,559	18	17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	55,636	2,530	5,979,591		9,263,680	1,447	30
31	INTENSIVE CARE UNIT	5,799	142,227	2,288,346		4,152,818	1,126	31
40	SUBPROVIDER - IPF	7,164		889,938		1,252,816	188	40
43	NURSERY	4,263	45,542	574,936		928,865	143	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		404,747	1,237,684		6,412,031	822	50
52	DELIVERY ROOM & LABOR ROOM	6,609	36,265	459,949		760,690	109	52
53	ANESTHESIOLOGY	416	25,797	738,196		458,620	2	53
54	RADIOLOGY-DIAGNOSTIC	13,412	394,290	1,620,560		2,916,053	259	54
54.01	CARDIAC REHABILITATION		5,267	79,593		119,376		54.01
56.01	NUCLEAR MEDICINE	944	133	994		784,725	17	56.01
57	CT SCAN	701	78,647	279,679		540,518	6	57
58	MRI	408	11,098	115,274		224,981	26	58
59	CARDIAC CATHETERIZATION	4,419	13,986	308,892		863,513	87	59
60	LABORATORY	7,271	65,681	1,555,921		4,547,985	366	60
64	INTRAVENOUS THERAPY	1,061	1,817	231,615		375,507	45	64
65	RESPIRATORY THERAPY	1,564	27,750	138,658		1,016,996	30	65
65.98	HYPERBARIC OXYGEN THERAPY	207	4,722	37,765		65,643		65.98
66	PHYSICAL THERAPY	4,761	13,040	2,156,545		2,234,088	60	66
68	SPEECH PATHOLOGY	723	2,440	12,651		123,123	23	68
69	ELECTROCARDIOLOGY	5,999	48,863	692,800		1,118,624	153	69
70.01	NEUROLOGY	2,205	17,193	294,898		460,453	25	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS	2,888	34,367	1,517,547		6,315,255	58	73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	305	4,722	259,737		292,286	272	90
90.01	DIABETES EDUCATION	64		19,560		39,147		90.01
90.02	PSYCH SERVICES	10,479	970	275,066		461,123	75	90.02
90.04	ANTICOAGULATION CLINIC	100		106,088		141,372		90.04
91	EMERGENCY	5,948	34,674	2,432,070		3,967,007	361	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	345,536	1,871,810	32,245,262	-26,438,384	60,541,568	18,547	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				168			190
193.05	OTHER NON-REIMBURSABLE	41,880	10,495	2,209,213		1,928,962	661	193.05
193.06	OUTSIDE ACCOUNTING			124,155		42,223		193.06
193.07	OUTSIDE PRINTING		10,139	39,579		134,906	8	193.07
193.08	FOUNDATION	144		437,726		334,722		193.08
194	AHEC					6,000		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,301,998	2,574,016	11,392,930		26,438,384	1,527,874	202
203	UNIT COST MULT-WS B PT I	5.939720	1.360154	0.324993		0.419734	79.510512	203
204	COST TO BE ALLOC PER B PT II			14,796		1,172,153	72,507	204
205	UNIT COST MULT-WS B PT II			0.000422		0.018609	3.773262	205

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OFL AUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA FULL TIME EQUIVALENT	
		6.01	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							6
6.01	BIOMEDICAL SERVICES	4,322						6.01
7	OPERATION OF PLANT		268,910					7
8	LAUNDRY & LINEN SERVICE		7,636	768,285				8
9	HOUSEKEEPING		5,575	38,755	20,667			9
10	DIETARY		2,919	1,533	5	99,507		10
11	CAFETERIA		8,327	5,243	20		52,440	11
13	NURSING ADMINISTRATION	164	800		20		1,010	13
16	MEDICAL RECORDS & LIBRARY		6,447		221		2,540	16
17	SOCIAL SERVICE		820		37		600	17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,020	55,636	247,154	5,778	72,884	13,800	30
31	INTENSIVE CARE UNIT	119	5,799	50,970	1,119	7,530	4,180	31
40	SUBPROVIDER - IPF	1	7,164	16,101	1,562	9,196	1,940	40
43	NURSERY	98	4,263	3,422	348		940	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	733	50,752	130,240	1,970	1,932	4,690	50
52	DELIVERY ROOM & LABOR ROOM	5	6,609	25,262	311		750	52
53	ANESTHESIOLOGY	280	416					53
54	RADIOLOGY-DIAGNOSTIC	328	13,412	59,202	605	1,658	3,040	54
54.01	CARDIAC REHABILITATION	4			273		170	54.01
56.01	NUCLEAR MEDICINE	47	944		59		220	56.01
57	CT SCAN	79	701		106		520	57
58	MRI	114	408		85		210	58
59	CARDIAC CATHETERIZATION	198	4,419	6,231	304	364	500	59
60	LABORATORY	70	7,271	167	466		4,010	60
64	INTRAVENOUS THERAPY		1,061	2,759	270	430	470	64
65	RESPIRATORY THERAPY	162	1,564		38		1,650	65
65.98	HYPERBARIC OXYGEN THERAPY	15	207		104		90	65.98
66	PHYSICAL THERAPY	117	4,761	31,784	679		1,310	66
68	SPEECH PATHOLOGY	1	723		34		170	68
69	ELECTROCARDIOLOGY	236	5,999	8,491	352	406	1,460	69
70.01	NEUROLOGY	241	2,205	5,711	166	234	600	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS		2,888	597	252		1,720	73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		305	3,807	328		520	90
90.01	DIABETES EDUCATION		64				50	90.01
90.02	PSYCH SERVICES	1	10,479		800		600	90.02
90.04	ANTICOAGULATION CLINIC		100		29		130	90.04
91	EMERGENCY	262	5,948	92,255	1,876	4,873	4,320	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,295	226,622	729,684	18,217	99,507	52,210	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
193.05	OTHER NON-REIMBURSABLE	27	42,288	38,601	2,450			193.05
193.06	OUTSIDE ACCOUNTING						30	193.06
193.07	OUTSIDE PRINTING						200	193.07
193.08	FOUNDATION							193.08
194	AHEC							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,254,112	4,456,845	1,015,395	1,855,967	761,661	1,783,852	202
203	UNIT COST MULT-WS B PT I	290.169366	16.573742	1.321638	89.803406	7.654346	34.017010	203
204	COST TO BE ALLOC PER B PT II	22,946	319,970	72,061	123,215	35,724	100,215	204
205	UNIT COST MULT-WS B PT II	5.309116	1.189878	0.093795	5.961920	0.359010	1.911041	205

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION FULL TIME EQUIVALENT	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT				
		13	16	17				
	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
6.01	BIOMEDICAL SERVICES							6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION	26,300						13
16	MEDICAL RECORDS & LIBRARY		10,015					16
17	SOCIAL SERVICE			100				17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	13,800	2,895	94				30
31	INTENSIVE CARE UNIT	4,180	480	6				31
40	SUBPROVIDER - IPF	1,940	392					40
43	NURSERY	940	98					43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,690	706					50
52	DELIVERY ROOM & LABOR ROOM	750	52					52
53	ANESTHESIOLOGY		84					53
54	RADIOLOGY-DIAGNOSTIC		719					54
54.01	CARDIAC REHABILITATION		13					54.01
56.01	NUCLEAR MEDICINE		245					56.01
57	CT SCAN		1,125					57
58	MRI		240					58
59	CARDIAC CATHETERIZATION		81					59
60	LABORATORY		1,054					60
64	INTRAVENOUS THERAPY		70					64
65	RESPIRATORY THERAPY		26					65
65.98	HYPERBARIC OXYGEN THERAPY		15					65.98
66	PHYSICAL THERAPY		65					66
68	SPEECH PATHOLOGY		5					68
69	ELECTROCARDIOLOGY		232					69
70.01	NEUROLOGY		99					70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS		547					73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		67					90
90.01	DIABETES EDUCATION		1					90.01
90.02	PSYCH SERVICES		50					90.02
90.04	ANTICOAGULATION CLINIC		3					90.04
91	EMERGENCY		651					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	26,300	10,015	100				118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
193.05	OTHER NON-REIMBURSABLE							193.05
193.06	OUTSIDE ACCOUNTING							193.06
193.07	OUTSIDE PRINTING							193.07
193.08	FOUNDATION							193.08
194	AHEC							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,566,326	2,346,382	465,468				202
203	UNIT COST MULT-WS B PT I	59.556122	234.286770	4,654.680000				203
204	COST TO BE ALLOC PER B PT II	160,283	82,917	12,876				204
205	UNIT COST MULT-WS B PT II	6.094411	8.279281	128.760000				205

Optimizer Systems, Inc. *WinLASH* Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

Optimizer Systems, Inc. WinLASH Micro System

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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 DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	18,295,620		18,295,620		18,295,620	30
31	INTENSIVE CARE UNIT	6,873,080		6,873,080		6,873,080	31
40	SUBPROVIDER - IPF	2,417,951		2,417,951	6,998	2,424,949	40
43	NURSERY	1,575,896		1,575,896		1,575,896	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	11,190,676		11,190,676	26,807	11,217,483	50
52	DELIVERY ROOM & LABOR ROOM	1,343,310		1,343,310		1,343,310	52
53	ANESTHESIOLOGY	759,099		759,099	19,942	779,041	53
54	RADIOLOGY-DIAGNOSTIC	4,895,206		4,895,206	8,723	4,903,929	54
54.01	CARDIAC REHABILITATION	203,988		203,988	10,394	214,382	54.01
56.01	NUCLEAR MEDICINE	1,214,919		1,214,919		1,214,919	56.01
57	CT SCAN	1,093,191		1,093,191		1,093,191	57
58	MRI	432,327		432,327		432,327	58
59	CARDIAC CATHETERIZATION	1,437,876		1,437,876	17,144	1,455,020	59
60	LABORATORY	7,052,265		7,052,265	38,600	7,090,865	60
64	INTRAVENOUS THERAPY	617,855		617,855		617,855	64
65	RESPIRATORY THERAPY	1,584,809		1,584,809	8,571	1,593,380	65
65.98	HYPERBARIC OXYGEN THERAPY	116,896		116,896		116,896	65.98
66	PHYSICAL THERAPY	3,452,215		3,452,215	5,250	3,457,465	66
68	SPEECH PATHOLOGY	198,911		198,911		198,911	68
69	ELECTROCARDIOLOGY	1,918,181		1,918,181	14,129	1,932,310	69
70.01	NEUROLOGY	830,035		830,035	10,622	840,657	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS	9,228,542		9,228,542		9,228,542	73
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	509,523		509,523	2,120	511,643	90
90.01	DIABETES EDUCATION	58,574		58,574		58,574	90.01
90.02	PSYCH SERVICES	938,568		938,568	4,095	942,663	90.02
90.04	ANTICOAGULATION CLINIC	210,097		210,097		210,097	90.04
91	EMERGENCY	6,462,576		6,462,576	35,626	6,498,202	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,384,455		2,384,455		2,384,455	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	87,296,641		87,296,641	209,021	87,505,662	200
201	LESS OBSERVATION BEDS	2,384,455		2,384,455		2,384,455	201
202	TOTAL (SEE INSTRUCTIONS)	84,912,186		84,912,186		85,121,207	202

Optimizer Systems, Inc. WinLASH Micro System

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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 SERV COST CENTERS							
30	ADULTS & PEDIATRICS	11,089,286		11,089,286				30
31	INTENSIVE CARE UNIT	3,368,395		3,368,395				31
40	SUBPROVIDER - IPF	1,432,569		1,432,569				40
43	NURSERY	422,792		422,792				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,168,947	16,753,549	27,922,496	0.400776	0.400776	0.401736	50
52	DELIVERY ROOM & LABOR ROOM	2,024,819	1,208,677	3,233,496	0.415436	0.415436	0.415436	52
53	ANESTHESIOLOGY	1,644,213	1,954,460	3,598,673	0.210939	0.210939	0.216480	53
54	RADIOLOGY-DIAGNOSTIC	3,790,082	17,477,222	21,267,304	0.230175	0.230175	0.230585	54
54.01	CARDIAC REHABILITATION		315,657	315,657	0.646233	0.646233	0.679161	54.01
56.01	NUCLEAR MEDICINE	877,251	5,913,254	6,790,505	0.178914	0.178914	0.178914	56.01
57	CT SCAN	10,160,521	27,201,702	37,362,223	0.029259	0.029259	0.029259	57
58	MRI	1,060,052	5,721,784	6,781,836	0.063748	0.063748	0.063748	58
59	CARDIAC CATHETERIZATION	2,410,260	1,833,966	4,244,226	0.338784	0.338784	0.342823	59
60	LABORATORY	17,976,604	25,416,199	43,392,803	0.162522	0.162522	0.163411	60
64	INTRAVENOUS THERAPY	10,862	1,715,247	1,726,109	0.357947	0.357947	0.357947	64
65	RESPIRATORY THERAPY	2,758,813	624,267	3,383,080	0.468452	0.468452	0.470985	65
65.98	HYPERBARIC OXYGEN THERAPY		185,712	185,712	0.629448	0.629448	0.629448	65.98
66	PHYSICAL THERAPY	530,160	3,678,130	4,208,290	0.820337	0.820337	0.821584	66
68	SPEECH PATHOLOGY	69,157	132,809	201,966	0.984874	0.984874	0.984874	68
69	ELECTROCARDIOLOGY	4,655,958	5,625,118	10,281,076	0.186574	0.186574	0.187948	69
70.01	NEUROLOGY	173,649	2,357,489	2,531,138	0.327930	0.327930	0.332126	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS	12,321,874	13,436,495	25,758,369	0.358274	0.358274	0.358274	73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	6,652	1,470,112	1,476,764	0.345027	0.345027	0.346462	90
90.01	DIABETES EDUCATION		17,542	17,542	3.339072	3.339072	3.339072	90.01
90.02	PSYCH SERVICES	521	1,218,026	1,218,547	0.770235	0.770235	0.773596	90.02
90.04	ANTICOAGULATION CLINIC	81	82,560	82,641	2.542285	2.542285	2.542285	90.04
91	EMERGENCY	5,299,697	15,953,069	21,252,766	0.304082	0.304082	0.305758	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	383,002	2,897,038	3,280,040	0.726959	0.726959	0.726959	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	93,636,217	153,190,084	246,826,301				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	93,636,217	153,190,084	246,826,301				202

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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 SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	998,437		998,437	18,039	55.35	11,372	629,440	30
31	INTENSIVE CARE UNIT	403,227		403,227	2,751	146.57	1,319	193,326	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	108,379		108,379	2,233	48.54	463	22,474	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	123,170		123,170	863	142.72			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,633,213		1,633,213	23,886		13,154	845,240	200

(A) Worksheet A line numbers

Optimizer Systems, Inc. *WinLASH* Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0034** **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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	839,243	27,922,496	0.030056	6,261,657	188,200	50
52	DELIVERY ROOM & LABOR ROOM	121,892	3,233,496	0.037697			52
53	ANESTHESIOLOGY	51,626	3,598,673	0.014346	580,822	8,332	53
54	RADIOLOGY-DIAGNOSTIC	711,822	21,267,304	0.033470	2,569,675	86,007	54
54.01	CARDIAC REHABILITATION	11,501	315,657	0.036435			54.01
56.01	NUCLEAR MEDICINE	24,637	6,790,505	0.003628	646,020	2,344	56.01
57	CT SCAN	133,528	37,362,223	0.003574	6,311,957	22,559	57
58	MRI	36,669	6,781,836	0.005407	633,240	3,424	58
59	CARDIAC CATHETERIZATION	74,014	4,244,226	0.017439	1,619,993	28,251	59
60	LABORATORY	337,616	43,392,803	0.007780	11,637,092	90,537	60
64	INTRAVENOUS THERAPY	20,792	1,726,109	0.012046	9,684	117	64
65	RESPIRATORY THERAPY	94,361	3,383,080	0.027892	1,897,363	52,921	65
65.98	HYPERBARIC OXYGEN THERAPY	10,133	185,712	0.054563			65.98
66	PHYSICAL THERAPY	150,576	4,208,290	0.035781	443,284	15,861	66
68	SPEECH PATHOLOGY	11,430	201,966	0.056594	55,276	3,128	68
69	ELECTROCARDIOLOGY	140,099	10,281,076	0.013627	3,529,420	48,095	69
70.01	NEUROLOGY	52,749	2,531,138	0.020840	123,557	2,575	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	865					71
73	DRUGS CHARGED TO PATIENTS	324,556	25,758,369	0.012600	8,062,208	101,584	73
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	19,035	1,476,764	0.012890	6,645	86	90
90.01	DIABETES EDUCATION	1,296	17,542	0.073880			90.01
90.02	PSYCH SERVICES	91,598	1,218,547	0.075170	521	39	90.02
90.04	ANTICOAGULATION CLINIC	3,835	82,641	0.046406	80	4	90.04
91	EMERGENCY	202,402	21,252,766	0.009524	3,140,014	29,905	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	130,124	3,280,040	0.039671	141,585	5,617	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	3,596,399	230,513,259		47,670,093	689,586	200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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

		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 SERV 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

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	18,039		11,372		30
31	INTENSIVE CARE UNIT	2,751		1,319		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	2,233		463		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	863				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	23,886		13,154		200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0034** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	CARDIAC REHABILITATION							54.01
56.01	NUCLEAR MEDICINE							56.01
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
65.98	HYPERBARIC OXYGEN THERAPY							65.98
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70.01	NEUROLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	DIABETES EDUCATION							90.01
90.02	PSYCH SERVICES							90.02
90.04	ANTICOAGULATION CLINIC							90.04
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0034** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		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	27,922,496			6,261,657		5,565,209		50
52	DELIVERY ROOM & LABOR ROOM	3,233,496							52
53	ANESTHESIOLOGY	3,598,673			580,822		557,187		53
54	RADIOLOGY-DIAGNOSTIC	21,267,304			2,569,675		7,048,054		54
54.01	CARDIAC REHABILITATION	315,657					170,829		54.01
56.01	NUCLEAR MEDICINE	6,790,505			646,020		2,771,826		56.01
57	CT SCAN	37,362,223			6,311,957		9,759,154		57
58	MRI	6,781,836			633,240		2,195,967		58
59	CARDIAC CATHETERIZATION	4,244,226			1,619,993		1,129,571		59
60	LABORATORY	43,392,803			11,637,092		799,174		60
64	INTRAVENOUS THERAPY	1,726,109			9,684		1,031,884		64
65	RESPIRATORY THERAPY	3,383,080			1,897,363		264,015		65
65.98	HYPERBARIC OXYGEN THERAPY	185,712					178,704		65.98
66	PHYSICAL THERAPY	4,208,290			443,284		117		66
68	SPEECH PATHOLOGY	201,966			55,276				68
69	ELECTROCARDIOLOGY	10,281,076			3,529,420		2,646,472		69
70.01	NEUROLOGY	2,531,138			123,557		820,521		70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
73	DRUGS CHARGED TO PATIENTS	25,758,369			8,062,208		7,926,933		73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1,476,764			6,645		832,397		90
90.01	DIABETES EDUCATION	17,542					39		90.01
90.02	PSYCH SERVICES	1,218,547			521		114,454		90.02
90.04	ANTICOAGULATION CLINIC	82,641			80				90.04
91	EMERGENCY	21,252,766			3,140,014		3,562,529		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,280,040			141,585		1,831,399		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	230,513,259			47,670,093		49,206,435		200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0034** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.400776	5,565,209			2,230,402			50
52	DELIVERY ROOM & LABOR ROOM	0.415436							52
53	ANESTHESIOLOGY	0.210939	557,187			117,532			53
54	RADIOLOGY-DIAGNOSTIC	0.230175	7,048,054			1,622,286			54
54.01	CARDIAC REHABILITATION	0.646233	170,829			110,395			54.01
56.01	NUCLEAR MEDICINE	0.178914	2,771,826			495,918			56.01
57	CT SCAN	0.029259	9,759,154			285,543			57
58	MRI	0.063748	2,195,967			139,989			58
59	CARDIAC CATHETERIZATION	0.338784	1,129,571			382,681			59
60	LABORATORY	0.162522	799,174			129,883			60
64	INTRAVENOUS THERAPY	0.357947	1,031,884			369,360			64
65	RESPIRATORY THERAPY	0.468452	264,015			123,678			65
65.98	HYPERBARIC OXYGEN THERAPY	0.629448	178,704			112,485			65.98
66	PHYSICAL THERAPY	0.820337	117			96			66
68	SPEECH PATHOLOGY	0.984874							68
69	ELECTROCARDIOLOGY	0.186574	2,646,472			493,763			69
70.01	NEUROLOGY	0.327930	820,521			269,073			70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
73	DRUGS CHARGED TO PATIENTS	0.358274	7,926,933		133,593	2,840,014		47,863	73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.345027	832,397			287,199			90
90.01	DIABETES EDUCATION	3.339072	39			130			90.01
90.02	PSYCH SERVICES	0.770235	114,454			88,156			90.02
90.04	ANTICOAGULATION CLINIC	2.542285							90.04
91	EMERGENCY	0.304082	3,562,529			1,083,301			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.726959	1,831,399			1,331,352			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		49,206,435		133,593	12,513,236		47,863	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		49,206,435		133,593	12,513,236		47,863	202

(A) Worksheet A line numbers

Optimizer Systems, Inc. *WinLASH* Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S034** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	839,243	27,922,496	0.030056	1,042	31	50
52	DELIVERY ROOM & LABOR ROOM	121,892	3,233,496	0.037697			52
53	ANESTHESIOLOGY	51,626	3,598,673	0.014346	3,812	55	53
54	RADIOLOGY-DIAGNOSTIC	711,822	21,267,304	0.033470	17,742	594	54
54.01	CARDIAC REHABILITATION	11,501	315,657	0.036435			54.01
56.01	NUCLEAR MEDICINE	24,637	6,790,505	0.003628			56.01
57	CT SCAN	133,528	37,362,223	0.003574	35,672	127	57
58	MRI	36,669	6,781,836	0.005407			58
59	CARDIAC CATHETERIZATION	74,014	4,244,226	0.017439			59
60	LABORATORY	337,616	43,392,803	0.007780	215,114	1,674	60
64	INTRAVENOUS THERAPY	20,792	1,726,109	0.012046			64
65	RESPIRATORY THERAPY	94,361	3,383,080	0.027892	1,341	37	65
65.98	HYPERBARIC OXYGEN THERAPY	10,133	185,712	0.054563			65.98
66	PHYSICAL THERAPY	150,576	4,208,290	0.035781	568	20	66
68	SPEECH PATHOLOGY	11,430	201,966	0.056594			68
69	ELECTROCARDIOLOGY	140,099	10,281,076	0.013627	9,483	129	69
70.01	NEUROLOGY	52,749	2,531,138	0.020840			70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	865					71
73	DRUGS CHARGED TO PATIENTS	324,556	25,758,369	0.012600	45,362	572	73
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	19,035	1,476,764	0.012890			90
90.01	DIABETES EDUCATION	1,296	17,542	0.073880			90.01
90.02	PSYCH SERVICES	91,598	1,218,547	0.075170			90.02
90.04	ANTICOAGULATION CLINIC	3,835	82,641	0.046406			90.04
91	EMERGENCY	202,402	21,252,766	0.009524	86,953	828	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		3,280,040				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	3,466,275	230,513,259		417,089	4,067	200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S034** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT 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
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	CARDIAC REHABILITATION							54.01
56.01	NUCLEAR MEDICINE							56.01
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
65.98	HYPERBARIC OXYGEN THERAPY							65.98
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70.01	NEUROLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	DIABETES EDUCATION							90.01
90.02	PSYCH SERVICES							90.02
90.04	ANTICOAGULATION CLINIC							90.04
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S034** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		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	27,922,496			1,042				50
52	DELIVERY ROOM & LABOR ROOM	3,233,496							52
53	ANESTHESIOLOGY	3,598,673			3,812				53
54	RADIOLOGY-DIAGNOSTIC	21,267,304			17,742				54
54.01	CARDIAC REHABILITATION	315,657							54.01
56.01	NUCLEAR MEDICINE	6,790,505							56.01
57	CT SCAN	37,362,223			35,672				57
58	MRI	6,781,836							58
59	CARDIAC CATHETERIZATION	4,244,226							59
60	LABORATORY	43,392,803			215,114				60
64	INTRAVENOUS THERAPY	1,726,109							64
65	RESPIRATORY THERAPY	3,383,080			1,341				65
65.98	HYPERBARIC OXYGEN THERAPY	185,712							65.98
66	PHYSICAL THERAPY	4,208,290			568				66
68	SPEECH PATHOLOGY	201,966							68
69	ELECTROCARDIOLOGY	10,281,076			9,483				69
70.01	NEUROLOGY	2,531,138							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
73	DRUGS CHARGED TO PATIENTS	25,758,369			45,362				73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1,476,764							90
90.01	DIABETES EDUCATION	17,542							90.01
90.02	PSYCH SERVICES	1,218,547							90.02
90.04	ANTICOAGULATION CLINIC	82,641							90.04
91	EMERGENCY	21,252,766			86,953				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,280,040							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	230,513,259			417,089				200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S034** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			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	0.400776							50
52	DELIVERY ROOM & LABOR ROOM	0.415436							52
53	ANESTHESIOLOGY	0.210939							53
54	RADIOLOGY-DIAGNOSTIC	0.230175							54
54.01	CARDIAC REHABILITATION	0.646233							54.01
56.01	NUCLEAR MEDICINE	0.178914							56.01
57	CT SCAN	0.029259							57
58	MRI	0.063748							58
59	CARDIAC CATHETERIZATION	0.338784							59
60	LABORATORY	0.162522							60
64	INTRAVENOUS THERAPY	0.357947							64
65	RESPIRATORY THERAPY	0.468452							65
65.98	HYPERBARIC OXYGEN THERAPY	0.629448							65.98
66	PHYSICAL THERAPY	0.820337							66
68	SPEECH PATHOLOGY	0.984874							68
69	ELECTROCARDIOLOGY	0.186574							69
70.01	NEUROLOGY	0.327930							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
73	DRUGS CHARGED TO PATIENTS	0.358274							73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.345027							90
90.01	DIABETES EDUCATION	3.339072							90.01
90.02	PSYCH SERVICES	0.770235							90.02
90.04	ANTICOAGULATION CLINIC	2.542285							90.04
91	EMERGENCY	0.304082							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.726959							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

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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 SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	998,437		998,437	18,039	55.35	2,759	152,711	30
31	INTENSIVE CARE UNIT	403,227		403,227	2,751	146.57	515	75,484	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	108,379		108,379	2,233	48.54	782	37,958	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	123,170		123,170	863	142.72	478	68,220	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,633,213		1,633,213	23,886		4,534	334,373	200

(A) Worksheet A line numbers

Optimizer Systems, Inc. *WinLASH* Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0034** **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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	839,243	27,922,496	0.030056	1,870,816	56,229	50
52	DELIVERY ROOM & LABOR ROOM	121,892	3,233,496	0.037697	1,618,693	61,020	52
53	ANESTHESIOLOGY	51,626	3,598,673	0.014346	637,171	9,141	53
54	RADIOLOGY-DIAGNOSTIC	711,822	21,267,304	0.033470	597,771	20,007	54
54.01	CARDIAC REHABILITATION	11,501	315,657	0.036435			54.01
56.01	NUCLEAR MEDICINE	24,637	6,790,505	0.003628	59,480	216	56.01
57	CT SCAN	133,528	37,362,223	0.003574	1,634,203	5,841	57
58	MRI	36,669	6,781,836	0.005407	132,750	718	58
59	CARDIAC CATHETERIZATION	74,014	4,244,226	0.017439	176,442	3,077	59
60	LABORATORY	337,616	43,392,803	0.007780	2,699,528	21,002	60
64	INTRAVENOUS THERAPY	20,792	1,726,109	0.012046			64
65	RESPIRATORY THERAPY	94,361	3,383,080	0.027892	518,497	14,462	65
65.98	HYPERBARIC OXYGEN THERAPY	10,133	185,712	0.054563			65.98
66	PHYSICAL THERAPY	150,576	4,208,290	0.035781	29,416	1,053	66
68	SPEECH PATHOLOGY	11,430	201,966	0.056594	4,619	261	68
69	ELECTROCARDIOLOGY	140,099	10,281,076	0.013627	406,270	5,536	69
70.01	NEUROLOGY	52,749	2,531,138	0.020840	27,876	581	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	865					71
73	DRUGS CHARGED TO PATIENTS	324,556	25,758,369	0.012600	2,175,087	27,406	73
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	19,035	1,476,764	0.012890			90
90.01	DIABETES EDUCATION	1,296	17,542	0.073880			90.01
90.02	PSYCH SERVICES	91,598	1,218,547	0.075170			90.02
90.04	ANTICOAGULATION CLINIC	3,835	82,641	0.046406			90.04
91	EMERGENCY	202,402	21,252,766	0.009524	835,109	7,954	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	130,124	3,280,040	0.039671			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	3,596,399	230,513,259		13,423,728	234,504	200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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

		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 SERV 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

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	18,039		2,759		30
31	INTENSIVE CARE UNIT	2,751		515		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	2,233		782		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	863		478		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	23,886		4,534		200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0034** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	CARDIAC REHABILITATION							54.01
56.01	NUCLEAR MEDICINE							56.01
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
65.98	HYPERBARIC OXYGEN THERAPY							65.98
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70.01	NEUROLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	DIABETES EDUCATION							90.01
90.02	PSYCH SERVICES							90.02
90.04	ANTICOAGULATION CLINIC							90.04
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0034** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		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	27,922,496			1,870,816				50
52	DELIVERY ROOM & LABOR ROOM	3,233,496			1,618,693				52
53	ANESTHESIOLOGY	3,598,673			637,171				53
54	RADIOLOGY-DIAGNOSTIC	21,267,304			597,771				54
54.01	CARDIAC REHABILITATION	315,657							54.01
56.01	NUCLEAR MEDICINE	6,790,505			59,480				56.01
57	CT SCAN	37,362,223			1,634,203				57
58	MRI	6,781,836			132,750				58
59	CARDIAC CATHETERIZATION	4,244,226			176,442				59
60	LABORATORY	43,392,803			2,699,528				60
64	INTRAVENOUS THERAPY	1,726,109							64
65	RESPIRATORY THERAPY	3,383,080			518,497				65
65.98	HYPERBARIC OXYGEN THERAPY	185,712							65.98
66	PHYSICAL THERAPY	4,208,290			29,416				66
68	SPEECH PATHOLOGY	201,966			4,619				68
69	ELECTROCARDIOLOGY	10,281,076			406,270				69
70.01	NEUROLOGY	2,531,138			27,876				70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
73	DRUGS CHARGED TO PATIENTS	25,758,369			2,175,087				73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1,476,764							90
90.01	DIABETES EDUCATION	17,542							90.01
90.02	PSYCH SERVICES	1,218,547							90.02
90.04	ANTICOAGULATION CLINIC	82,641							90.04
91	EMERGENCY	21,252,766			835,109				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,280,040							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	230,513,259			13,423,728				200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0034** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			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	0.400776							50
52	DELIVERY ROOM & LABOR ROOM	0.415436							52
53	ANESTHESIOLOGY	0.210939							53
54	RADIOLOGY-DIAGNOSTIC	0.230175							54
54.01	CARDIAC REHABILITATION	0.646233							54.01
56.01	NUCLEAR MEDICINE	0.178914							56.01
57	CT SCAN	0.029259							57
58	MRI	0.063748							58
59	CARDIAC CATHETERIZATION	0.338784							59
60	LABORATORY	0.162522							60
64	INTRAVENOUS THERAPY	0.357947							64
65	RESPIRATORY THERAPY	0.468452							65
65.98	HYPERBARIC OXYGEN THERAPY	0.629448							65.98
66	PHYSICAL THERAPY	0.820337							66
68	SPEECH PATHOLOGY	0.984874							68
69	ELECTROCARDIOLOGY	0.186574							69
70.01	NEUROLOGY	0.327930							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
73	DRUGS CHARGED TO PATIENTS	0.358274							73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.345027							90
90.01	DIABETES EDUCATION	3.339072							90.01
90.02	PSYCH SERVICES	0.770235							90.02
90.04	ANTICOAGULATION CLINIC	2.542285							90.04
91	EMERGENCY	0.304082							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.726959							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

Optimizer Systems, Inc. *WinLASH* Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S034** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: **[ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX** **[ ] HOSPITAL [XX] IPF [ ] IRF** **[ ] SUB (OTHER)** **[XX] PPS [ ] TEFRA**

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	839,243	27,922,496	0.030056	3,647	110	50
52	DELIVERY ROOM & LABOR ROOM	121,892	3,233,496	0.037697			52
53	ANESTHESIOLOGY	51,626	3,598,673	0.014346	13,342	191	53
54	RADIOLOGY-DIAGNOSTIC	711,822	21,267,304	0.033470	19,170	642	54
54.01	CARDIAC REHABILITATION	11,501	315,657	0.036435			54.01
56.01	NUCLEAR MEDICINE	24,637	6,790,505	0.003628	2,850	10	56.01
57	CT SCAN	133,528	37,362,223	0.003574	28,933	103	57
58	MRI	36,669	6,781,836	0.005407	3,383	18	58
59	CARDIAC CATHETERIZATION	74,014	4,244,226	0.017439			59
60	LABORATORY	337,616	43,392,803	0.007780	361,264	2,811	60
64	INTRAVENOUS THERAPY	20,792	1,726,109	0.012046			64
65	RESPIRATORY THERAPY	94,361	3,383,080	0.027892	2,607	73	65
65.98	HYPERBARIC OXYGEN THERAPY	10,133	185,712	0.054563			65.98
66	PHYSICAL THERAPY	150,576	4,208,290	0.035781			66
68	SPEECH PATHOLOGY	11,430	201,966	0.056594			68
69	ELECTROCARDIOLOGY	140,099	10,281,076	0.013627	12,742	174	69
70.01	NEUROLOGY	52,749	2,531,138	0.020840	803	17	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	865					71
73	DRUGS CHARGED TO PATIENTS	324,556	25,758,369	0.012600	60,727	765	73
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	19,035	1,476,764	0.012890			90
90.01	DIABETES EDUCATION	1,296	17,542	0.073880			90.01
90.02	PSYCH SERVICES	91,598	1,218,547	0.075170			90.02
90.04	ANTICOAGULATION CLINIC	3,835	82,641	0.046406			90.04
91	EMERGENCY	202,402	21,252,766	0.009524	146,108	1,392	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		3,280,040				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	3,466,275	230,513,259		655,576	6,306	200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S034** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	CARDIAC REHABILITATION							54.01
56.01	NUCLEAR MEDICINE							56.01
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
65.98	HYPERBARIC OXYGEN THERAPY							65.98
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70.01	NEUROLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	DIABETES EDUCATION							90.01
90.02	PSYCH SERVICES							90.02
90.04	ANTICOAGULATION CLINIC							90.04
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S034** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		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	27,922,496			3,647				50
52	DELIVERY ROOM & LABOR ROOM	3,233,496							52
53	ANESTHESIOLOGY	3,598,673			13,342				53
54	RADIOLOGY-DIAGNOSTIC	21,267,304			19,170				54
54.01	CARDIAC REHABILITATION	315,657							54.01
56.01	NUCLEAR MEDICINE	6,790,505			2,850				56.01
57	CT SCAN	37,362,223			28,933				57
58	MRI	6,781,836			3,383				58
59	CARDIAC CATHETERIZATION	4,244,226							59
60	LABORATORY	43,392,803			361,264				60
64	INTRAVENOUS THERAPY	1,726,109							64
65	RESPIRATORY THERAPY	3,383,080			2,607				65
65.98	HYPERBARIC OXYGEN THERAPY	185,712							65.98
66	PHYSICAL THERAPY	4,208,290							66
68	SPEECH PATHOLOGY	201,966							68
69	ELECTROCARDIOLOGY	10,281,076			12,742				69
70.01	NEUROLOGY	2,531,138			803				70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
73	DRUGS CHARGED TO PATIENTS	25,758,369			60,727				73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1,476,764							90
90.01	DIABETES EDUCATION	17,542							90.01
90.02	PSYCH SERVICES	1,218,547							90.02
90.04	ANTICOAGULATION CLINIC	82,641							90.04
91	EMERGENCY	21,252,766			146,108				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,280,040							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	230,513,259			655,576				200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S034** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [ ] TITLE XVIII, PART B [XX] TITLE XIX - O/P [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			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	0.400776							50
52	DELIVERY ROOM & LABOR ROOM	0.415436							52
53	ANESTHESIOLOGY	0.210939							53
54	RADIOLOGY-DIAGNOSTIC	0.230175							54
54.01	CARDIAC REHABILITATION	0.646233							54.01
56.01	NUCLEAR MEDICINE	0.178914							56.01
57	CT SCAN	0.029259							57
58	MRI	0.063748							58
59	CARDIAC CATHETERIZATION	0.338784							59
60	LABORATORY	0.162522							60
64	INTRAVENOUS THERAPY	0.357947							64
65	RESPIRATORY THERAPY	0.468452							65
65.98	HYPERBARIC OXYGEN THERAPY	0.629448							65.98
66	PHYSICAL THERAPY	0.820337							66
68	SPEECH PATHOLOGY	0.984874							68
69	ELECTROCARDIOLOGY	0.186574							69
70.01	NEUROLOGY	0.327930							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS								71
73	DRUGS CHARGED TO PATIENTS	0.358274							73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.345027							90
90.01	DIABETES EDUCATION	3.339072							90.01
90.02	PSYCH SERVICES	0.770235							90.02
90.04	ANTICOAGULATION CLINIC	2.542285							90.04
91	EMERGENCY	0.304082							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.726959							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

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0034** **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/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	18,039	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	18,039	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	13,222	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	2,466	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	11,372	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	18,295,620	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	18,295,620	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	11,236,274	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	8,863,046	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	2,373,228	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.628264	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	670.33	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	962.38	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 - line 36)	18,295,620	37

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COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0034** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,014.23	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					11,533,824	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)					11,533,824	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	6,873,080	2,751	2,498.39	1,319	3,295,376	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 (Worksheet D-3, column 3, line 200)					12,005,942	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					26,835,142	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	822,766	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	689,586	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	1,512,352	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	25,322,790	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0034** **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/MR
[XX] PPS [ ] TEFRA [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					2,351	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,014.23	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					2,384,455	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	998,437	18,295,620	0.054572	2,384,455	130,124	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S034** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	2,233	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	2,233	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)	2,233	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	463	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	2,424,949	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	2,424,949	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 - line 36)	2,424,949	37

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S034** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,085.96	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	502,799	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)	502,799	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	87,251	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	590,050	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	22,474	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	4,067	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	26,541	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	563,509	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0034** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	18,039	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	18,039	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	13,222	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	2,466	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	2,759	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 Title XIX only)	863	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	478	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)	18,295,620	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	18,295,620	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	11,236,274	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	8,863,046	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	2,373,228	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.628264	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	670.33	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	962.38	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 - line 36)	18,295,620	37

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0034** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,014.23	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					2,798,261	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)					2,798,261	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)	1,575,896	863	1,826.07	478	872,861	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	6,873,080	2,751	2,498.39	515	1,286,671	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 (Worksheet D-3, column 3, line 200)					3,661,505	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					8,619,298	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	296,415	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	234,504	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	530,919	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	8,088,379	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0034** **WORKSHEET D-1**
PARTS III & IV

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P
[XX] HOSPITAL [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF [ ] NF
[ ] ICF/MR
[XX] PPS [ ] TEFRA [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					2,351	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)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S034** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS
[ ] TITLE XVIII, PART A [XX] IPF [ ] SNF [ ] TEFRA
[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)	2,233	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	2,233	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)	2,233	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	782	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	2,424,949	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	2,424,949	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 - line 36)	2,424,949	37

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S034** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [ ] HOSPITAL [ ] SUB (OTHER) [XX] PPS
[ ] TITLE XVIII, PART A [XX] IPF [ ] TEFRA
[XX] TITLE XIX - I/P [ ] IRF [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,085.96	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	849,221	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)	849,221	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	139,702	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	988,923	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	37,958	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	6,306	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	44,264	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	944,659	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0034** **WORKSHEET D-3**

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/MR | [XX] PPS [ ] TEFRA [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		7,541,952		30
31	INTENSIVE CARE UNIT		2,178,158		31
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.401736	6,261,657	2,515,533	50
52	DELIVERY ROOM & LABOR ROOM	0.415436			52
53	ANESTHESIOLOGY	0.216480	580,822	125,736	53
54	RADIOLOGY-DIAGNOSTIC	0.230585	2,569,675	592,529	54
54.01	CARDIAC REHABILITATION	0.679161			54.01
56.01	NUCLEAR MEDICINE	0.178914	646,020	115,582	56.01
57	CT SCAN	0.029259	6,311,957	184,682	57
58	MRI	0.063748	633,240	40,368	58
59	CARDIAC CATHETERIZATION	0.342823	1,619,993	555,371	59
60	LABORATORY	0.163411	11,637,092	1,901,629	60
64	INTRAVENOUS THERAPY	0.357947	9,684	3,466	64
65	RESPIRATORY THERAPY	0.470985	1,897,363	893,630	65
65.98	HYPERBARIC OXYGEN THERAPY	0.629448			65.98
66	PHYSICAL THERAPY	0.821584	443,284	364,195	66
68	SPEECH PATHOLOGY	0.984874	55,276	54,440	68
69	ELECTROCARDIOLOGY	0.187948	3,529,420	663,347	69
70.01	NEUROLOGY	0.332126	123,557	41,036	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				71
73	DRUGS CHARGED TO PATIENTS	0.358274	8,062,208	2,888,480	73
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.346462	6,645	2,302	90
90.01	DIABETES EDUCATION	3.339072			90.01
90.02	PSYCH SERVICES	0.773596	521	403	90.02
90.04	ANTICOAGULATION CLINIC	2.542285	80	203	90.04
91	EMERGENCY	0.305758	3,140,014	960,084	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.726959	141,585	102,926	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		47,670,093	12,005,942	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		47,670,093		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. *WinLASH* Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S034** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF		293,487		40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.401736	1,042	419	50
52	DELIVERY ROOM & LABOR ROOM	0.415436			52
53	ANESTHESIOLOGY	0.216480	3,812	825	53
54	RADIOLOGY-DIAGNOSTIC	0.230585	17,742	4,091	54
54.01	CARDIAC REHABILITATION	0.679161			54.01
56.01	NUCLEAR MEDICINE	0.178914			56.01
57	CT SCAN	0.029259	35,672	1,044	57
58	MRI	0.063748			58
59	CARDIAC CATHETERIZATION	0.342823			59
60	LABORATORY	0.163411	215,114	35,152	60
64	INTRAVENOUS THERAPY	0.357947			64
65	RESPIRATORY THERAPY	0.470985	1,341	632	65
65.98	HYPERBARIC OXYGEN THERAPY	0.629448			65.98
66	PHYSICAL THERAPY	0.821584	568	467	66
68	SPEECH PATHOLOGY	0.984874			68
69	ELECTROCARDIOLOGY	0.187948	9,483	1,782	69
70.01	NEUROLOGY	0.332126			70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				71
73	DRUGS CHARGED TO PATIENTS	0.358274	45,362	16,252	73
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.346462			90
90.01	DIABETES EDUCATION	3.339072			90.01
90.02	PSYCH SERVICES	0.773596			90.02
90.04	ANTICOAGULATION CLINIC	2.542285			90.04
91	EMERGENCY	0.305758	86,953	26,587	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.726959			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		417,089	87,251	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		417,089		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0034** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		1,801,598		30
31	INTENSIVE CARE UNIT		633,452		31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.401736	1,870,816	751,574	50
52	DELIVERY ROOM & LABOR ROOM	0.415436	1,618,693	672,463	52
53	ANESTHESIOLOGY	0.216480	637,171	137,935	53
54	RADIOLOGY-DIAGNOSTIC	0.230585	597,771	137,837	54
54.01	CARDIAC REHABILITATION	0.679161			54.01
56.01	NUCLEAR MEDICINE	0.178914	59,480	10,642	56.01
57	CT SCAN	0.029259	1,634,203	47,815	57
58	MRI	0.063748	132,750	8,463	58
59	CARDIAC CATHETERIZATION	0.342823	176,442	60,488	59
60	LABORATORY	0.163411	2,699,528	441,133	60
64	INTRAVENOUS THERAPY	0.357947			64
65	RESPIRATORY THERAPY	0.470985	518,497	244,204	65
65.98	HYPERBARIC OXYGEN THERAPY	0.629448			65.98
66	PHYSICAL THERAPY	0.821584	29,416	24,168	66
68	SPEECH PATHOLOGY	0.984874	4,619	4,549	68
69	ELECTROCARDIOLOGY	0.187948	406,270	76,358	69
70.01	NEUROLOGY	0.332126	27,876	9,258	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				71
73	DRUGS CHARGED TO PATIENTS	0.358274	2,175,087	779,277	73
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.346462			90
90.01	DIABETES EDUCATION	3.339072			90.01
90.02	PSYCH SERVICES	0.773596			90.02
90.04	ANTICOAGULATION CLINIC	2.542285			90.04
91	EMERGENCY	0.305758	835,109	255,341	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.726959			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		13,423,728	3,661,505	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		13,423,728		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S034** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [XX] TITLE XIX - O/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF		498,908		40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.401736	3,647	1,465	50
52	DELIVERY ROOM & LABOR ROOM	0.415436			52
53	ANESTHESIOLOGY	0.216480	13,342	2,888	53
54	RADIOLOGY-DIAGNOSTIC	0.230585	19,170	4,420	54
54.01	CARDIAC REHABILITATION	0.679161			54.01
56.01	NUCLEAR MEDICINE	0.178914	2,850	510	56.01
57	CT SCAN	0.029259	28,933	847	57
58	MRI	0.063748	3,383	216	58
59	CARDIAC CATHETERIZATION	0.342823			59
60	LABORATORY	0.163411	361,264	59,035	60
64	INTRAVENOUS THERAPY	0.357947			64
65	RESPIRATORY THERAPY	0.470985	2,607	1,228	65
65.98	HYPERBARIC OXYGEN THERAPY	0.629448			65.98
66	PHYSICAL THERAPY	0.821584			66
68	SPEECH PATHOLOGY	0.984874			68
69	ELECTROCARDIOLOGY	0.187948	12,742	2,395	69
70.01	NEUROLOGY	0.332126	803	267	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				71
73	DRUGS CHARGED TO PATIENTS	0.358274	60,727	21,757	73
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.346462			90
90.01	DIABETES EDUCATION	3.339072			90.01
90.02	PSYCH SERVICES	0.773596			90.02
90.04	ANTICOAGULATION CLINIC	2.542285			90.04
91	EMERGENCY	0.305758	146,108	44,674	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.726959			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		655,576	139,702	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		655,576		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

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, 2013 (see instructions)	13,704,110			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	4,568,037			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	149,836			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	90.22			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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 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 LINES (8, 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 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
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
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 (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0531			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1956			31
32	SUM OF LINES 30 AND 31	0.2487			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0973			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	1,444,528			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		1,330,272		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		335,302		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	335,302			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

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
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 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)				46
47	SUBTOTAL (see instructions)	20,201,813			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)	21,510,058			48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	21,182,997			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	1,451,747			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part 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, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	22,634,744			59
60	PRIMARY PAYER PAYMENTS	19,511			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	22,615,233			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,212,988			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	74,275			63
64	ALLOWABLE BAD DEBTS (see instructions)	249,086			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	161,906			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	196,000			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	20,489,876			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (TECHNOLOGY)	1,246			70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	97,670			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-205,944			70.94
71	AMOUNT DUE PROVIDER (see instructions)	20,382,848			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	307,781			71.01
72	INTERIM PAYMENTS	19,930,694			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	144,373			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	100,000			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART 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

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0034** **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)	47,863			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	12,513,236			2
3	PPS PAYMENTS	8,944,066			3
4	OUTLIER PAYMENT (see instructions)	42,940			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0.863			5
6	LINE 2 TIMES LINE 5	10,798,923			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6	0.8322			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	47,863			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	133,593			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	133,593			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)	133,593			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	85,730			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)	47,863			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	8,987,006			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	2,020,713			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	7,014,156			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)	7,014,156			30
31	PRIMARY PAYER PAYMENTS	210			31
32	SUBTOTAL (line 30 minus line 31)	7,013,946			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)	78,906			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	51,289			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	63,125			36
37	SUBTOTAL (see instructions)	7,065,235			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS ()				39
40	SUBTOTAL (see instructions)	7,065,235			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	106,685			40.01
41	INTERIM PAYMENTS	7,213,726			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-255,176			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 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

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S034** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				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)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				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)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				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)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS ()				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 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

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0034** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				19,930,694		7,213,726	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				19,930,694		7,213,726	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		452,154			6.01
	BASED ON THE COST REPORT (1)		.02				-148,491	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				20,382,848		7,065,235	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.

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-S034** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] SUB (OTHER) [XX] 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				304,890			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				304,890			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		23,421			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				328,311			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.

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

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 FROM WKST S-3, PART I, COLUMN 15, LINE 14	4,600	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	12,691	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	50	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	18,439	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	246,826,301	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	9,547,812	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1,933,716	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	38,674	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,895,042	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,982,137	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-87,095	32

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S034** **WORKSHEET E-3 PART II**

CHECK APPLICABLE BOX: **[ ] HOSPITAL** **[XX] SUBPROVIDER IPF**

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (excluding outlier, ECT, and medical education payments)	403,064	1
2	NET IPF PPS OUTLIER PAYMENT		2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)		8
9	AVERAGE DAILY CENSUS (see instructions)	6.117808	9
10	TEACHING ADJUSTMENT FACTOR {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	TEACHING ADJUSTMENT (line 1 multiplied by line 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (sum of lines 1, 2, 3 and 11)	403,064	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)	403,064	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (line 16 less line 17)	403,064	18
19	DEDUCTIBLES	93,536	19
20	SUBTOTAL (line 18 minus line 19)	309,528	20
21	COINSURANCE		21
22	SUBTOTAL (line 20 minus line 21)	309,528	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	28,897	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	18,783	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	23,117	25
26	SUBTOTAL (sum of lines 22 and 24)	328,311	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IPF only)		27
28	OTHER PASS THROUGH COSTS (see instructions)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	328,311	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	4,957	31.01
32	INTERIM PAYMENTS	304,890	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	18,464	34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (see instructions)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)		52
53	TIME VALUE OF MONEY (see instructions)		53

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0034** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	13,423,728		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)	13,423,728		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE 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	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	13,423,728		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	13,423,728		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 TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			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	SUM OF LINES 27 AND 21			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 Worksheet 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 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S034** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XIX** **[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	655,576		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)	655,576		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE 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	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	655,576		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	655,576		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 TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			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	SUM OF LINES 27 AND 21			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 Worksheet 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 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

Optimizer Systems, Inc. WinLASH Micro System

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BALANCE SHEET **WORKSHEET G**

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

	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	-7,982,998				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	31,125,580				4
5	OTHER RECEIVABLES	768,886				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-10,529,000				6
7	INVENTORY	1,843,476				7
8	PREPAID EXPENSES	270,214				8
9	OTHER CURRENT ASSETS	2,607,813				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	18,103,971				11
	FIXED ASSETS					
12	LAND	1,259,000				12
13	LAND IMPROVEMENTS	667,527				13
14	ACCUMULATED DEPRECIATION	-635,771				14
15	BUILDINGS	25,028,891				15
16	ACCUMULATED DEPRECIATION	-8,232,306				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	1,709,304				19
20	ACCUMULATED DEPRECIATION	-570,297				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	20,570,176				23
24	ACCUMULATED DEPRECIATION	-10,635,253				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)	29,161,271				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	4,762,081				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	4,762,081				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	52,027,323				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	2,768,465				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	2,450,000				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	5,725,025				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	10,943,490				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE	4,905,000				46
47	NOTES PAYABLE	39,324,051				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	7,162,195				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	51,391,246				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	62,334,736				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	-10,307,413				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	-10,307,413				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	52,027,323				60

Optimizer Systems, Inc. WinLASH Micro System

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		519,964			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-7,375,070			2
3	TOTAL (sun of line 1 and line 2)		-6,855,106			3
4	ADDITIONS (credit adjustments)					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)		-6,855,106			11
12	DEDUCTIONS (debit adjustments)					12
13	FUND BALANCE ADJUSTMENT	3,422,074				13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		3,422,074			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		-10,277,180			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 (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					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)					12
13	FUND BALANCE ADJUSTMENT					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

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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	11,681,569		11,681,569	1
2	SUBPROVIDER IPF	1,436,367		1,436,367	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)	13,117,936		13,117,936	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	3,405,634		3,405,634	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)	3,405,634		3,405,634	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	16,523,570		16,523,570	17
18	ANCILLARY SERVICES	72,951,124	141,046,538	213,997,662	18
19	OUTPATIENT SERVICES	6,301,489	21,970,811	28,272,300	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
24.20	OPT				24.20
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)	95,776,183	163,017,349	258,793,532	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		98,686,428	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)		98,686,428	43

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	258,793,532	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	171,218,878	2
3	NET PATIENT REVENUES (line 1 minus line 2)	87,574,654	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	98,686,428	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-11,111,774	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	158,994	6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES	47	8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	8,688	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	359,410	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	62,857	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	11,858	21
22	RENTAL OF HOSPITAL SPACE	203,537	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER INCOME INCLUDING GRANTS)	3,040,030	24
25	TOTAL OTHER INCOME (sum of lines 6-24)	3,845,421	25
26	TOTAL (line 5 plus line 25)	-7,266,353	26
27	OTHER EXPENSES (LOSS ON INVESTMENTS)	108,717	27
28	TOTAL OTHER EXPENSES (sum of line 27 and subscripts)	108,717	28
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-7,375,070	29

Optimizer Systems, Inc. WinLASH Micro System

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CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0034** **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	1,445,327	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	6,420	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)	51.22	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		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 (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,451,747	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0034** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		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 (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		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

Optimizer Systems, Inc. WinLASH Micro System

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
6.01	BIOMEDICAL SERVICES							6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
40	SUBPROVIDER - IPF							40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	CARDIAC REHABILITATION							54.01
56.01	NUCLEAR MEDICINE							56.01
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
65.98	HYPERBARIC OXYGEN THERAPY							65.98
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70.01	NEUROLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	DIABETES EDUCATION							90.01
90.02	PSYCH SERVICES							90.02
90.04	ANTICOAGULATION CLINIC							90.04
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
193.05	OTHER NON-REIMBURSABLE							193.05
193.06	OUTSIDE ACCOUNTING							193.06
193.07	OUTSIDE PRINTING							193.07
193.08	FOUNDATION							193.08
194	AHEC							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202

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REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	63.04		15.29				78.33	30
31	INTENSIVE CARE UNIT	47.95		18.72				66.67	31
43	NURSERY			55.39				55.39	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	22.43	19.93	6.70				49.06	50
52	DELIVERY ROOM & LABOR ROOM			50.06				50.06	52
53	ANESTHESIOLOGY	16.14	15.48	17.71				49.33	53
54	RADIOLOGY-DIAGNOSTIC	12.08	33.14	2.81				48.03	54
54.01	CARDIAC REHABILITATION		54.12					54.12	54.01
56.01	NUCLEAR MEDICINE	9.51	40.82	0.88				51.21	56.01
57	CT SCAN	16.89	26.12	4.37				47.38	57
58	MRI	9.34	32.38	1.96				43.68	58
59	CARDIAC CATHETERIZATION	38.17	26.61	4.16				68.94	59
60	LABORATORY	26.82	1.84	6.22				34.88	60
64	INTRAVENOUS THERAPY	0.56	59.78					60.34	64
65	RESPIRATORY THERAPY	56.08	7.80	15.33				79.21	65
65.98	HYPERBARIC OXYGEN THERAPY		96.23					96.23	65.98
66	PHYSICAL THERAPY	10.53		0.70				11.23	66
68	SPEECH PATHOLOGY	27.37		2.29				29.66	68
69	ELECTROCARDIOLOGY	34.33	25.74	3.95				64.02	69
70.01	NEUROLOGY	4.88	32.42	1.10				38.40	70.01
73	DRUGS CHARGED TO PATIENTS	31.30	31.29	8.44				71.03	73
90	CLINIC	0.45	56.37					56.82	90
90.01	DIABETES EDUCATION		0.22					0.22	90.01
90.02	PSYCH SERVICES	0.04	9.39					9.43	90.02
90.04	ANTICOAGULATION CLINIC	0.10						0.10	90.04
91	EMERGENCY	14.77	16.76	3.93				35.46	91
92	OBSERVATION BEDS (NON-DISTINCT	4.32	55.83					60.15	92
200	TOTAL CHARGES	20.68	21.40	5.82				47.90	200

Optimizer Systems, Inc. WinLASH Micro System

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REPORT 97 - UTILIZATION STATISTICS - SUBPROVIDER-IPF

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
40	SUBPROVIDER - IPF	20.73		35.02				55.75	40
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM			0.01				0.01	50
53	ANESTHESIOLOGY	0.11		0.37				0.48	53
54	RADIOLOGY-DIAGNOSTIC	0.08		0.09				0.17	54
56.01	NUCLEAR MEDICINE			0.04				0.04	56.01
57	CT SCAN	0.10		0.08				0.18	57
58	MRI			0.05				0.05	58
60	LABORATORY	0.50		0.83				1.33	60
65	RESPIRATORY THERAPY	0.04		0.08				0.12	65
66	PHYSICAL THERAPY	0.01						0.01	66
69	ELECTROCARDIOLOGY	0.09		0.12				0.21	69
70.01	NEUROLOGY			0.03				0.03	70.01
73	DRUGS CHARGED TO PATIENTS	0.18		0.24				0.42	73
91	EMERGENCY	0.41		0.69				1.10	91
200	TOTAL CHARGES	0.18		0.28				0.46	200

Optimizer Systems, Inc. WinLASH Micro System

ST. MARY'S HOSPITAL Provider CCN: 14-0034	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 15:02 Version: 2014.03

REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	2,301,998	2.57	-2,301,998	-4.70			1
2	CAP REL COSTS-MVBLE EQUIP	2,574,016	2.88	-2,574,016	-5.25			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	11,378,134	12.72	-11,378,134	-23.22			4
5	ADMINISTRATIVE & GENERAL	23,283,846	26.04	-23,283,846	-47.51			5
6	MAINTENANCE & REPAIRS	1,013,661	1.13	-1,013,661	-2.07			6
6.01	BIOMEDICAL SERVICES	850,195	0.95	-850,195	-1.73			6.01
7	OPERATION OF PLANT	2,047,852	2.29	-2,047,852	-4.18			7
8	LAUNDRY & LINEN SERVICE	527,583	0.59	-527,583	-1.08			8
9	HOUSEKEEPING	1,104,186	1.23	-1,104,186	-2.25			9
10	DIETARY	464,634	0.52	-464,634	-0.95			10
11	CAFETERIA	857,148	0.96	-857,148	-1.75			11
13	NURSING ADMINISTRATION	853,240	0.95	-853,240	-1.74			13
16	MEDICAL RECORDS & LIBRARY	1,458,870	1.63	-1,458,870	-2.98			16
17	SOCIAL SERVICE	295,688	0.33	-295,688	-0.60			17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	ADULTS & PEDIATRICS	6,986,452	7.81	11,309,168	23.07	18,295,620	20.46	30
31	INTENSIVE CARE UNIT	3,181,227	3.56	3,691,853	7.53	6,873,080	7.69	31
40	SUBPROVIDER - IPF	921,040	1.03	1,496,911	3.05	2,417,951	2.70	40
43	NURSERY	654,750	0.73	921,146	1.88	1,575,896	1.76	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,459,272	6.10	5,731,404	11.69	11,190,676	12.51	50
52	DELIVERY ROOM & LABOR ROOM	522,628	0.58	820,682	1.67	1,343,310	1.50	52
53	ANESTHESIOLOGY	181,152	0.20	577,947	1.18	759,099	0.85	53
54	RADIOLOGY-DIAGNOSTIC	1,773,423	1.98	3,121,783	6.37	4,895,206	5.47	54
54.01	CARDIAC REHABILITATION	86,345	0.10	117,643	0.24	203,988	0.23	54.01
56.01	NUCLEAR MEDICINE	778,614	0.87	436,305	0.89	1,214,919	1.36	56.01
57	CT SCAN	338,488	0.38	754,703	1.54	1,093,191	1.22	57
58	MRI	170,000	0.19	262,327	0.54	432,327	0.48	58
59	CARDIAC CATHETERIZATION	717,854	0.80	720,022	1.47	1,437,876	1.61	59
60	LABORATORY	3,909,798	4.37	3,142,467	6.41	7,052,265	7.89	60
64	INTRAVENOUS THERAPY	291,461	0.33	326,394	0.67	617,855	0.69	64
65	RESPIRATORY THERAPY	924,899	1.03	659,910	1.35	1,584,809	1.77	65
65.98	HYPERBARIC OXYGEN THERAPY	45,717	0.05	71,179	0.15	116,896	0.13	65.98
66	PHYSICAL THERAPY	1,487,211	1.66	1,965,004	4.01	3,452,215	3.86	66
68	SPEECH PATHOLOGY	111,399	0.12	87,512	0.18	198,911	0.22	68
69	ELECTROCARDIOLOGY	791,376	0.88	1,126,805	2.30	1,918,181	2.14	69
70.01	NEUROLOGY	328,131	0.37	501,904	1.02	830,035	0.93	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS	5,758,165	6.44	3,470,377	7.08	9,228,542	10.32	73
90	CLINIC	199,638	0.22	309,885	0.63	509,523	0.57	90
90.01	DIABETES EDUCATION	32,410	0.04	26,164	0.05	58,574	0.07	90.01
90.02	PSYCH SERVICES	308,167	0.34	630,401	1.29	938,568	1.05	90.02
90.04	ANTICOAGULATION CLINIC	106,300	0.12	103,797	0.21	210,097	0.23	90.04
91	EMERGENCY	3,094,110	3.46	3,368,466	6.87	6,462,576	7.23	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-168				-168		190
193.05	OTHER NON-REIMBURSABLE	947,953	1.06	2,822,956	5.76	3,770,909	4.22	193.05
193.06	OUTSIDE ACCOUNTING	1,873		59,093	0.12	60,966	0.07	193.06
193.07	OUTSIDE PRINTING	108,252	0.12	90,718	0.19	198,970	0.22	193.07
193.08	FOUNDATION	191,609	0.21	283,607	0.58	475,216	0.53	193.08
194	AHEC	6,000	0.01	2,518	0.01	8,518	0.01	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	89,426,597	100.00			89,426,597	100.00	202

Optimizer Systems, Inc. WinLASH Micro System

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	839,243	27,922,496	0.030056	6,261,657	188,200	50
52	DELIVERY ROOM & LABOR ROOM	121,892	3,233,496	0.037697			52
53	ANESTHESIOLOGY	51,626	3,598,673	0.014346	580,822	8,332	53
54	RADIOLOGY-DIAGNOSTIC	711,822	21,267,304	0.033470	2,569,675	86,007	54
54.01	CARDIAC REHABILITATION	11,501	315,657	0.036435			54.01
56.01	NUCLEAR MEDICINE	24,637	6,790,505	0.003628	646,020	2,344	56.01
57	CT SCAN	133,528	37,362,223	0.003574	6,311,957	22,559	57
58	MRI	36,669	6,781,836	0.005407	633,240	3,424	58
59	CARDIAC CATHETERIZATION	74,014	4,244,226	0.017439	1,619,993	28,251	59
60	LABORATORY	337,616	43,392,803	0.007780	11,637,092	90,537	60
64	INTRAVENOUS THERAPY	20,792	1,726,109	0.012046	9,684	117	64
65	RESPIRATORY THERAPY	94,361	3,383,080	0.027892	1,897,363	52,921	65
65.98	HYPERBARIC OXYGEN THERAPY	10,133	185,712	0.054563			65.98
66	PHYSICAL THERAPY	150,576	4,208,290	0.035781	443,284	15,861	66
68	SPEECH PATHOLOGY	11,430	201,966	0.056594	55,276	3,128	68
69	ELECTROCARDIOLOGY	140,099	10,281,076	0.013627	3,529,420	48,095	69
70.01	NEUROLOGY	52,749	2,531,138	0.020840	123,557	2,575	70.01
71	MEDICAL SUPPLIES CHARGED TO PAT	865					71
73	DRUGS CHARGED TO PATIENTS	324,556	25,758,369	0.012600	8,062,208	101,584	73
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	19,035	1,476,764	0.012890	6,645	86	90
90.01	DIABETES EDUCATION	1,296	17,542	0.073880			90.01
90.02	PSYCH SERVICES	91,598	1,218,547	0.075170	521	39	90.02
90.04	ANTICOAGULATION CLINIC	3,835	82,641	0.046406	80	4	90.04
91	EMERGENCY	202,402	21,252,766	0.009524	3,140,014	29,905	91
92	OBSERVATION BEDS (NON-DISTINCT	130,124	3,280,040	0.039671	141,585	5,617	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	3,596,399	230,513,259		47,670,093	689,586	200

Optimizer Systems, Inc. WinLASH Micro System

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	998,437		998,437	18,039	55.35	11,372	629,440	30
31	INTENSIVE CARE UNIT	403,227		403,227	2,751	146.57	1,319	193,326	31
200	TOTAL	1,401,664		1,401,664	20,790		12,691	822,766	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	822,766
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	689,586
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	1,512,352
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	2,926
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	12,691
PER DISCHARGE CAPITAL COSTS	516.87

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I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	25,322,790
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	57,390,203
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.441

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 40 + Worksheet D, Part IV, column 11, line 200))	590,050
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	710,576
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.830

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	1,512,352
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.026

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	12,513,140
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	49,206,318
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.254