

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☒ Electronically filed cost report Date: 11/30/2018 Time: 11:18 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☐ 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MERCY HOSPITAL & MEDICAL CENTER (14-0158) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____
Chief Financial 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		-2,507,341	-112,307			1
2	SUBPROVIDER - IPF		34,153				2
3	SUBPROVIDER - IRF		-6,764				3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-2,479,952	-112,307			200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 2525 SOUTH MICHIGAN AVENUE	P.O. Box:		1
2	City: CHICAGO	State: IL	ZIP Code: 60616-2477	County: COOK

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	MERCY HOSPITAL & MEDICAL CENTER	14-0158	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF	MERCY HOSPITAL & MEDICAL CENTER	14-S158	16974	4	07 / 01 / 1984	N	P	O	4
5	Subprovider - IRF	MERCY HOSPITAL & MEDICAL CENTER	14-T158	16974	5	07 / 01 / 1984	N	P	O	5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2017	To: 06 / 30 / 2018	20
21	Type of control (see instructions)	1		21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,080	3,752	90	33	10,580	456	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	280				571		25

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

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

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

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)							64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)								
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
		1	2	3	4	5		
65								65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)							66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)								
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
		1	2	3	4	5		
67								67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	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.	Y			75
76	If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	Y	N		76

Long Term Care Hospital PPS

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

TEFRA Providers

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

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

Rural Providers

		1	2	
105	Does this hospital qualify as a CAH?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions)			107
	If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			
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	
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.	Speech	Respiratory	109

		1	2	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110
		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.			111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	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:	209,090	14,922,049	1,096,356
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

Transplant Center Information

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

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

All Providers

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

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

141	Name: TRINITY HEALTH	Contractor's Name: WPS	Contractor's Number: 05101	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N	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. (see instructions)					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	9.99			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07 / 01 / 2017	09 / 28 / 2017		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0		171

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

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

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	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 in the filed financial statements? If yes, submit reconciliation.	N			5

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

		Y	
Bed Complement		Y	
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	10/31/2017	N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	Y		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 Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	27

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

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

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

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

Cost Report Preparer Contact Information			
41	First name: MICHAEL	Last name: CADDICK	Title: VICE PRESIDENT
42	Employer: SRGROUPLLC.COM		
43	Phone number: 708 466-7240	E-mail Address: MICHAEL.CADDICK@SRGROUPLLC.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
**WORKSHEET S-3
PART I**

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	168	61,320			12,484	4,025	37,454	1
2	HMO and other (see instructions)						7,328	12,246		2
3	HMO IPF Subprovider						374	2,589		3
4	HMO IRF Subprovider						396			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)		168	61,320			12,484	4,025	37,454	7
8	Intensive Care Unit	31	14	5,110			1,440	438	3,944	8
9	Coronary Care Unit	32	6	2,190			537	103	1,444	9
9.01	NURSERY INTENSIVE CARE CENTER	32.01	15	5,475				851	1,840	9.01
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						1,160	3,076	13
14	Total (see instructions)		203	74,095			14,461	6,577	47,758	14
15	CAH Visits									15
16	Subprovider - IPF	40	39	14,235			919	1,040	7,282	16
17	Subprovider - IRF	41	16	5,840			2,190	1,181	4,190	17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		258							27
28	Observation Bed Days								5,841	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							578	698	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,698	1,093	10,248	1
2	HMO and other (see instructions)					1,403	3,378		2
3	HMO IPF Subprovider						524		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
9.01	NURSERY INTENSIVE CARE CENTER								9.01
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)	81.52	1,231.56			2,698	1,093	10,248	14
15	CAH Visits								15
16	Subprovider - IPF		29.47			183	245	1,525	16
17	Subprovider - IRF		18.88			225	115	391	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	81.52	1,279.91						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclass- ification 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	98,928,419		98,928,419	2,831,777.00	34.94	1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetest Part B							3
4 Physician-Part A - Administrative		261,868		261,868	1,530.00	171.16	4
4.01 Physician-Part A - Teaching							4.01
5 Physician-Part B		6,257,659		6,257,659	43,793.00	142.89	5
6 Non-physician-Part B							6
7 Interns & residents (in an approved program)	21	6,859,596		6,859,596	169,562.00	40.45	7
7.01 Contracted interns & residents (in an approved program)		1,899,979		1,899,979	59,592.00	31.88	7.01
8 Home office and/or related organization personnel		2,631,049		2,631,049	8,320.00	316.23	8
9 SNF	44						9
10 Excluded area salaries (see instructions)		14,095,252		14,095,252	347,298.00	40.59	10
OTHER WAGES & RELATED COSTS							
11 Contract labor (see instructions)		12,980,671		12,980,671	219,416.00	59.16	11
12 Contract management and administrative services							12
13 Contract labor: Physician-Part A - Administrative							13
14 Home office salaries & wage-related costs							14
14.01 Home office salaries		6,549,185		6,549,185	102,606.00	63.83	14.01
14.02 Related organization salaries							14.02
15 Home office: Physician Part A - Administrative							15
16 Home office & Contract Physicians Part A - Teaching							16
WAGE-RELATED COSTS							
17 Wage-related costs (core)(see instructions)		17,588,754		17,588,754			17
18 Wage-related costs (other)(see instructions)							18
19 Excluded areas		2,973,190		2,973,190			19
20 Non-physician anesthetist Part A							20
21 Non-physician anesthetist Part B							21
22 Physician Part A - Administrative		29,203		29,203			22
22.01 Physician Part A - Teaching							22.01
23 Physician Part B		593,251		593,251			23
24 Wage-related costs (RHC/FQHC)							24
25 Interns & residents (in an approved program)		1,700,208		1,700,208			25
25.50 Home office wage-related		1,647,181		1,647,181			25.50
25.51 Related organization wage-related							25.51
25.52 Home office: Physician Part A - Administrative - wage-related							25.52
25.53 Home office & Contract Physicians Part A - Teaching - wage-related							25.53
OVERHEAD COSTS - DIRECT SALARIES							
26 Employee Benefits Department		879,672		879,672	20,874.00	42.14	26
27 Administrative & General		12,014,319		12,014,319	438,236.00	27.42	27
28 Administrative & General under contract (see instructions)		505,981		505,981	5,372.00	94.19	28
29 Maintenance & Repairs							29
30 Operation of Plant		1,888,592		1,888,592	71,418.00	26.44	30
31 Laundry & Linen Service							31
32 Housekeeping		1,848,724		1,848,724	116,523.00	15.87	32
33 Housekeeping under contract (see instructions)		678,267		678,267	49,890.00	13.60	33
34 Dietary							34
35 Dietary under contract (see instructions)		1,437,736		1,437,736	45,821.00	31.38	35
36 Cafeteria							36
37 Maintenance of Personnel							37
38 Nursing Administration		1,449,608		1,449,608	27,732.00	52.27	38
39 Central Services and Supply		598,036		598,036	29,739.00	20.11	39
40 Pharmacy							40
41 Medical Records & Medical Records Library		603,913		603,913	43,168.00	13.99	41
42 Social Service							42
43 Other General Service							43

Part III - Hospital Wage Index Summary

1 Net salaries (see instructions)		83,902,120		83,902,120	2,651,593.00	31.64	1
2 Excluded area salaries (see instructions)		14,095,252		14,095,252	347,298.00	40.59	2
3 Subtotal salaries (line 1 minus line 2)		69,806,868		69,806,868	2,304,295.00	30.29	3
4 Subtotal other wages & related costs (see instructions)		19,529,856		19,529,856	322,022.00	60.65	4
5 Subtotal wage-related costs (see instructions)		19,265,138		19,265,138		27.60%	5
6 Total (sum of lines 3 through 5)		108,601,862		108,601,862	2,626,317.00	41.35	6
7 Total overhead cost (see instructions)		21,904,848		21,904,848	848,773.00	25.81	7

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HOSPITAL WAGE RELATED COSTS**WORKSHEET S-3****Part IV - Wage Related Cost****PART IV****Part A - Core List**

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	4,261,698	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)	9,899,036	8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	225,445	10
11	Life Insurance (If employee is owner or beneficiary)	8,647	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	333,046	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	693,531	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	7,227,614	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	70,785	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	164,804	23
24	Total Wage Related cost (Sum of lines 1-23)	22,884,606	24

Part B - Other Than Core Related Cost

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

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3****Part V - Contract Labor and Benefit Cost****PART V****Hospital and Hospital-Based Component Identification:**

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

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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)	0.332963	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	78,585,730	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 and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	220,661,966	6
7	Medicaid cost (line 1 times line 6)	73,472,270	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.		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

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

17	Private grants, donations, or endowment income restricted to fundng 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)		19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	10,135,013	26,188	10,161,201	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,374,584	26,188	3,400,772	21
22	Payments received from patients for amounts previously written off as charity care	253,375		253,375	22
23	Cost of charity care (line 21 minus line 22)	3,121,209	26,188	3,147,397	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	19,564,100	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,514,746	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,330,378	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	17,233,722	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	6,553,824	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	9,701,221	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,701,221	31

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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		1,265,551	1,265,551	3,849,511	5,115,062	1,607,187	6,722,249	1
2	00200	Cap Rel Costs-Mvble Equip		4,646,256	4,646,256		4,646,256		4,646,256	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	879,672	24,082,661	24,962,333		24,962,333	-2,256,188	22,706,145	4
5	00500	Administrative & General	12,014,319	91,458,634	103,472,953	-3,849,511	99,623,442	-44,816,033	54,807,409	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,888,592	9,744,860	11,633,452		11,633,452	-560	11,632,892	7
8	00800	Laundry & Linen Service		1,247,678	1,247,678		1,247,678		1,247,678	8
9	00900	Housekeeping	1,848,724	1,163,692	3,012,416		3,012,416	-250	3,012,166	9
10	01000	Dietary		3,653,351	3,653,351	-1,662,710	1,990,641		1,990,641	10
11	01100	Cafeteria				1,662,710	1,662,710	-826,911	835,799	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,449,608	263,722	1,713,330		1,713,330		1,713,330	13
14	01400	Central Services & Supply	598,036	528,572	1,126,608		1,126,608		1,126,608	14
15	01500	Pharmacy		15,803,550	15,803,550		15,803,550		15,803,550	15
16	01600	Medical Records & Library	603,913	606,775	1,210,688		1,210,688	-8,314	1,202,374	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	6,859,596	1,173,045	8,032,641		8,032,641		8,032,641	21
22	02200	I&R Services-Other Prgm Costs Apprvd	1,313,484	282,259	1,595,743		1,595,743	-1,101,620	494,123	22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	16,228,873	4,304,256	20,533,129		20,533,129	-866,011	19,667,118	30
31	03100	Intensive Care Unit	4,602,307	843,664	5,445,971		5,445,971	-1,327,673	4,118,298	31
32	03200	Coronary Care Unit	972,313	146,302	1,118,615		1,118,615		1,118,615	32
32.01	02060	NURSERY INTENSIVE CARE CENTER				2,342,760	2,342,760		2,342,760	32.01
40	04000	Subprovider - IPF	2,109,079	1,533,119	3,642,198		3,642,198	-235,327	3,406,871	40
41	04100	Subprovider - IRF	1,161,238	1,053,485	2,214,723		2,214,723		2,214,723	41
43	04300	Nursery	1,856,684	619,355	2,476,039	-2,342,760	133,279	-480,464	-347,185	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	3,310,879	5,951,028	9,261,907	-2,789,439	6,472,468	-75,000	6,397,468	50
50.01	03340	GI LAB	525,423	533,876	1,059,299	-11,367	1,047,932		1,047,932	50.01
51	05100	Recovery Room	585,941	30,345	616,286		616,286		616,286	51
52	05200	Delivery Room & Labor Room	2,536,169	631,657	3,167,826		3,167,826		3,167,826	52
53	05300	Anesthesiology	107,438	192,103	299,541		299,541		299,541	53
54	05400	Radiology-Diagnostic	3,162,058	785,871	3,947,929	-243,909	3,704,020	-255,756	3,448,264	54
54.01	05401	MRI CENTER								54.01
55	05500	Radiology-Therapeutic	388,233	804,935	1,193,168		1,193,168	-635,759	557,409	55
56	05600	Radioisotope	314,192	457,875	772,067		772,067	-3,776	768,291	56
57	05700	CT Scan	796,912	184,970	981,882		981,882		981,882	57
58	05800	MRI	240,288	1,862,518	2,102,806		2,102,806	980,541	3,083,347	58
59	05900	Cardiac Catheterization	2,190,780	5,723,378	7,914,158	-3,695,409	4,218,749	-1,730,544	2,488,205	59
60	06000	Laboratory	4,077,937	4,210,492	8,288,429		8,288,429	-190,658	8,097,771	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,305,915	370,074	1,675,989	-126,482	1,549,507		1,549,507	65
66	06600	Physical Therapy	1,032,849	165,470	1,198,319		1,198,319	-65	1,198,254	66
67	06700	Occupational Therapy	524,696	153,849	678,545		678,545	-349	678,196	67
68	06800	Speech Pathology	263,395	75,958	339,353		339,353		339,353	68
70	07000	Electroencephalography	52,818	1,079	53,897		53,897		53,897	70
71	07100	Medical Supplies Charged to Patients				2,514,290	2,514,290		2,514,290	71
72	07200	Impl. Dev. Charged to Patients				4,352,316	4,352,316		4,352,316	72
73	07300	Drugs Charged to Patients								73
74	07400	Renal Dialysis		982,334	982,334		982,334		982,334	74
76	03951	EMG	31,243	390	31,633		31,633		31,633	76
76.01	03952	CARDIOVASCULAR LAB								76.01
76.02	03953	MERCY EYE CENTER	186,320	16,227	202,547		202,547		202,547	76.02
76.03	03954	MERCY ENT								76.03
76.04	03955	WOUND CARE CENTER	196,535	6,730	203,265		203,265		203,265	76.04
76.05	03956	CARDIAC REHAB								76.05
76.06	03957	PRE-BIRTH CENTER	830,536	305,069	1,135,605		1,135,605	-803,668	331,937	76.06
76.07	03958	SLEEP LAB		394,806	394,806		394,806		394,806	76.07
76.08	03640	UROLOGY	87,497	234	87,731		87,731		87,731	76.08
76.09	03959	ADDP OP	109,685	500	110,185		110,185		110,185	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		1,017	1,017		1,017		1,017	76.10
76.11	03960	DIABETES TREATMENT	111,944	43,154	155,098		155,098		155,098	76.11
76.12	03961	MENTAL HEALTH CENTER	122,263	15,714	137,977		137,977		137,977	76.12
76.13	03650	VEIN CLINIC								76.13
76.97	07697	CARDIAC REHABILITATION	289,594	14,466	304,060		304,060	-26,301	277,759	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99

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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	
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	5,942,437	4,315,277	10,257,714		10,257,714	-2,657,268	7,600,446	90.01
90.02	09002	MERCY CLINIC STATE ST								90.02
90.03	09003	MERCY CLINIC POLK ST								90.03
91	09100	Emergency	4,393,069	3,588,060	7,981,129		7,981,129	-1,300,000	6,681,129	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		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)	88,103,484	196,240,243	284,343,727		284,343,727	-57,010,767	227,332,960	118
		NONREIMBURSABLE COST CENTERS								
191	19100	Research	177,366	2,296	179,662		179,662		179,662	191
192	19200	Physicians' Private Offices	10,365,095	7,832,826	18,197,921		18,197,921		18,197,921	192
192.01	19201	DNBAR CLINIC	54,851	132,045	186,896		186,896		186,896	192.01
192.02	19202	PHILLIPS HEALTH	53,763	112,806	166,569		166,569		166,569	192.02
192.03	19204	OTHER HOME HEALTH								192.03
192.04	19205	VITAS HOSPICE								192.04
192.05	19203	DOCTORS OFFICE	173,860	406,251	580,111		580,111		580,111	192.05
194	07950	OTHER NONREIMBURSABLE COST CENTERS								194
194.01	07951	SENIOR FRIENDS								194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS								194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS								194.03
200		TOTAL (sum of lines 118-199)	98,928,419	204,726,467	303,654,886		303,654,886	-57,010,767	246,644,119	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER
1	PROPERTY INSURANCE	1	2	3	4	5
500	Total reclassifications	A	Cap Rel Costs-Bldg & Fixt	1		147,216
	Code Letter - A					147,216
1	MEDICAL SUPPLIES	B	Medical Supplies Charged to P	71		2,514,290
2						2
3						3
4						4
500	Total reclassifications					2,514,290
	Code Letter - B					
1	CAFETERIA COSTS	C	Cafeteria	11		1,662,710
500	Total reclassifications					1,662,710
	Code Letter - C					
1	SPECIAL CARE NURSERY	D	NURSERY INTENSIVE CARE CENTER	32.01	1,099,157	72,223
500	Total reclassifications				1,099,157	72,223
	Code Letter - D					
1	IMPLANT SUPPLIES	E	Impl. Dev. Charged to Patient	72		4,352,316
2						2
3						3
4						4
500	Total reclassifications					4,352,316
	Code Letter - E					
1	INTEREST EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		3,702,295
500	Total reclassifications					3,702,295
	Code Letter - F					
1	NICU COSTS	G	NURSERY INTENSIVE CARE CENTER	32.01	1,099,157	72,223
500	Total reclassifications				1,099,157	72,223
	Code Letter - G					
	GRAND TOTAL (Increases)				2,198,314	12,523,273

(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

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	PROPERTY INSURANCE	A	Administrative & General	5		147,216	9	1
500	Total reclassifications					147,216		500
	Code letter - A							
1	MEDICAL SUPPLIES	B	Operating Room	50		649,598		1
2			Radiology-Diagnostic	54		220,689		2
3			Cardiac Catheterization	59		1,517,521		3
4			Respiratory Therapy	65		126,482		4
500	Total reclassifications					2,514,290		500
	Code letter - B							
1	CAFETERIA COSTS	C	Dietary	10		1,662,710		1
500	Total reclassifications					1,662,710		500
	Code letter - C							
1	SPECIAL CARE NURSERY	D	Nursery	43	1,099,157	72,223		1
500	Total reclassifications				1,099,157	72,223		500
	Code letter - D							
1	IMPLANT SUPPLIES	E	Operating Room	50		2,139,841		1
2			GI LAB	50.01		11,367		2
3			Radiology-Diagnostic	54		23,220		3
4			Cardiac Catheterization	59		2,177,888		4
500	Total reclassifications					4,352,316		500
	Code letter - E							
1	INTEREST EXPENSE	F	Administrative & General	5		3,702,295	9	1
500	Total reclassifications					3,702,295		500
	Code letter - F							
1	NICU COSTS	G	Nursery	43	1,099,157	72,223		1
500	Total reclassifications				1,099,157	72,223		500
	Code letter - G							
	GRAND TOTAL (Decreases)				2,198,314	12,523,273		

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

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	26,173,000					26,173,000		1
2	Land Improvements	5,122,158	29,602		29,602		5,151,760		2
3	Buildings and Fixtures	167,800,677	12,609,480		12,609,480	159,998,547	20,411,610		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	57,232,296	1,981,988		1,981,988	4,718,944	54,495,340		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	256,328,131	14,621,070		14,621,070	164,717,491	106,231,710		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	256,328,131	14,621,070		14,621,070	164,717,491	106,231,710		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	1,265,551						1,265,551	1
2	Cap Rel Costs-Mvble Equip	4,646,256						4,646,256	2
3	Total (sum of lines 1-2)	5,911,807						5,911,807	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 line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1	2	3	4	5	6	7	8	
*										
1	Cap Rel Costs-Bldg & Fi				0.000000					1
2	Cap Rel Costs-Mvble Equip				0.000000					2
3	Total (sum of lines 1-2)				0.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	6,722,249						6,722,249	1
2	Cap Rel Costs-Mvble Equip	4,646,256						4,646,256	2
3	Total (sum of lines 1-2)	11,368,505						11,368,505	3

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

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
				3	4		
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	5	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)	B	-89,549	Cap Rel Costs-Bldg & Fixt	1	9	6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-13,520,037				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	10,392,526				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-826,911	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
33.60	MARKETING NON ALLOW BEN	A	-18,751	Employee Benefits Department	4		33.60
33.61	MARKETING COSTS	A	-824,205	Administrative & General	5		33.61
33.62	MISC REVENUE	B	-1,099	Employee Benefits Department	4		33.62
33.73	MISCELLANEOUS INCOME	B	-12,767	Administrative & General	5		33.73
33.78	MISCELLANEOUS INCOME	B	-13,439	Radiology-Diagnostic	54		33.78
33.79	REFERRAL LAB REVENUE	B	-190,658	Laboratory	60		33.79
33.82	OTHER REVENUE	B	-349	Occupational Therapy	67		33.82
33.88	OTHER REVENUE	B	-65	Physical Therapy	66		33.88
33.94	OTHER REVENUE	B	-74,945	I&R Services-Other Prgm Costs Apprvd	22		33.94
33.97	OTHER REVENUE	B	-560	Operation of Plant	7		33.97
33.98	MISC REVENUE	B	-16,710	CARDIAC REHABILITATION	76.97		33.98
33.99	LOBBYING COSTS	B	-19,500	Administrative & General	5		33.99
34	OTHER REVENUE	B	-351,143	MERCY CLINICS	90.01		34
35	AMORT TIF EXPENSES	A	-727,103	Administrative & General	5		35
36							36
37							37
38	PHYSICIANS PART B BENEFITS	A	-1,756,928	Employee Benefits Department	4		38
39	OCCUPATIONAL MEDICINE ADMIN	A	-239,602	Administrative & General	5		39
40	HOSPICE COSTS	A	-39,689	Adults & Pediatrics	30		40
41	IMPAIRMENT EXPENSES	A	-37,992,859	Administrative & General	5		41
42	MEDICAID ASSESSMENT	A	-10,686,174	Administrative & General	5		42
42.01	OTHER REVENUE	B	-250	Housekeeping	9		42.01
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-57,010,767				50

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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) 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 Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	7	Operation of Plant	HOME OFFICE COSTS	2,851,111	2,851,111			1
2	1	Cap Rel Costs-Bldg & Fixt	INVESTMENT INCOME		-1,696,736	1,696,736	9	2
3	58	MRI	JOINT VENTURE	1,530,541	550,000	980,541		3
3.01	5	Administrative & General	TRINITY HEALTH	31,276,469	23,081,810	8,194,659		3.01
3.02	4	Employee Benefits Department	EMPLOYEE BENEFITS HOME OF	855,124	1,334,534	-479,410		3.02
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		36,513,245	26,120,719	10,392,526		5

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B	SISTERS OF MERCY	100.00			RELIGIOUS ORDER	6
7							7
8							8
9							9
10							10

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

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

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5	Administrative & Gen AGGREGATE	2,518,705	2,505,155	12,626	177,200	120	10,223	511	1
2	16	Medical Records & Li AGGREGATE	23,989		23,989	177,200	184	15,675	784	2
3	22	I&R Services-Other P AGGREGATE	1,831,742	734,489	1,097,253	177,200	9,450	805,067	40,253	3
4	30	Adults & Pediatrics AGGREGATE	826,322	826,322						4
5	31	Intensive Care Unit AGGREGATE	1,381,429	1,243,286	138,143	177,200	631	53,756	2,688	5
6	40	Subprovider - IPF AGGREGATE	235,327	235,327						6
7										7
8	43	Nursery AGGREGATE	480,464	480,464						8
9	54	Radiology-Diagnostic AGGREGATE	242,317	242,317						9
10	55	Radiology-Therapeuti AGGREGATE	635,759	635,759						10
11	56	Radioisotope AGGREGATE	24,989		24,989	177,200	249	21,213	1,061	11
12	59	Cardiac Catheterizat AGGREGATE	1,746,049	1,718,674	27,375	177,200	182	15,505	775	12
13	76.97	CARDIAC REHABILITATI AGGREGATE	15,043		15,043	177,200	64	5,452	273	13
14										14
15	76.06	PRE-BIRTH CENTER AGGREGATE	803,668	803,668						15
16	91	Emergency AGGREGATE	1,300,000	1,300,000						16
17	90.01	MERCY CLINICS AGGREGATE	2,306,125	2,306,125						17
18	50	Operating Room AGGEGRATE	75,000	75,000						18
19										19
20										20
200		TOTAL	14,446,928	13,106,586	1,339,418		10,880	926,891	46,345	200

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5	Administrative & Gen AGGREGATE					10,223	2,403	2,508,482	1
2	16	Medical Records & Li AGGREGATE					15,675	8,314	8,314	2
3	22	I&R Services-Other P AGGREGATE					805,067	292,186	1,026,675	3
4	30	Adults & Pediatrics AGGREGATE							826,322	4
5	31	Intensive Care Unit AGGREGATE					53,756	84,387	1,327,673	5
6	40	Subprovider - IPF AGGREGATE							235,327	6
7										7
8	43	Nursery AGGREGATE							480,464	8
9	54	Radiology-Diagnostic AGGREGATE							242,317	9
10	55	Radiology-Therapeuti AGGREGATE							635,759	10
11	56	Radioisotope AGGREGATE					21,213	3,776	3,776	11
12	59	Cardiac Catheterizat AGGREGATE					15,505	11,870	1,730,544	12
13	76.97	CARDIAC REHABILITATI AGGREGATE					5,452	9,591	9,591	13
14										14
15	76.06	PRE-BIRTH CENTER AGGREGATE							803,668	15
16	91	Emergency AGGREGATE							1,300,000	16
17	90.01	MERCY CLINICS AGGREGATE							2,306,125	17
18	50	Operating Room AGGEGRATE							75,000	18
19										19
20										20
200		TOTAL					926,891	412,527	13,520,037	200

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	6,722,249	6,722,249					1
2	Cap Rel Costs-Mvble Equip	4,646,256		4,646,256				2
4	Employee Benefits Department	22,706,145	61,019		22,767,164			4
5	Administrative & General	54,807,409	448,837	1,975,208	3,480,608	60,712,062	60,712,062	5
6	Maintenance & Repairs							6
7	Operation of Plant	11,632,892	2,382,691	15,532	547,135	14,578,250	4,757,962	7
8	Laundry & Linen Service	1,247,678	106,367			1,354,045	441,925	8
9	Housekeeping	3,012,166	25,271	4,095	535,585	3,577,117	1,167,478	9
10	Dietary	1,990,641	118,080	9,096		2,117,817	691,200	10
11	Cafeteria	835,799	94,833	7,594		938,226	306,213	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,713,330	17,098	3	419,959	2,150,390	701,831	13
14	Central Services & Supply	1,126,608	87,312	43,401	173,254	1,430,575	466,902	14
15	Pharmacy	15,803,550		19,954		15,823,504	5,164,380	15
16	Medical Records & Library	1,202,374	55,566	2,503	174,957	1,435,400	468,477	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	8,032,641	96,688	881	198,621	8,328,831	2,718,314	21
22	I&R Services-Other Prgm Costs Apprvd	494,123	32,151		380,523	906,797	295,955	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	19,667,118	981,783	314,851	4,521,563	25,485,315	8,317,822	30
31	Intensive Care Unit	4,118,298	76,858	526,643	973,125	5,694,924	1,858,675	31
32	Coronary Care Unit	1,118,615	81,231	10,297	281,684	1,491,827	486,894	32
32.01	NURSERY INTENSIVE CARE CENTER	2,342,760	24,349	19,579	318,431	2,705,119	882,881	32.01
40	Subprovider - IPF	3,406,871	150,658	665	551,526	4,109,720	1,341,306	40
41	Subprovider - IRF	2,214,723	59,883	13,493	336,416	2,624,515	856,573	41
43	Nursery	-347,185	14,220	25,889	219,459	-87,617		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,397,468	362,154	89,357	959,178	7,808,157	2,548,379	50
50.01	GI LAB	1,047,932	19,695	7,531	152,218	1,227,376	400,584	50.01
51	Recovery Room	616,286	24,282		169,750	810,318	264,467	51
52	Delivery Room & Labor Room	3,167,826	180,785	27,734	734,741	4,111,086	1,341,752	52
53	Anesthesiology	299,541	4,092	1,852	31,125	336,610	109,861	53
54	Radiology-Diagnostic	3,448,264	257,474	226,215	916,064	4,848,017	1,582,267	54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic	557,409	6,677	11,111	112,473	687,670	224,438	55
56	Radioisotope	768,291	24,360	867	91,023	884,541	288,691	56
57	CT Scan	981,882	5,621	81,562	230,869	1,299,934	424,265	57
58	MRI	3,083,347	41,695	507,620	69,613	3,702,275	1,208,326	58
59	Cardiac Catheterization	2,488,205	200,424	170,702	634,680	3,494,011	1,140,354	59
60	Laboratory	8,097,771	172,118	306,316	1,181,399	9,757,604	3,184,628	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,549,507	9,971	18,515	378,330	1,956,323	638,493	65
66	Physical Therapy	1,198,254	63,031	44,017	299,222	1,604,524	523,675	66
67	Occupational Therapy	678,196	24,079		152,007	854,282	278,815	67
68	Speech Pathology	339,353	18,638		76,307	434,298	141,744	68
70	Electroencephalography	53,897	23,652		15,302	92,851	30,304	70
71	Medical Supplies Charged to Patients	2,514,290				2,514,290	820,599	71
72	Impl. Dev. Charged to Patients	4,352,316				4,352,316	1,420,483	72
73	Drugs Charged to Patients							73
74	Renal Dialysis	982,334	9,982			992,316	323,866	74
76	EMG	31,633	6,734	967	9,051	48,385	15,792	76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER	202,547	54,813	981	53,978	312,319	101,933	76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER	203,265	7,667	19,262	56,937	287,131	93,712	76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER	331,937			84,115	416,052	135,789	76.06
76.07	SLEEP LAB	394,806				394,806	128,854	76.07
76.08	UROLOGY	87,731	10,016	1,971	25,348	125,066	40,818	76.08
76.09	ADDP OP	110,185			31,776	141,961	46,332	76.09
76.10	PSYCH PARTIAL HOSPITAL	1,017	16,356			17,373	5,670	76.10
76.11	DIABETES TREATMENT	155,098			32,431	187,529	61,205	76.11
76.12	MENTAL HEALTH CENTER	137,977			35,420	173,397	56,592	76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION	277,759		849	83,897	362,505	118,312	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS	7,600,446	50,890	83,609	704,919	8,439,864	2,754,552	90.01

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
90.02	MERCY CLINIC STATE ST							90.02
90.03	MERCY CLINIC POLK ST							90.03
91	Emergency	6,681,129	166,699	27,612	1,272,694	8,148,134	2,659,339	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	227,332,960	6,676,800	4,618,334	21,707,713	226,200,138	54,039,679	118
	NONREIMBURSABLE COST CENTERS							
191	Research	179,662			51,384	231,046	75,407	191
192	Physicians' Private Offices	18,197,921	45,449	16,769	926,233	19,186,372	6,261,933	192
192.01	DNBAR CLINIC	186,896			15,891	202,787	66,184	192.01
192.02	PHILLIPS HEALTH	166,569			15,575	182,144	59,447	192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE	580,111		11,153	50,368	641,632	209,412	192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	246,644,119	6,722,249	4,646,256	22,767,164	246,644,119	60,712,062	202

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	19,336,212						7
8	Laundry & Linen Service	537,046	2,333,016					8
9	Housekeeping	127,592		4,872,187				9
10	Dietary	596,188		155,570	3,560,775			10
11	Cafeteria	478,812		124,942		1,848,193		11
12	Maintenance of Personnel							12
13	Nursing Administration	86,329		22,527		23,560	2,984,637	13
14	Central Services & Supply	440,841		115,034		25,265		14
15	Pharmacy							15
16	Medical Records & Library	280,556		73,209		36,673		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	488,177		127,386		171,789		21
22	I&R Services-Other Prgm Costs Apprvd	162,328		42,358				22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,957,037	1,556,092	1,293,496	2,455,450	422,784	1,177,227	30
31	Intensive Care Unit	388,056	163,860	101,260	258,565	79,588	232,162	31
32	Coronary Care Unit	410,135	59,994	107,021	94,667	20,929	50,438	32
32.01	NURSERY INTENSIVE CARE CENTER	122,938	76,446	32,080		22,067	91,048	32.01
40	Subprovider - IPF	760,673	302,543	198,491	477,401	52,070	132,504	40
41	Subprovider - IRF	302,351	174,081	78,896	274,692	33,354	109,219	41
43	Nursery	71,799		18,735		15,208	135,088	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,828,522		477,137		77,249	244,470	50
50.01	GI LAB	99,440		25,948		12,080	42,643	50.01
51	Recovery Room	122,598		31,991		11,691	37,274	51
52	Delivery Room & Labor Room	912,785		238,184		60,603	188,115	52
53	Anesthesiology	20,660		5,391		3,623	11,146	53
54	Radiology-Diagnostic	1,299,990		339,221		72,573		54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic	33,714		8,797		8,501		55
56	Radioisotope	122,995		32,094		5,815		56
57	CT Scan	28,379		7,405		17,219		57
58	MRI	210,516		54,932		4,342		58
59	Cardiac Catheterization	1,011,942		264,058		47,930	136,021	59
60	Laboratory	869,025		226,765		112,700		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	50,345		13,137		31,986	98,672	65
66	Physical Therapy	318,243		83,043		23,349		66
67	Occupational Therapy	121,576		31,724		11,909		67
68	Speech Pathology	94,105		24,556		6,076		68
70	Electroencephalography	119,419		31,161		1,784		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	50,401		13,152				74
76	EMG	33,998		8,872		1,066	2,458	76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER	276,753		72,216		6,102		76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER	38,709		10,101		4,377	10,898	76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER					8,025		76.06
76.07	SLEEP LAB							76.07
76.08	UROLOGY	50,572		13,196		1,821		76.08
76.09	ADDP OP					2,777		76.09
76.10	PSYCH PARTIAL HOSPITAL	82,583		21,549				76.10
76.11	DIABETES TREATMENT					2,763		76.11
76.12	MENTAL HEALTH CENTER					3,385		76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION					6,651		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS	256,944		67,047		80,637		90.01
90.02	MERCY CLINIC STATE ST							90.02
90.03	MERCY CLINIC POLK ST							90.03

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
91	Emergency	841,667		219,626		96,722	285,254	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	19,106,739	2,333,016	4,812,308	3,560,775	1,627,043	2,984,637	118
	NONREIMBURSABLE COST CENTERS							
191	Research					4,204		191
192	Physicians' Private Offices	229,473		59,879		208,573		192
192.01	DNBAR CLINIC					544		192.01
192.02	PHILLIPS HEALTH					1,804		192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE					6,025		192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	19,336,212	2,333,016	4,872,187	3,560,775	1,848,193	2,984,637	202

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	2,478,617						14
15	Pharmacy	20,049	21,007,933					15
16	Medical Records & Library			2,294,315				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				11,834,497			21
22	I&R Services-Other Prgm Costs Apprvd	6				1,407,444		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	182,138		294,122	6,760,257	803,978	53,705,718	30
31	Intensive Care Unit	80,193		41,026	453,257	53,905	9,405,471	31
32	Coronary Care Unit	13,813		15,754	170,594	20,288	2,942,354	32
32.01	NURSERY INTENSIVE CARE CENTER	7,398		27,081	333,717	39,688	4,340,463	32.01
40	Subprovider - IPF	2,012		39,578			7,416,298	40
41	Subprovider - IRF	9,526		23,582	151,916	18,067	4,656,772	41
43	Nursery	5,099		15,879			174,191	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	254,330		87,234	996,170	118,472	14,440,120	50
50.01	GI LAB	53,543		23,145			1,884,759	50.01
51	Recovery Room	2,249		12,699			1,293,287	51
52	Delivery Room & Labor Room	51,256		52,246			6,956,027	52
53	Anesthesiology	29,566		15,232			532,089	53
54	Radiology-Diagnostic	26,344		183,725	1,525,385	181,410	10,058,932	54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic	1,853		26,607			991,580	55
56	Radioisotope	28,227		32,037			1,394,400	56
57	CT Scan	27,550		150,692			1,955,444	57
58	MRI	1,354		36,677			5,218,422	58
59	Cardiac Catheterization	2,928		199,649			6,296,893	59
60	Laboratory	458,153		383,771			14,992,646	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			61,356			2,850,312	65
66	Physical Therapy	1,057		19,151			2,573,042	66
67	Occupational Therapy	1,168		9,888			1,309,362	67
68	Speech Pathology	211		6,406			707,396	68
70	Electroencephalography	171		1,333			277,023	70
71	Medical Supplies Charged to Patients	400,337		37,693			3,772,919	71
72	Impl. Dev. Charged to Patients	690,948		46,317			6,510,064	72
73	Drugs Charged to Patients		21,007,933	195,301			21,203,234	73
74	Renal Dialysis	3,684		6,817			1,390,236	74
76	EMG	55		751			111,377	76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER	672		3,272			773,267	76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER	902		1,972			447,802	76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER	983		14,441			575,290	76.06
76.07	SLEEP LAB			7,604			531,264	76.07
76.08	UROLOGY	25		133			231,631	76.08
76.09	ADDP OP	3		161			191,234	76.09
76.10	PSYCH PARTIAL HOSPITAL			5,473			132,648	76.10
76.11	DIABETES TREATMENT			734			252,231	76.11
76.12	MENTAL HEALTH CENTER	23		1,105			234,502	76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION	417		5,423			493,308	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS	10,600		12,447			11,622,091	90.01
90.02	MERCY CLINIC STATE ST							90.02
90.03	MERCY CLINIC POLK ST							90.03

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	I&R SALARY & FRINGES 21	I&R PROGRAM COSTS 22	SUBTOTAL 24	
91	Emergency	100,891		195,801	1,443,201	171,636	14,162,271	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	2,469,734	21,007,933	2,294,315	11,834,497	1,407,444	219,008,370	118
	NONREIMBURSABLE COST CENTERS							
191	Research	13					310,670	191
192	Physicians' Private Offices	7,236					25,953,466	192
192.01	DNBAR CLINIC	119					269,634	192.01
192.02	PHILLIPS HEALTH	59					243,454	192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE	1,456					858,525	192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,478,617	21,007,933	2,294,315	11,834,497	1,407,444	246,644,119	202

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	-7,564,235	46,141,483				30
31	Intensive Care Unit	-507,162	8,898,309				31
32	Coronary Care Unit	-190,882	2,751,472				32
32.01	NURSERY INTENSIVE CARE CENTER	-373,405	3,967,058				32.01
40	Subprovider - IPF		7,416,298				40
41	Subprovider - IRF	-169,983	4,486,789				41
43	Nursery		174,191				43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	-1,114,642	13,325,478				50
50.01	GI LAB		1,884,759				50.01
51	Recovery Room		1,293,287				51
52	Delivery Room & Labor Room		6,956,027				52
53	Anesthesiology		532,089				53
54	Radiology-Diagnostic	-1,706,795	8,352,137				54
54.01	MRI CENTER						54.01
55	Radiology-Therapeutic		991,580				55
56	Radioisotope		1,394,400				56
57	CT Scan		1,955,444				57
58	MRI		5,218,422				58
59	Cardiac Catheterization		6,296,893				59
60	Laboratory		14,992,646				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		2,850,312				65
66	Physical Therapy		2,573,042				66
67	Occupational Therapy		1,309,362				67
68	Speech Pathology		707,396				68
70	Electroencephalography		277,023				70
71	Medical Supplies Charged to Patients		3,772,919				71
72	Impl. Dev. Charged to Patients		6,510,064				72
73	Drugs Charged to Patients		21,203,234				73
74	Renal Dialysis		1,390,236				74
76	EMG		111,377				76
76.01	CARDIOVASCULAR LAB						76.01
76.02	MERCY EYE CENTER		773,267				76.02
76.03	MERCY ENT						76.03
76.04	WOUND CARE CENTER		447,802				76.04
76.05	CARDIAC REHAB						76.05
76.06	PRE-BIRTH CENTER		575,290				76.06
76.07	SLEEP LAB		531,264				76.07
76.08	UROLOGY		231,631				76.08
76.09	ADDP OP		191,234				76.09
76.10	PSYCH PARTIAL HOSPITAL		132,648				76.10
76.11	DIABETES TREATMENT		252,231				76.11
76.12	MENTAL HEALTH CENTER		234,502				76.12
76.13	VEIN CLINIC						76.13
76.97	CARDIAC REHABILITATION		493,308				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	MERCY CLINICS		11,622,091				90.01
90.02	MERCY CLINIC STATE ST						90.02
90.03	MERCY CLINIC POLK ST						90.03

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL					
		25	26					
91	Emergency	-1,614,837	12,547,434					91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	-13,241,941	205,766,429					118
	NONREIMBURSABLE COST CENTERS							
191	Research		310,670					191
192	Physicians' Private Offices		25,953,466					192
192.01	DNBAR CLINIC		269,634					192.01
192.02	PHILLIPS HEALTH		243,454					192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE		858,525					192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	-13,241,941	233,402,178					202

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGs & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	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		61,019		61,019	61,019		4
5	Administrative & General	97,105	448,837	1,975,208	2,521,150	9,323	2,530,473	5
6	Maintenance & Repairs							6
7	Operation of Plant	86,780	2,382,691	15,532	2,485,003	1,466	198,308	7
8	Laundry & Linen Service		106,367		106,367		18,419	8
9	Housekeeping	8,175	25,271	4,095	37,541	1,435	48,660	9
10	Dietary	2,122	118,080	9,096	129,298		28,809	10
11	Cafeteria	1,771	94,833	7,594	104,198		12,763	11
12	Maintenance of Personnel							12
13	Nursing Administration		17,098	3	17,101	1,125	29,252	13
14	Central Services & Supply	481,336	87,312	43,401	612,049	464	19,460	14
15	Pharmacy			19,954	19,954		215,247	15
16	Medical Records & Library		55,566	2,503	58,069	469	19,526	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		96,688	881	97,569	532	113,297	21
22	I&R Services-Other Prgm Costs Apprvd		32,151		32,151	1,019	12,335	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	25,843	981,783	314,851	1,322,477	12,146	346,723	30
31	Intensive Care Unit	5,299	76,858	526,643	608,800	2,607	77,468	31
32	Coronary Care Unit	686	81,231	10,297	92,214	755	20,293	32
32.01	NURSERY INTENSIVE CARE CENTER		24,349	19,579	43,928	853	36,798	32.01
40	Subprovider - IPF	59	150,658	665	151,382	1,477	55,905	40
41	Subprovider - IRF	2,716	59,883	13,493	76,092	901	35,701	41
43	Nursery		14,220	25,889	40,109	588		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,086,762	362,154	89,357	1,538,273	2,569	106,214	50
50.01	GI LAB	149,230	19,695	7,531	176,456	408	16,696	50.01
51	Recovery Room	5,670	24,282		29,952	455	11,023	51
52	Delivery Room & Labor Room	9,345	180,785	27,734	217,864	1,968	55,923	52
53	Anesthesiology		4,092	1,852	5,944	83	4,579	53
54	Radiology-Diagnostic		257,474	226,215	483,689	2,454	65,948	54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic		6,677	11,111	17,788	301	9,354	55
56	Radioisotope		24,360	867	25,227	244	12,032	56
57	CT Scan		5,621	81,562	87,183	618	17,683	57
58	MRI	924,190	41,695	507,620	1,473,505	186	50,362	58
59	Cardiac Catheterization		200,424	170,702	371,126	1,700	47,529	59
60	Laboratory		172,118	306,316	478,434	3,164	132,733	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	44,839	9,971	18,515	73,325	1,013	26,612	65
66	Physical Therapy		63,031	44,017	107,048	801	21,826	66
67	Occupational Therapy		24,079		24,079	407	11,621	67
68	Speech Pathology		18,638		18,638	204	5,908	68
70	Electroencephalography		23,652		23,652	41	1,263	70
71	Medical Supplies Charged to Patients						34,202	71
72	Impl. Dev. Charged to Patients						59,205	72
73	Drugs Charged to Patients							73
74	Renal Dialysis		9,982		9,982		13,498	74
76	EMG		6,734	967	7,701	24	658	76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER		54,813	981	55,794	145	4,248	76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER	484	7,667	19,262	27,413	153	3,906	76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER					225	5,660	76.06
76.07	SLEEP LAB						5,371	76.07
76.08	UROLOGY		10,016	1,971	11,987	68	1,701	76.08
76.09	ADDP OP					85	1,931	76.09
76.10	PSYCH PARTIAL HOSPITAL		16,356		16,356		236	76.10
76.11	DIABETES TREATMENT					87	2,551	76.11
76.12	MENTAL HEALTH CENTER					95	2,359	76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION			849	849	225	4,931	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS	420,557	50,890	83,609	555,056	1,888	114,807	90.01
90.02	MERCY CLINIC STATE ST							90.02
90.03	MERCY CLINIC POLK ST							90.03

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
91	Emergency		166,699	27,612	194,311	3,409	110,839	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	3,352,969	6,676,800	4,618,334	14,648,103	58,180	2,252,373	118
	NONREIMBURSABLE COST CENTERS							
191	Research					138	3,143	191
192	Physicians' Private Offices		45,449	16,769	62,218	2,481	260,992	192
192.01	DNBAR CLINIC					43	2,759	192.01
192.02	PHILLIPS HEALTH					42	2,478	192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE			11,153	11,153	135	8,728	192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,352,969	6,722,249	4,646,256	14,721,474	61,019	2,530,473	202

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	2,684,777						7
8	Laundry & Linen Service	74,567	199,353					8
9	Housekeeping	17,716		105,352				9
10	Dietary	82,779		3,364	244,250			10
11	Cafeteria	66,482		2,702		186,145		11
12	Maintenance of Personnel							12
13	Nursing Administration	11,987		487		2,373	62,325	13
14	Central Services & Supply	61,209		2,487		2,545		14
15	Pharmacy							15
16	Medical Records & Library	38,954		1,583		3,694		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	67,782		2,754		17,302		21
22	I&R Services-Other Prgm Costs Apprvd	22,539		916				22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	688,269	132,966	27,969	168,431	42,579	24,584	30
31	Intensive Care Unit	53,880	14,002	2,190	17,736	8,016	4,848	31
32	Coronary Care Unit	56,946	5,126	2,314	6,494	2,108	1,053	32
32.01	NURSERY INTENSIVE CARE CENTER	17,070	6,532	694		2,223	1,901	32.01
40	Subprovider - IPF	105,617	25,852	4,292	32,747	5,244	2,767	40
41	Subprovider - IRF	41,981	14,875	1,706	18,842	3,359	2,281	41
43	Nursery	9,969		405		1,532	2,821	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	253,885		10,317		7,780	5,105	50
50.01	GI LAB	13,807		561		1,217	890	50.01
51	Recovery Room	17,022		692		1,178	778	51
52	Delivery Room & Labor Room	126,738		5,150		6,104	3,928	52
53	Anesthesiology	2,869		117		365	233	53
54	Radiology-Diagnostic	180,500		7,335		7,309		54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic	4,681		190		856		55
56	Radioisotope	17,078		694		586		56
57	CT Scan	3,940		160		1,734		57
58	MRI	29,230		1,188		437		58
59	Cardiac Catheterization	140,505		5,710		4,827	2,840	59
60	Laboratory	120,662		4,903		11,351		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,990		284		3,222	2,060	65
66	Physical Therapy	44,187		1,796		2,352		66
67	Occupational Therapy	16,880		686		1,199		67
68	Speech Pathology	13,066		531		612		68
70	Electroencephalography	16,581		674		180		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	6,998		284				74
76	EMG	4,721		192		107	51	76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER	38,426		1,562		615		76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER	5,375		218		441	228	76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER					808		76.06
76.07	SLEEP LAB							76.07
76.08	UROLOGY	7,022		285		183		76.08
76.09	ADDP OP					280		76.09
76.10	PSYCH PARTIAL HOSPITAL	11,466		466				76.10
76.11	DIABETES TREATMENT					278		76.11
76.12	MENTAL HEALTH CENTER					341		76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION					670		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS	35,676		1,450		8,122		90.01
90.02	MERCY CLINIC STATE ST							90.02
90.03	MERCY CLINIC POLK ST							90.03

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
91	Emergency	116,863		4,749		9,742	5,957	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	2,652,915	199,353	104,057	244,250	163,871	62,325	118
	NONREIMBURSABLE COST CENTERS							
191	Research					423		191
192	Physicians' Private Offices	31,862		1,295		21,007		192
192.01	DNBAR CLINIC					55		192.01
192.02	PHILLIPS HEALTH					182		192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE					607		192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,684,777	199,353	105,352	244,250	186,145	62,325	202

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	698,214						14
15	Pharmacy	5,648	240,849					15
16	Medical Records & Library			122,295				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				299,236			21
22	I&R Services-Other Prgm Costs Apprvd	2				68,962		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	51,307		15,684			2,833,135	30
31	Intensive Care Unit	22,590		2,188			814,325	31
32	Coronary Care Unit	3,891		840			192,034	32
32.01	NURSERY INTENSIVE CARE CENTER	2,084		1,444			113,527	32.01
40	Subprovider - IPF	567		2,111			387,961	40
41	Subprovider - IRF	2,683		1,258			199,679	41
43	Nursery	1,436		847			57,707	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	71,643		4,652			2,000,438	50
50.01	GI LAB	15,083		1,234			226,352	50.01
51	Recovery Room	634		677			62,411	51
52	Delivery Room & Labor Room	14,438		2,786			434,899	52
53	Anesthesiology	8,329		812			23,331	53
54	Radiology-Diagnostic	7,421		9,797			764,453	54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic	522		1,419			35,111	55
56	Radioisotope	7,951		1,708			65,520	56
57	CT Scan	7,761		8,036			127,115	57
58	MRI	381		1,956			1,557,245	58
59	Cardiac Catheterization	825		10,647			585,709	59
60	Laboratory	129,059		20,412			900,718	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			3,272			116,778	65
66	Physical Therapy	298		1,021			179,329	66
67	Occupational Therapy	329		527			55,728	67
68	Speech Pathology	59		342			39,360	68
70	Electroencephalography	48		71			42,510	70
71	Medical Supplies Charged to Patients	112,772		2,010			148,984	71
72	Impl. Dev. Charged to Patients	194,640		2,470			256,315	72
73	Drugs Charged to Patients		240,849	10,415			251,264	73
74	Renal Dialysis	1,038		364			32,164	74
76	EMG	15		40			13,509	76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER	189		174			101,153	76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER	254		105			38,093	76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER	277		770			7,740	76.06
76.07	SLEEP LAB			406			5,777	76.07
76.08	UROLOGY	7		7			21,260	76.08
76.09	ADDP OP	1		9			2,306	76.09
76.10	PSYCH PARTIAL HOSPITAL			292			28,816	76.10
76.11	DIABETES TREATMENT			39			2,955	76.11
76.12	MENTAL HEALTH CENTER	6		59			2,860	76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION	117		289			7,081	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS	2,986		664			720,649	90.01
90.02	MERCY CLINIC STATE ST							90.02
90.03	MERCY CLINIC POLK ST							90.03

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
91	Emergency	28,420		10,441			484,731	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	695,711	240,849	122,295			13,941,032	118
	NONREIMBURSABLE COST CENTERS							
191	Research	4					3,708	191
192	Physicians' Private Offices	2,038					381,893	192
192.01	DNBAR CLINIC	34					2,891	192.01
192.02	PHILLIPS HEALTH	17					2,719	192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE	410					21,033	192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross Foot Adjustments				299,236	68,962	368,198	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	698,214	240,849	122,295	299,236	68,962	14,721,474	202

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,833,135					30
31	Intensive Care Unit		814,325					31
32	Coronary Care Unit		192,034					32
32.01	NURSERY INTENSIVE CARE CENTER		113,527					32.01
40	Subprovider - IPF		387,961					40
41	Subprovider - IRF		199,679					41
43	Nursery		57,707					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,000,438					50
50.01	GI LAB		226,352					50.01
51	Recovery Room		62,411					51
52	Delivery Room & Labor Room		434,899					52
53	Anesthesiology		23,331					53
54	Radiology-Diagnostic		764,453					54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic		35,111					55
56	Radioisotope		65,520					56
57	CT Scan		127,115					57
58	MRI		1,557,245					58
59	Cardiac Catheterization		585,709					59
60	Laboratory		900,718					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		116,778					65
66	Physical Therapy		179,329					66
67	Occupational Therapy		55,728					67
68	Speech Pathology		39,360					68
70	Electroencephalography		42,510					70
71	Medical Supplies Charged to Patients		148,984					71
72	Impl. Dev. Charged to Patients		256,315					72
73	Drugs Charged to Patients		251,264					73
74	Renal Dialysis		32,164					74
76	EMG		13,509					76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER		101,153					76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER		38,093					76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER		7,740					76.06
76.07	SLEEP LAB		5,777					76.07
76.08	UROLOGY		21,260					76.08
76.09	ADDP OP		2,306					76.09
76.10	PSYCH PARTIAL HOSPITAL		28,816					76.10
76.11	DIABETES TREATMENT		2,955					76.11
76.12	MENTAL HEALTH CENTER		2,860					76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION		7,081					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS		720,649					90.01
90.02	MERCY CLINIC STATE ST							90.02
90.03	MERCY CLINIC POLK ST							90.03

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL					
		25	26					
91	Emergency		484,731					91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)		13,941,032					118
	NONREIMBURSABLE COST CENTERS							
191	Research		3,708					191
192	Physicians' Private Offices		381,893					192
192.01	DNBAR CLINIC		2,891					192.01
192.02	PHILLIPS HEALTH		2,719					192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE		21,033					192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross Foot Adjustments		368,198					200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		14,721,474					202

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	597,988						1
2	Cap Rel Costs-Mvble Equip		4,645,536					2
4	Employee Benefits Department	5,428		78,587,296				4
5	Administrative & General	39,927	1,974,901	12,014,319	-60,712,062	186,019,674		5
6	Maintenance & Repairs							6
7	Operation of Plant	211,956	15,530	1,888,592		14,578,250	340,677	7
8	Laundry & Linen Service	9,462				1,354,045	9,462	8
9	Housekeeping	2,248	4,094	1,848,724		3,577,117	2,248	9
10	Dietary	10,504	9,095			2,117,817	10,504	10
11	Cafeteria	8,436	7,593			938,226	8,436	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,521	3	1,449,608		2,150,390	1,521	13
14	Central Services & Supply	7,767	43,394	598,036		1,430,575	7,767	14
15	Pharmacy		19,951			15,823,504		15
16	Medical Records & Library	4,943	2,503	603,913		1,435,400	4,943	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	8,601	881	685,596		8,328,831	8,601	21
22	I&R Services-Other Prgm Costs Apprvd	2,860		1,313,484		906,797	2,860	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	87,336	314,802	15,607,365		25,485,315	87,336	30
31	Intensive Care Unit	6,837	526,561	3,359,021		5,694,924	6,837	31
32	Coronary Care Unit	7,226	10,295	972,313		1,491,827	7,226	32
32.01	NURSERY INTENSIVE CARE CENTER	2,166	19,576	1,099,157		2,705,119	2,166	32.01
40	Subprovider - IPF	13,402	665	1,903,752		4,109,720	13,402	40
41	Subprovider - IRF	5,327	13,491	1,161,238		2,624,515	5,327	41
43	Nursery	1,265	25,885	757,527	87,617		1,265	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	32,216	89,343	3,310,879		7,808,157	32,216	50
50.01	GI LAB	1,752	7,530	525,423		1,227,376	1,752	50.01
51	Recovery Room	2,160		585,941		810,318	2,160	51
52	Delivery Room & Labor Room	16,082	27,730	2,536,169		4,111,086	16,082	52
53	Anesthesiology	364	1,852	107,438		336,610	364	53
54	Radiology-Diagnostic	22,904	226,180	3,162,058		4,848,017	22,904	54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic	594	11,109	388,233		687,670	594	55
56	Radioisotope	2,167	867	314,192		884,541	2,167	56
57	CT Scan	500	81,549	796,912		1,299,934	500	57
58	MRI	3,709	507,541	240,288		3,702,275	3,709	58
59	Cardiac Catheterization	17,829	170,676	2,190,780		3,494,011	17,829	59
60	Laboratory	15,311	306,269	4,077,937		9,757,604	15,311	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	887	18,512	1,305,915		1,956,323	887	65
66	Physical Therapy	5,607	44,010	1,032,849		1,604,524	5,607	66
67	Occupational Therapy	2,142		524,696		854,282	2,142	67
68	Speech Pathology	1,658		263,395		434,298	1,658	68
70	Electroencephalography	2,104		52,818		92,851	2,104	70
71	Medical Supplies Charged to Patients					2,514,290		71
72	Impl. Dev. Charged to Patients					4,352,316		72
73	Drugs Charged to Patients							73
74	Renal Dialysis	888				992,316	888	74
76	EMG	599	967	31,243		48,385	599	76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER	4,876	981	186,320		312,319	4,876	76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER	682	19,259	196,535		287,131	682	76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER			290,348		416,052		76.06
76.07	SLEEP LAB					394,806		76.07
76.08	UROLOGY	891	1,971	87,497		125,066	891	76.08
76.09	ADDP OP			109,685		141,961		76.09
76.10	PSYCH PARTIAL HOSPITAL	1,455				17,373	1,455	76.10
76.11	DIABETES TREATMENT			111,944		187,529		76.11
76.12	MENTAL HEALTH CENTER			122,263		173,397		76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION		849	289,594		362,505		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS	4,527	83,596	2,433,230		8,439,864	4,527	90.01
90.02	MERCY CLINIC STATE ST							90.02

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
90.03	MERCY CLINIC POLK ST							90.03
91	Emergency	14,829	27,608	4,393,069		8,148,134	14,829	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	593,945	4,617,619	74,930,296	-60,624,445	165,575,693	336,634	118
	NONREIMBURSABLE COST CENTERS							
191	Research			177,366		231,046		191
192	Physicians' Private Offices	4,043	16,766	3,197,160		19,186,372	4,043	192
192.01	DNBAR CLINIC			54,851		202,787		192.01
192.02	PHILLIPS HEALTH			53,763		182,144		192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE		11,151	173,860		641,632		192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	6,722,249	4,646,256	22,767,164		60,712,062	19,336,212	202
203	Unit Cost Multiplier (Wkst. B, Part I)	11.241445	1.000155	0.289705		0.326374	56.758196	203
204	Cost to be allocated (Per Wkst. B, Part II)			61,019		2,530,473	2,684,777	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000776		0.013603	7.880711	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA PROD FTE'S	NURSING ADMINIS- TRATION NURS DIRECT FTE	CENTRAL SERVICES * SUPPLY COSTED REQUI	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	56,154						8
9	Housekeeping		328,967					9
10	Dietary		10,504	54,314				10
11	Cafeteria		8,436		2,175,501			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,521		27,732	1,164,248		13
14	Central Services & Supply		7,767		29,739		15,612,935	14
15	Pharmacy						126,290	15
16	Medical Records & Library		4,943		43,168			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		8,601		202,212			21
22	I&R Services-Other Prgm Costs Apprvd		2,860				35	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	37,454	87,336	37,454	497,657	459,213	1,147,296	30
31	Intensive Care Unit	3,944	6,837	3,944	93,683	90,562	505,143	31
32	Coronary Care Unit	1,444	7,226	1,444	24,635	19,675	87,009	32
32.01	NURSERY INTENSIVE CARE CENTER	1,840	2,166		25,975	35,516	46,599	32.01
40	Subprovider - IPF	7,282	13,402	7,282	61,292	51,687	12,675	40
41	Subprovider - IRF	4,190	5,327	4,190	39,261	42,604	60,005	41
43	Nursery		1,265		17,901	52,695	32,116	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		32,216		90,929	95,363	1,602,036	50
50.01	GI LAB		1,752		14,219	16,634	337,269	50.01
51	Recovery Room		2,160		13,762	14,540	14,167	51
52	Delivery Room & Labor Room		16,082		71,335	73,380	322,864	52
53	Anesthesiology		364		4,265	4,348	186,237	53
54	Radiology-Diagnostic		22,904		85,425		165,944	54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic		594		10,006		11,671	55
56	Radioisotope		2,167		6,845		177,802	56
57	CT Scan		500		20,268		173,542	57
58	MRI		3,709		5,111		8,529	58
59	Cardiac Catheterization		17,829		56,418	53,059	18,443	59
60	Laboratory		15,311		132,659		2,885,930	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		887		37,651	38,490		65
66	Physical Therapy		5,607		27,484		6,656	66
67	Occupational Therapy		2,142		14,018		7,359	67
68	Speech Pathology		1,658		7,152		1,326	68
70	Electroencephalography		2,104		2,100		1,079	70
71	Medical Supplies Charged to Patients						2,521,742	71
72	Impl. Dev. Charged to Patients						4,352,316	72
73	Drugs Charged to Patients							73
74	Renal Dialysis		888				23,206	74
76	EMG		599		1,255	959	344	76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER		4,876		7,183		4,235	76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER		682		5,152	4,251	5,681	76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER				9,446		6,195	76.06
76.07	SLEEP LAB							76.07
76.08	UROLOGY		891		2,144		159	76.08
76.09	ADDP OP				3,269		20	76.09
76.10	PSYCH PARTIAL HOSPITAL		1,455					76.10
76.11	DIABETES TREATMENT				3,252			76.11
76.12	MENTAL HEALTH CENTER				3,984		145	76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION				7,829		2,627	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS		4,527		94,918		66,769	90.01
90.02	MERCY CLINIC STATE ST							90.02

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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA PROD FTE'S	NURSING ADMINIS- TRATION NURS DIRECT FTE	CENTRAL SERVICES * SUPPLY COSTED REQUI	
		8	9	10	11	13	14	
90.03	MERCY CLINIC POLK ST							90.03
91	Emergency		14,829		113,851	111,272	635,519	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	56,154	324,924	54,314	1,915,185	1,164,248	15,556,980	118
	NONREIMBURSABLE COST CENTERS							
191	Research				4,949		84	191
192	Physicians' Private Offices		4,043		245,511		45,579	192
192.01	DNBAR CLINIC				640		750	192.01
192.02	PHILLIPS HEALTH				2,124		373	192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE				7,092		9,169	192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,333,016	4,872,187	3,560,775	1,848,193	2,984,637	2,478,617	202
203	Unit Cost Multiplier (Wkst. B, Part I)	41.546746	14.810565	65.559064	0.849548	2.563575	0.158754	203
204	Cost to be allocated (Per Wkst. B, Part II)	199,353	105,352	244,250	186,145	62,325	698,214	204
205	Unit Cost Multiplier (Wkst. B, Part II)	3.550112	0.320251	4.496999	0.085564	0.053532	0.044720	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUI	MEDICAL RECORDS + LIBRARY GROSS REVENUE	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME		
		15	16	21	22	23		

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	10,000						15
16	Medical Records & Library		617,986,025					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			9,504				21
22	I&R Services-Other Prgm Costs Apprvd				9,504			22
23	PARAMED ED PRGM-(SPECIFY)					100		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		79,214,069	5,429	5,429			30
31	Intensive Care Unit		11,049,255	364	364			31
32	Coronary Care Unit		4,242,900	137	137			32
32.01	NURSERY INTENSIVE CARE CENTER		7,293,494	268	268			32.01
40	Subprovider - IPF		10,659,340					40
41	Subprovider - IRF		6,351,219	122	122			41
43	Nursery		4,276,527					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		23,494,164	800	800			50
50.01	GI LAB		6,233,383					50.01
51	Recovery Room		3,420,230					51
52	Delivery Room & Labor Room		14,071,204					52
53	Anesthesiology		4,102,397					53
54	Radiology-Diagnostic		49,481,560	1,225	1,225			54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic		7,165,922					55
56	Radioisotope		8,628,242					56
57	CT Scan		40,585,003					57
58	MRI		9,877,884					58
59	Cardiac Catheterization		53,770,241					59
60	Laboratory		103,430,802					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		16,524,565					65
66	Physical Therapy		5,157,891					66
67	Occupational Therapy		2,663,150					67
68	Speech Pathology		1,725,298					68
70	Electroencephalography		359,039					70
71	Medical Supplies Charged to Patients		10,151,763					71
72	Impl. Dev. Charged to Patients		12,474,362					72
73	Drugs Charged to Patients	10,000	52,599,198			100		73
74	Renal Dialysis		1,835,925					74
76	EMG		202,239					76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER		881,179					76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER		531,204					76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER		3,889,209					76.06
76.07	SLEEP LAB		2,048,059					76.07
76.08	UROLOGY		35,819					76.08
76.09	ADDP OP		43,408					76.09
76.10	PSYCH PARTIAL HOSPITAL		1,473,896					76.10
76.11	DIABETES TREATMENT		197,571					76.11
76.12	MENTAL HEALTH CENTER		297,682					76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION		1,460,466					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUI	MEDICAL RECORDS + LIBRARY GROSS REVENUE	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME		
		15	16	21	22	23		
90.01	MERCY CLINICS		3,352,228					90.01
90.02	MERCY CLINIC STATE ST							90.02
90.03	MERCY CLINIC POLK ST							90.03
91	Emergency		52,734,038	1,159	1,159			91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	10,000	617,986,025	9,504	9,504	100		118
	NONREIMBURSABLE COST CENTERS							
191	Research							191
192	Physicians' Private Offices							192
192.01	DNBAR CLINIC							192.01
192.02	PHILLIPS HEALTH							192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE							192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	21,007,933	2,294,315	11,834,497	1,407,444			202
203	Unit Cost Multiplier (Wkst. B, Part I)	2,100.793300	0.003713	1,245.212226	148.089646			203
204	Cost to be allocated (Per Wkst. B, Part II)	240,849	122,295	299,236	68,962			204
205	Unit Cost Multiplier (Wkst. B, Part II)	24.084900	0.000198	31.485269	7.256103			205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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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 Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	46,141,483		46,141,483		46,141,483	30
31	Intensive Care Unit	8,898,309		8,898,309	84,387	8,982,696	31
32	Coronary Care Unit	2,751,472		2,751,472		2,751,472	32
32.01	NURSERY INTENSIVE CARE CENTER	3,967,058		3,967,058		3,967,058	32.01
40	Subprovider - IPF	7,416,298		7,416,298		7,416,298	40
41	Subprovider - IRF	4,486,789		4,486,789		4,486,789	41
43	Nursery	174,191		174,191		174,191	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	13,325,478		13,325,478		13,325,478	50
50.01	GI LAB	1,884,759		1,884,759		1,884,759	50.01
51	Recovery Room	1,293,287		1,293,287		1,293,287	51
52	Delivery Room & Labor Room	6,956,027		6,956,027		6,956,027	52
53	Anesthesiology	532,089		532,089		532,089	53
54	Radiology-Diagnostic	8,352,137		8,352,137		8,352,137	54
54.01	MRI CENTER						54.01
55	Radiology-Therapeutic	991,580		991,580		991,580	55
56	Radioisotope	1,394,400		1,394,400	3,776	1,398,176	56
57	CT Scan	1,955,444		1,955,444		1,955,444	57
58	MRI	5,218,422		5,218,422		5,218,422	58
59	Cardiac Catheterization	6,296,893		6,296,893	11,870	6,308,763	59
60	Laboratory	14,992,646		14,992,646		14,992,646	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,850,312		2,850,312		2,850,312	65
66	Physical Therapy	2,573,042		2,573,042		2,573,042	66
67	Occupational Therapy	1,309,362		1,309,362		1,309,362	67
68	Speech Pathology	707,396		707,396		707,396	68
70	Electroencephalography	277,023		277,023		277,023	70
71	Medical Supplies Charged to Patients	3,772,919		3,772,919		3,772,919	71
72	Impl. Dev. Charged to Patients	6,510,064		6,510,064		6,510,064	72
73	Drugs Charged to Patients	21,203,234		21,203,234		21,203,234	73
74	Renal Dialysis	1,390,236		1,390,236		1,390,236	74
76	EMG	111,377		111,377		111,377	76
76.01	CARDIOVASCULAR LAB						76.01
76.02	MERCY EYE CENTER	773,267		773,267		773,267	76.02
76.03	MERCY ENT						76.03
76.04	WOUND CARE CENTER	447,802		447,802		447,802	76.04
76.05	CARDIAC REHAB						76.05
76.06	PRE-BIRTH CENTER	575,290		575,290		575,290	76.06
76.07	SLEEP LAB	531,264		531,264		531,264	76.07
76.08	UROLOGY	231,631		231,631		231,631	76.08
76.09	ADDDP OP	191,234		191,234		191,234	76.09
76.10	PSYCH PARTIAL HOSPITAL	132,648		132,648		132,648	76.10
76.11	DIABETES TREATMENT	252,231		252,231		252,231	76.11
76.12	MENTAL HEALTH CENTER	234,502		234,502		234,502	76.12
76.13	VEIN CLINIC						76.13
76.97	CARDIAC REHABILITATION	493,308		493,308	9,591	502,899	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	MERCY CLINICS	11,622,091		11,622,091		11,622,091	90.01
90.02	MERCY CLINIC STATE ST						90.02
90.03	MERCY CLINIC POLK ST						90.03
91	Emergency	12,547,434		12,547,434		12,547,434	91
92	Observation Beds (Non-Distinct Part)	6,225,046		6,225,046		6,225,046	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORE						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 (sum of lines 30 thru 199)	211,991,475		211,991,475	109,624	212,101,099	200
201	Less Observation Beds	6,225,046		6,225,046		6,225,046	201
202	Total (line 200 minus line 201)	205,766,429		205,766,429		205,876,053	202

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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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 SERVICE COST CENTERS							
30	Adults & Pediatrics	70,035,111		70,035,111				30
31	Intensive Care Unit	11,049,255		11,049,255				31
32	Coronary Care Unit	4,242,900		4,242,900				32
32.01	NURSERY INTENSIVE CARE CENTER	7,293,494		7,293,494				32.01
40	Subprovider - IPF	10,659,340		10,659,340				40
41	Subprovider - IRF	6,351,219		6,351,219				41
43	Nursery	4,276,527		4,276,527				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,651,850	14,842,314	23,494,164	0.567182	0.567182	0.567182	50
50.01	GI LAB	1,578,091	4,655,292	6,233,383	0.302365	0.302365	0.302365	50.01
51	Recovery Room	1,076,188	2,344,042	3,420,230	0.378129	0.378129	0.378129	51
52	Delivery Room & Labor Room	13,296,214	774,990	14,071,204	0.494345	0.494345	0.494345	52
53	Anesthesiology	1,764,341	2,338,056	4,102,397	0.129702	0.129702	0.129702	53
54	Radiology-Diagnostic	9,824,951	39,656,609	49,481,560	0.168793	0.168793	0.168793	54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic	487,614	6,678,308	7,165,922	0.138374	0.138374	0.138374	55
56	Radioisotope	1,596,285	7,031,957	8,628,242	0.161609	0.161609	0.162046	56
57	CT Scan	13,761,604	26,823,399	40,585,003	0.048181	0.048181	0.048181	57
58	MRI	2,841,881	7,036,003	9,877,884	0.528294	0.528294	0.528294	58
59	Cardiac Catheterization	30,918,640	22,851,601	53,770,241	0.117107	0.117107	0.117328	59
60	Laboratory	49,539,611	53,891,191	103,430,802	0.144953	0.144953	0.144953	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	14,973,888	1,550,677	16,524,565	0.172489	0.172489	0.172489	65
66	Physical Therapy	2,976,965	2,180,926	5,157,891	0.498855	0.498855	0.498855	66
67	Occupational Therapy	1,986,565	676,585	2,663,150	0.491659	0.491659	0.491659	67
68	Speech Pathology	1,227,020	498,278	1,725,298	0.410014	0.410014	0.410014	68
70	Electroencephalography	236,703	122,336	359,039	0.771568	0.771568	0.771568	70
71	Medical Supplies Charged to Patients	8,169,634	1,982,129	10,151,763	0.371652	0.371652	0.371652	71
72	Impl. Dev. Charged to Patients	7,617,123	4,857,239	12,474,362	0.521876	0.521876	0.521876	72
73	Drugs Charged to Patients	20,631,346	31,967,852	52,599,198	0.403109	0.403109	0.403109	73
74	Renal Dialysis	1,730,625	105,300	1,835,925	0.757240	0.757240	0.757240	74
76	EMG		202,239	202,239	0.550720	0.550720	0.550720	76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER	1,683	879,496	881,179	0.877537	0.877537	0.877537	76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER	1,361	529,843	531,204	0.842994	0.842994	0.842994	76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER	170,687	3,718,522	3,889,209	0.147920	0.147920	0.147920	76.06
76.07	SLEEP LAB	2,484	2,045,575	2,048,059	0.259399	0.259399	0.259399	76.07
76.08	UROLOGY		35,819	35,819	6.466708	6.466708	6.466708	76.08
76.09	ADDP OP		43,408	43,408	4.405501	4.405501	4.405501	76.09
76.10	PSYCH PARTIAL HOSPITAL		1,473,896	1,473,896	0.089998	0.089998	0.089998	76.10
76.11	DIABETES TREATMENT	54	197,517	197,571	1.276660	1.276660	1.276660	76.11
76.12	MENTAL HEALTH CENTER	353	297,329	297,682	0.787760	0.787760	0.787760	76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION	1,275	1,459,191	1,460,466	0.337774	0.337774	0.344341	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS	981	3,351,247	3,352,228	3.466975	3.466975	3.466975	90.01
90.02	MERCY CLINIC STATE ST							90.02
90.03	MERCY CLINIC POLK ST							90.03
91	Emergency	14,568,048	38,165,990	52,734,038	0.237938	0.237938	0.237938	91
92	Observation Beds (Non-Distinct Part)	917,896	8,261,062	9,178,958	0.678187	0.678187	0.678187	92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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 (sum of lines 30 thru 199)	324,459,807	293,526,218	617,986,025				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	324,459,807	293,526,218	617,986,025				202

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	53,705,718		53,705,718		53,705,718	30
31	Intensive Care Unit	9,405,471		9,405,471		9,405,471	31
32	Coronary Care Unit	2,942,354		2,942,354		2,942,354	32
32.01	NURSERY INTENSIVE CARE CENTER	4,340,463		4,340,463		4,340,463	32.01
40	Subprovider - IPF	7,416,298		7,416,298		7,416,298	40
41	Subprovider - IRF	4,656,772		4,656,772		4,656,772	41
43	Nursery	174,191		174,191		174,191	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	14,440,120		14,440,120		14,440,120	50
50.01	GI LAB	1,884,759		1,884,759		1,884,759	50.01
51	Recovery Room	1,293,287		1,293,287		1,293,287	51
52	Delivery Room & Labor Room	6,956,027		6,956,027		6,956,027	52
53	Anesthesiology	532,089		532,089		532,089	53
54	Radiology-Diagnostic	10,058,932		10,058,932		10,058,932	54
54.01	MRI CENTER						54.01
55	Radiology-Therapeutic	991,580		991,580		991,580	55
56	Radioisotope	1,394,400		1,394,400		1,394,400	56
57	CT Scan	1,955,444		1,955,444		1,955,444	57
58	MRI	5,218,422		5,218,422		5,218,422	58
59	Cardiac Catheterization	6,296,893		6,296,893		6,296,893	59
60	Laboratory	14,992,646		14,992,646		14,992,646	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,850,312		2,850,312		2,850,312	65
66	Physical Therapy	2,573,042		2,573,042		2,573,042	66
67	Occupational Therapy	1,309,362		1,309,362		1,309,362	67
68	Speech Pathology	707,396		707,396		707,396	68
70	Electroencephalography	277,023		277,023		277,023	70
71	Medical Supplies Charged to Patients	3,772,919		3,772,919		3,772,919	71
72	Impl. Dev. Charged to Patients	6,510,064		6,510,064		6,510,064	72
73	Drugs Charged to Patients	21,203,234		21,203,234		21,203,234	73
74	Renal Dialysis	1,390,236		1,390,236		1,390,236	74
76	EMG	111,377		111,377		111,377	76
76.01	CARDIOVASCULAR LAB						76.01
76.02	MERCY EYE CENTER	773,267		773,267		773,267	76.02
76.03	MERCY ENT						76.03
76.04	WOUND CARE CENTER	447,802		447,802		447,802	76.04
76.05	CARDIAC REHAB						76.05
76.06	PRE-BIRTH CENTER	575,290		575,290		575,290	76.06
76.07	SLEEP LAB	531,264		531,264		531,264	76.07
76.08	UROLOGY	231,631		231,631		231,631	76.08
76.09	ADDP OP	191,234		191,234		191,234	76.09
76.10	PSYCH PARTIAL HOSPITAL	132,648		132,648		132,648	76.10
76.11	DIABETES TREATMENT	252,231		252,231		252,231	76.11
76.12	MENTAL HEALTH CENTER	234,502		234,502		234,502	76.12
76.13	VEIN CLINIC						76.13
76.97	CARDIAC REHABILITATION	493,308		493,308		493,308	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	MERCY CLINICS	11,622,091		11,622,091		11,622,091	90.01
90.02	MERCY CLINIC STATE ST						90.02
90.03	MERCY CLINIC POLK ST						90.03
91	Emergency	14,162,271		14,162,271		14,162,271	91
92	Observation Beds (Non-Distinct Part)	7,245,527		7,245,527		7,245,527	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORE						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 (sum of lines 30 thru 199)	226,253,897		226,253,897		226,253,897	200
201	Less Observation Beds	7,245,527		7,245,527		7,245,527	201
202	Total (line 200 minus line 201)	219,008,370		219,008,370		219,008,370	202

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
32	Coronary Care Unit							32
32.01	NURSERY INTENSIVE CARE CENTER							32.01
40	Subprovider - IPF							40
41	Subprovider - IRF							41
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
50.01	GI LAB							50.01
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic							55
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76	EMG							76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER							76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER							76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER							76.06
76.07	SLEEP LAB							76.07
76.08	UROLOGY							76.08
76.09	ADDP OP							76.09
76.10	PSYCH PARTIAL HOSPITAL							76.10
76.11	DIABETES TREATMENT							76.11
76.12	MENTAL HEALTH CENTER							76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS							90.01
90.02	MERCY CLINIC STATE ST							90.02
90.03	MERCY CLINIC POLK ST							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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 (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	14,440,120	2,000,438	12,439,682		50
50.01	GI LAB	1,884,759	226,352	1,658,407		50.01
51	Recovery Room	1,293,287	62,411	1,230,876		51
52	Delivery Room & Labor Room	6,956,027	434,899	6,521,128		52
53	Anesthesiology	532,089	23,331	508,758		53
54	Radiology-Diagnostic	10,058,932	764,453	9,294,479		54
54.01	MRI CENTER					54.01
55	Radiology-Therapeutic	991,580	35,111	956,469		55
56	Radioisotope	1,394,400	65,520	1,328,880		56
57	CT Scan	1,955,444	127,115	1,828,329		57
58	MRI	5,218,422	1,557,245	3,661,177		58
59	Cardiac Catheterization	6,296,893	585,709	5,711,184		59
60	Laboratory	14,992,646	900,718	14,091,928		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	2,850,312	116,778	2,733,534		65
66	Physical Therapy	2,573,042	179,329	2,393,713		66
67	Occupational Therapy	1,309,362	55,728	1,253,634		67
68	Speech Pathology	707,396	39,360	668,036		68
70	Electroencephalography	277,023	42,510	234,513		70
71	Medical Supplies Charged to Patients	3,772,919	148,984	3,623,935		71
72	Impl. Dev. Charged to Patients	6,510,064	256,315	6,253,749		72
73	Drugs Charged to Patients	21,203,234	251,264	20,951,970		73
74	Renal Dialysis	1,390,236	32,164	1,358,072		74
76	EMG	111,377	13,509	97,868		76
76.01	CARDIOVASCULAR LAB					76.01
76.02	MERCY EYE CENTER	773,267	101,153	672,114		76.02
76.03	MERCY ENT					76.03
76.04	WOUND CARE CENTER	447,802	38,093	409,709		76.04
76.05	CARDIAC REHAB					76.05
76.06	PRE-BIRTH CENTER	575,290	7,740	567,550		76.06
76.07	SLEEP LAB	531,264	5,777	525,487		76.07
76.08	UROLOGY	231,631	21,260	210,371		76.08
76.09	ADDP OP	191,234	2,306	188,928		76.09
76.10	PSYCH PARTIAL HOSPITAL	132,648	28,816	103,832		76.10
76.11	DIABETES TREATMENT	252,231	2,955	249,276		76.11
76.12	MENTAL HEALTH CENTER	234,502	2,860	231,642		76.12
76.13	VEIN CLINIC					76.13
76.97	CARDIAC REHABILITATION	493,308	7,081	486,227		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90.01	MERCY CLINICS	11,622,091	720,649	10,901,442		90.01
90.02	MERCY CLINIC STATE ST					90.02
90.03	MERCY CLINIC POLK ST					90.03
91	Emergency	14,162,271	484,731	13,677,540		91
92	Observation Beds (Non-Distinct Part)	7,245,527	382,223	6,863,304		92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	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	143,612,630	9,724,887	133,887,743		200
201	Less Observation Beds	7,245,527	382,223	6,863,304		201
202	Total	136,367,103	9,342,664	127,024,439		202

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
☐ Title V

☒ Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		14,440,120			50
50.01	GI LAB		1,884,759			50.01
51	Recovery Room		1,293,287			51
52	Delivery Room & Labor Room		6,956,027			52
53	Anesthesiology		532,089			53
54	Radiology-Diagnostic		10,058,932			54
54.01	MRI CENTER					54.01
55	Radiology-Therapeutic		991,580			55
56	Radioisotope		1,394,400			56
57	CT Scan		1,955,444			57
58	MRI		5,218,422			58
59	Cardiac Catheterization		6,296,893			59
60	Laboratory		14,992,646			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		2,850,312			65
66	Physical Therapy		2,573,042			66
67	Occupational Therapy		1,309,362			67
68	Speech Pathology		707,396			68
70	Electroencephalography		277,023			70
71	Medical Supplies Charged to Patients		3,772,919			71
72	Impl. Dev. Charged to Patients		6,510,064			72
73	Drugs Charged to Patients		21,203,234			73
74	Renal Dialysis		1,390,236			74
76	EMG		111,377			76
76.01	CARDIOVASCULAR LAB					76.01
76.02	MERCY EYE CENTER		773,267			76.02
76.03	MERCY ENT					76.03
76.04	WOUND CARE CENTER		447,802			76.04
76.05	CARDIAC REHAB					76.05
76.06	PRE-BIRTH CENTER		575,290			76.06
76.07	SLEEP LAB		531,264			76.07
76.08	UROLOGY		231,631			76.08
76.09	ADDP OP		191,234			76.09
76.10	PSYCH PARTIAL HOSPITAL		132,648			76.10
76.11	DIABETES TREATMENT		252,231			76.11
76.12	MENTAL HEALTH CENTER		234,502			76.12
76.13	VEIN CLINIC					76.13
76.97	CARDIAC REHABILITATION		493,308			76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90.01	MERCY CLINICS		11,622,091			90.01
90.02	MERCY CLINIC STATE ST					90.02
90.03	MERCY CLINIC POLK ST					90.03
91	Emergency		14,162,271			91
92	Observation Beds (Non-Distinct Part)		7,245,527	9,178,958	0.789363	92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	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		143,612,630	9,178,958		200
201	Less Observation Beds		7,245,527	9,178,958		201
202	Total		136,367,103			202

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,833,135		2,833,135	43,295	65.44	12,484	816,953	30
31	Intensive Care Unit	814,325		814,325	3,944	206.47	1,440	297,317	31
32	Coronary Care Unit	192,034		192,034	1,444	132.99	537	71,416	32
32.01	NURSERY INTENSIVE CARE CENTER	113,527		113,527	1,840	61.70			32.01
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF	387,961		387,961	7,282	53.28	919	48,964	40
41	Subprovider - IRF	199,679		199,679	4,190	47.66	2,190	104,375	41
42	Subprovider I								42
43	Nursery	57,707		57,707	3,076	18.76			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	4,598,368		4,598,368	65,071		17,570	1,339,025	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0158

WORKSHEET D
PART II

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)

☒ PPS
☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,000,438	23,494,164	0.085146	2,443,174	208,026	50
50.01	GI LAB	226,352	6,233,383	0.036313	594,292	21,581	50.01
51	Recovery Room	62,411	3,420,230	0.018248	317,830	5,800	51
52	Delivery Room & Labor Room	434,899	14,071,204	0.030907	13,502	417	52
53	Anesthesiology	23,331	4,102,397	0.005687	383,637	2,182	53
54	Radiology-Diagnostic	764,453	49,481,560	0.015449	3,667,015	56,652	54
54.01	MRI CENTER						54.01
55	Radiology-Therapeutic	35,111	7,165,922	0.004900	106,223	520	55
56	Radioisotope	65,520	8,628,242	0.007594	640,439	4,863	56
57	CT Scan	127,115	40,585,003	0.003132	5,462,450	17,108	57
58	MRI	1,557,245	9,877,884	0.157650	992,066	156,399	58
59	Cardiac Catheterization	585,709	53,770,241	0.010893	11,012,812	119,963	59
60	Laboratory	900,718	103,430,802	0.008708	16,309,448	142,023	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	116,778	16,524,565	0.007067	5,361,331	37,889	65
66	Physical Therapy	179,329	5,157,891	0.034768	614,405	21,362	66
67	Occupational Therapy	55,728	2,663,150	0.020926	213,047	4,458	67
68	Speech Pathology	39,360	1,725,298	0.022813	271,735	6,199	68
70	Electroencephalography	42,510	359,039	0.118399	77,575	9,185	70
71	Medical Supplies Charged to Pat	148,984	10,151,763	0.014676	3,171,567	46,546	71
72	Impl. Dev. Charged to Patients	256,315	12,474,362	0.020547	2,997,376	61,587	72
73	Drugs Charged to Patients	251,264	52,599,198	0.004777	6,392,832	30,539	73
74	Renal Dialysis	32,164	1,835,925	0.017519	848,849	14,871	74
76	EMG	13,509	202,239	0.066797			76
76.01	CARDIOVASCULAR LAB						76.01
76.02	MERCY EYE CENTER	101,153	881,179	0.114793			76.02
76.03	MERCY ENT						76.03
76.04	WOUND CARE CENTER	38,093	531,204	0.071711	557	40	76.04
76.05	CARDIAC REHAB						76.05
76.06	PRE-BIRTH CENTER	7,740	3,889,209	0.001990	2,403	5	76.06
76.07	SLEEP LAB	5,777	2,048,059	0.002821	2,460	7	76.07
76.08	UROLOGY	21,260	35,819	0.593540			76.08
76.09	ADDP OP	2,306	43,408	0.053124			76.09
76.10	PSYCH PARTIAL HOSPITAL	28,816	1,473,896	0.019551			76.10
76.11	DIABETES TREATMENT	2,955	197,571	0.014957			76.11
76.12	MENTAL HEALTH CENTER	2,860	297,682	0.009608	53	1	76.12
76.13	VEIN CLINIC						76.13
76.97	CARDIAC REHABILITATION	7,081	1,460,466	0.004848	104	1	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	MERCY CLINICS	720,649	3,352,228	0.214976	680	146	90.01
90.02	MERCY CLINIC STATE ST						90.02
90.03	MERCY CLINIC POLK ST						90.03
91	Emergency	484,731	52,734,038	0.009192	4,461,727	41,012	91
92	Observation Beds (Non-Distinct	382,224	9,178,958	0.041641	836,533	34,834	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	9,724,888	504,078,179		67,196,122	1,044,216	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V
Applicable ☒ Title XVIII, Part A
Boxes: ☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
32.01	NURSERY INTENSIVE CARE CENTER								32.01
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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	43,295		12,484		30
31	Intensive Care Unit	3,944		1,440		31
32	Coronary Care Unit	1,444		537		32
32.01	NURSERY INTENSIVE CARE CENTER	1,840				32.01
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF	7,282		919		40
41	Subprovider - IRF	4,190		2,190		41
42	Subprovider I					42
43	Nursery	3,076				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	65,071		17,570		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0158

WORKSHEET D PART IV

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GI LAB									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
54.01	MRI CENTER									54.01
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76	EMG									76
76.01	CARDIOVASCULAR LAB									76.01
76.02	MERCY EYE CENTER									76.02
76.03	MERCY ENT									76.03
76.04	WOUND CARE CENTER									76.04
76.05	CARDIAC REHAB									76.05
76.06	PRE-BIRTH CENTER									76.06
76.07	SLEEP LAB									76.07
76.08	UROLOGY									76.08
76.09	ADDP OP									76.09
76.10	PSYCH PARTIAL HOSPITAL									76.10
76.11	DIABETES TREATMENT									76.11
76.12	MENTAL HEALTH CENTER									76.12
76.13	VEIN CLINIC									76.13
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90.01	MERCY CLINICS									90.01
90.02	MERCY CLINIC STATE ST									90.02
90.03	MERCY CLINIC POLK ST									90.03
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0158

WORKSHEET D PART IV

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	23,494,164			2,443,174		2,657,548		50
50.01	GI LAB	6,233,383			594,292		1,207,418		50.01
51	Recovery Room	3,420,230			317,830		431,778		51
52	Delivery Room & Labor Room	14,071,204			13,502		560		52
53	Anesthesiology	4,102,397			383,637		430,131		53
54	Radiology-Diagnostic	49,481,560			3,667,015		5,034,420		54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic	7,165,922			106,223		1,751,269		55
56	Radioisotope	8,628,242			640,439		2,103,185		56
57	CT Scan	40,585,003			5,462,450		6,229,558		57
58	MRI	9,877,884			992,066		1,598,216		58
59	Cardiac Catheterization	53,770,241			11,012,812		7,291,912		59
60	Laboratory	103,430,802			16,309,448		4,485,093		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	16,524,565			5,361,331		262,266		65
66	Physical Therapy	5,157,891			614,405		19,638		66
67	Occupational Therapy	2,663,150			213,047		7,900		67
68	Speech Pathology	1,725,298			271,735		34,327		68
70	Electroencephalography	359,039			77,575		34,567		70
71	Medical Supplies Charged to Pat	10,151,763			3,171,567		1,013,278		71
72	Impl. Dev. Charged to Patients	12,474,362			2,997,376		1,387,924		72
73	Drugs Charged to Patients	52,599,198			6,392,832		9,186,669		73
74	Renal Dialysis	1,835,925			848,849		56,550		74
76	EMG	202,239					46,686		76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER	881,179					393,826		76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER	531,204			557		195,886		76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER	3,889,209			2,403		9,859		76.06
76.07	SLEEP LAB	2,048,059			2,460		432,772		76.07
76.08	UROLOGY	35,819					4,183		76.08
76.09	ADDP OP	43,408					5,135		76.09
76.10	PSYCH PARTIAL HOSPITAL	1,473,896					257,510		76.10
76.11	DIABETES TREATMENT	197,571					10,780		76.11
76.12	MENTAL HEALTH CENTER	297,682			53		114,150		76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION	1,460,466			104		454,380		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS	3,352,228			680		116,408		90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency	52,734,038			4,461,727		4,783,691		91
92	Observation Beds (Non-Distinct	9,178,958			836,533		1,800,721		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	504,078,179			67,196,122		53,850,194		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0158

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.567182	2,657,548			1,507,313			50
50.01	GI LAB	0.302365	1,207,418			365,081			50.01
51	Recovery Room	0.378129	431,778			163,268			51
52	Delivery Room & Labor Room	0.494345	560			277			52
53	Anesthesiology	0.129702	430,131			55,789			53
54	Radiology-Diagnostic	0.168793	5,034,420			849,775			54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic	0.138374	1,751,269			242,330			55
56	Radioisotope	0.161609	2,103,185			339,894			56
57	CT Scan	0.048181	6,229,558			300,146			57
58	MRI	0.528294	1,598,216			844,328			58
59	Cardiac Catheterization	0.117107	7,291,912			853,934			59
60	Laboratory	0.144953	4,485,093			650,128			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.172489	262,266			45,238			65
66	Physical Therapy	0.498855	19,638			9,797			66
67	Occupational Therapy	0.491659	7,900			3,884			67
68	Speech Pathology	0.410014	34,327			14,075			68
70	Electroencephalography	0.771568	34,567			26,671			70
71	Medical Supplies Charged to Pat	0.371652	1,013,278			376,587			71
72	Impl. Dev. Charged to Patients	0.521876	1,387,924			724,324			72
73	Drugs Charged to Patients	0.403109	9,186,669		25,486	3,703,229		10,274	73
74	Renal Dialysis	0.757240	56,550			42,822			74
76	EMG	0.550720	46,686			25,711			76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER	0.877537	393,826			345,597			76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER	0.842994	195,886			165,131			76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER	0.147920	9,859			1,458			76.06
76.07	SLEEP LAB	0.259399	432,772			112,261			76.07
76.08	UROLOGY	6.466708	4,183			27,050			76.08
76.09	ADDP OP	4.405501	5,135			22,622			76.09
76.10	PSYCH PARTIAL HOSPITAL	0.089998	257,510			23,175			76.10
76.11	DIABETES TREATMENT	1.276660	10,780			13,762			76.11
76.12	MENTAL HEALTH CENTER	0.787760	114,150			89,923			76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION	0.337774	454,380			153,478			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS	3.466975	116,408			403,584			90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency	0.237938	4,783,691			1,138,222			91
92	Observation Beds (Non-Distinct	0.678187	1,800,721			1,221,226			92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		53,850,194		25,486	14,862,090		10,274	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		53,850,194		25,486	14,862,090		10,274	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S158

WORKSHEET D PART II

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,000,438	23,494,164	0.085146			50
50.01	GI LAB	226,352	6,233,383	0.036313			50.01
51	Recovery Room	62,411	3,420,230	0.018248			51
52	Delivery Room & Labor Room	434,899	14,071,204	0.030907			52
53	Anesthesiology	23,331	4,102,397	0.005687			53
54	Radiology-Diagnostic	764,453	49,481,560	0.015449	7,974	123	54
54.01	MRI CENTER						54.01
55	Radiology-Therapeutic	35,111	7,165,922	0.004900			55
56	Radioisotope	65,520	8,628,242	0.007594	16,814	128	56
57	CT Scan	127,115	40,585,003	0.003132	13,860	43	57
58	MRI	1,557,245	9,877,884	0.157650			58
59	Cardiac Catheterization	585,709	53,770,241	0.010893	41,430	451	59
60	Laboratory	900,718	103,430,802	0.008708	154,280	1,343	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	116,778	16,524,565	0.007067	3,742	26	65
66	Physical Therapy	179,329	5,157,891	0.034768	572	20	66
67	Occupational Therapy	55,728	2,663,150	0.020926			67
68	Speech Pathology	39,360	1,725,298	0.022813			68
70	Electroencephalography	42,510	359,039	0.118399			70
71	Medical Supplies Charged to Pat	148,984	10,151,763	0.014676			71
72	Impl. Dev. Charged to Patients	256,315	12,474,362	0.020547			72
73	Drugs Charged to Patients	251,264	52,599,198	0.004777	64,320	307	73
74	Renal Dialysis	32,164	1,835,925	0.017519			74
76	EMG	13,509	202,239	0.066797			76
76.01	CARDIOVASCULAR LAB						76.01
76.02	MERCY EYE CENTER	101,153	881,179	0.114793			76.02
76.03	MERCY ENT						76.03
76.04	WOUND CARE CENTER	38,093	531,204	0.071711			76.04
76.05	CARDIAC REHAB						76.05
76.06	PRE-BIRTH CENTER	7,740	3,889,209	0.001990			76.06
76.07	SLEEP LAB	5,777	2,048,059	0.002821			76.07
76.08	UROLOGY	21,260	35,819	0.593540			76.08
76.09	ADDP OP	2,306	43,408	0.053124			76.09
76.10	PSYCH PARTIAL HOSPITAL	28,816	1,473,896	0.019551			76.10
76.11	DIABETES TREATMENT	2,955	197,571	0.014957			76.11
76.12	MENTAL HEALTH CENTER	2,860	297,682	0.009608	300	3	76.12
76.13	VEIN CLINIC						76.13
76.97	CARDIAC REHABILITATION	7,081	1,460,466	0.004848			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	MERCY CLINICS	720,649	3,352,228	0.214976			90.01
90.02	MERCY CLINIC STATE ST						90.02
90.03	MERCY CLINIC POLK ST						90.03
91	Emergency	484,731	52,734,038	0.009192	216,654	1,991	91
92	Observation Beds (Non-Distinct		9,178,958				92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	9,342,664	504,078,179		519,946	4,435	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S158

WORKSHEET D PART IV

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GI LAB									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
54.01	MRI CENTER									54.01
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76	EMG									76
76.01	CARDIOVASCULAR LAB									76.01
76.02	MERCY EYE CENTER									76.02
76.03	MERCY ENT									76.03
76.04	WOUND CARE CENTER									76.04
76.05	CARDIAC REHAB									76.05
76.06	PRE-BIRTH CENTER									76.06
76.07	SLEEP LAB									76.07
76.08	UROLOGY									76.08
76.09	ADDP OP									76.09
76.10	PSYCH PARTIAL HOSPITAL									76.10
76.11	DIABETES TREATMENT									76.11
76.12	MENTAL HEALTH CENTER									76.12
76.13	VEIN CLINIC									76.13
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90.01	MERCY CLINICS									90.01
90.02	MERCY CLINIC STATE ST									90.02
90.03	MERCY CLINIC POLK ST									90.03
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S158

WORKSHEET D PART IV

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

		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	23,494,164							50
50.01	GI LAB	6,233,383							50.01
51	Recovery Room	3,420,230							51
52	Delivery Room & Labor Room	14,071,204							52
53	Anesthesiology	4,102,397							53
54	Radiology-Diagnostic	49,481,560			7,974				54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic	7,165,922							55
56	Radioisotope	8,628,242			16,814				56
57	CT Scan	40,585,003			13,860				57
58	MRI	9,877,884							58
59	Cardiac Catheterization	53,770,241			41,430				59
60	Laboratory	103,430,802			154,280				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	16,524,565			3,742				65
66	Physical Therapy	5,157,891			572				66
67	Occupational Therapy	2,663,150							67
68	Speech Pathology	1,725,298							68
70	Electroencephalography	359,039							70
71	Medical Supplies Charged to Pat	10,151,763							71
72	Impl. Dev. Charged to Patients	12,474,362							72
73	Drugs Charged to Patients	52,599,198			64,320				73
74	Renal Dialysis	1,835,925							74
76	EMG	202,239							76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER	881,179							76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER	531,204							76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER	3,889,209							76.06
76.07	SLEEP LAB	2,048,059							76.07
76.08	UROLOGY	35,819							76.08
76.09	ADDP OP	43,408							76.09
76.10	PSYCH PARTIAL HOSPITAL	1,473,896							76.10
76.11	DIABETES TREATMENT	197,571							76.11
76.12	MENTAL HEALTH CENTER	297,682			300				76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION	1,460,466							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS	3,352,228							90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency	52,734,038			216,654				91
92	Observation Beds (Non-Distinct	9,178,958							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	504,078,179			519,946				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S158

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P
☒ Title XVIII, Part B
☐ Title XIX - O/P

☐ Hospital
☒ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ Swing Bed SNF
☐ Swing Bed NF
☐ ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.567182							50
50.01	GI LAB	0.302365							50.01
51	Recovery Room	0.378129							51
52	Delivery Room & Labor Room	0.494345							52
53	Anesthesiology	0.129702							53
54	Radiology-Diagnostic	0.168793							54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic	0.138374							55
56	Radioisotope	0.161609							56
57	CT Scan	0.048181							57
58	MRI	0.528294							58
59	Cardiac Catheterization	0.117107							59
60	Laboratory	0.144953							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.172489							65
66	Physical Therapy	0.498855							66
67	Occupational Therapy	0.491659							67
68	Speech Pathology	0.410014							68
70	Electroencephalography	0.771568							70
71	Medical Supplies Charged to Pat	0.371652							71
72	Impl. Dev. Charged to Patients	0.521876							72
73	Drugs Charged to Patients	0.403109							73
74	Renal Dialysis	0.757240							74
76	EMG	0.550720							76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER	0.877537							76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER	0.842994							76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER	0.147920							76.06
76.07	SLEEP LAB	0.259399							76.07
76.08	UROLOGY	6.466708							76.08
76.09	ADDP OP	4.405501							76.09
76.10	PSYCH PARTIAL HOSPITAL	0.089998							76.10
76.11	DIABETES TREATMENT	1.276660							76.11
76.12	MENTAL HEALTH CENTER	0.787760							76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION	0.337774							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS	3.466975							90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency	0.237938							91
92	Observation Beds (Non-Distinct	0.678187							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T158

WORKSHEET D PART II

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,000,438	23,494,164	0.085146			50
50.01	GI LAB	226,352	6,233,383	0.036313			50.01
51	Recovery Room	62,411	3,420,230	0.018248	548	10	51
52	Delivery Room & Labor Room	434,899	14,071,204	0.030907			52
53	Anesthesiology	23,331	4,102,397	0.005687			53
54	Radiology-Diagnostic	764,453	49,481,560	0.015449	50,622	782	54
54.01	MRI CENTER						54.01
55	Radiology-Therapeutic	35,111	7,165,922	0.004900			55
56	Radioisotope	65,520	8,628,242	0.007594	5,690	43	56
57	CT Scan	127,115	40,585,003	0.003132	63,403	199	57
58	MRI	1,557,245	9,877,884	0.157650	2,039	321	58
59	Cardiac Catheterization	585,709	53,770,241	0.010893	14,008	153	59
60	Laboratory	900,718	103,430,802	0.008708	305,295	2,659	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	116,778	16,524,565	0.007067	89,121	630	65
66	Physical Therapy	179,329	5,157,891	0.034768	798,429	27,760	66
67	Occupational Therapy	55,728	2,663,150	0.020926	802,241	16,788	67
68	Speech Pathology	39,360	1,725,298	0.022813	292,306	6,668	68
70	Electroencephalography	42,510	359,039	0.118399			70
71	Medical Supplies Charged to Pat	148,984	10,151,763	0.014676	38,049	558	71
72	Impl. Dev. Charged to Patients	256,315	12,474,362	0.020547	219	4	72
73	Drugs Charged to Patients	251,264	52,599,198	0.004777	267,157	1,276	73
74	Renal Dialysis	32,164	1,835,925	0.017519	28,275	495	74
76	EMG	13,509	202,239	0.066797			76
76.01	CARDIOVASCULAR LAB						76.01
76.02	MERCY EYE CENTER	101,153	881,179	0.114793			76.02
76.03	MERCY ENT						76.03
76.04	WOUND CARE CENTER	38,093	531,204	0.071711			76.04
76.05	CARDIAC REHAB						76.05
76.06	PRE-BIRTH CENTER	7,740	3,889,209	0.001990			76.06
76.07	SLEEP LAB	5,777	2,048,059	0.002821			76.07
76.08	UROLOGY	21,260	35,819	0.593540			76.08
76.09	ADDP OP	2,306	43,408	0.053124			76.09
76.10	PSYCH PARTIAL HOSPITAL	28,816	1,473,896	0.019551			76.10
76.11	DIABETES TREATMENT	2,955	197,571	0.014957			76.11
76.12	MENTAL HEALTH CENTER	2,860	297,682	0.009608			76.12
76.13	VEIN CLINIC						76.13
76.97	CARDIAC REHABILITATION	7,081	1,460,466	0.004848			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	MERCY CLINICS	720,649	3,352,228	0.214976			90.01
90.02	MERCY CLINIC STATE ST						90.02
90.03	MERCY CLINIC POLK ST						90.03
91	Emergency	484,731	52,734,038	0.009192	3,386	31	91
92	Observation Beds (Non-Distinct		9,178,958				92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	9,342,664	504,078,179		2,760,788	58,377	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T158

WORKSHEET D PART IV

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GI LAB									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
54.01	MRI CENTER									54.01
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76	EMG									76
76.01	CARDIOVASCULAR LAB									76.01
76.02	MERCY EYE CENTER									76.02
76.03	MERCY ENT									76.03
76.04	WOUND CARE CENTER									76.04
76.05	CARDIAC REHAB									76.05
76.06	PRE-BIRTH CENTER									76.06
76.07	SLEEP LAB									76.07
76.08	UROLOGY									76.08
76.09	ADDP OP									76.09
76.10	PSYCH PARTIAL HOSPITAL									76.10
76.11	DIABETES TREATMENT									76.11
76.12	MENTAL HEALTH CENTER									76.12
76.13	VEIN CLINIC									76.13
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90.01	MERCY CLINICS									90.01
90.02	MERCY CLINIC STATE ST									90.02
90.03	MERCY CLINIC POLK ST									90.03
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T158

WORKSHEET D
PART IV

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	23,494,164							50
50.01	GI LAB	6,233,383							50.01
51	Recovery Room	3,420,230			548				51
52	Delivery Room & Labor Room	14,071,204							52
53	Anesthesiology	4,102,397							53
54	Radiology-Diagnostic	49,481,560			50,622				54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic	7,165,922							55
56	Radioisotope	8,628,242			5,690				56
57	CT Scan	40,585,003			63,403				57
58	MRI	9,877,884			2,039				58
59	Cardiac Catheterization	53,770,241			14,008				59
60	Laboratory	103,430,802			305,295				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	16,524,565			89,121				65
66	Physical Therapy	5,157,891			798,429				66
67	Occupational Therapy	2,663,150			802,241				67
68	Speech Pathology	1,725,298			292,306				68
70	Electroencephalography	359,039							70
71	Medical Supplies Charged to Pat	10,151,763			38,049				71
72	Impl. Dev. Charged to Patients	12,474,362			219				72
73	Drugs Charged to Patients	52,599,198			267,157				73
74	Renal Dialysis	1,835,925			28,275				74
76	EMG	202,239							76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER	881,179							76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER	531,204							76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER	3,889,209							76.06
76.07	SLEEP LAB	2,048,059							76.07
76.08	UROLOGY	35,819							76.08
76.09	ADDP OP	43,408							76.09
76.10	PSYCH PARTIAL HOSPITAL	1,473,896							76.10
76.11	DIABETES TREATMENT	197,571							76.11
76.12	MENTAL HEALTH CENTER	297,682							76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION	1,460,466							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS	3,352,228							90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency	52,734,038			3,386				91
92	Observation Beds (Non-Distinct	9,178,958							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	504,078,179			2,760,788				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T158

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
50	Operating Room	0.567182							50
50.01	GI LAB	0.302365							50.01
51	Recovery Room	0.378129							51
52	Delivery Room & Labor Room	0.494345							52
53	Anesthesiology	0.129702							53
54	Radiology-Diagnostic	0.168793							54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic	0.138374							55
56	Radioisotope	0.161609							56
57	CT Scan	0.048181							57
58	MRI	0.528294							58
59	Cardiac Catheterization	0.117107							59
60	Laboratory	0.144953							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.172489							65
66	Physical Therapy	0.498855							66
67	Occupational Therapy	0.491659							67
68	Speech Pathology	0.410014							68
70	Electroencephalography	0.771568							70
71	Medical Supplies Charged to Pat	0.371652							71
72	Impl. Dev. Charged to Patients	0.521876							72
73	Drugs Charged to Patients	0.403109							73
74	Renal Dialysis	0.757240							74
76	EMG	0.550720							76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER	0.877537							76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER	0.842994							76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER	0.147920							76.06
76.07	SLEEP LAB	0.259399							76.07
76.08	UROLOGY	6.466708							76.08
76.09	ADDP OP	4.405501							76.09
76.10	PSYCH PARTIAL HOSPITAL	0.089998							76.10
76.11	DIABETES TREATMENT	1.276660							76.11
76.12	MENTAL HEALTH CENTER	0.787760							76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION	0.337774							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS	3.466975							90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency	0.237938							91
92	Observation Beds (Non-Distinct	0.678187							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

Check ☐ Title V
Applicable ☐ Title XVIII, Part A
Boxes: ☒ Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,833,135		2,833,135	43,295	65.44	4,025	263,396	30
31	Intensive Care Unit	814,325		814,325	3,944	206.47	438	90,434	31
32	Coronary Care Unit	192,034		192,034	1,444	132.99	103	13,698	32
32.01	NURSERY INTENSIVE CARE CENTER	113,527		113,527	1,840	61.70	851	52,507	32.01
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF	387,961		387,961	7,282	53.28	1,040	55,411	40
41	Subprovider - IRF	199,679		199,679	4,190	47.66	1,181	56,286	41
42	Subprovider I								42
43	Nursery	57,707		57,707	3,076	18.76	1,160	21,762	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	4,598,368		4,598,368	65,071		8,798	553,494	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0158

WORKSHEET D PART II

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,000,438	23,494,164	0.085146			50
50.01	GI LAB	226,352	6,233,383	0.036313			50.01
51	Recovery Room	62,411	3,420,230	0.018248			51
52	Delivery Room & Labor Room	434,899	14,071,204	0.030907			52
53	Anesthesiology	23,331	4,102,397	0.005687			53
54	Radiology-Diagnostic	764,453	49,481,560	0.015449			54
54.01	MRI CENTER						54.01
55	Radiology-Therapeutic	35,111	7,165,922	0.004900			55
56	Radioisotope	65,520	8,628,242	0.007594			56
57	CT Scan	127,115	40,585,003	0.003132			57
58	MRI	1,557,245	9,877,884	0.157650			58
59	Cardiac Catheterization	585,709	53,770,241	0.010893			59
60	Laboratory	900,718	103,430,802	0.008708			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	116,778	16,524,565	0.007067			65
66	Physical Therapy	179,329	5,157,891	0.034768			66
67	Occupational Therapy	55,728	2,663,150	0.020926			67
68	Speech Pathology	39,360	1,725,298	0.022813			68
70	Electroencephalography	42,510	359,039	0.118399			70
71	Medical Supplies Charged to Pat	148,984	10,151,763	0.014676			71
72	Impl. Dev. Charged to Patients	256,315	12,474,362	0.020547			72
73	Drugs Charged to Patients	251,264	52,599,198	0.004777			73
74	Renal Dialysis	32,164	1,835,925	0.017519			74
76	EMG	13,509	202,239	0.066797			76
76.01	CARDIOVASCULAR LAB						76.01
76.02	MERCY EYE CENTER	101,153	881,179	0.114793			76.02
76.03	MERCY ENT						76.03
76.04	WOUND CARE CENTER	38,093	531,204	0.071711			76.04
76.05	CARDIAC REHAB						76.05
76.06	PRE-BIRTH CENTER	7,740	3,889,209	0.001990			76.06
76.07	SLEEP LAB	5,777	2,048,059	0.002821			76.07
76.08	UROLOGY	21,260	35,819	0.593540			76.08
76.09	ADDP OP	2,306	43,408	0.053124			76.09
76.10	PSYCH PARTIAL HOSPITAL	28,816	1,473,896	0.019551			76.10
76.11	DIABETES TREATMENT	2,955	197,571	0.014957			76.11
76.12	MENTAL HEALTH CENTER	2,860	297,682	0.009608			76.12
76.13	VEIN CLINIC						76.13
76.97	CARDIAC REHABILITATION	7,081	1,460,466	0.004848			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	MERCY CLINICS	720,649	3,352,228	0.214976			90.01
90.02	MERCY CLINIC STATE ST						90.02
90.03	MERCY CLINIC POLK ST						90.03
91	Emergency	484,731	52,734,038	0.009192			91
92	Observation Beds (Non-Distinct	382,223	9,178,958	0.041641			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	9,724,887	504,078,179				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
32.01	NURSERY INTENSIVE CARE CENTER								32.01
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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	43,295		4,025		30
31	Intensive Care Unit	3,944		438		31
32	Coronary Care Unit	1,444		103		32
32.01	NURSERY INTENSIVE CARE CENTER	1,840		851		32.01
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF	7,282		1,040		40
41	Subprovider - IRF	4,190		1,181		41
42	Subprovider I					42
43	Nursery	3,076		1,160		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	65,071		8,798		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0158

WORKSHEET D PART IV

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GI LAB									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
54.01	MRI CENTER									54.01
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76	EMG									76
76.01	CARDIOVASCULAR LAB									76.01
76.02	MERCY EYE CENTER									76.02
76.03	MERCY ENT									76.03
76.04	WOUND CARE CENTER									76.04
76.05	CARDIAC REHAB									76.05
76.06	PRE-BIRTH CENTER									76.06
76.07	SLEEP LAB									76.07
76.08	UROLOGY									76.08
76.09	ADDP OP									76.09
76.10	PSYCH PARTIAL HOSPITAL									76.10
76.11	DIABETES TREATMENT									76.11
76.12	MENTAL HEALTH CENTER									76.12
76.13	VEIN CLINIC									76.13
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90.01	MERCY CLINICS									90.01
90.02	MERCY CLINIC STATE ST									90.02
90.03	MERCY CLINIC POLK ST									90.03
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0158

**WORKSHEET D
PART IV**

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

		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								50
50.01	GI LAB								50.01
51	Recovery Room								51
52	Delivery Room & Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	CT Scan								57
58	MRI								58
59	Cardiac Catheterization								59
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
70	Electroencephalography								70
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
76	EMG								76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER								76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER								76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER								76.06
76.07	SLEEP LAB								76.07
76.08	UROLOGY								76.08
76.09	ADDP OP								76.09
76.10	PSYCH PARTIAL HOSPITAL								76.10
76.11	DIABETES TREATMENT								76.11
76.12	MENTAL HEALTH CENTER								76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS								90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0158

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☐ Title XVIII, Part B

☒ Title XIX - O/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
50	Operating Room								50
50.01	GI LAB								50.01
51	Recovery Room								51
52	Delivery Room & Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	CT Scan								57
58	MRI								58
59	Cardiac Catheterization								59
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
70	Electroencephalography								70
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
76	EMG								76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER								76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER								76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER								76.06
76.07	SLEEP LAB								76.07
76.08	UROLOGY								76.08
76.09	ADDP OP								76.09
76.10	PSYCH PARTIAL HOSPITAL								76.10
76.11	DIABETES TREATMENT								76.11
76.12	MENTAL HEALTH CENTER								76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS								90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S158

WORKSHEET D PART II

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,000,438	23,494,164	0.085146			50
50.01	GI LAB	226,352	6,233,383	0.036313			50.01
51	Recovery Room	62,411	3,420,230	0.018248			51
52	Delivery Room & Labor Room	434,899	14,071,204	0.030907			52
53	Anesthesiology	23,331	4,102,397	0.005687			53
54	Radiology-Diagnostic	764,453	49,481,560	0.015449			54
54.01	MRI CENTER						54.01
55	Radiology-Therapeutic	35,111	7,165,922	0.004900			55
56	Radioisotope	65,520	8,628,242	0.007594			56
57	CT Scan	127,115	40,585,003	0.003132			57
58	MRI	1,557,245	9,877,884	0.157650			58
59	Cardiac Catheterization	585,709	53,770,241	0.010893			59
60	Laboratory	900,718	103,430,802	0.008708			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	116,778	16,524,565	0.007067			65
66	Physical Therapy	179,329	5,157,891	0.034768			66
67	Occupational Therapy	55,728	2,663,150	0.020926			67
68	Speech Pathology	39,360	1,725,298	0.022813			68
70	Electroencephalography	42,510	359,039	0.118399			70
71	Medical Supplies Charged to Pat	148,984	10,151,763	0.014676			71
72	Impl. Dev. Charged to Patients	256,315	12,474,362	0.020547			72
73	Drugs Charged to Patients	251,264	52,599,198	0.004777			73
74	Renal Dialysis	32,164	1,835,925	0.017519			74
76	EMG	13,509	202,239	0.066797			76
76.01	CARDIOVASCULAR LAB						76.01
76.02	MERCY EYE CENTER	101,153	881,179	0.114793			76.02
76.03	MERCY ENT						76.03
76.04	WOUND CARE CENTER	38,093	531,204	0.071711			76.04
76.05	CARDIAC REHAB						76.05
76.06	PRE-BIRTH CENTER	7,740	3,889,209	0.001990			76.06
76.07	SLEEP LAB	5,777	2,048,059	0.002821			76.07
76.08	UROLOGY	21,260	35,819	0.593540			76.08
76.09	ADDP OP	2,306	43,408	0.053124			76.09
76.10	PSYCH PARTIAL HOSPITAL	28,816	1,473,896	0.019551			76.10
76.11	DIABETES TREATMENT	2,955	197,571	0.014957			76.11
76.12	MENTAL HEALTH CENTER	2,860	297,682	0.009608			76.12
76.13	VEIN CLINIC						76.13
76.97	CARDIAC REHABILITATION	7,081	1,460,466	0.004848			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	MERCY CLINICS	720,649	3,352,228	0.214976			90.01
90.02	MERCY CLINIC STATE ST						90.02
90.03	MERCY CLINIC POLK ST						90.03
91	Emergency	484,731	52,734,038	0.009192			91
92	Observation Beds (Non-Distinct		9,178,958				92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	9,342,664	504,078,179				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S158

WORKSHEET D PART IV

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GI LAB									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
54.01	MRI CENTER									54.01
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76	EMG									76
76.01	CARDIOVASCULAR LAB									76.01
76.02	MERCY EYE CENTER									76.02
76.03	MERCY ENT									76.03
76.04	WOUND CARE CENTER									76.04
76.05	CARDIAC REHAB									76.05
76.06	PRE-BIRTH CENTER									76.06
76.07	SLEEP LAB									76.07
76.08	UROLOGY									76.08
76.09	ADDP OP									76.09
76.10	PSYCH PARTIAL HOSPITAL									76.10
76.11	DIABETES TREATMENT									76.11
76.12	MENTAL HEALTH CENTER									76.12
76.13	VEIN CLINIC									76.13
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90.01	MERCY CLINICS									90.01
90.02	MERCY CLINIC STATE ST									90.02
90.03	MERCY CLINIC POLK ST									90.03
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S158

WORKSHEET D
PART IV

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

		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								50
50.01	GI LAB								50.01
51	Recovery Room								51
52	Delivery Room & Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	CT Scan								57
58	MRI								58
59	Cardiac Catheterization								59
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
70	Electroencephalography								70
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
76	EMG								76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER								76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER								76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER								76.06
76.07	SLEEP LAB								76.07
76.08	UROLOGY								76.08
76.09	ADDP OP								76.09
76.10	PSYCH PARTIAL HOSPITAL								76.10
76.11	DIABETES TREATMENT								76.11
76.12	MENTAL HEALTH CENTER								76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS								90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S158

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
50	Operating Room								50
50.01	GI LAB								50.01
51	Recovery Room								51
52	Delivery Room & Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	CT Scan								57
58	MRI								58
59	Cardiac Catheterization								59
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
70	Electroencephalography								70
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
76	EMG								76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER								76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER								76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER								76.06
76.07	SLEEP LAB								76.07
76.08	UROLOGY								76.08
76.09	ADDP OP								76.09
76.10	PSYCH PARTIAL HOSPITAL								76.10
76.11	DIABETES TREATMENT								76.11
76.12	MENTAL HEALTH CENTER								76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS								90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T158

WORKSHEET D
PART II

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ Hospital
☐ IPF
☒ IRF

☐ SUB (Other)

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,000,438	23,494,164	0.085146			50
50.01	GI LAB	226,352	6,233,383	0.036313			50.01
51	Recovery Room	62,411	3,420,230	0.018248			51
52	Delivery Room & Labor Room	434,899	14,071,204	0.030907			52
53	Anesthesiology	23,331	4,102,397	0.005687			53
54	Radiology-Diagnostic	764,453	49,481,560	0.015449			54
54.01	MRI CENTER						54.01
55	Radiology-Therapeutic	35,111	7,165,922	0.004900			55
56	Radioisotope	65,520	8,628,242	0.007594			56
57	CT Scan	127,115	40,585,003	0.003132			57
58	MRI	1,557,245	9,877,884	0.157650			58
59	Cardiac Catheterization	585,709	53,770,241	0.010893			59
60	Laboratory	900,718	103,430,802	0.008708			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	116,778	16,524,565	0.007067			65
66	Physical Therapy	179,329	5,157,891	0.034768			66
67	Occupational Therapy	55,728	2,663,150	0.020926			67
68	Speech Pathology	39,360	1,725,298	0.022813			68
70	Electroencephalography	42,510	359,039	0.118399			70
71	Medical Supplies Charged to Pat	148,984	10,151,763	0.014676			71
72	Impl. Dev. Charged to Patients	256,315	12,474,362	0.020547			72
73	Drugs Charged to Patients	251,264	52,599,198	0.004777			73
74	Renal Dialysis	32,164	1,835,925	0.017519			74
76	EMG	13,509	202,239	0.066797			76
76.01	CARDIOVASCULAR LAB						76.01
76.02	MERCY EYE CENTER	101,153	881,179	0.114793			76.02
76.03	MERCY ENT						76.03
76.04	WOUND CARE CENTER	38,093	531,204	0.071711			76.04
76.05	CARDIAC REHAB						76.05
76.06	PRE-BIRTH CENTER	7,740	3,889,209	0.001990			76.06
76.07	SLEEP LAB	5,777	2,048,059	0.002821			76.07
76.08	UROLOGY	21,260	35,819	0.593540			76.08
76.09	ADDP OP	2,306	43,408	0.053124			76.09
76.10	PSYCH PARTIAL HOSPITAL	28,816	1,473,896	0.019551			76.10
76.11	DIABETES TREATMENT	2,955	197,571	0.014957			76.11
76.12	MENTAL HEALTH CENTER	2,860	297,682	0.009608			76.12
76.13	VEIN CLINIC						76.13
76.97	CARDIAC REHABILITATION	7,081	1,460,466	0.004848			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	MERCY CLINICS	720,649	3,352,228	0.214976			90.01
90.02	MERCY CLINIC STATE ST						90.02
90.03	MERCY CLINIC POLK ST						90.03
91	Emergency	484,731	52,734,038	0.009192			91
92	Observation Beds (Non-Distinct		9,178,958				92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	9,342,664	504,078,179				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-T158

**WORKSHEET D
PART IV**

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GI LAB									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
54.01	MRI CENTER									54.01
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76	EMG									76
76.01	CARDIOVASCULAR LAB									76.01
76.02	MERCY EYE CENTER									76.02
76.03	MERCY ENT									76.03
76.04	WOUND CARE CENTER									76.04
76.05	CARDIAC REHAB									76.05
76.06	PRE-BIRTH CENTER									76.06
76.07	SLEEP LAB									76.07
76.08	UROLOGY									76.08
76.09	ADDP OP									76.09
76.10	PSYCH PARTIAL HOSPITAL									76.10
76.11	DIABETES TREATMENT									76.11
76.12	MENTAL HEALTH CENTER									76.12
76.13	VEIN CLINIC									76.13
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90.01	MERCY CLINICS									90.01
90.02	MERCY CLINIC STATE ST									90.02
90.03	MERCY CLINIC POLK ST									90.03
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T158

WORKSHEET D
PART IV

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
50.01	GI LAB								50.01
51	Recovery Room								51
52	Delivery Room & Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	CT Scan								57
58	MRI								58
59	Cardiac Catheterization								59
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
70	Electroencephalography								70
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
76	EMG								76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER								76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER								76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER								76.06
76.07	SLEEP LAB								76.07
76.08	UROLOGY								76.08
76.09	ADDP OP								76.09
76.10	PSYCH PARTIAL HOSPITAL								76.10
76.11	DIABETES TREATMENT								76.11
76.12	MENTAL HEALTH CENTER								76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS								90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS**COMPONENT CCN: 14-T158****WORKSHEET D
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
50.01	GI LAB								50.01
51	Recovery Room								51
52	Delivery Room & Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
54.01	MRI CENTER								54.01
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	CT Scan								57
58	MRI								58
59	Cardiac Catheterization								59
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
70	Electroencephalography								70
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
76	EMG								76
76.01	CARDIOVASCULAR LAB								76.01
76.02	MERCY EYE CENTER								76.02
76.03	MERCY ENT								76.03
76.04	WOUND CARE CENTER								76.04
76.05	CARDIAC REHAB								76.05
76.06	PRE-BIRTH CENTER								76.06
76.07	SLEEP LAB								76.07
76.08	UROLOGY								76.08
76.09	ADDP OP								76.09
76.10	PSYCH PARTIAL HOSPITAL								76.10
76.11	DIABETES TREATMENT								76.11
76.12	MENTAL HEALTH CENTER								76.12
76.13	VEIN CLINIC								76.13
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	MERCY CLINICS								90.01
90.02	MERCY CLINIC STATE ST								90.02
90.03	MERCY CLINIC POLK ST								90.03
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0158****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	43,295	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	43,295	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)	37,454	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	12,484	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	46,141,483	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	46,141,483	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	46,141,483	37

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0158****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,065.75	38
39	Program general inpatient routine service cost (line 9 x line 38)						13,304,823	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						13,304,823	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	8,982,696	3,944	2,277.56	1,440	3,279,686		43
44	Coronary Care Unit	2,751,472	1,444	1,905.45	537	1,023,227		44
44.01	NURSERY INTENSIVE CARE CENTER	3,967,058	1,840	2,156.01				44.01
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						16,025,872	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						33,633,608	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,185,686	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						1,044,216	51
52	Total Program excludable cost (sum of lines 50 and 51)						2,229,902	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						31,403,706	53
TARGET AMOUNT AND LIMIT COMPUTATION								
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
PROGRAM INPATIENT ROUTINE SWING BED COST								
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0158

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					5,841	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,065.75	88
89	Observation bed cost (line 87 x line 88) (see instructions)					6,225,046	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	2,833,135	46,141,483	0.061401	6,225,046	382,224	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S158

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,282	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,282	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)	7,282	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	919	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,416,298	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,416,298	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,416,298	37

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S158

**WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	1,018.44	38
39	Program general inpatient routine service cost (line 9 x line 38)	935,946	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)	935,946	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	110,607	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,046,553	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	48,964	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,435	51
52	Total Program excludable cost (sum of lines 50 and 51)	53,399	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	993,154	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-T158****WORKSHEET D-1****PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,190	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,190	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	4,190	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,190	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	4,486,789	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,486,789	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,486,789	37

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-T158****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	1,070.83	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,345,118	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)	2,345,118	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,131,819	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	3,476,937	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	104,375	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	58,377	51
52	Total Program excludable cost (sum of lines 50 and 51)	162,752	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	3,314,185	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0158****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	43,295	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	43,295	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)	37,454	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,025	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	3,076	15
16	Nursery days (title V or XIX only)	1,160	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)	53,705,718	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	53,705,718	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	53,705,718	37

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0158****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,240.46 38
39	Program general inpatient routine service cost (line 9 x line 38)						4,992,852 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)						4,992,852 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)	174,191	3,076	56.63	1,160	65,691	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	9,405,471	3,944	2,384.75	438	1,044,521	43
44	Coronary Care Unit	2,942,354	1,444	2,037.64	103	209,877	44
44.01	NURSERY INTENSIVE CARE CENTER	4,340,463	1,840	2,358.95	851	2,007,466	44.01
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					8,320,407	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					441,797	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					441,797	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0158

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P
☐ Title XVIII, Part A
☒ Title XIX - I/P

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					5,841	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,240.46	88
89	Observation bed cost (line 87 x line 88) (see instructions)					7,245,527	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	2,833,135	53,705,718	0.052753	7,245,527	382,223	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-S158****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,282	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,282	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)	7,282	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,040	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,416,298	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,416,298	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,416,298	37

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S158

**WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		1
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,018.44 38
39	Program general inpatient routine service cost (line 9 x line 38)	1,059,178 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)	1,059,178 41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,059,178 49
PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	55,411 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	51
52	Total Program excludable cost (sum of lines 50 and 51)	55,411 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	53
TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges	54
55	Target amount per discharge	55
56	Target amount (line 54 x line 55)	56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	57
58	Bonus payment (see instructions)	58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.	59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.	60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	61
62	Relief payment (see instructions)	62
63	Allowable Inpatient cost plus incentive payment (see instructions)	63
PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	69

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-T158****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,190	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,190	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	4,190	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,181	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	4,656,772	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,656,772	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,656,772	37

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-T158****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	1,111.40	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,312,563	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)	1,312,563	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,312,563	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	56,286	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	56,286	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		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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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0158

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		23,204,478		30
31	Intensive Care Unit		4,015,009		31
32	Coronary Care Unit		1,499,431		32
32.01	NURSERY INTENSIVE CARE CENTER				32.01
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.567182	2,443,174	1,385,724	50
50.01	GI LAB	0.302365	594,292	179,693	50.01
51	Recovery Room	0.378129	317,830	120,181	51
52	Delivery Room & Labor Room	0.494345	13,502	6,675	52
53	Anesthesiology	0.129702	383,637	49,758	53
54	Radiology-Diagnostic	0.168793	3,667,015	618,966	54
54.01	MRI CENTER				54.01
55	Radiology-Therapeutic	0.138374	106,223	14,699	55
56	Radioisotope	0.162046	640,439	103,781	56
57	CT Scan	0.048181	5,462,450	263,186	57
58	MRI	0.528294	992,066	524,103	58
59	Cardiac Catheterization	0.117328	11,012,812	1,292,111	59
60	Laboratory	0.144953	16,309,448	2,364,103	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.172489	5,361,331	924,771	65
66	Physical Therapy	0.498855	614,405	306,499	66
67	Occupational Therapy	0.491659	213,047	104,746	67
68	Speech Pathology	0.410014	271,735	111,415	68
70	Electroencephalography	0.771568	77,575	59,854	70
71	Medical Supplies Charged to Patients	0.371652	3,171,567	1,178,719	71
72	Impl. Dev. Charged to Patients	0.521876	2,997,376	1,564,259	72
73	Drugs Charged to Patients	0.403109	6,392,832	2,577,008	73
74	Renal Dialysis	0.757240	848,849	642,782	74
76	EMG	0.550720			76
76.01	CARDIOVASCULAR LAB				76.01
76.02	MERCY EYE CENTER	0.877537			76.02
76.03	MERCY ENT				76.03
76.04	WOUND CARE CENTER	0.842994	557	470	76.04
76.05	CARDIAC REHAB				76.05
76.06	PRE-BIRTH CENTER	0.147920	2,403	355	76.06
76.07	SLEEP LAB	0.259399	2,460	638	76.07
76.08	UROLOGY	6.466708			76.08
76.09	ADDP OP	4.405501			76.09
76.10	PSYCH PARTIAL HOSPITAL	0.089998			76.10
76.11	DIABETES TREATMENT	1.276660			76.11
76.12	MENTAL HEALTH CENTER	0.787760	53	42	76.12
76.13	VEIN CLINIC				76.13
76.97	CARDIAC REHABILITATION	0.344341	104	36	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	MERCY CLINICS	3.466975	680	2,358	90.01
90.02	MERCY CLINIC STATE ST				90.02
90.03	MERCY CLINIC POLK ST				90.03
91	Emergency	0.237938	4,461,727	1,061,614	91
92	Observation Beds (Non-Distinct Part)	0.678187	836,533	567,326	92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		67,196,122	16,025,872	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		67,196,122		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S158

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
32	Coronary Care Unit				32
32.01	NURSERY INTENSIVE CARE CENTER				32.01
40	Subprovider - IPF		1,518,289		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.567182			50
50.01	GI LAB	0.302365			50.01
51	Recovery Room	0.378129			51
52	Delivery Room & Labor Room	0.494345			52
53	Anesthesiology	0.129702			53
54	Radiology-Diagnostic	0.168793	7,974	1,346	54
54.01	MRI CENTER				54.01
55	Radiology-Therapeutic	0.138374			55
56	Radioisotope	0.162046	16,814	2,725	56
57	CT Scan	0.048181	13,860	668	57
58	MRI	0.528294			58
59	Cardiac Catheterization	0.117328	41,430	4,861	59
60	Laboratory	0.144953	154,280	22,363	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.172489	3,742	645	65
66	Physical Therapy	0.498855	572	285	66
67	Occupational Therapy	0.491659			67
68	Speech Pathology	0.410014			68
70	Electroencephalography	0.771568			70
71	Medical Supplies Charged to Patients	0.371652			71
72	Impl. Dev. Charged to Patients	0.521876			72
73	Drugs Charged to Patients	0.403109	64,320	25,928	73
74	Renal Dialysis	0.757240			74
76	EMG	0.550720			76
76.01	CARDIOVASCULAR LAB				76.01
76.02	MERCY EYE CENTER	0.877537			76.02
76.03	MERCY ENT				76.03
76.04	WOUND CARE CENTER	0.842994			76.04
76.05	CARDIAC REHAB				76.05
76.06	PRE-BIRTH CENTER	0.147920			76.06
76.07	SLEEP LAB	0.259399			76.07
76.08	UROLOGY	6.466708			76.08
76.09	ADDP OP	4.405501			76.09
76.10	PSYCH PARTIAL HOSPITAL	0.089998			76.10
76.11	DIABETES TREATMENT	1.276660			76.11
76.12	MENTAL HEALTH CENTER	0.787760	300	236	76.12
76.13	VEIN CLINIC				76.13
76.97	CARDIAC REHABILITATION	0.344341			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	MERCY CLINICS	3.466975			90.01
90.02	MERCY CLINIC STATE ST				90.02
90.03	MERCY CLINIC POLK ST				90.03
91	Emergency	0.237938	216,654	51,550	91
92	Observation Beds (Non-Distinct Part)	0.678187			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		519,946	110,607	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		519,946		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T158

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
32	Coronary Care Unit				32
32.01	NURSERY INTENSIVE CARE CENTER				32.01
40	Subprovider - IPF				40
41	Subprovider - IRF		3,363,312		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.567182			50
50.01	GI LAB	0.302365			50.01
51	Recovery Room	0.378129	548	207	51
52	Delivery Room & Labor Room	0.494345			52
53	Anesthesiology	0.129702			53
54	Radiology-Diagnostic	0.168793	50,622	8,545	54
54.01	MRI CENTER				54.01
55	Radiology-Therapeutic	0.138374			55
56	Radioisotope	0.162046	5,690	922	56
57	CT Scan	0.048181	63,403	3,055	57
58	MRI	0.528294	2,039	1,077	58
59	Cardiac Catheterization	0.117328	14,008	1,644	59
60	Laboratory	0.144953	305,295	44,253	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.172489	89,121	15,372	65
66	Physical Therapy	0.498855	798,429	398,300	66
67	Occupational Therapy	0.491659	802,241	394,429	67
68	Speech Pathology	0.410014	292,306	119,850	68
70	Electroencephalography	0.771568			70
71	Medical Supplies Charged to Patients	0.371652	38,049	14,141	71
72	Impl. Dev. Charged to Patients	0.521876	219	114	72
73	Drugs Charged to Patients	0.403109	267,157	107,693	73
74	Renal Dialysis	0.757240	28,275	21,411	74
76	EMG	0.550720			76
76.01	CARDIOVASCULAR LAB				76.01
76.02	MERCY EYE CENTER	0.877537			76.02
76.03	MERCY ENT				76.03
76.04	WOUND CARE CENTER	0.842994			76.04
76.05	CARDIAC REHAB				76.05
76.06	PRE-BIRTH CENTER	0.147920			76.06
76.07	SLEEP LAB	0.259399			76.07
76.08	UROLOGY	6.466708			76.08
76.09	ADDP OP	4.405501			76.09
76.10	PSYCH PARTIAL HOSPITAL	0.089998			76.10
76.11	DIABETES TREATMENT	1.276660			76.11
76.12	MENTAL HEALTH CENTER	0.787760			76.12
76.13	VEIN CLINIC				76.13
76.97	CARDIAC REHABILITATION	0.344341			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	MERCY CLINICS	3.466975			90.01
90.02	MERCY CLINIC STATE ST				90.02
90.03	MERCY CLINIC POLK ST				90.03
91	Emergency	0.237938	3,386	806	91
92	Observation Beds (Non-Distinct Part)	0.678187			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,760,788	1,131,819	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,760,788		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,239,016			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	19,177,096			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	544,143			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	11,211,957			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	187.00			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)	87.01			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	-2.25			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)	16.00			8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	100.76			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	101.67			10
11	FTE count for residents in dental and podiatric programs	6.00			11
12	Current year allowable FTE (see instructions)	106.76			12
13	Total allowable FTE count for the prior year	107.72			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	109.21			14
15	Sum of lines 12 through 14 divided by 3	107.90			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	107.90			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.577005			19
20	Prior year resident to bed ratio (see instructions)	0.536750			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.536750			21
22	IME payment adjustment (see instructions)	6,265,199			22
22.01	IME payment adjustment - Managed Care (see instructions)	2,876,999			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)	0.91			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	6,265,199			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	2,876,999			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1392			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.3713			31
32	Sum of lines 30 and 31	0.5105			32
33	Allowable disproportionate share percentage (see instructions)	0.3133			33
34	Disproportionate share adjustment (see instructions)	1,912,392			34
	Prior to			On or after	
	October 1 (1.00)		(1.01)	October 1 (2.00)	
	Uncompensated Care Adjustment				
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000545053	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	4,295,779		3,688,208	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,082,773		2,758,577	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,841,350			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
47	Subtotal (see instructions)	36,979,196			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	39,856,195			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	2,824,807			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	3,504,361			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	6,286			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	46,191,649			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	46,191,649			61
62	Deductibles billed to program beneficiaries	2,308,496			62
63	Coinsurance billed to program beneficiaries	377,861			63
64	Allowable bad debts (see instructions)	1,436,881			64
65	Adjusted reimbursable bad debts (see instructions)	933,973			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	856,515			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	44,439,265			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	6,312			70.93
70.94	HRR adjustment amount (see instructions)	-320,042			70.94
70.99	HAC adjustment amount (see instructions)	423,735			70.99
71	Amount due provider (see instructions)	43,701,800			71
71.01	Sequestration adjustment (see instructions)	874,036			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	45,335,105			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-2,507,341			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	1,265,277			75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1		
100	HSP bonus amount (see instructions)				100
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION**EXHIBIT 5**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to October 1		On or After October 1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	5,239,016	5,239,016				5,239,016	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	19,177,096			19,177,096		19,177,096	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges	544,143	136,036		408,107		544,143	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	11,211,957	2,802,989		8,408,968		11,211,957	4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21	0.536750	0.536750		0.536750			5
6	IME payment adjustment	6,265,199	1,344,337		4,920,862		6,265,199	6
6.01	IME payment adjustment for managed care	2,876,999	719,250		2,157,749		2,876,999	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)	6,265,199	1,344,337		4,920,862		6,265,199	9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	2,876,999	719,250		2,157,749		2,876,999	9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage	0.3133	0.3133	0.3133	0.3133	0.3133		10
11	Disproportionate share adjustment	1,912,392	410,346		1,502,046		1,912,392	11
11.01	Uncompensated care payments	3,841,350	1,082,773		2,758,577		3,841,350	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	36,979,196	8,212,508		28,766,688		36,979,196	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)							14
15	Total payment for inpatient operating costs SCH and MDH only	39,856,195	8,931,758		30,924,437		39,856,195	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	2,824,807	706,201		2,118,606		2,824,807	16
17	Special add-on payments for new technologies	6,286	1,547		4,739		6,286	17
17.01	DO NOT USE THIS LINE							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL		9,639,506		33,047,782		42,687,288	19
20	Capital DRG other than outlier	1,985,922	496,480		1,489,442		1,985,922	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	71,525	17,881		53,644		71,525	21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage	27.7500	27.7500		27.7500			22
23	Indirect medical education adjustment	551,093	137,773		413,320		551,093	23
24	Allowable disproportionate share percentage	0.1089	0.1089		0.1089			24
25	Disproportionate share adjustment	216,267	54,067		162,200		216,267	25
26	Total prospective capital payments	2,824,807	706,201		2,118,606		2,824,807	26
27								27
28	Low volume adjustment prior to October 1							28
29	Low volume adjustment on or after October 1							29
30	HVBP payment adjustment	6,312	4,734		1,578		6,312	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-320,042	-240,031		-80,011		-320,042	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment		94,042		329,693		423,735	32

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-0158****WORKSHEET E
PART B**Check applicable box: ☒ **Hospital** ☐ **IPF** ☐ **IRF** ☐ **SUB (Other)** ☐ **SNF****PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	10,274			1
2	Medical and other services reimbursed under OPPS (see instructions)	14,862,090			2
3	OPPS payments	12,117,746			3
4	Outlier payment (see instructions)	63,429			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	10,274			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	25,486			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	25,486			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)	25,486			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	15,212			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	10,274			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	12,181,175			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,433,999			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	9,757,450			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	1,365,452			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	11,122,902			30
31	Primary payer payments	4,676			31
32	Subtotal (line 30 minus line 31)	11,118,226			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)	829,474			34
35	Adjusted reimbursable bad debts (see instructions)	539,158			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	508,744			36
37	Subtotal (see instructions)	11,657,384			37
38	MSP-LCC reconciliation amount from PS&R	-163			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	11,657,547			40
40.01	Sequestration adjustment (see instructions)	233,151			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	11,536,703			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-112,307			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-S158****WORKSHEET E
PART B**Check applicable box: ☐ Hospital ☒ IPF ☐ IRF ☐ SUB (Other) ☐ SNF**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.850			5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				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, col. 4, line 69)				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 (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				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 minus 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 (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-T158****WORKSHEET E
PART B**Check applicable box: ☐ Hospital ☐ IPF ☒ IRF ☐ SUB (Other) ☐ SNF**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.850			5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				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, col. 4, line 69)				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 (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				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 minus 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 (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**COMPONENT CCN: 14-0158****WORKSHEET E-1****PART I**

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

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
1			1	2	3	4
1	Total interim payments paid to provider			45,884,914		11,492,164
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				06/25/2018	44,539
		.01				3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51	06/25/2018	549,809		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		-549,809		44,539
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)			45,335,105		11,536,703
						4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01				6.01
		.02		-2,507,341		-112,307
7	Total Medicare program liability (see instructions)			42,827,764		11,424,396
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
COMPONENT CCN: 14-S158
**WORKSHEET E-1
PART I**

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

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
1			1	2	3	4
1	Total interim payments paid to provider			769,131		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					3.01
	amount based on subsequent revision of the interim					3.02
	rate for the cost reporting period. Also show date of	Program				3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to				3.04
		Provider				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		Provider				3.52
		to				3.53
		Program				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					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)			769,131		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment					5.01
	after desk review. Also show date of each payment.					5.02
	If none, write 'NONE' or enter a zero. (1)	Program				5.03
		to				5.04
		Provider				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		Provider				5.52
		to				5.53
		Program				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	Determined net settlement amount (balance due)			34,153		6.01
	based on the cost report (1)					6.02
7	Total Medicare program liability (see instructions)			803,284		7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
COMPONENT CCN: 14-T158
**WORKSHEET E-1
PART I**

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

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
1			1	2	3	4
1	Total interim payments paid to provider			4,071,345		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
		.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
		.52				3.52
		.53				3.53
		.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
		.99				3.99
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					
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)			4,071,345		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
		.03				5.03
		.04				5.04
		.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		.52				5.52
		.53				5.53
		.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
		.99				5.99
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					
6	Determined net settlement amount (balance due) based on the cost report (1)			-6,764		6.01
7	Total Medicare program liability (see instructions)			4,064,581		7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S158

WORKSHEET E-3
PART II

Check ☐ Hospital
Applicable ☒ Subprovider IPF
Box:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	950,884	1
2	Net IPF PPS Outlier payment	980	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 (see instructions)		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 42 CFR §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)	19.950685	9
10	Teaching adjustment factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$		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)	951,864	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	951,864	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	951,864	18
19	Deductibles	102,220	19
20	Subtotal (line 18 minus line 19)	849,644	20
21	Coinsurance	64,809	21
22	Subtotal (line 20 minus line 21)	784,835	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	53,605	23
24	Adjusted reimbursable bad debts (see instructions)	34,843	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,614	25
26	Subtotal (sum of lines 22 and 24)	819,678	26
27	Direct graduate medical education payments (from Wkst. 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
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	819,678	31
31.01	Sequestration adjustment (see instructions)	16,394	31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments	769,131	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	34,153	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T158

WORKSHEET E-3
PART III

Check ☐ Hospital
Applicable ☒ Subprovider IRF
Box:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	3,809,278		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.127300		2
3	Inpatient Rehabilitation LIP payments (see instructions)	361,500		3
4	Outlier payments	8,458		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	1.23		5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	11.479452		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	4,179,236		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	4,179,236		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	4,179,236		19
20	Deductibles	25,172		20
21	Subtotal (line 19 minus line 20)	4,154,064		21
22	Coinsurance	13,304		22
23	Subtotal (line 21 minus line 22)	4,140,760		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10,418		24
25	Adjusted reimbursable bad debts (see instructions)	6,772		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,249		26
27	Subtotal (sum of lines 23 and 25)	4,147,532		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	4,147,532		32
32.01	Sequestration adjustment (see instructions)	82,951		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	4,071,345		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	-6,764		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			36

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0158

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	8,320,407		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	8,320,407		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	8,320,407		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	2,459,906		8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	2,459,906		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	2,459,906		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	5,860,501		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	2,459,906		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	2,459,906		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	5,860,501		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,459,906		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)	2,459,906		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	2,459,906		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	2,459,906		40
41	Interim payments	2,459,906		41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S158

WORKSHEET E-3
PART VII

Check ☐ Title V ☐ Hospital ☐ NF ☐ PPS
 Applicable ☒ Title XIX ☒ Subprovider IPF ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☒ Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	1,059,178		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	1,059,178		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	1,059,178		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	1,059,178		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	1,059,178		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T158

WORKSHEET E-3
PART VII

Check ☐ Title V ☐ Hospital ☐ NF ☐ PPS
 Applicable ☒ Title XIX ☒ Subprovider IRF ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☒ Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	1,312,563		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	1,312,563		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	1,312,563		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	1,312,563		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	1,312,563		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

Check [] Title V
Applicable [XX] Title XVIII
Box: [] Title XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT						
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			88.01	1	
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2	
3	Amount of reduction to Direct GME cap under §422 of MMA				3	
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01	
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			-2.25	4	
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01	
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			17.00	4.02	
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			102.76	5	
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			101.83	6	
7	Enter the lesser of line 5 or line 6			101.83	7	
		Primary Care	Other	Total		
		1	2	3		
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	72.80	26.83	99.63	8	
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	72.80	26.83	99.63	9	
10	Weighted dental and podiatric resident FTE count for the current year		5.00		10	
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01	
11	Total weighted FTE count	72.80	31.83		11	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	73.02	33.10		12	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	68.30	33.87		13	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	71.37	32.93		14	
15	Adjustment for residents in initial years of new programs	0.00	0.00		15	
15.01	Unweighted adjustment for residents in initial years of new programs				15.01	
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16	
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01	
17	Adjusted rolling average FTE count	71.37	32.93		17	
18	Per resident amount	110,084.97	104,240.59		18	
19	Approved amount for resident costs	7,856,764	3,432,643	11,289,407	19	
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20	
21	Direct GME FTE unweighted resident count over cap (see instructions)				21	
22	Allowable additional direct GME FTE resident count (see instructions)				22	
23	Enter the locality adjustment national average per resident amount (see instructions)				23	
24	Multiply line 22 times line 23				24	
25	Total direct GME amount (sum of lines 19 and 24)			11,289,407	25	
COMPUTATION OF PROGRAM PATIENT LOAD						
26	Inpatient days (see instructions)	17,570	8,098		26	
27	Total inpatient days (see instructions)	56,852	56,852		27	
28	Ratio of inpatient days to total inpatient days	0.309048	0.142440		28	
29	Program direct GME amount	3,488,969	1,608,063		29	
30	Reduction for direct GME payments for Medicare Advantage		227,219		30	
31	Net Program direct GME amount			4,869,813	31	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)						
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32	
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			1,835,925	33	
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34	
35	Medicare outpatient ESRD charges (see instructions)				35	
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36	
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME						
Part A Reasonable Cost						
37	Reasonable cost (see instructions)			38,157,098	37	
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38	
39	Cost of physicians' services in a teaching hospital (see instructions)				39	
40	Primary payer payments (see instructions)				40	
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			38,157,098	41	
Part B Reasonable Cost						
42	Reasonable cost (see instructions)			14,872,364	42	
43	Primary payer payments (see instructions)			4,676	43	
44	Total Part B reasonable cost (line 42 minus line 43)			14,867,688	44	
45	Total reasonable cost (sum of lines 41 and 44)			53,024,786	45	
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.719609	46	
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.280391	47	
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B						
48	Total program GME payment (line 31)			4,869,813	48	
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			3,504,361	49	
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			1,365,452	50	

KPMG LLP Compu-Max 2552-10

MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**WORKSHEET E-4**

Check [] Title V
Applicable [] Title XVIII
Box: [XX] Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT			
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2
3	Amount of reduction to Direct GME cap under §422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6
7	Enter the lesser of line 5 or line 6			7
		Primary Care	Other	Total
		1	2	3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			10.01
11	Total weighted FTE count	0.00	0.00	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	
15	Adjustment for residents in initial years of new programs	0.00	0.00	
15.01	Unweighted adjustment for residents in initial years of new programs			15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure			16.01
17	Adjusted rolling average FTE count	0.00	0.00	
18	Per resident amount	0.00	0.00	
19	Approved amount for resident costs			
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	8,216	14,835	
27	Total inpatient days (see instructions)	56,852	56,852	
28	Ratio of inpatient days to total inpatient days	0.144516	0.260941	
29	Program direct GME amount			
30	Reduction for direct GME payments for Medicare Advantage			
31	Net Program direct GME amount			
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			
35	Medicare outpatient ESRD charges (see instructions)			
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME			
	Part A Reasonable Cost			
37	Reasonable cost (see instructions)			
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			
39	Cost of physicians' services in a teaching hospital (see instructions)			
40	Primary payer payments (see instructions)			
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			
	Part B Reasonable Cost			
42	Reasonable cost (see instructions)			
43	Primary payer payments (see instructions)			
44	Total Part B reasonable cost (line 42 minus line 43)			
45	Total reasonable cost (sum of lines 41 and 44)			
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B			
48	Total program GME payment (line 31)			
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			

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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 (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	-1,162,897				1
2	Temporary investments	9,766,991				2
3	Notes receivable					3
4	Accounts receivable	34,819,897				4
5	Other receivables	2,235,257				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	2,950,920				7
8	Prepaid expenses	1,469,281				8
9	Other current assets	9,269,340				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	59,348,789				11
	FIXED ASSETS					
12	Land	26,173,000				12
13	Land improvements	5,151,760				13
14	Accumulated depreciation	-2,016,522				14
15	Buildings	20,411,510				15
16	Accumulated depreciation	-1,442,617				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	54,495,340				23
24	Accumulated depreciation	-36,778,648				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)	65,993,823				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	16,012,627				34
35	Total other assets (sum of lines 31-34)	16,012,627				35
36	Total assets (sum of lines 11, 30 and 35)	141,355,239				36
	Liabilities and Fund Balances (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	11,924,137				37
38	Salaries, wages and fees payable	38,780,519				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	1,755,203				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	5,931,106				44
45	Total current liabilities (sum of lines 37 thru 44)	58,390,965				45
	LONG TERM LIABILITIES					
46	Mortgage payable	81,352,750				46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	501,445				49
50	Total long term liabilities (sum of lines 46 thru 49)	81,854,195				50
51	Total liabilities (sum of lines 45 and 50)	140,245,160				51
	CAPITAL ACCOUNTS					
52	General fund balance	1,110,079				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	1,110,079				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	141,355,239				60

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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		167,007,060		1
2	Net income (loss) (from Worksheet G-3, line 29)		-68,273,191		2
3	Total (sum of line 1 and line 2)		98,733,869		3
4	Additions (credit adjustments) (specify)				4
5					5
6		4,414,885			6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)		4,414,885		10
11	Subtotal (line 3 plus line 10)		103,148,754		11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		103,148,754		19

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

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	63,310,758		63,310,758	1
2	Subprovider IPF	7,980,992		7,980,992	2
3	Subprovider IRF	6,161,126		6,161,126	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)	77,452,876		77,452,876	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	10,336,531		10,336,531	11
12	Coronary Care Unit	3,044,794		3,044,794	12
12.01	NURSERY INTENSIVE CARE CENTER	8,916,929		8,916,929	12.01
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)	22,298,254		22,298,254	16
17	Total inpatient routine care services (sum of lines 10 and 16)	99,751,130		99,751,130	17
18	Ancillary services	208,849,381	296,492,452	505,341,833	18
19	Outpatient services		42,732,840	42,732,840	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	308,600,511	339,225,292	647,825,803	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		303,654,886	29
30	Add (specify)			30
31	OTHER NON OPER EXPENSES	108,878		31
32	TIF EXPENSES	1,197,731		32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		1,306,609	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)		304,961,495	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)	647,825,803	1
2	Less contractual allowances and discounts on patients' accounts	424,985,313	2
3	Net patient revenues (line 1 minus line 2)	222,840,490	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	304,961,495	4
5	Net income from service to patients (line 3 minus line 4)	-82,121,005	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	407,329	6
7	Income from investments	256,913	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	824,710	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		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (OTHER RENT REVENUE)	1,669,737	24
24.01	Other (CAPITATION REVENUE AND MGD CARE DIS)	6,921,261	24.01
24.02	Other (GRANTS)	1,856,878	24.02
24.03	Other (OTHER REVENUE)	132,602	24.03
24.04	Other (REFERRAL LAB)	99,034	24.04
24.05	Other (LAB REVENUE)		24.05
24.06	Other (CONTRACT REVENUE ACCESS COMMUNITY)		24.06
24.07	Other (COMMISSION REVENUE)		24.07
24.08	Other (EXPENSE REIMBURSEMENT)	435,261	24.08
24.09	Other (GAIN ON SALE OF EQUIPMENT)	46,358	24.09
24.10	Other (GENERAL MERCHANDISE REVENUE)		24.10
24.11	Other (OTHER NON OPER REVENUE)		24.11
24.12	Other (OTHER REVENUE PHYSICIANS OFFICES)		24.12
24.13	Other (TIF REVENUE)	1,197,731	24.13
25	Total other income (sum of lines 6-24)	13,847,814	25
26	Total (line 5 plus line 25)	-68,273,191	26
29	Net income (or loss) for the period (line 26 minus line 28)	-68,273,191	29

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0158

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	1,985,922	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	71,525	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)	124.33	3
4	Number of interns & residents (see instructions)	107.90	4
5	Indirect medical education percentage (see instructions)	27.75	5
6	Indirect medical education adjustment (see instructions)	551,093	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1392	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.3713	8
9	Sum of lines 7 and 8	0.5105	9
10	Allowable disproportionate share percentage (see instructions)	0.1089	10
11	Disproportionate share adjustment (see instructions)	216,267	11
12	Total prospective capital payments (see instructions)	2,824,807	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
32	Coronary Care Unit							32
32.01	NURSERY INTENSIVE CARE CENTER							32.01
40	Subprovider - IPF							40
41	Subprovider - IRF							41
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
50.01	GI LAB							50.01
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	MRI CENTER							54.01
55	Radiology-Therapeutic							55
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76	EMG							76
76.01	CARDIOVASCULAR LAB							76.01
76.02	MERCY EYE CENTER							76.02
76.03	MERCY ENT							76.03
76.04	WOUND CARE CENTER							76.04
76.05	CARDIAC REHAB							76.05
76.06	PRE-BIRTH CENTER							76.06
76.07	SLEEP LAB							76.07
76.08	UROLOGY							76.08
76.09	ADDP OP							76.09
76.10	PSYCH PARTIAL HOSPITAL							76.10
76.11	DIABETES TREATMENT							76.11
76.12	MENTAL HEALTH CENTER							76.12
76.13	VEIN CLINIC							76.13
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	MERCY CLINICS							90.01
90.02	MERCY CLINIC STATE ST							90.02
90.03	MERCY CLINIC POLK ST							90.03

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MERCY HOSPITAL & MEDICAL CENTER Provider CCN: 14-0158	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/30/2018 Run Time: 11:18 Version: 2018.04 (09/26/2018)
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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		
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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							
191	Research							191
192	Physicians' Private Offices							192
192.01	DNBAR CLINIC							192.01
192.02	PHILLIPS HEALTH							192.02
192.03	OTHER HOME HEALTH							192.03
192.04	VITAS HOSPICE							192.04
192.05	DOCTORS OFFICE							192.05
194	OTHER NONREIMBURSABLE COST CENTERS							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202