Heal th Financia	al Systems	ST JOSEPH MEDICAL	CENTER	In L	ieu of Form CMS-2552-10
This report is	required by law (42 USC 1395g since the beginning of the cos				im FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX CO SUMMARY	OST REPORT CERTIFICATION	Provi der CCN: 1500	047 Period: From 06/01/20 To 05/31/20	
PART I - COST	REPORT STATUS				
Provi der use only	1. [ X ] Electronically filed of 2. [ ] Manually submitted costs. [ 0 ] If this is an amended 4. [ F ] Medicare Utilization.	st report report enter the number of	fimes the provide	Date: 11/2/ er resubmitted this	
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened	7. Contractor No.	this Provider CCN		

PART II - CERTIFICATION

(5) Amended

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

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST JOSEPH MEDICAL CENTER (150047) for the cost reporting period beginning 06/01/2014 and ending 05/31/2015 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.

(Si gned)			
	Officer o	r Administrator	of Provider(s)
			• •
Title			
11 11 0			
Date			

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-150, 759	74, 545	-73, 576	0	1. 00
2.00	Subprovi der - IPF	0	6, 021	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	1, 037	0		0	7. 00
200.00	Total	0	-143, 701	74, 545	-73, 576	0	200. 00

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 and review the 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 the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX		EPH MEDICAL TA		der CCN:		Period: From 06/01/ To 05/31/	′2014 ′2015	of For Workshe Part I Date/Ti 10/30/2	et S-2 me Pre	pared:
	1.00	2.	00	3	3. 00			4. 00	10/ 30/ 2	013 3.0	JI DIII
	Hospital and Hospital Health Care Co										
1.00	Street: 700 BROADWAY STREET	PO Box:	N 7:	- 0	44000	0	ALLEN				1.00
2. 00	City: FORT WAYNE	State: I Component Na		p Code:	CBSA	Provi der	y: ALLEN Date	Paymer	nt Syste	-m (P	2. 00
		Component			Number	Type	Certified		0, or		
						31.		V	XVIII		
		1.00	2	. 00	3. 00	4.00	5. 00	6. 00	7. 00	8. 00	
	Hospital and Hospital-Based Componen						I			_	
3. 00	Hospi tal	ST JOSEPH MEDICAL CENTER	L   15	0047	23060	1	07/01/1996	N	P	Р	3. 00
4. 00	Subprovider - IPF	ST JOSPEH GENERA	TLONS 15	S047	23060	4	06/01/2003	N	P	Р	4. 00
5.00	Subprovider - IRF									·	5. 00
6.00	Subprovider - (Other)										6. 00
7. 00	Swing Beds - SNF										7. 00
8.00	Swing Beds - NF	CKILLED MUDGING	15	E3E4	22070		04/01/1990	l N	P	N.	8. 00
9. 00	Hospi tal -Based SNF	SKILLED NURSING FACILITY ST JOSEF		5356	23060		04/01/1990	N		N	9. 00
10.00	Hospi tal -Based NF	17,012111 31 30021	'''								10.00
11. 00	Hospi tal -Based OLTC										11.00
12. 00	Hospi tal -Based HHA										12.00
13.00	Separately Certified ASC										13.00
14. 00 15. 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14. 00 15. 00
16. 00	Hospital -Based Health Clinic - FQHC										16. 00
17. 00	Hospital-Based (CMHC) I										17. 00
18. 00	Renal Dialysis										18.00
19. 00	Other										19. 00
							From: 1.00		To: 2. 0		
20. 00	Cost Reporting Period (mm/dd/yyyy)						06/01/2		05/31/		20. 00
21. 00	Type of Control (see instructions)						00/01/2	4	00,01,	20.0	21. 00
	Inpatient PPS Information							<u>'</u>			
22. 00	Does this facility qualify and is it						Y		N		22. 00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en				. 00(0)(2	) (FICKIE					
22. 01	Did this hospital receive interim un				cost re	porting	N		Υ		22. 01
	period? Enter in column 1, "Y" for y										
	reporting period occurring prior to										
	for no for the portion of the cost r (see instructions)	eporting period o	occurring or	n or ar	ter ucto	ober I.					
22. 02	Is this a newly merged hospital that	requires final u	incompensate	ed care	payment	s to be	N		N		22. 02
	determined at cost report settlement	? (see instructio	ns) Enter i	n col u	mn 1, "Y	" for yes	5				
	or "N" for no, for the portion of th										
	in column 2, "Y" for yes or "N" for or after October 1.	no, for the porti	on of the o	cost re	porting	period or	ו				
22. 03	Did this hospital receive a geograph	ic reclassificati	on from urb	oan to	rural as	a result	. N		N		22. 03
	of the OMB standards for delineating										
	in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column cost reporting period occurring on o						9				
	hospital contain at least 100 but no						,				
	42 CFR 412.105)? Enter in column 3,				4000. 0						
23. 00	Which method is used to determine Me							3	N		23. 00
	1, enter 1 if date of admission, 2 i	<b>J</b> .			9						
	method of identifying the days in the used in the prior cost reporting per										
	, and the process of the second persons of t		In-State	In-Sta			Out-of N	ledi cai	d 0t	her	
			Medi cai d	Medi ca		tate		IMO day		i cai d	
			paid days	eligib			ledi cai d		d	ays	
				unpai days			el i gi bl e unpai d				
			1.00	2. 00		3. 00	4. 00	5. 00	6	. 00	
24. 00	If this provider is an IPPS hospital	, enter the	3, 374	2.00	379	18	4.00	3, 4			24. 00
	in-state Medicaid paid days in colum							-			
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in cout-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in										
25. 00	If this provider is an IRF, enter th	e in-state	O		0	0	0		0		25. 00
	Medicaid paid days in column 1, the										
	Medicaid eligible unpaid days in col out-of-state Medicaid days in column										
	Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid day										

care or general surgery. (see instructions)

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150047 Peri od: Worksheet S-2 From 06/01/2014 Part I Date/Time Prepared: 05/31/2015 10/30/2015 5:01 pm Program Name Program Code Unweighted IME Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 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. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of

unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 + column 4)). (see instructions)

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150047 Peri od: Worksheet S-2 From 06/01/2014 Part I Date/Time Prepared: 05/31/2015 10/30/2015 5:01 pm Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 0. 00 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 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) Program Name Unwei ghted Unwei ghted Ratio (col. 3/ Program Code FTFs FTEs in (col. 3 + colNonprovi der Hospi tal 4)) Si te 1.00 2 00 3. 00 4.00 5 00 67.00 Enter in column 1, the program 0.00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Υ Enter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 Ν Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) 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 or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 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 or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N 85.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

lealth Financial Systems		MEDICAL CENTER		- 15 .		eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENIIFICATION DATA	Provi der	CCN: 15004	7 Peri From To	od: n 06/01/2014 05/31/2015	Date/Time Pr	epared:
						10/30/2015 5	5: 01 pm
					1. 00	2. 00	
28.00 If this is a Medicare certified li in column 1 and termination date,	•		ication da	ite			128. 0
29.00 If this is a Medicare certified I	ung transplant center,	enter the certifi	cation dat	e in			129. 00
column 1 and termination date, if 30.00 of this is a Medicare certified page 20.00 ft.			ti fi cati on	,			130. 0
date in column 1 and termination of	date, if applicable, i	n column 2.					
31.00 If this is a Medicare certified in date in column 1 and termination (			certi fi cati	on			131. 0
32.00 If this is a Medicare certified is	slet transplant center	, enter the certif	ication da	ite			132. 0
in column 1 and termination date, 33.00 of this is a Medicare certified o			ication da	ite			133. 0
in column 1 and termination date,				,			124.0
34.00 If this is an organ procurement or and termination date, if applicable		er the UPO number	in column	1			134. 0
All Providers	a or home office costs	as defined in CMS	Dub 1E 1		Υ	679005	140. 0
40.00 Are there any related organization chapter 10? Enter "Y" for yes or '					ī	679005	140.0
are claimed, enter in column 2 the	e home office chain nu	mber. (see instruc 2.00	ctions)		3. 00		
If this facility is part of a cha	n organi zati on, enter		ough 143 th	ne name		of the	
home office and enter the home of 41.00 Name: COMMUNITY HEALTH SYSTEMS	fice contractor name a			actor's	Number: 1030	21	141. 0
42.00 Street: 4000 MERIDIAN BLVD	PO Box:	e. wrs, TNC.	Conti	actor 5	Number . 1030	J1	142. 0
43.00 Ci ty: FRANKLI N	State:	TN	Zi p C	ode:	370	57 T	143. 0
						1.00	
44.00 Are provider based physicians' cos			acata far	i nno+i o	n+ 00m/1000	Y	144. 0
45.00 If costs for renal services are clonly? Enter "Y" for yes or "N" for		Tine 74, are the	COSTS FOR	inpatie	nt services	Y	145. 0
· · ·					1 00	0.00	
46.00 Has the cost allocation methodolog	gy changed from the pr	eviously filed cos	st report?		1. 00 N	2. 00	146. 00
Enter "Y" for yes or "N" for no in		ub. 15-2, § 4020)	If yes, en	iter			
the approval date (mm/dd/yyyy) in 47.00Was there a change in the statisti		for yes or "N" for	no.		N		147. 0
48.00 Was there a change in the order of	allocation? Enter "Y	" for yes or "N" f	or no.		N		148. 0
49.00 Was there a change to the simplifino.	ed cost finding metho	a? Enter Y for S	es or N	TOF	N		149. 0
		Part A 1.00	Part 2.00		Title V 3.00	Title XIX 4.00	_
Does this facility contain a prov	der that qualifies fo						
or charges? Enter "Y" for yes or	'N" for no for each co			B. (See		3. 13) N	155.0
55.00 Hospital 56.00 Subprovider - IPF		N N	N N		N N	N N	155. 0 156. 0
57.00 Subprovi der - IRF		N	N		N	N	157. 0
58. 00 SUBPROVI DER 59. 00 SNF		N	N		N	N	158. 0 159. 0
60.00 HOME HEALTH AGENCY		N	N		N	N	160. 0
61. 00 CMHC			l N		N	N	161. 0
						1.00	
Multicampus 65.00 s this hospital part of a Multica	ampus hospital that ha	s one or more camr	ouses in di	fferent	CBSAs?	N	165. 0
Enter "Y" for yes or "N" for no.		<u> </u>					
	Name O	County 1.00	State 2.00	Zi p Co 3. 00		FTE/Campus 5.00	_
66.00 If line 165 is yes, for each	-						00 166. 0
campus enter the name in column 0, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
,						4.00	
Health Information Technology (HI	[) incentive in the Am	erican Recovery a	nd Reinvest	tment Ac	:t	1.00	
67.00 Is this provider a meaningful user	under Section §1886(	n)? Enter "Y" for	yes or "N	l" for n	Ο.	Y	167. 0
68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I			ne 167 is "	Y"), en	ter the		0168.00
69.00 If this provider is a meaningful of	user (line 167 is "Y")		(line 105	is "N")	, enter the	0.2	25 169. 0
transition factor. (see instruction	ons)						-

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	NTIFICATION DATA	Provi der CCN: 150047	Peri od:	Worksheet S-2	
			From 06/01/2014 To 05/31/2015		narod:
			10 03/31/2013	10/30/2015 5:	01 pm
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 06/01/2014 period respectively (mm/dd/yyyy)					170. 00
				1.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)					171. 00

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ST JOSEPH MEDICAL CENTER STIONNALRE Provider	CCN: 150047 F	Peri od:	eu of Form CMS- Worksheet S-:	
55111	AL AND HOSPITAL HEALTH CARE REINBURSEMENT QUE	311 ONNAI RE FI OVI dei	F	from 06/01/2014 o 05/31/2015	Part II Date/Time Pr	epared
				Y/N	10/30/2015 5 Date	: 01 pr
				1. 00	2. 00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format.	oonses. Enter N for all NO ro	esponses. Enter	all dates in	the 	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
00	Has the provider changed ownership immediatel	y prior to the beginning of	the cost	N		1.
	reporting period? If yes, enter the date of	the change in column 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in yes, enter in column 2 the date of termination		N			2.
	voluntary or "I" for involuntary.					
. 00	Is the provider involved in business transaction contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or the	, chain home offices, drug d to the provider or its , or members of the board	Y			3.
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
. 00	Financial Data and Reports  Column 1: Were the financial statements prepared to the column and the column are considered to the column and the column are column are column.	pared by a Certified Public	l N		1	4.0
. 00	Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled,				1.
. 00	column 3. (see instructions) If no, see instructions are the cost report total expenses and total		N			5.0
. 00	those on the filed financial statements? If y		IN IN			3. (
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
. 00	Column 1: Are costs claimed for nursing scho	ool? Column 2: If yes, is t	he provider is	N		6. (
. 00	the legal operator of the program? Are costs claimed for Allied Health Programs	? If "Y" see instructions.		N		7. (
. 00	Were nursing school and/or allied health prog	grams approved and/or renewe	d during the	N		8. (
. 00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program		st report? If	Υ		9. (
	yes, see instructions.					
0. 00	Was an Intern-Resident program been initiated period? If yes, see instructions.	d or renewed in the current	cost reporting	N		10.0
1. 00	Are GME cost directly assigned to cost center		proved	N		11. (
	Teaching Program on Worksheet A? If yes, see	Instructions.			Y/N	
					1. 00	
2. 00	Bad Debts Is the provider seeking reimbursement for bad	d debts? If yes, see instruc	tions.		Y	12. (
	If line 12 is yes, did the provider's bad del			t reporting	N	13. (
4. 00	period? If yes, submit copy.  If line 12 is yes, were patient deductibles a	and/or co-payments waived? I	f yes, see inst	ructions.	N	14. (
	Bed Complement					
5.00	Did total beds available change from the price	or cost reporting period? If		uctions. t A	N Part B	15. 0
		Description	Y/N	Date	Y/N	
				0 00	0 00	
	PS&R Data	0	1.00	2. 00	3. 00	
b. 00	PS&R Data 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			2.00	3. 00 Y	16.
6. 00 7. 00	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) Was the cost report prepared using the PS&R		1.00			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) 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		1. 00 Y		Y	
7. 00	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) 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) 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		1. 00 Y		Y	17.
	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) 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		1. 00 Y		Y N	

Health Financial Systems	ST JOSEPH MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period: From 06/01/2014 Fo 05/31/2015	Worksheet S-2 Part II Date/Time Pre 10/30/2015 5:	pared:
			Pa	rt A	Part B	
	Description	n	Y/N	Date	Y/N	
	0		1. 00	2. 00	3. 00	
21.00 Was the cost report prepared only using the provider's records? If yes, see			N		N	21. 00

	provider s records? IT yes, see					
	instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPI	TALS ONLY (EXCEPT CHILDRENS HO	OSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purpos	es? If yes, see instructions			N	22. 00
23.00	Have changes occurred in the Medicare deprec	iation expense due to appraisa	als made durin	the cost	N	23. 00
	reporting period? If yes, see instructions.			·		
24.00	Were new Leases and/or amendments to existin	g Leases entered into during	this cost repo	rting period?	N	24. 00
	If yes, see instructions	-	•			
25.00	Have there been new capitalized leases enter	ed into during the cost report	ting period? I	f yes, see	N	25. 00
	instructions.		0 .			
26.00	Were assets subject to Sec. 2314 of DEFRA acq	uired during the cost reporting	ng period? If	yes, see	N	26. 00
	instructions.					
27.00	Has the provider's capitalization policy cha	nged during the cost reporting	g period? If y	es, submit	N	27. 00
	copy.					
	Interest Expense					
28.00	Were new loans, mortgage agreements or lette	rs of credit entered into duri	ing the cost re	eporting	N	28. 00
	period? If yes, see instructions.					
29.00	00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)				N	29. 00
	treated as a funded depreciation account? If					
30.00	.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see				N	30.00
	instructions.					
31. 00	Has debt been recalled before scheduled matu	rity without issuance of new o	debt? If yes, :	see	N	31.00
	instructions.					
	Purchased Services					1
32. 00	Have changes or new agreements occurred in p		d through cont	ractual	N	32. 00
	arrangements with suppliers of services? If					
33. 00	If line 32 is yes, were the requirements of	Sec. 2135.2 applied pertaining	g to competiti	ve bidding? If	N	33. 00
	no, see instructions.					
	Provi der-Based Physi ci ans					1
34. 00	Are services furnished at the provider facil	ity under an arrangement with	provi der-base	d physi ci ans?	N	34. 00
	If yes, see instructions.					
35. 00	If line 34 is yes, were there new agreements	9 9	ts with the pr	ovi der-based	N	35. 00
	physicians during the cost reporting period?	If yes, see instructions.				
				Y/N	Date	
				1. 00	2. 00	
	Home Office Costs			1		
	Were home office costs claimed on the cost r			Υ		36. 00
37. 00	If line 36 is yes, has a home office cost st	atement been prepared by the h	nome office?	Υ		37. 00
	If yes, see instructions.					
38. 00	If line 36 is yes , was the fiscal year end	of the home office different t	from that of	Υ	12/31/2014	38. 00

		Y/N	Date	
		1. 00	2. 00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Υ		36. 00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office?	Υ		37. 00
	If yes, see instructions.			
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of	Υ	12/31/2014	38. 00
	the provider? If yes, enter in column 2 the fiscal year end of the home office.			
39. 00	If line 36 is yes, did the provider render services to other chain components? If yes,	N		39. 00
	see instructions.			
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see	N		40.00
	i nstructi ons.			
	1.00	2.	00	
	Cost Doport Droparor Contact Information			

	Joost Roport Froparci Goritage Fili of matron			I
41.00	Enter the first name, last name and the title/position	LISA	PARRI SH	41. 00
	held by the cost report preparer in columns 1, 2, and 3,			
	respecti vel y.			
42.00	Enter the employer/company name of the cost report	COMMUNITY HEALTH SYSTEMS		42.00
	preparer.			
43.00	Enter the telephone number and email address of the cost	6154657554	LI SA_PARRI SH@CHS. NET	43.00
	report preparer in columns 1 and 2, respectively.			

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lieu	u of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE	REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150047	Peri od:	Worksheet S-2

HUSPII	AL AND HOSPITAL HEALTH CARE RETMBURSEMENT QUE:	STIUNNALRE	Provider CCN: 150047	From 06/01/2014 To 05/31/2015		
		Part B				
		Date				
		4. 00				
	PS&R Data					
16.00	Was the cost report prepared using the PS&R	09/10/2015			16. C	00
	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)					
17.00	Was the cost report prepared using the PS&R				17. C	00
	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)					
18.00	If line 16 or 17 is yes, were adjustments				18. C	00
	made to PS&R Report data for additional					
	claims that have been billed but are not					
	included on the PS&R Report used to file					
	this cost report? If yes, see instructions.					
19.00	If line 16 or 17 is yes, were adjustments				19.0	00
	made to PS&R Report data for corrections of					
	other PS&R Report information? If yes, see					
	instructions.					
20.00	If line 16 or 17 is yes, were adjustments				20.0	00
	made to PS&R Report data for Other? Describe					
	the other adjustments:					
21.00	Was the cost report prepared only using the				21.0	00
	provider's records? If yes, see					
	i nstructi ons.					
			3. 00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title	e/position M/	ANGER, REVENUE MANAGEMENT		41. C	00
	held by the cost report preparer in columns 1	I, 2, and 3,				
	respecti vel y.					
42.00	Enter the employer/company name of the cost r	report			42.0	00
	preparer.					
43.00	Enter the telephone number and email address	of the cost			43. C	00
	report preparer in columns 1 and 2, respective	∕el y.				

| Period: | Worksheet S-3 | From 06/01/2014 | Part | To 05/31/2015 | Date/Time Prepared: Provi der CCN: 150047

					Т	o 05/31/2015	Date/Time Prep 10/30/2015 5:0	
							I/P Days / 0/P	J I DIII
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	30portot	Line Number		0. 2000	Avai I abl e	57 HT 110 GT 5		
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		101			0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			101	32, 850	0.00	0	7. 00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT	31. 00		8	6, 935		0	8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	31. 01		C	0	0.00	0	8. 01
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00		12	4, 380	0.00	0	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13. 00
14.00	Total (see instructions)			121	44, 165	0.00	0	14.00
15.00	CAH visits	40.00		0.0	40.050		0	15.00
16.00	SUBPROVI DER - I PF	40. 00		30	10, 950		0	16.00
17. 00	SUBPROVI DER - I RF							17. 00
18.00	SUBPROVI DER	44.00		2.1	7 //5			18.00
19.00	SKILLED NURSING FACILITY	44. 00		21	7, 665		0	19.00
20. 00 21. 00	NURSING FACILITY							20. 00 21. 00
	OTHER LONG TERM CARE							21.00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24. 00	HOSPICE							24. 00
24. 00	HOSPICE (non-distinct part)	30. 00						24. 00
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			172	,			27. 00
28. 00	Observation Bed Days			172			0	28. 00
29. 00	Ambulance Trips						O	29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			C	0			32. 00
32. 00	Total ancillary labor & delivery room				]			32. 00
02.01	outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days		1		1			33.00
	1	1	'		1	1	'	

Provider CCN: 150047

				Т	o 05/31/2015	Date/Time Pre 10/30/2015 5:	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 369	1, 963	25, 508			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	3, 822	4, 348				2.00
3. 00	HMO IPF Subprovider	862	0				3.00
4.00	HMO IRF Subprovider	0	O				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	O	O	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	5, 369	1, 963	25, 508			7. 00
0.00	beds) (see instructions)	400	0.4	4 4/7			0.00
8.00	INTENSIVE CARE UNIT	423	81	1, 167			8. 00
8. 01 9. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0			8. 01 9. 00
10.00	BURN INTENSIVE CARE UNIT	162	207	1, 072			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	102	207	1,072			11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		811	1, 853			13. 00
14.00	Total (see instructions)	5, 954	3, 062	29, 600		561. 51	14. 00
15.00	CAH visits	O	0	0			15. 00
16. 00	SUBPROVI DER - I PF	4, 052	532	8, 539	0. 00	13. 49	
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER	4 000				07.00	18. 00
19. 00	SKILLED NURSING FACILITY	1, 902	0	4, 847	0. 00	27. 80	
20. 00 21. 00	NURSING FACILITY						20. 00 21. 00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )		•				23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	o	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				5. 14	602.80	
28. 00	Observation Bed Days		0	2, 513			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			Ü			32. 01
33 00	LTCH non-covered days	o	ŀ				33. 00
55. 50		١	1			ı	, 55. 55

| Period: | Worksheet S-3 | From 06/01/2014 | Part | To 05/31/2015 | Date/Time Prepared: Health Financial Systems ST JOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 150047

					To	05/31/2015	Date/Time Prep 10/30/2015 5:0	
		Full Time Equivalents	<u>'</u>		Di scha	arges		
	Component	Nonpai d Workers	Title V		Title XVIII	Title XIX	Total All Patients	
		11.00	12.00		13.00	14.00	15. 00	
1. 00	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)			0	1, 195	1, 273	5, 032	1. 00
2. 00 3. 00 4. 00 5. 00 6. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF				0	O		2. 00 3. 00 4. 00 5. 00 6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)							7. 00
8. 01 9. 00 10. 00 11. 00 12. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							8. 01 9. 00 10. 00 11. 00 12. 00
13. 00 14. 00	NURSERY Total (see instructions)	0. 00		0	1, 195	1, 273	5, 032	13. 00 14. 00
15. 00 16. 00 17. 00 18. 00	CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	0.00		0	331	108	715	15. 00 16. 00 17. 00 18. 00
19. 00 20. 00 21. 00 22. 00 23. 00 24. 00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE	0.00						19. 00 20. 00 21. 00 22. 00 23. 00 24. 00
24. 10 25. 00 26. 00 26. 25	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER							24. 10 25. 00 26. 00 26. 25
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0.00						27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33.00	LTCH non-covered days	1		- 1		1		33. 00

| Peri od: | Worksheet S-3 | From 06/01/2014 | Part II | To 05/31/2015 | Date/Time Prepared: | 100/2014 | Fold Feet | 100/2014 | Fold Fee Provider CCN: 150047

					To	05/31/2015	Date/Time Prep 10/30/2015 5:0	
		Worksheet A		Recl assi fi cati			Average Hourly	ў., р
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col . 4	COI . 3)	
	DADT II WACE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	33, 385, 826	0	33, 385, 826	1, 253, 830. 00	26. 63	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
2.00	A		9			0.00	0.00	2.00
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4.00	Physician-Part A -		0	0	О	0.00	0. 00	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0		0.00	0. 00	4. 01
5. 00	Physician-Part B		0	Ö	Ö	0.00		
6.00	Non-physician-Part B	21. 00	0	0	0	0.00		
7. 00	Interns & residents (in an approved program)	21.00	U			0. 00	0.00	7.00
7. 01	Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)							
8.00	Home office personnel	44.00	0	0	0	0.00	0.00	
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	1, 054, 861 1, 370, 739	0 187, 055	, ,	35, 377. 00 64, 397. 00		
	instructions)			,				
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		0	0	0	0.00	0.00	11. 00
11.00	Care		0					11.00
12. 00	Contract labor: Top level management and other		0	0	0	0. 00	0. 00	12. 00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		89, 113	0	89, 113	655. 00	136. 05	12 00
13.00	A - Administrative		09, 113		09, 113	655.00	130.03	13.00
14. 00	Home office salaries & wage-related costs		1, 830, 569	0	1, 830, 569	29, 250. 00	62. 58	14. 00
15. 00	Home office: Physician Part A		0	0	0	0.00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0.00	16. 00
10.00	Physicians Part A - Teaching		0			0.00	0.00	10.00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		6, 162, 332	0	6, 162, 332			17. 00
17.00	instructions)		0, 102, 332		0, 102, 332			17.00
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00	Excluded areas		547, 744	0	547, 744			19. 00
20. 00	Non-physician anesthetist Part		0	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A -		0	0				22. 00
22.00	Administrative		0					22.00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0				22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	0				24. 00
25. 00	Interns & residents (in an		0	0	0			25. 00
	approved program)  OVERHEAD COSTS - DIRECT SALARIE	TS .						
26. 00	Employee Benefits Department	4. 00	235, 236		·	7, 926. 00		
27. 00 28. 00	Administrative & General Administrative & General under	5. 00	4, 433, 456 0	170, 758 0	4, 604, 214 0	179, 069. 00 0. 00		
	contract (see inst.)		_	_				
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	0 1, 010, 906	)   0		0. 00 48, 421. 00		
31. 00	Laundry & Linen Service	8. 00	2, 866	-2, 866	0	0.00		
32. 00 33. 00	Housekeeping under contract	9. 00	593, 435	0	593, 435	51, 348. 00 0. 00		
	(see instructions)		0					
34. 00 35. 00	Di etary Di etary under contract (see	10. 00	0	0	0	0. 00 0. 00		
33.00	instructions)		U			0.00	0.00	33.00
36.00	Cafeteria	11. 00	0	0	0	0. 00 0. 00		
37. 00 38. 00	Maintenance of Personnel Nursing Administration	12. 00 13. 00	1, 804, 852	0		54, 283. 00		
39. 00	Central Services and Supply	14. 00	354, 947	-354, 947	0	0.00	0. 00	39. 00
40. 00	Pharmacy	15. 00	1, 401, 563	0	1, 401, 563	35, 698. 00	39. 26	40. 00

Health Financial Systems		ST JOSEPH MED	OLCAL CENTER		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	F	Period: From 06/01/2014 To 05/31/2015		pared:
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
		·	(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2. 00	3.00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	466, 025	0	466, 025	26, 066. 00	17. 88	41.00
Records Library							
42.00 Social Service	17. 00	0	0	(	0.00	0.00	42.00
43.00 Other General Service	18. 00	0	0	(	0.00	0.00	43. 00

Worksheet A Line Number Reported on of Salaries Salaries Related to Wage (col. 4 ÷ (from (col. 2 ± col. Salaries in col. 5)	
(from   (col.2 ± col.   Salaries in   col. 5)	
Worksheet A-6) 3) col. 4	
1.00 2.00 3.00 4.00 5.00 6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY	
1.00 Net salaries (see   33,385,826 0 33,385,826 1,253,830.00 26.60	1.00
instructions)	
2. 00 Excluded area salaries (see 2, 425, 600 187, 055 2, 612, 655 99, 774. 00 26. 10	2.00
instructions)	
3. 00   Subtotal salaries (line 1   30, 960, 226   -187, 055   30, 773, 171   1, 154, 056. 00   26. 67	3.00
minus line 2)	
4.00   Subtotal other wages & related   1,919,682   0   1,919,682   29,905.00   64.10	4.00
costs (see inst.)	
5.00   Subtotal wage-related costs   6,162,332   0 6,162,332   0.00   20.00	5.00
(see inst.)	
6.00   Total (sum of lines 3 thru 5)   39,042,240   -187,055   38,855,185   1,183,961.00   32.82	6.00
7. 00 Total overhead cost (see   10, 303, 286 -187, 055 10, 116, 231 402, 811. 00 25. 1	7.00
instructions)	

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150047	Period: Worksheet S-3 From 06/01/2014 Part IV

PART IV - WAGE RELATED COSTS   1.00		To 05/31/2015	Date/Time Prep 10/30/2015 5:0	
PART IV - WAGE RELATED COSTS   Part A - Core List   RETIREMENT COST   Separation   Separation			Amount	
PART IV - WAGE RELATED COSTS   Part A - Core List   RETIREMENT OOST			Reported	
Part A - Core List   RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2. 00   Tax Sheltered Annuity (TSA) Employer Contribution   0   0. 0		RETI REMENT COST		
3. 00   Nonqualified Defined Benefit Plan Cost (see instructions)   0   0. 0	1.00	401K Employer Contributions	579, 406	1.00
3. 00   Nonqualified Defined Benefit Plan Cost (see instructions)   0   0. 0	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
A.00	3.00		ol	3.00
PLAN ADMINI STRATIVE COSTS (Paid to External Organization)	4.00		0	4. 00
S. 00			_	
The color of the	5.00		0	5. 00
The color of the	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
HEALTH AND INSURANCE COST	7.00		0	7. 00
9.00   Prescription Drug Plan   0   9.00   10.00   Dental   Hearing and Vision Plan   51,829   10.00   11.00   Life Insurance (If employee is owner or beneficiary)   25,184   11.00   12.00   Accident Insurance (If employee is owner or beneficiary)   -567   12.00   13.00   Disability Insurance (If employee is owner or beneficiary)   15,187   13.00   14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   15.00   Workers' Compensation Insurance   531,578   15.00   16.00   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0   16.00   Non cumulative portion)   TAXES				
10.00   Dental, Hearing and Vision Plan   51,829   10.00     11.00   Life Insurance (If employee is owner or beneficiary)   25,184   11.00     12.00   Accident Insurance (If employee is owner or beneficiary)   -567   12.00     13.00   Disability Insurance (If employee is owner or beneficiary)   15,187   13.00     14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00     15.00   Workers' Compensation Insurance   531,578   15.00     16.00   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0     Non cumulative portion)   1,887,414     17.00   FICA-Employers Portion Only   441,411   18.00     19.00   Unemployment Insurance   0   19.00     20.00   State or Federal Unemployment Taxes   258,277     20.00   OTHER   20.00     21.00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see   0   21.00     21.00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see   0   22.00     23.00   Total Wage Related cost (Sum of Lines 1 -23)   Part B - Other than Core Related Cost	8.00	Health Insurance (Purchased or Self Funded)	2, 920, 356	8. 00
11.00	9.00	Prescription Drug Plan	0	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	51, 829	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuit ion Rei mbursement 24.00 First B - Other than Core Related Cost	11. 00	Life Insurance (If employee is owner or beneficiary)	25, 184	11. 00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary)  15.00 'Workers' Compensation Insurance  Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only  18.00 Medicare Taxes - Employers Portion Only  19.00 Unemployment Insurance  21.00 State or Federal Unemployment Taxes  OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  24.00 Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	-567	12. 00
15.00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion)  TAXES  17.00 FI CA-Employers Portion Only 1,887,414 17.00 Medicare Taxes - Employers Portion Only 441,411 18.00 19.00 Unemployment Insurance 0 19.00 State or Federal Unemployment Taxes 258,277 20.00 OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances 0 23.00 Tuition Reimbursement 0 23.00 Total Wage Related cost (Sum of Lines 1 -23) 6,710,075 24.00 Part B - Other than Core Related Cost	13.00	Disability Insurance (If employee is owner or beneficiary)	15, 187	13. 00
16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17. 00 FI CA-Empl oyers Portion Only  Medicare Taxes - Employers Portion Only  Unemployment Insurance  20. 00 State or Federal Unemployment Taxes  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22. 00 Day Care Cost and Allowances  Tuition Reimbursement  24. 00 Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
Non cumulative portion) TAXES  17. 00 FI CA-Employers Portion Only  18. 00 Medicare Taxes - Employers Portion Only  19. 00 Unemployment Insurance  20. 00 State or Federal Unemployment Taxes  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see of instructions))  22. 00 Day Care Cost and Allowances  23. 00 Tuition Reimbursement  24. 00 Part B - Other than Core Related Cost	15. 00	'Workers' Compensation Insurance	531, 578	15. 00
TAXES     17. 00   FI CA-Employers Portion Only     1,887,414   17. 00   18. 00   Medicare Taxes - Employers Portion Only   441,411   18. 00   19	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00   Fi CA-Employers Portion Only   1,887,414   17. 00   18. 00   Medicare Taxes - Employers Portion Only   441,411   18. 00   19. 00   Unemployment Insurance   0   19. 00   258,277   20. 00   OTHER   21. 00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))   22. 00   Day Care Cost and Allowances   0   22. 00   23. 00   Tuition Reimbursement   0   23. 00   24. 00   Part B - Other than Core Related Cost   24. 00   Part B - Other than Core Related Cost   258,277   26. 00   26. 00   27. 00   2		Non cumulative portion)		
18.00       Medicare Taxes - Employers Portion Only       441, 411       18.00         19.00       Unemployment Insurance       0       19.00         20.00       State or Federal Unemployment Taxes       258, 277       20.00         OTHER         21.00       Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))       0       21.00         22.00       Day Care Cost and Allowances       0       22.00         23.00       Tuition Reimbursement       0       23.00         24.00       Total Wage Related cost (Sum of Lines 1 -23)       6,710,075       24.00         Part B - Other than Core Related Cost		TAXES		
19. 00       Unempl oyment I nsurance       0       19. 00         20. 00       State or Federal Unempl oyment Taxes       258, 277       20. 00         OTHER         21. 00       Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))       0       21. 00         22. 00       Day Care Cost and Allowances       0       22. 00         23. 00       Tuition Reimbursement       0       23. 00         24. 00       Total Wage Related cost (Sum of Lines 1 -23)       6, 710, 075       24. 00         Part B - Other than Core Related Cost	17. 00	FICA-Employers Portion Only	1, 887, 414	17. 00
19. 00       Unempl oyment I nsurance       0       19. 00         20. 00       State or Federal Unempl oyment Taxes       258, 277       20. 00         OTHER         21. 00       Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))       0       21. 00         22. 00       Day Care Cost and Allowances       0       22. 00         23. 00       Tuition Reimbursement       0       23. 00         24. 00       Total Wage Related cost (Sum of Lines 1 -23)       6, 710, 075       24. 00         Part B - Other than Core Related Cost	18. 00	Medicare Taxes - Employers Portion Only	441, 411	18. 00
OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  23.00 Tuition Reimbursement  24.00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	19. 00	Unempl oyment Insurance	0	19. 00
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  24.00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost  21.00 22.00  22.00 23.00  24.00 6,710,075	20.00	State or Federal Unemployment Taxes	258, 277	20.00
instructions))  22.00 Day Care Cost and Allowances  23.00 Tuition Reimbursement  24.00 Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost  24.00 Part B - Other than Core Related Cost		OTHER		
22. 00       Day Care Cost and Allowances       0       22. 00         23. 00       Tuition Reimbursement       0       23. 00         24. 00       Total Wage Related cost (Sum of lines 1 -23)       6,710,075       24. 00         Part B - Other than Core Related Cost       24. 00       24. 00	21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
23. 00 Tuition Reimbursement 0 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 6,710,075 Part B - Other than Core Related Cost (24. 00)		instructions))		
24.00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost  6,710,075 24.00	22. 00	Day Care Cost and Allowances	0	22. 00
Part B - Other than Core Related Cost	23.00	Tuition Reimbursement	0	23. 00
	24. 00		6, 710, 075	24. 00
25. 00 OTHER WAGE RELATED COSTS (SPECIFY) 117, 195   25. 00				
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	117, 195	25. 00

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Li∈	eu of Form CMS-:	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15004	From 06/01/2014	Worksheet S-3 Part V Date/Time Pre 10/30/2015 5:	pared:
Cost Center Description			Contract Labor	Benefit Cost	
			1. 00	2. 00	
PART V - Contract Labor and Benefit Cost					
Hospital and Hospital-Based Component Identifi	cation.				1

	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1. 00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10. 00
11.00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12. 00
13.00	Hospi tal -Based Hospi ce			13. 00
14.00	Hospital-Based Health Clinic RHC			14. 00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17. 00	Renal Di al ysi s	0	0	17. 00
18. 00	0ther	0	0	18. 00

Health Financial Systems	ST JOSEPH MEDICAL (	CENTER		In lie	eu of Form CMS-:	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA			CCN: 150047	Peri od:	Worksheet S-7	
TROST ESTIVE TRUMENT FOR SIN STATISTISTE BATA		i i ovi dei	0014. 100017	From 06/01/2014	Worksheet 5 7	
				To 05/31/2015		
			0115 5	0 1 0 1 0 1 0 1 5	10/30/2015 5:	01 pm
	(-	roup	SNF Days	Swing Bed SNF		
		1. 00	2.00	Days 3.00	col. 2 + 3) 4.00	
69.00		PE2	2.00	0 0		69. 00
70.00	l l	PE1				
71. 00	l l	PD2				
72.00	l l	PD1		0 0	0	1
73. 00		PC2		0 0	Ö	
74. 00		PC1		0 0	Ö	
75. 00		PB2		0 0	Ō	75. 00
76. 00		PB1		4 0	4	76. 00
77. 00		PA2		0 0	0	77. 00
78. 00		PA1		0 0	0	78. 00
199. 00		AAA		0 0	0	199. 00
200. 00 TOTAL			1, 90	02	1, 902	200. 00
				CBSA at	CBSA on/after	
				Beginning of	October 1 of	
				Cost Reporting		
				Peri od	Reporting	
					Period (if	
				1. 00	appl i cabl e) 2.00	
SNF SERVICES				1.00	2.00	
201.00 Enter in column 1 the SNF CBSA code or 5 chara	octer non-CBSA code	if a run	al facility	23060	23060	201. 00
in effect at the beginning of the cost reporti				20000	20000	2011 00
in effect on or after October 1 of the cost re						
			Expenses	Percentage	Associ ated	
					with Direct	
					Patient Care	
					and Related	
			1.00	2.00	Expenses?	
A notice published in the Federal Register Vol	(O N 440 A		1.00	2. 00	3.00	
payments beginning 10/01/2003. Congress expect						
expenses. For lines 202 through 207: Enter in						
column 2 the percentage of total expenses for						
line 7, column 3. In column 3, enter "Y" for y						
with direct patient care and related expenses						
202. 00 Staffing		•		0.00		202. 00
203.00 Recrui tment				0.00		203. 00
204.00 Retention of employees				0.00		204. 00
205. 00 Trai ni ng				0.00		205. 00
206. 00 OTHER (SPECIFY)				0.00		206. 00
207.00 Total SNF revenue (Worksheet G-2, Part I, line	e 7, column 3)		3, 264, 40	00		207. 00

Heal th	Financial Systems ST JOSEPH MEDICAL (	CENTER		In lie	u of Form CMS-2	2552-10			
			CCN: 150047	Peri od:	Worksheet S-10				
	THE STREET FIRST THE STREET STREET STREET			From 06/01/2014					
				To 05/31/2015					
				,	10/30/2015 5:0	JI pm			
	1.00								
	Uncompensated and indigent care cost computation								
1.00									
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid				22, 066, 460	2. 00			
3. 00	Did you receive DSH or supplemental payments from Medicaid?				N	3. 00			
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental		from Medicaid	1?	N	4. 00			
5.00	If line 4 is "no", then enter DSH or supplemental payments from !	Medicaid			0	5. 00			
6.00	Medi cai d charges				116, 267, 080	6. 00			
7.00	Medicaid cost (line 1 times line 6)		6 11	0 1 5 . 1 6	19, 421, 137	7. 00			
8. 00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)	ine / min	us sum of iir	ies 2 and 5; ir	0	8. 00			
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for e	ach line)						
9. 00	Net revenue from stand-alone SCHIP	5113 101 6	acii iiiic)		0	9. 00			
10. 00	Stand-alone SCHIP charges				Ö	10.00			
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	11. 00			
12. 00	Difference between net revenue and costs for stand-alone SCHIP (	line 11 m	inus line 9	if < zero then	0	12. 00			
.2.00	enter zero)			20.0 (	, and the second se				
	Other state or local government indigent care program (see instru	uctions f	or each line)						
13.00	Net revenue from state or local indigent care program (Not include	ded on li	nes 2, 5 or 9	))	1, 135, 448	13.00			
14.00	Charges for patients covered under state or local indigent care	program (	Not included	in lines 6 or	9, 025, 370	14.00			
	10)								
15. 00	State or local indigent care program cost (line 1 times line 14)				1, 507, 589				
16. 00	Difference between net revenue and costs for state or local indig	gent care	program (lir	ne 15 minus line	372, 141	16. 00			
	13; if < zero then enter zero)								
17. 00	Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to func	ding char	ity caro		0	17. 00			
18. 00	Government grants, appropriations or transfers for support of hos				0	18. 00			
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local			ns (sum of lines	372, 141				
19.00	8, 12 and 16)	rnar gent	care program	is (suil of fiftes	372, 141	17.00			
			Uni nsured	Insured	Total (col. 1				
			pati ents	pati ents	+ col . 2)				
			1. 00	2. 00	3. 00				
20. 00	Total initial obligation of patients approved for charity care (a		1, 318, 57	78 54, 620	1, 373, 198	20. 00			
21 00	charges excluding non-reimbursable cost centers) for the entire		220 20	0 104	220 270	21 00			
21. 00	Cost of initial obligation of patients approved for charity care times line 20)	(Tine i	220, 25	9, 124	229, 378	21. 00			
22. 00	Partial payment by patients approved for charity care		39	93 0	393	22. 00			
23. 00	Cost of charity care (line 21 minus line 22)		219. 86		228, 985				
20.00	cost of chartty care (fillo 21 millas fillo 22)		217,00	7, 121	220, 700	20.00			
					1. 00				
24. 00	Does the amount in line 20 column 2 include charges for patient of		nd a Length o	of stay limit	N	24. 00			
25 02	imposed on patients covered by Medicaid or other indigent care program?								
25. 00	If line 24 is "yes," charges for patient days beyond an indigen			in or stay limit	0	25. 00			
26. 00	Total bad debt expense for the entire hospital complex (see insti				25, 996, 420				
27. 00	Medicare bad debts for the entire hospital complex (see instructi	,	c line 27)		379, 041	27. 00 28. 00			
28. 00 29. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line Cost of non-Medicare and non-reimbursable Medicare bad debt expe		,	. 201	25, 617, 379 4, 279, 101				
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	nse (TTNE	i tilles iille	: 20)	4, 279, 101 4, 508, 086				
	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			4, 880, 227				
51.00	Trotal and or mode sed and uncompensated early cost (Trile 17 prus Trile	c 30)			4,000,227	51.00			

	rFinancial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	ST JOSEPH MEDI(		CCN: 150047 F	In Lie eriod:	u of Form CMS-: Worksheet A	2552-10
KLULA	SSTITEATION AND ADJUSTMENTS OF TRIAL DALANCE O	I LAFLINGES	Frovider	F	rom 06/01/2014		
					o 05/31/2015	Date/Time Pre 10/30/2015 5:	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVI CE COST CENTERS			1 11 10	4 400 05/	0.040.445	
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		1, 816, 609 4, 539, 780			2, 949, 665 5, 917, 204	
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	235, 236	151, 900			4, 621, 950	
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL	4, 433, 456	49, 072, 839	53, 506, 295		28, 282, 561	1
5. 02 5. 03	00550 DATA PROCESSING	0	0	C	-,,	2, 501, 822	1
5. 03	00591 PURCHASING AND RECEIVING 00540 CENTRAL SCHEDULING		0		1, 219, 079 1, 195, 167	1, 219, 079 1, 195, 167	1
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	c	2, 107, 075	2, 107, 075	1
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	0	0	0 (70 716	12, 666, 718		
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 010, 906 2, 866	2, 668, 812 530, 084			3, 769, 302 479, 451	1
9. 00	00900 HOUSEKEEPI NG	593, 435	426, 005	1		1, 025, 941	1
10.00	01000 DI ETARY	0	2, 207, 585	2, 207, 585		907, 489	
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 1, 738, 752	0 224, 277	1, 963, 029	1, 300, 096 221, 301	1, 300, 096 2, 184, 330	
13. 00	01850 PASTORAL CARE	66, 100	23, 460			2, 164, 330 89, 560	
14. 00	01400 CENTRAL SERVICES & SUPPLY	354, 947	7, 319, 304	7, 674, 251	-7, 674, 251	0	14. 00
15.00	01500 PHARMACY	1, 401, 563	4, 324, 160			1, 964, 840	
16. 00 21. 00	01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRV	466, 025	324, 769 2, 700, 834			790, 148 0	1
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	o o	2, 700, 001			2, 700, 834	1
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	6, 541, 451 917, 103	2, 543, 896 185, 495			7, 386, 041 1, 102, 598	1
31. 00	02060 NEONATAL INTENSIVE CARE UNIT	795, 473	193, 756			1, 102, 598	1 .
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	c	1, 697, 585	1, 697, 585	
40.00	04000 SUBPROVI DER - I PF	1, 367, 722	211, 327	1, 579, 049		1, 579, 049	
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	1, 054, 861	145, 332	1, 200, 193	989, 229 0	989, 229 1, 200, 193	1
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	1, 355, 731	1, 830, 972	1		2, 657, 095	1
50. 01 51. 00	03330 ENDOSCOPY 05100 RECOVERY ROOM	495, 708	54, 567	550, 275		527, 935 550, 187	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	849, 509	459, 801	1		1, 307, 881	1
53.00	05300 ANESTHESI OLOGY	0	1, 762, 802			1, 762, 802	
54. 00 54. 01	05400  RADI OLOGY-DI AGNOSTI C   03630  ULTRA SOUND	1, 210, 923 334, 108	1, 224, 203 31, 923			3, 191, 022 0	1
56. 00	05600 RADI OI SOTOPE	92, 653	317, 236	409, 889	-409, 889	0	1
57. 00	05700 CT SCAN	191, 092	41, 057	232, 149	-232, 149	0	
58. 00 59. 00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON		0		1, 670, 108	0 1, 670, 108	
	06000 LABORATORY	2, 027, 500	2, 261, 846	1			
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	) c	549, 704	549, 704	•
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	657, 275 584, 650	195, 673 167, 687			824, 465 655, 742	
67. 00		300, 845	27, 123	1		327, 968	1
68. 00	06800 SPEECH PATHOLOGY	73, 139	8, 100	81, 239	0	81, 239	68. 00
69.00	06900 ELECTROCARDI OLOGY	921, 791	895, 194	1, 816, 985		63, 432	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		0		3, 826, 621 2, 320, 229	3, 826, 621 2, 320, 229	
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0	d	3, 650, 230		1
74.00		0	285, 080	285, 080	0	285, 080	1
76. 00 76. 01	03950 OTHER ANCILLARY SERVICE COST CENTER 03951 SLEEP LAB		0		0	0	
	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	349, 956	34, 461	384, 417	0	384, 417	1
76. 03	03952 WOUND CARE	820, 782	183, 774	1, 004, 556	-489	1, 004, 067	76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	155, 657	26, 070	181, 727	0	181, 727	90.00
	09100 EMERGENCY	1, 981, 594	664, 563	1		2, 646, 157	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	33, 382, 809	90, 082, 356	123, 465, 165	-841, 710	122, 623, 455	110 00
110.00	NONREI MBURSABLE COST CENTERS	33, 362, 604	90, 082, 330	123, 405, 105	-841, 710	122, 023, 433	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 017	56, 019	59, 036	0		190. 00
	) 19100 RESEARCH ) 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0		191. 00 192. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS		0		0		194. 00
194. 01	07951 MARKETI NG	0	0	ď	841, 710	841, 710	194. 01
	207952 SENI OR CI RCLE	0	-1, 737	_			194. 02
	3 07953 SELECT SPECIALTY 1 07954 FREE MEALS		0		-		194. 03 194. 04
	1	<u>, 31 </u>					

Heal th Financial	Systems	ST JOSEPH MEDIC	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECLASSI FI CATION	I AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		eriod: rom 06/01/2014	Worksheet A	
						Date/Time Pre 10/30/2015 5:	
Cost	Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
200. 00 TOTA	AL (SUM OF LINES 118-199)	33, 385, 826	90, 136, 638	123, 522, 464	. 0	123, 522, 464	200.00

Provi der CCN: 150047 Peri od: From 06/01/2014 To 05/31/2015

Worksheet A Date/Time Prepared: 10/30/2015 5:01 pm

			10/30/2015 5: 01 pm
Cost Center Description		Net Expenses For Allocation	
	6. 00	7. 00	
GENERAL SERVICE COST CENTERS	1 2.22		
1.00 O0100 CAP REL COSTS-BLDG & FLXT	3, 584, 914	6, 534, 579	1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	-1, 000, 663	4, 916, 541	2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	-2, 333	4, 619, 617	4.00
5. 01 00560 OTHER ADMINISTRATIVE AND GENERAL	-28, 282, 561	0	5. 01
5. 02 00550 DATA PROCESSING	0	2, 501, 822	5. 02
5. 03   00591 PURCHASING AND RECEIVING 5. 04   00540 CENTRAL SCHEDULING	0	1, 219, 079	5. 03 5. 04
5. 04   00540  CENTRAL SCHEDULI NG 5. 05   00580  CASHI ERI NG/ACCOUNTS RECEI VABLE	-61, 623	1, 195, 167 2, 045, 452	5. 05
5. 06 00590 OTHER ADMINISTRATIVE AND GENERAL	-1, 817, 149	10, 849, 569	5. 06
7. 00 00700 OPERATION OF PLANT	-27, 707	3, 741, 595	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	-12, 620	466, 831	8.00
9. 00 00900 HOUSEKEEPI NG	o	1, 025, 941	9.00
10. 00  01000 DI ETARY	0	907, 489	10.00
11. 00   01100   CAFETERI A	-166, 438	1, 133, 658	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-4, 624	2, 179, 706	13.00
13. 01 01850 PASTORAL CARE	0	89, 560	13. 01
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY	0	0 1, 964, 840	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	-175	789, 973	16.00
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRV	1,3	0	21.00
22. 00   02200   L&R SERVICES-OTHER PRGM COSTS APPRV	o	2, 700, 834	22.00
INPATIENT ROUTINE SERVICE COST CENTERS	. 9		
30. 00 03000 ADULTS & PEDIATRICS	-936, 763	6, 449, 278	30.00
31.00 03100 INTENSIVE CARE UNIT	0	1, 102, 598	31.00
31. 01   02060   NEONATAL   INTENSIVE CARE UNIT	0	0	31. 01
33. 00 03300 BURN INTENSIVE CARE UNIT	-536, 425	1, 161, 160	33.00
40. 00   04000   SUBPROVI DER - I PF	3, 450	1, 582, 499	40.00
43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSI NG   FACI LI TY	-54, 542 438	934, 687 1, 200, 631	43.00
ANCILLARY SERVICE COST CENTERS	430	1, 200, 031	44. 00
50. 00   05000   OPERATING ROOM	-636, 297	2, 020, 798	50.00
50. 01   03330 ENDOSCOPY	-167, 000	360, 935	50. 01
51.00   05100   RECOVERY ROOM	O	550, 187	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	-328, 050	979, 831	52.00
53. 00 05300 ANESTHESI OLOGY	-1, 760, 172	2, 630	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	-2, 566	3, 188, 456	54.00
54. 01   03630   ULTRA SOUND	0	0	54. 01
56. 00   05600   RADI 01 SOTOPE 57. 00   05700   CT   SCAN	0	0	56. 00 57. 00
58. 00   05800 MRI	0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o o	1, 670, 108	59.00
60. 00   06000   LABORATORY	l ol	3, 527, 420	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	549, 704	62. 00
65. 00 06500 RESPI RATORY THERAPY	O	824, 465	65. 00
66. 00 06600 PHYSI CAL THERAPY	-4, 292	651, 450	66. 00
67. 00   06700   0CCUPATI ONAL THERAPY	0	327, 968	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	81, 239	68.00
69. 00 06900 ELECTROCARDI OLOGY	-69	63, 432	69. 00 71. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS	-09	3, 826, 552 2, 320, 229	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		3, 650, 230	72.00
74. 00   07400   RENAL DI ALYSI S	o	285, 080	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	o	0	76. 00
76. 01   03951   SLEEP LAB	o	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	384, 417	76. 02
76. 03 03952 WOUND CARE	0	1, 004, 067	76. 03
OUTPATIENT SERVICE COST CENTERS		101 707	22.22
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	0	181, 727	90. 00 91. 00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART		2, 646, 157	91.00
SPECIAL PURPOSE COST CENTERS			72.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	-32, 213, 267	90, 410, 188	118. 00
NONREI MBURSABLE COST CENTERS		.,,,	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59, 036	190. 00
191. 00 19100 RESEARCH	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	194. 00
194. 01 07951 MARKETI NG	0	841, 710	194. 01
194. 02 07952 SENI OR CIRCLE	0	-1, 737	194. 02
194. 03 07953 SELECT_SPECIALTY 194. 04 07954 FREE_MEALS		0	194. 03 194. 04
200.00 TOTAL (SUM OF LINES 118-199)	-32, 213, 267	91, 309, 197	200. 00
(25			200. 00

Health Financial Systems
RECLASSIFICATIONS

Provi der CCN: 150047 | Peri od: From 06/01/2014 | To 05/31/2015 | Date/Ti me Prepared: 10/30/2015 5: 01 pm

					10/30/2015 5: 0	)1 pm
		Increases		0.11		
	Cost Center	Li ne #	Sal ary	Other 5.00		
	2.00 A - EMPLOYEE BENEFITS	3.00	4. 00	5. 00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	ol	4, 234, 814		1. 00
1.00	0		- —  —	4, 234, 814		1.00
	B - OXYGEN		-1	., = 0 ., 0		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	63, 824		1.00
	PATI ENT					
2.00		0.00	0	0		2.00
3. 00			0			3. 00
	C - LEASE AND RENTAL		U <sub>I</sub>	03, 024		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	ol	1, 363, 312		1. 00
2.00		0.00	o	0		2. 00
3.00		0. 00	o	0		3.00
4.00		0. 00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	O O	0		7. 00 8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	o	Ö		10. 00
11.00		0. 00	o	0		11.00
12.00		0. 00	0	0		12.00
13.00		0. 00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0. 00 0. 00	O O	0		15.00
16. 00				1, 363, 312		16. 00
	D - OTHER CAPITAL COSTS		<u> </u>	1, 303, 312		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	147, 375		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	985, 681		2. 00
3.00	CAP REL COSTS-MVBLE EQUIP		•	14, 112		3. 00
	E - MARKETING		0	1, 147, 168		
1. 00	MARKETING	194. 01	187, 055	654, 655		1. 00
	0		187, 055	654, 655		
	F - CNO					
1. 00	NURSING ADMINISTRATION	1300	•	22 <u>1, 8</u> 40		1. 00
	G - MEDICAL SUPPLIES		0	221, 840		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 762, 797		1. 00
	PATI ENT			5, 152, 111		
2.00	IMPL. DEV. CHARGED TO	72. 00	0	2, 320, 229		2. 00
	PATI ENTS	+				
	H - DRUGS AND IV COSTS		0	6, 083, 026		
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	3, 650, 230		1. 00
	0			3, 650, 230		
	I - A&G COSTS					
1.00	DATA PROCESSING	5. 02	782, 923	1, 718, 899		1. 00
2. 00 3. 00	PURCHASING AND RECEIVING CENTRAL SCHEDULING	5. 03 5. 04	437, 896 1, 061, 283	781, 183 133, 884		2. 00 3. 00
4.00	CASHI ERI NG/ACCOUNTS	5. 05	279, 181	1, 827, 894		4. 00
1. 00	RECEI VABLE	0.00	277, 101	1,027,071		1. 00
5.00	OTHER ADMINISTRATIVE AND	5. 06	2, 229, 986	16, 914, 198		5.00
	GENERAL	+				
	U		4, 791, 269	21, 376, 058		
1. 00	RADI OLOGY – DI AGNOSTI C	54.00	617, 853	390, 216		1. 00
2. 00	INDIOLOGI BINGNOSTIO	0.00	0	0		2. 00
3.00		0.00	О	0		3.00
	0		617, 853	390, 216		
	K - DI ETARY					
1. 00	CAFETERI A		0	1, 300, 096		1. 00
	L - MISC DEPARTMENTS		U	1, 300, 096		
1.00	BURN INTENSIVE CARE UNIT	33.00	962, 904	734, 681		1. 00
2.00	CARDIAC CATHETERIZATION	59. 00	792, 576	877, 532		2. 00
3.00	NURSERY	43.00	795, 473	193, 756		3.00
4.00	ENDOSCOPY	50. 01	206, 094	321, 841		4. 00
5.00	WHOLE BLOOD & PACKED RED	62. 00	0	549, 704		5. 00
	BLOOD CELL	+	2, 757, 047			
		l	2, 707, 047	2,011,014		

Financial Systems		ST JOSEPH ME	DI CAL	CENTER		In Lie	u of Form CMS-	-2552-10
SI FI CATI ONS				Provi der	CCN: 150047	Peri od:	Worksheet A-	6
						To 05/31/2015	Date/Time Pro 10/30/2015 5:	epared: :01 pm_
	Increases							
Cost Center	Li ne #	Sal ary	C	)ther				
2. 00	3. 00	4. 00		5. 00				
M - UTILITIES RECLASS								
OPERATION OF PLANT	7. 00	0		90, 191				1. 00
HOUSEKEEPI NG	9.00	0	İ	6, 501				2. 00
	0.00	0	ĺ	0				3.00
0 = = = = =				96, 692				1
N - INTERNS AND RESIDENT COST	S							1
I&R SERVICES-OTHER PRGM	22.00	0		2, 700, 834				1.00
COSTS APPRV								
0				2, 700, 834				
	2.00 M - UTILITIES RECLASS OPERATION OF PLANT HOUSEKEEPING O N - INTERNS AND RESIDENT COST I&R SERVICES-OTHER PRGM	Increases   Line #   2.00   3.00	Increases	Increases   Cost Center   Line # Salary   Cost Center   Cost C	Increases   Cost Center   Li ne #   Salary   Other	Increases   Cost Center   Li ne #   Salary   Other	Provider CCN: 150047   Period: From 06/01/2014   To 05/31/2015	Provider CCN: 150047   Period: From 06/01/2014   To 05/31/2015   Date/Time Provider CCN: 150047   Period: From 06/01/2014   To 05/31/2015   Date/Time Provider CCN: 150047   Period: From 06/01/2014   Date/Time Provider CCN: 150047   Period: From 06/01/2014   Date/Time Provider CCN: 150047   Date

8, 353, 224

2, 700, 834 45, 960, 279

500.00

500.00 Grand Total: Increases

RECLASSI FI CATIONS

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 Provider CCN: 150047 Peri od: Worksheet A-6 From 06/01/2014 05/31/2015 Date/Time Prepared: 10/30/2015 5:01 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - EMPLOYEE BENEFITS 5.06 OTHER ADMINISTRATIVE AND 4, 234, 814 0 1.00 GENERAL o 4, 234, 814 B - OXYGEN 1.00 OPERATION OF PLANT 7. 00 0 415 0 1.00 CENTRAL SERVICES & SUPPLY 0 34, 926 2.00 14.00 0 2.00 RESPI RATORY\_THERAPY 3.00 <u>65.</u>00 0 28, 483 0 3.00 63, 824 - LEASE AND RENTAL 1.00 OTHER ADMINISTRATIVE AND 5.06 0 31, 468 10 1.00 GENERAL OPERATION OF PLANT 2 00 7 00 0 0 192 2 00 3.00 LAUNDRY & LINEN SERVICE 8.00 0 284 0 3.00 4.00 NURSING ADMINISTRATION 13.00 539 0 4.00 0 CENTRAL SERVICES & SUPPLY 14.00 0 630, 071 5.00 5.00 PHARMACY 0 0 6.00 15.00 110, 653 6.00 7.00 MEDICAL RECORDS & LIBRARY 16.00 646 0 7.00 ADULTS & PEDIATRICS 0 8.00 30.00 1,721 8.00 0 OPERATING ROOM 9 00 50 00 120 9 00 10.00 RECOVERY ROOM 51.00 88 10.00 11.00 DELIVERY ROOM & LABOR ROOM 52.00 1, 429 0 11.00 RADI OLOGY-DI AGNOSTI C 12.00 54.00 193, 350 0 12.00 0 0 I ABORATORY 60 00 212, 222 13 00 13 00 14.00 PHYSICAL THERAPY 66.00 0 96, 595 0 14.00 ELECTROCARDI OLOGY 0 15.00 69.00 83, 445 0 15.00 Ō WOUND CARE 16 00 <u>76.</u>03 0 489 16 00 0 1, 363, 312 D - OTHER CAPITAL COSTS 1.00 OTHER ADMINISTRATIVE AND 5.06 0 1, 147, 168 12 1.00 GENERAL

2.00 0.00 2.00 0 13 3.00 0.00 12 3.00 1, 147, 168 - MARKETING OTHER ADMINISTRATIVE AND 1.00 187, 055 5.06 654,655 0 1.00 GENERAL 187, 055 654, 655 F - CNO OTHER ADMINISTRATIVE AND 1 00 5 06 0 221, 840 1 00 GENERAL 221, 840 G - MEDICAL SUPPLIES 1.00 CENTRAL SERVICES & SUPPLY 14. 00 0 6, 081, 473 0 1.00 OPERATING ROOM 2.00 50.00 1, 553 0 2.00 o 6, 083, 026 H - DRUGS AND IV COSTS 15. 00 1.00 1.00 PHARMACY 0 3, 650, 230 0 3, 650, 230 - A&G COSTS 1.00 OTHER ADMINISTRATIVE AND 5. 01 4, 433, 456 20, 790, 278 0 1.00 GENERAL 2 00 LAUNDRY & LINEN SERVICE 8 00 2 866 12 946 0 2 00 3.00 CENTRAL SERVICES & SUPPLY 14.00 354, 947 572, 834 0 3.00 4.00 0.00 0 4.00

0

0

0

5 00

1.00

2.00

3.00

1.00

1.00

2 00

3.00

4.00

5.00

3.00 CT\_SCAN 57.00 191, 092 41, 057 0 390, 216 617, 853 K - DIETARY 1, 300, 096 1.00 DI ETARY 10.00 0 0 1, 300, 096 - MISC DEPARTMENTS NEONATAL INTENSIVE CARE UNIT 1.00 31. 01 795, 473 193, 756 0 2 00 ADULTS & PEDLATRICS 30.00 962.904 734, 681 0 3.00 LABORATORY 60.00 549, 704 0 4.00 ELECTROCARDI OLOGY 69.00 792, 576 877, 532 0 OPERATING ROOM 50.00 206, 094 5.00 321, 841 0 2, 757, 047 2, 677, 514

4, 791, 269

334, 108

92.653

21, 376, 058

31, 923

317, 236

0.00

54.01

56.00

5 00

1.00

2 00

J - RADI OLOGY

ULTRA SOUND

RADI OI SOTOPE

Hea	alth F	inancial Systems		ST JOSEPH ME	DI CAL	CENTER			In Lie	u of Form CMS-	2552-10
RE	CLASSI	FI CATI ONS				Provi der	CCN:		Peri od: From 06/01/2014	Worksheet A-6	ò
									To 05/31/2015	Date/Time Pro 10/30/2015 5:	
			Decreases								
		Cost Center	line #	Salary	0	ther	Wkst	A_7 Ref			

						10/30/2013 3.	O I DIII
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	M - UTILITIES RECLASS						
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	466	0		1.00
	GENERAL						
2.00	LAUNDRY & LINEN SERVICE	8.00	0	37, 403	0		2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	5 <u>8, 8</u> 23	0		3.00
	0		0	96, 692			]
	N - INTERNS AND RESIDENT COST	TS					
1.00	I&R SERVICES-SALARY &	21.00	0	2, 700, 834	0		1. 00
	FRI_NGES_APPRV						
	0		0	2, 700, 834			
500.00	Grand Total: Decreases		8, 353, 224	45, 960, 279			500.00

CENTER In Lieu of Form CMS-2552-10
Provider CCN: 150047 | Period: | Worksheet A-7 | From 06/01/2014 | Part I Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

					-rom 06/01/2014 To 05/31/2015		pared:
						10/30/2015 5:	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	9, 348, 028	0	(	0	0	1. 00
2.00	Land Improvements	1, 759, 459	0	(	0	0	2. 00
3.00	Buildings and Fixtures	28, 316, 159	0	(	0	0	3. 00
4.00	Building Improvements	23, 926, 322	3, 525, 656	(	3, 525, 656		4. 00
5.00	Fi xed Equipment	17, 558, 642	62, 400	(	62, 400	18, 327	5. 00
6.00	Movable Equipment	49, 142, 075	1, 705, 548	(	1, 705, 548	840, 192	6. 00
7.00	HIT designated Assets	2, 834, 603	0	(	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	132, 885, 288	5, 293, 604	(	5, 293, 604	858, 519	8. 00
9.00	Reconciling Items	1, 866, 808	0	(	0	0	9. 00
10.00	Total (line 8 minus line 9)	131, 018, 480	5, 293, 604	(	5, 293, 604	858, 519	10.00
		Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	9, 348, 028	0				1. 00
2.00	Land Improvements	1, 759, 459	0				2. 00
3.00	Buildings and Fixtures	28, 316, 159	0				3. 00
4.00	Building Improvements	27, 451, 978	0				4. 00
5.00	Fi xed Equipment	17, 602, 715	0				5. 00
6.00	Movable Equipment	50, 007, 431	0				6. 00
7.00	HIT designated Assets	2, 834, 603	0				7. 00
8.00	Subtotal (sum of lines 1-7)	137, 320, 373	0				8. 00
9.00	Reconciling Items	1, 866, 808	0				9. 00
10.00	Total (line 8 minus line 9)	135, 453, 565	0				10. 00

Heal th	Health Financial Systems		ICAL CENTER		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150047	Peri od:	Worksheet A-7	
					From 06/01/2014 To 05/31/2015		narod:
					10 03/31/2013	10/30/2015 5:	01 pm
			Sl	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10. 00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			1
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 816, 609	1, 816, 609				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 539, 780	4, 539, 780				2. 00
3.00	Total (sum of lines 1-2)	6, 356, 389					3. 00
			•				•

Heal th	Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 06/01/2014 To 05/31/2015	Worksheet A-7 Part III Date/Time Prep 10/30/2015 5:0	
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1. 000000	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0. 000000	0	2. 00
3.00	Total (sum of lines 1-2)	0	0	1	1. 000000		3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS	-				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1, 102, 673		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		-1, 000, 663		2.00
3.00	Total (sum of lines 1-2)	0	0	INMARY OF CARL	0 102, 010	1, 305, 898	3. 00
			SL	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CE		447.075	005 10	1 1 01 ( 100	( 504 570	4 00
1.00	CAP REL COSTS-BLDG & FIXT	2, 539, 655					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0 520 (55	14, 112		4, 539, 780		2.00
3. 00	Total (sum of lines 1-2)	2, 539, 655	161, 487	985, 68	1 6, 356, 389	11, 451, 120	3. 00

Heal th Financial Systems

ST JOSEPH MEDICAL CENTER

In Lieu of Form CMS-2552-10

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Expense Classification on Worksheet A
To/From Which the Amount is to be Adjusted

					0 05/31/2015	Date/lime Prep   10/30/2015 5:0	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1 00		1. 00	2. 00	3.00	4. 00	5. 00	1.00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	1. 00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	O	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
3.00	(chapter 2)		O		0.00	Ĭ	3. 00
4.00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)			0.5 551 00070 5150 4 5177			
6. 00	Rental of provider space by suppliers (chapter 8)	В	-5/, 414	CAP REL COSTS-BLDG & FLXT	1. 00	10	6. 00
7. 00	Tel ephone servi ces (pay	A	-5, 904	OTHER ADMINISTRATIVE AND	5. 06	0	7. 00
	stations excluded) (chapter 21)			GENERAL			
8.00	Television and radio service	A	-27, 707	OPERATION OF PLANT	7. 00	o	8. 00
0.00	(chapter 21)		0		0.00	0	9. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-5, 301, 439		0. 00	0	10.00
	adj ustment						
11. 00	Sale of scrap, waste, etc. (chapter 23)	В	-2, 361	RADI OLOGY-DI AGNOSTI C	54.00	0	11. 00
12.00	Related organization	A-8-1	2, 104, 782			0	12.00
12 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
13. 00 14. 00	Cafeteria-employees and guests	В	-166, 438	CAFETERI A	11. 00	1	14. 00
15. 00	Rental of quarters to employee		0		0.00	o	15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than		· ·		0.00		10.00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
17.00	pati ents		0		0.00		17.00
18. 00	Sale of medical records and	В	-175	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)	_				_	
20. 00	Vending machines	В	-4, 307	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	20. 00
21. 00	Income from imposition of		0	i e	0.00	o	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	o	22. 00
	overpayments and borrowings to repay Medicare overpayments	1					
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	Ω	PHYSI CAL THERAPY	66. 00		24. 00
00	therapy costs in excess of		· ·		22.00		00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
20.00	physicians' compensation		O	Jost Jointon Belleteu	114.00		20.00
26. 00	(chapter 21) Depreciation - CAP REL	A	040 507	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
20.00	COSTS-BLDG & FIXT		940, 307	ON RECOSIS-DEDG & FIXI	1.00	9	20.00
27. 00	Depreciation - CAP REL	A	-910, 803	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	1	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
	Depreciation and Interest						
33. 00	INSERVICE EDUCATION REVENUE	В	-3, 388	NURSING ADMINISTRATION	13. 00	[ O	33. 00

				To	05/31/2015	Date/Time Pre 10/30/2015 5:	
				Expense Classification on	Worksheet A	, , , , , , , , , , , , , , , , , , , ,	
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
33. 01	FITNESS REVENUE	В		OTHER ADMINISTRATIVE AND	5. 06		33. 01
00.0.	T THESE NEVERSE			GENERAL	0.00	Ĭ	00.0.
33. 02	TELEPHONE COMMISSION	В		OTHER ADMINISTRATIVE AND	5. 06	0	33. 02
00.02	TEEET HONE GOMMIN GOT GIV			GENERAL	0.00	Ĭ	00.02
33. 03	SALE OF SUPPLIES	В		MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 03
00.00	67.22 07 007 27 20			PATI FNT	, 00	Ĭ	00.00
33. 04	MISC REVENUE	В		OTHER ADMINISTRATIVE AND	5. 06	0	33. 04
00.01	I WI SO KEVENSE			GENERAL	0.00		00.01
33. 05	HOSPITAL BAD DEBT	A		OTHER ADMINISTRATIVE AND	5. 01	0	33. 05
00.00	THOUSE THE BRID BEB!	, ,		GENERAL	0.0.	Ĭ	00.00
33. 06	PATIENT PHONE WAGE COSTS	A		OTHER ADMINISTRATIVE AND	5. 06	0	33. 06
33.00	TATTENT THONE WAGE GOSTS	Α		GENERAL	3.00		33.00
33. 07	PATIENT PHONES BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 07
33. 08	PATIENT TV DEPRECIATION COSTS	A	•	CAP REL COSTS-MVBLE EQUIP	2.00		33. 08
33. 09	PATIENT TV DEPRECIATION	Ä		CAP REL COSTS-MVBLE EQUIP	2.00		
33. 10	NONALLOWABLE MARKETING	Ä		OTHER ADMINISTRATIVE AND	5. 06	l	1
33. 10	NONALLOWABLE WARRETTING	A		GENERAL	5.00	٥	33. 10
33. 11	PHYSICIAN RECRUITING	A		OTHER ADMINISTRATIVE AND	5. 06	0	33. 11
33. 11	FITTST CTAIN RECRUITTING	A	•	GENERAL	5.00	٥	33.11
33. 12	LOBBYING EXPENSE IN DUES	A		OTHER ADMINISTRATIVE AND	5. 06	0	33. 12
33. 12	LOBBITING EXPENSE IN DOES	A		GENERAL	5.00	٥	33. 12
33. 13	CHARI TABLE CONTRI BUTI ONS	A		OTHER ADMINISTRATIVE AND	5. 06	0	33. 13
33. 13	CHART TABLE CONTRIBUTIONS	A		GENERAL	5.00	0	33.13
33. 14	PENALTI ES	A		PHYSI CAL THERAPY	66.00	_	33. 14
33. 14	IMPUTED RENT	A		OTHER ADMINISTRATIVE AND	5. 06		33. 15
33. 13	I IMPUTED KENT	A		GENERAL	5.00	0	33. 13
33. 16	NONALLOWABLE LEGAL EXPENSES	A		OTHER ADMINISTRATIVE AND	5. 06	0	33. 16
33. 10	(DOJ)	A		GENERAL	5.00	0	33. 10
33. 17	(003)		0	GENERAL	0.00	0	33. 17
33. 17	•		0			l e	33. 17
	TOTAL (our of lines 1 the 40)		22 212 277		0. 00		
50. 00	TOTAL (sum of lines 1 thru 49)		-32, 213, 267				50. 00
	(Transfer to Worksheet A,						
-	column 6, line 200.)						L

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

  A. Costs if cost, including applicable overhead, can be determined.
  B. Amount Received if cost cannot be determined.
  (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
- Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 150047 Peri od: Worksheet A-8-1 From 06/01/2014
To 05/31/2015 Date/Time Prepared: OFFICE COSTS

				10 05/31/2015	10/30/2015 5:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			'	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00			Direct Allocation - Capital-	2, 490, 046		1. 00
2.00	1		PASI Capital Costs - Bldg &	12, 096		2.00
3.00		CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Moveabl	1, 767		3.00
4.00		CASHI ERI NG/ACCOUNTS RECEI VAB	PASI Operating Costs	189, 316		4. 00
4. 01	1	CAP REL COSTS-BLDG & FIXT	Pre-Acq. Legacy Capital Cost			4. 01
4.02	•	CAP REL COSTS-BLDG & FIXT	Pre-Acq. Legacy Capital Cost	30, 569	0	4. 02
4.03	•	OTHER ADMINISTRATIVE AND GEN		317, 611		4. 03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	20, 182	0	4. 04
4.05		CAP REL COSTS-BLDG & FIXT	New Capital - Movable Equipm		0	4. 05
4.06		OTHER ADMINISTRATIVE AND GEN			0	4.06
4.07	5. 06	OTHER ADMINISTRATIVE AND GEN	Malpractice Costs (See Exhib	99, 041	0	4. 07
4.08	2. 00	CAP REL COSTS-MVBLE EQUIP	CIG Leased Equipment (See Ex	239, 049	0	4. 08
4.09	8. 00	LAUNDRY & LINEN SERVICE	Hospital Laundry Services (S	447, 655	0	4. 09
4. 10	5. 06	OTHER ADMINISTRATIVE AND GEN	Management Fees	0	1, 558, 556	4. 10
4. 11	5. 06	OTHER ADMINISTRATIVE AND GEN	401K Fees	0	3, 128	4. 11
4. 12	5. 06	OTHER ADMINISTRATIVE AND GEN	Audit Fees	0	49, 000	4. 12
4.13	5. 06	OTHER ADMINISTRATIVE AND GEN	Corporate overhead allocatio	0	992, 205	4. 13
4.14	5. 06	OTHER ADMINISTRATIVE AND GEN	PPSI Fees	0	18, 315	4. 14
4. 15	5. 05	CASHI ERI NG/ACCOUNTS RECEI VAB	PASI Collection Fees	0	250, 939	4. 15
4. 16	5. 06	OTHER ADMINISTRATIVE AND GEN	EBOS Fees	0	4, 735	4. 16
4. 17	5. 06	OTHER ADMINISTRATIVE AND GEN	PASI Lien Unit Collection Fe	0	25, 784	4. 17
4. 18	5. 06	OTHER ADMINISTRATIVE AND GEN	Malpractice Allocations (Per	0	124, 533	4. 18
4. 19	2.00	CAP REL COSTS-MVBLE EQUIP	CIG Leased Equipment (Per Ex	0	327, 239	4. 19
4.20	8.00	LAUNDRY & LINEN SERVICE	Hospital Laundry Services (P	0	460, 275	4. 20
4. 21	0.00			0	O	4. 21
5.00	TOTALS (sum of lines 1-4).			5, 919, 491	3, 814, 709	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2.00	3.00	4. 00	5. 00			
B. INTERRELATIONSHIP TO 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	В	0. 00 CHS, INC 100. 0	6. 00
7.00	В	0. 00 PASI 100. 0	7.00
8.00	С	33.00 SHARED LAUNDRY 33.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider. 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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

OFFI CE	COSTS				To 05/31/2015	Date/Time Prep 10/30/2015 5:0	pared:
	Net	Wkst. A-7 Ref.				10/30/2015 5: 0	J I pili
	Adjustments	WKSL. A-7 Kel.					
	(col. 4 minus						
	col. 5)*						
	6.00	7. 00					
			MENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED O	RGANIZATIONS OR O	CLAI MED	
	HOME OFFICE CO	STS:					
1.00	2, 490, 046	11					1.00
2.00	12, 096	11					2.00
3.00	1, 767	11					3.00
4.00	189, 316	0					4.00
4. 01	5, 177						4. 01
4.02	30, 569	11					4. 02
4.03	317, 611	0					4. 03
4.04	20, 182	9					4. 04
4.05	133, 984	. 9					4. 05
4.06	1, 932, 998	0					4. 06
4.07	99, 041						4. 07
4. 08	239, 049	9					4. 08
4.09	447, 655	0					4. 09
4. 10	-1, 558, 556						4. 10
4. 11	-3, 128						4. 11
4. 12	-49,000	0					4. 12
4. 13	-992, 205	0					4. 13
4.14	-18, 315	0					4. 14
4. 15	-250, 939	0					4. 15
4. 16	-4, 735						4. 16
4. 17	-25, 784	0					4. 17
4. 18	-124, 533	0					4. 18
4. 19	-327, 239						4. 19
4. 20	-460, 275	0					4. 20
4. 21	0	1					4. 21
5.00	2, 104, 782						5. 00
* The	amounts on lin	es 1-4 (and sub	oscripts as appropriate) are transf	erred in detail to Worl	ksheet A column	6 lines as	

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

1100 110 0	boon pooted to normanost m	cordinate and or 2, the dimedite difference should be that cated in cordinate for this part.	
	Rel ated Organization(s)		
	and/or Home Office		
	Type of Business		
	31		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming

	Termbursement under title XVIII.						
6	. 00	OWNER		6. 00			
7	. 00	DEBT COLLECTION		7. 00			
8	. 00	LAUNDRY		8.00			
	. 00			9.00			
1	0. 00			10.00			
1	00.00			100.00			

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 06/01/2014 | To 05/31/2015 | Date/Time Prepared: Provider CCN: 150047

					1	To 05/31/2015		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	10/30/2015 5: Physi ci an/Prov	
	WKSt. A LITTO #	I denti fi er	Remuneration	Component	Component	NOL AMOUNT	ider Component	
		1 40.111 11 01	Tromanor a cr on	00porrorre	ooporrorre		Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	5. 06	OTHER ADMINISTRATIVE AND	884, 637	884, 637	0	0	0	1. 00
		GENERAL						
2. 00		NURSING ADMINISTRATION	1, 236	1, 236	0	0		2. 00
3. 00	22. 00	I &R SERVI CES-OTHER PRGM	0	0	0	0	0	3. 00
4 00	20.00	COSTS APPRV	02/ 7/2	02/ 7/2	0	0	0	4 00
4.00		ADULTS & PEDIATRICS BURN INTENSIVE CARE UNIT	936, 763 536, 425		0	0	1	4.00
5. 00 6. 00		SUBPROVIDER - IPF	-3, 450		0	0	-	5. 00 6. 00
7. 00		NURSERY	54, 542		0	0	1	7. 00
8. 00		SKILLED NURSING FACILITY	-438		0	0		8. 00
9. 00		OPERATING ROOM	636, 297	1	0	0	o o	9. 00
10. 00		ENDOSCOPY	167, 000		0	Ö	o	10. 00
11. 00	52. 00	DELIVERY ROOM & LABOR ROOM	328, 050	328, 050	0	0	o	11.00
12. 00	53. 00	ANESTHESI OLOGY	1, 760, 172	1, 760, 172	0	0	o	12.00
13.00	54. 00	RADI OLOGY-DI AGNOSTI C	205	205	0	0	0	13.00
200.00			5, 301, 439	5, 301, 439	0			200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identi fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1 00	2.00	0.00	9. 00	Educati on	12 13. 00	14.00	
1.00	1.00	2. 00 OTHER ADMI NI STRATI VE AND	8. 00		12. 00 0			1. 00
1.00	3.00	GENERAL		1	U	U	0	1.00
2. 00	13 00	NURSING ADMINISTRATION	1	0	0	0	0	2. 00
3. 00		I &R SERVI CES-OTHER PRGM	0	0	0	0		3. 00
		COSTS APPRV		_	_			
4.00	30. 00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00		BURN INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6. 00		SUBPROVI DER - I PF	0	0	0	0	0	6. 00
7. 00		NURSERY	0	0	0	0	-	7. 00
8. 00		SKILLED NURSING FACILITY	0	0	0	0	0	8. 00
9. 00		OPERATI NG ROOM	0	0	0	0	0	9. 00
10.00		ENDOSCOPY	0	0	0	0	0	10.00
11. 00		DELIVERY ROOM & LABOR ROOM	0		0	0	0	11. 00
12.00		ANESTHESI OLOGY	0	0	0	0	1	12.00
13. 00 200. 00	54.00	RADI OLOGY-DI AGNOSTI C		0	0	0	1	13. 00 200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		racittifici	Share of col.		Di Sai i Owanee			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	5. 06	OTHER ADMINISTRATIVE AND	0	0	0	884, 637		1. 00
		GENERAL						
2.00		NURSING ADMINISTRATION	0	0	0	1, 236		2. 00
3. 00	22. 00	I&R SERVICES-OTHER PRGM	0	0	0	0		3. 00
		COSTS APPRV						
4.00		ADULTS & PEDIATRICS	0	1	0	936, 763		4. 00
5.00		BURN INTENSIVE CARE UNIT	0	1	0	536, 425		5. 00
6.00		SUBPROVIDER - IPF	0		0	-3, 450		6. 00
7.00		NURSERY	0	_	0	54, 542	1	7. 00
8.00		SKILLED NURSING FACILITY	0			-438		8. 00
9.00		OPERATING ROOM	0	_	0	636, 297	1	9.00
10.00		ENDOSCOPY	0			167, 000	1	10.00
11. 00		DELIVERY ROOM & LABOR ROOM	0	_	0	328, 050	1	11.00
12. 00 13. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0		0	1, 760, 172 205		12. 00 13. 00
200.00	54.00	KADI OLOGI -DI AGNOSTI C		i e				200. 00
200.00	I	I	1	1	0	3,301,437	1	200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150047

Cost Center Description					10	05/31/2015	Date/lime Prep   10/30/2015 5:0	
Part				CAPI TAL REI	LATED COSTS		10/00/2010 0.	O I PIII
Part								
All cachi on   CPUMP   All cachi on		Cost Center Description		BLDG & FIXT	MVBLE EQUIP			
CEREBAL SERVICE COST CENTERS   0   1.00   2.00   4.00   5.01						DEPARIMENT	AND GENERAL	
PRINCIPLE SENUET COST CENTERS   0								
CHERNAL SERVICE COST CENTERS   1.00				1.00	2.00	4. 00	5. 01	
2.00 002000 CAP REL COSTS-AVELE EDUIP 4.916, 941 7.90, 6541 5.01 002000 CAP REL COSTS-AVELE EDUIP 4.916, 941 7.90, 657 1.00 00200 CAP REL COSTS CAPPER 1.00 1.00 1.00 00200 CAPPER 2.00 MINISTRATI VE AND CENERAL 2.501, 822 210, 690 1.58, 37 097 6.2, 734 0.0 5.00 5.00 5.00 5.00 5.00 5.00 5.00		GENERAL SERVICE COST CENTERS						
4.00   00-000   DEPLOYEE SERVET TO DEPLOYEE STATE   4,619,617   73,961   55,648   4,749,226   4,00   0   5,01	1.00	00100 CAP REL COSTS-BLDG & FIXT	6, 534, 579	6, 534, 579				1. 00
5 OI 000560 OTHER ADMINISTRATIVE AND CENERAL 0 0 0 0 0 0 0 0 0 0 5 0 0 5 0 0 5 0 0 5 0	2.00		4, 916, 541		4, 916, 541			2. 00
5 0.2   0.0550   DATA PROCESSING   2, 501, 522   210, 900   158, 370   112, 163   0 5 0.02   5 0.0   0.0590   DENTRAL SCHEDULING   1, 719, 079   181, 710   137, 097   152, 042   0 5 0.02   5 0.0   0.0590   DENTRAL SCHEDULING   1, 719, 079   141, 763   0 5 0.02   5 0.0   0.0590   DENTRAL SCHEDULING   1, 719, 079   141, 763   0 5 0.02   5 0.0   0.0590   DENTRAL SCHEDULING   1, 719, 079   141, 763   0 7, 00   5 0.0   0.0590   DENTRAL SCHEDULING   1, 719, 179   1, 112, 685   837, 188   144, 824   0 7, 700   6 0.0   0.0590   DENTRAL SCHEDULING   1, 725, 744   179, 186   661, 477   1, 48, 690   0 8, 00   7 0.0   0.00500   DELETAT   1, 707, 489   2, 744   179, 186   661, 477   1, 48, 690   0 8, 00   7 0.0   0.00500   DELETAT   1, 707, 489   2, 746   1, 727, 460   0 6, 1, 477   1, 48, 690   0 8, 00   7 0.0   0.00500   DELETAT   1, 707, 489   2, 746   1, 727, 460   0 6, 1, 477   1, 48, 690   0 8, 00   7 0.0   0.00500   DELETAT   1, 707, 489   2, 746   1, 727, 460   0 6, 1, 477   1, 48, 690   0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 707, 489   2, 746   1, 747, 460   0 9, 00   0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 0 9, 470   0 13, 00   7 0.0   0.00500   DELETAT   1, 746, 460   0 9, 0 9, 0 9, 0 9, 0 9, 0 9, 0 9, 0			4, 619, 617	73, 961	55, 648	4, 749, 226		
5.03   00099  PURCHASIN & AND RECELY IN G			0	0	0	0		
5.04   0.0540  CENTRAL SCHEDILLING   1.105, 167   51,862   39,021   152,042   0.5,045   0.0   0.0   9.996   0.5,05   0.5   0.0550  O.5   0.0				l				
0.0586  CASHI ERINK ACCOUNTS RECT LYABLE   2, 0.45, 452   0 0 0 30, 0.96   0 5 0.65							- 1	
5.00   0.0090  OTHER ABMINISTRATIVE AND GENERAL   10,849,569   141,762   100,051   292,674   0 5.00   8.00   0.0000  CHEART 100 OF PLEATION OF PLEATIO				l				
7. 00   00700   OPERATION OF PLANT   3,741,995   1.112,685   837,168   144,824   0.7.00   9.00   0.0				ł	ı			
8.00   00800   LANIDRY & LINEN SERVICE   466, 331   58,069   43,690   0   8 8.00   10.				l				
9.00   0.9900   0.0USELEPING   1.025, 941   879, 1618   661, 476   85, 017   0.9. 0.0   11. 00   0.0100   0.1 ETAINY   997, 489   274, 640   0.0				1			1	
10.00   01000   DETARY				l			- 1	
11.00 0 1100 (CAFETRIA   1,133,658   0 0 0 0 11.00   11.00   13.00   1				l				
13.01   01850   PASTORAL CARE   89, 560   36, 550   27, 500   9, 470   0   13, 01	11. 00			l		0	0	11. 00
14.00 0 1400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 0 0 0 15.00 16.00 16.00 16.00 PERMARCY 1, 964, B40 0 0 0 0 200, 791 0 15.00 16.00 16.00 PERMARCY 789, 973 164, 568 123, 819 66, 764 0 16.00 22.00 0 10 0 0 0 21.00 10 0 0 0 22.00 PERMARCY 789, 973 164, 568 123, 819 66, 764 0 16.00 0 0 22.00 PERMARCY 789, 973 164, 568 123, 819 66, 764 0 16.00 0 0 22.00 PERMARCY 789, 979, 979 79, 979 99 0 0 22.00 PERMARCY 898, 982 0 0 0 0 0 0 0 0 22.00 PERMARCY 898, 982 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13.00	01300 NURSING ADMINISTRATION	2, 179, 706	31, 644	23, 809	249, 097	0	13. 00
15.00   01500   PHARMARCY   1, 944, B40   0   20, 071   0   15.00   16.00	13. 01	01850 PASTORAL CARE	89, 560	36, 550	27, 500	9, 470	0	13. 01
16.00   01600   MEDICAL RECORDS & LIBRARY   789, 973   164, 568   123, 819   66, 764   0   16.00   22.00   22.00   2200   18R SERVICES-SALARY & RINGES APPRW   2,700, 834   0   0   0   0   0   22.0			0	1		-	- 1	
21.00				l e	_	•		
22.00			789, 973	164, 568				
INPATI ENT ROUTINE SERVICE COST CENTERS   0, 449, 278   594, 780   439, 982   799, 199   0 30. 00   31. 00   30100   ADULTS & PEDIA INTICS   1, 102, 598   192, 826   145, 080   131, 386   0 31. 00   31. 01   01. 00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 700 004	0				
30.00   3000   ADULTS & PEDI ATRICS   6,449,278   584,780   439,982   799,199   0   30.00	22. 00		2, 700, 834	0	0	0	0	22.00
31.00   03100   INTERSIVE CARE UNIT	30 00		6 440 278	594 790	130 082	700 100	0	30 00
31.01   02060   NEONATAL INTENSIVE CARE UNIT   1, 161, 160   109, 916   82, 699   137, 948   0 33, 00   030   04000   SURPI NITENSIVE CARE UNIT   1, 161, 160   109, 916   82, 699   137, 948   0 33, 00   04000   SURPIN NITENSIVE CARE UNIT   1, 161, 160   109, 916   82, 699   137, 948   0 33, 00   04300   04000   SURPROVIDER - IPF   1, 582, 499   83, 522   62, 841   195, 943   0 40, 00   04400   SURPROVIDER - IPF   94, 46, 87   74, 2023   22, 370   113, 961   0 44, 00   04400   SURITURE COST CENTERS				l		·		
33.00   03300   BURN INTENSIVE CARE UNIT			0	0		0 101,000		
40.00   0.4000   SUBPROVI   DER - I   PF   1.582, 499   83,522   62, 841   195, 943   0   40.00   43.00   43.00   0.4400   0.4400   SKI LLED NURSI NG FACILITY   934, 687   43.003   32.370   113.961   0   43.00   43.00   0.4400   SKI LLED NURSI NG FACILITY   1.200, 631   153.706   115.647   151.121   0   44.00   44.			1, 161, 160	109, 916	82, 699	137, 948		
43.00   04300   NURSERY   1,200,631   153,706   115,647   151,121   0   44,00	40.00					195, 943	0	40. 00
ANCIL LARY SERVICE COST CENTERS	43.00	04300 NURSERY			32, 370	113, 961	0	43.00
50. 00	44. 00	04400 SKILLED NURSING FACILITY	1, 200, 631	153, 706	115, 647	151, 121	0	44. 00
50. 01   03330   ENDOSCOPY   360, 935   32, 396   24, 375   29, 525   0   50. 01					1			
51.00     05.100   05.100     05.100     05.100     05.100     05.100     05.100   05.100     05.100     05.100     05.100     05.100     05.100   05.100     05.100     05.100     05.100     05.100     05.100   05.100     05.100     05.100     05.100     05.100     05.100   05.100     05.100     05.100     05.100     05.100     05.100   05.100     05.100     05.100     05.100     05.100     05.100   05.100     05.100     05.100     05.100     05.100     05.100   05.100     05.100     05.100     05.100     05.100     05.100   05.100     05.100     05.100     05.100     05.100     05.100   05.100     05.100     05.100     05.100     05.100     05.100   05.100     05.100     05.100     05.100     05.100     05.100   0								
52.00   05200   DELI VIERY ROOM & LABOR ROOM   979, 831   89, 865   67, 629   121, 702   0   52.00				l				
53.00   05300   ANESTHESI OLOGY   2,630   0   0   0   0   53.00				l				
54. 00   05400   RADI OLOGY—DI AGNOSTI C   3, 188, 456   258, 324   194, 360   261, 994   0   54. 00   56. 00   0   0   0   0   0   0   0   0   0				l				
54. 01   03430   ULTRA SOUND   0   0   0   0   0   0   54. 01		· ·		ł	-	-		
56.00   0500   RADIO I SOTOPE   0   0   0   0   0   0   0   0   0		· ·	0	0	0	0		
58. 00   0500   0500   0500   0   0   0   0			0	0	О	0	0	
59.00   05900   CARDI AC CATHETERI ZATI ON   1, 670, 108   28, 776   21, 651   113, 546   0   59.00   60.00	57.00	05700 CT SCAN	0	0	0	0	0	57. 00
60. 00   06000   LABORATORY   3, 527, 420   221, 101   166, 354   290, 464   0   60. 00   62. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   549, 704   12, 115   9, 115   0   0   62. 00   65. 00   65.00   RESPIRATORY THERAPY   824, 465   89, 838   67, 593   94, 163   0   65. 00   65. 00   66.00   06600   PHYSI CAL THERAPY   651, 450   116, 733   87, 829   83, 758   0   66. 00   66. 00   66. 00   66. 00   67. 00   67. 00   6800   SPEECH PATHOLOGY   81, 239   17, 209   12, 948   10, 478   0   68. 00   69. 00			0	0	0	0		
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   549, 704   12, 115   9, 115   0   0   62. 00   65. 00   06500   RESPI RATORY THERAPY   824, 465   89, 838   67, 593   94, 163   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   651, 450   116, 733   87, 829   83, 758   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   327, 968   44, 684   33, 620   43, 100   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   81, 239   17, 209   12, 948   10, 478   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   63, 432   16, 378   12, 323   18, 512   0   69, 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   3, 826, 552   0   0   0   0   0   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   2, 320, 229   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   3, 650, 230   38, 713   29, 127   0   0   73. 00   74. 00   07400   RENAL DI ALYSI S   285, 080   31, 503   23, 702   0   0   74. 00   76. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0   0   0   0   0   76. 01   03951   SLEEP LAB   0   0   0   0   0   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   384, 417   51, 063   38, 419   50, 135   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   384, 417   51, 063   38, 419   50, 135   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   384, 417   51, 063   38, 419   50, 135   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   384, 417   51, 063   38, 419   50, 135   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   384, 417   51, 063   38, 419   50, 135   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   384, 417   51, 063   38, 419   50, 135   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   384, 417   51, 063   38, 419   50, 135   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   384, 417   51, 063   38, 419   50, 135   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   77. 00   07600   01000   01000   01000   01000   01000   010000   78. 00   070								
65. 00   06500   RESPI RATORY THERAPY   824, 465   89, 838   67, 593   94, 163   0   65. 00   66. 00   06600   O6500   OCCUPATI ONAL THERAPY   651, 450   116, 733   87, 829   83, 758   0   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   651, 450   146, 884   33, 620   43, 100   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   81, 239   17, 209   12, 948   10, 478   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   63, 432   16, 378   12, 323   18, 512   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   3, 826, 552   0   0   0   0   0   0   72. 00   07200   IMPL   DEV   CHARGED TO PATI ENTS   2, 320, 229   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   3, 650, 230   38, 713   29, 127   0   0   73. 00   74. 00   07400   RENAL DI ALYSI S   285, 080   31, 503   23, 702   0   0   74. 00   76. 01   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0   0   0   0   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   384, 417   51, 063   38, 419   50, 135   0   76. 02   76. 03   03952   WOUND CARE   1, 004, 067   134, 616   101, 284   117, 587   0   76. 03   09000   CLI INI C   181, 727   33, 321   25, 070   22, 300   0   90. 00   09000   CLI INI C   181, 727   30, 321   25, 070   22, 300   0   09000   DEBERVATI ON BEDS (NON-DISTINCT PART   SPECIAL PURPOSE COST CENTERS   90. 00   90. 00   0   0   0   09000   DEBERVATI ON BEDS (NON-DISTINCT PART   SPECIAL PURPOSE COST CENTERS   90. 00   90. 00   0   0   0   0   191. 00   09100   DESERVATI ON BEDS (NON-DISTINCT PART   SPECIAL PURPOSE COST CENTERS   90. 00   0   0   0   0   0   191. 00   09100   GIFT, FLOWER, COFFEE SHOP & CANTEEN   59, 036   15, 861   11, 934   432   0   190. 00   09100   DESERVATIONSE PRIVATE OFFICES   0   0   0   0   0   0   191. 00   09100   DESERVATIONSE PRIVATE OFFICES   0   0   0   0   0   0   0   0   0						•		
66. 00   06600   PHYSICAL THERAPY   651, 450   116, 733   87, 829   83, 758   0   66. 00   67. 00   06700   0CCUPATIONAL THERAPY   327, 968   44, 684   33, 620   43, 100   0   68. 00   06800   SPEECH PATHOLOGY   81, 239   17, 209   12, 948   10, 478   0   68. 00   06800   SPEECH PATHOLOGY   63, 432   16, 378   12, 323   18, 512   0   69. 00   06900   ELECTROCARDI OLOGY   63, 432   16, 378   12, 323   18, 512   0   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   3, 826, 552   0   0   0   0   0   71. 00   07200   MPLD DEV. CHARGED TO PATIENTS   2, 320, 229   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   3, 650, 230   38, 713   29, 127   0   0   74. 00   07400   RENAL DI ALYSIS   285, 080   31, 503   23, 702   0   0   74. 00   76. 00   03950   OTHER ANCILLARY SERVICE COST CENTER   0   0   0   0   0   76. 01   03951   SLEEP LAB   0   0   0   0   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   384, 417   51, 063   38, 419   50, 135   0   76. 02   03550   DSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   384, 417   51, 063   38, 419   50, 135   0   76. 02   03952   WOUND CARE   1, 004, 067   134, 616   101, 284   117, 587   0   90. 00   09000   CLI NI C   181, 727   33, 321   25, 070   22, 300   0   90. 00   91. 00   09000   CLI NI C   2, 646, 157   206, 838   155, 623   283, 887   0   91. 00   09100   SMERGENCY   2, 646, 157   206, 838   155, 623   283, 887   0   91. 00   09200   OSERVATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   90, 4624, 765   4, 721, 996   0   191. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   59, 036   15, 861   11, 934   432   0   190. 00   191. 00   19200   PHYSICI ANS' PRI VATE OFFICES   0   0   0   0   0   0   191. 00   192. 00   19200   1940, 00   00   0   0   0   191. 00   1940, 00   00   00   0   0   0   0   194. 00   007950   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   194. 00   007950   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   194. 00   007950   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0						-		
67. 00   06700   0CCUPATI ONAL THERAPY   327, 968   44, 684   33, 620   43, 100   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   81, 239   17, 209   12, 948   10, 478   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   63, 432   16, 378   12, 323   18, 512   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   3, 826, 552   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   2, 320, 229   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   3, 650, 230   38, 713   29, 127   0   74. 00   07400   RENAL DI ALYSI S   285, 080   31, 503   23, 702   0   0   76. 01   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0   0   0   76. 02   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0   0   0   76. 03   03952   WOUND CARE   1, 004, 067   134, 616   101, 284   117, 587   76. 03   03952   WOUND CARE   1, 004, 067   134, 616   101, 284   117, 587   77. 03   03952   WOUND CARE   1, 004, 067   134, 616   101, 284   117, 587   78. 03   03950   OSBERVATI ON BEDS (NON-DI STI NCT PART   500   00   00   00   792. 00   09000   CLI NI C   181, 727   206, 838   155, 623   283, 887   091. 00   792. 00   09100   BMERGENCY   2, 646, 157   206, 838   155, 623   283, 887   091. 00   792. 00   09100   BMERGENCY   2, 646, 157   206, 838   155, 623   283, 887   091. 00   792. 00   09100   DMERGENCY   2, 646, 157   206, 838   155, 623   283, 887   091. 00   792. 00   09100   DMERGENCY   2, 646, 157   206, 838   155, 623   283, 887   091. 00   793. 00   09000   0000   0000   0000   0000   0000   0000   794. 00   0000   0000   0000   0000   0000   794. 00   0000   0000   0000   0000   0000   794. 00   0000   0000   0000   0000   0000   794. 00   0000   0000   0000   0000   0000   794. 00   0000   0000   0000   0000   0000   794. 00   0000   0000   0000   0000   0000   794. 00   0000   0000   0000   0000   0000   794. 00   0000   0000   0000   0000   0000   794. 00   0000   0000   0000   0000   0000   794. 00   0000   00000   00000   0000   0000   794. 00   00000   00000   00000   00000   794. 00				l				
68. 00   06800   SPEECH PATHOLOGY   81, 239   17, 209   12, 948   10, 478   0   68. 00   69. 00   69. 00   69. 00   ELECTROCARDI OLOGY   63, 432   16, 378   12, 323   18, 512   0   69. 00   71. 00   70. 00   ELECTROCARDI OLOGY   63, 432   16, 378   12, 323   18, 512   0   69. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00				l		·		
69. 00   06900   ELECTROCARDI OLOGY   63, 432   16, 378   12, 323   18, 512   0   69. 00   071. 00   MEDI CAL SUPPLIES CHARGED TO PATI ENT   3, 826, 552   0   0   0   0   071. 00   071. 00   072. 00   072. 00   072. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   074.								
71. 00								
72. 00				l				
74. 00					0	0	0	
76. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	3, 650, 230	38, 713	29, 127	0	0	73. 00
76. 01	74.00	07400 RENAL DIALYSIS	285, 080	31, 503	23, 702	0	0	74. 00
76. 02			0	0	0	0	0	
76. 03			0	0		0		
90. 00   09000   CLINIC   181, 727   33, 321   25, 070   22, 300   0 90. 00   91. 00   91. 00   92. 00				l				
90. 00	76. 03		1,004,067	134, 616	101, 284	117, 587	0	76.03
91. 00   09100   EMERGENCY   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   SPECI AL PURPOSE COST CENTERS   118. 00   NONREI MBURSABLE COST CENTERS   59,036   15,861   11,934   432   0190. 00   191. 00   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0 0 0 0 0 0   194. 00   194. 00   194. 00   07950   OTHER NONREI MBURSABLE COST CENTERS   0 0 0 0 0 0   194. 00   194. 00   194. 00   07950   OTHER NONREI MBURSABLE COST CENTERS   0 0 0 0 0 0   194. 00   194. 00   194. 00   07950   OTHER NONREI MBURSABLE COST CENTERS   0 0 0 0 0 0   194. 00   194. 00   194. 00   07950   OTHER NONREI MBURSABLE COST CENTERS   0 0 0 0 0 0 0   194. 00   194. 00   194. 00   00 0 0 0 0 0   194. 00	00.00		101 727	22 221	25 070	22 200		00.00
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   92. 00   SPECI AL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LI NES 1-117)   90, 410, 188   6, 146, 779   4, 624, 765   4, 721, 996   0   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   59, 036   15, 861   11, 934   432   0   190. 00   191. 00   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   0   0   0   0   0   0   192. 00   194. 00   07950   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   194. 00   194. 00   0   0   0   0   0   0   0   0   0				l				
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1-117)   90, 410, 188   6, 146, 779   4, 624, 765   4, 721, 996   0			2,040,137	200, 030	133, 023	203, 007		
118. 00 SUBTOTALS (SUM OF LINES 1-117) 90, 410, 188 6, 146, 779 4, 624, 765 4, 721, 996 0 118. 00  NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 59, 036 15, 861 11, 934 432 0 190. 00  191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00  194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 00	55							
190. 00     19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN     59,036     15,861     11,934     432     0 190. 00       191. 00     19100 RESEARCH     0     0     0     0     0 191. 00       192. 00     19200 PHYSI CLANS' PRI VATE OFFI CES     0     0     0     0     0 192. 00       194. 00     07950 OTHER NONREI MBURSABLE COST CENTERS     0     0     0     0     0 194. 00	118.00	SUBTOTALS (SUM OF LINES 1-117)	90, 410, 188	6, 146, 779	4, 624, 765	4, 721, 996	0	118. 00
191. 00   19100   RESEARCH 0 0 0 0 0 191. 00 192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   194. 00   1								
192.00   19200   PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 192.00 194.00   074.00   0750   074.00   075			59, 036	l .				
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 00			0	0	0	0		
					0	0		
9 9 20,779 0,774.01			841 710			26 798		
		1 1	1 0,710		<u>,                                    </u>	23, , 70	,	

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 06/01/2014 To 05/31/2015		
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		OTHER ADMINISTRATIVE AND GENERAL	
	0	1.00	2.00	4. 00	5. 01	
194. 02 07952 SENI OR CI RCLE	-1, 737	0		0 0	0	194. 02
194. 03 07953 SELECT SPECIALTY	0	371, 939	279, 84	2 0	0	194. 03
194.04 07954 FREE MEALS	0	0		0 0	0	194. 04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	91, 309, 197	6, 534, 579	4, 916, 54	1 4, 749, 226	0	202. 00

| Peri od: | Worksheet B | From 06/01/2014 | Part | To 05/31/2015 | Date/Time Prepared: | Provider CCN: 150047

					T	o 05/31/2015	Date/Time Pre 10/30/2015 5:	
		Cost Center Description		PURCHASING AND		CASHI ERI NG/ACC	Subtotal	O I PIII
			PROCESSI NG	RECEI VI NG	SCHEDULI NG	OUNTS		
			5. 02	5. 03	5. 04	RECEI VABLE 5. 05	5A. 05	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	1	OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02		DATA PROCESSING	2, 982, 845					5. 02
5.03		PURCHASING AND RECEIVING	0	1, 601, 126				5. 03
5.04		CENTRAL SCHEDULING	0	0	,			5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	2, 085, 448	11 200 //7	5. 05
5. 06 7. 00		OTHER ADMINISTRATIVE AND GENERAL OPERATION OF PLANT	0	0	0	0	11, 390, 667 5, 836, 272	5. 06 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE	0	0	l ő	Ö	568, 590	1
9.00		HOUSEKEEPI NG	0	0	0	0	2, 651, 602	•
10. 00	1	DI ETARY	0	0	0	0	1, 388, 765	1
11.00		CAFETERI A	0	0	0	0	1, 133, 658	1
13. 00 13. 01	1	NURSING ADMINISTRATION PASTORAL CARE	0	0	0	0	2, 484, 256 163, 080	1
14. 00		CENTRAL SERVICES & SUPPLY	0	0	0	o	103, 000	14. 00
15. 00		PHARMACY	0	23, 461	0	o	2, 189, 092	•
16. 00	1	MEDICAL RECORDS & LIBRARY	0	735			1, 145, 859	1
21. 00		I &R SERVICES-SALARY & FRINGES APPRV	0	0			0	21. 00
22. 00	02200 LNDAT	I&R SERVICES-OTHER PRGM COSTS APPRV IENT ROUTINE SERVICE COST CENTERS	0	0	0	0	2, 700, 834	22. 00
30. 00		ADULTS & PEDIATRICS	239, 789	63, 432	115, 597	167, 653	8, 859, 710	30.00
31. 00		INTENSIVE CARE UNIT	21, 602				1, 630, 014	•
31. 01		NEONATAL INTENSIVE CARE UNIT	0	0		0	0	31. 01
33. 00		BURN INTENSIVE CARE UNIT	37, 615	19, 075			1, 592, 846	1
40.00		SUBPROVI DER - I PF	119, 410				2, 191, 860	1
43. 00 44. 00	1	NURSERY SKILLED NURSING FACILITY	19, 881 19, 218	11, 490 7, 337			1, 178, 896 1, 670, 360	•
44.00		LARY SERVICE COST CENTERS	17, 210	7,337	7, 204	13, 430	1, 070, 300	1 44.00
50.00		OPERATING ROOM	237, 056	100, 877	114, 280	165, 742	3, 218, 564	50. 00
50. 01	1	ENDOSCOPY	25, 628				520, 825	•
51.00	1	RECOVERY ROOM	27, 533				860, 474	1
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	9, 466 34, 432		1		1, 290, 259 77, 750	1
54. 00	1	RADI OLOGY-DI AGNOSTI C	443, 697	6, 164	1		4, 877, 175	1
54. 01		ULTRA SOUND	0	0		0	0	54. 01
56. 00		RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	1	CT SCAN	0	0	0	0	0	57. 00
58. 00 59. 00	05800	CARDI AC CATHETERI ZATI ON	125, 932	87, 794	60, 709	88, 048	0 2, 196, 564	58. 00 59. 00
60.00	1	LABORATORY	356, 405				5, 050, 959	
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	21, 971	4, 718			623, 576	•
65. 00		RESPI RATORY THERAPY	84, 023				1, 277, 065	
66.00		PHYSI CAL THERAPY	30, 482				1, 007, 706	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	19, 061 4, 360	166 179			491, 115 131, 563	
69. 00	1	ELECTROCARDI OLOGY	18, 907	1, 032			152, 918	
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	94, 060				4, 670, 805	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	217, 275	394, 077			3, 188, 237	1
73. 00		DRUGS CHARGED TO PATIENTS	409, 761	0			4, 611, 860	
74. 00 76. 00		RENAL DIALYSIS OTHER ANCILLARY SERVICE COST CENTER	14, 103	612 0		9, 860 0	371, 659 0	•
76. 00 76. 01	1	SLEEP LAB	0	0		0	0	76.00
76. 02		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	33, 497	892		-	597, 991	1
76. 03	03952	WOUND CARE	40, 544	18, 955	19, 546	28, 347	1, 464, 946	76. 03
		TIENT SERVICE COST CENTERS						
90.00	1	CLI NI C	552				265, 871	90. 00 91. 00
91. 00 92. 00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	276, 585	73, 598	133, 336	193, 379	3, 969, 403 0	1
72.00		AL PURPOSE COST CENTERS						72.00
118.00		SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS	2, 982, 845	1, 591, 390	1, 438, 092	2, 085, 448	89, 693, 646	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 943	0	O	96, 206	190. 00
191.00	19100	RESEARCH	0	0	0	o	0	191. 00
		PHYSICIANS' PRIVATE OFFICES	0	0		0		192.00
		OTHER NONREIMBURSABLE COST CENTERS MARKETING	0	0 793		0	0 869, 301	194. 00
	1	SENI OR CIRCLE	0	793				194. 01
	1	SELECT SPECIALTY	0	0			651, 781	
194. 04	07954	FREE MEALS	0	0	0	o	0	194. 04
200.00	)	Cross Foot Adjustments					0	200. 00

Health Financial Systems	ST JOSEPH MED	DI CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 06/01/2014		
				To 05/31/2015	Date/Time Pre	pared:
					10/30/2015 5:	01 pm
Cost Center Description	DATA	PURCHASING AND	CENTRAL	CASHI ERI NG/ACC	Subtotal	
	PROCESSI NG	RECEI VI NG	SCHEDULI NG	OUNTS		
				RECEI VABLE		

5.04

1, 601, 126

0 1, 438, 092 5. 05

2, 085, 448

0 201. 00 91, 309, 197 202. 00

5.02

0 2, 982, 845

201. 00 202. 00 Negative Cost Centers TOTAL (sum lines 118-201)

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 06/01/2014 | Part |
| To 05/31/2015 | Date/Time Prepared: | 10/30/2015 5:01 pm Provider CCN: 150047

					'	0 05/31/2015	10/30/2015 5:	
		Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
			ADMI NI STRATI VE	PLANT	LINEN SERVICE			
			AND GENERAL 5.06	7. 00	8.00	9. 00	10.00	
	GENER	AL SERVICE COST CENTERS	3.00	7.00	0.00	7. 00	10.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02		DATA PROCESSING						5. 02
5. 03 5. 04	1	PURCHASING AND RECEIVING CENTRAL SCHEDULING						5. 03 5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06	1	OTHER ADMINISTRATIVE AND GENERAL	11, 390, 667					5. 06
7.00	1	OPERATION OF PLANT	831, 815	6, 668, 087				7. 00
8.00		LAUNDRY & LINEN SERVICE	81, 038	81, 319	730, 947			8. 00
9.00		HOUSEKEEPI NG	377, 920			4, 260, 699		9. 00
10.00	1	DIETARY	197, 934	384, 602	1	305, 975	2, 277, 276	
11. 00 13. 00	1	CAFETERIA	161, 575	0		25 254	0	11. 00 13. 00
13. 00		NURSI NG ADMINISTRATION PASTORAL CARE	354, 069 23, 243	44, 314 51, 184		35, 254 40, 720	0	
14. 00		CENTRAL SERVICES & SUPPLY	0	01,101		0	0	1
15. 00		PHARMACY	312, 000			ō	0	
16.00	01600	MEDICAL RECORDS & LIBRARY	163, 314	230, 459	0	183, 344	0	16. 00
21. 00		I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRV	384, 936	0	0	0	0	22. 00
30. 00		ADULTS & PEDIATRICS	1, 262, 762	818, 918	288, 502	651, 499	939, 907	30.00
31. 00		INTENSIVE CARE UNIT	232, 318			214, 826	43, 000	1
31. 01		NEONATAL INTENSIVE CARE UNIT	0	0		0	0	
33. 00	03300	BURN INTENSIVE CARE UNIT	227, 020	153, 924	0	122, 456	39, 499	33. 00
40.00		SUBPROVIDER - IPF	312, 395	116, 963	64, 789	93, 051	314, 637	40. 00
43.00	1	NURSERY	168, 022	60, 248		47, 931	0	43. 00
44. 00		SKILLED NURSING FACILITY	238, 068	215, 248	36, 883	171, 243	178, 594	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	458, 726	331, 729	38, 655	263, 910	0	50. 00
50. 01		ENDOSCOPY	74, 231	45, 367		36, 093	0	50. 01
51.00	05100	RECOVERY ROOM	122, 639	141, 458	12, 885	112, 538	0	51.00
52.00		DELIVERY ROOM & LABOR ROOM	183, 894	125, 874	1	100, 141	0	
53. 00	1	ANESTHESI OLOGY	11, 081	0	-	0	0	
54.00		RADI OLOGY-DI AGNOSTI C	695, 119	361, 754	60, 865	287, 797	0	
54. 01 56. 00	1	ULTRA SOUND RADI OI SOTOPE	0	)   0	0		0	54. 01 56. 00
57. 00	1	CT SCAN	0	0	0	0	0	57. 00
58. 00	05800		0	0	0	O	0	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	313, 065	40, 297	0	32, 059	0	59. 00
60.00	1	LABORATORY	719, 888			l	0	
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	88, 875	16, 966		13, 498	0	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	182, 014 143, 623	125, 808 163, 472		100, 088 130, 052	0	65. 00 66. 00
67. 00		OCCUPATIONAL THERAPY	69, 996			I	0	
68. 00		SPEECH PATHOLOGY	18, 751	24, 099		19, 173	0	
69. 00		ELECTROCARDI OLOGY	21, 795			18, 247	0	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	665, 706	0	0	O	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	454, 403			0	0	1
73.00		DRUGS CHARGED TO PATIENTS	657, 305			43, 129	0	
74. 00 76. 00		RENAL DIALYSIS OTHER ANCILLARY SERVICE COST CENTER	52, 971	44, 116	6, 135	35, 097	0	74. 00 76. 00
76. 00		SLEEP LAB	0	0	0		0	76. 01
76. 02		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	85, 229	71, 508	Ö	56, 889	0	76. 02
76. 03	03952	WOUND CARE	208, 791	188, 515		149, 975	0	
	OUTPA	TIENT SERVICE COST CENTERS						
90. 00 91. 00		CLINIC	37, 893				0	
91.00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	565, 739	289, 653	141, 814	230, 437	0	91. 00 92. 00
72.00		AL PURPOSE COST CENTERS						72.00
118.00	)	SUBTOTALS (SUM OF LINES 1-117)	11, 160, 163	6, 125, 017	730, 947	3, 828, 654	1, 515, 637	118. 00
190. 00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	13, 712	22, 212	0	17, 671	0	190. 00
191.00	19100	RESEARCH	0	0	0	o	0	191. 00
		PHYSICIANS' PRIVATE OFFICES	0	0	0	0	304, 297	
		OTHER NONREIMBURSABLE COST CENTERS MARKETING	123, 897	0				194. 00 194. 01
		SENIOR CIRCLE	123, 697	0	١		0	194. 01
		SELECT SPECIALTY	92, 895	520, 858	0	414, 374	284, 134	
194. 04	07954	FREE MEALS	0	0	0	o	173, 208	194. 04
200.00	)	Cross Foot Adjustments						200. 00

Heal th Financi	al Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-:	2552-10
COST ALLOCATIO	ON - GENERAL SERVICE COSTS		Provi der	CCN: 150047	Peri od:	Worksheet B	
					From 06/01/2014		
					To 05/31/2015		
						10/30/2015 5:	01 pm
Co	ost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE			
		AND GENERAL					
		5. 06	7. 00	8.00	9. 00	10.00	
201. 00 Ne	egative Cost Centers	0	0		0 0	0	201. 00
202. 00 TO	OTAL (sum lines 118-201)	11, 390, 667	6, 668, 087	730, 94	7 4, 260, 699	2, 277, 276	202. 00

					To	05/31/2015	Date/Time Pre 10/30/2015 5:	
		Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PASTORAL CARE	CENTRAL SERVI CES & SUPPLY	PHARMACY	O I piii
			11. 00	13. 00	13. 01	14. 00	15. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT				T		1. 00
2. 00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	1	OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02 5. 03	1	DATA PROCESSING PURCHASING AND RECEIVING						5. 02 5. 03
5. 04	1	CENTRAL SCHEDULING						5. 04
5.05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06		OTHER ADMINISTRATIVE AND GENERAL						5.06
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPI NG						9. 00
10. 00	1	DI ETARY						10. 00
11.00	1	CAFETERI A	1, 295, 233					11.00
13. 00 13. 01		NURSING ADMINISTRATION PASTORAL CARE	73, 261 4, 210	2, 991, 154 0				13. 00 13. 01
14. 00	1	CENTRAL SERVICES & SUPPLY	0	0		О		14. 00
15. 00	1	PHARMACY	48, 167	0	0	o	2, 550, 232	15. 00
16.00	1	MEDICAL RECORDS & LIBRARY	35, 171	0	0	0	0	16.00
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	21. 00 22. 00
22.00		IENT ROUTINE SERVICE COST CENTERS		0	<u> </u>	<u> </u>	0	22.00
30.00	03000	ADULTS & PEDI ATRI CS	278, 869	1, 091, 665	103, 079	0	0	30. 00
31.00		INTENSIVE CARE UNIT	37, 866			0	0	31.00
31. 01 33. 00		NEONATAL INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT	46, 595	0 182, 438	-	0	0	31. 01 33. 00
40. 00		SUBPROVI DER - I PF	78, 033			o	0	40.00
43.00		NURSERY	31, 999	125, 313	11, 833	О	0	43. 00
44. 00		SKILLED NURSING FACILITY	47, 746	0	0	0	0	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	57, 570	225, 322	21, 276	ol	0	50. 00
50. 00	1	ENDOSCOPY	7, 719			o	0	
51. 00	1	RECOVERY ROOM	23, 915	93, 607		o	0	51. 00
52.00		DELIVERY ROOM & LABOR ROOM	37, 866	148, 276		0	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	94, 734	0	0	0	0	53. 00 54. 00
54. 00	1	ULTRA SOUND	94, 734	0		o	0	54. 00
56. 00	1	RADI OI SOTOPE	0	0	0	o	0	56. 00
57. 00		CT SCAN	0	0		0	0	
58. 00 59. 00	05800	MRI CARDI AC CATHETERI ZATI ON	0 33, 066	0 129, 459		0	0	58. 00 59. 00
60.00	1	LABORATORY	110, 172	431, 320		o	0	60.00
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	o	0	62. 00
65. 00		RESPI RATORY THERAPY	32, 757	0		0	0	65.00
66.00	1	PHYSI CAL THERAPY	25, 627	0	0	0	0	66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	9, 965 2, 667	0		0	0	
69. 00	1	ELECTROCARDI OLOGY	5, 866		Ö	ō	0	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	0 2, 550, 232	
74.00		RENAL DIALYSIS	0	0		ol Ol	2, 550, 252	•
76. 00		OTHER ANCILLARY SERVICE COST CENTER	0	0	Ö	ō	0	•
76. 01		SLEEP LAB	0	0	0	o	0	76. 01
76. 02		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	18, 021	0		0	0	
76. 03		WOUND CARE TIENT SERVICE COST CENTERS	37, 501	0	<u> </u>	U <sub>I</sub>	0	76. 03
90.00	09000	CLI NI C	8, 561	0	0	0	0	90. 00
91. 00		EMERGENCY	98, 439	385, 320	36, 383	o	0	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
118. 00	+	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	1, 286, 363	2, 991, 154	282, 437	ol	2, 550, 232	1 118. 00
	NONRE	IMBURSABLE COST CENTERS	.,230,333		232, 137			1 3. 30
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	337	0		0		190. 00
		RESEARCH PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		191.00
		OTHER NONREIMBURSABLE COST CENTERS		) O	0	0		192. 00 194. 00
		MARKETI NG	8, 533	Ö	0	Ö		194. 01
		SENI OR CIRCLE	0	0	0	o		194. 02
		SELECT SPECIALTY FREE MEALS	0	0	0	0		194. 03 194. 04
200.00		Cross Foot Adjustments		0		٥	Ü	200. 00
	1		1	1	ı			

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 06/01/2014	Worksheet B	
					Date/Time Pre 10/30/2015 5:	
Cost Center Description	CAFETERI A	NURSI NG	PASTORAL CARE	CENTRAL	PHARMACY	
		ADMI NI STRATI ON		SERVICES &		
				SUPPLY		
	11.00	13.00	13. 01	14.00	15. 00	
201.00 Negative Cost Centers	0	0	) (	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	1, 295, 233	2, 991, 154	282, 437	7  o	2, 550, 232	202. 00

In Lieu of Form CMS-2552-10
Worksheet B
Part I
B1/2015 Date/Time Prepared:
10/30/2015 5: 01 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST JOSEPH MEDICAL CENTER Provi der CCN: 150047 Peri od: From 06/01/2014 To 05/31/2015 INTERNS & RESIDENTS

Cost Center Description	MEDI CAL RECORDS & LI BRARY	SERVI CES-SALAR Y & FRI NGES APPRV	SERVI CES-OTHER PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	16. 00	21. 00	22. 00	24. 00	25. 00	
GENERAL SERVI CE COST CENTERS  1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00560 OTHER ADMINISTRATI VE AND GENERAL 5. 02 00550 DATA PROCESSI NG 5. 03 00591 PURCHASI NG AND RECEI VI NG 5. 04 00540 CENTRAL SCHEDULI NG 5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 06 00590 OTHER ADMINISTRATI VE AND GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINISTRATI ON 13. 01 01850 PASTORAL CARE 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	1, 758, 147 0	C	3, 085, 770			1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 13. 01 14. 00 15. 00 21. 00 22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			3,003,770			22.00
30. 00	141, 340 12, 733 0 22, 172 70, 385 11, 719 11, 327	0 0 0	0 0 0	14, 892, 103 2, 619, 609 0 2, 404, 177 3, 242, 113 1, 647, 924 2, 569, 469	0 0 0 0	30. 00 31. 00 31. 01 33. 00 40. 00 43. 00 44. 00
50. 00   05000   OPERATI NG ROOM 50. 01   03330   ENDOSCOPY	139, 729 15, 106	ł		5, 439, 260 732, 399		50. 00 50. 01
51. 00   05100   RECOVERY ROOM   52. 00   05200   DELI VERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY   54. 01   03630   ULTRA SOUND   56. 00   05600   RADI OLOGY-DI AGNOSTI C   57. 00   05700   CT   SCAN   58. 00   05800   MRI	16, 229 5, 579 20, 296 261, 486 0 0	0 0	0 0 0	1, 392, 584 1, 905, 890 109, 127 6, 638, 930 0 0	0 0	51. 00 52. 00 53. 00 54. 00 54. 01 56. 00 57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	74, 229 210, 077 12, 950	0	0	2, 830, 963 7, 121, 865 755, 865	0	59. 00 60. 00 62. 00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	49, 526 17, 967	0	0 0	1, 767, 258 1, 489, 629	0	65. 00 66. 00
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	11, 235 2, 570 11, 145	0	0	694, 668 198, 823 236, 290	0	67. 00 68. 00 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	55, 442 128, 069	0	0	5, 391, 953 3, 770, 709	0	71. 00 72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS 76. 00   03950   OTHER ANCILLARY SERVICE COST CENTER	241, 527 8, 313 0	l	0 0	8, 158, 266 518, 291 0	0 0	73. 00 74. 00 76. 00
76. 01   03951   SLEEP LAB 76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL   SERVI CES 76. 03   03952   WOUND   CARE	19, 744 23, 898	ł	o	0 849, 382 2, 152, 167		76. 01 76. 02 76. 03
0UTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC	325					
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS   (NON-DISTINCT PART	163, 029			5, 880, 217		91. 00
SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1-117)  NONREI MBURSABLE COST CENTERS	1, 758, 147	O	2, 892, 909	87, 524, 657	-2, 892, 909	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	0	Ö	150, 138 0	0	190. 00 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	O	0	497, 158 0	0	194. 00
194. 01 07951 MARKETI NG	0	0	0	1, 001, 731	0	194. 01

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150047	Peri od: From 06/01/2014 To 05/31/2015	Date/Time Pre	
		LATERNO	DECLIDENTS		10/30/2015 5:	01 pm
		INTERNS &	RESI DENTS			
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SERVI CES-SALAR Y & FRI NGES APPRV	SERVICES-OTHI PRGM COSTS APPRV		Intern & Residents Cost & Post Stepdown	
					Adjustments	
	16. 00	21.00	22. 00	24. 00	25. 00	
194. 02 07952 SENI OR CI RCLE	0	0		0 -1, 737	0	194. 02
194. 03 07953 SELECT SPECIALTY	0	0		0 1, 964, 042	0	194. 03
194.04 07954 FREE MEALS	0	0		0 173, 208	0	194. 04
200.00 Cross Foot Adjustments		0		0	0	200. 00
201.00 Negative Cost Centers	0	0		0	<b>l</b>	201. 00
202.00   TOTAL (sum lines 118-201)	1, 758, 147	0	3, 085, 7	70 91, 309, 197	-3, 085, 770	202. 00

		Cost Center Description	Total	10/30/2015 5: 01 pm
	CENED	AL SERVICE COST CENTERS	26. 00	
1.00		CAP REL COSTS-BLDG & FIXT		1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5. 01		OTHER ADMINISTRATIVE AND GENERAL		5. 01
5. 02	1	DATA PROCESSING		5. 02
5. 03 5. 04	1	PURCHASING AND RECEIVING CENTRAL SCHEDULING		5. 03 5. 04
5. 05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE		5.05
5. 06		OTHER ADMINISTRATIVE AND GENERAL		5. 06
7.00	00700	OPERATION OF PLANT		7. 00
8. 00		LAUNDRY & LINEN SERVICE		8.00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY		9.00
11. 00	1	CAFETERIA		10. 00   11. 00
13. 00	1	NURSING ADMINISTRATION		13. 00
13. 01		PASTORAL CARE		13. 01
14. 00	4	CENTRAL SERVICES & SUPPLY		14. 00
15. 00	1	PHARMACY		15.00
16. 00 21. 00		MEDICAL RECORDS & LIBRARY I&R SERVICES-SALARY & FRINGES APPRV		16. 00   21. 00
22. 00	1	I &R SERVI CES-OTHER PRGM COSTS APPRV		22.00
		IENT ROUTINE SERVICE COST CENTERS		
30.00		ADULTS & PEDIATRICS	14, 436, 251	30.00
31.00		INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	2, 619, 609	31.00
31. 01 33. 00	1	BURN INTENSIVE CARE UNIT	2, 404, 177	31. 01
40. 00	1	SUBPROVI DER - I PF	3, 242, 113	40.00
43.00	1	NURSERY	1, 647, 924	43. 00
44. 00		SKILLED NURSING FACILITY	2, 569, 469	44. 00
FO 00		LARY SERVICE COST CENTERS	4 755 401	F0.00
50. 00 50. 01		OPERATING ROOM ENDOSCOPY	4, 755, 481 732, 399	50. 00 50. 01
51. 00		RECOVERY ROOM	1, 392, 584	51. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	1, 905, 890	52. 00
53. 00	4	ANESTHESI OLOGY	109, 127	53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	6, 638, 930	54. 00
54. 01 56. 00	1	ULTRA SOUND RADI OI SOTOPE	0	54. 01 56. 00
57. 00		CT SCAN	0	57.00
58. 00			O	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	2, 830, 963	59. 00
60.00	1	LABORATORY	7, 121, 865	60.00
62. 00 65. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL RESPIRATORY THERAPY	755, 865	62. 00 65. 00
66. 00	4	PHYSI CAL THERAPY	1, 767, 258 1, 489, 629	66.00
67. 00	1	OCCUPATIONAL THERAPY	694, 668	67. 00
68. 00	06800	SPEECH PATHOLOGY	198, 823	68. 00
69. 00		ELECTROCARDI OLOGY	236, 290	69. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	5, 391, 953	71. 00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	3, 770, 709 8, 158, 266	72. 00 73. 00
74. 00		RENAL DIALYSIS	518, 291	73.00
76. 00	1	OTHER ANCILLARY SERVICE COST CENTER	0	76. 00
76. 01		SLEEP LAB	0	76. 01
76. 02	4	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	849, 382	76.02
76. 03		WOUND CARE TIENT SERVICE COST CENTERS	2, 117, 101	76. 03
90. 00		CLINIC	396, 514	90.00
91.00	1	EMERGENCY	5, 880, 217	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART		92.00
110.0		AL PURPOSE COST CENTERS	04 (21 740	110.00
118. 0		SUBTOTALS (SUM OF LINES 1-117)  IMBURSABLE COST CENTERS	84, 631, 748	118. 00
190. 0		GIFT, FLOWER, COFFEE SHOP & CANTEEN	150, 138	190.00
191. 0	0 19100	RESEARCH	О	191. 00
		PHYSICIANS' PRIVATE OFFICES	304, 297	192. 00
		OTHER NONREIMBURSABLE COST CENTERS	0	194. 00
		MARKETING SENIOR CIRCLE	1, 001, 731 -1, 737	194. 01 194. 02
	1	SELECT SPECIALTY	1, 964, 042	194. 02
		FREE MEALS	173, 208	194. 04
200.0	О	Cross Foot Adjustments	O	200. 00
201.0	1	Negative Cost Centers	0	201. 00
202.0	U	TOTAL (sum lines 118-201)	88, 223, 427	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150047

				To	05/31/2015	Date/Time Prep 10/30/2015 5:0	
			CAPI TAL REI	LATED COSTS		107 307 2013 3.	эт рііі
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capital Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	73, 961	55, 648	129, 609		4. 00
5. 01 5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL 00550 DATA PROCESSING	0	210, 490	158, 370	0 368, 860	0 3, 061	5. 01 5. 02
5. 03	00591 PURCHASING AND RECEIVING	0	182, 216		319, 313		5. 03
5.04	00540 CENTRAL SCHEDULING	0	51, 862		90, 883		5. 04
5. 05 5. 06	OO580   CASHI ERI NG/ACCOUNTS RECEI VABLE   OO590   OTHER ADMINI STRATI VE AND GENERAL	0	0 141, 763	-	0 248, 424	1, 092 7, 988	5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	0	1, 112, 685		1, 949, 853		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	58, 069		101, 759		8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	879, 168 274, 640		1, 540, 644 481, 276	2, 320 0	9. 00 10. 00
11. 00	01100 CAFETERI A	0	0		0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	31, 644		55, 453		13.00
13. 01 14. 00	01850   PASTORAL CARE   01400   CENTRAL SERVI CES & SUPPLY	0	36, 550 0	1	64, 050 0	258 0	13. 01 14. 00
15. 00	01500 PHARMACY	0	ő		0	5, 480	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	164, 568		288, 387	1, 822	16. 00
21. 00 22. 00	02100   &R SERVICES-SALARY & FRINGES APPRV   02200   &R SERVICES-OTHER PRGM COSTS APPRV	0	0	-	0	0	21. 00 22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	0		J	J	U	22.00
30.00	03000 ADULTS & PEDIATRICS	0	001,700		1, 024, 762		30. 00
31. 00 31. 01	03100   INTENSI VE CARE UNIT   02060   NEONATAL   INTENSI VE CARE UNIT	0	192, 826	145, 080 0	337, 906 0	3, 586 0	31. 00 31. 01
33. 00	03300 BURN INTENSIVE CARE UNIT	0	109, 916		192, 615		33. 00
40. 00	04000 SUBPROVI DER - I PF	0	83, 522		146, 363		40. 00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	43, 023 153, 706		75, 393 269, 353		43. 00 44. 00
44.00	ANCILLARY SERVICE COST CENTERS		155, 700	113,047	207, 333	4, 123	44.00
50.00	05000 OPERATING ROOM	0	200,00.		415, 112		50.00
50. 01 51. 00	03330 ENDOSCOPY 05100 RECOVERY ROOM	0	32, 396 101, 013	1	56, 771 177, 014	806 1, 938	50. 01 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	89, 885		157, 514	3, 322	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	-	452 (04	7 151	53.00
54. 00 54. 01	05400   RADI OLOGY-DI AGNOSTI C   03630   ULTRA SOUND	0	258, 324 0	194, 360 0	452, 684 0	7, 151 0	54. 00 54. 01
56. 00	05600 RADI OI SOTOPE	0	O	0	0	0	56. 00
57. 00 58. 00	05700   CT   SCAN   05800   MRI	0	0	0	0	0	57. 00
59. 00	05900   CARDI AC   CATHETERI ZATI ON	0	28, 776	21, 651	50, 427	-	58. 00 59. 00
60.00	06000 LABORATORY	0	221, 101		387, 455		
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	12, 115		21, 230		62.00
65. 00 66. 00	06500   RESPI RATORY   THERAPY   06600   PHYSI CAL   THERAPY	0	89, 838 116, 733		157, 431 204, 562		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	44, 684	33, 620	78, 304	1, 176	67. 00
68. 00	06800  SPEECH PATHOLOGY   06900  ELECTROCARDI OLOGY	0	17, 209		30, 157		68. 00
69. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	16, 378 0		28, 701 0	505 0	69. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	38, 713 31, 503		67, 840	0	73.00
74. 00 76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	31,503	23, 702	55, 205 0	0	74. 00 76. 00
76. 01	03951 SLEEP LAB	0	0	0	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	51, 063		89, 482		76. 02
76. 03	O3952  WOUND CARE   OUTPATIENT SERVICE COST CENTERS	0	134, 616	101, 284	235, 900	3, 209	76. 03
90.00	09000 CLI NI C	0	33, 321	25, 070	58, 391	609	90. 00
91.00	09100 EMERGENCY	0	206, 838	155, 623	362, 461	7, 748	
92. 00	O9200   OBSERVATION BEDS (NON-DISTINCT PART   SPECIAL PURPOSE COST CENTERS				0		92. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	6, 146, 779	4, 624, 765	10, 771, 544	128, 866	118. 00
100.00	NONREI MBURSABLE COST CENTERS		15.074	11 001	27 705	10	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  19100 RESEARCH	0	15, 861 0	11, 934	27, 795 0		190. 00 191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	Ö	o o	0	0	192. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
	07951  MARKETI NG  07952  SENI OR CI RCLE	0	0	0	0		194. 01 194. 02
		1 0	1	<u> </u>	<u> </u>	١	

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 06/01/2014	Part II	
				To 05/31/2015	Date/Time Pre 10/30/2015 5:	
		CAPI TAL REL	ATED COSTS		10/30/2013 3.	O I PIII
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
·	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
194. 03 07953 SELECT SPECIALTY	0	371, 939	279, 84	2 651, 781	0	194. 03
194.04 07954 FREE MEALS	0	0		0	0	194. 04
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	6, 534, 579	4, 916, 54	11, 451, 120	129, 609	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 06/01/2014 | Part II |
| To 05/31/2015 | Date/Time Prepared: | 10/30/2015 5:01 pm

					05/31/2015	10/30/2015 5:	
	Cost Center Description	OTHER	DATA	PURCHASI NG AND		CASHI ERI NG/ACC	
		ADMI NI STRATI VE AND GENERAL	PROCESSI NG	RECEIVING	SCHEDULI NG	OUNTS RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00560 OTHER ADMINISTRATIVE AND GENERAL						4. 00 5. 01
5. 01	00550 DATA PROCESSING	0	371, 921				5. 01
5. 02	00591 PURCHASING AND RECEIVING		3/1, 7/21	321, 025			5. 02
5. 04	00540 CENTRAL SCHEDULING		(	0 321, 023	95, 033		5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	O	C	o o	0	1, 092	5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	0	C	0	0	0	5. 06
7.00	00700 OPERATION OF PLANT	0	C	0	0	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	C	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	C	0	0	0	9. 00
10.00	01000 DI ETARY	0	(	0	0	0	10.00
11. 00 13. 00	01100 CAFETERI A	0	(		0	0	11. 00 13. 00
13. 00	01300 NURSI NG ADMINI STRATI ON 01850 PASTORAL CARE	0	(		0	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY		(		0	0	14. 00
15. 00	01500 PHARMACY	o	C	4, 704	0	o o	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	Č	147	0	0	16.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	C	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	C	0	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00	03000 ADULTS & PEDIATRICS	0	29, 897		· ·	81	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	2, 693	1	690	7	31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	4 (00	0	1 201	0	31. 01
33. 00 40. 00	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	4, 690 14, 888		1, 201 3, 813	13 41	33. 00 40. 00
43. 00	04300 NURSERY		2, 479	1	635	7	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	2, 396		614	7	44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	2, 370	7, 7,1	014	,	44.00
50.00	05000 OPERATI NG ROOM	0	29, 556	20, 226	7, 570	81	50.00
50. 01	03330 ENDOSCOPY	o	3, 195	3, 547	818	9	50. 01
51.00	05100 RECOVERY ROOM	0	3, 433	441	879	9	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 180			3	52. 00
53. 00	05300 ANESTHESI OLOGY	0	4, 293		1, 100	12	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	55, 339	1, 236	13, 944	230	54.00
54. 01	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	(		0	0	54. 01 56. 00
56. 00 57. 00	05700 CT SCAN	0	(		0		57.00
58. 00	05800 MRI		(		0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		15, 701	17, 603	4, 022	43	59.00
60. 00	06000 LABORATORY	o	44, 437		11, 382	121	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	2, 739			7	62.00
65.00	06500 RESPI RATORY THERAPY	0	10, 476	3, 555	2, 683	29	65. 00
66.00	06600 PHYSI CAL THERAPY	0	3, 801		973	10	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	2, 376			6	67. 00
	06800 SPEECH PATHOLOGY	0	544			1	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	2, 357		604		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	11, 728				71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	27, 090 51, 090		6, 939 13, 086		72. 00 73. 00
74.00	07400 RENAL DIALYSIS		1, 758		450	5	74.00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER		1, 750	0	0	o o	76.00
76. 01	03951 SLEEP LAB	o		ol o	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	4, 176	179	1, 070	11	76. 02
76. 03	03952 WOUND CARE	0	5, 055	3, 800	1, 295	14	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	69		18		90. 00
91. 00	09100 EMERGENCY	0	34, 485	14, 757	8, 833	94	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
110 00	SPECIAL PURPOSE COST CENTERS		271 021	210.072	OF 022	1 000	110 00
118.00	SUBTOTALS (SUM OF LINES 1-117)   NONREIMBURSABLE COST CENTERS	0	371, 921	319, 073	95, 033	1, 092	118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	(	1, 793	0	0	190. 00
	19100 RESEARCH			1, 7,73	0	l e	191.00
	19200 PHYSICIANS' PRIVATE OFFICES		(		0	<b>l</b>	192. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS		C	ol ő	0		194. 00
	07951 MARKETI NG		Č	159	0	0	194. 01
194. 02	07952 SENI OR CI RCLE	0	C	0	0		194. 02
	07953 SELECT SPECIALTY	0	C	0	0		194. 03
	07954 FREE MEALS	0	C	0	0	0	194. 04
200.00	Cross Foot Adjustments						200. 00

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-	<u> 2552-10</u>
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 06/01/2014		nonod.
	_		'	o 05/31/2015	Date/Time Pre 10/30/2015 5:	
Cost Center Description	OTHER	DATA	PURCHASING AND	CENTRAL	CASHI ERI NG/ACC	
	ADMI NI STRATI VE	PROCESSI NG	RECEI VI NG	SCHEDULI NG	OUNTS	
	AND GENERAL				RECEI VABLE	
	5. 01	5. 02	5. 03	5. 04	5. 05	
201.00 Negative Cost Centers	0	0	C	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	371, 921	321, 025	95, 033	1, 092	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 06/01/2014 | Part II |
| To 05/31/2015 | Date/Time Prepared: | 10/30/2015 5:01 pm

				'	0 05/31/2015	10/30/2015 5:	
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE AND GENERAL	PLANT	LINEN SERVICE			
		5. 06	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00 5. 01
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL 00550 DATA PROCESSING						5. 01
5. 02	00591 PURCHASING AND RECEIVING						5. 02
5. 04	00540 CENTRAL SCHEDULING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	256, 412					5. 06
7.00	00700 OPERATION OF PLANT	18, 723	1, 972, 529				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 824	24, 055	127, 638			8. 00
9.00	00900 HOUSEKEEPI NG	8, 506	l	1	.,		9. 00
10.00	01000 DI ETARY	4, 455	1	i	137, 571	737, 074	10.00
11.00	01100 CAFETERI A	3, 637	0	_	15 051	0	11.00
13. 00 13. 01	O1300   NURSI NG ADMI NI STRATI ON   O1850   PASTORAL CARE	7, 969 523	1	0	15, 851	0	13. 00 13. 01
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	15, 141		18, 308	0	14. 00
15. 00	01500 PHARMACY	7, 023	١	170	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 676	l e	l .		0	16.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	Ö		0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	8, 664	0	0	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	28, 450	242, 249	50, 378	292, 922	304, 215	30. 00
31. 00	03100 INTENSIVE CARE UNIT	5, 229	79, 880	1		13, 918	31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	0		0	31. 01
33. 00	03300 BURN INTENSIVE CARE UNIT	5, 110	1	l .	55, 058	12, 784	33. 00
40.00	04000 SUBPROVI DER - I PF	7, 031	34, 600	1		101, 837	40.00
43.00	04300 NURSERY	3, 782 5, 359	17, 822	1		0 E7 00E	43. 00 44. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	5, 359	63, 674	6, 441	76, 993	57, 805	44.00
50. 00	05000 OPERATING ROOM	10, 325	98, 131	6, 750	118, 658	0	50.00
50. 01	03330 ENDOSCOPY	1, 671	13, 420			0	50. 01
51.00	05100 RECOVERY ROOM	2, 760	l	1		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 139	37, 236	0	45, 025	0	52. 00
53.00	05300 ANESTHESI OLOGY	249	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	15, 646	107, 013	10, 628	129, 398	0	54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00 59. 00	05800 MRI	7 047	11 021		14 414	0	58. 00 59. 00
60.00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	7, 047 16, 203	11, 921 91, 593	l .	,	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 000	· ·	l .		0	62.00
65. 00	06500 RESPIRATORY THERAPY	4, 097	37, 216	l .		0	65.00
66. 00	06600 PHYSI CAL THERAPY	3, 233				0	66.00
67.00	1	1, 575	l	l .		0	67.00
68.00	06800 SPEECH PATHOLOGY	422	7, 129	0	8, 620	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	491	6, 785	591	8, 204	0	69. 00
71. 00		14, 984		0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	10, 228	l .	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	14, 795	l	l .	19, 392	0	73. 00
74.00	07400 RENAL DIALYSIS	1, 192	13, 050	1, 071	15, 780	0	74.00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER 03951 SLEEP LAB	0	0		0	0	76.00
76. 01 76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 918	21, 153		25, 578	0	76. 01 76. 02
76. 02		4, 700	1	1		0	76. 02
70.03	OUTPATIENT SERVICE COST CENTERS	4,700	33, 700	1, 372	07, 431	0	70.03
90. 00		853	13, 803	14	16, 691	0	90.00
91.00	09100 EMERGENCY	12, 734	85, 684	1		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		251, 223	1, 811, 880	127, 638	1, 721, 418	490, 559	118. 00
	NONREI MBURSABLE COST CENTERS		Г	T			
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	309	6, 571	0	7, 945		190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0			0		192. 00 194. 00
	D 07950 0THER NONREIMBURSABLE COST CENTERS 1 07951 MARKETING	2,789					194. 00
	2 07952 SENI OR CI RCLE	2, 789				0	194. 01
	3 07953 SELECT SPECIALTY	2, 091	154, 078		186, 309	91, 964	
	4 07954 FREE MEALS	2,371	0 101,070	i o	0	56, 061	
200.00						22, 30.	200. 00
-	· · · · · · · · · · · · · · · · · · ·		•	•		•	

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi d	er CCN: 150047	Peri od:	Worksheet B	
				From 06/01/2014		
				To 05/31/2015	Date/Time Pre	pared:
					10/30/2015 5:	01 pm
Cost Center Description	OTHER	OPERATION (	F LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVIC	E		
	AND GENERAL					
	5.06	7. 00	8. 00	9. 00	10.00	
201.00 Negative Cost Centers	0		0	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	256, 412	1, 972, !	127, 6	1, 915, 672	737, 074	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150047

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 06/01/2014 | Part II |
| To 05/31/2015 | Date/Time Prepared: | 10/30/2015 5:01 pm

					05/31/2015	10/30/2015 5:	01 pm_
	Cost Center Description	CAFETERI A	NURSI NG	PASTORAL CARE	CENTRAL	PHARMACY	
			ADMI NI STRATI ON		SERVI CES & SUPPLY		
		11. 00	13.00	13. 01	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL 00550 DATA PROCESSING						5. 01 5. 02
5. 02 5. 03	00591 PURCHASING AND RECEIVING						5. 02
5. 04	00540 CENTRAL SCHEDULING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	0 (07					10.00
11. 00	01100 CAFETERI A	3, 637	ł .				11.00
13. 00 13. 01	01300 NURSI NG ADMINI STRATI ON 01850 PASTORAL CARE	206 12		98, 292			13. 00 13. 01
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0		70, 272	٥		14. 00
15. 00	01500 PHARMACY	135		Ö	ol	17, 512	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	99		0	Ö	0	16. 00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	o	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			,			
30. 00	03000 ADULTS & PEDIATRICS	784		35, 873	0	0	30. 00
31. 00	03100   INTENSI VE CARE UNIT	106		4, 871	0	0	31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0		0 5, 995	0	0	31. 01 33. 00
33. 00 40. 00	04000 SUBPROVI DER – I PF	131 219	6, 062	5, 995	0	0	40. 00
43. 00	04300 NURSERY	90		4, 118	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	134	1, 101	0	ol	0	44. 00
00	ANCILLARY SERVICE COST CENTERS			<u> </u>	<u> </u>		
50.00	05000 OPERATING ROOM	162	7, 487	7, 404	0	0	50. 00
50. 01	03330 ENDOSCOPY	22	1, 004	993	0	0	50. 01
51.00	05100 RECOVERY ROOM	67	3, 110		0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	106	1	4, 872	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0		0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	266		0	0	0	54.00
54. 01 56. 00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	0	0	0	0	54. 01 56. 00
57. 00	05700 CT SCAN	0		0	0	0	57. 00
58. 00	05800 MRI	0	0	Ö	ol	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	93		4, 254	Ö	0	59. 00
60.00	06000 LABORATORY	309		14, 174	o	0	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	O	0	62.00
65.00	06500 RESPI RATORY THERAPY	92	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	72		0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	28	0	0	0	0	67. 00
	06800 SPEECH PATHOLOGY	1/	0	0	0	0	68. 00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16		0	0	0	69. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0		0	Ö	17, 512	73. 00
	07400 RENAL DIALYSIS	0	Ö	O	ō	0	74. 00
	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	o	0	76. 00
76. 01	03951 SLEEP LAB	0	0	0	O	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	51	0	0	0	0	76. 02
76. 03	03952 WOUND CARE	105	0	0	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS				ام		
	09000 CLINIC	24		12 ((2	0	0	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	276	12, 803	12, 662	0	0	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118. 00		3, 612	99, 387	98, 292	o	17, 512	118 00
110.00	NONREI MBURSABLE COST CENTERS	0,012	77,007	70, 272	<u> </u>	17,012	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	0	0	0	0	190. 00
	19100 RESEARCH	0	0	0	o		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	o		192. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o		194. 00
	07951 MARKETI NG	24	0	0	0		194. 01
	07952 SENI OR CI RCLE	0	0	0	0		194. 02
	07953 SELECT SPECIALTY	0	0	0	0		194. 03
194. 04 200. 00	07954 FREE MEALS   Cross Foot Adjustments	0	0		O		194. 04 200. 00
200.00	Toruss rout Aujustillerits		l .				200.00

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 06/01/2014 To 05/31/2015		narad.
				10 03/31/2013	10/30/2015 5:	
Cost Center Description	CAFETERI A	NURSI NG	PASTORAL CARE	E CENTRAL	PHARMACY	
		ADMI NI STRATI ON		SERVICES &		
				SUPPLY		
	11. 00	13.00	13. 01	14.00	15. 00	
201.00 Negative Cost Centers	0	0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	3, 637	99, 387	98, 29	2 0	17, 512	202. 00

Health Financial Systems In Lieu of Form CMS-2552-10 ST JOSEPH MEDICAL CENTER Provi der CCN: 150047 ALLOCATION OF CAPITAL RELATED COSTS Peri od: Worksheet B From 06/01/2014 Part II Date/Time Prepared: 05/31/2015 10/30/2015 5:01 pm INTERNS & RESIDENTS Cost Center Description MEDI CAL SERVI CES-SALAR SERVI CES-OTHER Subtotal Intern & Y & FRINGES Residents Cost RECORDS & PRGM COSTS LI BRARY **APPRV APPRV** & Post Stepdown Adjustments 16.00 21.00 22.00 24. 00 25. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00560 OTHER ADMINISTRATIVE AND GENERAL 5 01 5 01 5.02 00550 DATA PROCESSING 5.02 5.03 00591 PURCHASING AND RECEIVING 5.03 00540 CENTRAL SCHEDULING 5.04 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5 05 5 05 5.06 00590 OTHER ADMINISTRATIVE AND GENERAL 5.06 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 13 01 01850 PASTORAL CARE 13 01 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 444, 738 16,00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 8,664 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30.00 35.763 2, 123, 823 0 31.00 03100 INTENSIVE CARE UNIT 3, 222 558, 726 0 31.00 02060 NEONATAL INTENSIVE CARE UNIT 31.01 0 31.01 33.00 03300 BURN INTENSIVE CARE UNIT 5.610 342, 392 0 33.00 04000 SUBPROVIDER - IPF 40.00 17,809 386, 421 0 40.00 2, 965 04300 NURSERY 0 43.00 43.00 140.509 04400 SKILLED NURSING FACILITY 44.00 2,866 491, 238 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 35, 355 761, 312 0 50.00 03330 ENDOSCOPY 50.01 50.01 3,822 102, 306 0 05100 RECOVERY ROOM 291, 527 51.00 51.00 4.106 0 05200 DELIVERY ROOM & LABOR ROOM 1, 412 52.00 262, 156 0 52.00 53.00 05300 ANESTHESI OLOGY 5, 135 10, 792 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 66,044 859, 579 0 54.00 03630 ULTRA SOUND 54 01 0 O 0 54 01 05600 RADI OI SOTOPE 56.00 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 57.00 58.00 05800 MRI 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 18 782 151, 708 0 06000 LABORATORY 60.00 53, 155 766, 000 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 3, 277 41, 989 62.00 62.00 0 65.00 06500 RESPIRATORY THERAPY 12,531 275, 681 0 65.00 06600 PHYSI CAL THERAPY 66.00 4, 546 326, 810 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 2,843 127, 844 0 67.00 47, 991 06800 SPEECH PATHOLOGY 68.00 650 68.00 06900 ELECTROCARDI OLOGY 2,820 69.00 51, 287 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 14.028 171, 911 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 32, 405 155, 749 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 61, 113 261,004 0 73.00 07400 RENAL DIALYSIS 74 00 74 00 2, 103 90, 737 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTER 0 76.00 03951 SLEEP LAB 76.01 76.01 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 4, 996 149, 982 76.02 0 76.02 03952 WOUND CARE <u>6,</u>047 76.03 390.914 0 76.03 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 82 91,005 0 90.00 91.00 09100 EMERGENCY 722, 160 91.00 41, 251 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREIMBURSABLE COST CENTERS 118.00 444, 738 0 0 10, 153, 553 0 118. 00

0

0

0

44, 426

98.490

3,703

0 190, 00

0 191.00

0 192. 00

0 194.00

0 194. 01

191. 00 19100 RESEARCH

194. 01 07951 MARKETI NG

190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

194.00 07950 OTHER NONREIMBURSABLE COST CENTERS

192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES

Health Financial Systems	ST JOSEPH MED	DI CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 06/01/2014 To 05/31/2015	Part II   Date/Time Pre	nared:
				10 03/31/2013	10/30/2015 5:	01 pm
		INTERNS &	RESI DENTS			
Cost Center Description		SERVI CES-SALAR			Intern &	
	RECORDS &	Y & FRINGES	PRGM COSTS		Residents Cost	
	LI BRARY	APPRV	APPRV		& Post	
					Stepdown	
					Adjustments	
	16. 00	21.00	22. 00	24.00	25. 00	
194. 02 07952 SENI OR CI RCLE	C	)		0	0	194. 02
194. 03 07953 SELECT SPECIALTY	C			1, 086, 223	0	194. 03
194.04 07954 FREE MEALS	C			56, 061	0	194. 04
200.00 Cross Foot Adjustments		0	8, 66	8, 664	0	200. 00
201.00 Negative Cost Centers	C	0		0	0	201. 00
202.00 TOTAL (sum lines 118-201)	444, 738	0	8, 66	11, 451, 120	0	202. 00

2.00   00200 CAP REL COSTS-MYBLE EQUIP   4.00   00400   EMPLOYUSE BENEFITS DEPARTMENT   5.01   00560   OTHER ADMIN IN STRATI VE AND GENERAL   5.02   00550   DATA PROCESSI MG   5.03   00550   DATA PROCESSI MG   5.04   00560   OTHER ADMIN IN STRATI VE AND GENERAL   5.05   00590   OSH FRING-ACCOUNTS RECEI VABLE   6.06   00590   OTHER ADMIN ISTRATI VE AND GENERAL   7.00   00700   OPERATI ON OF PLANT   7.00   00700   OPERATI ON OF PLANT   7.00   00700   OPERATI ON OF PLANT   7.00   00700   ODERATI ON OF PLANT   7.00   00700   OD	
1.00	
2.00   00200 CAP REL COSTS-MYBLE EQUIP   4.00   00400   EMPLOYUSE BENEFITS DEPRATIMENT   5.01   00560 OTHER ADMIN IN STRATI VE AND GENERAL   5.02   00550 DATA PROCESSI NG   5.03   00501   PURCHASING AND RECEI VI NG   5.04   00560   CENTRAL SCHEDULI NG   5.05   00580 CASHI ERI NG/ACCOUNTS RECEI VABLE   6.06   00700   OPERATION OF PLANT   6.00   00700   OPERATION OF PLANT   6.00   00700   OPERATION OF PLANT   7.00   00800 LAUNGRY & LI NEN SERVI CE   7.00   010000   HOUSEKEPI NG   7.00   010000   HOUSEKEPI NG   7.00   010000   HOUSEKEPI NG   7.00   010000   OPERATION OF PLANT   7.01   010000   OPERATION OF PLANT   7.00   010000   OPERATION OF PLANT   7.01   010000   OPERATION OF PLANT   7.01   01000   OPERATION OF PLANT   7.02   010000   HOUSEKEPI NG   7.03   010000   HOUSEKEPI NG   7.04   010000   OPERATION OF PLANT   7.05   010000   OPERATION OF PLANT   7.06   010000   OPERATION OF PLANT   7.07   010000   OPERATION OF PLANT   7.08   010000   OPERATION OF PLANT   7.09   010000   OPERATION OF PLANT   7.00   010000   OPERATION OF PLANT	1. 00
5.01	2. 00
5. 02   00550   DATA PROCESSI NO	4.00
5. 03 00591 PURCHASI NG AND RECEIVING 5. 05 00590 CASHI ERI NG/ACCOUNTS RECEIVABLE 6. 00590 OTHER ADMINISTRATI VE AND GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00500 CASHI ERI NG/ACCOUNTS RECEIVABLE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINISTRATI ON 11. 13. 00 01300 NURSI NG ADMINISTRATI ON 11. 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01400 CENTRAL SERVI CES & SUPPLY 17. 00 01400 CENTRAL SERVI CES & SUPPLY 18. 00 01400 MEDI CAL RECORDS & LI BRARY 19. 00 01400 MEDI CAL RECORDS	5. 01
5.04   OG\$40   CENTRAL SCHEDULI NG   S.05   OG\$80   CASH ERI RIKG/ACCOUNTS RECEIVABLE   S.06   OO\$90   OTHER ADMINI STRATI VE AND GENERAL   S.00   OO\$90   OFHATI ON OF PLANT   S.00   OO\$90   OO\$90   CHANDRY & LI NEN SERVI CE   S.00   OO\$90   CHANDRY & LI NEN SERVI CE   S.00   OO\$90   HOUSEKEEPI NG   S.00   OO\$90   HOUSEKEEPI NG   S.00   OO\$90   HOUSEKEEPI NG   S.00   OO\$90   HOUSEKEEPI NG   S.00   OO\$90   OO\$90   HOUSEKEEPI NG   S.00   OO\$90   OO\$90   HOUSEKEEPI NG   S.00   OO\$90   OO\$90	5. 02
5. 05   ODSBO CASH FER INC/ACCOUNTS RECEI VABLE	5. 03 5. 04
5.06   00590   OTHER ADMINISTRATIVE AND GENERAL   7.00   0700   OPERATION OF PLANT   7.00   0700   OPERATION OF PLANT   7.00   0700	5. 05
8. 00   00800   LAUNDRY & LINEN SERVICE	5. 06
9.00 00900 HOUSEKEEPING 11.00 011000 DIETARY 11.00 01100 CAFETERIA 1 13.00 01300 NURSING ADMINISTRATION 1 13.01 01050 PASTORAL CARE 1 14.00 01400 CENTRAL SERVICES & SUPPLY 1 15.00 01500 PHARMACY 1 16.00 01600 MEDICAL RECORDS & LIBRARY 1 17.00 02100 I&R SERVICES-SALLARY & SIRVICES & SUPPLY 1 18.00 01600 MEDICAL RECORDS & LIBRARY 1 19.00 02100 I&R SERVICES-SALLARY & SIRVICES-OTHER PROM COSTS APPRV 1 19.00 02100 I&R SERVICES-SALLARY & SIRVICES-OTHER PROM COSTS APPRV 1 19.00 02100 I&R SERVICES-SALLARY & SIRVICES-OTHER PROM COSTS APPRV 1 10.00 03000 ADULTS & PEDIATRIC ST 1 10.00 03000 BURN INTENSIVE CARE UNIT 1 558, 726 3 10.01 03000 BURN INTENSIVE CARE UNIT 1 342, 392 3 140.00 04000 SUBPROVIDER - IPF 386, 421 4 140.00 04000 SUBPROVIDER - IPF 386, 421 4 141.00 04000 SUBPROVIDER - IPF 386, 421 4 142.00 04000 SUBPROVIDER - IPF 386, 421 4 143.00 04000 SUBPROVIDER - IPF 386, 421 4 144.00 0400 SUBPROVIDER - IPF 386, 421 4 145.00 04300 NURSERY 140, 509 4 150.00 05000 OPERATING ROOM 761, 312 7 150.00 05000 OPERATING ROOM 291, 527 5 150.00 05000 OPERATING ROOM 291, 792 5 150.0	7. 00
10.00   01000   DIETARY	8. 00
11.00   01100   CAFETERI A     1   13.00   01100   NURSI NG ADMINISTRATION     1   14.00   01400   CENTRAL SERVICES & SUPPLY     1   15.00   101500   PASTORAL CARE     1   16.00   01600   MEDI CAL RECORDS & LI BRARY     1   16.00   01600   MEDI CAL RECORDS & LI BRARY     1   16.00   01600   MEDI CAL RECORDS & LI BRARY     1   16.00   01600   MEDI CAL RECORDS & LI BRARY     1   1   16.00   01600   MEDI CAL RECORDS & LI BRARY     1   1   1   1   1   1   1   1   1	9. 00 0. 00
13. 00   01300   NURSING ADMINISTRATION   1   1   1   1   1   1   1   1   1	1. 00
14. 00   01400   CENTRAL SERVICES & SUPPLY	3. 00
15.00   01500   PHARMACY   16.00   01500   MEDI CAL RECORDS & LI BRARY   17.00   02100   I &R SERVI CES-SALARY & FRI NGES APPRV   22.00   02200   I &R SERVI CES-OTHER PRGM COSTS APPRV   1.00   03000   ADULTS & PEDI ATRI CS   2.123, 823   33.00   03000   ADULTS & PEDI ATRI CS   2.123, 823   33.00   03100   I NTENSI VE CARE UNI T   558, 726   33.00   03300   BURN I NTENSI VE CARE UNI T   342, 392   33.00   03300   BURN I NTENSI VE CARE UNI T   342, 392   34.00   04000   SUBPROVI DER - I PF   386, 421   44.00   04400   SKI LLED NURSERY   140, 509   44.00   04400   SKI LLED NURSI NG FACI LI TY   491, 238   44.00   04400   SKI LLED NURSI NG FACI LI TY   491, 238   4	3. 01
16. 00 01600 MEDI CAL RECORDS & LI BRARY 21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 22. 00 0200 I &R SERVI CES-CHER PROM COSTS APPRV 22. 00 0200 I &R SERVI CES-CHER PROM COSTS APPRV 22. 01. 00 03000 ADULTS & PEDI ATRI CS 2. 123, 823 31. 00 03000 ADULTS & PEDI ATRI CS 2. 123, 823 31. 01 03010 INTENSI VE CARE UNI T 558, 726 33. 00 03300 BURN INTENSI VE CARE UNI T 0. 03300 BURN INTENSI VE CARE UNI T 342, 392 33. 00 03300 BURN INTENSI VE CARE UNI T 342, 392 33. 00 03300 BURN INTENSI VE CARE UNI T 342, 392 344. 00 04000 SUBPROVI DER - I PF 386, 421 44. 3. 00 04300 NURSERY 140, 509 44. 00 04400 SUBPROVI DER - I DEP 386, 421 491, 238 491, 23	4.00
21.00   02100   1&R SERVI CES-SALARY & FRINGES APPRV   20.00   1&R SERVI CES-OTHER PRGM COSTS APPRV   1.00   1&R SERVI CES-OTHER PRGM COSTS APPRV   20.00   1&R SERVI CES-OTHER PRGM COST CENTERS   31.00   03000   ADULTS & PEDI ATRI CS   2,123,823   33.00   03100   INTENSI VE CARE UNI T   558,726   33.00   03300   BURN INTENSI VE CARE UNI T   342,392   33.00   03300   BURN INTENSI VE CARE UNI T   342,392   34.00   04000   SUBPROVI DER - I PF   386,421   44.00   04400   SVI LLED NURSI NG FACI LI TY   491,238   44.00   04400   SVI LLED NURSI NG FACI LI TY   491,238   44.00   04400   SVI LLED NURSI NG FACI LI TY   491,238   44.00   0500   OFERATI NG ROOM   761,312   55.00   05000   OFERATI NG ROOM   291,527   55.00   05000   DELI VERY ROOM & LABOR ROOM   262,156   55.00   05200   DELI VERY ROOM & LABOR ROOM   262,156   55.00   05300   ANESTHESI OLOGY   10,792   55.00   05400   RADI OLOGY-DI AGNOSTI C   859,579   55.00   05400   RADI OLOGY-DI AGNOSTI C   859,579   55.00   05700   CT SCAN   0   05700   CADIDIAC CATHETERIZATION   151,708   55.00   05900   CARDI IAC CATHETERIZATION   151,708   56.00   06000   CARDI IAC CATHETERIZATION	5. 00 6. 00
22.00   02200   &R SERVICES-OTHER PRGM COSTS APPRV   INPATI ENT ROUTI NE SERVICE COST CENTERS   3   3   3   3   3   3   3   3   3	21. 00
NPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   03000   ADULTS & PEDI ATRI CS   2,123,823   31.00   03100   INTENSI VE CARE UNI T   558,726   33.01   00.00   00.	22. 00
31. 00	
31. 01 02060 NEONATAL INTENSIVE CARE UNIT 0 0 33.0 03300 BURN INTENSIVE CARE UNIT 342, 392 3 40. 00 04000 SUBPROVI DER - IPF 386, 421 41. 00 04400 SUBPROVI DER - IPF 386, 421 44. 00 04400 SKILLED NURSING FACILITY 491, 238 44. 00 0500 OPERATING ROOM 761, 312 50. 00 05000 OPERATING ROOM 761, 312 50. 00 05000 OPERATING ROOM 291, 527 52. 00 05200 DELIVERY ROOM LABOR ROOM 262, 156 53. 00 05300 ANESTHESI OLOGY 10, 792 55. 00 05300 ANESTHESI OLOGY 10, 792 55. 00 05000 RADI OLOGY-DI AGNOSTIC 859, 579 55. 00 05600 RADI	30.00
33.00 03300 BURN INTENSIVE CARE UNIT 342, 392 40.00 04000 SUBPROVI DER - I PF 386, 421 43.00 04300 NURSERY 140, 509 44.00 04400 SKI LLED NURSI NG FACI LI TY 491, 238  ANCI LLARY SERVI CE COST CENTERS  50.00 05000 DERATI NG ROOM 761, 312 50.01 03330 ENDOSCOPY 102, 306 51.00 05100 RECOVERY ROOM 291, 527 52.00 05200 DELI VERY ROOM 262, 156 53.00 05300 ANESTHESI OLOGY 10, 792 54.00 05400 RADI OLOGY-DI AGNOSTI C 859, 579 54.01 03630 ULTRA SOUND 0 5500 RADI OL SOTOPE 0 5500 OS600 RADI OL SOTOPE 0 0 0 5500 OS600 RADI OL SOTOPE 0 0 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05600 CARDI AC CATHETERI ZATI ON 151, 708 0 05	31. 00
40. 00	31. 01 33. 00
43. 00	10.00
ANCI LLARY SERVI CE COST CENTERS  50. 00 05000 OPERATI NG ROOM 761, 312 50. 01 03330 ENDOSCOPY 102, 306 51. 00 05100 RECOVERY ROOM 291, 527 52. 00 05200 DELI VERY ROOM & LABOR ROOM 262, 156 53. 00 05300 ANESTHESI OLOGY 10, 792 54. 00 05400 RADI OLOGY-DI AGNOSTI C 859, 579 54. 01 03630 ULTRA SOUND 0 56 60. 00 05600 RADI OI SOTOPE 0 0 57 78. 00 05700 CT SCAN 0 58 78. 00 05800 MRI 0 0 79. 00 05900 CARDI AC CATHETERI ZATI ON 151, 708 60. 00 06000 LABORATORY 766, 000 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 41, 989	13.00
50. 00       05000       OPERATI NG ROOM       761, 312       50. 01       03330       ENDOSCOPY       102, 306       50. 01 <td< td=""><td>4. 00</td></td<>	4. 00
50. 01       03330       ENDOSCOPY       102, 306       5         51. 00       05100       RECOVERY ROOM       291, 527       5         52. 00       05200       DELI VERY ROOM & LABOR ROOM       262, 156       5         53. 00       05300       ANESTHESI OLOGY       10, 792       5         54. 00       05400       RADI OLOGY-DI AGNOSTI C       859, 579       5         56. 01       03630       ULTRA SOUND       0       5         57. 00       05600       RADI OI SOTOPE       0       5         57. 00       05700       CT SCAN       0       5         58. 00       05800       MRI       0       5         59. 00       05900       CARDI AC CATHETERI ZATI ON       151, 708       5         60. 00       06000       LABORATORY       766, 000       6         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       41, 989       6	
51. 00       05100       RECOVERY ROOM       291, 527       5         52. 00       05200       DELI VERY ROOM & LABOR ROOM       262, 156       5         53. 00       05300       ANESTHESI OLOGY       10, 792       5         54. 00       05400       RADI OLOGY-DI AGNOSTI C       859, 579       5         56. 01       03630       ULTRA SOUND       0       5         56. 00       05600       RADI OI SOTOPE       0       5         57. 00       05700       CT SCAN       0       5         59. 00       05800       MRI       0       5         59. 00       05900       CARDI AC CATHETERI ZATI ON       151, 708       5         60. 00       06000       LABORATORY       766, 000       6         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       41, 989       6	50. 00 50. 01
52. 00       05200       DELI VERY ROOM & LABOR ROOM       262, 156         53. 00       05300       ANESTHESI OLOGY       10, 792         54. 01       05400       RADI OLOGY-DI AGNOSTI C       859, 579         54. 01       03630       ULTRA SOUND       0         56. 00       05600       RADI OLOGY-DI AGNOSTI C       5         57. 00       05700       CT SCAN       0         58. 00       05800       MRI       0         59. 00       05900       CARDI AC CATHETERI ZATI ON       151, 708         60. 00       06000       LABORATORY       766, 000         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       41, 989	51. 00
54. 00     05400     RADI OLOGY - DI AGNOSTI C     859, 579       54. 01     03630     ULTRA SOUND     0       56. 00     05600     RADI OI SOTOPE     0       57. 00     05700     CT SCAN     0       58. 00     05800     MRI     0       59. 00     05900     CARDI AC CATHETERI ZATI ON     151, 708       60. 00     06000     LABORATORY     766, 000       62. 00     06200     WHOLE BLOOD & PACKED RED BLOOD CELL     41, 989	52. 00
54. 01 03630 ULTRA SOUND 0 5. 56. 00 05600 RADI 0I SOTOPE 0 0 5. 57. 00 05700 CT SCAN 0 5. 58. 00 05800 MRI 0 5. 59. 00 05900 CARDI AC CATHETERI ZATI ON 15. 60. 00 06000 LABORATORY 766, 000 62.00 WHOLE BLOOD & PACKED RED BLOOD CELL 41, 989	3. 00
56. 00     05600     RADI OI SOTOPE     0       57. 00     05700     CT SCAN     0       58. 00     05800     MRI     0       59. 00     05900     CARDI AC CATHETERI ZATI ON     151, 708       60. 00     06000     LABORATORY     766, 000       62. 00     06200     WHOLE BLOOD & PACKED RED BLOOD CELL     41, 989	4.00
57. 00     05700     CT SCAN     0       58. 00     05800     MRI     0       59. 00     05900     CARDI AC CATHETERI ZATI ON     151, 708       60. 00     06000     LABORATORY     766, 000       62. 00     06200     WHOLE BLOOD & PACKED RED BLOOD CELL     41, 989	64. 01 66. 00
58. 00     05800 MRI     0       59. 00     05900 CARDI AC CATHETERI ZATI ON     151, 708       60. 00     06000 LABORATORY     766, 000       62. 00     06200 WHOLE BLOOD & PACKED RED BLOOD CELL     41, 989	57. 00
60. 00   06000   LABORATORY   766, 000   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   41, 989   6.	8. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 41, 989	9. 00
	0. 00
05. UU	2. 00
66. 00   06600   PHYSI CAL THERAPY 326, 810 6.	5. 00 6. 00
	7. 00
	8. 00
	9. 00
	1.00
	72. 00 73. 00
	4. 00
	6. 00
	6. 01
	6. 02
76. 03   03952   WOUND CARE   390, 914   79   79   79   79   79   79   79   7	6. 03
	0. 00
	1. 00
	2. 00
SPECIAL PURPOSE COST CENTERS	
118. 00   SUBTOTALS (SUM OF LINES 1-117)   10, 153, 553   115   116   117   117   117   118   117   119   11	8. 00
	0. 00
	1. 00
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES 98, 490   19.	2. 00
	4. 00
	94. 01
	94. 02 94. 03
	94. 03 94. 04
	00.00
201.00   Negative Cost Centers   0   20	1. 00
202.00 TOTAL (sum lines 118-201) 11,451,120 20.	2. 00

	Financial Systems ALLOCATION - STATISTICAL BASIS	ST JOSEPH MED		CCN: 150047 F	In Lie Period:	u of Form CMS-: Worksheet B-1	
0031 7	ALLOCATION - STATISTICAL BASIS		Trovider	F	From 06/01/2014 To 05/31/2015	Date/Time Pre	
				,	0 03/31/2013	10/30/2015 5:	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	OTHER	DATA	
		(SQUARE FOO TAGE)	(SQUARE FOO TAGE)	BENEFITS DEPARTMENT	ADMI NI STRATI VE AND GENERAL	PROCESSING (GROSS CHAR	
			,	(GROSS	(ACCUM. COST)	GES)	
		1.00	2. 00	SALARI ES) 4. 00	5. 01	5. 02	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	416, 929	416, 929				1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 719					4. 00
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL	0	0	702.022	0	FO/ /FO 070	5. 01
5. 02 5. 03	OO550 DATA PROCESSING   OO591 PURCHASING AND RECEIVING	13, 430 11, 626	13, 430 11, 626			506, 659, 878 0	5. 02 5. 03
5.04	00540 CENTRAL SCHEDULING	3, 309	3, 309	1, 061, 283	0	0	
5. 05 5. 06	OO580   CASHI ERI NG/ACCOUNTS   RECEI VABLE   OO590   OTHER   ADMI NI STRATI VE   AND   GENERAL	9, 045	0 9, 045	,		0	5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	70, 993	70, 993			0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 705	3, 705		0	0	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	56, 094 17, 523	56, 094 17, 523			0	9. 00 10. 00
11.00	01100 CAFETERI A	0	0	( 700 750	0	0	11.00
13. 00 13. 01	O1300   NURSI NG   ADMI NI STRATI ON   O1850   PASTORAL   CARE	2, 019 2, 332	2, 019 2, 332			0	13. 00 13. 01
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	(	o	0	14. 00
15. 00 16. 00	O1500   PHARMACY   O1600   MEDI CAL RECORDS & LI BRARY	0 10, 500	0 10, 500	1, 401, 563 466, 025		0	15. 00 16. 00
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRV	10, 500	0 0	466, 023		0	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	(	0	0	22. 00
30. 00	O3000 ADULTS & PEDIATRICS	37, 311	37, 311	5, 578, 547	7 0	40, 731, 948	30.00
31. 00	03100 INTENSIVE CARE UNIT	12, 303	12, 303	917, 103	0	3, 669, 384	31. 00
31. 01 33. 00	02060 NEONATAL INTENSIVE CARE UNIT	7, 013	0 7, 013	962, 90 <sup>4</sup>	1	0 6, 389, 552	
40. 00	04000 SUBPROVI DER – I PF	5, 329				20, 283, 754	
43.00	04300 NURSERY	2, 745				3, 377, 102	1
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	9, 807	9, 807	1, 054, 861	0	3, 264, 400	44.00
50.00	05000 OPERATING ROOM	15, 114				40, 267, 709	
50. 01 51. 00	03330   ENDOSCOPY   05100   RECOVERY   ROOM	2, 067 6, 445	2, 067 6, 445			4, 353, 242 4, 676, 866	
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 735	5, 735			1, 607, 871	52. 00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY - DI AGNOSTI C	0 16, 482	0 16, 482	1, 828, 77 <i>6</i>	0	5, 848, 900 75, 345, 733	
54. 01	03630 ULTRA SOUND	0	0	1, 020, 770	o o	73, 343, 733	1
	05600 RADI OI SOTOPE	0	0	(	0	0	
	05700   CT   SCAN   05800   MRI	0	0	1		0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 836				21, 391, 562	
60. 00 62. 00	O6000   LABORATORY   O6200   WHOLE   BLOOD & PACKED   RED   BLOOD   CELL	14, 107 773	14, 107 773			60, 540, 956 3, 732, 086	1
65.00	06500 RESPIRATORY THERAPY	5, 732	5, 732	657, 275	0	14, 272, 596	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	7, 448 2, 851	7, 448 2, 851			5, 177, 835 3, 237, 736	
68. 00	06800 SPEECH PATHOLOGY	1, 098				740, 554	
69.00	06900 ELECTROCARDI OLOGY	1, 045	1, 045			3, 211, 701	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		1	15, 977, 588 36, 907, 635	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 470			0	69, 604, 391	73. 00
74. 00 76. 00	07400   RENAL DIALYSIS   03950   OTHER ANCILLARY SERVICE COST CENTER	2, 010	2, 010	(	0	2, 395, 600 0	1
76. 01	03951 SLEEP LAB	0	0			0	1
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 258				5, 689, 966	
76. 03	03952  WOUND CARE   OUTPATIENT SERVICE COST CENTERS	8, 589	8, 589	820, 782	2 0	6, 887, 112	76. 03
	09000 CLI NI C	2, 126	2, 126			93, 747	
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS   (NON-DISTINCT   PART	13, 197	13, 197	1, 981, 594	0	46, 982, 352	91.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	392, 186	392, 186	32, 960, 518	0	506, 659, 878	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 012	1, 012	3, 017	7 0	0	190. 00
	19100 RESEARCH	0	0	(	o		191.00
	19200   PHYSICIANS' PRIVATE OFFICES   07950   OTHER NONREIMBURSABLE COST CENTERS	0	0				192. 00 194. 00
	07951 MARKETI NG	o	0	187, 055			194. 01

Health Financial Systems	ST JOSEPH MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od: From 06/01/2014	Worksheet B-1	
					Date/Time Prep 10/30/2015 5:0	
	CAPITAL RELATED	COSTS				•
C-+ C+ D	DIDC & FLYT MYE	U.E. FOULD	EMBL OVEE	OTHER	DATA	

						10/30/2015 5:	UT PIII
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	OTHER	DATA	
	odst denter beschiptron	(SQUARE FOO	(SQUARE FOO		ADMI NI STRATI VE		
		TAGE)	TAGE)	DEPARTMENT	AND GENERAL	(GROSS CHAR	
				(GROSS	(ACCUM. COST)	GES)	
				SALARI ES)			
		1. 00	2. 00	4. 00	5. 01	5. 02	
194. 02 0795	2 SENI OR CIRCLE	0	0	0	0	0	194. 02
194. 03 0795	3 SELECT SPECIALTY	23, 731	23, 731	0	0	0	194. 03
194. 04 0795	4 FREE MEALS	0	0	0	0	0	194. 04
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	6, 534, 579	4, 916, 541	4, 749, 226	0	2, 982, 845	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	15. 673122	11. 792274	0. 143262	0. 000000	0. 005887	203. 00
204.00	Cost to be allocated (per Wkst. B,			129, 609	0	371, 921	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 003910	0. 000000	0. 000734	205. 00
	11)						

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150047 Peri od: Worksheet B-1 From 06/01/2014 05/31/2015 Date/Time Prepared: 10/30/2015 5:01 pm Cost Center Description PURCHASING AND CENTRAL CASHIERING/ACC Reconciliation **OTHER** OUNTS ADMI NI STRATI VE RECEI VI NG SCHEDULI NG (COSTED REQ S) (GROSS CHAR RECEI VABLE AND GENERAL (GROSS CHAR GES) (ACCUM. COST) GES) 5.06 5.03 5.04 5.05 5A. 06 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00560 OTHER ADMINISTRATIVE AND GENERAL 5.01 5. 01 00550 DATA PROCESSING 5.02 5.02 5.03 00591 PURCHASING AND RECEIVING 5.03 9, 427, 060 5.04 00540 CENTRAL SCHEDULING 506, 659, 878 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 0 506, 659, 878 5.05 00590 OTHER ADMINISTRATIVE AND GENERAL 0 -11, 390, 667 79, 920, 267 5.06 5 06 0 00700 OPERATION OF PLANT 0 7.00 0 0 5, 836, 272 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 568, 590 8.00 9.00 00900 HOUSEKEEPI NG 0 0 0 0 2, 651, 602 9.00 0 01000 DI ETARY 0 1, 388, 765 10 00 Ω 10 00 11.00 01100 CAFETERI A 0 0 1, 133, 658 11.00 01300 NURSING ADMINISTRATION 0 13.00 0 0 2, 484, 256 13.00 0 01850 PASTORAL CARE 13 01 Ω 0 163, 080 13 01 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 Λ 14.00 01500 PHARMACY 138, 132 0 0 0 2, 189, 092 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 1, 145, 859 16.00 4, 326 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 o 21 00 21 00 0 C 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 2, 700, 834 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 373, 471 40, 731, 948 40, 731, 948 0 8, 859, 710 30.00 0 03100 INTENSIVE CARE UNIT 31.00 64, 792 3, 669, 384 3, 669, 384 1, 630, 014 31 00 0 31.01 02060 NEONATAL INTENSIVE CARE UNIT 31.01 Λ 03300 BURN INTENSIVE CARE UNIT 112, 307 6, 389, 552 6, 389, 552 0 1, 592, 846 33.00 33.00 0 04000 SUBPROVI DER - I PF 20, 283, 754 20, 283, 754 2, 191, 860 40.00 38.811 40.00 04300 NURSERY 3, 377, 102 3, 377, 102 1, 178, 896 43.00 67,651 43.00 04400 SKILLED NURSING FACILITY 43, 201 3, 264, 400 3, 264, 400 1, 670, 360 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 593, 940 40, 267, 709 40, 267, 709 0 3, 218, 564 50.00 03330 ENDOSCOPY 0 50.01 104 172 4, 353, 242 4, 353, 242 520, 825 50 01 05100 RECOVERY ROOM 12, 957 4, 676, 866 4, 676, 866 0 860, 474 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 62, 203 1, 607, 871 1, 607, 871 0 1, 290, 259 52.00 05300 ANESTHESI OLOGY 5, 848, 900 5, 848, 900 77, 750 88 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 36, 291 75, 345, 733 75, 345, 733 4, 877, 175 54.00 54.01 03630 ULTRA SOUND 0 0 0 54.01 05600 RADI OI SOTOPE 0 56.00 0 56.00 0 05700 CT SCAN 0 0 57 00 57.00 Ω Ω 58.00 05800 MRI 0 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 516, 911 21, 391, 562 21, 391, 562 2, 196, 564 59.00 60, 540, 956 06000 LABORATORY 60, 540, 956 5, 050, 959 60.00 401, 623 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 27.780 3, 732, 086 3, 732, 086 623, 576 62.00 65.00 06500 RESPIRATORY THERAPY 104, 396 14, 272, 596 14, 272, 596 0 0 0 1, 277, 065 65.00 06600 PHYSI CAL THERAPY 8,522 5, 177, 835 5, 177, 835 1,007,706 66.00 66.00 06700 OCCUPATIONAL THERAPY 3, 237, 736 3, 237, 736 491, 115 67.00 978 67.00 68.00 06800 SPEECH PATHOLOGY 1,051 740, 554 740, 554 131, 563 68.00 06900 ELECTROCARDI OLOGY 3, 211, 701 3, 211, 701 69.00 6,078 0 0 0 152, 918 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 762, 798 15, 977, 588 15, 977, 588 4, 670, 805 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 3, 188, 237 72.00 2, 320, 229 36, 907, 635 36, 907, 635 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 69, 604, 391 69, 604, 391 4, 611, 860 73.00 07400 RENAL DIALYSIS 74.00 3,602 2, 395, 600 2, 395, 600 0 371, 659 74.00 76 00 03950 OTHER ANCILLARY SERVICE COST CENTER 76 00 0 C 0 Ω 03951 SLEEP LAB 76.01 0 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 5, 251 5, 689, 966 5, 689, 966 0 597, 991 76.02 76.02 03952 WOUND CARE 6, 887, 112 6, 887, 112 0 1, 464, 946 76.03 76.03 111,602 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 13.243 93, 747 93.747 0 265, 871 90.00 09100 EMERGENCY 433, 328 46, 982, 352 3, 969, 403 91.00 91.00 46, 982, 352 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 9, 369, 734 506, 659, 878 506, 659, 878 -11, 390, 667 78, 302, 979 118. 00 00 00

NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	52, 657	0	0	0	96, 206	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01 07951 MARKETI NG	4, 669	0	0	0	869, 301	194. 01
194. 02 07952 SENI OR CI RCLE	0	0	0	1, 737	0	194. 02
194. 03 07953 SELECT SPECIALTY	0	0	0	0	651, 781	194. 03

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CCN: 150047	Peri od: From 06/01/2014	Worksheet B-1

				-	To 05/31/2015	Date/Time Pre 10/30/2015 5:	
	Cost Center Description	PURCHASING AND	CENTRAL	CASHI ERI NG/AC	Reconciliation	OTHER	
		RECEI VI NG	SCHEDULI NG	OUNTS		ADMI NI STRATI VE	
		(COSTED REQ S)	(GROSS CHAR	RECEI VABLE		AND GENERAL	
			GES)	(GROSS CHAR		(ACCUM. COST)	
				GES)			
		5. 03	5. 04	5. 05	5A. 06	5. 06	
194. 04 079	54 FREE MEALS	0	(	0	0 (0	0	194. 04
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 601, 126	1, 438, 09	2, 085, 44	В	11, 390, 667	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 169844	0. 00283	0. 00411	6	0. 142525	203. 00
204.00	Cost to be allocated (per Wkst. B,	321, 025	95, 03	1, 09:	2	256, 412	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 034054	0. 00018	0. 00000:	2	0. 003208	205. 00
	[11]						

	Financial Systems	ST JUSEPH MEL		0011 450047   0		U OT FORM CMS-	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 06/01/2014 o 05/31/2015	Worksheet B-1 Date/Time Pre 10/30/2015 5:	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FOO TAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FOO TAGE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	J . p
		7. 00	8. 00	9. 00	10.00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00560 OTHER ADMINISTRATI VE AND GENERAL 00550 DATA PROCESSI NG 00591 PURCHASI NG AND RECEI VI NG 00540 CENTRAL SCHEDULI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05
5. 06 7. 00	00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	303, 807					5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	3, 705	871, 729				8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	56, 094 17, 523	0	244, 008 17, 523			9.00
11. 00	01100 CAFETERI A	0	ő	0	0	46, 144	11. 00
13. 00 13. 01	01300 NURSI NG ADMI NI STRATI ON 01850 PASTORAL CARE	2, 019	0	2, 019		2, 610	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 332	0	2, 332		150 0	1
15. 00	01500 PHARMACY	0	1, 160		0	1, 716	
16. 00 21. 00	01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRV	10, 500	0	10, 500		1, 253 0	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	o o	0		0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	07.044	244.040	07.044	(0.040	0.005	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	37, 311 12, 303	344, 068 19, 793			9, 935 1, 349	
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31. 01
33. 00 40. 00	03300   BURN INTENSIVE CARE UNIT   04000   SUBPROVIDER - IPF	7, 013 5, 329		7, 013 5, 329		1, 660 2, 780	
43. 00	04300 NURSERY	2, 745				1, 140	
44. 00	04400 SKILLED NURSING FACILITY	9, 807	43, 987	9, 807	13, 162	1, 701	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	15, 114	46, 100	15, 114	O	2, 051	50.00
50. 01	03330 ENDOSCOPY	2, 067	0	2, 067	0	275	50. 01
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELI VERY ROOM & LABOR ROOM	6, 445 5, 735		6, 445 5, 735		852 1, 349	
53. 00	05300 ANESTHESI OLOGY	0,733	ő	0,733		0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 482	72, 588	16, 482	0	3, 375 0	1
54. 01 56. 00	03630 ULTRA SOUND 05600 RADI OI SOTOPE		0		0	0	
57. 00	05700 CT SCAN	0	0	0	0	0	
58. 00 59. 00	05800 MRI   05900 CARDI AC CATHETERI ZATI ON	1, 836	0	0 1, 836	0	0 1, 178	
60.00	06000 LABORATORY	14, 107	3, 301	14, 107	0	3, 925	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY	773 5, 732		773 5, 732			62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	7, 448	l .			913	1
67. 00		2, 851	l	2, 851			67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 098 1, 045		1, 098 1, 045		95 209	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	2, 470	0	0 2, 470	<u> ۱</u>	0	
74.00	07400 RENAL DIALYSIS	2, 470	ł	2, 470		0	74.00
	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	_	0	
76. 01 76. 02	03951   SLEEP LAB   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 258	0	0 3, 258		0 642	
	03952 WOUND CARE	8, 589	ł			1, 336	
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2, 126	94	2, 126	O	305	90.00
91. 00	09100 EMERGENCY	13, 197	ł			3, 507	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
118. 00	SPECIAL PURPOSE COST CENTERS  SUBTOTALS (SUM OF LINES 1-117)  NONREI MBURSABLE COST CENTERS	279, 064	871, 729	219, 265	111, 699	45, 828	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 012	l	1, 012			190. 00
	19100 RESEARCH  19200 PHYSICIANS'PRIVATE OFFICES	0	0	0	0 22, 426		191. 00 192. 00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS		0	0	22, 420	0	194. 00
	07951 MARKETI NG	0	0	0	0		194. 01
	207952  SENI OR CIRCLE 307953  SELECT SPECIALTY	23, 731	0	23, 731	20, 940		194. 02 194. 03
	07954 FREE MEALS	0	0	0			194. 04
				<u> </u>			

Health Fir	nancial Systems	ST JOSEPH MEDICAL CENTER			In Lieu of Form CMS-2552-10		
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 06/01/2014 Fo 05/31/2015	Date/Time Pre	nared:
						10/30/2015 5:	01 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FOO	(MEALS SERVED)	(FTE'S)	
		(SQUARE FOO	(POUNDS OF	TAGE)			
		TAGE)	LAUNDRY)				
		7.00	8. 00	9. 00	10.00	11. 00	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	6, 668, 087	730, 947	4, 260, 699	2, 277, 276	1, 295, 233	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	21. 948431	0. 838503	17. 461309	13. 568945	28. 069370	203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 972, 529	127, 638	1, 915, 672	737, 074	3, 637	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	6. 492704	0. 146419	7. 850857	4. 391789	0. 078818	205. 00
	11)						

Health Financial Systems	ST JOSEPH MEDICAL	CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der (		Period: From 06/01/2014 Fo 05/31/2015	Worksheet B-1 Date/Time Pre 10/30/2015 5:	pared:
Cost Center Description	NURSI NG PAS ADMI NI STRATI ON (DI F (DI RECT NRSI NG HRS)	TORAL CARE RECT NRSING HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. )	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHAR GES)	
	13.00	13. 01	14. 00	15.00	16. 00	
CAP REL COSTS CENTERS						1. 00 2. 00 4. 00 5. 01 5. 02 5. 03
5. 04   00540   CENTRAL SCHEDULING 5. 05   00580   CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 06   00590   OTHER ADMINISTRATI VE AND GENERAL 7. 00   00700   OPERATI ON OF PLANT 8. 00   00800   LAUNDRY & LINEN SERVICE 9. 00   00900   HOUSEKEEPING 10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG ADMINISTRATI ON 13. 01   01850   PASTORAL CARE 14. 00   01400   CENTRAL SERVICES & SUPPLY 15. 00   01500   PHARMACY 16. 00   01600   MEDICAL RECORDS & LIBRARY 21. 00   02100   L&R SERVICES-SALLARY & FRINGES APPRV 22. 00   02200   L&R SERVICES-OTHER PRGM COSTS APPRV	1	566, 233 0 0 0 0	(	0 0 3, 650, 230 0 0 0 0	506, 659, 878 0 0	21.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	206, 655	206, 655	(		40, 731, 948	30.00
31.00 03100 INTENSIVE CARE UNIT	28, 060	28, 060			3, 669, 384	
31.01   02060   NEONATAL INTENSIVE CARE UNIT 33.00   03300   BURN INTENSIVE CARE UNIT	0 34, 536	0 34, 536			0 6, 389, 552	
40. 00   04000   SUBPROVI DER - 1 PF	0	О	(		20, 283, 754	40.00
43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSI NG   FACI LI TY	23, 722	23, 722 0			3, 377, 102 3, 264, 400	
ANCI LLARY SERVI CE COST CENTERS		<u> </u>		<u> </u>	3, 204, 400	1 44. 00
50. 00 05000 OPERATI NG ROOM	42, 654	42, 654		0 0	40, 267, 709	
50. 01   03330   ENDOSCOPY 51. 00   05100   RECOVERY ROOM	5, 718 17, 720	5, 718 17, 720			4, 353, 242 4, 676, 866	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	28, 069	28, 069			1, 607, 871	
53. 00 05300 ANESTHESI OLOGY	0	0	(	0	5, 848, 900	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   03630   ULTRA SOUND	0	0	(		75, 345, 733 0	
56. 00   05600 RADI 0I SOTOPE	0	0	(		0	1
57. 00 05700 CT SCAN	0	О	(	o o	0	
58. 00   05800   MRI	0	0	(		0	
59. 00   05900   CARDI AC   CATHETERI ZATI ON   060. 00   06000   LABORATORY	24, 507 81, 650	24, 507 81, 650	(		21, 391, 562 60, 540, 956	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0	(	o	3, 732, 086	62.00
65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY	0	0	(		14, 272, 596 5, 177, 835	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(		3, 237, 736	
68.00 06800 SPEECH PATHOLOGY	0	О	(	o o	740, 554	68.00
69. 00   06900   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT	- 0	0	(		3, 211, 701 15, 977, 588	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(		36, 907, 635	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o	(	3, 650, 230	69, 604, 391	
74. 00   07400   RENAL DIALYSIS 76. 00   03950   OTHER ANCILLARY SERVICE COST CENTER	0	0	(		2, 395, 600 0	
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTER		o	(		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	O	(	o	5, 689, 966	
76. 03 03952 WOUND CARE	0	0	(	0	6, 887, 112	76. 03
90. 00   O9000   CLINIC	0	O		lo lo	93, 747	90.00
91. 00   09100   EMERGENCY	72, 942	72, 942	(		46, 982, 352	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-					92.00
SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1-117)	566, 233	566, 233	(	3, 650, 230	506, 659, 878	]    118. 00
NONREI MBURSABLE COST CENTERS		000, 200		3, 000, 200		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(			190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(			191. 00 192. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	Ö	o	(			194. 00
194. 01 07951 MARKETI NG	0	0	(	o  o		194. 01
194. 02 07952 SENI OR CI RCLE	0	0	(			194. 02 194. 03
194. 03 07953  SELECT SPECI ALTY	ı	U	(	J 이	U	1174. US

Heal th Finar	ncial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 06/01/2014 To 05/31/2015	Date/Time Pre	pared:
						10/30/2015 5:	
	Cost Center Description	NURSI NG	PASTORAL CARE	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	(DIRECT NRSING	SERVICES &	(COSTED	RECORDS &	
			HRS)	SUPPLY	REQUIS.)	LI BRARY	
		(DIRECT NRSING		(COSTED		(GROSS CHAR	
		HRS)		REQUI S. )		GES)	
		13. 00	13. 01	14. 00	15. 00	16. 00	
194. 04 07954	FREE MEALS	0	0		0	0	194. 04
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 991, 154	282, 437		0 2, 550, 232	1, 758, 147	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	5. 282550	0. 498800	0.00000	0. 698650	0.003470	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	99, 387	98, 292		0 17, 512	444, 738	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 175523	0. 173589	0. 00000	0. 004798	0. 000878	205. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150047

				10/30/2015 5	5: 01 pm
		INTERNS &	RESI DENTS		
	Cost Conton Dogorintian	CEDVI CEC CALAD	SERVI CES-OTHER		
	Cost Center Description	Y & FRINGES	PRGM COSTS		
		APPRV	APPRV		
		(ROTATIONS)	(ROTATIONS)		
		21.00	22.00		
4 00	GENERAL SERVICE COST CENTERS	T	I		4
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP				1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL				5. 01
5. 02	00550 DATA PROCESSING				5. 02
5. 03	00591 PURCHASING AND RECEIVING				5. 03
5.04	00540 CENTRAL SCHEDULING 00580 CASHI ERING/ACCOUNTS RECEIVABLE				5. 04
5. 05 5. 06	00590 OTHER ADMINISTRATIVE AND GENERAL				5. 05 5. 06
7. 00	00700 OPERATION OF PLANT				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9. 00
10.00	1				10.00
11. 00 13. 00	1				11. 00
13. 01	1				13. 01
14.00					14.00
15. 00					15. 00
16. 00	1				16. 00
21. 00	1	8, 800			21. 00
22. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRV   INPATIENT ROUTINE SERVICE COST CENTERS		8, 800		22. 00
30. 00		1, 300	1, 300		30.00
31. 00		0	0		31.00
31. 01	1	0	O		31. 01
33. 00		0	0		33. 00
40. 00 43. 00		0	0		40.00
44. 00	I I	0	0		43. 00 44. 00
00	ANCILLARY SERVICE COST CENTERS		<u> </u>		1 55
50.00	I I	1, 950	1, 950		50.00
50. 01	I I	0	0		50. 01
51.00	l l	0	0		51.00
52. 00 53. 00	l l	0	0		52. 00 53. 00
54. 00		0	l o		54. 00
54. 01	03630 ULTRA SOUND	0	o		54. 01
56.00	1	0	0		56. 00
57. 00		0	0		57.00
58. 00 59. 00	1	0	0		58. 00 59. 00
60. 00		0	l ő		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	o		62. 00
65.00		0	0		65. 00
66.00		0	0		66. 00
67. 00 68. 00	1	0	0		67. 00 68. 00
69. 00	1	0			69. 00
71. 00		0	l ol		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o		72. 00
73.00		0	이		73.00
74. 00 76. 00		0	0		74. 00 76. 00
76. 00 76. 01	I I				76. 00
76. 02			o		76. 02
76. 03	03952 WOUND CARE	100			76. 03
	OUTPATIENT SERVICE COST CENTERS				
90.00		4, 900			90.00
91. 00 92. 00	l l	0	0		91. 00 92. 00
72. UU	SPECIAL PURPOSE COST CENTERS				72.00
118.00		8, 250	8, 250		118. 00
	NONREI MBURSABLE COST CENTERS				
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	0 19100 RESEARCH	0	0		191.00
	0 19200 PHYSICIANS' PRIVATE OFFICES 0 07950 OTHER NONREIMBURSABLE COST CENTERS	550	550 0		192. 00 194. 00
	0 07950 OTHER NONRETMBURSABLE COST CENTERS	0			194. 00
	2 07952 SENI OR CI RCLE	0	o o		194. 02
	· · · · · · · · · · · · · · · · · · ·	•	. 1	•	<u> </u>

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10	
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 150047	Period: Worksheet B-1 From 06/01/2014	
		To 05/31/2015 Date/Time Prepared: 10/30/2015 5:01 pm	
·	INTERNS & RESIDENTS		

					10/30/2015 5:01 pm
		INTERNS &	RESI DENTS		
	Cost Center Description	SERVI CES-SALAR			
		Y & FRINGES	PRGM COSTS		
		APPRV	APPRV		
		(ROTATIONS)	(ROTATIONS)		
		21.00	22. 00		
194. 03 07953	SELECT SPECIALTY	0	0		194. 03
194. 04 07954	FREE MEALS	0	0		194. 04
200.00	Cross Foot Adjustments				200. 00
201. 00	Negative Cost Centers				201. 00
202.00	Cost to be allocated (per Wkst. B,	0	3, 085, 770		202. 00
	Part I)				
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	350. 655682		203. 00
204.00	Cost to be allocated (per Wkst. B,	0	8, 664		204. 00
	Part II)				
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 984545		205. 00
	11)				

						10/30/2015 5:	01 pm
			Ti tl	e XVIII	Hospi tal	PPS	
	·				Costs		
	0 1 0 1 0 1 1			T		T	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
20.00	03000 ADULTS & PEDIATRICS	14 424 251		14 424 251	ام	14 424 251	20.00
30.00		14, 436, 251		14, 436, 251	0	14, 436, 251	
31. 00	03100 INTENSIVE CARE UNIT	2, 619, 609		2, 619, 609	0	2, 619, 609	
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0		0	0	0	31. 01
33. 00	03300 BURN INTENSIVE CARE UNIT	2, 404, 177		2, 404, 177	0	2, 404, 177	33. 00
40.00	04000 SUBPROVI DER - I PF	3, 242, 113		3, 242, 113	0	3, 242, 113	40.00
43.00	04300 NURSERY	1, 647, 924		1, 647, 924	ol	1, 647, 924	43.00
44.00	04400 SKILLED NURSING FACILITY	2, 569, 469		2, 569, 469	ام	2, 569, 469	
00	ANCI LLARY SERVI CE COST CENTERS	2,007,107		2,007,107	٩	2,007,107	
50.00	05000 OPERATING ROOM	4, 755, 481		4, 755, 481	ol	4, 755, 481	50.00
	03330 ENDOSCOPY						
50. 01		732, 399		732, 399	l	732, 399	
51.00	05100 RECOVERY ROOM	1, 392, 584		1, 392, 584	0	1, 392, 584	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 905, 890		1, 905, 890	0	1, 905, 890	
53.00	05300 ANESTHESI OLOGY	109, 127		109, 127	0	109, 127	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 638, 930		6, 638, 930	0	6, 638, 930	54.00
54.01	03630 ULTRA SOUND	0		l 0	ol	0	54. 01
56. 00	05600 RADI OI SOTOPE	0		0	ام	0	56. 00
57. 00	05700 CT SCAN	0			٥	0	57. 00
58. 00	05800 MRI				0	0	58.00
		2 020 0/2		2 020 0/2	0	-	
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 830, 963		2, 830, 963		2, 830, 963	
60.00	06000 LABORATORY	7, 121, 865		7, 121, 865	0	7, 121, 865	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	755, 865		755, 865	0	755, 865	62. 00
65.00	06500 RESPI RATORY THERAPY	1, 767, 258	0	1, 767, 258	0	1, 767, 258	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 489, 629			l	1, 489, 629	
67. 00	06700 OCCUPATI ONAL THERAPY	694, 668		.,,	l	694, 668	
68. 00	06800 SPEECH PATHOLOGY					·	
		198, 823		198, 823		198, 823	
69. 00	06900 ELECTROCARDI OLOGY	236, 290		236, 290		236, 290	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 391, 953		5, 391, 953		5, 391, 953	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 770, 709		3, 770, 709		3, 770, 709	
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 158, 266		8, 158, 266	0	8, 158, 266	73. 00
74.00	07400 RENAL DIALYSIS	518, 291		518, 291	0	518, 291	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0		1 0	ol	. 0	76. 00
76. 01	03951 SLEEP LAB	0		١	ol	0	76. 01
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	849, 382		849, 382	Ö	849, 382	
		1			0		
76. 03	03952 WOUND CARE	2, 117, 101		2, 117, 101	<u> </u>	2, 117, 101	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	396, 514		396, 514	l	396, 514	
91. 00	09100 EMERGENCY	5, 880, 217		5, 880, 217	0	5, 880, 217	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 294, 672		1, 294, 672		1, 294, 672	92.00
200.00	Subtotal (see instructions)	85, 926, 420	0	85, 926, 420	o	85, 926, 420	200. 00
201.00	1 1	1, 294, 672		1, 294, 672		1, 294, 672	
202.00		84, 631, 748				84, 631, 748	
202.00	1 10 tal (300 1 113 ti dott 0113)	07,001,740	1	1 07,031,740	١	07, 001, 740	202.00

				'	0 03/31/2013	10/30/2015 5:	
			Ti tl	e XVIII	Hospi tal	PPS	
	·	Charges					
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		•	+ col. 7)	Rati o	Inpati ent	
						Rati o	
		6. 00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	35, 458, 401		35, 458, 401			30. 00
31. 00	03100 INTENSIVE CARE UNIT	3, 669, 384		3, 669, 384			31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0		[ C			31. 01
33.00	03300 BURN INTENSIVE CARE UNIT	6, 389, 552		6, 389, 552			33. 00
40.00	04000 SUBPROVI DER - I PF	20, 283, 754		20, 283, 754			40. 00
43.00	04300 NURSERY	3, 377, 102		3, 377, 102	2		43. 00
44.00	04400 SKILLED NURSING FACILITY	3, 264, 400		3, 264, 400	)		44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	21, 000, 624	19, 267, 085			0. 000000	
50. 01	03330 ENDOSCOPY	1, 229, 000	3, 124, 242			0. 000000	
51. 00	05100 RECOVERY ROOM	1, 912, 621	2, 764, 245			0.000000	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 127, 325	480, 546			0. 000000	1
53.00	05300 ANESTHESI OLOGY	3, 526, 353	2, 322, 547			0.000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 894, 083	54, 451, 650	75, 345, 733		0.000000	1
54. 01	03630 ULTRA SOUND	0	0	[ C		0.000000	1
56. 00	05600 RADI 0I SOTOPE	0	0	[ C		0.000000	1
57. 00	05700 CT SCAN	0	0	· -		0.000000	1
58. 00	05800 MRI	0	0		0. 000000	0.000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	10, 506, 885	10, 884, 677			0.000000	1
60.00	06000 LABORATORY	30, 565, 750	29, 975, 206			0.000000	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	3, 583, 489	148, 597			0.000000	
65. 00	06500 RESPI RATORY THERAPY	12, 898, 893	1, 373, 703			0.000000	
66. 00	06600 PHYSI CAL THERAPY	2, 032, 867	3, 144, 968			0.000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	2, 916, 473	321, 263			0.000000	1
68. 00	06800 SPEECH PATHOLOGY	486, 016	254, 538			0.000000	1
69. 00	06900 ELECTROCARDI OLOGY	600, 000	2, 611, 701			0.000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 849, 911	9, 127, 677			0.000000	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	19, 578, 104	17, 329, 531			0.000000	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	55, 929, 703	13, 674, 688			0.000000	
74. 00	07400 RENAL DI ALYSI S	2, 369, 910	25, 690	2, 395, 600		0.000000	1
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	[ C		0.000000	•
76. 01	03951 SLEEP LAB	0	0	١ ٠	0. 000000	0.000000	•
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 664, 187	3, 025, 779			0.000000	•
76. 03	03952 WOUND CARE	1, 817, 476	5, 069, 636	6, 887, 112	0. 307400	0.000000	76. 03
	OUTPATIENT SERVICE COST CENTERS	, ,					
90.00	09000 CLI NI C	4, 604	89, 143	·		0. 000000	1
91. 00	09100 EMERGENCY	8, 363, 492	38, 618, 860			0. 000000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	744, 948	4, 528, 599			0. 000000	1
200.00	,	284, 045, 307	222, 614, 571	506, 659, 878	3		200. 00
201.00	1						201. 00
202.00	Total (see instructions)	284, 045, 307	222, 614, 571	506, 659, 878	]		202. 00

Health Financial Systems	ST JOSEPH MEDICAL CENT	ITER	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Prov		From 06/01/2014 To 05/31/2015	Worksheet C Part I Date/Time Prepared: 10/30/2015 5:01 pm

Cost Center Description					10/30/2015 5:01 pm
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   30.00   ADULTS & PEDIATRICS   30.00   31.00			Title XVIII	Hospi tal	PPS
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   30000   ADULTS & PEDIATRI CS   31.00   31.00   31.00   10.2060   NEONATAL INTENSIVE CARE UNIT   31.00   31.01   32.00   32.00   MENIATAL INTENSIVE CARE UNIT   33.00   32.00   03.00   04.000   SUBPROVIDER - IPP   40.00   44.00   44.00   44.00   MURSERY   43.00	Cost Center Description	PPS Inpatient			
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   31.00   3100   ADULTS & PEDIATRIC S   31.00   31.00   31.00   31.00   ADULTS & PEDIATRIC S   31.00   31.01   31.00   31.01   ADULTS & PEDIATRIC S   31.00   31.01   31.00   31.00   ADULTS & PEDIATRIC S   31.00   31.01   31.00   31.00   ADULTS & PEDIATRIC S   31.00   31.00   31.00   31.00   ADULTS & PEDIATRIC S   31.00   31.00   31.00   ADULTS & PEDIATRIC S   31.00   31.00   31.00   ADULTS & PEDIATRIC S   31.00   31.00   ADULTS & PEDIATRIC S   44.00   ADULTS & 44.00   ADULTS & AD		Ratio			
30.00   30000   ADULTS & PEDI ATRICS   31.00   31.01   20.00   NETRIN SE CARE UNIT   31.00   31.00   31.00   31.00   31.00   NITENSI VE CARE UNIT   31.00   33.00   33.00   03.00   04.00   05.000   BURN INTENSI VE CARE UNIT   44.00   44.00   04.00   SURIPERIN SIVE CARE UNIT   43.00   44.00   44.00   44.00   44.00   44.00   44.00   44.00   44.00   54.11 LED NURSI NG FACILLITY   44.00   44.00   44.00   54.11 LED NURSI NG FACILLITY   44.00   44.00   54.11 LED NURSI NG FACILLITY   44.00   44.00   54.11 LED NURSI NG FACILLITY   45.00   50.0		11. 00			
31. 00   03100   INTENSIVE CARE UNIT	INPATIENT ROUTINE SERVICE COST CENTERS				
31. 01   02060   NEONATAL INTENSIVE CARE UNIT   33. 01   33. 00   0300   04000   04000   SUBPROVIDER - IPF   40. 00   44.00   04400   04400   04400   05410   05410   04400   05410	30. 00  03000 ADULTS & PEDIATRICS				30.00
33. 00   03300   BURN I NTENSI VE CARE UNIT   33. 00   40. 00   04000   SUBPROVI DER - I PF   43. 00   43. 00   04300   NURSERY   44. 00   04000   SUBPROVI DER - I PF   44. 00   04000   SULED NURSI NG FACILITY   44. 00   04000   SULED NURSI NG FACILITY   44. 00   05000   SUBPROVI DER - I PF   50. 00   05000   OFFARI NG ROOM   0.118097   50. 00   05000   OFFARI NG ROOM   0.297760   51. 00   05100   ECCUPERY ROOM   0.297760   51. 00   05100   ECCUPERY ROOM   0.297760   51. 00   05100   ECCUPERY ROOM   0.297760   51. 00   05300   OBLITVERY ROOM   0.408668   53. 00   05300   OBLITVERY ROOM   0.408668   53. 00   05300   OBLITVERY ROOM   0.408668   53. 00   05400   OBLITVERY ROOM   0.408668   053. 00   05300   RADIO STOPE   0.000000   05400   05400   OB400   RADIO STOPE   0.000000   05400   05400   OB400	31.00 03100 INTENSIVE CARE UNIT				31.00
40.00   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000	31.01 02060 NEONATAL INTENSIVE CARE UNIT				31. 01
43. 00   04300   NURSERY	33.00 03300 BURN INTENSIVE CARE UNIT				33.00
43. 00   04300   NURSERY	40. 00   04000   SUBPROVI DER - 1 PF				40.00
ANCILLARY SERVICE COST CENTERS	43. 00   04300 NURSERY				43.00
50.00	44.00 04400 SKILLED NURSING FACILITY				44. 00
50.00	ANCILLARY SERVICE COST CENTERS				
51.00   05100   RECOVERY ROOM & LABOR ROOM   1. 185350   52.00   05200   DELI VERY ROOM & LABOR ROOM   1. 185350   53.00   05300   ANESTHESI OLOGY   0. 018658   53.00   05300   ANESTHESI OLOGY   0. 088113   54.00   54.01   03630   ULTRA SOUND   0. 000000   54.01   03630   ULTRA SOUND   0. 000000   55.00   05500   ARIO ILOGY-DI AGNOSTI C   0. 088113   0. 000000   55.00   05500	50. 00 05000 OPERATI NG ROOM	0. 118097			50.00
51.00   05100   RECOVERY ROOM & LABOR ROOM   1. 185350   52.00   05200   DELI VERY ROOM & LABOR ROOM   1. 185350   52.00   05300   ANESTHESI OLOGY   0. 018658   53.00   05300   ANESTHESI OLOGY   0. 088113   54.00   05400   RADI OLOGY-DI AGNOSTI C   0. 088113   54.00   05400   RADI OLOGY-DI AGNOSTI C   0. 088113   54.00   05600   RADI OLOGY-DI AGNOSTI C   0. 080000   54.01   03630   ULTRA SOUND   0. 000000   55.00   05500   CT SCAN   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	50. 01 03330 ENDOSCOPY				50. 01
52.00   05200   DELI VERY ROOM & LABOR ROOM   1. 185350   53.00   05300   ARSTHESI OLOGY   0. 018658   53.00   05400   RADI OLOGY-DI AGNOSTI C   0. 088113   54.00   05400   RADI OLOGY-DI AGNOSTI C   0. 088113   54.00   05400   RADI OLOGY-DI AGNOSTI C   0. 000000   55.00   05600   RADI OLOGY-DI AGNOSTI C   0. 000000   55.00   05500   RADI OLOGY-DI AGNOSTI C   0. 000000   55.00   05700   CT SCAN   0. 000000   55.00   05700   CT SCAN   0. 000000   55.00   05900   CARDI AC CATHETERI ZATI ON   0. 132340   59.00   06500   RADI DELI C   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000					
53.00   05300   AMESTHESI OLOGY   0.018658   53.00   05400   RADI OLOGY-DI AGNOSTI C   0.088113   54.00   05400   RADI OLOGY-DI AGNOSTI C   0.000000   54.01   05600   RADI OLOGY-DI AGNOSTI C   0.000000   55.00   05700   CT SCAN   0.000000   57.00   05700   CT SCAN   0.000000   57.00   05800   MRI   0.000000   58.00   05800   MRI   0.000000   59.00   05800   MRI   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	· · · · · · · · · · · · · · · · · · ·	1			
54. 00       05400 RADI OLOCY-DI AGNOSTI C       0.088113       54. 01         54. 01       03630 ULTRA SOUND       0.000000       54. 01         56. 00       05600 RADI OL STOPE       0.000000       55. 00         57. 00       05700 CT SCAN       0.000000       57. 00         58. 00       05800 MRI       0.000000       58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0.132340       59. 00         60. 00       06000 LABORATORY       0.117637       60. 00         62. 00       060200 WHOLE BLOOD & PACKED RED BLOOD CELL       0.202532       62. 00         65. 00       06500 RESPI RATORY THERAPY       0.123822       65. 00         66. 00       06600 PYSI CAL THERAPY       0.287693       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.214554       67. 00         68. 00       06800 SPEECH PATHOLOGY       0.268479       68. 00         69. 00       06900 ELECTROCARDI OLOCY       0.73572       68. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.33740       71. 00         72. 00       07200 IMPL DEV. CHARGED TO PATI ENTS       0.117209       73. 00         76. 01       03950 OTHER ANCI LLARY SERVI CE COST CENTER       0.000000					
54. 01   03630   ULTRA SOUND   0. 000000   54. 01   56. 00   05600   RADI OI SOTOPE   0. 000000   55. 00   57. 00   05700   CT SCAN   0. 000000   55. 00   58. 00   05800   MRI   0. 000000   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   0. 132340   59. 00   60. 00   06000   LABGRATORY   0. 117637   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0. 202532   65. 00   65. 00   06500   RESPI RATORY THERAPY   0. 123822   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 287693   65. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0. 24854   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 268479   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 073572   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 337470   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 117209   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 117209   73. 00   74. 00   07400   RENAL DI ALYSI S   0. 117209   74. 00   76. 01   03951   SLEEP LAB   0. 000000   76. 01   76. 02   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0. 000000   76. 01   76. 03   03952   WOUND CARE   0. 000000   0. 000000   76. 01   76. 03   03952   WOUND CARE   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 00000000					•
56. 00   05600   RADI OI SOTOPE   0.000000   57. 00   5700   CT SCAN   0.000000   57. 00   57. 00   58. 00   05800   MRI   0.0000000   58. 00   05800   MRI   0.0000000   58. 00   05900   CARDI AC CATHETERI ZATI ON   0.132340   59. 00   60. 00   60000   LABORATORY   0.117637   60. 00   60. 00   60000   LABORATORY   0.117637   62. 00   60. 200   MPOLE BLOOD & PACKED RED BLOOD CELL   0.202532   62. 00   65. 00   6500   RESPI RATORY THERAPY   0.123822   65. 00   66. 00					
57. 00	· ·				
58. 00					
59. 00       05900   CARDI AC CATHETERI ZATI ON       0. 132340       59. 00         60. 00       06000   LABORATORY       0. 117637       60. 00         62. 00       06200   WHOLE BLOOD & PACKED RED BLOOD CELL       0. 202532       62. 00         65. 00       06500   RESPI RATORY THERAPY       0. 123822       65. 00         66. 00       06600   PHYSI CAL THERAPY       0. 287693       66. 00         67. 00       06700   OCCUPATI ONAL THERAPY       0. 214554       67. 00         68. 00       06800   SPEECH PATHOLOGY       0. 268479       68. 00         69. 00       06900   ELECTROCARDI OLOGY       0. 073572       69. 00         71. 00       07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT       0. 337470       71. 00         72. 00       07200   IMPL. DEV. CHARGED TO PATI ENTS       0. 102166       72. 00         73. 00       07300   DRUGS CHARGED TO PATI ENTS       0. 117209       73. 00         74. 00       07400   RENAL DI ALYSI S       0. 216351       74. 00         76. 01       03951   SLEEP LAB       0. 000000       76. 01         76. 02       03952   WOUND CARE       0. 000000       0. 149277       76. 02         76. 03       03952   WOUND CARE       0. 000000       0. 125158       90. 00					
60. 00   06000   LABORATORY   0. 117637   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0. 202532   65. 00   65. 00   06500   RESPI RATORY THERAPY   0. 123822   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 287693   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   0. 214554   67. 00   68. 00   06800   SPECH PATHOLOGY   0. 264479   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 073572   69. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   0. 337470   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 102166   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 117209   73. 00   74. 00   07400   RENAL DI ALYSI S   0. 216351   74. 00   76. 01   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0. 000000   76. 00   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0. 149277   76. 02   76. 03   09000   CLI NI C   0. 307400		1			
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 202532 62. 00 6500 RESPI RATORY THERAPY 0. 123822 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 287693 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 214554 67. 00 68. 00 6800 SPEECH PATHOLOGY 0. 268479 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 073572 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 337470 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 102166 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 117209 73. 00 07400 RENAL DI ALYSI S 0. 216351 74. 00 07400 RENAL DI ALYSI S 0. 216351 74. 00 07500 OTHER ANCI LLARY SERVI CE COST CENTER 0. 000000 76. 01 03951 SLEEP LAB 0. 000000 76. 01 03951 SLEEP LAB 0. 000000 76. 01 03951 SLEEP LAB 0. 000000 76. 01 03950 OTHER ANCI LLARY SERVI CES 0. 149277 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 149277 76. 02 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 76. 01 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 0. 000000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 000000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 000000		1			
65. 00		1			
66. 00					
67. 00	· ·				
68. 00	· ·				
69. 00	· ·				
71. 00					
72. 00					•
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 117209 74. 00 07400 RENAL DIALYSIS 0. 216351 74. 00 76. 00 03950 OTHER ANCILLARY SERVICE COST CENTER 0. 000000 76. 01 76. 01 03951 SLEEP LAB 0. 0000000 76. 01 76. 02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0. 149277 76. 02 76. 03 03952 WOUND CARE 0. 307400 76. 03  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 4. 229618 91. 00 91. 00 09100 EMERGENCY 0. 125158 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 245503 92. 00 200. 00 Subtotal (see instructions) Less Observation Beds	1 1				
74. 00 07400 RENAL DI ALYSI S 0. 216351 74. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST CENTER 0. 0000000 76. 01 76. 01 03951 SLEEP LAB 0. 0000000 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 149277 76. 02 76. 03 03952 WOUND CARE 0. 307400 76. 03  OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 4. 229618 91. 00 91. 00 09100 EMERGENCY 0. 125158 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 245503 92. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00	· ·				
76. 00					
76. 01 03951 SLEEP LAB 0. 000000 76. 02 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0. 149277 76. 03 03952 WOUND CARE 0. 307400 76. 03 000000 CLI NI C 4. 229618 91. 00 09100 EMERGENCY 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 200. 00 00000 CLI NO CLESS Observati on Beds 0. 000000 CLI NO CLESS Observation Beds 0. 0000000000000000000000000000000000					
76. 02					
76. 03 03952 WOUND CARE 0. 307400 76. 03 0000 CLI NI C 90. 00 09100 EMERGENCY 91. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 200. 00 Subtotal (see instructions) Less Observation Beds 90. 00 201. 00 1000 EMERGENCY 90. 00 000					
OUTPATIENT SERVICE COST CENTERS   90.00   O9000   CLI NI C   4.229618   90.00   O9100   EMERGENCY   0.125158   91.00   O9200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0.245503   92.00   Subtotal (see i nstructions)   Less Observation Beds   201.00					
90. 00   09000   CLI NI C   4. 229618   90. 00   91. 00   09100   EMERGENCY   0. 125158   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0. 245503   92. 00   201. 00   Less Observation Beds   201. 00   201. 00   0. 245503   201. 00   0. 245503   201. 00   0. 245503   0. 245		0. 307400			76.03
91. 00		4 220/10			00.00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0. 245503   92. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00					•
200. 00         Subtotal (see instructions)         200. 00           201. 00         Less Observation Beds         201. 00					
201.00 Less Observation Beds 201.00		0. 245503			
202. 00   Total (see Histractions)        202. 00	1 1				
	202. 00    Total (see Instructions)				J202. 00

| Peri od: | Worksheet C | From 06/01/2014 | Part | To 05/31/2015 | Date/Time Prepared: | Provider CCN: 150047

					0 05/31/2015	10/30/2015 5:	
			Ti t	le XIX	Hospi tal	PPS	<u>от р</u>
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	14, 436, 251		14, 436, 251	0	14, 436, 251	30. 00
31.00	03100 INTENSIVE CARE UNIT	2, 619, 609		2, 619, 609	o	2, 619, 609	31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0			o	0	31. 01
33.00	03300 BURN INTENSIVE CARE UNIT	2, 404, 177		2, 404, 177	ol	2, 404, 177	33. 00
40.00	04000 SUBPROVI DER - I PF	3, 242, 113		3, 242, 113		3, 242, 113	40. 00
43.00	04300 NURSERY	1, 647, 924		1, 647, 924	ı o	1, 647, 924	43.00
44.00	04400 SKILLED NURSING FACILITY	2, 569, 469		2, 569, 469		2, 569, 469	
	ANCILLARY SERVICE COST CENTERS				'		
50.00	05000 OPERATI NG ROOM	4, 755, 481		4, 755, 481	0	4, 755, 481	50.00
50. 01	03330 ENDOSCOPY	732, 399		732, 399		732, 399	50. 01
51.00	05100 RECOVERY ROOM	1, 392, 584		1, 392, 584	ı o	1, 392, 584	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 905, 890		1, 905, 890		1, 905, 890	
53.00	05300 ANESTHESI OLOGY	109, 127		109, 127	ol	109, 127	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 638, 930		6, 638, 930	ol	6, 638, 930	54.00
54. 01	03630 ULTRA SOUND	0		(	o	0	54. 01
56. 00	05600 RADI OI SOTOPE	0			o	0	56. 00
57.00	05700 CT SCAN	0		(	o	0	57. 00
58. 00	05800 MRI	0			o	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 830, 963		2, 830, 963	o	2, 830, 963	59. 00
60.00	06000 LABORATORY	7, 121, 865		7, 121, 865	ol ol	7, 121, 865	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	755, 865	l .	755, 865		755, 865	
65.00	06500 RESPIRATORY THERAPY	1, 767, 258	l			1, 767, 258	
66. 00	06600 PHYSI CAL THERAPY	1, 489, 629		1, 489, 629		1, 489, 629	
67. 00	06700 OCCUPATI ONAL THERAPY	694, 668		694, 668		694, 668	
68. 00	06800 SPEECH PATHOLOGY	198, 823	ł	198, 823		198, 823	
69. 00	06900 ELECTROCARDI OLOGY	236, 290	l e	236, 290		236, 290	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 391, 953	ł	5, 391, 953		5, 391, 953	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 770, 709	ł	3, 770, 709		3, 770, 709	
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 158, 266		8, 158, 266		8, 158, 266	
74. 00	07400 RENAL DI ALYSI S	518, 291		518, 291		518, 291	
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.0,2,1		(		0.0,2,1	76. 00
76. 01	03951 SLEEP LAB	0		ì		0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	849, 382		849, 382	ol ol	849, 382	
76. 03	03952 WOUND CARE	2, 117, 101		2, 117, 101		2, 117, 101	
	OUTPATIENT SERVICE COST CENTERS			_,, 10	, <u> </u>	_, ,	
90.00	09000 CLINIC	396, 514		396, 514	. 0	396, 514	90. 00
91. 00	09100 EMERGENCY	5, 880, 217	ŀ	5, 880, 217		5, 880, 217	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 294, 672	l e	1, 294, 672		1, 294, 672	
200.00		85, 926, 420				85, 926, 420	
201.00	, ,	1, 294, 672	l	1, 294, 672		1, 294, 672	
202.00	l l	84, 631, 748	l .			84, 631, 748	
			•				

| Peri od: | Worksheet C | From 06/01/2014 | Part I | To 05/31/2015 | Date/Time Prepared: Provider CCN: 150047

					0 03/31/2013	10/30/2015 5:	
			Ti t	le XIX	Hospi tal	PPS	
			Charges		•		
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	Inpati ent	
				·		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	35, 458, 401		35, 458, 40°			30. 00
31. 00	03100 INTENSIVE CARE UNIT	3, 669, 384		3, 669, 384	ļ		31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0		(			31. 01
33.00	03300 BURN INTENSIVE CARE UNIT	6, 389, 552		6, 389, 552			33. 00
40.00	04000 SUBPROVI DER - I PF	20, 283, 754		20, 283, 754	l		40. 00
43.00	04300 NURSERY	3, 377, 102		3, 377, 102	2		43.00
44.00	04400 SKILLED NURSING FACILITY	3, 264, 400		3, 264, 400	)		44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	21, 000, 624	19, 267, 085			0.000000	
50. 01	03330 ENDOSCOPY	1, 229, 000	3, 124, 242			0.000000	
51. 00	05100 RECOVERY ROOM	1, 912, 621	2, 764, 245			0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 127, 325	480, 546			0.000000	
53.00	05300 ANESTHESI OLOGY	3, 526, 353	2, 322, 547			0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 894, 083	54, 451, 650	75, 345, 733		0.000000	
54. 01	03630 ULTRA SOUND	0	0	(		0.000000	
56.00	05600 RADI OI SOTOPE	0	0	(		0.000000	
57. 00	05700 CT SCAN	0	0			0.000000	
58.00	05800 MRI	0	0	`	0. 000000	0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	10, 506, 885	10, 884, 677			0.000000	
60.00	06000 LABORATORY	30, 565, 750	29, 975, 206			0.000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	3, 583, 489	148, 597			0.000000	
65. 00	06500 RESPI RATORY THERAPY	12, 898, 893	1, 373, 703			0.000000	
66.00	06600 PHYSI CAL THERAPY	2, 032, 867	3, 144, 968			0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 916, 473	321, 263			0.000000	
68. 00	06800 SPEECH PATHOLOGY	486, 016	254, 538			0.000000	
69. 00	06900 ELECTROCARDI OLOGY	600, 000	2, 611, 701			0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 849, 911	9, 127, 677			0.000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	19, 578, 104	17, 329, 531			0.000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	55, 929, 703	13, 674, 688			0.000000	
74. 00	07400 RENAL DIALYSIS	2, 369, 910	25, 690	2, 395, 600		0.000000	
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	(		0.000000	
76. 01	03951 SLEEP LAB	0	0	`	0. 000000	0.000000	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 664, 187	3, 025, 779			0.000000	76. 02
76. 03	03952 WOUND CARE	1, 817, 476	5, 069, 636	6, 887, 112	0. 307400	0.000000	76. 03
	OUTPATIENT SERVICE COST CENTERS	T					
90.00	09000 CLI NI C	4, 604	89, 143			0. 000000	
91. 00	09100 EMERGENCY	8, 363, 492	38, 618, 860			0. 000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	744, 948	4, 528, 599			0. 000000	
200.00	,	284, 045, 307	222, 614, 571	506, 659, 878	3		200. 00
201.00							201. 00
202.00	Total (see instructions)	284, 045, 307	222, 614, 571	506, 659, 878	ا ا		202. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15004	From 06/01/2014	Worksheet C Part I Date/Time Prepared: 10/30/2015 5:01 pm

Cost Center Description					10/30/2015 5: 0	1 pm
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   30.00   ADULTS & PEDIATRICS   30.00   31.00			Title XIX	Hospi tal	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   30000   ADULTS & PEDIATRI CS   31.00   31.00   31.00   10.2060   NEONATAL INTENSIVE CARE UNIT   31.00   31.01   32.00   32.00   MENIATAL INTENSIVE CARE UNIT   33.00   32.00   03.00   04.000   SUBPROVIDER - IPP   40.00   44.00   44.00   44.00   VILLE ON INTENSIVE CARE UNIT   42.00   44.00   44.00   VILLE ON INSTITUTE OF THE UNIT   45.00   44.00   44.00   VILLE ON INSTITUTE OF THE UNIT   44.00   44.00   VILLE ON INSTITUTE OF THE UNIT   45.00   44.00   54.00   44.00   54.10   LED NURSING FACILITY   45.00   44.00   54.00   44.00   54.00   44.00   54.00   44.00   54.00   44.00   54.00   44.00   54.00   44.00   54.00   44.00   54.00   44.00   54.00   44.00   54.00   44.00   54.00   44.00   54.00   44.00   54.00	Cost Center Description	PPS Inpatient				
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   31.00   3100   ADULTS & PEDIATRIC S   31.00   31.00   31.00   31.00   ADULTS & PEDIATRIC S   31.00   31.01   31.00   31.01   ADULTS & PEDIATRIC S   31.01   31.01   31.01   31.00   31.00   ADULTS & PEDIATRIC S   31.01   31.01   31.01   31.00   31.00   ADULTS & PEDIATRIC S   31.00   31.00   31.00   SUBPROVIDE CARE UNIT   31.01   3		Ratio				
30.00   30000   ADULTS & PEDI ATRICS   31.00   31.01   20.00   NETRIN SE CARE UNIT   31.00   31.00   31.00   31.00   31.00   NITENSI VE CARE UNIT   31.00   33.00   33.00   03.00   04.00   04.000   SUBRI NITENSI VE CARE UNIT   44.00   44		11.00				
31. 00   03100   INTENSIVE CARE UNIT	INPATIENT ROUTINE SERVICE COST CENTERS					
31. 01   02060   NEONATAL INTENSIVE CARE UNIT   33. 01   33. 00   0300   04000   04000   SUBPROVIDER - IPF   40. 00   44.00   04400   04400   04400   05410   05410   04400   05410	30. 00   03000   ADULTS & PEDI ATRI CS					30.00
33. 00   03300   BURN I NTENSI VE CARE UNIT   33. 00   40. 00   04000   SUBPROVI DER - I PF   43. 00   43. 00   04300   NURSERY   44. 00   04000   SUBPROVI DER - I PF   44. 00   04000   SULED NURSI NG FACILITY   44. 00   04000   SULED NURSI NG FACILITY   44. 00   05000   SUBPROVI DER - I PF   50. 00   05000   OFFARI NG ROOM   0.118097   50. 00   05000   OFFARI NG ROOM   0.297760   51. 00   05100   ECCUPERY ROOM   0.297760   51. 00   05100   ECCUPERY ROOM   0.297760   51. 00   05100   ECCUPERY ROOM   0.297760   51. 00   05300   OBLITYERY ROOM   0.40868   53. 00   05300   OBLITYERY ROOM   0.40868   53. 00   05300   OBLITYERY ROOM   0.40868   053. 00   05300   OBLITYERY ROOM   0.50800   0.50800   0.50800   0.50800   0.50800   0.50800   0.508	31.00 03100 INTENSIVE CARE UNIT					31.00
40.00   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0	31.01 02060 NEONATAL INTENSIVE CARE UNIT					31.01
43. 00   04300   NURSERY	33.00 03300 BURN INTENSIVE CARE UNIT					33.00
43. 00   04300   NURSERY	40. 00   04000   SUBPROVI DER - 1 PF					40.00
ANCILLARY SERVICE COST CENTERS	43. 00   04300   NURSERY					43.00
ANCILLARY SERVICE COST CENTERS	44.00 04400 SKILLED NURSING FACILITY					44.00
50.00	ANCILLARY SERVICE COST CENTERS					
51.00   05100   RECOVERY ROOM & LABOR ROOM   1.185350   52.00   05200   DELI VERY ROOM & LABOR ROOM   1.185350   52.00   05300   ANESTHESI OLOGY   0.018658   53.00   05300   ANESTHESI OLOGY   0.088113   54.00   54.01   03630   ULTRA SOUND   0.000000   54.01   03630   ULTRA SOUND   0.000000   54.01   03630   ULTRA SOUND   0.000000   55.00   057.00   05700   CT SCAN   0.000000   0.000000   0.5000   0.000000   0.000000   0.5000   0.000000   0.5000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	50. 00 05000 OPERATI NG ROOM	0. 118097				50.00
51.00   05100   RECOVERY ROOM & LABOR ROOM   1. 185350   52.00   05200   DELI VERY ROOM & LABOR ROOM   1. 185350   52.00   05300   ANESTHESI OLOGY   0. 018658   53.00   05300   ANESTHESI OLOGY   0. 088113   54.00   05400   RADI OLOGY-DI AGNOSTI C   0. 088113   54.00   05400   RADI OLOGY-DI AGNOSTI C   0. 088113   54.00   05600   RADI OLOGY-DI AGNOSTI C   0. 080000   54.01   03630   ULTRA SOUND   0. 000000   55.00   05500   CT SCAN   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	50. 01 03330 ENDOSCOPY	1				50. 01
52.00   05200   DELI VERY ROOM & LABOR ROOM   1. 185350   53.00   05300   ARSTHESI OLOGY   0. 018658   53.00   05400   RADI OLOGY-DI AGNOSTI C   0. 088113   54.00   05400   RADI OLOGY-DI AGNOSTI C   0. 088113   54.00   05400   RADI OLOGY-DI AGNOSTI C   0. 000000   55.00   05600   RADI OLOGY-DI AGNOSTI C   0. 000000   55.00   05500   RADI OLOGY-DI AGNOSTI C   0. 000000   55.00   05700   CT SCAN   0. 000000   55.00   05700   CT SCAN   0. 000000   55.00   05900   CARDI AC CATHETERI ZATI ON   0. 132340   59.00   06500   RADI DELI C   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000					l l	
53.00   05300   AMESTHESI OLOGY   0.018658   53.00   05400   RADI OLOGY-DI AGNOSTI C   0.088113   54.00   05400   RADI OLOGY-DI AGNOSTI C   0.080100   0.000000   54.01   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   57.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   55.00   0.000000   0.000000   55.00   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	1					
54. 00       05400 RADI OLOCY-DI AGNOSTI C       0.088113       54. 01         54. 01       03630 ULTRA SOUND       0.000000       54. 01         56. 00       05600 RADI OL STOPE       0.000000       55. 00         57. 00       05700 CT SCAN       0.000000       57. 00         58. 00       05800 MRI       0.000000       58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0.132340       59. 00         60. 00       06000 LABORATORY       0.117637       60. 00         62. 00       060200 WHOLE BLOOD & PACKED RED BLOOD CELL       0.202532       62. 00         65. 00       06500 RESPI RATORY THERAPY       0.123822       65. 00         66. 00       06600 PYSI CAL THERAPY       0.287693       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.214554       67. 00         68. 00       06800 SPEECH PATHOLOGY       0.268479       68. 00         69. 00       06900 ELECTROCARDI OLOCY       0.73572       68. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.33740       71. 00         72. 00       07200 IMPL DEV. CHARGED TO PATI ENTS       0.117209       73. 00         76. 01       03950 OTHER ANCI LLARY SERVI CE COST CENTER       0.000000						
54. 01   03630   ULTRA SOUND   0. 000000   54. 01   56. 00   05600   RADI OI SOTOPE   0. 000000   55. 00   57. 00   05700   CT SCAN   0. 000000   57. 00   58. 00   05800   MRI   0. 000000   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   0. 132340   59. 00   60. 00   06000   LABGRATORY   0. 117637   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0. 202532   62. 00   65. 00   06500   RESPI RATORY THERAPY   0. 123822   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 287693   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0. 248479   68. 00   68. 00   06800   SPEECH PATHOLOGY   0. 268479   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 073572   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 337470   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 117209   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 117209   73. 00   74. 00   07400   RENAL DI ALYSIS   0. 216551   74. 00   76. 01   03951   SLEEP LAB   0. 000000   76. 01   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0. 149277   76. 02   0900   0000   OSECRIATI ON BEDS (NON-DISTINCT PART   0. 245503   90. 000   0900   OSECRIATI ON BEDS (NON-DISTINCT PART   0. 245503   0. 216503   0. 201. 000   0000   Subtotal (see instructions)   200. 00   001. 00   Subtotal (see instructions)   201. 00   001. 00   Subtotal (see instructions)   201. 00   001. 00   Subtotal (see instructions)   201. 00   001. 00   Cless Observation Beds   201. 00   001. 00   Cle						
56. 00   05600   RADI OI SOTOPE   0.000000   57. 00   5700   CT SCAN   0.000000   57. 00   57. 00   58. 00   05800   MRI   0.0000000   58. 00   05800   MRI   0.0000000   58. 00   05900   CARDI AC CATHETERI ZATI ON   0.132340   59. 00   60. 00   60000   LABORATORY   0.117637   60. 00   60. 00   60000   LABORATORY   0.117637   60. 00   60. 00   60000   LABORATORY   0.12822   62. 00   65. 00   66500   RESPI RATORY THERAPY   0.123822   65. 00   66. 00   66600   PHYSI CAL THERAPY   0.287693   66. 00   66600   PHYSI CAL THERAPY   0.287693   66. 00   66600   PHYSI CAL THERAPY   0.287693   66. 00   66800   SPEECH PATHOLOGY   0.268479   68. 00   6800   SPEECH PATHOLOGY   0.268479   68. 00   69. 00   6900   ELECTROCARDI OLOGY   0.073572   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.102166   72. 00   72. 00   72. 00   72. 00   TMPL. DEV. CHARGED TO PATI ENTS   0.102166   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.117209   73. 00   74. 00					· · · · · · · · · · · · · · · · · · ·	
57. 00						
58. 00						
59. 00       05900   CARDI AC CATHETERI ZATI ON       0. 132340       59. 00         60. 00       06000   LABORATORY       0. 117637       60. 00         62. 00       06200   WHOLE BLOOD & PACKED RED BLOOD CELL       0. 202532       62. 00         65. 00       06500   RESPI RATORY THERAPY       0. 123822       65. 00         66. 00       06600   PHYSI CAL THERAPY       0. 287693       66. 00         67. 00       06700   OCCUPATI ONAL THERAPY       0. 214554       67. 00         68. 00       06800   SPEECH PATHOLOGY       0. 268479       68. 00         69. 00       06900   ELECTROCARDI OLOGY       0. 073572       69. 00         71. 00       07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT       0. 337470       71. 00         72. 00       07200   IMPL. DEV. CHARGED TO PATI ENTS       0. 102166       72. 00         73. 00       07300   DRUGS CHARGED TO PATI ENTS       0. 117209       73. 00         74. 00       07400   RENAL DI ALYSI S       0. 216351       74. 00         76. 01       03951   SLEEP LAB       0. 000000       76. 01         76. 02       03952   WOUND CARE       0. 000000       0. 149277       76. 02         76. 03       03952   WOUND CARE       0. 000000       0. 125158       90. 00						
60. 00   06000   LABORATORY   0. 117637   60. 00   62. 00   66200   WHOLE BLOOD & PACKED RED BLOOD CELL   0. 202532   65. 00   66. 00   06500   RESPI RATORY THERAPY   0. 123822   66. 00   06500   RESPI RATORY THERAPY   0. 287693   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0. 214554   67. 00   06700   0CCUPATI ONAL THERAPY   0. 248479   68. 00   06900   SPECCH PATHOLOGY   0. 073572   69. 00   06900   ELECTROCARDI OLOGY   0. 073572   69. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   0. 337470   71. 00   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 102166   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 117209   73. 00   07400   RENAL DI ALYSI S   0. 216351   74. 00   07400   RENAL DI ALYSI S   0. 216351   74. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0. 000000   0. 3950   OTHER ANCI LLARY SERVI CE S   0. 149277   76. 01   03952   WOUND CARE   0. 307400   09000   CLI NI C   0. 307400   09000   EMERGENCY   0. 125158   0. 125158   91. 00   09000   09000   09000   09000   09000   09000   000000   000000   000000   0000000	I I	1				
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 202532 62. 00 6500 RESPI RATORY THERAPY 0. 123822 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 287693 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 214554 67. 00 68. 00 6800 SPEECH PATHOLOGY 0. 268479 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 073572 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 337470 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 102166 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 117209 73. 00 07400 RENAL DI ALYSI S 0. 216351 74. 00 07400 RENAL DI ALYSI S 0. 216351 74. 00 07500 OTHER ANCI LLARY SERVI CE COST CENTER 0. 000000 76. 01 03951 SLEEP LAB 0. 000000 76. 01 03951 SLEEP LAB 0. 000000 76. 01 03951 SLEEP LAB 0. 000000 76. 01 03950 OTHER ANCI LLARY SERVI CES 0. 149277 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 149277 76. 02 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 76. 01 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTER 0. 000000 0. 000000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 000000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 0. 00000 CUPPATI ENT SERVI CE COST CENTERS 0. 000000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 000000	1 1	1			l l	
65. 00		1				
66. 00						
67. 00						
68. 00						
69. 00						
71. 00						
72. 00					l l	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 117209 74. 00 07400 RENAL DIALYSIS 0. 216351 74. 00 76. 00 03950 OTHER ANCILLARY SERVICE COST CENTER 0. 000000 76. 01 76. 01 03951 SLEEP LAB 0. 0000000 76. 01 76. 02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0. 149277 76. 02 76. 03 03952 WOUND CARE 0. 307400 76. 03  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 4. 229618 91. 00 91. 00 09100 EMERGENCY 0. 125158 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 245503 92. 00 200. 00 Subtotal (see instructions) Less Observation Beds	l l				•	
74. 00 07400 RENAL DI ALYSI S 0. 216351 74. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST CENTER 0. 0.000000 76. 01 76. 01 03951 SLEEP LAB 0. 0.000000 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 149277 76. 02 76. 03 03952 WOUND CARE 0. 307400 76. 03 0UTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 4. 229618 91. 00 91. 00 09100 EMERGENCY 0. 125158 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 245503 92. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00						
76. 00						
76. 01 03951 SLEEP LAB 0. 000000 76. 02 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0. 149277 76. 03 03952 WOUND CARE 0. 307400 76. 03 000000 CLI NI C 4. 229618 91. 00 09100 EMERGENCY 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 200. 00 00000 CLI NO CLESS Observati on Beds 0. 000000 CLI NO CLESS Observation Beds 0. 0000000000000000000000000000000000						
76. 02						
76. 03 03952 WOUND CARE 0. 307400 76. 03 0000 CLI NI C 90. 00 09100 EMERGENCY 91. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 200. 00 Subtotal (see instructions) Less Observation Beds 90. 00 201. 00 1000 EMERGENCY 90. 00 000						
OUTPATIENT SERVICE COST CENTERS   90.00   O9000   CLI NI C   4.229618   90.00   O9100   EMERGENCY   0.125158   91.00   O9200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0.245503   92.00   Subtotal (see i nstructions)   Less Observation Beds   201.00						
90. 00   09000   CLI NI C   4. 229618   90. 00   91. 00   09100   EMERGENCY   0. 125158   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0. 245503   92. 00   201. 00   Less Observation Beds   201. 00   0000000000000000000000000000000		0. 307400				70.03
91. 00		4 220/18				00 00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0. 245503   92. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00					l l	
200. 00       Subtotal (see instructions)       200. 00         201. 00       Less Observation Beds       201. 00		1				
201.00 Less Observation Beds 201.00		0. 245503				
202. 00   Total (see Histractions)        202. 00	l l					
	202.00   Total (see Instructions)	I I			J2	202.00

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO	CHARGE RATIOS NET OF	Provider CCN: 150047	Peri od:	Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 06/01/2014	Part II

REDUCT	TONS FOR MEDICALD ONLY			T	0 05/31/2015		
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reducti on	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						1
	05000 OPERATING ROOM	4, 755, 481	761, 312			0	00.00
	03330 ENDOSCOPY	732, 399	102, 306		0	0	50. 01
	05100 RECOVERY ROOM	1, 392, 584	291, 527		0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	1, 905, 890	262, 156			0	52. 00
	05300 ANESTHESI OLOGY	109, 127	10, 792		0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	6, 638, 930	859, 579	5, 779, 351	0	0	54. 00
	03630 ULTRA SOUND	0	0	0	0	0	54. 01
	05600  RADI 0I S0T0PE	0	0	0	0	0	56. 00
	05700 CT SCAN	0	0	0	0	0	
	05800 MRI	0	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 830, 963	151, 708	2, 679, 255	0	0	59. 00
	06000 LABORATORY	7, 121, 865	766, 000		0	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	755, 865	41, 989	713, 876	0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	1, 767, 258	275, 681	1, 491, 577	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 489, 629	326, 810	1, 162, 819	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	694, 668	127, 844	566, 824	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	198, 823	47, 991	150, 832	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	236, 290	51, 287	185, 003	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 391, 953	171, 911	5, 220, 042	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 770, 709	155, 749	3, 614, 960	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 158, 266	261, 004	7, 897, 262	0	0	73. 00
74.00	07400 RENAL DIALYSIS	518, 291	90, 737	427, 554	0	0	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	O	0	0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	0	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	849, 382	149, 982	699, 400	0	0	76. 02
76. 03	03952 WOUND CARE	2, 117, 101	390, 914	1, 726, 187	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	396, 514	91, 005	305, 509	0	0	90. 00
91.00	09100 EMERGENCY	5, 880, 217	722, 160	5, 158, 057	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 294, 672	190, 468			0	92.00
200.00	Subtotal (sum of lines 50 thru 199)	59, 006, 877	6, 300, 912	52, 705, 965	0	0	200. 00
201.00		1, 294, 672	190, 468			0	201.00
202.00	Total (line 200 minus line 201)	57, 712, 205	6, 110, 444	51, 601, 761	0	· O	202. 00

Health Financial Systems	ST	<b>JOSEPH</b>	MEDI CAL	CENTER		In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	ΓΟ CHARGE RATIOS	NET OF		Provi der C	CN: 150047	From 06/01/2014	Worksheet C Part II Date/Time Prepared:

						10/30/2015 5:01 pm
				le XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,	Cost to Charg		
		Operating Cost	Part I, column	Ratio (col.	6	
		Reducti on	8)	/ col. 7)		
		6.00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	4, 755, 481	40, 267, 709	0. 11809	97	50.00
50. 01	03330 ENDOSCOPY	732, 399			12	50. 01
51.00	05100 RECOVERY ROOM	1, 392, 584	4, 676, 866	0. 29776	50	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 905, 890		l .		52. 00
	05300 ANESTHESI OLOGY	109, 127				53.00
	05400 RADI OLOGY-DI AGNOSTI C	6, 638, 930		l .		54. 00
54. 01	03630 ULTRA SOUND	0,000,700	0	0.00000		54. 01
56. 00	05600 RADI OI SOTOPE	0	0	0. 00000		56. 00
57. 00	05700 CT SCAN	0	١	0. 00000		57. 00
	05800 MRI	0	0	0. 00000		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 830, 963	21, 391, 562			59.00
60.00	06000 LABORATORY	7, 121, 865				60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	7, 121, 865		l .		62. 00
	06500 RESPIRATORY THERAPY	1, 767, 258		l .		65. 00
	06600 PHYSI CAL THERAPY	1, 489, 629				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	694, 668				67.00
68. 00	06800 SPEECH PATHOLOGY	198, 823				68. 00
69. 00	06900 ELECTROCARDI OLOGY		1			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	236, 290				71. 00
		5, 391, 953				•
	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 770, 709				72.00
	07300 DRUGS CHARGED TO PATIENTS	8, 158, 266		l .		73. 00
	07400 RENAL DIALYSIS	518, 291	2, 395, 600			74. 00
	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.00000		76. 00
	03951 SLEEP LAB	0	0	0. 00000		76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	849, 382				76. 02
76. 03	03952 WOUND CARE	2, 117, 101	6, 887, 112	0. 30740	00	76. 03
	OUTPATIENT SERVICE COST CENTERS					
	09000  CLI NI C	396, 514	93, 747	4. 22961	18	90.00
	09100 EMERGENCY	5, 880, 217				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 294, 672	5, 273, 547	0. 24550	)3	92.00
200.00	Subtotal (sum of lines 50 thru 199)	59, 006, 877	434, 217, 285			200. 00
201.00	Less Observation Beds	1, 294, 672	0			201. 00
202.00	Total (line 200 minus line 201)	57, 712, 205	434, 217, 285			202. 00
				•		•

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL			CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part I	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2, 123, 823		2, .20, 01		75. 79	
31.00   INTENSIVE CARE UNIT	558, 726		558, 72	26 1, 167	478. 77	31. 00
31.01 NEONATAL INTENSIVE CARE UNIT	0			0	0.00	
33.00 BURN INTENSIVE CARE UNIT	342, 392		342, 39		319. 40	
40. 00   SUBPROVI DER - I PF	386, 421	0	7 000, 12		45. 25	40. 00
43. 00 NURSERY	140, 509		140, 50	1, 853		
44.00 SKILLED NURSING FACILITY	491, 238		491, 23	4, 847	101. 35	44. 00
200.00 Total (lines 30-199)	4, 043, 109		4, 043, 10	9 45, 499		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	5, 369		1			30. 00
31.00 INTENSIVE CARE UNIT	423	202, 520	)			31. 00
31.01 NEONATAL INTENSIVE CARE UNIT	0	0	)			31. 01
33.00 BURN INTENSIVE CARE UNIT	162					33. 00
40. 00   SUBPROVI DER - I PF	4, 052	183, 353	3			40. 00
43. 00 NURSERY	0	0	)			43.00
44.00 SKILLED NURSING FACILITY	1, 902	192, 768	3			44. 00
200.00 Total (lines 30-199)	11, 908	1, 037, 301				200. 00

Health Financial Sys	stems	ST JOSEPH MEI	OI CAL	CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF IN	PATIENT ANCILLARY SERVICE (	CAPITAL COSTS		Provi der		Peri od:	Worksheet D	
						From 06/01/2014		
						To 05/31/2015	Date/Time Pre	pared:
							10/30/2015 5:	01 pm_
				Ti tl	e XVIII	Hospi tal	PPS	
Cost Ce	nter Description	Capi tal	Tota	I Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(fror	m Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part	t I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
		1 00		2 00	2 00	4 00	F 00	

			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col .	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS			,			
50.00   05000   OPERATING ROOM	761, 312			5, 636, 162		
50. 01   03330   ENDOSCOPY	102, 306			388, 223	•	
51.00   05100   RECOVERY ROOM	291, 527			449, 670	•	
52.00   05200   DELIVERY ROOM & LABOR ROOM	262, 156			5, 326		
53. 00   05300   ANESTHESI OLOGY	10, 792			782, 299	•	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	859, 579	75, 345, 733		6, 950, 192	79, 288	
54.01   03630   ULTRA SOUND	0	0	0.000000	0	0	54. 01
56. 00   05600   RADI OI SOTOPE	0	0	0.000000	0	0	56. 00
57. 00   05700   CT   SCAN	0	0	0.000000	0	0	57. 00
58. 00   05800   MRI	0	0	0.000000	0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	151, 708	21, 391, 562	0. 007092	3, 308, 685	23, 465	59. 00
60. 00   06000   LABORATORY	766, 000	60, 540, 956	0. 012653	7, 637, 466	96, 637	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	41, 989	3, 732, 086	0. 011251	1, 098, 632	12, 361	62.00
65. 00 06500 RESPIRATORY THERAPY	275, 681	14, 272, 596	0. 019315	3, 883, 474	75, 009	65. 00
66. 00 06600 PHYSI CAL THERAPY	326, 810	5, 177, 835	0. 063117	408, 602	25, 790	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	127, 844	3, 237, 736	0. 039486	318, 369	12, 571	67. 00
68. 00 06800 SPEECH PATHOLOGY	47, 991	740, 554	0. 064804	60, 088	3, 894	68. 00
69. 00 06900 ELECTROCARDI OLOGY	51, 287	3, 211, 701	0. 015969	400, 382	6, 394	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	171, 911	15, 977, 588	0. 010760	2, 605, 686	28, 037	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	155, 749	36, 907, 635	0.004220	6, 755, 730	28, 509	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	261, 004	69, 604, 391	0.003750	12, 973, 200	48, 650	73.00
74.00 07400 RENAL DIALYSIS	90, 737	2, 395, 600	0. 037877	796, 036	30, 151	74. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76. 00
76. 01   03951   SLEEP LAB	0	0	0.000000	0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	149, 982	5, 689, 966	0. 026359	501, 948	13, 231	76. 02
76. 03   03952   WOUND CARE	390, 914	6, 887, 112	0. 056760	353, 892	20, 087	76. 03
OUTPATIENT SERVICE COST CENTERS	*		,	,		
90. 00 09000 CLI NI C	91, 005	93, 747	0. 970751	131	127	90. 00
91. 00 09100 EMERGENCY	722, 160	46, 982, 352	0. 015371	2, 161, 646	33, 227	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	190, 468			213, 929	7, 727	92. 00
200.00 Total (lines 50-199)	6, 300, 912	434, 217, 285		57, 689, 768	691, 177	200. 00

Health Financial Systems	ST JOSEPH MED				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	IS Provider		Period: From 06/01/2014	Worksheet D Part III	
				Fo 05/31/2014		nared.
				10 00/01/2010	10/30/2015 5:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	(	0	_	00.00
31.00 03100 INTENSIVE CARE UNIT	0	0	(	O	0	31. 00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0	(	O	0	31. 01
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	(	O	0	33. 00
40. 00   04000   SUBPROVI DER - I PF	0	0	(	0	_	40. 00
43. 00   04300   NURSERY	0	0	(	O	0	
44.00 04400 SKILLED NURSING FACILITY	0	) 0	(	)	0	
200.00 Total (lines 30-199)	0	0	(	)	0	200. 00
Cost Center Description		Per Diem (col.	Inpatient	Inpati ent		
	Days	5 ÷ col . 6)	Program Days	9		
				Pass-Through		
				Cost (col. 7 x		
	6, 00	7. 00	8. 00	col. 8) 9.00	-	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
30. 00 03000 ADULTS & PEDIATRICS	28, 021	0.00	5, 36	9 0		30.00
31. 00   03100   NTENSI VE CARE UNI T	1, 167	1	1			31. 00
31. 01   02060  NEONATAL INTENSIVE CARE UNIT	1, 107	0.00				31.00
33. 00 03300 BURN INTENSIVE CARE UNIT	1, 072	1	1			33. 00
40. 00   04000   SUBPROVI DER -   1 PF	8, 539		1			40. 00
43. 00   04300   NURSERY	1, 853					43. 00
44. 00 04400 SKILLED NURSING FACILITY	4, 847			2 0		44. 00
200. 00 Total (lines 30-199)	45, 499	1	11, 908			200. 00
255.55	10, 17,	1	11,700	٥,	I	1200.00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT / THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Provider CCN: 15004	7 Peri od: From 06/01/2014 To 05/31/2015 Worksheet D Part IV Date/Time Prepared: 10/30/2015 5:01 pm

					10 05/31/2015	10/30/2015 5:	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
	1	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
50. 01	03330 ENDOSCOPY	0	0		0	0	50. 01
51.00	05100 RECOVERY ROOM	0	0			0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0			0	53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0			0	54.00
54. 01	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	0			0	54. 01
56. 00 57. 00	05700 CT SCAN	0	0			0	56. 00 57. 00
58.00	05800 MRI	0	0				58.00
59. 00	05900   CARDI AC   CATHETERI ZATI ON	0	0				59.00
60.00	06000 LABORATORY	0	0				60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
65. 00	06500 RESPIRATORY THERAPY	0	0				65.00
66. 00	06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	ol o	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	م ا	73. 00
74. 00	07400 RENAL DI ALYSI S	0	0		0		74. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	Ö		0	ol o	76. 00
76. 01	03951 SLEEP LAB	0	0		0	ol o	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	76. 02
	03952 WOUND CARE	0	0		0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS			•			1
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92.00
200.00	Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS		<u> </u>	Period: From 06/01/2014 Fo 05/31/2015	Worksheet D Part IV Date/Time Pre 10/30/2015 5:	pared: 01 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cost		I npati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.		Charges	
	col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
	4)	7.00	0.00	7)	40.00	
ANOULL ARV. CERVILOE, COCT, CENTERC	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS		10.0/7.700	0.00000	0.00000	F (0) 4(0	
50. 00   05000   OPERATI NG   ROOM	0				5, 636, 162	1
50. 01   03330   ENDOSCOPY	0	4, 353, 242	1		388, 223	50. 01
51. 00 05100 RECOVERY ROOM	0	4, 676, 866			449, 670	
52.00   05200   DELIVERY ROOM & LABOR ROOM   53.00   05300   ANESTHESIOLOGY	0	1, 607, 871			5, 326	52. 00 53. 00
54. 00   05400   RADI OLOGY	0	5, 848, 900			782, 299 6, 950, 192	
54. 00   05400   RADI OLOGY - DI AGNOSTI C 54. 01   03630   ULTRA SOUND	0	75, 345, 733	0.00000		6, 950, 192 0	54. 00
	0		0.00000		0	
56. 00   05600   RADI 01 SOTOPE 57. 00   05700   CT   SCAN	0		0.00000		0	56. 00 57. 00
58. 00   05800   MRI	0		0.00000		0	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	21, 391, 562			3, 308, 685	
60. 00   06000   LABORATORY		60, 540, 956			7, 637, 466	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 732, 086			1, 098, 632	l
65. 00 06500 RESPIRATORY THERAPY	0		1		3, 883, 474	65.00
66. 00   06600 PHYSI CAL THERAPY	0	5, 177, 835			408, 602	66.00
67. 00   06700   OCCUPATI ONAL THERAPY		3, 237, 736			318, 369	67. 00
68. 00   06800   SPEECH PATHOLOGY		740, 554			60, 088	
69. 00   06900   ELECTROCARDI OLOGY	0				400, 382	l
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				2, 605, 686	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	36, 907, 635			6, 755, 730	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		1		12, 973, 200	
74. 00   07400   RENAL DI ALYSI S		2, 395, 600			796, 036	
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTER		2, 393, 000	1		740,030	76.00
76. 01   03951   SLEEP LAB			0.00000		0	76. 00
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		5, 689, 966	1		501, 948	76. 01
76. 03 03952 WOUND CARE	0	6, 887, 112	1		353, 892	76. 02

0 0 0

0.000000

0.000000

0.000000

46, 982, 352 5, 273, 547 434, 217, 285

93, 747

0.000000

0.000000

0.000000

90.00

131

2, 161, 646 91. 00

213, 929 92. 00 57, 689, 768 200. 00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50-199)

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150047	From 06/01/2014	Worksheet D Part IV Date/Time Prepared:

Title XVIII   Hospital   PPS						10/30/2015 5:	.01 pm
Program Pass-Through Costs (col. 8 x col. 10)			Ti tl	e XVIII	Hospi tal	PPS	
Pass-Through Costs (col 8   x col 10)	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
ANCILLARY SERVICE COST CENTERS		Program	Program	Program			
ANCILLARY SERVICE COST CENTERS   11.00   12.00   13.00		Pass-Through	Charges	Pass-Through	1		
NOTES   NOTE		Costs (col. 8		Costs (col.	9		
ANCI LLARY SERVICE COST CENTERS   50.00   50		x col. 10)		x col. 12)			
50.00		11. 00	12.00	13. 00			
50. 01   03330   ENDOSCOPY   0   921, 043   0   51. 00	ANCILLARY SERVICE COST CENTERS						
51. 00		0	4, 801, 927		0		50.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0   3, 302   0   52. 00   53. 00   05300   ANESTHESI OLOGY   0   545, 583   0   53. 00   54. 01   03630   ULTRA SOUND   0   0   0   0   54. 01   03630   ULTRA SOUND   0   0   0   0   55. 00   05600   RADIO I OSTOPE   0   0   0   0   57. 00   05700   CT SCAN   0   0   0   0   0   58. 00   05800   MRI   0   0   0   0   0   59. 00   05900   CARDI I AC CATHETERI ZATI ON   0   3, 396, 338   0   59. 00   59. 00   05900   CARDI I AC CATHETERI ZATI ON   0   3, 396, 338   0   59. 00   60. 00   06000   LABORATORY   0   2, 777, 369   0   0   61. 00   06500   RESPIRATORY   THERAPY   0   353, 481   0   0   65. 00   06500   RESPIRATORY   THERAPY   0   0   353, 481   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   324   0   68. 00   06800   SPEECH PATHOLOGY   0   425, 493   0   69. 00   06900   ELECTROCARDI OLOGY   0   425, 493   0   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   2, 145, 167   0   71. 00   07300   MRUG LAS UPPLIES CHARGED TO PATI ENT   0   2, 145, 167   0   71. 00   07300   MRUG SCHARGED TO PATI ENTS   0   3, 058, 516   0   71. 00   07300   DRUGS CHARGED TO PATI ENTS   0   3, 058, 516   0   74. 00   07400   REDIACL SUPPLIES CHARGED TO PATI ENTS   0   3, 058, 516   0   75. 00   073951   SLEEP LAB   0   0   0   76. 01   03951   SLEEP LAB   0   0   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   1, 178, 635   0   76. 03   07900   CALPRI ENTS   0   1, 178, 635   0   76. 04   07400   MEDICAL SERVI CE COST CENTER   0   0   0   76. 00   09000   CALPRI ENTS   0   1, 178, 635   0   76. 01   03952   WOUND CARE   0   1, 379, 597   0   76. 00   09000   CALPRI ENTS   0   4, 492, 538   0   76. 01   09100   EMERGENCY   0   4, 492, 538   0   76. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART   0   636, 725   0   77. 00   09200   085ERVATI ON BEDS (NON-DI STINCT PART   0   636, 725   0   77. 00   09200   085ERVATI ON BEDS (NON-DI STINCT PART   0   636, 725   0		0	921, 043		0		
53. 00   05300   ANESTHESI OLOGY   0   545, 583   0   54. 00   54. 00   540,		0	1, 501, 099		0		51.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0   10, 030, 173   0   54. 00   54. 01   03630   ULTRA SOUND   0   0   0   0   54. 01   54. 01   55. 00   05600   RADI OLOGY-DE   0   0   0   0   0   55. 00   55. 00   05600   RADI OLOGY-DE   0   0   0   0   0   0   55. 00   57. 00   58. 00   05800   MRI   0   0   0   0   0   0   0   58. 00   05800   MRI   0   0   0   0   0   0   0   0   58. 00   05900   CARDI AC CATHETERI ZATI ON   0   3, 396, 338   0   59, 00   05000   CARDI AC CATHETERI ZATI ON   0   2, 777, 369   0   0   0   0   0   0   0   0   0		0			0		
54. 01 03630 ULTRA SOUND 56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 55600 RADI OI SOTOPE 57. 00 05700 CT SCAN 0 0 0 0 0 0 57700 CT SCAN 58. 00 05800 MRI 0 0 0 0 0 0 5800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 58. 00 69. 00 06000 LABORATORY 0 0 2, 777, 369 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 58. 733 0 62.00 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 6600 PHYSI CAL THERAPY 0 0 353, 481 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 324 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0900 ELECTROCARDI OLOGY 0 0 425, 493 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 74. 00 07400 RENAL DI ALYSI S 0 07400 RENAL DI ALYSI S 0 07400 RENAL DI ALYSI S 0 0 07400 THER ANCI LLARY SERVI CE COST CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0			0		
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 57:00 CT SCAN 0 0 0 0 0 58:00 MRI 0 0 0 0 0 58:00 MRI 0 0 0 0 58:00 MRI 0 0 0 0 59:00 CARDI AC CATHETERI ZATI ON 0 3,396,338 0 59:00 60:00 CARDI AC CATHETERI ZATI ON 0 2,777,369 0 60:00 CARDI AC CATHETERI ZATI ON 0 2,777,369 0 60:00 CARDI AC CATHETERI ZATI ON 0 58:733 0 60:00 CARDI AC CATHETERI ZATI ON 0 58:733 0 60:00 CARDI AC CATHETERI ZATI ON 0 65:00 CARDI AC CATHETERI ZATI ON 0 60:00 CARDI AC CATHETERI ZATI ON 0 60:00 CARDI AC CA	54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	10, 030, 173		0		54.00
57. 00   05700   CT SCAN   0   0   0   0   0   58. 00   58. 00   05800   MRI	54. 01   03630   ULTRA SOUND	0	0		0		54. 01
58. 00	56. 00   05600 RADI 0I SOTOPE	0	0		0		56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 3, 396, 338 0 50. 60. 00 06000 LABORATORY 0 2, 777, 369 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 58, 733 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 353, 481 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 324 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 2, 145, 167 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 7, 911, 722 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 7, 911, 722 0 72. 00 74. 00 07400 RENAL DI ALYSI S 0 16, 030 0 74. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST CENTER 0 0 0 0 76. 00 76. 01 03951 SLEEP LAB 0 0 0 0 76. 00 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 1, 178, 635 0 76. 02 76. 03 03952 WOUND CARE 0 1, 178, 635 0 76. 02 76. 00 09100 EMERGENCY 0 10, 676 0 99. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 636, 725 0 992. 00	57. 00   05700 CT SCAN	0	0		0		57. 00
60. 00 06000 LABORATORY 0 2,777, 369 0 60. 00 62. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 58,733 0 62. 00 65. 00 65. 00 06500 RESPI RATORY THERAPY 0 353, 481 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 324 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 425, 493 0 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 2,145, 167 0 71. 00 07100 MPL DEV. CHARGED TO PATI ENTS 0 7,911, 722 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 7,911, 722 0 72. 00 07400 RENAL DI ALYSI S 0 16,030 0 74. 00 07400 RENAL DI ALYSI S 0 16,030 0 74. 00 07400 RENAL DI ALYSI S 0 16,030 0 74. 00 07500 OTHER ANCI LLARY SERVI CE COST CENTER 0 0 0 0 0 76. 01 03951 SLEEP LAB 0 0 0 0 0 76. 01 03951 SLEEP LAB 0 0 0 0 0 76. 01 03951 SLEEP LAB 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58. 00   05800 MRI	0	0		0		58. 00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   58,733   0   62. 00   65. 00   06500   RESPI RATORY THERAPY   0   353,481   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   67. 00   06700   0CCUPATI ONAL THERAPY   0   324   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   425,493   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   2,145,167   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   7,911,722   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   3,058,516   0   73. 00   74. 00   07400   RENAL DI ALYSI S   0   16,030   0   74. 00   76. 01   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0   0   76. 00   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   1,178,635   0   76. 01   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   1,379,597   0   76. 03   03952   WOUND CARE   0   10,676   0   90. 00   09000   CLI NI C   0   4,492,538   0   91. 00   91. 00   09100   EMERGENCY   0   4,492,538   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   636,725   0   92. 00	59. 00   05900 CARDI AC CATHETERI ZATI ON	0	3, 396, 338		0		59. 00
65. 00	60. 00   06000   LABORATORY	0	2, 777, 369		0		60.00
66. 00	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	58, 733		0		62. 00
67. 00	65. 00 06500 RESPIRATORY THERAPY	0	353, 481		0		65. 00
68. 00	66. 00   06600 PHYSI CAL THERAPY	0	0		0		66. 00
69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0	324		0		67. 00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0	0		0		68. 00
72. 00	69. 00 06900 ELECTROCARDI OLOGY	0	425, 493		0		69. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   3,058,516   0   73.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 145, 167		0		71. 00
74. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	7, 911, 722		0		72. 00
76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 058, 516		0		73. 00
76. 01 03951 SLEEP LAB 0 0 0 0 76. 01 76. 02 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 1, 178, 635 0 76. 02 76. 03 03952 WOUND CARE 0 1, 379, 597 0 76. 03  OUTPATIENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0 10, 676 0 90. 00 91. 00 09100 EMERGENCY 0 4, 492, 538 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 636, 725 0 92. 00	74. 00 07400 RENAL DIALYSIS	0	16, 030		0		74.00
76. 02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 1, 178, 635 0 76. 02 76. 03 03952 WOUND CARE 0 1, 379, 597 0 76. 03  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0 10, 676 0 90. 00 91. 00 09100 EMERGENCY 0 4, 492, 538 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 636, 725 0 92. 00	76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0		76. 00
76. 03 03952 WOUND CARE 0 1, 379, 597 0 76. 03 0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 10, 676 0 90. 00 91. 00 09100 EMERGENCY 0 4, 492, 538 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 636, 725 0 92. 00	76. 01 03951 SLEEP LAB	0	0		0		76. 01
OUTPATIENT SERVICE COST CENTERS           90. 00         09000 CLINIC         0         10, 676         0         90. 00           91. 00         09100 EMERGENCY         0         4, 492, 538         0         91. 00           92. 00         09200 OBSERVATI ON BEDS (NON-DISTINCT PART         0         636, 725         0         92. 00	76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 178, 635		0		76. 02
90. 00	76. 03 03952 WOUND CARE	o			0		76. 03
91. 00   09100   EMERGENCY	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
91. 00   09100   EMERGENCY		0	10, 676		0		90.00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0   636, 725   0   92. 00		o					
		o			0		92. 00
		0		•	0		200.00

	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der	F	Period: From 06/01/2014 To 05/31/2015		pared:
			Ti tl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			1			
50. 00	05000 OPERATING ROOM	0. 118097			-	567, 093	
50. 01	03330 ENDOSCOPY	0. 168242	1	1	-	154, 958	1
51. 00	05100 RECOVERY ROOM	0. 297760		l .		446, 967	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1. 185350				3, 914	52. 00
53.00	05300 ANESTHESI OLOGY	0. 018658	545, 583	C	0	10, 179	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 088113	10, 030, 173	C	0	883, 789	54.00
54.01	03630 ULTRA SOUND	0. 000000	0	(	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0. 000000	0	(	0	0	56.00
57.00	05700 CT SCAN	0. 000000	0	·	0	0	57. 00
58.00	05800 MRI	0. 000000			0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 132340			0	449, 471	59. 00
60.00	06000 LABORATORY	0. 117637			0		
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 202532				11, 895	
65. 00	06500 RESPIRATORY THERAPY	0. 123822	1	1	-	43, 769	1
66. 00	06600 PHYSI CAL THERAPY	0. 287693				0	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 214554	l l			70	1
68. 00	06800 SPEECH PATHOLOGY	0. 268479				0	
69. 00	06900 ELECTROCARDI OLOGY	0. 073572				31, 304	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 337470			-	723, 930	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 102166			-	808, 309	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 102100		l .	-	358, 486	1
74.00	07400 RENAL DIALYSIS	0. 117209		1		3, 468	
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0. 000000			_	3, 400	1
76. 00	03951 SLEEP LAB				_	0	1
	1 1	0.000000	l control of the cont	1	,	175 042	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 149277			-	1,0,,.0	1
76. 03	03952 WOUND CARE	0. 307400	1, 379, 597		) 0	424, 088	76. 03
00.00	OUTPATIENT SERVICE COST CENTERS	4 000/40	10 (7)			45.455	00.00
	09000 CLINIC	4. 229618				45, 155	
91.00	09100 EMERGENCY	0. 125158			-	562, 277	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 245503		1	-	156, 318	1
200.00			45, 644, 471	C	20, 781	6, 188, 104	
201.00					0		201. 00
000 5	Only Charges		45 :=:	_		,	000 00
202.00	Net Charges (line 200 +/- line 201)		45, 644, 471	(	20, 781	6, 188, 104	J202. 00

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150047		Worksheet D
			From 06/01/2014	

				From 06/01/2014 To 05/31/2015	Part V   Date/Time Pre   10/30/2015 5:	
·		Ti tl	e XVIII	Hospi tal	PPS	от рііі
	Co	sts	, , , , , , , , , , , , , , , , , , ,	noopi tai		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0					50. 00
50. 01   03330   ENDOSCOPY	0					50. 01
51.00   05100   RECOVERY ROOM	0	0				51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00   05300   ANESTHESI OLOGY	0	0				53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
54.01  03630 ULTRA SOUND	0	0				54. 01
56. 00   05600   RADI 0I SOTOPE	0	0				56. 00
57.00  05700   CT   SCAN	0	0				57. 00
58. 00   05800   MRI	0	0				58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00  06000 LAB0RAT0RY	0	0				60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62. 00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0				69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	2, 436				73. 00
74. 00 07400 RENAL DIALYSIS		0				74. 00
76.00   03950 OTHER ANCILLARY SERVICE COST CENTER 76.01   03951   SLEEP LAB		0				76. 00 76. 01
76. 01   03951   SLEEP LAB 76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0				76. 01
76. 02   03550   PSYCHIATRI C/PSYCHOLOGICAL SERVICES 76. 03   03952   WOUND CARE		0				76. 02
OUTPATIENT SERVICE COST CENTERS		l o				76.03
90. 00 09000 CLI NI C	1 0	0				90.00
91. 00   09100   EMERGENCY	Ö					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92. 00
200.00 Subtotal (see instructions)		1				200.00
201.00 Less PBP Clinic Lab. Services-Program		2, 430				201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	0	2, 436				202. 00

Health Financial Systems	ST JOSEPH MED		00N 450047		eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		CCN: 150047 t CCN: 15S047	Peri od: From 06/01/2014 To 05/31/2015	Worksheet D Part II Date/Time Pre 10/30/2015 5:	pared: 01 pm
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	761, 312					
50. 01   03330   ENDOSCOPY	102, 306					
51.00   05100   RECOVERY ROOM	291, 527				16, 526	
52.00 05200 DELIVERY ROOM & LABOR ROOM	262, 156				1	
53. 00   05300   ANESTHESI OLOGY	10, 792					
54. 00   05400   RADI OLOGY-DI AGNOSTI C	859, 579	75, 345, 733				
54. 01   03630   ULTRA SOUND	0	0			0	
56. 00   05600   RADI 0I SOTOPE	0	0			0	56. 00
57. 00  05700 CT SCAN	0	0	0.0000		0	
58. 00   05800   MRI	0		0. 00000		0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	151, 708				0	
60. 00   06000   LABORATORY	766, 000	60, 540, 956	0. 0126	1, 205, 991	15, 259	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	41, 989				0	62. 00
65. 00 06500 RESPI RATORY THERAPY	275, 681				4, 621	65. 00
66. 00   06600 PHYSI CAL THERAPY	326, 810					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	127, 844	3, 237, 736	0. 03948			67. 00
68. 00   06800   SPEECH PATHOLOGY	47, 991	740, 554	0. 06480	18, 948	1, 228	68. 00
69. 00 06900 ELECTROCARDI OLOGY	51, 287	3, 211, 701	0. 01596	77, 601	1, 239	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	171, 911			50 52, 349	563	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	155, 749	36, 907, 635	0. 00422	20 59, 237	250	
73.00 07300 DRUGS CHARGED TO PATIENTS	261, 004	69, 604, 391	0. 00375	2, 085, 508	7, 821	73. 00
74. 00   07400   RENAL DIALYSIS	90, 737	2, 395, 600	0. 03787	77 10, 892	413	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0. 00000	00	0	76. 00
76. 01   03951   SLEEP LAB	0	0	0. 00000	00	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	149, 982	5, 689, 966	0. 0263	59 271, 257	7, 150	76. 02
76. 03   03952   WOUND CARE	390, 914	6, 887, 112	0. 05676	8, 420	478	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	91, 005	93, 747				90.00
91. 00 09100 EMERGENCY	722, 160				4, 405	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0,2,0,0,,			0	92. 00
200.00 Total (lines 50-199)	6, 110, 444	434, 217, 285	5	5, 457, 855	77, 782	200. 00

Hool +b	Financial Systems	CT IOSEDII MED	NICAL CENTED		In Lie	of Form CMS	2552 10
APPORT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	ST JOSEPH MED RVICE OTHER PASS	S Provi der	CCN: 150047 t CCN: 15S047	Period: From 06/01/2014 To 05/31/2015		
			Componen	t CON. 155047	03/31/2013	10/30/2015 5:	01 pm
			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description		Nursing School	Allied Healt	h All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost		
		1.00	2.00	3.00	4. 00	4) 5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50.00	05000 OPERATING ROOM	0	(		0 0	0	50.00
50. 01	03330 ENDOSCOPY	0	d		0 0	0	50. 01
51.00	05100 RECOVERY ROOM	0	C		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	C		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54. 00
54. 01	03630 ULTRA SOUND	0	C		0 0	0	54. 01
56. 00	05600 RADI OI SOTOPE	0	C		0 0	0	56. 00
57. 00	05700 CT SCAN	0	C		0	0	57. 00
58. 00	05800 MRI	0	0	2	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		2	0	0	
60.00	06000 LABORATORY	0			0	0	60.00
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY	0			0	0	62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0			0		
67. 00	06700 OCCUPATI ONAL THERAPY	0				0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0				0	
69. 00	06900 ELECTROCARDI OLOGY	0		ó	0 0	o o	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o o			o o	Ö	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	d		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	C		0 0	0	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	C		0 0	0	76. 00
76. 01	03951 SLEEP LAB	0	(	)	0 0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	-	1	0	0	
76. 03	03952 WOUND CARE	0	C	)	0 0	0	76. 03
00.00	OUTPATIENT SERVICE COST CENTERS			<u></u>	0 0	_	00.00
	09000 CLI NI C	0		1	0 0	l	
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART	0	1		0 0	0	
200.00			1	íl	0 0		200.00
200.00	1 1000 (111103 30 177)	1	1	1	0	1	1200.00

Health Financial Systems	ST JOSEPH MED	NICAI CENTER		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CCN: 150047	Peri od:	Worksheet D	2332-10
THROUGH COSTS				From 06/01/2014	Part IV	
		Component	t CCN: 15SO47	To 05/31/2015	Date/Time Pre 10/30/2015 5:	pared: 01 pm
		Ti tl	e XVIII	Subprovi der  - I PF	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cos		Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS	_					
50. 00   05000   OPERATI NG   ROOM	0				21, 456	
50. 01   03330   ENDOSCOPY	0	.,			27, 340	
51. 00   05100   RECOVERY ROOM	0	.,,			265, 116	
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	1, 607, 871			0	
53. 00   05300   ANESTHESI OLOGY	0				72, 738	
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0				563, 243	
54. 01   03630   ULTRA SOUND	0	0	0.0000		0	
56. 00   05600   RADI 0I SOTOPE	0	0	0. 00000		0	
57. 00   05700   CT   SCAN	0	0	0. 00000		0	
58. 00   05800   MRI	0				0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0				0	
60. 00   06000   LABORATORY	0	,,			1, 205, 991	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				0	
65. 00 06500 RESPI RATORY THERAPY	0	, ,			239, 230	
66. 00 06600 PHYSI CAL THERAPY	0	-, ,			106, 648	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0,20,,,00			85, 162	
68. 00 06800 SPEECH PATHOLOGY	0				18, 948	
69. 00 06900 ELECTROCARDI OLOGY	0				77, 601	1
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0				52, 349	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0				59, 237	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				2, 085, 508	
74. 00 07400 RENAL DIALYSIS 76. 00 03950 OTHER ANCILLARY SERVICE COST CENTER		2, 395, 600			10, 892	
		0			0	1
76. 01   03951   SLEEP LAB		5 (00 0(	0.0000		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0				271, 257	76. 02
76. 03 03952 WOUND CARE	0	6, 887, 112	0.00000	0.000000	8, 420	76. 03
OUTPATIENT SERVICE COST CENTERS		02.747	0.00000	0 000000	404	00.00
90. 00   09000   CLI NI C	0		1			1
91. 00 09100 EMERGENCY	0				286, 588	
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART 200.00   Total (lines 50-199)	0	-,,	1	0.000000	0 5, 457, 855	92.00
200.00   10tal (111es 30-199)	1	434, 217, 283	Ч		J, 4J7, 833	<sub>1</sub> 200.00

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150047	Peri od: From 06/01/2014	Worksheet D Part IV
		Component CCN: 15SO47	To 05/31/2015	Date/Time Prepared: 10/30/2015 5:01 pm
		Title XVIII	Subprovi der -	PPS

		Ti tl	e XVIII	Subprovi der – I PF	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent	111		
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through	n		
	Costs (col. 8	J	Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	C	)	0		50. 00
50. 01   03330   ENDOSCOPY	0	C	)	0		50. 01
51.00   05100   RECOVERY ROOM	0	C	)	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	)	0		52. 00
53. 00 05300 ANESTHESI OLOGY	0	C	)	0		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C		0		54. 00
54. 01   03630   ULTRA SOUND	0	C	)	0		54. 01
56. 00   05600   RADI OI SOTOPE	0	C	)	0		56. 00
57. 00   05700   CT   SCAN	0	C		0		57. 00
58. 00   05800   MRI	0	C	)	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	)	0		59. 00
60. 00   06000   LABORATORY	0	C	)	0		60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C	)	0		62. 00
65. 00 06500 RESPI RATORY THERAPY	0	C	)	0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C	)	0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C	2	0		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	C	2	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C	2	0		69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	C	2	0		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	(	0		72. 00 73. 00
73.00   07300   DRUGS CHARGED TO PATIENTS 74.00   07400   RENAL DIALYSIS	0		(	0		74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER				0		76.00
76. 00   03930   OTHER ANCITLARY SERVICE COST CENTER  76. 01   03951   SLEEP LAB	0			0		76.00
76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES						76. 01
76. 02   03330   PSTCHIATRI C/PSTCHOLOGI CAL SERVI CES  76. 03   03952   WOUND CARE				0		76. 02
OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	Ч		10.03
90. 00 09000 CLINIC	0	C	1	0		90.00
91. 00   09100   EMERGENCY				0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				o o		92.00
200.00 Total (lines 50-199)		C		0		200. 00
255.55	١	_	1	91		1200.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	ST JOSEPH MEDI RVICE OTHER PASS	Provi der	CCN: 150047 t CCN: 155356	Peri od: From 06/01/2014	Worksheet D Part IV Date/Time Pre	pared:
		Ti tl	e XVIII	Skilled Nursing Facility		
Cost Center Description	Non Physician Anesthetist Cost			th All Other Medical Education Cost	4)	
ANCILLARY SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
50. 00   05000	000000000000000000000000000000000000000		•		-	
73. 00   07300   DRUGS CHARGED TO PATIENTS   74. 00   07400   RENAL DI ALYSI S   76. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTER   76. 01   03951   SLEEP LAB   03950   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   76. 03   03952   WOUND CARE   03952   WOUND CARE	000000000000000000000000000000000000000	0 0 0 0 0	1	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	73. 00
90. 00   09000   CLI NI C   91. 00   09200   0	0 0 0 0	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0	0	91.00

Health Financial Systems	ST JOSEPH MED	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der	CCN: 150047	Peri od:	Worksheet D	
THROUGH COSTS		Componen	t CCN: 155356	From 06/01/2014 To 05/31/2015	Part IV Date/Time Pre 10/30/2015 5:	pared:
		Ti +I	e XVIII	Skilled Nursing	PPS	O i pili
		11.61	CAVIII	Facility	113	
Cost Center Description	Total	Total Charges	Ratio of Cos		Inpati ent	
·	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS		10.017.70			4 070	
50. 00   05000   OPERATING ROOM	C		1		1, 070	
50. 01 03330 ENDOSCOPY	C	.,,			0	
51. 00   O5100   RECOVERY ROOM	C		•		0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	C	.,,			0	52.00
53. 00 05300 ANESTHESI OLOGY	C	-, ,	•		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C				108, 810	
54. 01   03630   ULTRA SOUND			0,0000		0	
56. 00   05600   RADI OI SOTOPE 57. 00   05700   CT   SCAN		1			0	56. 00 57. 00
58. 00   05800   MRI			0.00000		0	58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON		1	1		0	59.00
60. 00   06000   LABORATORY					405, 365	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			1		3, 395	62.00
65. 00 06500 RESPIRATORY THERAPY					289, 223	
66. 00   06600 PHYSI CAL THERAPY			•		663, 996	66.00
67. 00 06700 OCCUPATI ONAL THERAPY			•		679, 789	
68. 00 06800 SPEECH PATHOLOGY			•		30, 448	
69. 00 06900 ELECTROCARDI OLOGY			•		7, 177	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT					127, 227	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		1 ' '	•		0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS					1, 570, 445	
74. 00   07400   RENAL DI ALYSI S	, c	1 ' '	1		0	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	C		1		0	76. 00
76. 01   03951   SLEEP LAB	C		1		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C	5, 689, 966			0	76. 02
76. 03   03952   WOUND CARE	C	6, 887, 112	0.00000	0. 000000	71, 371	76. 03
OUTPATIENT SERVICE COST CENTERS	•					1
90. 00 09000 CLI NI C	C	93, 747	0.00000	0. 000000	0	90.00
91. 00 09100 EMERGENCY	C	46, 982, 352	0.00000	0. 000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C	5, 273, 547	0.00000	0. 000000	3, 277	92.00
200.00 Total (lines 50-199)	C	434, 217, 285	5		3, 961, 593	200.00

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150047  Component CCN: 155356	Peri od: From 06/01/2014 To 05/31/2015	Date/Time Prepared:
				10/30/2015 5:01 pm
		Title XVIII	Skilled Nursing	PPS

			11 11	e xviii	Skilled Nursing	PPS	
	Cook Cooker Doorwinking	1	0	I 0	Facility		
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col.	9		
		x col. 10) 11.00	12.00	x col . 12) 13.00			
ANCLLI	LARY SERVICE COST CENTERS	11.00	12.00	13.00			
	OPERATING ROOM	l ol	0	1	0		50.00
	ENDOSCOPY		0		0		50. 00
	RECOVERY ROOM		0		0		51. 00
	DELIVERY ROOM & LABOR ROOM		0		0		52.00
	ANESTHESI OLOGY		0				53. 00
	RADI OLOGY-DI AGNOSTI C		0				54.00
4	ULTRA SOUND		0				54. 00
	RADI OI SOTOPE		0				56.00
	CT SCAN		0		0		57.00
58. 00 05800			0		0		58.00
	CARDI AC CATHETERI ZATI ON	0	0		0		59.00
	LABORATORY	0	0		0		60.00
4		0	0		0		62.00
	WHOLE BLOOD & PACKED RED BLOOD CELL RESPIRATORY THERAPY	0	U	1	0		65.00
		0	U		0		
	PHYSI CAL THERAPY	0	U		0		66.00
	OCCUPATIONAL THERAPY	0	U	'	0		67.00
	SPEECH PATHOLOGY	0	Ü	1	0		68. 00
	ELECTROCARDI OLOGY	0	Ü	1	0		69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ü	1	0		71.00
	IMPL. DEV. CHARGED TO PATIENTS	0	Ü		0		72. 00
	DRUGS CHARGED TO PATIENTS	0	Ü		0		73. 00
	RENAL DIALYSIS	0	0	1	0		74. 00
	OTHER ANCILLARY SERVICE COST CENTER	0	0	1	0		76. 00
	SLEEP LAB	0	0	1	0		76. 01
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	1	0		76. 02
76. 03 03952		0	0		0		76. 03
	TIENT SERVICE COST CENTERS			1	_1		
90. 00 09000		0	O	1	0		90. 00
4	EMERGENCY	0	O	1	0		91. 00
	OBSERVATION BEDS (NON-DISTINCT PART	0	O	1	0		92. 00
200. 00	Total (lines 50-199)	0	0	1	0		200. 00

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL			CCN: 150047	Peri od: From 06/01/2014 To 05/31/2015	Worksheet D Part I	pared:
			le XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost	:		
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 123, 823	0	2, 123, 82		75. 79	30.00
31.00 INTENSIVE CARE UNIT	558, 726		558, 72	26 1, 167	478. 77	31.00
31.01 NEONATAL INTENSIVE CARE UNIT	0			0 0	0.00	
33.00 BURN INTENSIVE CARE UNIT	342, 392		342, 39	1, 072	319. 40	33.00
40. 00 SUBPROVI DER - I PF	386, 421	0	386, 42	21 8, 539	45. 25	40.00
43. 00 NURSERY	140, 509		140, 50	1, 853		
44.00 SKILLED NURSING FACILITY	491, 238		491, 23	4, 847	101. 35	44.00
200.00 Total (lines 30-199)	4, 043, 109		4, 043, 10	9 45, 499		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 963					30.00
31.00   INTENSIVE CARE UNIT	81	38, 780	)			31. 00
31.01 NEONATAL INTENSIVE CARE UNIT	0	_				31. 01
33.00 BURN INTENSIVE CARE UNIT	207	66, 116	,			33. 00
40. 00 SUBPROVIDER - IPF	532	24, 073				40.00
43. 00 NURSERY	811	61, 498				43.00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
200.00 Total (lines 30-199)	3, 594	339, 243				200. 00

Heal th Financial	Systems		ST JOSEPH MED	I CAL	CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF	INPATIENT ANCILLARY SERVICE CA	API TAL	_ COSTS		Provi der		Peri od: From 06/01/2014 To 05/31/2015	Worksheet D Part II Date/Time Pre 10/30/2015 5:	
					Ti t	le XIX	Hospi tal	PPS	
Cost	Center Description		Capi tal	Tota	I Charges	Ratio of Cos	t Inpatient	Capital Costs	
			Related Cost	(fror	n Wkst. C,	to Charges	Program	(column 3 x	
			(from Wkst. B,	Part	t I, col.	(col . 1 ÷ col	. Charges	column 4)	

Capital   Capital   Capital   Related Costs   From Wisst. E,   Ratio of Cost   Column 4   Column 5   Column 5   Column 6   Column 7   Column 8   Column			Ti t	le XIX	Hospi tal	PPS	
Crom Wisst. B, Part II, col. 26)   Rent II, col. 200   Rent II, col. 26)   Rent II, col. 27,	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
Part II, col.   26)			(from Wkst. C,	to Charges	Program		
ANCILLARY SERVICE COST CENTERS					Charges	column 4)	
NAILLLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00		Part II, col.	8)	2)			
ANCILLARY SERVICE COST CENTERS							
50. 00   05000   05000   05PERATI NG ROOM   761, 312   40, 267, 709   0.018906   2, 049, 091   38, 740   50. 00   50. 01   03330   ENDOSCOPY   102, 306   4, 353, 242   0.023501   100, 629   2, 365   50. 01   51. 00   05100   RECOVERY ROOM   291, 527   4, 676, 866   0.062334   237, 681   14, 816   51. 00   52. 00   05200   DELI VERY ROOM & LABOR ROOM   262, 156   1, 607, 871   0.163045   439, 220   71, 613   52. 00   52. 00   05300   ANESTREIS IOLOGY   10, 792   5, 848, 900   0.001845   395, 556   730   53. 00   05300   ANESTREIS IOLOGY   10, 792   5, 848, 900   0.000000   0   0.000000   0   0.000000   0		1.00	2. 00	3. 00	4. 00	5. 00	
50. 01   03330   ENDOSCOPY   102, 306   4, 353, 242   0, 023501   100, 629   2, 365   50. 01     51. 00   05100   RECOVERY ROOM   291, 527   4, 676, 866   0, 062334   237, 681   14, 816   51. 00     52. 00   05200   DELI VERY ROOM & LABOR ROOM   262, 156   1, 607, 871   0, 163045   439, 220   71, 613   52. 00     53. 00   05300   ANESTHESI GLOCY   10, 792   5, 848, 900   0, 001845   395, 556   730   53. 00     54. 00   05400   RADIO LOGY-DI AGNOSTI C   859, 579   75, 345, 733   0, 011408   2, 336, 800   26, 558   54. 00     54. 01   03630   ULTRA SOUND   0   0   0, 000000   0   0   54. 01     55. 00   05500   RADIO ISOTOPE   0   0   0, 000000   0   0   56. 00     57. 00   05700   CT SCAN   0   0   0, 000000   0   0   0   57. 00     58. 00   05800   MRI   0   0   0, 000000   0   0   0   58. 00     59. 00   05800   MRI   0   0   0, 000000   0   0   0   58. 00     60. 00   06000   LABORATORY   766, 000   60, 540, 956   0, 012653   3, 634, 731   45. 990   60. 00     60. 00   06000   LABORATORY   275, 681   41, 989   3, 732, 086   0, 011251   439, 750   4, 948   62. 00     60. 00   06500   MEDIR RATORY THERAPY   275, 681   41, 272, 596   0, 019315   1, 303, 168   25, 171   65. 00     60. 00   06600   PHYSI CAL THERAPY   326, 810   5, 177, 835   0, 063117   153, 572   9, 693   66. 00     60. 00   06600   PHYSI CAL THERAPY   326, 810   5, 177, 835   0, 063117   153, 572   9, 693   66. 00     60. 00   06900   ELECTROCARDIO LOGY   47, 991   740, 554   0, 064804   110, 965   7, 191   68. 00     69. 00   06900   ELECTROCARDIO LOGY   51, 287   3, 211, 701   0, 015969   112, 020   1, 789   69. 00     70. 00   0700   DRIGS CHARGED TO PATI ENTS   155, 749   36, 907, 635   0, 004220   1, 208, 255   5, 099   72. 00     70. 00   0700   DRIGS CHARGED TO PATI ENTS   155, 749   36, 907, 635   0, 004220   1, 208, 255   5, 099   72. 00     70. 00   0700   DRIGS CHARGED TO PATI ENTS   155, 749   36, 907, 635   0, 004220   1, 208, 255   5, 099   72. 00     70. 00   0700   DRIGS CHARGED TO PATI ENTS   156, 1004   69, 604, 391   0, 003		1					
51.00						•	1
52.00   05200   DELIVERY ROOM & LABOR ROOM   262, 156   1, 607, 871   0. 163045   439, 220   71, 613   52, 00   53.00   05300   ANESTHESI OLOGY   10,792   5, 848, 900   0. 001845   395, 556   730   53.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   859, 579   75, 345, 733   0. 011408   2, 336, 800   26, 658   54.00   054, 01   03630   ULTRA SOUND   0   0. 000000   0   0. 054, 01   03630   ULTRA SOUND   0   0. 000000   0   0. 056, 00   057, 00   05700   CT SCAN   0   0   0. 000000   0   0. 000000   0	1	•			·	•	1
53. 00 05300 ANESTHESI OLOGY 10,792 5,848,900 0.001845 395,556 730 53. 00 54. 01 03630 ULTRA SOUND 0 0.000000 0 0.54. 01 56. 00 05400 RADI OLOGY-DI AGNOSTI C 859,579 75,345,733 0.011408 2,336,800 26,658 54. 00 56. 00 05600 RADI OL SOTOPE 0 0 0.000000 0 0.56. 00 57. 00 05700 CT SCAN 0 0 0.000000 0 0 0.57. 00 58. 00 05800 MRI 0 0.000000 0 0 0.57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 151,708 21,391,562 0.007092 665, 166 4,717 59. 00 60. 00 06000 LABORATORY 766,000 060. 06,540,956 0.012653 3,634,731 45,990 60. 00 65. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 41,999 3,732,086 0.011251 439,750 4,986 62. 00 65. 00 06500 RESPI RATORY THERAPY 275,661 14,272,596 0.019315 1,303, 168 25,171 65. 00 66. 00 06600 PLYSI CAL THERAPY 326,811 14,272,596 0.019315 1,303, 168 25,171 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 127,844 3,237,736 0.039486 131,910 5,209 67. 00 68. 00 06800 SPEECH PATHOLOGY 47,991 740,554 0.064804 110,965 7,191 68. 00 69. 00 06900 LECTROCARDI OLOGY 51,287 3,211,701 0.015969 112,020 1,789 69. 00 69. 00 06900 LECTROCARDI OLOGY 51,287 3,211,701 0.015969 112,020 1,789 69. 00 69. 00 06900 LECTROCARDI OLOGY 51,287 3,211,701 0.015969 112,020 1,789 69. 00 69. 00 06900 LECTROCARDI OLOGY 51,287 3,211,701 0.015969 112,020 1,789 69. 00 60. 00 07000 CRENAL DI ALYSI S 90,737 2,395,600 0.037877 157,288 5,958 74. 00 67. 00 07300 DRUGS CHARGED TO PATI ENTS 155,749 36,907,635 0.004220 1,208,255 5,099 72. 00 67. 00 07300 DRUGS CHARGED TO PATI ENTS 155,749 36,907,635 0.004220 1,208,255 5,099 72. 00 67. 00 07300 DRUGS CHARGED TO PATI ENTS 261,004 69,904,391 0.003750 6,271,132 23,517 73. 00 67. 00 07300 DRUGS CHARGED TO PATI ENTS 155,749 36,907,635 0.004220 1,208,255 5,099 72. 00 67. 00 07300 DRUGS CHARGED TO PATI ENTS 261,004 69,904,391 0.003750 6,271,132 23,517 73. 00 67. 00 03950 OTHER ANCILLARY SERVICE COST CENTER 0 0 0.000000 0 0 0 0.00000 0 0 0 0.00000 0 0 0							1
54. 00   05400   RADI OLOGY-DI AGNOSTI C   859, 579   75, 345, 733   0. 011408   2, 336, 800   26, 658   54. 00   54. 01   03630   ULTRA SOUND   0   0. 0000000   0   0   54. 01   56. 00   05600   RADI OLOGY-DI AGNOSTI C   0   0   0. 0000000   0   0   55. 00   57. 00   05700   CT SCAN   0   0   0. 0000000   0   0   57. 00   58. 00   05800   MRI   0   0. 0000000   0   0   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   151, 708   21, 391, 562   0. 007092   665, 166   4, 717   59. 00   60. 00   06000   LABORATORY   766, 000   60, 540, 956   0. 012653   3, 634, 731   45, 990   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   41, 989   3, 732, 086   0. 011251   439, 750   4, 948   62. 00   65. 00   06500   RESPIRATORY THERAPY   326, 810   5, 177, 835   0. 063117   153, 572   9, 693   66. 00   66. 00   06600   PHYSI CAL THERAPY   326, 810   5, 177, 835   0. 063117   153, 572   9, 693   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   127, 844   3, 237, 736   0. 039486   131, 910   5, 209   67. 00   68. 00   06800   SPECEH PATHOLOGY   47, 991   740, 554   0. 064804   110, 965   7, 191   68. 00   69. 00   06900   ELECTROCARDI OLOGY   51, 287   3, 211, 701   0. 015969   112, 020   1, 789   69. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   155, 749   36, 907, 635   0. 004220   1, 208, 255   5, 099   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   155, 749   36, 907, 635   0. 004220   1, 208, 255   5, 099   72. 00   74. 00   07400   RENAL DI ALYSI S   90, 737   2, 395, 600   0. 037877   157, 288   5, 958   74. 00   76. 01   03951   SLEEP LAB   0   0. 000000   0   0   76. 01   76. 02   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0. 000000   0   0   0. 076. 01   76. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0. 000000   0   0. 000000   0   0		262, 156	1, 607, 871	0. 163045	439, 220	71, 613	
54. 01   03630   LLTRA SQUIND   0   0   0   0   0   0   0   54. 01   55. 00   05600   RADI 0I SOTOPE   0   0   0   0   0   0   0   0   57. 00   05700   CT SCAN   0   0   0   0   0   0   0   58. 00   05800   MRI   0   0   0   0   0   0   0   59. 00   05900   CARDI AC CATHETERI ZATI ON   151,708   21,391,562   0   0   0   0   60. 00   06000   LABORATORY   766,000   60,540,956   0   0   0   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   41,989   3,732,086   0   0   0   0   65. 00   06500   RESPIRATORY   THERAPY   275,681   14,272,596   0   0   0   0   66. 00   06600   RESPIRATORY   THERAPY   275,681   14,272,596   0   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   127,844   3,237,736   0   0   0   0   0   68. 00   06800   SPECH PATHOLOGY   47,991   740,554   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   51,287   3,211,701   0   0   0   0   0   71. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATI ENT   171,911   15,977,588   0   0   0   0   0   74. 00   07300   DRUGS CHARGED TO PATI ENT   155,749   90,737   2,395,600   0   0   0   0   0   76. 01   03951   SLEEP LAB   0   0   0   0   0   0   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   149,982   5,689,966   0   0   0   0   0   0   79. 00   09000   CLINI C   90,000   0   0   0   0   79. 00   09000   CLINI C   0   0   0   0   0   79. 00   09000   CLINI C   0   0   0   0   0   79. 00   09000   CLINI C   0   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09000   CLINI C   0   0   0   0   70. 00   09		•					
56. 00         05600 RADI OI SOTOPE         0         0         0.000000         0         56. 00           57. 00         05700 CT SCAN         0         0         0.000000         0         0         57. 00           58. 00         05800 MRI         0         0         0.000000         0         0         57. 00           59. 00         05900 CARDI AC CATHETERI ZATI ON         151, 708         21, 391, 562         0.007092         665, 166         4, 717         59. 00           60. 00         06000 LABORATORY         766, 000         60, 540, 956         0.012653         3, 634, 731         45, 990         60. 00           65. 00         06500 RESPI RATORY THERAPY         275, 681         14, 272, 596         0.011251         439, 750         4, 948         62. 00           66. 00         06600 PHYSI CAL THERAPY         326, 810         5, 177, 835         0.063117         153, 572         9, 693         66. 00           67. 00         06700 OCCUPATI ONAL THERAPY         127, 844         3, 237, 736         0.039486         131, 910         5, 299         67. 00           69. 00         06800 SPEECH PATHOLOGY         47, 991         740, 554         0.064804         110, 965         7, 191         68. 00		859, 579	75, 345, 733	0. 011408	2, 336, 800	26, 658	54. 00
57. 00 05700 CT SCAN 0 0 05800 MRI 0 0 0.000000 0 0 58. 00 58. 00 5800 MRI 0 0 0.000000 0 0 0 58. 00 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 151,708 21,391,562 0.007092 665,166 4,717 59. 00 60. 00 06000 LABORATORY 766,000 60,540,956 0.012653 3,634,731 45,990 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 41,989 3,732,086 0.011251 439,750 4,948 62. 00 65. 00 06500 RESPI RATORY THERAPY 275,681 14,272,596 0.019315 1,303,168 25,171 65. 00 66. 00 06600 PhySi CAL THERAPY 326,810 5,177,835 0.063117 153,572 9,693 66. 00 06600 PhySi CAL THERAPY 127,844 3,237,736 0.039486 131,910 5,209 67. 00 68. 00 06800 SPEECH PATHOLOGY 47,991 740,554 0.064804 110,965 7,191 68. 00 06900 ELECTROCARDI OLOGY 51,291 740,554 0.064804 110,965 7,191 68. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 171,911 15,977,588 0.010760 994,484 10,701 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 155,749 36,907,635 0.004220 1,208,255 5,099 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 261,004 69,604,391 0.003750 6,271,132 23,517 73. 00 7400 RENAL DI ALYSI S 90,737 2,395,600 0.03981 SLEEP LAB 0 0 0.000000 0 0 76. 01 76. 00 76. 01 03951 SLEEP LAB 0 0 0.000000 0 0 0 76. 01 76. 00 03950 OTHER ANCI LLARY SERVI CE COST CENTER 0 0 0.000000 0 0 0 76. 01 76. 00 03950 DYSCH ATRI C/PSYCHOLOGI CAL SERVI CES 149,982 5,689,966 0.026359 304,655 8,030 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 149,982 5,689,966 0.026359 304,655 8,030 76. 02 00 09000 CLI NI C 91.005 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 149,982 5,689,966 0.026359 304,655 8,030 76. 02 00 09000 CLI NI C 91.005 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 149,982 5,689,966 0.026359 304,655 8,030 76. 02 00 09000 CLI NI C 91.005 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 149,982 5,689,966 0.026359 304,655 8,030 76. 02 00 09000 CLI NI C 91.005 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 149,982 5,689,966 0.026359 304,655 8,030 76. 02 00 00 00 00 00 00 00 00 00 00 00 00		0	0	0.000000	0	0	
58. 00         05800 MRI         0         0         0.000000 O.000000 O.000000 O.000000 O.000000 O.000000 O.000000 O.000000 O.00000 O.00000 O.00000 CARDIAC CATHETERI ZATI ON         151, 708		0	0		0	0	
59.00         05900         CARDI AC CATHETERI ZATI ON         151, 708         21, 391, 562         0.007092         665, 166         4, 717         59.00           60.00         06000         LABORATORY         766,000         60, 540, 956         0.012653         3, 634, 731         45, 990         60.00           62.00         06000         WHOLE BLOOD & PACKED RED BLOOD CELL         41, 989         3, 732, 086         0.011251         439, 750         4, 948         62.00           65.00         06500         RESPI RATORY THERAPY         275, 681         14, 272, 596         0.019315         1, 303, 168         25, 171         65.00           66.00         06600         PHYSI CAL THERAPY         326, 810         5, 177, 835         0.063117         153, 572         9, 693         66.00           67.00         06700         OCCUPATI ONAL THERAPY         127, 884         3, 237, 736         0.039486         131, 910         5, 209         67.00           69.00         06900         ELECTROCARDI OLOGY         47, 991         740, 554         0.04804         110, 965         7, 191         68.00           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENT         171, 911         15, 977, 588         0.010760         994, 484         10,		0	0		0	0	
60. 00	58. 00   05800   MRI	0	0	0.000000	0	0	58. 00
62. 00	59. 00   05900   CARDI AC   CATHETERI ZATI ON	151, 708	21, 391, 562	0. 007092	665, 166	4, 717	59. 00
65. 00	60. 00   06000   LABORATORY	766, 000	60, 540, 956	0. 012653	3, 634, 731	45, 990	60.00
66. 00	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	41, 989	3, 732, 086	0. 011251	439, 750	4, 948	62. 00
67. 00   06700   0CCUPATI ONAL THERAPY   127, 844   3, 237, 736   0. 039486   131, 910   5, 209   67. 00   68. 00   06800   SPEECH PATHOLOGY   47, 991   740, 554   0. 064804   110, 965   7, 191   68. 00   69. 00   06900   ELECTROCARDI OLOGY   51, 287   3, 211, 701   0. 015969   112, 020   1, 789   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   171, 911   15, 977, 588   0. 010760   994, 484   10, 701   71. 00   72. 00   72.00   MPL. DEV. CHARGED TO PATI ENTS   155, 749   36, 907, 635   0. 004220   1, 208, 255   5, 099   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   261, 004   69, 604, 391   0. 003750   6, 271, 132   23, 517   73. 00   74. 00   07400   RENAL DI ALYSI S   90, 737   2, 395, 600   0. 037877   157, 288   5, 958   74. 00   76. 01   03951   SLEEP LAB   0   0   0. 000000   0   0   76. 01   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   149, 982   5, 689, 966   0. 026359   304, 655   8, 030   76. 02   76. 03   03952   WOUND CARE   390, 914   6, 887, 112   0. 056760   164, 020   9, 310   76. 03   000000   000000   000000   000000   000000	65. 00 06500 RESPIRATORY THERAPY	275, 681	14, 272, 596	0. 019315	1, 303, 168	25, 171	65.00
68. 00   06800   SPEECH PATHOLOGY   47, 991   740, 554   0. 064804   110, 965   7, 191   68. 00   69. 00   06900   ELECTROCARDI OLOGY   51, 287   3, 211, 701   0. 015969   112, 020   1, 789   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   171, 911   15, 977, 588   0. 010760   994, 484   10, 701   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   155, 749   36, 907, 635   0. 004220   1, 208, 255   5, 099   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   261, 004   69, 604, 391   0. 03750   6, 271, 132   23, 517   73. 00   07400   RENAL DI ALYSI S   90, 737   2, 395, 600   0. 037877   157, 288   5, 958   74. 00   76. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0   0. 000000   0   0   76. 01   76. 02   03951   SLEEP LAB   0   0   0. 000000   0   0   76. 01   76. 02   03952   WOUND CARE   390, 914   6, 887, 112   0. 056760   164, 020   9, 310   76. 03   000000   000000   000000   000000   000000	66. 00 06600 PHYSI CAL THERAPY	326, 810	5, 177, 835	0. 063117	153, 572	9, 693	66. 00
69. 00   06900   ELECTROCARDI OLOGY   51, 287   3, 211, 701   0. 015969   112, 020   1, 789   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   171, 911   15, 977, 588   0. 010760   994, 484   10, 701   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   155, 749   36, 907, 635   0. 004220   1, 208, 255   5, 099   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   261, 004   69, 604, 391   0. 003750   6, 271, 132   23, 517   73. 00   07400   RENAL DI ALYSIS   90, 737   2, 395, 600   0. 037877   157, 288   5, 958   74. 00   03950   0THER ANCI LLARY SERVI CE COST CENTER   0   0   0. 000000   0   0. 76. 00   76. 00   76. 01   76. 02   03950   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   149, 982   5, 689, 966   0. 026359   304, 655   8, 030   76. 02   76. 03   03952   WOUND CARE   390, 914   6, 887, 112   0. 056760   164, 020   9, 310   76. 03   000000   0   0   000000   0   0	67. 00 06700 OCCUPATI ONAL THERAPY	127, 844	3, 237, 736	0. 039486	131, 910	5, 209	67.00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   171, 911   15, 977, 588   0. 010760   994, 484   10, 701   71. 00   72. 00   72. 00   1MPL. DEV. CHARGED TO PATIENTS   155, 749   36, 907, 635   0. 004220   1, 208, 255   5, 099   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   261, 004   69, 604, 391   0. 003750   6, 271, 132   23, 517   73. 00   74. 00   07400   RENAL DIALYSIS   90, 737   2, 395, 600   0. 037877   157, 288   5, 958   74. 00   76. 00   0. 03950   OTHER ANCILLARY SERVICE COST CENTER   0   0   0. 000000   0   0   76. 00   76. 01   76. 02   0. 03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES   149, 982   5, 689, 966   0. 026359   304, 655   8, 030   76. 02   76. 03   0. 0000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	68. 00 06800 SPEECH PATHOLOGY	47, 991	740, 554	0. 064804	110, 965	7, 191	68. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   155, 749   36, 907, 635   0.004220   1, 208, 255   5, 099   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   261, 004   69, 604, 391   0.003750   6, 271, 132   23, 517   73. 00   74. 00   07400   RENAL DIALYSIS   90, 737   2, 395, 600   0.037877   157, 288   5, 958   74. 00   76. 00   0.3950   OTHER ANCILLARY SERVICE COST CENTER   0   0   0.000000   0   0   76. 00   76. 01   76. 02   0.3550   PSYCHIATRIC/PSYCHOLOGICAL SERVICES   149, 982   5, 689, 966   0.026359   304, 655   8, 030   76. 02   76. 03   0.3952   WOUND CARE   390, 914   6, 887, 112   0.056760   164, 020   9, 310   76. 03   0.000000   0   0   0.000000   0   0	69. 00 06900 ELECTROCARDI OLOGY	51, 287	3, 211, 701	0. 015969	112, 020	1, 789	69. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   261, 004   69, 604, 391   0.003750   6, 271, 132   23, 517   73. 00   74. 00   07400   RENAL DI ALYSIS   90, 737   2, 395, 600   0.037877   157, 288   5, 958   74. 00   76. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0   0.000000   0   0   76. 00   76. 01   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   149, 982   5, 689, 966   0.026359   304, 655   8, 030   76. 02   76. 03   03952   WOUND CARE   390, 914   6, 887, 112   0.056760   164, 020   9, 310   76. 03   0017PATI ENT SERVI CE COST CENTERS   91, 005   93, 747   0.970751   240   233   90. 00   91. 00   09100   EMERGENCY   722, 160   46, 982, 352   0.015371   978, 917   15, 047   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   190, 468   5, 273, 547   0.036118   81, 188   2, 932   92. 00   0017PATI ENT SERVI CE COST CENTERS   91. 00   0017PATI ENT SERVI CE COST CENTERS   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   190, 468   5, 273, 547   0.036118   81, 188   2, 932   92. 00   0017PATI ENT SERVI CE COST CENTERS   91. 00   0017PATI ENT SERVI CE COST CENTERS   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   190, 468   5, 273, 547   0.036118   81, 188   2, 932   92. 00   0017PATI ENT SERVI CE COST CENTERS   91. 0017PATI ENT SERVI CE COST CENTERS   91. 0017PATI ENT SERVI CE COST CENTERS   92. 0017PATI ENT SERVI CE COST CENTERS   93. 0017PATI ENT SERVI CE COST CENTERS   94. 0017PATI ENT SER	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	171, 911	15, 977, 588	0. 010760	994, 484	10, 701	71. 00
74. 00   07400   RENAL DI ALYSI S   90, 737   2, 395, 600   0. 037877   157, 288   5, 958   74. 00   76. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0   0. 000000   0   0   76. 00   76. 01   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   149, 982   5, 689, 966   0. 026359   304, 655   8, 030   76. 02   76. 03   03952   WOUND CARE   390, 914   6, 887, 112   0. 056760   164, 020   9, 310   76. 03   76	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	155, 749	36, 907, 635	0. 004220	1, 208, 255	5, 099	72. 00
76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	261, 004	69, 604, 391	0. 003750	6, 271, 132	23, 517	73. 00
76. 01 03951 SLEEP LAB 0 0 0.000000 0 0 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 149, 982 5, 689, 966 0.026359 304, 655 8, 030 76. 02 390, 914 6, 887, 112 0.056760 164, 020 9, 310 76. 03 03952 WOUND CARE 0.0000 CLI NI C 91, 005 93, 747 0.970751 240 233 90. 00 91. 00 09100 EMERGERCY 722, 160 46, 982, 352 0.015371 978, 917 15, 047 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 190, 468 5, 273, 547 0.036118 81, 188 2, 932 92. 00	74. 00   07400   RENAL DI ALYSI S	90, 737	2, 395, 600	0. 037877	157, 288	5, 958	74. 00
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 149, 982 5, 689, 966 0. 026359 304, 655 8, 030 76. 02 390, 914 6, 887, 112 0. 056760 164, 020 9, 310 76. 03 000 000 000 000 000 000 000 000 000	76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76. 00
76. 03   03952   WOUND CARE   390, 914   6, 887, 112   0.056760   164, 020   9, 310   76. 03   017PATI ENT SERVICE COST CENTERS   90. 00   09000   CLI NI C   91, 005   93, 747   0.970751   240   233   90. 00   91. 00   09100   EMERGENCY   722, 160   46, 982, 352   0.015371   978, 917   15, 047   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   190, 468   5, 273, 547   0.036118   81, 188   2, 932   92. 00   09200   09	76. 01   03951   SLEEP LAB	0	0	0.000000	0	0	76. 01
OUTPATI ENT SERVICE COST CENTERS           90. 00         09000 CLI NI C         91, 005         93, 747         0. 970751         240         233         90. 00           91. 00         09100 EMERGENCY         722, 160         46, 982, 352         0. 015371         978, 917         15, 047         91. 00           92. 00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART         190, 468         5, 273, 547         0. 036118         81, 188         2, 932         92. 00	76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	149, 982	5, 689, 966	0. 026359	304, 655	8, 030	76. 02
90. 00   09000   CLI NI C   91, 005   93, 747   0. 970751   240   233   90. 00   91. 00   09100   EMERGENCY   722, 160   46, 982, 352   0. 015371   978, 917   15, 047   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   190, 468   5, 273, 547   0. 036118   81, 188   2, 932   92. 00	76. 03  03952  WOUND CARE	390, 914	6, 887, 112	0. 056760	164, 020	9, 310	76. 03
91. 00   09100   EMERGENCY   722, 160   46, 982, 352   0. 015371   978, 917   15, 047   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   190, 468   5, 273, 547   0. 036118   81, 188   2, 932   92. 00	OUTPATIENT SERVICE COST CENTERS						
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART   190, 468   5, 273, 547   0.036118   81, 188   2, 932   92.00	90. 00 09000 CLI NI C	91, 005	93, 747	0. 970751	240	233	90.00
	91. 00  09100 EMERGENCY	722, 160	46, 982, 352	0. 015371	978, 917	15, 047	91.00
200. 00   Total (lines 50-199)   6, 300, 912   434, 217, 285   22, 270, 438   340, 457   200. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	190, 468	5, 273, 547	0. 036118	81, 188	2, 932	92.00
	200.00   Total (lines 50-199)	6, 300, 912	434, 217, 285		22, 270, 438	340, 457	200. 00

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 06/01/2014		
				To 05/31/2015	Date/Time Pre 10/30/2015 5:	
		Ti t	le XIX	Hospi tal	PPS	or piii
Cost Center Description	Nursi na School	Allied Health		Swi ng-Bed	Total Costs	
, , , , , , , , , , , , , , , , , , ,		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	)	0 0	0	30.00
31.00   03100   INTENSIVE CARE UNIT	0	0	)	O	0	31. 00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0	)	O	0	31. 01
33.00   03300   BURN INTENSIVE CARE UNIT	0	0	)	O	0	33. 00
40. 00   04000   SUBPROVI DER - 1 PF	0	0	)	0	0	40.00
43. 00   04300 NURSERY	0	0	)	O	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	)	O	0	44.00
200.00 Total (lines 30-199)	0	0	)	O	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7.00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	28, 021					30. 00
31. 00   03100   INTENSIVE CARE UNIT	1, 167			1 0		31. 00
31. 01   02060   NEONATAL INTENSIVE CARE UNIT	0	1 0.00		0		31. 01
33.00 03300 BURN INTENSIVE CARE UNIT	1, 072					33. 00
40. 00   04000   SUBPROVI DER - 1 PF	8, 539					40. 00
43. 00   04300   NURSERY	1, 853			1 0	1	43. 00
44.00 O4400 SKILLED NURSING FACILITY	4, 847	1	1	0		44. 00
200.00   Total (lines 30-199)	45, 499	1	3, 59	4 0	1	200. 00

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150047	Peri od: From 06/01/2014 To 05/31/2015	Worksheet D Part IV Date/Time Prepared: 10/30/2015 5:01 pm

					10 05/31/2015	10/30/2015 5:	
			Ti t	le XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	·	Anesthetist	_		Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS					1	
	05000 OPERATING ROOM	0	0		0 0	0	50.00
	03330 ENDOSCOPY	0	0		0	0	50. 01
	05100 RECOVERY ROOM	0	0		0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	03630 ULTRA SOUND	0	0		0	0	54. 01
	05600 RADI OI SOTOPE	0	0		0	0	56. 00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
	05800 MRI	0	0		0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	07400 RENAL DIALYSIS	0	0		0	0	74. 00
	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0	0	76. 00
	03951 SLEEP LAB	0	0		0	0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	76. 02
76. 03	03952 WOUND CARE	0	0		0 0	0	76. 03
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
	09000 CLINIC	0	0		0 0	0	
	09100 EMERGENCY	0	0		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			0	92.00
200.00	Total (lines 50-199)	0	0		0	1 0	200. 00

Heal th F	inancial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
	DNMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provi der		Period: From 06/01/2014 To 05/31/2015	Worksheet D Part IV Date/Time Pre 10/30/2015 5:	pared:
			Ti 1	le XIX	Hospi tal	PPS	
	Cost Center Description	Total		Ratio of Cost		Inpati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col . 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
		4) 6. 00	7. 00	8.00	7) 9. 00	10.00	
Al	NCILLARY SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
	5000 OPERATING ROOM	0	40, 267, 709	0.00000	0.00000	2, 049, 091	50.00
	3330 ENDOSCOPY	0					50. 00
	5100 RECOVERY ROOM	0	4, 676, 866	1			51.00
	5200 DELIVERY ROOM & LABOR ROOM	0	1, 607, 871	1		439, 220	52.00
	5300 ANESTHESI OLOGY	0	5, 848, 900	1		395, 556	
	5400 RADI OLOGY-DI AGNOSTI C	0	75, 345, 733	1		2, 336, 800	
	3630 ULTRA SOUND	0	(	0.00000		0	54. 01
56.00 0	5600 RADI OI SOTOPE	0		0.00000	0.000000	0	56.00
57.00 0	5700 CT SCAN	0		0.00000	0.000000	0	57. 00
58.00 0	5800 MRI	0	(	0.00000	0. 000000	0	58. 00
59.00 0	5900 CARDI AC CATHETERI ZATI ON	0	21, 391, 562	0.00000	0. 000000	665, 166	59. 00
60.00 0	6000 LABORATORY	0	60, 540, 956				60.00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 732, 086	1			
	6500 RESPI RATORY THERAPY	0	1 1/2/2/0/0	1			
	6600 PHYSI CAL THERAPY	0	5, 177, 835			153, 572	66. 00
	6700 OCCUPATI ONAL THERAPY	0	3, 237, 736			131, 910	
	6800 SPEECH PATHOLOGY	0	740, 554			110, 965	
	6900 ELECTROCARDI OLOGY	0	0,2				
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				· ·	
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	, ,	1		1, 208, 255	
	7300 DRUGS CHARGED TO PATIENTS	0	0,,00,,00			6, 271, 132	
	7400 RENAL DIALYSIS	0	2, 395, 600			157, 288	
	3950 OTHER ANCILLARY SERVICE COST CENTER	0		, 0.0000		0	76. 00
	3951 SLEEP LAB	0	F (00 0)	0.00000			76. 01
	3550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 3952 WOUND CARE		5, 689, 966 6, 887, 112	1			76. 02 76. 03
70.03	3732 WOUND CARE		η υ, 887, 11 <sub>2</sub>	1 0.00000	J 0. 000000	164, 020	1 /0.03

0 0 0

0.000000

0.000000

0.000000

46, 982, 352 5, 273, 547 434, 217, 285

93, 747

0.000000

0.000000

0.000000

240

978, 917 91. 00

81, 188 92. 00 22, 270, 438 200. 00

90.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50-199)

Health Financial Systems		ST	J0SEPH	MEDI CAL	CENTER			In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY	SERVI CE	OTHER	PASS	Provi der	CCN:	150047	06/01/2014 05/31/2015	Worksheet D Part IV Date/Time Prepared:

				10 05/31/2015	10/30/2015 5:0	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col.	7		
	x col. 10)		x col. 12)			
	11.00	12.00	13. 00			
ANCI LLARY SERVI CE COST CENTERS	T		Г	T		
50. 00   05000   OPERATI NG ROOM	0	(	)	0		50.00
50. 01   03330   ENDOSCOPY	0	C	)	0		50. 01
51.00   05100   RECOVERY ROOM	0	C	)	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	)	0		52.00
53. 00   05300   ANESTHESI OLOGY	0	(	)	0		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	(	)	0		54. 00
54. 01   03630   ULTRA SOUND	0	C	)	0		54. 01
56. 00   05600   RADI 0I SOTOPE	0	C	)	0		56. 00
57. 00   05700   CT   SCAN	0	C	)	0		57. 00
58. 00   05800   MRI	0	C	)	0		58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	C	)	0		59. 00
60. 00   06000   LABORATORY	0	C		0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0		62.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0	I	65.00
66. 00   06600 PHYSI CAL THERAPY	0	C		0		66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	C		0	1	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	C		0		68.00
69. 00  06900   ELECTROCARDI OLOGY	0	C	)	0	1	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	)	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	)	0		73.00
74. 00   07400   RENAL DIALYSIS	0	C	)	0		74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	C	)	0		76.00
76. 01  03951  SLEEP LAB	0	C	)	0		76. 01
76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C	)	0		76. 02
76. 03 03952 WOUND CARE	0	C	)	0		76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	0	C	)	0		90.00
91. 00   09100   EMERGENCY	0	C	)	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C	)	0		92.00
200.00   Total (lines 50-199)	0	C	)	0	2	200. 00

near tr	Financiai systems	31 JUSEPH WEL	TICAL CENTER		III LI E	u or Form CW3-	2552-10
APP0R	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provi der	CCN: 150047	Peri od:	Worksheet D	
					From 06/01/2014	Part V	
					To 05/31/2015		pared:
			т: .	tle XIX	Hooni tal	10/30/2015 5: PPS	UI pm
			111		Hospi tal		
		0 01	550 5 1 1	Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Servi ces (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 118097	(		0 1, 506, 328	0	50.00
50. 01	03330 ENDOSCOPY	0. 168242			0 174, 268	0	50. 01
51.00	05100 RECOVERY ROOM	0. 297760	(		0 298, 824	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1. 185350		ol	0 115, 380	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 018658	1 (		0 258, 765	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 088113			0 4, 861, 328	0	1
54. 01	03630 ULTRA SOUND	0. 000000			0 1,001,020	n	54. 01
56. 00	05600 RADI OI SOTOPE	0. 000000			0 0	0	1
57. 00	05700 CT SCAN	0. 000000				0	57. 00
	1 1	0. 000000			0	0	
58. 00	05800 MRI				0 4/7 00/	0	00.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 132340	l .	1	0 467, 086	0	59.00
60.00	06000 LABORATORY	0. 117637	(	)	0 3, 011, 619	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 202532	(	)	0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	0. 123822	(		0 171, 400		65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 287693	(		0 127, 860	0	00.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 214554	(		0 15, 924	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 268479	(		0 7, 747	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 073572	(		0 183, 799	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 337470	(		0 421, 456	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 102166		ol	0 1, 046, 096	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 117209	l c	ol	0 1, 244, 142	0	73.00
74.00	07400 RENAL DI ALYSI S	0. 216351	1		0 0	0	74.00
76. 00		0. 000000			0 0	0	76. 00
76. 01	03951 SLEEP LAB	0. 000000			0 0	i n	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 149277	l e		0 87, 974	ľ	76. 02
76. 02	03952 WOUND CARE	0. 307400		1	0 268, 290		1
70.03	OUTPATIENT SERVICE COST CENTERS	0.307400		<u>/ </u>	0 200, 290		70.03
00 00	09000 CLINIC	4. 229618		1	0 7, 130	0	00 00
90.00	1 1					0	
	09100 EMERGENCY	0. 125158			-,,	_	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 245503		(	0 284, 647	0	
200.00			(	ון	0 19, 735, 461	0	200.00
201.00					0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		(	기	0 19, 735, 461	0	202. 00

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150047	Peri od: From 06/01/2014	Worksheet D

05/31/2015 Date/Time Prepared: 10/30/2015 5:01 pm Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 177, 893 50.00 50.01 03330 ENDOSCOPY 0 0 0 29, 319 50.01 51.00 05100 RECOVERY ROOM 88, 978 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 136, 766 52.00 53. 00 | 05300 | ANESTHESI OLOGY 4, 828 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 000000000000000000000 428, 346 54.00 03630 ULTRA SOUND 54.01 C 54.01 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 57.00 0 57.00 05800 MRI 58 00 58 00 Ω 59.00 05900 CARDI AC CATHETERI ZATI ON 61,814 59.00 60.00 06000 LABORATORY 354, 278 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 06500 RESPIRATORY THERAPY 65.00 21, 223 65.00 66.00 06600 PHYSI CAL THERAPY 36, 784 66.00 67.00 06700 OCCUPATI ONAL THERAPY 3, 417 67.00 68.00 06800 SPEECH PATHOLOGY 2, 080 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 13, 522 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 142, 229 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 106, 875 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 145, 825 73.00 07400 RENAL DIALYSIS 74.00 Ω 74 00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTER 0 76.00 03951 SLEEP LAB 76.01 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.02 13, 132 76.02 03952 WOUND CARE 76.03 82, 472 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 30, 157 90.00 91.00 09100 EMERGENCY 647, 742 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 69, 882 92.00 200.00 2, 597, 562 200. 00 Subtotal (see instructions) Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 0 202.00 2, 597, 562 202.00

Pacific   Financial Systems   ST JOSEPH MEDICAL CENTER   To Use of Form QMS-2562-10	Health Figureial Customs	CT IOCEDII MED	NICAL CENTED		la li o	u of Form CMC	2552 10
Component CCN: 15S047   To 06/31/2015   Date/Time Prepared: 10/30/2015   PPS	Health Financial Systems			CCN: 150047			2552-10
Capital   Related Cost (From Wisst B, Part II, col.   20	APPORTIONMENT OF INPATTENT ANGILLARY SERVICE CAPITA	L C0313			From 06/01/2014	Part II	pared: 01 pm
Cost Center Description			Ti t	le XIX			
Related Cost   Cfrom Wist B, Part II, col.   26)   Col. 1 + col.   Charges   Charges   Column 3 x   Column 4)   Part II, col.   26)   20   3.00   4.00   5.00	0 1 0 1 0 1	1 0 111	T + 1 01	In 11 60			
Column 4   Part I, col.   Col.   Col.   1   Col.   Charges   Column 4   Part II, col.   26   2   2   2   2   2   2   2   2	Cost Center Description						
Part II							
ANCILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00			·	`	. Charges	column 4)	
NOTE			8)	2)			
ANCILLARY SERVICE COST CENTERS			2.00	2.00	4.00	F 00	
50.00	ANCILLADY CEDVICE COCT CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 01   03330   ENDOSCOPY   102, 306   4, 353, 242   0.023501   0   0   50. 01		741 212	40 247 700	0.0100	24	0	E0 00
51.00   05.100   RECOVERY ROOM   291,527   4,676,866   0.062334   0   0   51.00							
S2				1			
53. 00   05300   ANESTHESI OLOGY   10,792   5,848,900   0.001845   0   0   53. 00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   859,579   75,345,733   0.011408   0   0   54. 00   54. 01   03630   LITRA SOUND   0   0   0.000000   0   0   54. 01   55. 00   05600   RADI OLOGY-DI AGNOSTI C   0   0   0   0.000000   0   0   54. 01   55. 00   05600   RADI OLOGY-DI AGNOSTI C   0   0   0   0.000000   0   0   56. 00   57. 00   05700   CT SCAN   0   0   0   0.000000   0   0   55. 00   58. 00   05800   MRI   0   0   0.000000   0   0   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   151,708   21,391,562   0.007092   0   0   59. 00   60. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   41,989   3,732,086   0.011251   0   0   62. 00   65. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   41,989   3,732,086   0.011251   0   0   62. 00   65. 00   06500   RESPI RATORY THERAPY   275,681   14,272,596   0.019315   0   0   65. 00   66. 00   06600   PAYSI CAL THERAPY   326,810   5,177,835   0.063117   0   0   65. 00   67. 00   06700   0CCUPATI ONAL THERAPY   127,844   3,237,736   0.039486   0   0   67. 00   68. 00   06600   ELECTROCARDI OLOGY   47,991   740,554   0.064804   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   51,287   3,211,701   0.015969   0   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   155,749   36,907,635   0.004220   0   72. 00   73. 00   07300   RURS CHARGED TO PATI ENTS   155,749   36,907,635   0.004220   0   72. 00   74. 00   07400   RENAL DI ALYSI S   90,737   2,395,600   0.037877   0   74. 00   76. 01   03951   SLEEP LAB   0   0   0   0   0   0   76. 01   03951   SLEEP LAB   0   0   0   0   0   76. 01   03951   SLEEP LAB   0   0   0   0   0   76. 01   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0   0   0   0   76. 01   03950   OSERVATI ON BEDS (NON-DI STI NCT PART O   0   5,273,547   0   0   0   0   0   0   76. 02   03950   OSERVATI ON BEDS (NON-DI STI NCT PART O   5,273,547   0   0   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   0   0   79. 00   09							
54. 00   05400   RADI OLOCY-DI AGNOSTI C   859, 579   75, 345, 733   0. 011408   0   0   54. 00   54. 01   03630   ULTRA SOUND   0   0   0. 000000   0   0   54. 01   55. 00   05600   RADI OL SOTOPE   0   0   0. 000000   0   0   56. 00   57. 00   05700   CT SCAN   0   0   0. 000000   0   0   57. 00   58. 00   05800   MRI   0   0   0. 000000   0   0   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   151, 708   21, 391, 562   0. 007092   0   0. 59. 00   60. 00   06000   LABORATORY   766, 000   60, 540, 956   0. 012653   0   0   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   41, 989   3, 732, 086   0. 011251   0   0   62. 00   65. 00   06500   RESPI RATORY THERAPY   275, 681   14, 272, 596   0. 019315   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   326, 810   5, 177, 835   0. 063117   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   127, 844   3, 237, 736   0. 039486   0   0   67. 00   69. 00   06900   ELECTROCARDI OLOGY   47, 991   740, 554   0. 064804   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   51, 287   3, 211, 701   0. 015969   0   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   171, 911   15, 977, 588   0. 010760   0   0   71. 00   72. 00   07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   261, 004   69, 604, 391   0. 003750   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   261, 004   69, 604, 391   0. 003750   0   0   72. 00   74. 00   07400   RENAL DI ALYSI S   90, 737   2, 395, 600   0. 037877   0   0   74. 00   76. 01   03951   SLEEP LAB   0   0   0. 000000   0   0   76. 01   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   149, 982   5, 689, 966   0. 026359   0   0   76. 02   000   09000   CLI NI C   91, 005   93, 747   0. 970751   0   0   91. 00   91. 00   09000   CLI NI C   91, 005   93, 747   0. 000000   0   0   92. 00   92. 00   09000   09000   09000   00000   0							
54. 01   03630   LITRA SOUND				1		1	
56. 00   05600   RADI OI SOTOPE   0   0   0   0   0   0   0   0   56. 00   57. 00   05700   CT SCAN   0   0   0   0   0   0   0   0   0							
S7.00   O5700   CT   SCAN   O   O   O   O   O   O   O   O   O		-	1			-	
58. 00		1	0				
59. 00 05900 CARDI AC CATHETERI ZATI ON 151, 708 21, 391, 562 0.007092 0 0 59. 00 60. 00 06000 LABORATORY 766, 000 60, 540, 956 0.012653 0 0 60. 00 62. 00 62. 00 62. 00 65. 00 06500 RHOLE BLOOD & PACKED RED BLOOD CELL 41, 989 3, 732, 086 0.011251 0 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 275, 681 14, 272, 596 0.019315 0 0 65. 00 06600 PHYSI CAL THERAPY 326, 810 5, 177, 835 0.063117 0 0 66. 00 6700 0CCUPATI ONAL THERAPY 127, 844 3, 237, 736 0.039486 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 47, 991 740, 554 0.064804 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 51, 287 3, 211, 701 0.015969 0 0 69. 00 06900 ELECTROCARDI OLOGY 51, 287 3, 211, 701 0.015969 0 0 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 155, 749 36, 907, 635 0.004220 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 155, 749 36, 907, 635 0.004220 0 0 72. 00 07400 RENAL DI ALYSIS 90, 737 2, 395, 600 0.037877 0 0 74. 00 07400 RENAL DI ALYSIS 90, 737 2, 395, 600 0.037877 0 0 74. 00 07400 RENAL DI ALYSIS 90, 737 2, 395, 600 0.037877 0 0 74. 00 07400 RENAL DI ALYSIS 90, 737 2, 395, 600 0.000000 0 0 0 0 0 0.000000 0 0 0 0			0			1	
60. 00 06000 LABORATORY 766, 000 60, 540, 956 0. 012653 0 0 60. 00 62. 00 62. 00 6200 WHOLE BLOOD & PACKED RED BLOOD CELL 41, 989 3, 732, 086 0. 011251 0 0 62. 00 65. 00 650. 00 66500 RESPI RATORY THERAPY 275, 681 14, 272, 596 0. 019315 0 0 65. 00 66. 00 6600 PHYSI CAL THERAPY 326, 810 5, 177, 835 0. 063117 0 0 66. 00 67. 00 670 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	-	
62. 00	I I					1	
65. 00 06500 RESPI RATORY THERAPY 275, 681 14, 272, 596 0. 019315 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 326, 810 5, 177, 835 0. 063117 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 127, 844 3, 237, 736 0. 039486 0 0 67. 00 68. 00 680. 00 6900 SPEECH PATHOLOGY 47, 991 740, 554 0. 064804 0 0 68. 00 6900 ELECTROCARDI OLOGY 51, 287 3, 211, 701 0. 015969 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 171, 911 15, 977, 588 0. 010760 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 155, 749 36, 907, 635 0. 004220 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 261, 004 69, 604, 391 0. 003750 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 261, 004 69, 604, 391 0. 003750 0 0 73. 00 074. 00 07400 RENAL DI ALYSI S 90, 737 2, 395, 600 0. 037877 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1			
66. 00					3.	1	
67. 00		· ·		1		0	65. 00
68. 00   06800   SPEECH PATHOLOGY   47, 991   740, 554   0. 064804   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   51, 287   3, 211, 701   0. 015969   0   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   171, 911   15, 977, 588   0. 010760   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   155, 749   36, 907, 635   0. 004220   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   261, 004   69, 604, 391   0. 003750   0   0   73. 00   74. 00   07400   RENAL DI ALYSI S   90, 737   2, 395, 600   0. 037877   0   0   74. 00   76. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0   0. 000000   0   0   76. 01   76. 01   03951   SLEEP LAB   0   0   0. 000000   0   0   76. 01   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   149, 982   5, 689, 966   0. 026359   0   0   76. 02   76. 03   03952   WOUND CARE   390, 914   6, 887, 112   0. 056760   0   0   76. 03   90. 00   09000   CLI NI C   91, 005   93, 747   0. 970751   0   0   90. 00   91. 00   09100   EMERGENCY   722, 160   46, 982, 352   0. 015371   0   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   5, 273, 547   0. 000000   0   0   92. 00    00   00000   0   0   0   0   0					.,		1
69. 00						0	
71. 00		47, 991	740, 554			0	68. 00
72. 00	69. 00   06900   ELECTROCARDI OLOGY	51, 287	3, 211, 701	0. 0159	69 0	0	69. 00
73. 00					0	0	71. 00
74. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	155, 749	36, 907, 635	0.0042	20 0	0	72. 00
76. 00		261, 004	69, 604, 391	0. 0037	50 0	0	73.00
76. 01 03951 SLEEP LAB 0 0.000000 0 0.000000 0 0 76. 01 76. 02 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 149, 982 5, 689, 966 0.026359 0 0 76. 02 76. 03 03952 WOUND CARE 390, 914 6, 887, 112 0.056760 0 0 76. 03  OUTPATIENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 91, 005 93, 747 0.970751 0 0 90. 00 91. 00 09100 EMERGENCY 722, 160 46, 982, 352 0.015371 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 5, 273, 547 0.000000 0 0 92. 00	74.00   07400   RENAL DIALYSIS	90, 737	2, 395, 600	0. 0378	77 0	0	74.00
76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   149, 982   5, 689, 966   0.026359   0   0   76. 02   76. 03	76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.0000	00	0	76.00
76. 03 03952 WOUND CARE 390, 914 6, 887, 112 0. 056760 0 0 76. 03 0UTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 91, 005 93, 747 0. 970751 0 0 90. 00 91. 00 09100 EMERGENCY 722, 160 46, 982, 352 0. 015371 0 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 5, 273, 547 0. 000000 0 0 92. 00	76. 01   03951   SLEEP LAB	0	0	0.0000	00	0	76. 01
OUTPATI ENT         SERVI CE         COST         CENTERS           90. 00         09000 CLI NI C         91,005         93,747         0.970751         0         0         90.00           91. 00         09100 EMERGENCY         722,160         46,982,352         0.015371         0         0         91.00           92. 00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART         0         5,273,547         0.000000         0         92.00	76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	149, 982	5, 689, 966	0. 0263	59 0	0	76. 02
OUTPATI ENT         SERVI CE         COST         CENTERS           90. 00         09000 CLI NI C         91,005         93,747         0.970751         0         0         90.00           91. 00         09100 EMERGENCY         722,160         46,982,352         0.015371         0         0         91.00           92. 00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART         0         5,273,547         0.000000         0         92.00	76. 03 03952 WOUND CARE	390, 914	6, 887, 112	0. 0567	60 0	0	76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS		•				1
91. 00   09100   EMERGENCY   722, 160   46, 982, 352   0. 015371   0   0   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0   5, 273, 547   0. 000000   0   92. 00		91, 005	93, 747	0. 9707	51 0	0	90.00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0 5, 273, 547   0.000000   0 92. 00	l						
		1				0	92.00
		6, 110, 444				0	1

llool +b	Financial Customs	CT LOCEDII MED	NICAL CENTED		la li	ou of Form CMC	2552 10
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	ST JOSEPH MED		CCN: 150047	Peri od:	eu of Form CMS-2 Worksheet D	2552-10
	COSTS	WICE OTHER TAS		t CCN: 15S047	From 06/01/2014 To 05/31/2015	Part IV	pared: 01 pm
			Ti t	le XIX	Subprovi der - I PF	PPS	•
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Healt	h All Other Medical Education Cost	Total Cost (sum of col 1 through col.	
						4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1 -	1 .	1			
50.00	05000 OPERATI NG ROOM	0	0	1	0 0		
50. 01	03330 ENDOSCOPY	0	0		0 0	1	
51. 00 52. 00	05100 RECOVERY ROOM	0				0	
53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0					53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0					
54. 00	03630 ULTRA SOUND						
56. 00	05600 RADI OI SOTOPE	0					56.00
57. 00	05700 CT SCAN	0					
58. 00	05800 MRI	0			0 0		1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0	ol o	1
60.00	06000 LABORATORY	0			0	ol o	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	ol o	62. 00
65. 00	06500 RESPIRATORY THERAPY	0	l o	,	o c	ol o	1
66. 00	06600 PHYSI CAL THERAPY	0	l o	)	0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	l o	)	0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	l c	,	0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	1	0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	1	0 0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	)	0 0	0	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	l .	0 0	1	1
76. 03	03952 WOUND CARE	0	0		0 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS	_	T -	1	_1		
	09000 CLINIC	0		1	0 0		
91.00	09100 EMERGENCY	0	1		0 0	1	
92. 00 200. 00	O9200   OBSERVATION BEDS (NON-DISTINCT PART   Total (lines 50-199)		0	1	0 0	0	92. 00 200. 00
200.00	ol local (lilles 50-199)	1	1	"I	o <sub>l</sub>	1	1200.00

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CCN: 150047	Peri od:	Worksheet D	
THROUGH COSTS			CCN: 15SO47	From 06/01/2014 To 05/31/2015	Part IV Date/Time Pre 10/30/2015 5:	pared:
		Ti t	le XIX	Subprovi der -	PPS	от рііі
Cost Center Description	Total	Total Charges	Ratio of Cos		Inpati ent	
Social Secondary Con	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.	3 - 3	
	4)	,	,	7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0				0	50.00
50. 01   03330   ENDOSCOPY	0	4, 353, 242			0	
51. 00   05100   RECOVERY ROOM	0	4, 676, 866			0	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	1, 607, 871			0	
53. 00   05300   ANESTHESI OLOGY	0	-, ,	l .		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	75, 345, 733			0	
54. 01  03630  ULTRA SOUND	0	0			0	1
56. 00   05600   RADI 0I SOTOPE	0	0	0. 00000		0	
57. 00  05700   CT SCAN	0	0	0.00000		0	
58. 00   05800   MRI	0		0. 00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				0	
60. 00   06000   LABORATORY	0	,,	l .		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				0	
65. 00 06500 RESPI RATORY THERAPY	0	, = . = ,	l .		0	
66. 00   06600   PHYSI CAL THERAPY	0	-, ,			0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	-,,			0	
68. 00 06800 SPEECH PATHOLOGY	0		l .		0	
69. 00   06900   ELECTROCARDI OLOGY	0				0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0				0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	,,			0	
74. 00 07400 RENAL DIALYSIS	0	2,0,0,000			0	1
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTER	0				0	
76. 01   03951   SLEEP LAB	0	·	0.0000		0	1
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0				0	
76. 03 03952 WOUND CARE	0	6, 887, 112	0. 00000	0.000000	0	76. 03
OUTPATIENT SERVICE COST CENTERS		02.747	0.00000	0 000000		00.00
90. 00   09000   CLI NI C	0				0	
91. 00   09100   EMERGENCY	0				0	
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART 200. 00   Total (lines 50-199)	0	-,,		0.000000	-	92. 00 200. 00
200.00   Total (lines 50-199)	1	434, 217, 285	I	1	Ü	I∠UU. UU

Health Financial Systems	ST JOSEPH MEDICAL			of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150047	Peri od: From 06/01/2014	Worksheet D Part IV
TIKOUGII COSTS		Component CCN: 15SO47		
		Title XIX	Subprovi der -	PPS

		111	TIE XIX	Subprovider -	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent		L	
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9	)		
	x col. 10)		x col . 12)			
ANCI LLARY SERVI CE COST CENTERS	11.00	12. 00	13. 00			
50. 00 05000 OPERATING ROOM		(		n		50.00
50. 01   03330  ENDOSCOPY	0			2		50.00
51. 00   05100   RECOVERY ROOM	0	(		2		51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0			2		52.00
53. 00   05300   ANESTHESI OLOGY		(		)		53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C		(		) )		54.00
54. 01   03630   ULTRA SOUND		(		) )		54. 01
56. 00   05600 RADI 0I SOTOPE	0	(		o n		56.00
57. 00   05700   CT   SCAN	o o	(		n n		57. 00
58. 00   05800   MRI	0	(		Ď		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(		0		59. 00
60. 00   06000   LABORATORY	o	(		0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	Ċ		o o		62.00
65. 00 06500 RESPIRATORY THERAPY	o	(		0		65.00
66. 00 06600 PHYSI CAL THERAPY	o	(		0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(		0		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	(		0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	(		0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(		O		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(		O		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	(		O		73. 00
74.00 07400 RENAL DIALYSIS	0	(		O		74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	(	)	O		76. 00
76. 01   03951   SLEEP LAB	0	(	)	O		76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	(		O		76. 02
76. 03 03952 WOUND CARE	0	(	)	0		76. 03
OUTPATIENT SERVICE COST CENTERS				_		
90. 00   09000   CLI NI C	0	(		0		90.00
91. 00 09100 EMERGENCY	0	(		)		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	(		ט פ		92.00
200.00   Total (lines 50-199)	0	(	ال (	0		200. 00

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047	Peri od: From 06/01/2014 To 05/31/2015	Worksheet D-1 Date/Time Prep 10/30/2015 5:0	
		Title XVIII	Hospi tal	PPS	

			10 00/01/2010	10/30/2015 5:	01 pm
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		28, 021	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			28, 021	2. 00
3.00	Private room days (excluding swing-bed and observation bed days	). If you have only pr	ivate room days,	0	3. 00
4 00	do not complete this line.			05 500	4 00
4.00	Semi-private room days (excluding swing-bed and observation bed		04 6 11	25, 508	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through becembe	r 31 or the cost	Ü	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember	or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	31 of the cost	0	7. 00	
	reporting period	3 / 3			
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	5, 369	9. 00
10.00	newborn days)	. (including private p	aam daya)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		udys)	U	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		nom davs) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		days) arter	· ·	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14.00	after December 31 of the cost reporting period (if calendar yea			0	14 00
14.00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0	14. 00 15. 00
15. 00 16. 00	Nursery days (title V or XIX only)			0	16. 00
10.00	SWING BED ADJUSTMENT		0	10.00	
17. 00	Medicare rate for swing-bed SNF services applicable to services	0.00	17. 00		
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost				18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
20.00	reporting period	arter becomber 31 or t	110 0031	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			14, 436, 251	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	21 of the cost reporti	ng poriod (line	0	24. 00
24.00	7 x line 19)	or the cost reporti	ing period (Title	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)	3	, , , , ,		
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		14, 436, 251	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		<u> </u>		00.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cn	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	7716 20)		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line	,	0.00	35. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	fferential (line	14, 436, 251	37. 00	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST Adjusted general inpatient routine service cost per diem (see i			E1E 10	38. 00
38. 00 39. 00	Program general inpatient routine service cost per diem (see i	,		515. 19 2, 766, 055	
40. 00	Medically necessary private room cost applicable to the Program	•		2, 700, 033	40. 00
	Total Program general inpatient routine service cost (line 39 +	•		2, 766, 055	
		•	'		•

Heal th	Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST				Peri od:	Worksheet D-1	
					From 06/01/2014 To 05/31/2015	Date/Time Pre	
			Ti +I	e XVIII	Hospi tal	10/30/2015 5: PPS	01 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1. 00	2.00	3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	C		0 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	2, 619, 609	1, 167	2, 244. 7	4 423	949, 525	43.00
43. 01	NEONATAL INTENSIVE CARE UNIT	2,017,007	1			1	
44.00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	2, 404, 177	1, 072	2, 242. 7	0 162	363, 317	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					4.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	3 Line 200)			1. 00 7, 538, 952	48. 00
	Total Program inpatient costs (sum of lines			ns)		11, 617, 849	
FO 00	PASS THROUGH COST ADJUSTMENTS			What Daile	-£ D II	//1 100	] ]
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	I WKSt. D, SUM	or Parts I and	661, 180	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	691, 177	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				1, 352, 357	52. 00
53. 00	Total Program inpatient operating cost exclu	ıding capital re	elated, non-phy	sician anesth	etist, and	10, 265, 492	
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	argot amount (1	ino E4 minus	lino E2)	0	
58. 00	Bonus payment (see instructions)	ing cost and ta	inger amount (i	The 50 minus	111le 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	0.00	59. 00				
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	ndated by the m	arket hasket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0.00	1
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	rnstructrons)				0	62. 00
	Allowable Inpatient cost plus incentive paym	nent (see instru	ıcti ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of the	cost reporti	ng period (See	1 0	64. 00
0 00	instructions)(title XVIII only)	o o		·			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66. 00
/7.00	CAH (see instructions)		D 1 01	6.11			/7.00
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ie costs through	n December 31 c	or the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	December 31 of	the cost repo	rting period	0	68. 00
69 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 ± line	68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						07.00
70.00	Skilled nursing facility/other nursing facil	,		,			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		rne 70 ÷ rrne	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic	able to Program					73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II column		74. 00 75. 00
75.00	26, line 45)	Toutine service	COSTS (TIOIII II	orksneet b, F	art II, Corumii		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	. *					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	,					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p					79. 00
	Total Program routine service costs for comp		cost limitation	(line 78 min	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (	see instruction	* .				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in		nne)				84. 00 85. 00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	- line 2)			2, 513 515, 19	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•				1, 294, 672	1

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 06/01/2014 To 05/31/2015	Date/Time Prep 10/30/2015 5:0	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	2, 123, 823	14, 436, 251	0. 14711	7 1, 294, 672	190, 468	90.00
91.00 Nursing School cost	0	14, 436, 251	0.00000	0 1, 294, 672	0	91.00
92.00 Allied health cost	0	14, 436, 251	0.00000	0 1, 294, 672	0	92.00
93.00 All other Medical Education	0	14, 436, 251	0.00000	0 1, 294, 672	0	93. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150047		Worksheet D-1
		From 06/01/2014	
	Component CCN: 15SO47	To 05/31/2015	
			10/30/2015 5:01 pm
	Title XVIII	Subprovi der -	PPS

PART L. L. REQUIRED COMPONENTS    PART L. ALL REQUIRED REQUIRED COMPONENTS			TI LIE AVIII	I PF	FF3	
NeXT   I - ALL PROVIDER CORPOWERS   Next		Cost Center Description			1.00	
IMPATEENT DAYS						
Impatient days (including private room days, excluding saing-bed and nestorn days)   3.00   Private room days (seculding saing-bed and observation bed days)   17 you have only private room days.   3.00   3.00   4.00   5.00						
Devivate room days (excluding swing-bed and observation bed days). If you have only private room days. do do not complete this line.  4.00 Somi-private room days (excluding swing-bed and observation bed days).  5.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale ender year, enter 0 on this line).  7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale ender year, enter 0 on this line).  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale ender year, enter 0 on this line).  8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale ender year, enter 0 on this line).  8.01 Total swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and newborn days).  8.02 Swing-bed SMF type inpatient days applicable to the Iti XVIII only (including private room days).  8.03 Total swing-bed SMF type inpatient days applicable to the Iti XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line).  8.04 Total swing-bed SMF type inpatient days applicable to tile V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line).  8.04 Total swing-bed SMF type inpatient days applicable to tile V or XIX only (including private room days).  9.05 Swing-bed SMF type inpatient days applicable to tile V or XIX only (including private room days).  9.06 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed days).  9.07 Total swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed days).  9.08 Total swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed days).  9.09 Total swing-bed SMF type inpatient days appli						
do not complete this line.  4. 05 Sell-private room days (excluding swing-bed and observation bed days) through Becember 31 of the cost Coporting period Self type inpatient days. (including private room days) after December 31 of the cost Coporting period (if calendar year, enter 0 on this line) Coporting				voto room dave		
Semi-private room days (excluding swing-bed Ard doservation bed days) To Total swing-bed SK type inpatient days (including private room days) after December 31 of the cost paper ting period (Fit type inpatient days (including private room days) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost Total swing-bed NF type inpatient days (including private room days) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost Poper ting period (Fit Caindare year, enter 0 on this Line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost Poper ting period (Fit Caindare year, enter 0 on this Line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and Poper ting period (Fit Caindare year, enter 0 on this Line) Total inpatient days applicable to title XVIII only (including private room days) Through December 31 of the cost reporting period (Fit caindare year, enter 0 on this Line) Total December 31 of the cost reporting period (Fit caindare year, enter 0 on this Line) Total December 31 of the cost reporting period (Fit caindare year, enter 0 on this Line) Total December 31 of the cost reporting period (Fit caindare year, enter 0 on this Line) Total December 31 of the cost reporting period (Fit caindare year, enter 0 on this Line) Total December 31 of the cost reporting period (Fit caindare year, enter 0 on this Line) Total December 31 of the cost reporting period (Fit caindare year, enter 0 on this Line) Total December 31 of the cost reporting period (Fit caindare year, enter 0 on this Line) Total December 31 of the cost reporting period (Fit caindare year, enter 0 on this Line) Total December 31 of the cost reporting period (Fit caindare year, enter 0 on this Line) Total December 31 of the cost reporting period (Fit caindare year, enter 0 on this Line) Total December 31 of the cost reporting period (Fit caindare year) Total December 31 of the	3.00				U	3.00
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reporting period (if calendar year, enter 0 on this line)  10. 00 himpsys including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through becember 31 of the cost reporting period (see instructions)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only on this line)  13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only on this line)  13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only on this line)  13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  14. 00 Medically necessary private room days applicable to title XVIII only (including private room days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Nursery days (title V or XIX only)  17. 00 SWING-BED ADUSTRIEWS  18. 00 Medically necessary private room days applicable to services through December 31 of the cost  18. 00 Medically necessary private room days applicable to services through December 31 of the cost  18. 00 Medically necessary private room days applicable to services through December 31 of the cost  18. 00 Medically necessary private room days applicable to services through December 31 of the cost  18. 00 Medically necessary private room days applicable to services after December 31 of the cost  18. 00 Medically necessary private room days applicable to services after December 31 of the cost  18. 00 Medically necessary private room days applicable to services after December 31 of the cost  18. 00 Medically necessary private room days applicable to services after December 31 of the cost  18. 00 Medically necessary	9 00	1 91	Mays) after December 21	of the cost	0	9 00
newborn days	0.00		days) arter becember 51	or the cost	O	0.00
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13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)   13.00   13.00   after December 31 of the cost reporting period (Icale andary year, enter 0 on this line)   0   15.00   0   1	12.00		only (including private	e room days)	U	12.00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   15.00	13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
15.00   Total nursery days (title V or XIX only)   0   15.00   16.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   18.00	44.00	1 91 .		, I		44.00
16. 00   Nursery days (title V or XIX only)   0   16. 00   Nursery days (title V or XIX only)   17. 00   17. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   19.			(excluding swing-bed of	iays)	-	
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19.00   Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   21.00   Total general inpatient routine service cost (see instructions)   3,242,113   21.00   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5   x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6   0   23.00   x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6   0   24.00   x line 18)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7   x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8   24.00   25.00   26.00   27.00   28.00   28.00   29.00	18. 00		after December 31 of t	he cost	0.00	18. 00
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (1:00 Total general inpatient routine service cost (see instructions)  20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (1:00 5 x line 17)  21.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (1:00 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (1:00 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (1:00 7 x line 19)  25.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (1:00 7 x line 19)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (1:00 21 minus line 26)  28.00 Total swing-bed cost (see instructions)  29.00 Private ROOM DIFFERENTIAL ADJUSTMENT  29.00 Private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  29.00 Average private room per diem charge (1:00 29 + line 3)  30.00 Average private room per diem charge (1:00 29 + line 3)  30.00 Average per diem private room cost differential (1:00 32 minus line 33) (see instructions)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (1:00 3 x line 35)  37.00 Average per diem private room cost differential (1:00 3 x line 35)  38.00 Average per diem private room cost differential (1:00 3 x line 35)  39.00 Program general inpatient routine service cost per diem (see instructions)  39.00 Average general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  39.00 Program	40.00				0.00	40.00
20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   21.00   Total general inpatient routine service cost (see instructions)   3, 242, 113   21.00   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)   24.00   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   Total swing-bed cost (see instructions)   26.00   Total swing-bed cost (see instructions)   26.00   Cost also wing-bed cost (see instructions)   26.00   Cost also wing-bed cost (see instructions)   26.00   PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   27.00   PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   27.00	19.00			the cost	0.00	19.00
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x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Swing-private room charges (excluding swing-bed charges)  Swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Swing-private room charges (excluding swing-bed charges)  Average private room charges (excluding swing-bed charges)  Swing-private room charges (excluding swing-bed charges)  Average private room per diem charge (line 27 + line 28)  Average private room per diem charge (line 30 + line 4)  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  O Average per diem private room cost differential (line 34 x line 31)  O Private room cost differential adjustment (line 3 x line 35)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instru		5 x line 17)	·			
24.00  24.00  25.00  26.00  26.00  26.00  27.00  28.00  29.00  29.00  20	23. 00		l of the cost reporting	period (line 6	0	23. 00
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28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113 27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 29.00  29.00 30.00  20.00 30.00  20.00 31.00  20.00 32.00  32.00 32.00  32.00 32.00  32.00 32.00  32.00 32.00  32.00 32.00  32.00 32.00  32.00 32.00  32.00 32.00  33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  0 0.00 33.00  34.00 35.00  35.00 36.00  37.00 General inpatient routine service cost and private room cost differential (line 3, 242, 113 37.00  37.00 37.00 37.00 37.00  38.00 37.00	27. 00		ne 21 minus line 26)		3, 242, 113	27. 00
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35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 . 00 35. 00  36. 00  37. 00			s line 33)(see instruct	ions)		
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PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  379.68 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			d private room cost dif	ferential (line	3, 242, 113	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  379.68 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		27 minus line 36)				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 379.68 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,538,463 39.00 40.00	38. 00				379. 68	38. 00
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   1,538,463   41.00		, , , , , , , , , , , , , , , , , , , ,	•			
	41.00	41.00   Iotal Program general inpatient routine service cost (line 39 + line 40)   1,538,463				

CUMPLIA	Financial Systems TATION OF INPATIENT OPERATING COST	ST JOSEPH MEDIC		CCN: 150047	Peri od:	eu of Form CMS-: Worksheet D-1	
COMPU	ATION OF INPATIENT OPERATING COST				From 06/01/2014		
			Component	CCN: 15SO47	To 05/31/2015	Date/Time Pre 10/30/2015 5:	
			Title	e XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost In	oatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. (	00 0	0	42.0
43. 00	INTENSIVE CARE UNIT	0	0	0. (	00	0	43. 0
43. 01	NEONATAL INTENSIVE CARE UNIT	O	О	0.0	00	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0.0	00	0	44. 0 45. 0
46. 00	SURGI CAL INTENSI VE CARE UNI T		Ŭ	0			46. 0
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 0
	· ·					1. 00	
48. 00	Program inpatient ancillary service cost (W					718, 319	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(se	<u>e instructio</u>	ns)		2, 256, 782	49. 0
50. 00	Pass through costs applicable to Program in	patient routine se	rvices (from	Wkst. D, sur	n of Parts I and	183, 353	50.0
51. 00	<pre>                                    </pre>	natient ancillary	services (fr	nm Wkst D «	sum of Parts II	77, 782	51.0
01.00	and IV)	patrent unerriary	301 11 003 (11)	om with b,	Jam or Tarts II	77,702	01.0
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		tod non nhy	cician anosth	notict and	261, 135 1, 995, 647	1
33.00	medical education costs (line 49 minus line		ted, non-pny	si ci ali allesti	letist, and	1, 775, 047	] 55. 0
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54. 0
55. 00	Target amount per discharge					•	55. 0
56. 00	Target amount (line 54 x line 55)				==.	0	
57. 00 58. 00	Difference between adjusted inpatient operations payment (see instructions)	ting cost and targ	et amount (I	ine 56 minus	line 53)	0 0	1
59. 00							59.0
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.0
61. 00	If line 53/54 is less than the lower of line	es 55, 59 or 60 en	ter the less	er of 50% of		0.00	
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(lines 54 x	60), or 1% of	f the target		
62. 00	Relief payment (see instructions)	matructions)				0	62. 0
63. 00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instruct	i ons)			0	63.0
64. 00	Medicare swing-bed SNF inpatient routine cos	sts through Decemb	er 31 of the	cost reporti	ng period (See	0	64. 0
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	sta aftar Dacambar	21 of the c	oct roportin	a pariod (Saa	0	65. 0
03.00	instructions) (title XVIII only)	sts after becember	31 Of the C	ost reportini	g perrou (see		05.0
66. 00	Total Medicare swing-bed SNF inpatient routi	ine costs (line 64	plus line 6	5)(title XVII	I only). For	0	66. 0
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	ne costs through D	ecember 31 o	f the cost re	eporting period	0	67. 0
	(line 12 x line 19)						,,,,
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after Dec	ember 31 or	tne cost repo	orting period	0	68. 0
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 0
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70. 0
71. 00	Adjusted general inpatient routine service	cost per diem (lin					71.0
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		line 14 x li	ne 35)		-	72. 0 73. 0
74. 00	Total Program general inpatient routine serv			10 33)			74. 0
75. 00	Capital -related cost allocated to inpatient	routine service c	osts (from W	orksheet B, F	Part II, column		75. 0
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ine 2)					76. 0
77. 00	Program capital -related costs (line 9 x line						77. 0
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for excess		vi der record	s)			78. 0 79. 0
80. 00	Total Program routine service costs for comp	parison to the cos		*.	nus line 79)		80.0
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (						81. 0 82. 0
83. 00	Reasonable inpatient routine service costs						83. 0
84.00	Program inpatient ancillary services (see in		`				84.0
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sur						85. 0 86. 0
	PART IV - COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST	<u> </u>				
	Total observation bed days (see instructions	s )				1 0	87.0
87. 00 88. 00	Adjusted general inpatient routine cost per		i ne 2)				88.0

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 06/01/2014 To 05/31/2015	Date/Time Prep 10/30/2015 5:0	
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	col umn 1 ÷ col umn 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O		2.00	0.00	11.00	0.00	
90.00 Capital -related cost	386, 421	3, 242, 113	0. 11918	8 0	0	90. 00
91.00 Nursing School cost	0	3, 242, 113			0	91. 00
92.00 Allied health cost	0	3, 242, 113			0	92.00
93.00   All other Medical Education	0	3, 242, 113	0.00000	0  0	0	93. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER		In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CC			Worksheet D-1
	Component (		From 06/01/2014 To 05/31/2015	Date/Time Prepared:
	osiiiperierre v	00N. 100000	10 00/01/2010	10/30/2015 5: 01 pm
	Ti tl e	XVIII	Skilled Nursing	PPS
			Eacility	

		Title XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS		I.	1.00	
1 00	I NPATI ENT DAYS			4 047	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			4, 847 4, 847	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed days)	<i>3</i> ,	ivate room days,	0	3. 00
	do not complete this line.	J .			
4.00	Semi-private room days (excluding swing-bed and observation bed		04 6 11	4, 847	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through December	r 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room of	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room of	1 of the cost	0	8. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember 3	To the cost	O	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	1, 902	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		oom davs) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, enter	er 0 on this line)		0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of through December 31 of the cost reporting period	only (including privat	e room days)	Ü	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of after December 31 of the cost reporting period (if calendar year			0	13. 00
14.00	Medically necessary private room days applicable to the Program			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 c	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services a	after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			2, 569, 469	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	l of the cost reportin	a period (line 6	0	23. 00
	x line 18)	·			
24. 00	Swing-bed cost applicable to NF type services through December $(7 \times 1)$ I in (19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 $\times$ line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (li PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus line 26)		2, 569, 469	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ l	ine 28)		0. 000000	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	•
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	>		0.00	•
34.00	Average per diem private room charge differential (line 32 minus	, ,	tions)	0.00	•
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	•
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	d private room cost di	fforontial (line	2, 569, 469	36. 00 37. 00
37.00	General inpatient routine service cost net of swing-bed cost and 27 minus line 36)	, private room cost di	rierential (Tiffe	2, 309, 409	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	MENTO			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST				20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see in Program general inpatient routine service cost (line 9 x line 3)				38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Program				40.00
	Total Program general inpatient routine service cost (line 39 +				41. 00
	, 5 5 1	•	ı		

	Financial Systems ATION OF INPATIENT OPERATING COST	ST JOSEPH MEDIC		CCN: 150047	Peri od:	eu of Form CMS-2 Worksheet D-1	
JIVII O I	ATTON OF THE ATTENT OF ENATING COST			t CCN: 155356	From 06/01/2014		
			Ti tl	e XVIII	Skilled Nursing	10/30/2015 5: 0 PPS	01 pi
					Facility		
	Cost Center Description	Total Inpatient Costlr	Total npatient Days			Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	3.00	42.
	Intensive Care Type Inpatient Hospital Uni	ts					
3. 00	INTENSIVE CARE UNIT						43.
3. 01	NEONATAL INTENSIVE CARE UNIT						43.
l. 00 5. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 45.
5. 00	SURGICAL INTENSIVE CARE UNIT						46.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
						1. 00	
	Program inpatient ancillary service cost (						48.
9. 00	Total Program inpatient costs (sum of line: PASS THROUGH COST ADJUSTMENTS	s 41 through 48)(Se	ee instructio	ins)			49.
0. 00	Pass through costs applicable to Program in	npatient routine se	ervices (from		of Parts L and		50.
, 00		npatront routino of	3. 1. 000 ( 0	et. by ean			"
. 00	Pass through costs applicable to Program i	npatient ancillary	services (fr	om Wkst. D, s	sum of Parts II		51
	and IV)	- 50 ! 54)					
2. 00	Total Program excludable cost (sum of lines		atad non nh	cician anacth	notict and		52
3. 00	Total Program inpatient operating cost exc medical education costs (line 49 minus line		ateu, non-pny	siciali allestr	ictist, dilu		53
	TARGET AMOUNT AND LIMIT COMPUTATION	<u> </u>					
	Program di scharges						54
	Target amount per discharge						55
	Target amount (line 54 x line 55)	ating cost and ton	ast smount (1	ino E/ minuo	Line E2)		56
. 00	Difference between adjusted inpatient opera Bonus payment (see instructions)	ating cost and targ	get amount (i	The 50 III hus	11 ne 53)		57
. 00	Lesser of lines 53/54 or 55 from the cost	reportina period er	ndi na 1996. u	updated and co	mpounded by the		59
	market basket	5 1	5				
0. 00	Lesser of lines 53/54 or 55 from prior year						60
. 00	If line 53/54 is less than the lower of li						61
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		(Tines 54 X	60), OF 1% OF	the target		
2. 00	Relief payment (see instructions)	c matructions)					62
	Allowable Inpatient cost plus incentive page	yment (see instruct	tions)				63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
1. 00	Medicare swing-bed SNF inpatient routine co	osts through Decemb	per 31 of the	cost reporti	ng period (See		64
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	nsts after December	r 31 of the c	ost renorting	neriod (See		65
, 00	instructions)(title XVIII only)	osts arter becomber	31 01 110 0	ost reporting	perrou (see		00
6. 00	Total Medicare swing-bed SNF inpatient rou	tine costs (line 64	4 plus line 6	5)(title XVII	I only). For		66
	CAH (see instructions)						
7. 00	9 '	ine costs through L	December 31 c	if the cost re	porting period		67
3. 00	(line 12 x line 19)  Title V or XIX swing-bed NF inpatient rout	ine costs after Dec	cember 31 of	the cost reno	orting period		68
	(line 13 x line 20)	00010 4. 10. 500	Joinipol 0 . 01	т.ю ооот горо	Tring portion		"
9. 00	Total title V or XIX swing-bed NF inpatien						69
	PART III - SKILLED NURSING FACILITY, OTHER					0.5/0.4:5	٦.
). 00  . 00	Skilled nursing facility/other nursing faci					2, 569, 469	
2. 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ie /o = iiile	۷)		530. 12 1, 008, 288	
	Medically necessary private room cost appli		(line 14 x li	ne 35)		0	
1. 00	Total Program general inpatient routine se	rvice costs (line 7	72 + line 73)			1, 008, 288	74
5. 00	Capital-related cost allocated to inpatien	t routine service o	costs (from V	lorksheet B, F	art II, column	0	75
5. 00	26, line 45)  Per diem capital-related costs (line 75 ÷	line 2)				0.00	76
7. 00	Program capital -related costs (line 9 x line)						77
	Inpatient routine service cost (line 74 min					Ö	
9. 00	Aggregate charges to beneficiaries for exc	ess costs (from pro				0	
0.00	Total Program routine service costs for co	•	st limitation	ı(line 78 mir	nus line 79)	0	
. 00	Inpatient routine service cost per diem li					0.00	
2. 00 3. 00	Inpatient routine service cost limitation Reasonable inpatient routine service costs		)			1, 008, 288	
1. 00	Program inpatient ancillary services (see		,			689, 230	1
5. 00	Utilization review - physician compensation		s)			0	
. 00	Total Program inpatient operating costs (s	um of lines 83 thro				1, 697, 518	86
5. 00							1
5. 00	PART IV - COMPUTATION OF OBSERVATION BED PA					_	
	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction Adjusted general inpatient routine cost per	ns)	ine 2)			0.00	87

Health Financial Systems	ST	J0SEPH	MED	I CAL CE	NTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Pr	ovi der	CCN: 150047	Peri od:	Worksheet D-1	
				Co	mponent	CCN: 155356	From 06/01/2014 To 05/31/2015		
					Ti tl	e XVIII	Skilled Nursing	PPS	
							Facility		
Cost Center Description		Cost			e Cost	column 1 ÷	Total	Observation	
				(from I	ine 27)	column 2	Observati on	Bed Pass	
							Bed Cost (from	Through Cost	
							line 89)	(col. 3 x col.	
								4) (see	
								instructions)	
		1.00		2.	00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST								
90.00 Capital -related cost			0		0	0.00000	00	0	90.00
91.00 Nursing School cost			0		0	0.00000	0 0	0	91.00
92.00 Allied health cost			0		0	0.00000	0 0	0	92.00
93.00 All other Medical Education			0		0	0.00000	00	0	93.00
·							·		

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150047	Peri od: From 06/01/2014	Worksheet D-1	
				Date/Time Prep 10/30/2015 5:0	
		Title XIX	Hospi tal	PPS	
Cost Center Description					

		Ti +Lo VIV	Hooni tol	10/30/2015 5:0	01 pm_
	Cost Center Description	Title XIX	Hospi tal	PPS	
	oust defited beschiption			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			28, 021	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days	<i>y</i> ,	vata room dave	28, 021 0	2. 00 3. 00
3.00	do not complete this line.	). IT you have only pri	vate room days,	١	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		25, 508	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	r 31 of the cost	0	5. 00
	reporting period			_	
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period			-	
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3°	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	1, 963	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	nom days)	o	10. 00
	through December 31 of the cost reporting period (see instructi		som days)		10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, ent				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea				
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)				15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			811	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 or	f the cost	0.00	17. 00
17.00	reporting period	through becomber or o	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)			14, 436, 251	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ line 17)	31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	a period (line 6	o	23. 00
	x line 18)	•			
24. 00	] 3	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	neriod (line 8	o	25. 00
23.00	x line 20)	or the cost reporting	perrod (Trie o	ı "I	25.00
26.00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	ine 21 minus line 26)		14, 436, 251	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				00.00
28. 00 29. 00	Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0 0	28. 00 29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34. 00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line		,	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	14, 436, 251	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			515. 19	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	,		1, 011, 318	
40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		1, 011, 318	41.00

Privature DDX 150047   Private DDX 150047   Priva	Heal th	Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Li∈	eu of Form CMS-2	2552-10
To Octal 2010   Title V N						Peri od:	Worksheet D-1	
Designation								pared:
Cost Center Description				T: +	I o VI V	Hospi tal		01 pm
Program inpatient Cost Impatient Cost Impatient Cost Cost Cost Cost Cost Cost Cost Cos		Cost Center Description	Total					
1.00					Diem (col. 1		(col. 3 x col.	
A. C.   AUSSERY (11TE V X XX entry)			1.00	2.00		4.00		
Interest voc Care V Type I reput in the Hospital Unit 15   2, 619,609   1, 167   2, 244,74   81   181,824   43,00   INTEREST V CARE UNIT   0   0   0,00   0   0   43,01	42.00	NURSERY (title V & XIX only)						42. 00
				.,				
44.00				1				
1.00   1.00			0	O	0.0	0	0	
3.00   Continue   1.00   Section   1.0			2, 404, 177	1, 072	2, 242. 7	0 207	464, 239	
Cost Center Description		1						
1.00	47. 00							47. 00
Program Inpattent ancillary service cost (Misst D-3, col. 3, line 2000)   3,40,631 46:00   749.00   Total Program Inpattent costs (sum of Flunes 4) through all (see Instructions)   5,786.259 40:00   749.00   Total Program Inpattent costs (sum of Flunes 4) through costs applicable to Program inpattent ancillary services (from Wast. D, sum of Parts II and 19)   315,700   70.00		cost center bescription					1. 00	
PASS THROUGH COST ADJUSTMENTS	48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)				48. 00
10.00   Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and 151.70   50.00   111.51.00	49. 00		41 through 48)(	(see instructio	ns)		5, 786, 259	49. 00
1110   285 through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II   340, 457   51.00   and IV)   52.00   Total Program excludable cost (sum of lines 50 and 51)   655, 627   52.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   5, 130, 632   53.00   75.00	50.00		atient routine	services (from	Wkst D sum	of Parts I and	315 170	50.00
and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and ended and costs (line 49 minus line 52)  54.00 Program inpatient operating cost excluding capital related, non-physician anesthetist, and ended and costs (line 49 minus line 52)  54.00 Program discharges  55.00 Program discharges  56.00 Program dipplication di	00.00		atront routine	301 11 003 (11 0111	mot. b, sam	or rares r and	010, 170	00.00
52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program injent operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 54.00 Program injent operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 55.00 Target amount per discharges 57.00 Injent mount per discharges 58.00 Target amount per discharges 59.00 Injent emount per discharges 60.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket on the prior of the mount by discharges (lines 53/54 or 55 from prior year cost report, updated by the market basket on the prior of the same prior of the cost of the amount by discharges (lines 53/54 or 55 from prior year cost report, updated by the market basket on the prior of the same prior of the	51. 00	1	atient ancillar	ry services (fr	om Wkst. D, s	um of Parts II	340, 457	51. 00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	52 00	1 ,	50 and 51)				655 627	52 00
FARCET MOUNT AND LINIT COMPUTATION   54.00   54.00   55.00   1   55.00   1   1   55.00   1   1   55.00   1   1   55.00   1   1   55.00   1   1   55.00   1   1   55.00   1   1   55.00   1   55.00   1   55.00   1   55.00   55.00   1   55.00   55.				elated, non-phy	sician anesth	etist, and		
54. 00   Program discharges   0. 05. 00   55. 00   55. 00   Target amount per discharges   0. 00   55. 00   55. 00   Target amount per discharges   0. 00   55. 00   55. 00   Target amount (line 54 x line 55)   0. 56. 00   56. 00   57.			52)					
55.00   Target amount per discharge   0.00   55.00   0.50   0.0	54 00						1	54.00
57. 00 DITFerence between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57. 00 58. 00 Bons payment (see instructions) 0 58. 00 Bons payment (see instructions) 0 58. 00 Bons payment (see instructions) 0 59. 00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 between the basket 0.00 between 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 (lines 54 x 60), or 1% of the target amount (line 56), otherwise senter zero (see instructions) 0 0 63. 00 Allowable Inpatient cost plus incentive payment (see instructions) 0 0 63. 00 Allowable Inpatient cost plus incentive payment (see instructions) 0 0 63. 00 Allowable Inpatient cost plus incentive payment (see instructions) 0 0 63. 00 Allowable Inpatient cost plus incentive payment (see instructions) 0 0 63. 00 Allowable Inpatient cost plus incentive payment (see instructions) 0 0 63. 00 Allowable Inpatient cost plus incentive payment (see instructions) 0 0 64. 00 Instructions) (title XVIII only) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
58.00   Bonus payment (see instructions)   0   58.00   59.00   Esser of lines \$3/54 or \$5 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   59.00   60.00   Lesser of lines \$3/54 or \$5 from prior year cost report, updated by the market basket   0.00   60.00   Color of lines \$4.00   61.00   If line \$5/54 is less than the lower of lines \$5, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line \$3) are less than expected costs (lines \$4 x 60), or 1% of the target amount (line \$6), otherwise enter zero (see instructions)   0   62.00   63.00   Good of lines \$4.00   Good of lines \$4.00								
Section   Lesser of Tines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the more thanker basket   0.00   89.00		, , , , , , , , , , , , , , , , , , , ,	ing cost and ta	arget amount (I	ine 56 minus I	line 53)		
market basket  0.00 60.00  1.00 lf lines 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 (lines 54 x 60), or 1% of the target amount (line 56), therwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 PROGRAM INPATIENT ROUTINE SUNG BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) especially (see instructions) for cost instructions) especially (see instructi			portina period	endi na 1996. u	pdated and cor	mpounded by the		
Section   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 (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		market basket		-		,		
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  Relief payment (see instructions) (title XVIII only)  Relief payment (see instructions) (title XVIII only)  Relief payment (see instructions) (title XVIII only)  Relief payment (see instructions)  Relief payme						the amount by	1	
amount (line 56), otherwise enter zero (see instructions)   0 62.00	01.00							01.00
Allowable Inpatient cost plus incentive payment (see instructions) PRORMALINATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)  70.00 Program routine service cost (line 9 x line 71)  71.00 Ajusted general inpatient routine service costs (line 72 + line 73)  72.00 Program general inpatient routine service costs (line 72 + line 73)  73.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Capital-related costs (line 75 + line 2)  76.00 Program capital-related costs (line 75 + line 76)  77.00 Program capital-related costs (line 75 + line 76)  78.00 Program capital-related costs (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Reasonable inpatient routine service costs (see instructions)  82.00 Inpatient routine service cost (see instructions		amount (line 56), otherwise enter zero (see				J. 1. 1. J. 1		
PROGRAM INPATIENT ROUTINE SWING BED COST  4. 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65. 00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 0 CAH (see instructions)  67. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 0 CAH (see instructions)  67. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70. 00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)  71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72. 00 Porgram routine service cost (line 9 x line 71)  73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75. 00 Capital-related costs (line 75 + line 2)  76. 00 Per diem capital-related costs (line 75 + line 2)  77. 00 Program capital-related costs (line 75 + line 2)  78. 00 Aggregate charges to benefic aries for excess costs (from provider records)  80. 00 Total Program routine service cost (from provider records)  81. 00 Aggregate charges to benefic aries for excess costs (from provider records)  82. 01 Inpatient routine service costs (see instructions)  83. 00 Aggregate charges to benefic aries for excess			ont (coo inctr	ictions)				
64.00   Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)   65.00   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)   66.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For   06.00   CAH (See Instructions)   07.00   CAH (See Instructions)   07.00   CAH (See Instructions)   08.00   CAH (See Instructions)	03.00		lent (see mistro	ictions)			0	03.00
66.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 67 + line 68)  70.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 67 + line 68)  70.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 67 + line 68)  70.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 67 + line 68)  70.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37)  70.00 Program routine service cost (line 9 x line 71)  70.00 Program general inpatient routine service costs (line 14 x line 35)  70.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26. line 45)  70.00 Per diem capital-related costs (line 75 + line 2)  70.00 Program capital related costs (line 74 minus line 77)  70.00 Program capital related costs (line 9 x line 76)  70.00 Inpatient routine service cost (line 74 minus line 77)  70.00 Total Program routine service cost (see instructions)  80.00 Reasonable inpatient routine service cost (see instructions)  81.00 Line 14 Program inpatient routine service (see instructions)  82.00 Total Program inpatient routine service (se	64. 00		ts through Dece	ember 31 of the	cost reporti	ng period (See	0	64. 00
instructions) (itle XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 9 x line 76)  77.00 Inpatient routine service cost (line 75 + line 2)  78.00 Total Program routine service costs (from provider records)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Inpatient routine service cost (line 74 minus line 77)  80.00 Program inpatient routine service costs (see instructions)  81.00 Inpatient routine service cost (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Villization review - physician compensation (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient routine cost per diem (line	6E 00		ts after Decemb	or 21 of the c	ost roporting	pariod (Saa		45 OO
CAH (see instructions)  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  88.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/Other nursing facility/Other Nursing FACILITY, AND ICFMR ONLY  70.00 Skilled nursing facility/Other nursing facility/	03.00		ts arter becenik	ber 31 of the c	ost reporting	perrou (see		03.00
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(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) On Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED BURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program general inpatient routine service costs (line 72 + line 73) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 75 + line 2) 77.00 Program capital related costs (line 75 + line 2) 77.00 Total Program routine service cost (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient ancillary services (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 515.19 88.00	67 00		e costs through	December 31 o	f the cost re	norting period	0	67.00
(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Reasonable inpatient routine services (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	07.00		c costs till ougi	i becember 31 0	T the cost rep	oor tring period		07.00
69.00   Total title V or XÍX swing-bed NF inpatient routine costs (line 67 + line 68)   PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY   70.00   71.00   71.00   72.00   71.00   72.00   72.00   73.00   73.00   74.00   74.00   74.00   75.00	68. 00		e costs after [	December 31 of	the cost repo	rting period	0	68. 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY  70. 00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)  71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72. 00 Program routine service cost (line 9 x line 71)  73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74. 00 Total Program general inpatient routine service costs (line 72 + line 73)  75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76. 00 Per diem capital-related costs (line 75 ÷ line 2)  77. 00 Program capital-related costs (line 75 * line 2)  78. 00 Inpatient routine service cost (line 74 minus line 77)  79. 00 Aggregate charges to beneficiaries for excess costs (from provider records)  80. 00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81. 00 Inpatient routine service cost per diem limitation  81. 00  82. 00 Inpatient routine service cost limitation (line 9 x line 81)  82. 00 Reasonable inpatient routine service (see instructions)  84. 00 Program inpatient ancillary services (see instructions)  85. 00 Utilization review - physician compensation (see instructions)  86. 00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87. 00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  515. 19	69 00	1 `	routine costs (	line 67 + line	68)		0	69 00
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Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der			Worksheet D-1	
Provider CCN: 150047   Period: From 06/01/2014   To 05/31/2015   Date/Time Prepared: 10/30/2015 5:01 pm						
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	2, 123, 823	14, 436, 251	0. 14711	7 1, 294, 672	190, 468	90.00
91.00 Nursing School cost	0	14, 436, 251	0.00000	0 1, 294, 672	0	91.00
92.00 Allied health cost	0	14, 436, 251	0.00000	0 1, 294, 672	0	92.00
93.00 All other Medical Education	0	14, 436, 251	0.00000	0 1, 294, 672	0	93. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150047	Peri od: From 06/01/2014	Worksheet D-1
	Component CCN: 15SO47		
	Title XIX	Subprovi der -	PPS

NAT   ALL PROVIDER CONFORENTS   1.00			TI LIE XIX	I PF	FF3	
NAME   MAX		Cost Center Description				
NATLERT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
1.00   Impatient days (including private room days, excluding saing-bed and newborn days)   0.30   0.0   Private room days (seculding saing-bed and observation bed days)   1.7 you have only private room days, 6.0   3.00   0.30   0.						
200   200	1.00				8, 539	
do not complete this I line.  4. 00 Sele-private room days (excluding saing-bed and observation bed days) 10tal saing-bed SW type Inpatient days (including private room days) after December 31 of the cost 10tal saing-bed SW type Inpatient days (including private room days) after December 31 of the cost 10tal saing-bed SW type Inpatient days (including private room days) after December 31 of the cost 10tal saing-bed W type Inpatient days (including private room days) after December 31 of the cost 10tal saing-bed W type Inpatient days (including private room days) after December 31 of the cost 10tal saing-bed W type Inpatient days (including private room days) after December 31 of the cost 10tal saing-bed W type Inpatient days (including private room days) after December 31 of the cost 10tal saing-bed W type Inpatient days (including private room days) after December 31 of the cost 10tal saing-bed SW type Inpatient days applicable to the Program (excluding saing-bed and nesborn days) 10tal saing-bed SW type Inpatient days applicable to the Program (excluding saing-bed and nesborn days) 10tal saing-bed SW type Inpatient days applicable to the Program (excluding private room days) 10tal saing-bed SW type Inpatient days applicable to the Program (excluding private room days) 10tal saing-bed SW type Inpatient days applicable to the Exclusion of the Program (excluding private room days) 10tal saing-bed SW type Inpatient days applicable to the Exclusion of the Program (excluding private room days) 10tal saing-bed SW type Inpatient days applicable to the Exclusion of the Program (excluding private room days) 10tal saing-bed SW type Inpatient days applicable to the Exclusion of the Exclusion of the Cost Troom days applicable to the Exclusion of the Cost Troom days) 10tal saing-bed SW type Inpatient days applicable to the Exclusion of the Cost Troom days applicable to Exclusion of the Cost Troom days applicable to Exclusion of the Cost Troom days) 10tal saing-bed Oxfort SW type Inpatient Cost Sw type Inpatient Cost Troom						
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Total swingbed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)   7.00	4.00		davs)		8. 539	4. 00
10   10   10   10   10   10   10   10				r 31 of the cost		
reporting period (if calendar year, enter 0 on this line)  1.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost of reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days (including private room days) after December 31 of the cost incoming period (if calendar year, enter 0 on this line)  1.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and private room days) including private room days) including private room days including private room days including private room days applicable to the program (excluding private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF 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)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  1.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  1.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  1.00 Swing-bed NF type inpatient days applicable to services through December 31 of the cost  1.00 Swing-bed NF type inpatient days applicable to services after December 31 of the cost  1.00 Swing-bed NF type inpatient days applicable to services after December 31 of the cost  1.00 Swing-bed NF type inpatient days applicable to services after December 31 of the cost  1.00 Swing-bed cost applicable to SwF type services after December 31 of the cost  1.00 Swing-bed cost applicable to SwF type services after December 31 of the cost  1.00 Swing-bed cost applicable to SwF type services after December 31 of the cost reporting period (line 8 x line 12)  1.00 Swing-bed cost applicable to SwF type services after December 31 of						
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SWING BED ADJUSTMENT  1. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period (19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost (19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Proporting period (19.00 Medicare) rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Proporting period (19.00 Proporting						
17. 00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17. 00   18. 00   18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost   0.00   18. 00   19. 00	16. 00				811	16. 00
reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (led caid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 reporting period (led caid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period (line services applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  32.00 Total general inpatient routine service cost (see instructions) 3.242.113 21.00 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  33.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  34.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  35.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  36.00 Total swing-bed cost (see instructions) 0 25.00  37.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3.242.113 21.00  38.00 Total swing-bed cost (see instructions) 0 28.00  39.00 Semi-private room charges (excluding swing-bed charges) 0 29.00  30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00  30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00  30.00 Average private room per diem charge (line 29 + line 23) 0.00  30.00 Average per diem private room charge (line 29 + line 3) 0.00  30.00 Average per diem private room charge (line 30 x line 4) 0.00  30.00 Average per diem private room cost differential (line 3 x line 37) 0.00  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113 37.00  30.00 Average per diem private room cost d	17. 00		through December 31 of	f the cost	0.00	17. 00
reporting period  Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  26.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 Control of the cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  28.00 Total swing-bed cost (see instructions)  29.00 Private room charges (excluding swing-bed charges)  29.00 Total swing-bed cost (see instructions)  29.00 Private room charges (excluding swing-bed charges)  29.00 O Semi-private room charges (excluding swing-bed charges)  20.00 Average perivate room per diem charge (line 29 + line 3)  20.00 Average perivate room per diem charge (line 30 + line 4)  20.00 Average perivate room cost differential (line 3x line 31)  20.00 Average per diem private room cost differential (line 3x line 35)  20.00 Average per diem private room cost differential (line 3x line 35)  20.00 General inpatient routine service cost per diem (see instructions)  20.00 Adjusted general inpatient routine service cost per diem (see instructions)  20.00 Adjusted general inpatient						
19. 00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20. 00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   20. 00	18. 00		after December 31 of 1	the cost	0. 00	18. 00
reporting period Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 7.00 20.00 7.00 7.00 7.00 7.00 7.00 7.0	19 00		through December 31 of	the cost	0.00	19 00
reporting period Total general inpatient routine service cost (see instructions) 3, 242, 113 21.00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 3, 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 18) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT  8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT  8.00 General inpatient routine service cost/charges (excluding swing-bed and observation bed charges) OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT  8.00 OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT  8.00 OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT  9.00 OPRIVATE ROOM D	. ,		in dagn boombon or or		0.00	. ,
21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Swing-bed cost (see instructions) 29.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Semi-private room charges (excluding swing-bed charges) 29.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 29.00 Average private room per diem charge (line 29 + line 3) 20.00 Average per idem private room per diem charge (line 29 + line 3) 20.00 Average per diem private room cost differential (line 30 + line 4) 20.00 Average per diem private room cost differential (line 31 x line 31) 20.00 Average per diem private room cost differential (line 32 x line 31) 20.00 Average per diem private room cost differential (line 32 x line 31) 20.00 Average per diem private room cost differential (line 32 x line 31) 20.00 Average per diem private room cost differential (line 32 x line 35) 20.00 Average per diem private room cost differential (line 32 x line 35) 20.00 Average per diem private room cost differential (line 32 x line 35) 20.00 Average per diem private room cost differential (line 32 x line 35) 20.00 Average per diem private room cost differential (line 32 x line 35) 20.00 Average per diem private room cost differential (line 32 x line 35) 20.00 Average per diem private room cost differential (line 32 x line 35) 20.00 Average per diem private room cost differ	20. 00		after December 31 of th	ne cost	0. 00	20. 00
22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   Total swing-bed cost (see instructions)   0 26.00   27.00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   0 24.01   28.00   Fivate room charges (excluding swing-bed charges)   0 29.00   29.00   Semi-private room charges (excluding swing-bed charges)   0 29.00   30.00   Semi-private room charges (excluding swing-bed charges)   0 29.00   31.00   General inpatient routine service cost/charge ratio (line 27 + line 28)   0 0.000000   32.00   Average private room per diem charge (line 29 + line 3)   0 0.00   33.00   Average semi-private room per diem charge (line 30 + line 4)   0 0.00   34.00   Average per diem private room cost differential (line 34 x line 31)   0 0.00   35.00   Average per diem private room cost differential (line 34 x line 31)   0 0.00   36.00   Private room cost differential adjustment (line 3 x line 35)   0 36.00   37.00   Private room cost differential adjustment (line 3 x line 35)   0 36.00   37.00   Program general inpatient routine service cost per diem (see instructions)   379.68   38.00   Adjusted general inpatient routine service cost (line 9 x line 38)   201,990   39.00   Program general inpatient routine service cost (line 9 x line 38)   201,990   39.00   Program general inpatient routine service cost (line 9 x line 38)   201,990   39.00   Program general inpatient routine service cost (line 9 x line 38)   201,990   39.00   Program general inpatient routine service cost (line 9 x line 38)   201,990   39.00   Program general inpatient routine service cost	21 00				3 242 113	21 00
23. 00			31 of the cost reporti	ng period (line		
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average per diem private room per diem charge (line 29 + line 3)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Private que per diem private room cost net of swing-bed cost and private room cost differential (line 32 minus line 36)  30.00 PARIVATE ROOM DIFFERNITIAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  30.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)					_	
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 29 ÷ line 3) 34.00 Average semi-private room cost differential (line 30 ± line 4) 35.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113 27.00 27 minus line 36)  PARTI II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 379.60 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Average service cost applicable to the Program (line 14 x line 35) 40.00 Average service cost applicable to the Program (line 14 x line 35)	23. 00		l of the cost reporting	g period (line 6	0	23. 00
7 x line 19)  25.00	24. 00	1	31 of the cost reportir	ng period (line	0	24. 00
X   I i ne 20   Total   swing-bed cost (see instructions)   0   26. 00		7 x line 19)	•			
26.00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERNTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Private room charges (excluding swing-bed charges)  10 29.00  10 29.00  10 29.00  10 29.00  11 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  11 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  12 00 Average private room per diem charge (line 29 ÷ line 3)  13 00 Average semi-private room per diem charge (line 30 ÷ line 4)  14 00 Average per diem private room cost differential (line 34 x line 31)  15 00 Average per diem private room cost differential (line 34 x line 31)  16 00 Private room cost differential adjustment (line 3 x line 35)  17 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113)  18 00 Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113)  18 00 Adjusted general inpatient routine service cost (line 9 x line 38)  19 00 Program general inpatient routine service cost (line 9 x line 38)  20 0 Adjusted general inpatient routine service cost (line 9 x line 38)  20 0 Adjusted general inpatient routine service cost (line 9 x line 38)  20 0 Adjusted general inpatient routine service cost (line 9 x line 38)  20 0 Adjusted general inpatient routine service cost (line 9 x line 38)	25. 00		of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average per diem private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 40. 00  Program general inpatient routine service cost to the Program (line 14 x line 35)  O 40. 00	26. 00	1			0	26. 00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113)  30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		, ,	ne 21 minus line 26)		3, 242, 113	27. 00
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Private room cost differential adjustment (line 3 x line 35)  34.00 Private room cost differential adjustment (line 3 x line 35)  35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Program general inpatient routine service cost (line 9 x line 38)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00  29.00  29.00  30.00  30.00  30.00  30.00  31.00  32	00.00					00.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 33.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00			and observation bed cha	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 00 00 00 00 00 00 00 00 00 00 00 00						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			i ne 28)		0. 000000	
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  379.68 38.00  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room cost differential (line 3, 242, 113)  37.00 Average per diem private room			line 22) (cas instruct	ti ana)		
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  379.00 Program general inpatient routine service cost (line 9 x line 38)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 Adout the program (line 14 x line 35)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				LI ONS)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 242, 113 37.00 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  379.68 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 Adjusted general inpatient routine service cost per diem (see instructions)  37.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			31)			
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  379.68 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			d private room cost dif	fferential (line	3, 242, 113	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  379.68 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  379.68 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  379.68 38.00 201,990 39.00			MENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  201,990 39.00 40.00	38. 00				379. 68	38. 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00   Total Program general inpatient routine service cost (line 39 + line 40)			•			
	41.00	lotal Program general inpatient routine service cost (line 39 +	iine 40)	l	201, 990	41.00

COMPUT	Financial Systems	ST JOSEPH MEDIC				eu of Form CMS-	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der CCN		Period: From 06/01/2014	Worksheet D-1	
			Component CC		To 05/31/2015	Date/Time Pre	pared:
			<u>'</u>			10/30/2015 5:	
			Title	KLX	Subprovider - IPF	PPS	
	Cost Center Description	Total	Total Av	verage Per	Program Days	Program Cost	
	out conton possification	Inpatient CostIn				(col. 3 x col.	
		·		col . 2)		4)	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	O	0. 00	0 0	0	43.00
43. 01	NEONATAL INTENSIVE CARE UNIT		Ö	0. 00		l .	43. 01
44.00	CORONARY CARE UNIT						44. 00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0 0	0	45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			0	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(se	e instructions)			201, 990	49. 00
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inpa	atient routine se	ervices (from WK	st. D, sum	of Parts I and	24, 073	50.00
51. 00		atient ancillarv	services (from \	Wkst. D si	um of Parts II	0	51.00
01.00	and IV)	atront anorrary	00.1.000 (				01100
52.00	Total Program excludable cost (sum of lines					24, 073	•
53.00	Total Program inpatient operating cost exclu		ited, non-physici	ian anesth	etist, and	177, 917	53. 00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56. 00
57. 00	Difference between adjusted inpatient operation	ing cost and targ	get amount (line	56 minus I	ine 53)	0	57.00
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the							58. 00 59. 00
39.00	market basket	portring period er	idi ilg 1996, upda	teu anu coi	iipourided by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upda	ited by the mark	et basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(lines 54 x 60)	or 1% of	the target		
62. 00	Relief payment (see instructions)	i iisti ucti olis)				0	62. 00
63.00	0	•					
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decemb	er 31 of the co	st reportii	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cost	reporti ng	period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line 64	plus line 65)(	title XVIII	only). For	0	66. 00
67 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through D	ecember 31 of th	ne cost rei	norting period	0	67. 00
07.00	(line 12 x line 19)	o ocoto tili ougii s			sor tring porrou		07.00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after Dec	ember 31 of the	cost repor	rting period	0	68. 00
69. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routino costs (li	no 67 : lino 60°	`		0	69. 00
09.00	PART III - SKILLED NURSING FACILITY, OTHER NU					<u> </u>	09.00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service co		ne 70 ÷ line 2)				71.00
	Program routine service cost (line 9 x line Medically necessary private room cost applications)		line 14 v line	35)			72. 00 73. 00
72.00	Total Program general inpatient routine services			JJ)			74.00
73.00		•	•	sheet B, Pa	art II, column		75. 00
	Capital -related cost allocated to inpatient	i outille selvice c					
73. 00 74. 00 75. 00	Capital-related cost allocated to inpatient 26, line 45)						1
73. 00 74. 00 75. 00 76. 00	Capital -related cost allocated to inpatient 26, line 45) Per diem capital -related costs (line 75 ÷ li	ne 2)					
73. 00 74. 00 75. 00 76. 00 77. 00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 45) Program capital-related costs (line 9 x line 45)	ne 2) 76)					77. 00
73. 00 74. 00 75. 00 76. 00	Capital -related cost allocated to inpatient 26, line 45) Per diem capital -related costs (line 75 ÷ li	ne 2) 76) s line 77)	ovider records)				77. 00 78. 00
73. 00 74. 00 75. 00 76. 00 77. 00 78. 00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 1 Program capital-related costs (line 9 x line 1 Inpatient routine service cost (line 74 minus 1 Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	ne 2) 76) s line 77) s costs (from pro arison to the cos		ine 78 minu	us line 79)		77. 00 78. 00 79. 00
73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 1 Program capital-related costs (line 9 x line 1 Inpatient routine service cost (line 74 minus 1 Aggregate charges to beneficiaries for excess Total Program routine service costs for compunpatient routine service cost per diem limit	ne 2) 76) S line 77) s costs (from pro arison to the cos tation		ine 78 minu	us line 79)		77. 00 78. 00 79. 00 80. 00 81. 00
73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 1 + line 1 + line 2 + line 2 + line 2 + line 3 + line 4 + line 4 + line 4 + line 4 + line 5 + line 5 + line 6 + line 7 + line 6 + line 7 + line 8 + lin	ne 2) 76) s line 77) s costs (from pro arison to the cos tation ine 9 x line 81)	st limitation (li	ine 78 minu	us line 79)		77. 00 78. 00 79. 00 80. 00 81. 00 82. 00
73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 1 + line 1 + line 2 + line 2 + line 3 + line 4 + line 4 + line 4 + line 4 + line 5 + line 5 + line 6 + line 7 + line 6 + line 7 + line 8 + lin	ne 2) 76) s line 77) s costs (from pro arison to the cost tation ine 9 x line 81) see instructions)	st limitation (li	ine 78 minu	us line 79)		77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00
73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 1 + line 1 + line 2 + line 2 + line 2 + line 3 + line 3 + line 3 + line 3 + line 4 + line 5 + line 6 + line 7 + line 8 + lin	ne 2) 76) s line 77) s costs (from proarison to the costation ine 9 x line 81) see instructions)	t limitation (li	ine 78 minu	us line 79)		77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00
73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 1 + line 1 + line 2 + line 2 + line 3 + line 4 + line 4 + line 4 + line 4 + line 5 + line 5 + line 6 + line 7 + line 6 + line 7 + line 8 + lin	ne 2) 76) s line 77) s costs (from production ine 9 x line 81) see instructions) structions) (see instructions)	et limitation (li	ine 78 minu	us line 79)		76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00
73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 1 Program capital-related costs (line 9 x line 1 Inpatient routine service cost (line 74 minus 1 Aggregate charges to beneficiaries for excess Total Program routine service costs for compunpatient routine service cost per diem limit Inpatient routine service cost limitation (line 1 Reasonable inpatient routine service costs (see insufficial inpatient routine service costs (see insufficial inpatient routine services (see insufficial inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	ne 2) 76) s line 77) s costs (from production in 9 x line 81) see instructions) structions) (see instructions of lines 83 thros THROUGH COST	et limitation (li	ine 78 minu	us line 79)		77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00
73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 19 Program capital-related costs (line 9 x line 19 Inpatient routine service cost (line 74 minux) Aggregate charges to beneficiaries for excess Total Program routine service costs for compulnpatient routine service cost per diem limitinpatient routine service cost limitation (line Reasonable inpatient routine service costs (see insultivation of the cost of	ne 2) 76) s line 77) s costs (from production ine 9 x line 81) see instructions) structions) (see instructions of lines 83 thro	st limitation (li	ine 78 minu	us line 79)	0 0 00	77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 00

Health Financial Systems	ST JOSEPH MEI	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 06/01/2014 To 05/31/2015	Date/Time Prep 10/30/2015 5:0	
		Ti t	le XIX	Subprovi der  - I PF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH C	OST					
90.00 Capital-related cost	386, 421	3, 242, 113	0. 11918	8 0	0	90.00
91.00 Nursing School cost	(	3, 242, 113	0.00000	0 0	0	91.00
92.00 Allied health cost	(	3, 242, 113	0.00000	0	0	92.00
93.00 All other Medical Education	C	3, 242, 113	0.00000	0 0	0	93. 00

Health Financial Systems	ST JOSEPH MEDICAL	CENTER		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der		Peri od:	Worksheet D-3	
				From 06/01/2014 To 05/31/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				12, 002, 414		30.00
31. 00 03100 INTENSIVE CARE UNIT				1, 563, 082		31.00
31 O1 O2O6O NEONATAL INTENSIVE CARE UNIT				0		31 01

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS		12, 002, 414		30. 00
31.00	03100 INTENSIVE CARE UNIT		1, 563, 082		31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT		0		31. 01
33.00	03300 BURN INTENSIVE CARE UNIT		924, 952		33. 00
40.00	04000 SUBPROVI DER - I PF		0		40. 00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 118097	5, 636, 162	665, 614	50.00
50. 01	03330 ENDOSCOPY	0. 168242	388, 223	65, 315	50. 01
51.00	05100 RECOVERY ROOM	0. 297760	449, 670	133, 894	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1. 185350	5, 326	6, 313	52.00
53.00	05300 ANESTHESI OLOGY	0. 018658	782, 299	14, 596	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 088113	6, 950, 192		54.00
54. 01	03630 ULTRA SOUND	0.000000	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0.000000	0	0	56. 00
57.00	05700 CT SCAN	0.000000	0	0	57. 00
58.00	05800 MRI	0.000000	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 132340	3, 308, 685	437, 871	59. 00
60.00	06000 LABORATORY	0. 117637	7, 637, 466		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 202532	1, 098, 632		62.00
65.00	06500 RESPI RATORY THERAPY	0. 123822	3, 883, 474		65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 287693	408, 602		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 214554	318, 369		67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 268479	60, 088		68. 00
	06900 ELECTROCARDI OLOGY	0. 073572	400, 382		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 337470	2, 605, 686		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 102166	6, 755, 730		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 117209	12, 973, 200		73. 00
	07400 RENAL DI ALYSI S	0. 216351	796, 036		
	03950 OTHER ANCILLARY SERVICE COST CENTER	0. 000000	, , , , , , ,	0	76. 00
	03951 SLEEP LAB	0. 000000	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 149277	501, 948	_	76. 02
76. 03	03952 WOUND CARE	0. 307400	353, 892		76. 03
, 0. 00	OUTPATIENT SERVICE COST CENTERS	0.007.100	300,072	1007700	70.00
90.00	09000 CLI NI C	4. 229618	131	554	90. 00
	09100 EMERGENCY	0. 125158	2, 161, 646		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 245503	213, 929		
200.00		1 2 2 3 3 3 3 3	57, 689, 768		
201.00			0.7,00.7,700		201. 00
202.00			57, 689, 768		202. 00

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150047 t CCN: 15S047	Peri od: From 06/01/2014 To 05/31/2015		pared:
		Ti tl	e XVIII	Subprovi der -	PPS	or piii
	Cost Center Description	,	Ratio of Cos To Charges	_	Inpatient Program Costs (col. 1 x col. 2)	
	LANDATI ENT. DOUTLAS OFFICE COOT OFFITEDO		1.00	2. 00	3. 00	
00.00	INPATIENT ROUTINE SERVICE COST CENTERS			1		
30.00	03000 ADULTS & PEDI ATRI CS			0	l	30.00
31. 00 31. 01	03100   INTENSIVE CARE UNIT   02060   NEONATAL INTENSIVE CARE UNIT			0	l	31. 00 31. 01
33. 00	03300 BURN INTENSIVE CARE UNIT			0		33.00
40.00	04000 SUBPROVI DER - I PF			11, 449, 606		40.00
43. 00	04300 NURSERY			11, 117, 000		43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 11809	21, 456	2, 534	50.00
50. 01	03330 ENDOSCOPY		0. 16824	12 27, 340	4, 600	50. 01
51.00	05100 RECOVERY ROOM		0. 29776	265, 116	78, 941	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1. 18535	50 0	0	
53.00	05300 ANESTHESI OLOGY		0. 01865			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 08811	· ·		
54. 01	03630 ULTRA SOUND		0.00000		0	54. 01
56.00	05600 RADI OI SOTOPE		0.00000		0	
57. 00	05700 CT SCAN		0.00000		0	57.00
58. 00 59. 00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON		0.00000		0	58. 00 59. 00
60.00	06000 LABORATORY		0. 1323 <sup>2</sup> 0. 11763		141, 869	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 20253		141,007	1
65. 00	06500 RESPI RATORY THERAPY		0. 12382		1	
66. 00	06600 PHYSI CAL THERAPY		0. 28769			
67.00	06700 OCCUPATI ONAL THERAPY		0. 21455	· ·		
68.00	06800 SPEECH PATHOLOGY		0. 26847	18, 948	5, 087	68. 00
69.00	06900 ELECTROCARDI OLOGY		0. 07357	77, 601	5, 709	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 33747	70 52, 349	17, 666	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 10216	59, 237	6, 052	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 11720		l	
74. 00	07400 RENAL DIALYSIS		0. 21635		2, 356	
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER		0.00000		0	76.00
76. 01	03951 SLEEP LAB		0.00000		0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 14927	·		1
76.03	03952 WOUND CARE		0. 30740	00 8, 420	2, 588	76. 03
00 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC		4. 22961	10 121	554	90.00
90.00	109000 CLINIC		4. 2296 0. 12516		l	90.00

0. 125158

0. 245503

286, 588

5, 457, 855

5, 457, 855

91.00

201. 00

202. 00

0 92.00

718, 319 200. 00

35, 869

09100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

91.00

201.00

202.00

Health Financial Systems	ST JOSEPH MEDICAL				eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 150047	Peri od:	Worksheet D-3	
		Componen	t CCN: 155356	From 06/01/2014 To 05/31/2015		pared: 01 pm
		Ti tl	e XVIII	Skilled Nursing Facility		
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					T	
30. 00   03000   ADULTS & PEDI ATRI CS				0		30.00
31.00 03100 INTENSIVE CARE UNIT				0		31. 00
31.01 02060 NEONATAL INTENSIVE CARE UNIT				0		31. 01
33.00 03300 BURN INTENSIVE CARE UNIT				0		33. 00
40. 00   04000   SUBPROVI DER - 1 PF				0		40. 00
43. 00 04300 NURSERY						43. 00
ANCILLARY SERVICE COST CENTERS					1	
50.00   05000   OPERATING ROOM			0. 1180			1
50. 01 03330 ENDOSCOPY			0. 1682		_	
51. 00   05100   RECOVERY ROOM			0. 29770		0	0 00
52.00   05200   DELIVERY ROOM & LABOR ROOM			1. 1853		0	52. 00
53. 00 05300 ANESTHESI OLOGY			0. 0186		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 0881	·		1
54. 01   03630   ULTRA SOUND			0.00000		0	
56. 00   05600   RADI 0I SOTOPE			0.00000		0	00.00
57. 00   05700   CT   SCAN			0.00000		0	57. 00
58. 00   05800   MRI			0.00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON			0. 13234		0	59. 00
60. 00   06000   LABORATORY			0. 11763			1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0. 20253	·	l .	
65. 00 06500 RESPIRATORY THERAPY			0. 12382			1
66. 00 06600 PHYSI CAL THERAPY			0. 28769	·		1
67. 00 06700 OCCUPATI ONAL THERAPY			0. 2145			67. 00
68. 00 06800 SPEECH PATHOLOGY			0. 2684			1
69. 00 06900 ELECTROCARDI OLOGY			0. 0735			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 3374			1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 10216		104 070	, 2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 11720			1
74. 00 07400 RENAL DIALYSIS			0. 2163		0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER			0.00000		0	76.00
76. 01   03951   SLEEP LAB			0.00000		_	

0.149277

0. 307400

4. 229618

0.125158

0. 245503

71, 371

3, 277

3, 961, 593

3, 961, 593

0

0

0 91.00

689, 230 200. 00

805

21, 939

76.02

76. 03

90.00

92.00

201. 00

202. 00

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

03952 WOUND CARE
OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

76.02

76. 03

90.00

91.00

200.00

201.00

202.00

09000 CLI NI C

09100 EMERGENCY

Heal th	Financial Systems	ST JOSEPH MEDICAL	CENTER		In Lie	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der		Peri od:	Worksheet D-3	
					From 06/01/2014 To 05/31/2015	Date/Time Prep 10/30/2015 5:0	pared: 01 pm
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description			Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
				1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS				3, 935, 238		30. 00
31.00	03100 INTENSIVE CARE UNIT				298, 694		31. 00
31.01	02060 NEONATAL INTENSIVE CARE UNIT				0		31. 01
	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF				1, 257, 143 989, 875		33. 00 40. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet E Part A Date/Time Pre	epared:
		Ti +I	e XVIII	Hospi tal	10/30/2015 5: PPS	
		11 (1	before 1/1	on/after 1/1	FF3	
	DADT A LANDATI FAIT LIGODI TAL CERVI OFC LIMPER LIDEC	0	1. 00	1. 01	2. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0		1.00
1. 01	DRG amounts other than outlier payments for discharges		2, 854, 43	5		1. 01
1. 02	occurring prior to October 1 (see instructions) DRG amounts other than outlier payments for discharges		6, 759, 48	) E		1. 02
1.02	occurring on or after October 1 (see instructions)		0, 759, 40			1.02
1. 03	DRG for federal specific operating payment for Model 4			0		1. 03
	BPCI for discharges occurring prior to October 1 (see instructions)					
1.04	DRG for federal specific operating payment for Model 4			0		1. 04
	BPCI for discharges occurring on or after October 1 (see instructions)					
2.00	Outlier payments for discharges. (see instructions)		761, 35	60		2. 00
2. 01	Outlier reconciliation amount			0		2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0		2. 02
3.00	Managed Care Simulated Payments		5, 937, 25			3.00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)		114. 1	2		4. 00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the		0.0	00		5. 00
	most recent cost reporting period ending on or before 12/31/1996. (see instructions)					
6. 00	FTE count for allopathic and osteopathic programs which		0.0	00		6. 00
	meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)					
7. 00	MMA Section 422 reduction amount to the IME cap as		1.8	19		7. 00
7. 01	specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA Section 5503 reduction amount to the IME cap as		0.0	10		7. 01
7.01	specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the		0.0	,0		7.01
0.00	cost report straddles July 1, 2011 then see instructions.					0.00
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated		9.0	00		8. 00
	programs in accordance with 42 CFR 413.75(b),					
	413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).					
8. 01	The amount of increase if the hospital was awarded FTE cap		0.0	00		8. 01
	slots under section 5503 of the ACA. If the cost report					
8. 02	straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap		0.0	00		8. 02
	slots from a closed teaching hospital under section 5506					
9. 00	of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		7. 1	1		9.00
	lines (8, 8,01 and 8,02) (see instructions)					
10. 00	FTE count for allopathic and osteopathic programs in the current year from your records		5. 1	4		10.00
11. 00	FTE count for residents in dental and podiatric programs.		0.0			11.00
12. 00 13. 00	Current year allowable FTE (see instructions)		5. 1 5. 7			12. 00 13. 00
14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that		7. 1			14. 00
	year ended on or after September 30, 1997, otherwise enter					
15. 00	zero. Sum of lines 12 through 14 divided by 3.		5. 9	98		15. 00
16. 00	Adjustment for residents in initial years of the program		0.0	00		16.00
17. 00	Adjusment for residents displaced by program or hospital closure		0.0	00		17. 00
18. 00	Adjusted rolling average FTE count		5. 9	98		18. 00
19. 00	, ,		0. 05240	01		19. 00
20. 00	line 4). Prior year resident to bed ratio (see instructions)		0. 05615	59		20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)		0. 05240			21. 00
22. 00 22. 01	IME payment adjustment (see instructions)  IME payment adjustment - Managed Care (see instructions)		438, 77	(6) (0)		22. 00 22. 01
22.01	Indirect Medical Education Adjustment for the Add-on for Secti	on 422 of t	he MMA	<u> </u>		22.01
23. 00	Number of additional allopathic and osteopathic IME FTE		4.0	00		23. 00
24. 00	resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).  IME FTE Resident Count Over Cap (see instructions)		-1.9	77		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter		0.0			25. 00
26. 00	the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4)		0.00000	00		26. 00
27. 00	IME payments adjustment factor. (see instructions)		0. 00000			27. 00
	IME add-on adjustment amount (see instructions)			0		28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)					28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)		438, 77	·6		29. 00

Heal th	Financial Systems	ST JOSEPH MEDICA	L CENTER		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der		Period: From 06/01/2014 To 05/31/2015		pared: 01 pm
			Ti tl	e XVIII	Hospi tal	PPS	<u>от р</u>
				before 1/1	on/after 1/1		
			0	1. 00	1. 01	2. 00	
29. 01	Total IME payment - Managed Care (sum of line 28.01)	es 22.01 and			)		29. 01
	Disproportionate Share Adjustment						1
30. 00	Percentage of SSI recipient patient days to	Medicare Part		11. 0	7		30.00
31. 00	A patient days (see instructions) Percentage of Medicaid patient days (see instructions)	tructions)		25. 03	3		31.00
32. 00	Sum of lines 30 and 31			36. 10			32. 00
33. 00	Allowable disproportionate share percentage	(see		19.00	)		33. 00
34.00	instructions) Disproportionate share adjustment (see instru	uctions)		456, 662	2		34.00
		,		Prior to		On/After	
		0		0ctober 1 1.00	1. 01	0ctober 1 2.00	
	Uncompensated Care Adjustment	0		1.00	1.01	2.00	
35. 00	Total uncompensated care amount (see			9, 046, 380, 143	3	0	35. 00
25 01	instructions)			0.00000000		0.00000000	25 01
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If			0. 00022929° 2, 074, 254		0. 000000000 1, 671, 243	
33. 02	line 34 is zero, enter zero on this line)			2,074,25		1,071,243	33.02
05.00	(see instructions)			(00.04)		4 440 (05	05.00
35. 03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			693, 313	3	1, 112, 635	35. 03
36. 00	Total uncompensated care (sum of columns 1			1, 805, 948	3		36.00
	and 2 on line 35.03)	D	(1:		4/)		
40. 00	Additional payment for high percentage of ESF Total Medicare discharges on Worksheet S-3,	р beneтiciary dis	scnarges (II	nes 40 through	1 46)		40. 00
.0.00	Part I excluding discharges for MS-DRGs 652,						
41 00	682, 683, 684 and 685 (see instructions)				0		41. 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see			,			41.00
	instructions)						
41. 01	Total ESRD Medicare covered and paid				0		41. 01
	discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)						
42.00	Divide line 41 by line 40 (if less than 10%,			0.00			42.00
40.00	you do not qualify for adjustment)						40.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see				,		43. 00
	instructions)						
44. 00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7			0.000000			44.00
	days)						
45.00	Average weekly cost for dialysis treatments			0.00	0.00		45. 00
46. 00	(see instructions) Total additional payment (line 45 times line						46. 00
40.00	44 times line 41.01)			,			46.00
47. 00	Subtotal (see instructions)			13, 076, 656	5		47. 00
48. 00	Hospital specific payments (to be completed						48. 00
	by SCH and MDH, small rural hospitals only. (see instructions)						
49. 00	Total payment for inpatient operating costs			13, 076, 656	5		49. 00
50. 00	(see instructions) Payment for inpatient program capital (from			997, 46	,		50.00
55.00	Wkst. L, Pt. I and Pt. II, as applicable)			777, 40			30.00
51. 00	Exception payment for inpatient program						51.00
52. 00	capital (Wkst. L, Pt. III, see instructions) Direct graduate medical education payment			148, 592			52.00
	(from Wkst. E-4, line 49 see instructions).						
53. 00	Nursing and Allied Health Managed Care						53. 00
54. 00	payment Special add-on payments for new technologies						54.00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt.			1			55. 00
56. 00	III, col. 1, line 69)			,			56. 00
50.00	Cost of physicians' services in a teaching hospital (see intructions)				΄		30.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30						57. 00
58. 00	through 35). Ancillary service other pass through costs						58. 00
	from Wkst. D, Pt. IV, col. 11 line 200)						
59. 00	Total (sum of amounts on lines 49 through			14, 222, 71!			59. 00
60. 00	58)   Primary payer payments			44, 72	1		60.00
61. 00	Total amount payable for program			14, 177, 99			61. 00
62. 00	beneficiaries (line 59 minus line 60) Deductibles billed to program beneficiaries			971, 804	1		62. 00
	1 5 5 5 1 1 1 6 5 5 1 1 1 6 6 10 program benefit ordities	l		1 //1,004	·I	l	1 52.00

| Period: | Worksheet E | From 06/01/2014 | Part A | Date/Time Prepared: | 10/30/2015 5:01 pm Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 150047

						10/30/2015 5:	01 pm
			Ti tl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
		0		October 1	1 01	October 1	
/2.00	Coinquespas hilled to program haneficiaries	0		1.00	1. 01	2. 00	(2.00
63. 00 64. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			42, 352 232, 565			63. 00 64. 00
65. 00	Adjusted reimbursable bad debts (see			252, 565 151, 167			65. 00
03.00	instructions)			131, 107			03.00
66. 00	Allowable bad debts for dual eligible			104, 083	3		66. 00
00.00	beneficiaries (see instructions)			101,000			00.00
67.00	Subtotal (line 61 plus line 65 minus lines			13, 315, 002	2		67.00
	62 and 63)						
68. 00	Credits received from manufacturers for			C	)		68. 00
	replaced devices for applicable to MS-DRGs						
	(see instructions)			_			
69. 00	Outlier payments reconciliation (sum of			C	)		69. 00
	lines 93, 95 and 96). (For SCH see instructions)						
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			(			70. 00
70.00	(SPECIFY)						70.00
70. 50	RURAL DEMONSTRATION PROJECT			C			70. 50
70. 89	Pioneer ACO demonstration payment adjustment			C			70. 89
	amount (see instructions)						
70. 90	HSP bonus payment HVBP adjustment amount			C	)		70. 90
	(see instructions)						
70. 91	HSP bonus payment HRR adjustment amount (see			C	)		70. 91
70.00	instructions)						70.00
70. 92	Bundled Model 1 discount amount (see instructions)			(	,		70. 92
70. 93	HVBP payment adjustment amount (see			-19, 333	3		70. 93
70. 70	instructions)			17,000			70.70
70. 94	HRR adjustment amount (see instructions)			-36, 806			70. 94
70. 95	Recovery of accelerated depreciation			. (			70. 95
70. 96	Low volume adjustment for federal fiscal		o	C			70. 96
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
70.07	prior to 10/1)						70.07
70. 97	Low volume adjustment for federal fiscal		U	(	,		70. 97
	year (yyyy) (Enter in column 0 the corresponding federal year for the period						
	ending on or after 10/1)						
70. 98	Low Volume Payment-3			C			70. 98
70. 99	HAC adjustment amount (see instructions)			C			70. 99
71.00	Amount due provider (line 67 minus lines 68			13, 258, 863	3		71. 00
	plus/minus lines 69 & 70)						
71. 01	Sequestration adjustment (see instructions)			265, 177			71. 01
72. 00	Interim payments			13, 144, 445			72. 00
73. 00	Tentative settlement (for contractor use			C	)		73. 00
74. 00	only) Balance due provider (Program) (line 71			-150, 759			74. 00
74.00	minus lines 71.01, 72, and 73)			-130, 73,			74.00
75. 00	Protested amounts (nonallowable cost report			2, 543, 883	3		75. 00
	items) in accordance with CMS Pub. 15-2,			, ,			
	chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR (lines 90 throu	gh 96)					
90. 00	Operating outlier amount from Wkst. E, Pt.			C	)		90. 00
04 00	A, line 2 (see instructions)						04.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			(			91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)				,		92. 00
93. 00	Capital outlier reconciliation adjustment			C	)		93. 00
, 5. 55	amount (see instructions)						75.00
94.00	The rate used to calculate the time value of			0.00			94.00
	money (see instructions)						
95. 00	Time value of money for operating expenses			C	)		95. 00
0/ 05	(see instructions)			_			0/ 00
96. 00	Time value of money for capital related expenses (see instructions)			C	ή		96. 00
	levhenses (see Histinctions)				I	ı	I

Health Financial Systems	ST JOSEPH MEDICAL	CENTER		In	Lieu of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 150047	Period: From 06/01/2	Worksheet E 2014 Part A	
				To 05/31/2		pared: 01 pm
		Ti tl	e XVIII	Hospi tal	PPS	
			Prior to 10/	′1	On/After 10/1	
			1.00	1. 01	2. 00	
HSP Bonus Payment Amount						
100.00 HSP bonus amount (see instructions)				0	0	100. 00
HVBP Adjustment for HSP Bonus Payment						
101.00 HVBP adjustment factor (see instructions)				0	0	101.00
102.00 HVBP adjustment amount for HSP bonus payment	(see instructions)			0	0	102. 00
HRR Adjustment for HSP Bonus Payment						
103.00 HRR adjustment factor (see instructions)			0.00	00	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (	(see instructions)			0	0	104. 00

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047	Peri od: From 06/01/2014 To 05/31/2015	Worksheet E Part B Date/Time Prepared: 10/30/2015 5:01 pm

			To 05/31/2015	Date/Time Pre 10/30/2015 5:	
		Title XVIII	Hospi tal	PPS	<u> </u>
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			2, 436	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		6, 188, 104	
3.00	PPS payments			6, 102, 946	3. 00
4.00	Outlier payment (see instructions)			61, 525	
5.00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0. 000	
6.00	Line 2 times line 5			0	
7. 00 8. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	/ col 13 line 200		0	1
10. 00	Organ acqui si ti ons	, cor. 10, 11110 200		Ö	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			2, 436	1
	COMPUTATION OF LESSER OF COST OR CHARGES				]
	Reasonabl e charges				
12.00	Ancillary service charges				12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	01. 4)		0	1
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			20, 781	14. 00
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	3	•	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)	. 3	Ü		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	1
	Total customary charges (see instructions)		44)	20, 781	1
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	18, 345	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only</pre>	rifline 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)	TI TITLE TI EXCEEDES TI	110 10) (300		20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		2, 436	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see instru	ıcti ons)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			6, 164, 471	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT  Deductibles and coinsurance (for CAH, see instructions)			10, 319	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)		1, 186, 212	
27. 00	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) pl			4, 970, 376	
	CAH, see instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	ie 50)		59, 193	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)				
	Subtotal (sum of lines 27 through 29)			5, 029, 569	
31.00	Primary payer payments Subtotal (line 30 minus line 31)			529 5, 029, 040	1
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		3,027,040	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			339, 909	34.00
	Adjusted reimbursable bad debts (see instructions)			220, 941	
	Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)		259, 426	
	Subtotal (see instructions)			5, 249, 981	
39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	1
39. 98	Partial or full credits received from manufacturers for replace		tions)	0	
39. 99				0	39. 99
40.00				5, 249, 981	40. 00
40. 01				105, 000	
41. 00				5, 070, 436	
42. 00	· · · · · · · · · · · · · · · · · · ·			74 545	1
43.00					1
44. 00	§115. 2	e with two Pub. 10-2,	спартег Г,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			l 0	94. 00

Health Financial Systems ST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 06/01/2014 Part I
To 05/31/2015 Date/Time Prepared: 10/30/2015 5:01 pm Provider CCN: 150047

					10/30/2015 5:0	01 pm_
			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		12, 846, 81	-	4, 869, 146	1.00
2.00	Interim payments payable on individual bills, either		(	O	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	05/31/2015	297, 630	05/31/2015	169, 290	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	03/31/2013		0 05/31/2015	32, 000	
3. 03				0070172010	0	3. 03
3. 04				Ö	0	3. 04
3. 05				0	0	3. 05
	Provider to Program			-	_	
3.50	ADJUSTMENTS TO PROGRAM		(	O	0	3. 50
3.51			(	0	0	3. 51
3.52			(	O	0	3. 52
3.53			(	O	0	3. 53
3.54			(	O	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		297, 630	0	201, 290	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		13, 144, 44	5	5, 070, 436	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate) TO BE COMPLETED BY CONTRACTOR			_		
5.00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			*	•	
5. 01	TENTATI VE TO PROVI DER		(	O	0	5. 01
5.02			(	0	0	5. 02
5.03			(	O	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				O	0	5. 51
5. 52				O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(	O	0	5. 99
4 00	5. 50-5. 98)					4 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		,	o	74, 545	6. 01
6. 02	SETTLEMENT TO PROGRAM		150, 75	-	74, 343	6. 02
7. 00	Total Medicare program liability (see instructions)		12, 993, 68		5, 144, 981	7. 00
7.50	1.0 tal. mour our of program in ability (300 moth dottons)		12, 775, 001	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	

 
 CENTER
 In Lieu of Form CMS-2552-10

 Provi der CCN: 150047
 Peri od: From 06/01/2014
 Worksheet E-1 Part I Date/Time Prepared: 10/30/2015 5: 01 pm

 Title XVIII
 Subprovi der PPS
 Health Financial Systems ST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Ti tl	e XVIII	Subprovi der - I PF	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 189, 439		0	
2.00	Interim payments payable on individual bills, either		C	)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.04	Program to Provider					0.01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER				0	
3. 02					0	
3. 04					Ö	3. 04
3. 05			ĺ		Ö	3. 05
	Provider to Program			•		
3.50	ADJUSTMENTS TO PROGRAM		C		0	
3. 51			C		0	
3. 52			C		0	3. 52
3. 53 3. 54					0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 189, 439	P	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02 5. 03					0	
5.03	Provider to Program			<u>/</u>	0	5.03
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C	)	0	5. 51
5. 52			C	)	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C	)	0	5. 99
	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		6, 021		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		C		0	
7.00	Total Medicare program liability (see instructions)		3, 195, 460		0	7. 00
				Contractor	NPR Date	
		,	)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00	manic or contractor			I	ı	1 0.00

Health Financial Systems ST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		618, 89		0	1. 00
2.00	Interim payments payable on individual bills, either		(	O	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		(	O	0	3. 01
3.02				0	0	3. 02
3. 03				O	0	3. 03
3. 04				0	0	3. 04
3. 05			(	O	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM				0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 52				0	Ö	3. 52
3. 53				Ö	0	3. 53
3. 54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(	Ö	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		618, 89	7	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after			1		5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(	O	0	5. 01
5.02			(	O	0	5. 02
5.03				0	0	5. 03
	Provi der to Program			_1	_	
5. 50	TENTATIVE TO PROGRAM			0	0	5. 50
5. 51 5. 52				0	0	5. 51 5. 52
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			)	0	5. 52 5. 99
5. 77	5. 50-5. 98)		'	J	U	5. 77
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		1, 03	7	0	6. 01
6.02	SETTLEMENT TO PROGRAM		(	O	0	6. 02
7. 00	Total Medicare program liability (see instructions)		619, 93		0	7. 00
				Contractor	NPR Date	
		(	)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor	(	J	1.00	2.00	8. 00
5.00	Indino of contractor			Ţ	!	0.00

Heal th	Financial Systems ST JOSEPH MED	I CAL CENTER	In Lie	u of Form CMS-2	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 150047   Period:   From 06/01/2014   Form 05/31/2015   From 05/31/2015   Fr					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI	ON				
1.00	Total hospital discharges as defined in AARA §4102 from Wks	st. S-3, Pt. I col. 15 line	14	5, 032	1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12		5, 954	2. 00	
3.00	D   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2   3,822					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		27, 747	4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			506, 659, 878	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	Bline 20		1, 373, 198	6. 00	
7. 00						
8.00	Calculation of the HIT incentive payment (see instructions)			245, 243	8. 00	
9.00	Sequestration adjustment amount (see instructions)			4, 905	9. 00	
10.00						
	I NPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			313, 914	30.00	
	Other Adjustment (specify)			0	31. 00	
	00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) -73 576 33					

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

313, 914 30. 00 0 31. 00 -73, 576 32. 00

Health Financial Systems	ST JOSEPH MEDICAL C	CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	F	Provider CCN: 150047	Peri od: From 06/01/2014	Worksheet E-3
	C	Component CCN: 15SO47		
		Title XVIII	Subprovi der -	PPS

15, 2004, (see Instructions)		IPF		
Name			1.00	
Net Federal   IPF PPS Payments (excluding outlier, ECT, and medical education payments)   3,483,393   1.00		DADT II MEDICADE DADT A SEDVICES LDE DDS	1.00	
Net IPF PPS Cut1ier Payments   28, 420   2.00	1 00		3 483 303	1 00
Net IPF PPS ECT Payments   0   3.00				
Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)   0.00   4.00		·		
15, 2004, (see InStructions)   1, 10.1   2004, (see Instructions)   2, 20	4. 00		1	
Cap increases for the unwelghted 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)	4.00		0.00	4.00
New Teaching program adjustment (see instructions)   0.00   5.00   0.0	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	0. 00	4. 01
Current year's unweighted FTE count of IAR excluding FTEs in the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   Courrent year's unweighted IAR	F 00		0.00	F 00
teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  1.00				
Courrent year's unweighted IRR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   7.00	6.00		0.00	6. 00
teaching program" (see instructions) 1.00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 2.00 Average Daily Census (see instructions) 2.00 Adjustment Factor (((1 + (line 8/line 9)) raised to the power of .5150 -1). 2.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 2.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 2.00 Aursing and Allied Health Managed Care payment (see instruction) 2.00 Aursing and Allied Health Managed Care payment (see instructions) 2.00 Cost of physicians' services in a teaching hospital (see instructions) 2.00 Cost of physicians' services in a teaching hospital (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.00 Cost of physicians' services in a teaching hospital (see instructions) 2.00 Cost of physicians' services in a teaching hospital (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.01 Aursing and Allied Health Managed Care payment (see instructions) 2.02 Aursing and Allied Health Managed Care payment (see instructions) 2.03 Aursing and Allied Health Managed Care payment (see instructions) 2.03 Aursing and	7 00		0.00	7 00
23.394521   9.00	7.00		0.00	7.00
Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1).	8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8. 00
11.00   Teaching Adjustment (line 1 multiplied by line 10).   0   10.00   Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)   3, 511, 813   12.00   0   13.00   0   0   0   0   0   0   0   0   0	9.00		23. 394521	9. 00
Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)   3,511,813   12.00     3.00   Nursing and Allied Heal th Managed Care payment (see instruction)   13.00     14.00   Organ acquisition (D0 NOT USE THIS LINE)   14.00     15.00   Cost of physicians' services in a teaching hospital (see instructions)   0   15.00     15.00   Subtotal (see instructions)   0   15.00     16.00   Subtotal (see instructions)   0   17.00     17.00   Primary payments   0   17.00     18.00   Subtotal (line 16 less line 17).   3,511,813   18.00     18.00   Subtotal (line 16 less line 17).   3,511,813   18.00     18.00   Subtotal (line 18 minus line 19)   233,856   19.00     19.00   Subtotal (line 20 minus line 21)   23,159   21.00     21.00   Coinsurance   23,159   21.00     22.00   Subtotal (line 20 minus line 21)   3,254,798   22.00     23.00   Aljowable bad debts (exclude bad debts for professional services) (see instructions)   9,039   23.00     24.00   Adjusted reimbursable bad debts (see instructions)   7,039   23.00     25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   2,684   25.00     26.00   Subtotal (sum of lines 20 and 24)   27.00     27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   27.00     28.00   Other pass through costs (see instructions)   28.00     29.00   Ottlier payments reconciliation   0   29.00     29.00   Ottlier payments reconciliation   0   30.50     29.00   Ottlier payments reconciliation   0	10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
13.00   Nursing and Allied Health Managed Care payment (see instruction)   0   13.00     14.00   Organ acquisition (DO NOT USE THIS LINE)   14.00     15.00   Cost of physicians' services in a teaching hospital (see instructions)   3,511,813     15.00   Detection   15.00     16.00   Subtotal (see instructions)   3,511,813     16.00   Primary payer payments   0   17.00     17.00   Deductibles   233,856     19.00   Deductibles   233,856     19.00   Subtotal (line 18 minus line 19)   3,277,957     19.00   Coinsurance   3,254,798     22.00   Subtotal (line 20 minus line 21)   23,159     23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   9,039     23.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   5,875     24.00   Subtotal (sum of lines 22 and 24)   3,260,673     25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   27.00     26.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0     27.00   Other pass through costs (see instructions)   0   28.00     28.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0     29.00   Outlier payments reconciliation   0   29.00     29.00   Other pass through costs (see instructions)   3, 260, 673     20.01   Sequestration adjustment (see instructions)   3, 260, 673     20.01   Sequestration adjustment (see instructions)   3, 260, 673     20.01   Sequestration adjustment (see instructions)   3, 260, 673     20.02   Sequestration adjustment (see instructions)   3, 260, 673     20.03   Sequestration adjustment (see instructions)   3, 260, 673     20.03   Sequestration adjustment (see instructions)   3, 260, 673     20.03   Sequestration adjustment (see instructions)   3, 260, 673     20.04   Sequestration adjustment (see instructions)   3, 260, 673     20.05   Sequestration adjustment (see instructions)   3, 260, 673     20.06   Sequestration adjustment (see instructions)   3, 260, 673     20.07   Sequestration adjustment (see instructions)   3, 260, 673	11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11. 00
14.00   Organ acquisition (DO NOT USE THIS LINE)   14.00   Cost of physicians' services in a teaching hospital (see instructions)   0   15.00   15.00   17.0	12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	3, 511, 813	12. 00
15. 00   Cost of physicians' services in a teaching hospital (see instructions)   3, 511, 813   16. 00	13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
Subtotal (see instructions)   3,511,813   16.00   17.00   17.00   17.00   18.00   19	14.00			
17. 00   Primary payer payments	15. 00			
18.00   Subtotal (line 16 less line 17).   3,511,813   18.00   19.00   Deductibles   233,856   19.00   20.00   Subtotal (line 18 minus line 19)   22,77,957   20.00   22,159   21.00   21.00   23,159   21.00   22.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   21.00   23,159   23.00   24.00   24.00   24.00   25.00	16. 00			
19.00   Deductibles   233, 856   19.00   Subtotal (line 18 minus line 19)   3, 277, 957   20.00   20.00   20.00   Subtotal (line 20 minus line 21)   23, 159   21.00   21.00   33, 254, 798   22.00   22.00   34.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   9, 039   23.00   24.00   Adjusted reimbursable bad debts (see instructions)   5, 875   24.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   2, 684   25.00   26.00   Subtotal (sum of lines 22 and 24)   3, 260, 673   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 27.00   28.00   Other pass through costs (see instructions)   0 28.00   Other pass through costs (see instructions)   0 29.00   Other pass through costs (see instructions)   0 29.00   Other pass through costs (see instructions)   0 30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 30.50   Pioneer ACO demonstration payment adjustment (see instructions)   0 30.50   Recovery of Accelerated Depreciation   0 30.99   Recovery of Accelerated Depreciation   0 30.99   31.00   Total amount payable to the provider (see instructions)   65,213   31.01   Sequestration adjustment (see instructions)   0 33.00   Total inverse payments (for contractor use only)   0 33.00   0 33.00   Tentative settlement (for contractor use only)	17. 00		1	
20.00   Subtotal (line 18 minus line 19)   3, 277, 957   20.00   21.00   Coinsurance   23, 159   21.00   22.00   Subtotal (line 20 minus line 21)   3, 254, 798   22.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   9, 039   23.00   24.00   Adjusted reimbursable bad debts (see instructions)   5,875   24.00   Adjusted reimbursable bad debts (see instructions)   2, 684   25.00   26.00   Subtotal (sum of lines 22 and 24)   3, 260, 673   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 27.00   28.00   Other pass through costs (see instructions)   0 28.00   Other pass through costs (see instructions)   0 28.00   Other pass through costs (see instructions)   0 29.00   Other pass through costs (see instructions)   0 30.50   Pioneer ACO demonstration payment adjustment (see instructions)   0 30.50   Recovery of Accelerated Depreciation   0 30.99   Recovery of Accelerated Depreciation   0 30.99   31.00   Total amount payable to the provider (see instructions)   3, 260, 673   31.00   23.00   Interim payments   3, 189, 439   32.00   Interim payments   3, 189, 439   32.00   Tentative settlement (for contractor use only)   0 33.00		,		
23, 159   21.00   22.00   Subtotal (line 20 minus line 21)   3, 254, 798   22.00   3, 254, 798   22.00   3, 254, 798   22.00   3, 254, 798   22.00   3, 254, 798   22.00   3, 254, 798   22.00   3, 254, 798   22.00   3, 254, 798   22.00   3, 254, 798   22.00   3, 254, 798   22.00   3, 254, 798   22.00   3, 254, 798   23.00   41 lowable bad debts (see instructions)   5, 875   24.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   2, 684   25.00   27.00   Subtotal (sum of lines 22 and 24)   3, 260, 673   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 27.00   28.00   0 Uther pass through costs (see instructions)   0 28.00   0 Uther pass through costs (see instructions)   0 29.00   29.00   0 Uther payments reconciliation   0 29.00   29.00   0 Uther payments reconciliation   0 29.00   0 Uther payments (SEE INSTRUCTIONS) (SPECIFY)   0 30.00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
3, 254, 798   22.00   Subtotal (line 20 minus line 21)   3, 254, 798   22.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   9, 039   23.00   25.00   Adjusted reimbursable bad debts (see instructions)   5, 875   24.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   2, 684   25.00   25.00   Subtotal (sum of lines 22 and 24)   3, 260, 673   26.00   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   27.00   28.00   Other pass through costs (see instructions)   0   28.00   00   Other pass through costs (see instructions)   0   29.00   29.00   00   Other pass through costs (see instructions)   0   29.00   29.00   00   00   00   00   00   00   00				
Allowable bad debts (exclude bad debts for professional services) (see instructions)  Adjusted reimbursable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Boundary of the pass through costs (see instructions)  Control of the				
Adjusted reimbursable bad debts (see instructions)  5, 875   24.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)  20, 684   25.00   25.00   26.00   27.00				
25.00				
3, 260, 673   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   27.00   27.		· · · · · · · · · · · · · · · · · · ·		
Direct graduate medical education payments (from Wkst. E-4, line 49)  Other pass through costs (see instructions)  Outlier payments reconciliation  OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pioneer ACO demonstration payment adjustment (see instructions)  Recovery of Accelerated Depreciation  Total amount payable to the provider (see instructions)  31.01  Sequestration adjustment (see instructions)  32.00  Interim payments  3, 189, 439  32.00  Tentative settlement (for contractor use only)				
28.00       Other pass through costs (see instructions)       0       28.00         29.00       Outlier payments reconciliation       0       29.00         30.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30.00         30.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30.50         30.99       Recovery of Accelerated Depreciation       0       30.99         31.00       Total amount payable to the provider (see instructions)       3, 260, 673       31.00         31.01       Sequestration adjustment (see instructions)       65, 213       31.01         32.00       Interim payments       3, 189, 439       32.00         33.00       Tentative settlement (for contractor use only)       0       33.00				
29.00   Outlier payments reconciliation   0   29.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30.50   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   30.50   OTHER ADJUSTMENTS (SEE INSTRUCTI				
30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30.00   30.50   30.50   90.50			1	
No. 50 Pi oneer ACO demonstration payment adjustment (see instructions) No. 99 Recovery of Accelerated Depreciation No. 100 Total amount payable to the provider (see instructions) No. 101 Sequestration adjustment (see instructions) No. 102 No. 103 No. 104 No. 105 No. 10			1	
Recovery of Accelerated Depreciation 0 30.99 Recovery of Accelerat			-	
31.00   Total amount payable to the provider (see instructions)   3,260,673   31.00   31.01   32.00   Interim payments   3,189,439   32.00   33.00   Tentative settlement (for contractor use only)   0   33.00		, , , , , , , , , , , , , , , , , , ,	1	
31.01       Sequestration adjustment (see instructions)       65, 213       31.01         32.00       Interim payments       3, 189, 439       32.00         33.00       Tentative settlement (for contractor use only)       0       33.00	31.00			
32.00 Interim payments 3, 189, 439 32.00 Tentative settlement (for contractor use only) 0 33.00	31. 01			
33.00 Tentative settlement (for contractor use only) 0 33.00	32. 00			
· • • • • • • • • • • • • • • • • • • •	33. 00			
34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 6,021 34.00	34.00	1	6, 021	34.00
	35. 00		0	35. 00
§115. 2 TO BE COMPLETED BY CONTRACTOR		·		
50.00 Original outlier amount from Worksheet E-3, Part II, line 2	50.00		28, 420	50.00
	51.00			
	52.00	· · · · · · · · · · · · · · · · · · ·	0.00	52. 00
53.00   Time Value of Money (see instructions) 0   53.00	53.00	Time Value of Money (see instructions)	0	53. 00

Heal th	Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047	Peri od:	Worksheet E-3	
			0 1 000 455057	From 06/01/2014		
			Component CCN: 155356	To 05/31/2015	Date/Time Prep 10/30/2015 5:0	
			Title XVIII	Skilled Nursing	PPS	
				Facility		
					1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETT	TLEMEMENT - ALL OTHER	HEALTH SERVICES FOR T	ITLE XVIII PART A	PPS SNF	
	SERVICES	10)				
1 00	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTION Resource Utilization Group Payment (RUGS)	NS)			700 ((0	1 00
1. 00 2. 00	Routine service other pass through costs				700, 669	1. 00 2. 00
3.00	Ancillary service other pass through costs				0	3.00
4. 00	Subtotal (sum of lines 1 through 3)				700, 669	4.00
4.00	COMPUTATION OF NET COST OF COVERED SERVICES	2			700, 009	4.00
5. 00	Medical and other services (Do not use this		ts are included in lin	e 1 of W/S F		5. 00
3.00	Part B. This line is now shaded.)	3 Trile d3 vaccriic c03	ts are meraded in in	C 1 01 W/3 L,		3.00
6.00	Deducti bl e				0	6. 00
7. 00	Coinsurance				69, 141	7. 00
8.00	Allowable bad debts (see instructions)				1, 628	8. 00
9.00	Reimbursable bad debts for dual eligible be	eneficiaries (see ins	tructions)		0	9. 00
10.00	Adjusted reimbursable bad debts (see instru	uctions)	,		1, 058	10.00
11.00	Utilization review				0	11. 00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 a	and 7, plus lines 10	and 11)(see instruction	ns)	632, 586	12. 00
13.00	Inpatient primary payer payments				0	13. 00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI	IFY)			0	14.00
14.50	Pioneer ACO demonstration payment adjustmen	nt (see instructions)			0	14. 50
14. 99	Recovery of Accelerated Depreciation				0	14. 99
15.00	Subtotal (see instructions				632, 586	15. 00
1E 01	Sequestration adjustment (see instructions)	<b>\</b>			12 452	1 1 5 01

15. 01

16.00

17.00 0 1, 037

18.00

19. 00 0

12, 652

618, 897

15. 01

16.00 | Interim payments

Sequestration adjustment (see instructions)

17.00 Tentative settlement (for contractor use only)
18.00 Balance due provider/program (line 15 minus lines 15.01, 16, and 17)

19.00 Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047	From 06/01/2014	Worksheet E-3 Part VII Date/Time Prepared:

			o 05/31/2015	Date/Time Pre 10/30/2015 5:	
		Title XIX	Hospi tal	PPS	
			Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			2, 597, 562	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	2, 597, 562	4. 00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		0	2, 597, 562	7. 00
	Reasonable Charges				
8. 00	Routine service charges		0		8. 00
9. 00	Ancillary service charges		22, 270, 438	19, 735, 461	9. 00
10. 00	Organ acquisition charges, net of revenue		0	1777007101	10.00
			0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		22, 270, 438	19, 735, 461	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis			_	
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15. 00	a charge basis had such payment been made in accordance with 42 Ratio of line 13 to line 14 (not to exceed 1.000000)	CFR §413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		22, 270, 438	19, 735, 461	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	22, 270, 438	17, 137, 899	17. 00
17.00	line 4) (see instructions)	TT TTTE TO EXCECUS	22,270,100	17, 107, 077	17.00
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru		0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		0	2, 597, 562	21. 00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be continuous than outlier payments	ompretea for PPS provide	0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0	U	24. 00
25. 00			0		25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	,		0	2, 597, 562	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	2, 597, 562	
32. 00	Deducti bl es		0	0	32.00
33. 00 34. 00			0	0	33. 00 34. 00
35. 00	,		0	U	35. 00
36. 00			0	2, 597, 562	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
	Subtotal (line 36 ± line 37)		0	2, 597, 562	
	0 Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00			0	2, 597, 562	40. 00
41.00	1 1		0	2, 597, 562	
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	42. 00
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				I

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047		Worksheet E-3
			From 06/01/2014	
		Component CCN: 15SO47	To 05/31/2015	
				10/30/2015 5:01 pm
		Title XIX	Subprovi der -	PPS

		litle XIX	Subprovi der -	PPS	
			I PF I npati ent	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	323 T GR. 11 1223 T GR. 2017	02.111.020		1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		O		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8. 00	Routine service charges		0	_	8. 00
9.00	Ancillary service charges		0	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		l 0	0	12. 00
13. 00	Amount actually collected from patients liable for payment for s	services on a charge	l	0	13.00
13.00	basis	services on a charge	l o	U	13.00
14. 00	Amounts that would have been realized from patients liable for ;	payment for services on	o	0	14. 00
	a charge basis had such payment been made in accordance with 42	9		_	
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		o	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)		_	_	
19. 00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instruc	,	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co		0	0	21. 00
22. 00	Other than outlier payments	mipreted for PPS provide	0	0	22. 00
	Outlier payments			0	
24. 00	Program capital payments		0	O	24. 00
	Capital exception payments (see instructions)		o o		25. 00
	Routine and Ancillary service other pass through costs		o	0	1
	Subtotal (sum of lines 22 through 26)		O	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
32. 00	Deducti bl es		0	0	
	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	
	Utilization review	20)	0		35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	0	0	
38. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)			0	
	Direct graduate medical education payments (from Wkst. E-4)			U	39.00
40. 00	, , , , , , , , , , , , , , , , , , , ,			0	1
41. 00	Interim payments			0	
42. 00	Balance due provider/program (line 40 minus line 41)			0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2.	o	0	
	chapter 1, §115.2	·			

Heal th	Financial Systems ST JOSEPH MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT LL EDUCATION COSTS	Provi der		Period: From 06/01/2014 To 05/31/2015	Worksheet E-4 Date/Time Prep 10/30/2015 5:0	
		Ti tl	e XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1. 00	Unweighted resident FTE count for allopathic and osteopathic prending on or before December 31, 1996.	· ·	·		0. 00	1. 00
2. 00 3. 00	Unweighted FTE resident cap add-on for new programs per 42 CFR Amount of reduction to Direct GME cap under section 422 of MMA	413. 79(e)(	1) (see instr	uctions)	0. 00 0. 00	2. 00 3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance winstructions for cost reporting periods straddling 7/1/2011)	th 42 CFR	§413.79 (m).	(see	0. 00	3. 01
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and os GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	teopathi c	programs due	to a Medicare	6. 84	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instrustraddling 7/1/2011)	ctions for	cost reporti	ng periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	(see inst	ructions for	cost reporting	0. 00	4. 02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus 4.02 plus applicable subscripts	or minus	line 4 plus l	ines 4.01 and	6. 84	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic pricecords (see instructions)	ograms for	the current	year from your	5. 14	6. 00
7. 00	Enter the lesser of line 5 or line 6		1		5. 14	7. 00
			Primary Care		Total	
8. 00	Weighted FTE count for physicians in an allopathic and osteopat	ni c	1. 00 5. 1	2. 00	3. 00 5. 14	8. 00
9. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwis		5. 1		5. 14	9. 00
7. 00	multiply line 8 times the result of line 5 divided by the amoun		3. 1	0.00	5. 14	7. 00
10. 00 11. 00	Weighted dental and podiatric resident FTE count for the curren Total weighted FTE count	t year	5. 1	0. 00 4 0. 00		10. 00 11. 00
12. 00	Total weighted resident FTE count for the prior cost reporting instructions)	year (see	5. 7	0.00		12. 00
13. 00	Total weighted resident FTE count for the penultimate cost repo year (see instructions)	rti ng	6. 4	0.00		13. 00
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided by	y 3).	5. 7			14. 00
15. 00 16. 00	Adjustment for residents in initial years of new programs Adjustment for residents displaced by program or hospital closu	20	0. 0 0. 0			15. 00 16. 00
17. 00	Adjusted rolling average FTE count	e	5. 7			17. 00
18. 00	Per resident amount		93, 148. 6			18. 00
19. 00	Approved amount for resident costs		537, 46	7 0	537, 467	19. 00
					1 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME FTE	roci dont	can clate roo	olyad undar 42	1. 00	20. 00
20.00	Sec. 413.79(c)(4)	i esi delit	cap siots rec	erved under 42	5.00	20.00
21. 00	Direct GME FTE unweighted resident count over cap (see instruct	ons)			0. 00	21.00
22. 00	Allowable additional direct GME FTE Resident Count (see instruc				0.00	22.00
23. 00	Enter the locally adjustment national average per resident amou	nt (see in	structions)		92, 633. 77	23. 00
	Multiply line 22 time line 23				0	
25. 00	Total direct GME amount (sum of lines 19 and 24)		Inpatient Par	t Managed care	537, 467	25. 00
			A A	wanaged care		
			1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26. 00	Inpatient Days (see instructions)		10, 00			26. 00
27. 00	Total Inpatient Days (see instructions)		36, 28			27. 00
28. 00 29. 00	Ratio of inpatient days to total inpatient days Program direct GME amount		0. 27575			28. 00 29. 00
30. 00	Reduction for direct GME payments for Medicare Advantage		148, 20	9 69, 379 9, 803		30.00
	Net Program direct GME amount			7, 003	207, 785	
	•		•			

Heal th	Financial Systems ST JOSEPH MEDICAL	. CENTER	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 150047	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 06/01/2014 To 05/31/2015	Date/Time Prep 10/30/2015 5:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)			CAL	
32.00	1	. I, sum of col. 20 an	d 23, lines 74	0	32. 00
	and 94)				
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I,		74 and 94)	2, 395, 600	
34.00	Ratio of direct medical education costs to total charges (line	32 ÷ line 33)		0. 000000	
	Medicare outpatient ESRD charges (see instructions)			0	
36. 00	Medicare outpatient ESRD direct medical education costs (line 3			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII O	INLY			
27.00	Part A Reasonable Cost		T	1F F02 F00	27 00
37. 00				15, 583, 588 0	•
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	iati ana)		0	39.00
40. 00	Cost of physicians' services in a teaching hospital (see instru Primary payer payments (see instructions)	ictions)		44, 724	
	Total Part A reasonable cost (sum of lines 37 through 39 minus	Line 40)		15, 538, 864	
41.00	Part B Reasonable Cost	111le 40)		10, 000, 004	41.00
42 00	Reasonable cost (see instructions)			6, 190, 540	42 00
	Primary payer payments (see instructions)			529	1
44. 00	Total Part B reasonable cost (line 42 minus line 43)			6, 190, 011	
45. 00	Total reasonable cost (sum of lines 41 and 44)			21, 728, 875	
46. 00	,	41 ÷ line 45)		0. 715125	1
	Ratio of Part B reasonable cost to total reasonable cost (line			0. 284875	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART				
48.00	Total program GME payment (line 31)			207, 785	48. 00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (	see instructions)		148, 592	49. 00
	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (			59, 193	50.00
	37		,	'	

Health Financial Systems ST JOSEPH MEDICA
BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Peri od: Worksheet G From 06/01/2014 To 05/31/2015 Date/Time Prepared:

				0 05/31/2015	Date/Time Pre 10/30/2015 5:	
		General Fund	Speci fi c	Endowment Fund	Plant Fund	O I PIII
			Purpose Fund			
	CHIDDENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	CURRENT ASSETS  Cash on hand in banks	-1, 433, 757		) 0	0	1.00
2. 00	Temporary investments	0	ď		0	2. 00
3.00	Notes receivable	0	c	0	0	3. 00
4.00	Accounts receivable	33, 232, 206	C	0	0	
5.00	Other recei vable	0	C	0	0	
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-11, 064, 238 3, 508, 186	l .	0	0	6. 00 7. 00
8.00	Prepai d expenses	613, 593	l .	0	0	8.00
9. 00	Other current assets	809, 940		Ö	0	9. 00
10.00	Due from other funds	0	c	0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	25, 665, 930	<u>C</u>	0	0	11. 00
10.00	FI XED ASSETS	1 010 000			0	10.00
12. 00 13. 00	Land improvements	1, 010, 000 400, 981	1		0	
14. 00	Accumulated depreciation	-316, 600	1		0	
15. 00	Bui I di ngs	28, 318, 373	1		0	15. 00
16. 00	Accumulated depreciation	-11, 998, 890	1	0	0	16. 00
17. 00	Leasehold improvements	18, 931, 472	1	0	0	17. 00
18. 00 19. 00	Accumulated depreciation Fixed equipment	-4, 711, 018	1	0	0	18. 00 19. 00
20. 00	Accumulated depreciation	415, 382		0	0	20.00
21. 00	Automobiles and trucks	Ö		0	0	21.00
22. 00	Accumulated depreciation	0	c	0	0	22. 00
23. 00	Major movable equipment	19, 579, 297	l .	0	0	23. 00
24. 00	Accumulated depreciation	-14, 964, 269	l .		0	24. 00
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation	7, 476, 419 -5, 386, 960	l .	0	0	25. 00 26. 00
27. 00	HIT desi gnated Assets	-5, 360, 960		0	0	27. 00
28. 00	Accumul ated depreciation	Ö		0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	c	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	38, 754, 187	<u> </u>	0	0	30. 00
21 00	OTHER ASSETS		J		0	1 24 00
31. 00 32. 00	Investments Deposits on Leases	0	1		0	31. 00 32. 00
33. 00	Due from owners/officers	0		0	0	33.00
34. 00	Other assets	4, 250, 620	d	0	0	34. 00
35.00	Total other assets (sum of lines 31-34)	4, 250, 620			0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	68, 670, 737	<u> </u>	0	0	36. 00
37. 00	CURRENT LIABILITIES  Accounts payable	2, 446, 243		0	0	37. 00
38. 00	Salaries, wages, and fees payable	3, 290, 517	1		0	
39. 00	Payrol I taxes payable	353, 166	1	Ö	0	39. 00
40.00	Notes and Loans payable (short term)	22, 222	c	0	0	40. 00
41.00	Deferred income	0	C	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds Other current liabilities	23, 754, 032 2, 020, 421			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	31, 886, 601	1	1	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	C		0	1
47. 00	Notes payable	59, 259	C	0	0	
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	0		0	0	ı
50.00	Total long term liabilities (sum of lines 46 thru 49	59, 259	l .		0	1
51. 00	Total liabilites (sum of lines 45 and 50)	31, 945, 860	l .		0	ł
	CAPI TAL ACCOUNTS					
52.00	General fund balance	36, 724, 877	1			52.00
53. 00	Specific purpose fund		C	)		53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 00	replacement, and expansion	2/ 704 677			_	F0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	36, 724, 877 68, 670, 737	l .	0	0	59. 00 60. 00
00.00	[59]	00,070,737		,		00.00
		•	•	,		•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1 From 06/01/2014 Date/Time Prepa Provider CCN: 150047

					To 05/31/2015	Date/Time Prep 10/30/2015 5:0	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	·
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		34, 585, 911 232, 180		0		1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		34, 818, 091		0		3.00
4. 00	Additions (credit adjustments) (specify)	0	01,010,071		0	0	4. 00
5.00		0			0	0	5. 00
6. 00 7. 00		0			0	0	6. 00 7. 00
8. 00		0			0		8.00
9. 00		0			0	O	9. 00
10.00	Total additions (sum of line 4-9)		0		0		10. 00
11.00	Subtotal (line 3 plus line 10)		34, 818, 091		0		11. 00 12. 00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0	0	12.00
14. 00		o o			Ö	0	14. 00
15. 00		0			0	0	15. 00
16. 00 17. 00		0			0	0	16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)		0		٥		18.00
19. 00	Fund balance at end of period per balance		34, 818, 091		0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		Lildowillett Turid	Frant	T UTIO			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00 2. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0			0		3. 00
4. 00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5. 00
6. 00 7. 00			0				6. 00 7. 00
8. 00			0				8. 00
9. 00			0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0		0		11. 00 12. 00
13. 00	beddetrons (debit adjustillents) (specify)		0				13. 00
14.00			0				14. 00
15.00			0				15. 00
16. 00			()				16. 00
17 ∩∩			٥				
17. 00 18. 00	Total deductions (sum of lines 12-17)	ol	0		0		17. 00 18. 00
	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0		0		17. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 150047

			Т	o 05/31/2015	Date/Time Pre 10/30/2015 5:	
	Cost Center Description		Inpatient	Outpati ent	Total	5 T
	'		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		38, 835, 503		38, 835, 503	1.00
2.00	SUBPROVI DER - I PF		20, 283, 754		20, 283, 754	2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY		3, 264, 400		3, 264, 400	7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		62, 383, 657		62, 383, 657	10.00
	Intensive Care Type Inpatient Hospital Services	•				
11.00	INTENSIVE CARE UNIT		3, 669, 384		3, 669, 384	11.00
11. 01	NEONATAL INTENSIVE CARE UNIT		0		0	11. 01
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT		6, 389, 552		6, 389, 552	13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of I	i nes	10, 058, 936		10, 058, 936	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		72, 442, 593		72, 442, 593	17.00
18.00	Ancillary services		211, 227, 986	O	211, 227, 986	18.00
19.00	Outpati ent services		0	222, 989, 299	222, 989, 299	19.00
20.00	RURAL HEALTH CLINIC		0	O	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	O	0	21.00
22. 00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)		0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3 to	o Wkst.	283, 670, 579	222, 989, 299	506, 659, 878	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			123, 522, 464		29.00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38.00
39. 00			0			39. 00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		123, 522, 464		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems ST JOSEPH MEDICAL	CENTER	In lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 150047	Peri od:	Worksheet G-3	
			From 06/01/2014 To 05/31/2015		pared:
1 00	Tatal anti-out annual (form What C 2 Double and an 2 line	20)		1. 00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			506, 659, 878	1.00
2.00	Less contractual allowances and discounts on patients' accounts	S		381, 951, 837	2.00
3.00	Net patient revenues (line 1 minus line 2)	2)		124, 708, 041	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		123, 522, 464	
5.00	Net income from service to patients (line 3 minus line 4)			1, 185, 577	5. 00
6. 00	OTHER INCOME			0	6. 00
7. 00	Contributions, donations, bequests, etc Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication:	corvi coc		0	8.00
9.00	Revenue from television and radio service	Sei vi ces		0	9.00
10. 00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12. 00	Parking Lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	13. 00
14. 00	Revenue from meals sold to employees and quests			0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other that	an nationts		0	16.00
	Revenue from sale of drugs to other than patients	all patreits		0	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER (SPECIFY)			-953, 397	
	Total other income (sum of lines 6-24)			-953, 397 -953, 397	
	Total (line 5 plus line 25)			232, 180	
	OTHER EVRENCES (SPECIEV)			232, 100	

27. 00 28. 00

232, 180 29. 00

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

LALCUI	n Financial Systems ST JOSEPH MEDI LATION OF CAPITAL PAYMENT	Provi der CCN: 150047	Peri od:	u of Form CMS-2 Worksheet L	-502 1
			From 06/01/2014 To 05/31/2015	Parts I-III Date/Time Prep 10/30/2015 5:0	
		Title XVIII	Hospi tal	PPS	от рііі
	DART I FILLY PROPERTIVE METURE			1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			764, 189	1. 0
. 00	Model 4 BPCI Capital DRG other than outlier			704, 189	1. 0
2. 00	Capital DRG outlier payments			158, 234	2. 0
2. 01	Model 4 BPCI Capital DRG outlier payments			130, 234	2. 0
3. 00	Total inpatient days divided by number of days in the cost r	eporting period (see inst	ructions)	76. 02	3. 0
1.00	Number of interns & residents (see instructions)	oper tring period (see this	. 40 (1 0110)	5. 98	4. 0
5. 00	Indirect medical education percentage (see instructions)			2. 24	5. 0
. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)			17, 118	6. 0
. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)			11. 07	7. 0
3. 00	Percentage of Medicaid patient days to total days (see instr	uctions)		25. 03	8. 0
9. 00	Sum of lines 7 and 8			36. 10	9. 0
10.00	Allowable disproportionate share percentage (see instruction	s)		7. 58	10.00
11.00	, , ,			57, 926	
2. 00	Total prospective capital payments (sum of lines 1, 1.01, 2,	2.01, 6 and 11)		997, 467	12. 0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			0	1 0
. 00 2. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)			0	1. 00 2. 00
3. 00	Total inpatient program capital cost (see Instructions)			0	3. 0
1. 00	Capital cost payment factor (see instructions)			0	4. 0
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	1
<del>). 00</del>	Trotal Impatrent program capital cost (ITHE 6 X TITLE 1)			0	0. 0.
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 0
. 00	Program inpatient capital costs (see instructions)	( :+:)		0	1. 0
	Program inpatient capital costs for extraordinary circumstan	ces (see instructions)		0	2. 0
2. 00					3. 0
2. 00	Net program inpatient capital costs (line 1 minus line 2)				
2. 00 3. 00 4. 00	Applicable exception percentage (see instructions)			0.00	
2. 00 3. 00 4. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	nstructions)		0	5. 0
2. 00 3. 00 4. 00 5. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i		line 6)	0 0. 00	5. 0 6. 0
2. 00 3. 00 4. 00 5. 00 7. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar		:line 6)	0 0. 00 0	5. 0 6. 0 7. 0
2. 00 3. 00 4. 00 5. 00 5. 00 7. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7)	y circumstances (line 2 x	:line 6)	0 0. 00 0 0	5. 0 6. 0 7. 0 8. 0
. 00 . 00 . 00 . 00 . 00 . 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl	y circumstances (line 2 x	ŕ	0 0.00 0 0	5. 0 6. 0 7. 0 8. 0 9. 0
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	y circumstances (line 2 x icable) capital payments (line 8	less line 9)	0 0. 00 0 0	5. 0 6. 0 7. 0 8. 0 9. 0 10. 0
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri	less line 9) or year	0 0.00 0 0 0	5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 1. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus lir	less line 9) or year ne 11)	0.00 0.00 0 0 0	5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0
2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 7. 00 9. 00 1. 00 1. 00 2. 00 3. 00 3. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus line r the amount on this line	less line 9) or year ne 11)	0.00 0.00 0 0 0	5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00 9. 00 10. 00 11. 00 12. 00 14. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus line r the amount on this line capital payment for the f	less line 9) or year ne 11)	0.00 0.00 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 5.00 7.00 3.00 7.00 10.00 11.00 12.00 13.00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus line r the amount on this line capital payment for the f	less line 9) or year ne 11)	0.00 0.00 0 0 0 0	5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 14. 0