payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION		Worksheet S
AND SETTLEMENT SUMMARY	From 06/01/2018	Parts I-III
	To 05/31/2019	Date/Time Prepared:
		10/30/2019 3:37 pm

						10/30/2019	3:37 pm
PART I - COST	REPORT STATUS						
Provi der	1. [X] El ectroni cal	ly filed cost report			Date: 10/30/	/2019 Time:	3: 37 p
use only	2. [] Manually sub	mitted cost report					
		n amended report enter lization. Enter "F" fo	the number of times the rfull or "L" for low.	e provider re	submitted this	cost report	
Contractor use only	(1) As Submitted	ut Audit 8. [N] Initia		der CCN 12. [

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST JOSEPH MEDICAL CENTER (15-0047) for the cost reporting period beginning 06/01/2018 and ending 05/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)
Officer or Administrator of Provider(s)
Ti tl e
Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	346, 817		0	0	1. 00
2.00	Subprovi der - I PF	0	845	-372		0	2. 00
3.00	Subprovi der - IRF	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	0	0		0	7. 00
200.00	Total	0	347, 662	-83, 663	0	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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0047 Peri od: Worksheet S-2 From 06/01/2018 Part I 05/31/2019 Date/Time Prepared: 10/30/2019 3:37 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 700 BROADWAY STREET 1.00 PO Box: 1.00 City: FORT WAYNE State: IN Zi p Code: 46802 2.00 County: ALLEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal ST JOSEPH MEDICAL 150047 23060 07/01/1996 N 3.00 1 Subprovider - IPF 23060 Р ST JOSPEH GENERATIONS Р 4.00 15S047 4 06/01/2003 N 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF SKILLED NURSING 155356 23060 04/01/1990 Ρ Р 9.00 FACILITY ST JOSEPH 10.00 Hospital -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital-Based Health Clinic - RHC 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: To: 1 00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 06/01/2018 05/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 4 1. 00 2. 00 3.00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to 22 03 N Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost

	reporting period different from the method used in th	ne prior cos	st					
	reporting period? In column 2, enter "Y" for yes or	"N" for no.						
		In-State	In-State	Out-of	Out-of	Medi cai	d Other	
		Medi cai d	Medi cai d	State	State	HMO day	s Medicaid	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	el i gi bl e			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	1
24. 00	If this provider is an IPPS hospital, enter the	1, 666	905	22	10	4, 7	21 0	24.00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	AT.	Provider CC	N: 15-0047	Period: From 06		8 Par		
		1 - C+-+-	l C+-+-	0+ - =		/31/201	10/	e/Time Pr 30/2019 3	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	HMO	cai d days	Other Medicaid days	
F 00	hour in the	1.00	2. 00	3. 00	4. 00	5.		6. 00	05.0
5. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	Haban	(Dunal	0	e of Geog	25. (
						. 00	3 Dati	2. 00	-
7. 00	Enter your standard geographic classification (not was cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not was reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifile is a sole community hospital (SCH), enter the effect in the cost reporting period.	rural. age) status r"2" for ro cation in o	at the end ural. If ap column 2.	of the cos plicable,	t		1 1 0		26. C 27. C 35. C
						nni ng:		Endi ng:	
6. 00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb		. 00		2. 00	36. C
7. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		of period	s MDH statu	s		0		37. (
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37. (
3. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
						Y/N . 00		Y/N 2.00	_
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage i)? Enter i	(iii)? Ent requiremen n column 2	er in colum ts in "Y" for ye	me in	N		N	39. (
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobno in column 2, for discharges on or after October 1.	oer 1. Ente	"Y" for y			N	/ / / /	N /	40.
						1.		. 00 3. 00	_
	Prospective Payment System (PPS)-Capital								
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)							Y	45.
o. 00	Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete WkstPt. III.					1	'	N N	46.
7. 00	Is this a new hospital under 42 CFR §412.300(b) PPS of	capital? E	nter "Y for	yes or "N"	for no.	1	ı	N N	47.
	Is the facility electing full federal capital payment Teaching Hospitals						J	N N	48.
5. 00	Is this a hospital involved in training residents in or "N" for no.	approved GI	ME programs	? Enter "Y	" for yes)	′		56.
	If line 56 is yes, is this the first cost reporting process of the programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N' th of this of (", completo , if applio	'for no in cost report e Worksheet cable.	column 1. ing period? E-4. If co	If columr 'Enter " Iumn 2 is	1 Y"	ı		57.
	If line 56 is yes, did this facility elect cost reimble defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		s as				58.
. 00	Are costs claimed on line 100 of Worksheet A? If yes	s, complete	wkst. D-2,	Pt. I. NAHE 413.8 Y/N		heet A	Qua	 ss-Through lification cerion Cod	n
	Are you claiming nursing and allied health education			1. 00	:	2. 00		3. 00	60.

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0047 Peri od: Worksheet S-2 From 06/01/2018 Part I Date/Time Prepared: 05/31/2019 10/30/2019 3:37 pm Y/N IME Direct GME IME Direct GME 5.00 1.00 2.00 3. 00 4.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE 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. Enter in column 4, the 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. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.

3. 00	Has your facility trained residents in nonprovider settings during this compared for yes or "N" for no in column 1. If yes, complete lines 64 through 6			N	63. 00
	, ,	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
		Nonprovi der Si te	Hospi tal	2))	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	1.00	2.00	3.00	
	period that begins on or after July 1, 2009 and before June 30, 2010.	iiiis base year	is your cost i	epor tring	
4. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0. 000000	64. 00

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0047 Period: Worksheet S-2

Provider CCN: 15-0047 Worksheet S-2 From 06/01/2018 Part I Date/Time Prepared: 05/31/2019 10/30/2019 3:37 pm Program Code Unwei ghted Unwei ghted 3/ Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 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 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col 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 Enter in column 1 the number of unweighted non-primary care resident 0.00 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 ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 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 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν O N 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, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 Ν subprovider? Enter "Y" for yes and "N" for no. If line 75 is 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, indicate which program year began during this cost reporting period. (see instructions)

ealth Financial Systems ST JOSEPH MEDICA OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	N: 15-0047	Peri od:	u of Form CMS Worksheet S	
			From 06/01/2018 To 05/31/2019	Part I Date/Time P 10/30/2019	repared:
			1	1.00	
Long Term Care Hospital PPS				1.00	
Is this a long term care hospital (LTCH)? Enter "Y" for yes and "1.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no. TEFRA Providers			ng period? Enter	N N	80. 0 81. 0
is this a new hospital under 42 CFR Section §413.40(f)(1)(i) T bid this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 0 86. 0
7.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified ι	under sectio	n	N	87. 0
[1000(d)(1)(b)(vi). Enter 1 101 yes of 10 101 no.			V 1.00	XI X 2. 00	
Title V and XIX Services					
0.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? Er	nter "Y" for	N	Υ	90.0
1.00 Is this hospital reimbursed for title V and/or XIX through the			N	Υ	91.0
full or in part? Enter "Y" for yes or "N" for no in the applic 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual	certi fi cati			N	92. 0
instructions) Enter "Y" for yes or "N" for no in the applicabl 3.00 Does this facility operate an ICF/IID facility for purposes of		I XIX? Enter	N	N	93. 0
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, an	nd "N" for no	in the	N	N	94. 0
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the appli	cable column	۱.	0. 00	0.00	95. 0
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes of applicable column.	or "N" for no	in the	N	N	96. 0
7.00 If line 96 is "Y", enter the reduction percentage in the appli 8.00 Does title V or XIX follow Medicare (title XVIII) for the inte stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	rns and resi	dents post	0. 00 Y	0. 00 Y	97. 0 98. 0
column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the repo C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for titl title XIX.				Y	98. 0
8.02 Does title V or XIX follow Medicare (title XVIII) for the calc bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.			Y	Y	98. 0
8.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N	98. 0
8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH re outpatient services cost? Enter "Y" for yes or "N" for no in c in column 2 for title XIX.			d N	N	98. 0
8.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col column 2 for title XIX.				Y	98. 0
18.06 Does title V or XIX follow Medicare (title XVIII) when cost re Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.			Y	Y	98. 0
Rural Providers			N		105. 0
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-in	ıclusive meth	nod of payme	nt N		106. 0
for outpatient services? (see instructions) 07.00 If this facility qualifies as a CAH, is it eligible for cost r training programs? Enter "Y" for yes or "N" for no in column 1 yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2	. (see instr	uctions) If			107. 0
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 Is this a rural hospital qualifying for an exception to the CR	NA fee sched	dul e? See 4	2 N		108. 0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati on	al Speech	Respi ratory	у
00 00 If this bospital qualifies as a CAU on a cost provider	1.00	2.00	3.00	4.00	100.0
09.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109. 0
				1 00	
10.00 Did this hospital participate in the Rural Community Hospital				1.00 N	110. 0
Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Works applicable.					

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN	: 15-0047	Peri od:		Worksheet S	S-2552- -2
		From 06/01/2 To 05/31/2	2018 2019	Part I Date/Time P 10/30/2019	repared
		1. 00		2. 00	_
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Com Health Integration Project (FCHIP) demonstration for this cost reporting pe "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, er integration prong of the FCHIP demo in which this CAH is participating in c Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter iter the column 2.	N		2.00	111.
			1. 00	2.00 3.0	0
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 3 either "93" percent for short term hospital or "98" percent for long term psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1.	s "E", enter n care (incl e definition	in column udes	N	0	
16.00 s this facility classified as a referral center? Enter "Y" for yes or "N" 17.00 s this facility legally-required to carry malpractice insurance? Enter "Y" no.		"N" for	N N		116. 117.
18.00 is the malpractice insurance a claims-made or occurrence policy? Enter 1 if claim-made. Enter 2 if the policy is occurrence.	the policy	is	1		118.
grafill liade. Effect 2 11 the porrey 13 decurrence.	Premi ums	Losses		Insurance	
	1. 00	2.00		3.00	-
18.01 List amounts of malpractice premiums and paid losses:	252, 8	74 -17	, 872		0 118.
		1. 00		2. 00	
18.02 Are malpractice premiums and paid losses reported in a cost center other the Administrative and General? If yes, submit supporting schedule listing cos and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless proving \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y"	st centers sion in ACA for yes or			N	118. 119. 120.
"N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruenter in column 2, "Y" for yes or "N" for no.	icti ons)				404
21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	cnarged to	Y			121.
22.00 Does the cost report contain healthcare related taxes as defined in §1903(w Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.					122.
Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" f	or no. If	N			125.
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certifiin column 1 and termination date, if applicable, in column 2.	cation date				126.
7.00 f this is a Medicare certified heart transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.	ation date				127.
8.00 f this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.	ation date				128.
9.00 f this is a Medicare certified lung transplant center, enter the certifical column 1 and termination date, if applicable, in column 2.	ition date i	n			129
0.00 of this is a Medicare certified pancreas transplant center, enter the certifate in column 1 and termination date, if applicable, in column 2.	fi cati on				130
1.00 of this is a Medicare certified intestinal transplant center, enter the cer date in column 1 and termination date, if applicable, in column 2.	tification				131.
2.00 f this is a Medicare certified islet transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.	ation date				132.
3.00 of this is a Medicare certified other transplant center, enter the certification in column 1 and termination date, if applicable, in column 2.	ation date				133.
34.00 If this is an organ procurement organization (OPO), enter the OPO number in and termination date, if applicable, in column 2.	column 1				134
All Providers 40.00 Are there any related organization or home office costs as defined in CMS F)ub 1E 1	Y	- 1	679005	140.

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0047 Peri od: Worksheet S-2 From 06/01/2018 Part I 05/31/2019 Date/Time Prepared: To 10/30/2019 3:37 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141.00 Name: COMMUNITY HEALTH SYSTEMS Contractor's Name: WPS, INC. Contractor's Number: 10301 141 00 142.00 Street: 4000 MERIDIAN BLVD PO Box: 142.00 143.00 City: FRANKLIN State: 37067 143. 00 Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 of costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

168.00 f this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), reasonable cost incurred for the HIT assets (see instructions)	enter the	(168. 00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	•		168. 01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	"), enter the	9. 99	169. 00
transition factor. (see instructions)			
	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 period respectively (mm/dd/yyyy)	06/01/2018	05/31/2019	170. 00
	1. 00	2. 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 in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	(171.00

167 00

167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.

Heal th	Financial Systems ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co		Peri od: From 06/01/2018 To 05/31/2019	Worksheet S-2 Part II	pared:
				Y/N	Date	J / piii
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	lfor all NO re	esponses. Ente	r all dates in t	he	
1.00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
00	reporting period? If yes, enter the date of the change in o					
			Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.00
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
	Total onom por (edo rinot dott ono)		Y/N	Type	Date	
			1.00	2.00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	N			4. 00
5.00	Are the cost report total expenses and total revenues diffe	erent from	N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If ves. is th	ne provider is	N		6.00
7. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.	•	N		7. 00
8. 00 9. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		J	N Y		8. 00 9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	is.		N		10. 00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
	Tradelling Tragitum on Norksheet N: TT yes, see Thatractions.				Y/N 1. 00	
4.5	Bad Debts					
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti	Par	t A	Par	Y t B	15. 00
		Y/N 1.00	2. 00	Y/N	Date 4.00	
	PS&R Data	1.00	2.00	3. 00	4.00	
16. 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	Y	09/10/2019	Y	09/10/2019	16. 00
17. 00	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	N		N		17. 00
18. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems ST JOSEPH MED	DICAL CENTER		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN	: 15-0047	Peri od: From 06/01/2018 To 05/31/2019	Worksheet S-2 Part II Date/Time Pre 10/30/2019 3:	epared:
		Descri p	ti on	Y/N	Y/N	J pin
		0		1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
		Y/N 1.00	Date 2.00	Y/N 3. 00	Date 4.00	
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	4.00	21. 00
	records? If yes, see instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HOS	SPI TALS)			-
22.00	Capi tal Related Cost				N	1 22 00
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		s made dur	ing the cost	N N	22. 00 23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during th	nis cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost reporti	ng period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reportino	g period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporting	period? If	yes, submit	N	27. 00
28. 00	Interest Expense	ntered into durin	na the cost	reporting	N	28. 00
29. 00	period? If yes, see instructions.					
30. 00	treated as a funded depreciation account? If yes, see instructions					
31. 00	i nstructi ons.					
	instructions. Purchased Services		3 · ·	,		31.00
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		through co	ntractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with p	provi der-ba	sed physi ci ans?	N	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		s with the	provi der-based	N	35. 00
				Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					I
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the ho	ome office?	Y		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off			Y	12/31/2017	38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other			, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office? If	yes, see	N		40. 00
	instructions.					
		1.00)	2.	00	
41. 00	l ·	VI CTORI A		ROMANKO		41. 00
42.00	held by the cost report preparer in columns 1, 2, and 3, respectively.	COMMUNITY LIEATT	LCVCTEME			42.00
42. 00	preparer.	COMMUNITY HEALTH	1 SYSTEMS	MI CTORLA DOMAN	VOCCUE NET	42.00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 925-4333		VI CTORI A_ROMANI	VU∉CHS. NE I	43.00

Heal th	Financial Systems ST JOSEPH	MEDI	CAL CENTER	?		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi de	r CCN: 15		Period: From 06/01/2018	Worksheet S-2	
							Date/Time Pre 10/30/2019 3:	pared: 37 pm
	· · · · · · · · · · · · · · · · · · ·		·					
				3.00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	- 1	IANGER, REV	'ENUE MANA	AGEMENT			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							42. 00
	preparer.							
43.00	Enter the telephone number and email address of the cost							43. 00
	report preparer in columns 1 and 2, respectively.							

| Peri od: | Worksheet S-3 | From 06/01/2018 | Part | To 05/31/2019 | Date/Time Prepared: Health Financial Systems ST JOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0047

Component						1	o 05/31/2019	Date/Time Pre 10/30/2019 3:	
Component Worksheet A No. of Beds Bed Days Available CAH Hours Title V									
Component									
Line Number		Component	Worksheet A	No.	of Beds	Bed Davs			
1.00			Line Number			, ,			
8 exclude Swing Bed, Observation Bed and Hospice days) (Soe instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 JPF Subprovider 4.00 HM0 JPF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed SNF 7.00 Total Adults & Peds. Swing Bed NF 7.00 Total Adults & Area Swing Bed NF 8.00 Hispital Adults & Peds. Swing Bed NF 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 SWING LAIL INTENSIVE CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 10.10 CAH VISITS 10.00 SUBPROVIDER - IPF 10.00 SUBPROVIDER - IFF 10.00 SUBPROVIDER - IFF 10.00 SUBPROVIDER - IFF 10.00 SUBPROVIDER - IFF 10.00 SUBPROVIDER - IRF 10.00 SWINSING FACILITY 10.00 OTHER LONG TERM CARE 10.00 OWN LEATH CARE CONTROLLED CONTR					2.00		4. 00	5. 00	
Hospice days) (see instructions for col. 2 2 00	1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		76	34, 105	0.00	0	1. 00
For the portion of LDP room available beds		8 exclude Swing Bed, Observation Bed and							
2.00 HMO and other (see instructions) 2.00 4.00 6.00		1 3 / 1							
3.00									
4.00									
5.00 Hospi tal Adult ts & Peds. Swing Bed SNF 0 6.00 0 7.00 0 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00		•							
6.00 Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) Notes of the peds o								_	
Total Adults and Peds (exclude observation beds) (see instructions) Total Adults and Peds (exclude observation beds) (see instructions) Total (sum of instructions		·						-	1
beds) (see instructions) 8.00 1NTENSIVE CARE UNIT 9.00 10.00					=.				1
8.00	7.00				/6	34, 105	0.00	0	7.00
9.00 CORONARY CARE UNIT	0.00								0.00
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 14.00 Total (see instructions) 88 38,485 0.00 0 14.00 15.00 CAH visits 0 15.00 16.00 SUBPROVIDER - IPF 40.00 19 6,935 0 16.00 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 18.00 19.00 SKILLED NURSING FACILITY 44.00 20 7,300 0 19.00 NURSING FACILITY 44.00 20 7,300 0 19.00 NURSING FACILITY 20.00 10.00 HOME HEALTH AGENCY 22.00 10.00 HOME HEALTH AGENCY 23.00 24.00 HOSPICE (non-distinct part) 30.00 25.00 CMHC - CMHC 24.10 26.00 RURAL HEALTH CLINIC 26.00 26.00 RURAL HEALTH CLINIC 26.00 27.00 Total (sum of lines 14-26) 27.00 28.00 Ambul ance Trips 30.00 29.00 Ambul ance Trips 30.00 20.00 Cate of the country of the countr									
11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 14. 00 15. 00 CAH visits 0. 15. 00 0. 14. 00 15. 00 0. 17. 00 0. 18. 00 0. 19. 00			22.00		10	4 200	0.00		
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 40. 00 SUBPROVIDER - IRF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 SKILLED NURSING FACILITY 20. 00 ONESING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 05 FEDERALLY OUALIFIED HEALTH CENTER 27. 00 ODServation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room 12. 00 OD 14. 00 OD 13. 00 OD 14. 00 OD 0D			33.00		12	4, 380	0.00	U	1
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14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 19. 00 SKI LLED NURSI NG FACILITY 19. 00 SKI LLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 CMBCAL CENTER (D. P.) 26. 00 CMBCAL CENTER (D. P.) 27. 00 Total (sum of lines 14-26) 28. 00 Observati on Bed Days 29. 00 Ambul ance Tri ps 30. 00 Empl oyee discount days (see instruction) 31. 00 Empl oyee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room 30. 00 Total (sum of lines) & delivery room 30. 00 Total ancillary labor & delivery room									
15. 00 CAH visits CAH vis					00	20 405	0.00	0	
16. 00 SUBPROVI DER - I PF 40. 00 19 6, 935 0 16. 00 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 18. 00 SKILLED NURSI NG FACILITY 44. 00 20 7, 300 0 19. 00 19. 00 20. 00					00	30, 400	0.00		
17. 00 SUBPROVI DER - IRF 18. 00 18. 00 19. 00		i i	40.00		10	6 935		_	1
18.00 SUBPROVI DER 18.00 19.00 SKI LLED NURSI NG FACILITY 44.00 20 7,300 0 19.00 20.00 NURSI NG FACILITY 44.00 20 7,300 0 19.00 20.00 20.00 0 0 0 0 0 0 0 0 0		i i	10.00		. ,	0, 700			1
19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 44.00 HOSPICE 44.00 HOSPICE 44.00 CMHC - CMHC 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 27.00 Observation Bed Days 29.00 Ambul ance Tri ps 29.00 Ambul ance Tri ps 29.00 Labor & delivery days (see instruction) 31.00 Empl oyee di scount days (see instructions) 32.00 Total ancillary labor & delivery room 32.01 Total ancillary labor & delivery room 44.00 20 7,300 20 7,300 20 7,300 20 7,300 20 7,300 20 7,300 21 0.00 21.00 22.00 23.00 24.00 25.00 26.05 27.00 28.00 29.00 2		i i							
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23.00 AMBULATORY SURGICAL CENTER (D. P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 27.00 Observation Bed Days 29.00 Ambul ance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room 23.00 24.00 24.00 24.00 25.00 26.25 27.00 28.00 29.00 29.00 30.00 Employee discount days (see instruction) 31.00 Total ancillary labor & delivery room 23.00 24.00 24.00 24.00 25.00 26.25 27.00 26.25 27.00 26.25 27.00 27.00 28.00 29.00 29.00 29.00 30.00 Total ancillary labor & delivery room	21.00	OTHER LONG TERM CARE							21. 00
24.00 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 PERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room 24.00 24.10 25.00 26.00 26.25 27.00 26.00 26.25 27.00 26.25 27.00 27.00 28.00 29.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00	22.00	HOME HEALTH AGENCY							22. 00
24. 10 HOSPICE (non-distinct part) 30.00 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27. 00 Observation Bed Days 29. 00 Ambul ance Tri ps 30.00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room 30. 00 24. 10 25. 00 26. 00 26. 25 27. 00 26. 25 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 30. 00 31. 00 32. 00 32. 01	23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
25. 00 CMHC - CMHC 25. 00 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 27. 00 Total (sum of lines 14-26) 27. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 30. 00 31. 00 Employee discount days - IRF 31. 00 32. 00 Labor & delivery days (see instructions) 32. 00 32. 01 Total ancillary labor & delivery room 32. 01	24.00	HOSPI CE							
26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room 32. 01	24. 10	HOSPICE (non-distinct part)	30. 00						
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 26. 25 27.00 Total (sum of lines 14-26) 27.00 Observation Bed Days 0 28.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01		· ·							
27.00 Total (sum of lines 14-26) 27.00 28.00 Observation Bed Days 0 28.00 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 0 0 0 32.00 32.01 Total ancillary labor & delivery room 32.01		l e							
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 0 28.00 29.00 30.00 30.00 31.00 32.00 32.01			89. 00					0	
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room 29.00 30.00 30.00 30.00 31.00 32.00		· ·			127				
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01		,						0	
31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) 0 0 0 32.01 Total ancillary labor & delivery room 32.01		·							
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room 32.01									
32.01 Total ancillary labor & delivery room 32.01						_			
					O				1
outpatient days (see instructions)	32.01								32.01
33.00 LTCH non-covered days 33.00	33 00								33 00
33. 01 LTCH si te neutral days and discharges 33. 01		,							

Health Financial Systems ST JOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0047

				1	0 05/31/2019	10/30/2019 3:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	O7 piii
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 754	832	14, 272			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)	2, 432	6, 355				2.00
3. 00	HMO IPF Subprovider	1, 699	0, 333				3.00
4. 00	HMO IRF Subprovider	1,077	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF		0				5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	١	0				6.00
7. 00	Total Adults and Peds. (exclude observation	2, 754	832				7. 00
	beds) (see instructions)	_,		,			
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT	458	137	2, 524			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	3, 212	969		0. 50	402. 96	
15. 00	CAH visits	0	0		0.00	0, 05	15.00
16.00	SUBPROVIDER - I PF	2, 882	544	5, 300	0.00	26. 85	•
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER						17. 00 18. 00
19.00	SKILLED NURSING FACILITY	1, 695	279	4, 623	0.00	14. 48	
20. 00	NURSING FACILITY	1,093	217	4,023	0.00	14.40	20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			19			24. 10
25.00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)				0. 50	444. 29	1
28. 00	Observation Bed Days		0	1, 635			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			51			30.00
31.00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	0	0				32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			l "			32. 01
33. 00	LTCH non-covered days						33. 00
	LTCH site neutral days and discharges						33. 00
		١		ı	ı	1	

| Period: | Worksheet S-3 | From 06/01/2018 | Part | To 05/31/2019 | Date/Time Prepared: Provider CCN: 15-0047

				To	05/31/2019	Date/Time Prep 10/30/2019 3:	
		Full Time		Di scha	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	645	1, 694	3, 901	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			4.40			0.00
2.00	HMO and other (see instructions)			442	U		2.00
3.00	HMO I PF Subprovi der				U		3.00
4.00	HMO I RF Subprovi der				U		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	645	1, 694	3, 901	14. 00
15. 00	CAH visits	0.00	0	043	1, 074	3, 701	15. 00
16. 00	SUBPROVI DER - I PF	0. 00	0	224	112	415	16. 00
17. 00	SUBPROVI DER - I RF	0.00	O		112	110	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20. 00	NURSING FACILITY	0.00					20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						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)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	,			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 06/01/2018 | Part II | To 05/31/2019 | Date/Time Prepared: |

					'	o 05/31/2019	Date/lime Pre 10/30/2019 3:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3.00	3) 4.00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA							
1.00	SALARIES Total salaries (see	200. 00	28, 460, 672	0	28, 460, 672	924, 125. 00	30. 80	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	C	0.00	0. 00	2. 00
3.00	A Non-physician anesthetist Part		0	0	C	0.00	0. 00	3. 00
4. 00	B Physician-Part A -		0	0	C	0.00	0. 00	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	l c	0.00	0.00	4. 01
5.00	Physician and Non Physician-Part B		0	0	C	0.00	l .	1
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	С	0.00	0.00	6. 00
7.00	Interns & residents (in an	21. 00	0	О	С	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	C	0.00	0.00	7. 01
8.00	programs) Home office and/or related		0	0	С	0.00	0. 00	8. 00
9.00	organization personnel	44. 00	1, 071, 481		.,,			
10. 00	Excluded area salaries (see instructions)		1, 542, 117	0	1, 542, 117	55, 847. 00	27. 61	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		842, 173	0	842, 173	11, 336. 00	74. 29	11. 00
12. 00	Care Contract Labor: Top Level		0	0	C	0.00	0. 00	12. 00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		2, 087, 330	0	2, 087, 330	31, 485. 00	66. 30	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	С	0.00	0.00	14. 00
14. 01	Home office salaries		2, 746, 691	0	2, 746, 691			14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0		0. 00 0. 00		14. 02 15. 00
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	C	0.00	0. 00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		5, 544, 744	0	5, 544, 744	I	I	17. 00
	instructions)							
18. 00	Wage-related costs (other) (see instructions)		0					18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		580, 614 0	0				19. 00 20. 00
21. 00	Non-physician anesthetist Part		0	0	C			21. 00
22. 00	B Physician Part A -		0	0	C			22. 00
22. 01	Administrative Physician Part A - Teaching		0		1)		22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0		· ·			23. 00 24. 00
25. 00	Interns & residents (in an		0	1				25. 00
25. 50	approved program) Home office wage-related		509, 004	0	509, 004			25. 50
25. 51	(core) Related organization		0	0	C			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	0	C			25. 52
25. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	C			25. 53
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	ES 4. 00	284, 206	l 0	284, 206	8, 098. 00	35. 10	26. 00
27. 00	1 . ,	4. 00 5. 00						27. 00

| Peri od: | Worksheet S-3 | From 06/01/2018 | Part II | To 05/31/2019 | Date/Time Prepared: |

							10/30/2019 3:	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0. 00	0. 00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00		0	1, 064, 243	45, 734. 00	23. 27	30. 00
31.00	Laundry & Linen Service	8. 00	1, 114	0	1, 114	56. 00	19. 89	31.00
32.00	Housekeepi ng	9. 00	628, 059	0	628, 059	43, 882. 00	14. 31	32.00
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	0	0	0	0. 00	0.00	34.00
35.00	Dietary under contract (see		724, 896	0	724, 896	38, 566. 00	18. 80	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	0	0	0. 00	0.00	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	1, 662, 335	210, 113	1, 872, 448	44, 086. 00	42. 47	38. 00
39.00	Central Services and Supply	14. 00	222, 127	0	222, 127	9, 907. 00	22. 42	39. 00
40.00	Pharmacy	15. 00	1, 437, 960	0	1, 437, 960	30, 590. 00	47. 01	40.00
41.00	Medical Records & Medical	16. 00	138, 109	0	138, 109	6, 945. 00	19. 89	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	789, 392	0	789, 392	21, 981. 00	35. 91	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

					'	0 03/31/2019	10/30/2019 3:	
		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	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		29, 185, 568	0	29, 185, 568	962, 691. 00	30. 32	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 613, 598	0	2, 613, 598	85, 965. 00	30. 40	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		26, 571, 970	0	26, 571, 970	876, 726. 00	30. 31	3.00
	minus line 2)							
4.00	Subtotal other wages & related		5, 676, 194	0	5, 676, 194	131, 361. 00	43. 21	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		6, 053, 748	0	6, 053, 748	0.00	22. 78	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		38, 301, 912	0	38, 301, 912	1, 008, 087. 00	37. 99	6.00
7.00	Total overhead cost (see		10, 455, 448	0	10, 455, 448	369, 019. 00	28. 33	7.00
	instructions)							

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0047	Peri od: Worksheet S-3
		From 06/01/2018 Part IV
		T 0E (04 (0040 D 1 /T) D 1

	To 05/31/2019	Date/Time Prep 10/30/2019 3:3	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	576, 894	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	ol	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	ol	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	o	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	o	6. 00
7.00	Employee Managed Care Program Administration Fees	o	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	ol	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	3, 040, 892	8. 02
8. 03	Heal th Insurance (Purchased)	0	1
9. 00	Prescription Drug Plan	o l	9. 00
10.00	Dental, Hearing and Vision Plan	14, 886	1
	Life Insurance (If employee is owner or beneficiary)	20, 602	
	Accident Insurance (If employee is owner or beneficiary)	447	1
	Disability Insurance (If employee is owner or beneficiary)	6, 467	13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00		367, 065	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	007,000	
	Non cumulative portion)	آ	
	TAXES		1
17. 00	FICA-Employers Portion Only	1, 641, 761	17. 00
	Medicare Taxes - Employers Portion Only	383, 960	
	Unemployment Insurance	0	19.00
	State or Federal Unemployment Taxes	72, 385	
	OTHER	,	
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
200	instructions))	آ	
22. 00	Day Care Cost and Allowances	ol	22. 00
23. 00	Tuition Reimbursement	ol	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	6, 125, 359	24. 00
·	Part B - Other than Core Related Cost	., ., .,	
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
	\(\frac{1}{2} \)	۳۱	

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-			
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0047	From 06/01/2018 Part To 05/31/2019 Date			

		0 05/31/2019	10/30/2019 3:3	
	Cost Center Description	Contract Labor		
		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	842, 173	6, 125, 359	1.00
2.00	Hospi tal	842, 173	6, 125, 359	2.00
3.00	Subprovi der - I PF	0	0	3.00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (0ther)	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 Dialysis	0	0	17.00
18. 00	Other	0	0	18. 00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Health Financial Systems ST JOSEPH I	MEDICAL CENTER		In Li	eu of Form CMS-	2552-10
From 0x/07/12018 Date/Time Prepared: 10.06/31/2019 Date/Time Prepared: 10.06/31/2019 SWIng Bed SWF Col. 2 ± 3) Date/Time Prepared: 10.07/2019 SWIng Bed SWF Col. 2 ± 3) Date/Time Prepared: 10.07/2019 SWIng Bed SWF Col. 2 ± 3) Date/Time Prepared: 10.07/2019 Date/Time Prepa			CN: 15-0047			
10/30/2019 3: 37 pm	THOSE ESTITE THINE IT TON ON OTHER TONE BITT					
Group SNF Days Suing Bed SNF Total (sum of books Col. 2 + 3)				To 05/31/2019		
1.00						37 pm
1.00		Group	SNF Days			
PE2		4.00				
20.00 PE1	10.00		2.00			10.00
PD2		•		-		
PD1		•				
20.00 20.0		•			1	
PC1		•		-	1	
PB2				-		
PB1				-		
PA2		•		-		
PA1		•		-	1	1
AAA				-	1	1
200.00 TOTAL 1,695			1			
CBSA at Beginning of October 1 of Cotober 1		AAA	1			
Beginning of Cost Reporting Period	200. 00 TOTAL		1, 6			200. 00
SNF SERVICES 1.00 2.00						
SNF SERVICES 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). Expenses A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "I" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 Staffing 0 0.00 203.00 Recruitment 0 0.00 204.00 Retention of employees 0 0.00 205.00 Training 0 0.00 206.00 OTHER (SPECIFY)						
SNF SERVICES 1.00 2.00 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). Expenses Percentage Associated with Direct Patient Care and Related Expenses? 1.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00						
SNF SERVICES 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). Expenses Percentage Associated with Direct Patient Care and Related Expenses? 1.00 2.00 3.00 A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2, the code with direct patient care and related expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 Staffing 202.00 Staffing 0 0.00 203.00 204.00 Retention of employees 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00 207.00				Perrod	'	
SNF SERVICES 201. 00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). Expenses Percentage Associated with Direct Patient Care and Related Expenses? 1.00 2.00 3.00 A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202. 00 Staffing 203. 00 Recruit ment 0 0.00 204. 00 205. 00 Training 0 0.00 206. 00 206. 00 206. 00 207. 00 208. 00 208. 00 208. 00 208. 00 209. 00 200. 00						
SNF SERVICES 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). Expenses Percentage Associated with Direct Patient Care and Related Expenses? 1.00 2.00 3.00 A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 Staffing 0 0.00 203.00 Recruit ment 0 0.00 204.00 205.00 Training 0 0.00 206.00 206.00 OTHER (SPECIFY)				1 00		
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in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). Expenses		RSA code if a rur	al facility	23060	23060	201 00
in effect on or after October 1 of the cost reporting period (if applicable). Expenses				20000	20000	201.00
Expenses Percentage Associated with Direct Patient Care and Related Expenses? A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202. 00 Staffing 202. 00 Staffing 0 0.00 203. 00 204. 00 Recruitment 0 0.00 205. 00 Training 0 0.00 206. 00 0 0.00 206. 00 0 0.00 206. 00 0 0.00 206. 00						
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A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202. 00 Staffing 0 0.00 202. 00 203. 00 Recruit ment 0 0.00 204. 00 Retention of employees 0 0.00 205. 00 7 Trai ning 0 0.00 205. 00 206. 00 7 Trai ning 0 0.00 206. 00						
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202. 00 Staffing 202. 00 Recruitment 204. 00 Retention of employees 0 0.00 205. 00 206. 00 OTHER (SPECIFY) 0 0.00 206. 00					Patient Care	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202. 00 Staffing 202. 00 Recruitment 0 0.00 203. 00 204. 00 Retention of employees 0 0.00 205. 00 7 Training 0 0.00 205. 00 206. 00 7 Training 0 0.00 206. 00					and Related	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 Staffing 202.00 Recruitment 0 0.00 203.00 Retention of employees 0 0.00 204.00 205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY)					Expenses?	
payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 Staffing 202.00 Recruitment 0 0.00 203.00 Retention of employees 0 0.00 204.00 205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY)						
expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 Staffing 0 0.00 202.00 203.00 Recruitment 0 0.00 203.00 204.00 Retention of employees 0 0.00 204.00 205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00	A notice published in the Federal Register Volume 68, No	. 149 August 4, 2	003 provi ded	for an increase	in the RUG	
column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 Staffing 0 0.00 202.00 203.00 Recruitment 0 0.00 203.00 204.00 Retention of employees 0 0.00 204.00 205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00						
line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions) 202.00 Staffing 203.00 Recruitment 0 0.00 203.00 204.00 Retention of employees 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00						
with direct patient care and related expenses for each category. (see instructions) 0 0.00 202.00 203.00 Recruitment 0 0.00 203.00 204.00 Retention of employees 0 0.00 204.00 205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00						
202. 00 Staffing 0 0.00 202. 00 203. 00 Recruitment 0 0.00 203. 00 204. 00 Retention of employees 0 0.00 204. 00 205. 00 Training 0 0.00 205. 00 206. 00 OTHER (SPECIFY) 0 0.00 206. 00				s increases ass	oci ated	
203. 00 Recruitment 0 0.00 203. 00 204. 00 Retention of employees 0 0.00 204. 00 205. 00 Training 0 0.00 205. 00 206. 00 OTHER (SPECIFY) 0 0.00 206. 00		ategory. (see ins	tructions)		.1	
204. 00 Retention of employees 0 0.00 204. 00 205. 00 Training 0 0.00 205. 00 206. 00 OTHER (SPECIFY) 0 0.00 206. 00					1	
205. 00 Trai ni ng 0 0. 00 205. 00 206. 00 0THER (SPECIFY) 0 0. 00 206. 00						
206. 00 OTHER (ŠPECI FY) 0 0. 00 206. 00	1 3					
			1			
-207 OULIOTAL SNE revenue (Worksheet G-2 Part I line 7 column 3) 1 3 878 4251 1 1207 00		0)			7	
257.55[1514] 518.145 (1.617.61.65) 5 27.141.17 (1.617.61.65)	207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column	3)	3, 878, 42	25		207. 00

105PI	TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 15-0047	Peri od:	Worksheet S-10	0
			From 06/01/2018 To 05/31/2019	Date/Time Pre	narod
			10 03/31/2017	10/30/2019 3:	
				1. 00	
	Uncompensated and indigent care cost computation				
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid Medicaid (see instructions for each line)	led by line 202 colu	mn 8)	0. 187854	1. (
. 00	Net revenue from Medicaid			18, 411, 787	2. (
. 00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3. (
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental	payments from Medi	cai d?	N	4. (
. 00	If line 4 is no, then enter DSH and/or supplemental payments from		1, 501, 923	1	
. 00 . 00	Medicaid charges	118, 989, 238			
. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (li	22, 352, 604 2, 438, 894			
. 00	<pre>< zero then enter zero)</pre>	TIC 7 III TIGS Sain Of T	THOS Z and G, TT	2, 100, 071	0. (
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			
. 00	Net revenue from stand-alone CHIP			0	
0. 00 1. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)			0	1
2. 00	Difference between net revenue and costs for stand-alone CHIP (li	ne 11 minus line 9.	if < zero then	0	1
2. 00	enter zero)	TIC TT IIITIGS TTTIC 7,	TT \ Zero then	G	
	Other state or local government indigent care program (see instru				
3. 00	Net revenue from state or local indigent care program (Not includ			86, 416	
4. 00	Charges for patients covered under state or local indigent care p 10)	rogram (Not include	a in lines 6 or	1, 737, 479	14.
5. 00	State or local indigent care program cost (line 1 times line 14)			326, 392	15.
6. 00	Difference between net revenue and costs for state or local indig	ent care program (I	ine 15 minus line	239, 976	16.
	13; if < zero then enter zero)	: : : : : : : : :		- (
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and State/Tocal Ind	igent care program	is (see	
7. 00	1 9 1			_	17.
8. 00 9. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i		mc (cum of lines	0 2, 678, 870	
7. 00	8, 12 and 16)	ndigent care progra	ilis (suil of fiftes	2,070,070	17.0
		Uni nsured		Total (col. 1	
		patients		+ col . 2)	
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3. 00	
0. 00	Charity care charges and uninsured discounts for the entire facil	i ty 12, 083,	588 0	12, 083, 588	20. (
1 00	(see instructions)	2 2/0	050	2 2/0 050	21.
1. 00	Cost of patients approved for charity care and uninsured discount instructions)	s (see 2, 269,	950 0	2, 269, 950	21.0
2. 00	Payments received from patients for amounts previously written of	f as	0 0	0	22. (
	charity care				
3. 00	Cost of charity care (line 21 minus line 22)	2, 269,	950 0	2, 269, 950	23. (
				1. 00	
4. 00	Does the amount on line 20 column 2, include charges for patient		h of stay limit	N	24. (
5. 00	imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the		am's length of	0	25. (
5. 00	stay limit Total bad debt expense for the entire hospital complex (see instr	ructions)		12, 273, 585	26. (
7. 00	Medicare reimbursable bad debts for the entire hospital complex (see Insti	,		12, 273, 585 275, 749	
7. 01	Medicare allowable bad debts for the entire hospital complex (see	· · · · · · · · · · · · · · · · · · ·		424, 230	1
8. 00	Non-Medicare bad debt expense (see instructions)	ŕ		11, 849, 355	28. 0
	Cost of non-Medicare and non-reimbursable Medicare bad debt expen	se (see instruction	s)	2, 374, 430	
9. 00	la l				
0. 00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line	20)		4, 644, 380 7, 323, 250	

Heal th	Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der Co		eri od:	Worksheet A	
					rom 06/01/2018		
					o 05/31/2019		
				I = 1 1 1 1 1	5 1 16 11	10/30/2019 3:	3/ pm
	Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		2, 027, 679				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		3, 284, 181	3, 284, 181	750, 759	4, 034, 940	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	284, 206	107, 640	391, 846	4, 090, 166	4, 482, 012	4. 00
5. 01	00590 REVENUE CYCLE	1, 775, 452	4, 083, 791	5, 859, 243	-231, 715	5, 627, 528	5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	56, 393	165, 034	221, 427	0	221, 427	5. 02
5.03	00591 ADMINISTRATIVE AND GENERAL	1, 671, 162	20, 576, 791	22, 247, 953	-5, 371, 542	16, 876, 411	5. 03
7.00	00700 OPERATION OF PLANT	1, 064, 243	2, 743, 235			4, 745, 775	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 114	323, 215			324, 329	8. 00
9. 00	00900 HOUSEKEEPI NG	628, 059	278, 894	1		908, 781	9. 00
10.00	01000 DI ETARY	020,007	1, 937, 842			988, 250	
11. 00	01100 CAFETERI A		1, 737, 042		948, 382	948, 382	
	01300 NURSI NG ADMI NI STRATI ON	1 ((2 225	-	1			
13.00		1, 662, 335	332, 529				
14.00	01400 CENTRAL SERVI CES & SUPPLY	222, 127	4, 156, 011	1		615, 282	14.00
15. 00	01500 PHARMACY	1, 437, 960	3, 109, 883			1, 570, 720	
16. 00	01600 MEDICAL RECORDS & LIBRARY	138, 109	398, 667			536, 776	16. 00
17. 00	01700 SOCI AL SERVI CE	789, 392	69, 123	858, 515	0	858, 515	17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	468, 734	468, 734	0	468, 734	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 383, 725	3, 347, 901	9, 731, 626	-3, 064, 854	6, 666, 772	30.00
33.00	03300 BURN INTENSIVE CARE UNIT	O	0	0	3, 061, 443	3, 061, 443	33.00
40.00	04000 SUBPROVI DER - I PF	1, 542, 117	685, 598	2, 227, 715	0	2, 227, 715	40. 00
44.00	04400 SKILLED NURSING FACILITY	1, 071, 481	163, 558	1		1, 235, 030	
	ANCILLARY SERVICE COST CENTERS	., ., ., .,		1, 200, 001	-	.,	
50.00	05000 OPERATI NG ROOM	708, 457	1, 336, 790	2, 045, 247	185, 846	2, 231, 093	50. 00
51. 00	05100 RECOVERY ROOM	246, 216	17, 496			263, 712	
53. 00	05300 ANESTHESI OLOGY	0	1, 284, 254			1, 284, 254	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 051, 553	840, 181			2, 310, 864	
54. 01	03630 ULTRA SOUND	322, 750	70, 808			2, 010, 001	54. 01
56. 00	05600 RADI OI SOTOPE	90, 780	132, 376				56. 00
57. 00	05700 CT SCAN	208, 592	146, 096			0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	200, 372	140, 090	1	1, 750, 685	1, 750, 685	
	06000 LABORATORY	1 041 220	-	1			
60.00	1 1	1, 841, 228	1, 303, 674	3, 144, 902	-310, 086	2, 834, 816	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	504 000	400.000	700 001	156, 911	156, 911	
65.00	06500 RESPI RATORY THERAPY	591, 898	129, 008			713, 071	
66. 00	06600 PHYSI CAL THERAPY	396, 030	35, 425			431, 349	
67. 00	06700 OCCUPATI ONAL THERAPY	303, 978	24, 450			328, 428	
68. 00	06800 SPEECH PATHOLOGY	37, 834	4, 606			42, 440	
69. 00	06900 ELECTROCARDI OLOGY	992, 142	1, 207, 297	2, 199, 439		98, 360	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	636, 114	636, 114	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	2, 837, 664	2, 837, 664	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	2, 700, 722	2, 700, 722	73. 00
74.00	07400 RENAL DIALYSIS	0	262, 854	262, 854	0	262, 854	74.00
76.00	03950 MISC ANCILLARY	O	0	0	0	0	76. 00
76. 01	03951 SLEEP LAB	O	0	0	0	0	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	393, 279	-62, 959	330, 320	-159	330, 161	76. 02
	03952 WOUND CARE	657, 094	309, 635			965, 069	76. 03
	OUTPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,			,		
90.00	09000 CLINIC	18, 275	1, 542	19, 817	0	19, 817	90.00
91. 00	09100 EMERGENCY	1, 872, 691	1, 383, 333			3, 255, 326	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,072,071	1, 303, 333	3, 230, 024	-070	3, 233, 320	92.00
92.00	SPECIAL PURPOSE COST CENTERS						72.00
110 00		20 4/0 /72	F/ /07 170	OF 147 044	2.750	05 150 504	110 00
118.00		28, 460, 672	56, 687, 172	85, 147, 844	2, 750	85, 150, 594	1 1 8. UU
100 00	NONREI MBURSABLE COST CENTERS	اء					100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57	1			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 750	2, 750	· _		192. 00
	07950 MEALS ON WHEELS	0 110 175	0	0 452 453	0		194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	28, 460, 672	56, 689, 979	85, 150, 651	0	85, 150, 651	₁ 200. 00

Peri od: From 06/01/2018 To 05/31/2019

Date/Time Prepared: 10/30/2019 3:37 pm

				10/30/2019 3:	3/ pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 766, 495	4, 866, 017		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-216, 523	3, 818, 417	'	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 662	4, 478, 350		4. 00
5. 01	00590 REVENUE CYCLE	-90, 528	5, 537, 000		5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	0	221, 427		5. 02
5. 03	00591 ADMINISTRATIVE AND GENERAL	-2, 617, 537	14, 258, 874		5. 03
7. 00	00700 OPERATION OF PLANT	-35, 801	4, 709, 974		7. 00
	00800 LAUNDRY & LINEN SERVICE	1			8.00
8.00		-6, 347	317, 982		
9.00	00900 HOUSEKEEPI NG	0	908, 781		9.00
10.00	01000 DI ETARY	0	988, 250	l e e e e e e e e e e e e e e e e e e e	10.00
11. 00	01100 CAFETERI A	-2, 931	945, 451		11. 00
13. 00	01300 NURSING ADMINISTRATION	0	2, 198, 540		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	615, 282		14. 00
15.00	01500 PHARMACY	0	1, 570, 720		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-5	536, 771		16. 00
17. 00	01700 SOCIAL SERVICE	0	858, 515		17. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	468, 734		22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS		100/701		1 22.00
30. 00	03000 ADULTS & PEDIATRICS	-1, 332, 307	5, 334, 465		30.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	3, 061, 443	·	33.00
		-		•	1
40. 00	04000 SUBPROVI DER - I PF	-509, 220	1, 718, 495	•	40.00
44. 00	04400 SKILLED NURSING FACILITY	0	1, 235, 030)	44. 00
	ANCILLARY SERVICE COST CENTERS				4
50. 00	05000 OPERATI NG ROOM	-807, 864	1, 423, 229	l control of the cont	50.00
51. 00	05100 RECOVERY ROOM	0	263, 712		51. 00
53.00	05300 ANESTHESI OLOGY	0	1, 284, 254		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-1, 139	2, 309, 725		54.00
54. 01	03630 ULTRA SOUND	0	0		54. 01
56.00	05600 RADI OI SOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	1, 750, 685		59.00
60.00	06000 LABORATORY	-800	2, 834, 016		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	156, 911		62.00
65. 00	06500 RESPIRATORY THERAPY	0			65. 00
			713, 071		
66. 00	06600 PHYSI CAL THERAPY	0	431, 349		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	328, 428		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	42, 440		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-35, 454	62, 906		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	636, 114		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 837, 664		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2, 700, 722		73. 00
74.00	07400 RENAL DI ALYSI S	0	262, 854		74. 00
76.00	03950 MISC ANCILLARY	0	0		76. 00
76. 01	03951 SLEEP LAB	0	0		76. 01
76. 02	1 1	0	330, 161		76. 02
76. 03	03952 WOUND CARE	-5, 000	960, 069	•	76. 03
70.03	OUTPATIENT SERVICE COST CENTERS	-3,000	700,007		70.03
00.00		0	10 017	·I	1 00 00
	09000 CLINIC	-	,		90.00
	09100 EMERGENCY	-400, 938	2, 854, 388		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	SPECIAL PURPOSE COST CENTERS				
118.00		-4, 299, 561	80, 851, 033		118. 00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
	07950 MEALS ON WHEELS	0	0	l .	194. 00
200.00		-4, 299, 561	80, 851, 090		200.00
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	., 2,,,, 501		1	,

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0047 Peri od: Worksheet A-6 From 06/01/2018 To 05/31/2019 Date/Time Prepared:

					10 05/31/2019	Date/lime Prepared: 10/30/2019 3:37 pm
	Cost Center	Increases Line #	Sal ary	Other		
	2. 00	3.00	4. 00	5. 00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 090, 572		1.00
2.00			0	<u>0</u> 4, 090, 572		2. 00
	C - LEASE AND RENTAL		U	4, 090, 572		
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	741, 093		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	28, 502		2. 00
3. 00		0. 00	0	0		3. 00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6.00		0.00	o	0		6. 00
7. 00		0.00	Ö	0		7. 00
8. 00		0. 00	o	0		8. 00
9.00		0.00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10.00
12. 00		0.00	o	0		12.00
13. 00		0.00	Ö	0		13. 00
14. 00		0.00	0	0		14. 00
	0		0	769, 595		
1. 00	D - OTHER CAPITAL COSTS CAP REL COSTS-BLDG & FIXT	1.00	ol	148, 571		1.00
2. 00	CAP REL COSTS-BLDG & FIXT	1.00	o	894, 770		2.00
3. 00	CAP REL COSTS-MVBLE EQUIP	2.00	Ö	9, 666		3. 00
	0			1, 053, 007		
	E - REPAIRS & MAINTENANCE	- aal	ام	201 201		
1. 00 2. 00	OPERATION OF PLANT	7. 00 0. 00	0	926, 804 0		1.00
3.00		0.00	ol	0		3.00
4. 00		0.00	o	ő		4. 00
5.00		0.00	o	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0. 00 0. 00	0	0		7.00
8. 00 9. 00		0.00	o	0		8. 00 9. 00
10. 00		0.00	o	ő		10.00
11.00		0.00	О	0		11. 00
12.00		0. 00	0	0		12. 00
13.00		0.00	0	0		13. 00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	Ö	ő		16. 00
17.00		0.00	О	0		17. 00
18. 00		0.00	0	0		18. 00
19.00		0.00	0	0		19.00
20. 00	TOTALS — — — —	0.00		0 926, 804		20. 00
	F - CNO			720, 004		
1.00	NURSING ADMINISTRATION	13.00	210, 113	<u>0</u>		1.00
	0		210, 113	0		
1 00	G - MEDI CAL SUPPLIES	71 00	ما	(2/ 114		1 00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	636, 114		1.00
2.00	IMPL. DEV. CHARGED TO	72.00	o	2, 837, 664		2. 00
	PATI ENTS					
3. 00	OPERATING ROOM	50.00	0	<u>214, 006</u>		3. 00
	H - DRUGS AND IV COSTS		0	3, 687, 784		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	ol	2, 700, 722		1.00
	0		o	2, 700, 722		
	J - RADI OLOGY					
1.00	RADI OLOGY-DI AGNOSTI C	54.00	622, 122	157, 636		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2.00
3.00			0 622, 122	<u></u> <u></u> <u>0</u> 157, 636		3.00
	K - DI ETARY		022/ 122/	107,000		
1.00	CAFETERI A	1100	0	948, 382		1. 00
	0		0	948, 382		
1 00	L - MISC DEPARTMENTS	22 00	1 005 024	1 155 500		1.00
1. 00 2. 00	BURN INTENSIVE CARE UNIT CARDIAC CATHETERIZATION	33. 00 59. 00	1, 905, 934 904, 390	1, 155, 509 846, 295		1.00
3.00	WHOLE BLOOD & PACKED RED	62. 00	904, 390	156, 911		3.00
			Ĭ			1.00
	BLOOD CELL		2, 810, 324	2, 158, 715		l l

Heal th Financial Systems

ST JOSEPH MEDICAL CENTER

In Lieu of Form CMS-2552-10

Provider CCN: 15-0047

Period: From 06/01/2018 To 05/31/2019 Date/Time Prepared: 10/30/2019 3: 37 pm

					10/30/2019 3	:3/ pm_
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		1
	2. 00	3. 00	4.00	5. 00		
	M - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7. 00	0	11, 923		1. 00
2.00	HOUSEKEEPI NG	9.00	0	2, 815		2. 00
3.00		0.00	0	0		3. 00
	0		0	14, 738		
500.00	Grand Total: Increases		3, 642, 559	16, 507, 955		500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0047 Peri od: Worksheet A-6 From 06/01/2018 To 05/31/2019 Date/Time Prepared:

					11	o 05/31/2019 Date/lime 10/30/2019	
		Decreases		•			
	Cost Center	Li ne #	Salary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
1. 00	A - EMPLOYEE BENEFITS ADMINISTRATIVE AND GENERAL	5. 03	0	4, 090, 463	0		1.00
2. 00	REVENUE CYCLE	5. 01	ő	109			2. 00
	0		— — 	4, 090, 572			
	C - LEASE AND RENTAL						
1.00	ADMINISTRATIVE AND GENERAL	5. 03	0	13, 687	10		1. 00
2.00	OPERATION OF PLANT	7.00	0	430			2.00
3. 00 4. 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	1, 210 1, 122	0		3. 00 4. 00
5. 00	PHARMACY	15. 00	0	276, 401	0		5. 00
6. 00	ADULTS & PEDIATRICS	30.00	o	1, 119	1		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	165, 422	0		7. 00
8.00	LABORATORY	60.00	0	109, 112	0		8. 00
9. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 02	0	159	0		9. 00
10. 00	SERVICES WOUND CARE	76. 03	0	333	0		10. 00
11. 00	REVENUE CYCLE	5. 01	0	3, 430			11.00
12. 00	CENTRAL SERVICES & SUPPLY	14. 00	O	195, 778			12. 00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	307	0		13. 00
14.00	OPERATI NG ROOM	<u>50.</u> 00	0	1, 085			14. 00
	O CARLED CARLED COSTS		0	769, 595			
1. 00	D - OTHER CAPITAL COSTS ADMINISTRATIVE AND GENERAL	5. 03	O	1, 053, 007	12		1.00
2. 00	ADMINISTRATIVE AND GENERAL	0.00	o	1, 053, 007	1		2. 00
3.00		0.00	o	0	12		3. 00
	0			1, 053, 007			
	E - REPAIRS & MAINTENANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	99			1.00
2. 00 3. 00	REVENUE CYCLE ADMINISTRATIVE AND GENERAL	5. 01 5. 03	0	221, 356 2, 082	0		2. 00 3. 00
4. 00	HOUSEKEEPI NG	9.00	0	987	0		4. 00
5. 00	NURSI NG ADMI NI STRATI ON	13. 00	ő	5, 315	o		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14.00	О	118, 563	0		6. 00
7.00	ADULTS & PEDIATRICS	30.00	0	2, 292			7. 00
8.00	SKILLED NURSING FACILITY	44.00	0	9	0		8. 00
9.00	OPERATING ROOM	50.00	0	27, 075			9.00
10. 00 11. 00	RADI OLOGY-DI AGNOSTI C ULTRA SOUND	54. 00 54. 01	0	189, 478 35, 772			10. 00 11. 00
12. 00	RADI OI SOTOPE	56.00	0	29, 872	0		12.00
13. 00	CT SCAN	57. 00	o	126, 000	o		13. 00
14.00	LABORATORY	60.00	O	44, 063	0		14. 00
15. 00	RESPI RATORY THERAPY	65. 00	0	7, 673			15. 00
16.00	PHYSI CAL THERAPY	66.00	0	106			16.00
17. 00 18. 00	ELECTROCARDI OLOGY WOUND CARE	69. 00 76. 03	0	111, 287 1, 327	0		17. 00 18. 00
19. 00	EMERGENCY	91.00	0	698			19.00
20. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	2, 750			20.00
	TOTALS			926, 804			
	F - CNO						
1. 00	ADMI NI STRATI VE AND GENERAL	<u>5.</u> 03	<u>210, 1</u> 13	0	9		1. 00
	G - MEDICAL SUPPLIES		210, 113	0			
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	3, 448, 515	0		1.00
2. 00	RESPIRATORY THERAPY	65. 00	o	162			2. 00
3.00	ELECTROCARDI OLOGY	69.00	0	239, 107	0		3. 00
	0		0	3, 687, 784			
	H - DRUGS AND IV COSTS	45.00	ما				
1. 00	PHARMACY			2, 700, 722 2, 700, 722			1. 00
	J - RADI OLOGY		<u> </u>	2, 100, 122			
1.00	ULTRA SOUND	54. 01	322, 750	35, 036	0		1.00
2.00	RADI OI SOTOPE	56.00	90, 780	102, 504			2. 00
3.00	CT_SCAN	5700	20 <u>8, 5</u> 92	20, 096	0		3. 00
	0		622, 122	157, 636			
4 00	K - DI ETARY	40.00	ما	0.40, 000			4.00
1. 00	DI ETARY	10.00		94 <u>8, 3</u> 82 948, 382			1. 00
	L - MISC DEPARTMENTS		J J	740, 302			
1.00	ADULTS & PEDIATRICS	30.00	1, 905, 934	1, 155, 509	0		1. 00
2.00	LABORATORY	60.00	0	156, 911	0		2. 00
3.00	ELECTROCARDI OLOGY	<u>69.</u> 00	904, 390	84 <u>6, 2</u> 95			3. 00
	0		2, 810, 324	2, 158, 715	l l		I

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

RECLASSIFICATIONS

Provider CCN: 15-0047
From 06/01/2018
To 05/31/2019
Date/Time Prepared:

						.0	00/01/201/	10/30/2019 3:	
		Decreases		<u> </u>					
	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	ADMINISTRATIVE AND GENERAL	5. 03	0	2, 190	(1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	5, 728	(2. 00
3.00	REVENUE CYCLE	5. 01	0	6, 820	(3. 00
	0		0	14, 738					
500.00	Grand Total: Decreases		3, 642, 559	16, 507, 955					500.00

				10	05/31/2019	10/30/2019 3:3	
				Acqui si ti ons		1070072017 0.	5. p
		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	0	1. 00
2.00	Land Improvements	1, 775, 835	0	0	0	0	2. 00
3.00	Buildings and Fixtures	28, 546, 021	13, 628	0	13, 628		3. 00
4.00	Building Improvements	30, 465, 532	1, 031, 831	0	1, 031, 831		4. 00
5.00	Fixed Equipment	18, 710, 278	27, 364	0	27, 364		5. 00
6.00	Movable Equipment	54, 148, 241	664, 337	0	664, 337	1, 125, 583	
7.00	HIT designated Assets	2, 833, 813	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	145, 827, 748	1, 737, 160	0	1, 737, 160	1, 133, 467	
9.00	Reconciling Items	0	0	0	0	0	9. 00
10. 00	Total (line 8 minus line 9)	145, 827, 748	1, 737, 160	0	1, 737, 160	1, 133, 467	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_1				
1.00	Land	9, 348, 028	0				1. 00
2.00	Land Improvements	1, 775, 835	0				2. 00
3.00	Buildings and Fixtures	28, 559, 649	0				3. 00
4.00	Building Improvements	31, 497, 363	0				4. 00
5.00	Fi xed Equi pment	18, 729, 758	0				5. 00
6.00	Movable Equipment	53, 686, 995	0				6. 00
7.00	HIT designated Assets	2, 833, 813	0				7. 00
8.00	Subtotal (sum of lines 1-7)	146, 431, 441	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	146, 431, 441	0				10.00

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 06/01/2018 To 05/31/2019		pared:
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (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			
1.00	CAP REL COSTS-BLDG & FLXT	2, 027, 679	0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 284, 181	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	5, 311, 860	0		0 0	0	3. 00
		SUMMARY OF	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	0	2, 027, 679				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 284, 181				2. 00
3.00	Total (sum of lines 1-2)	o	5, 311, 860				3. 00

Heal th	n Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od: From 06/01/2018 To 05/31/2019		
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FLXT	71, 178, 347	C	71, 178, 34	7 0. 486538	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	75, 117, 296	C	75, 117, 29	6 0. 513462	0	2.00
3.00	Total (sum of lines 1-2)	146, 295, 643		146, 295, 64			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	INTERS 0			0 2, 635, 215	26, 252	1. 00
2.00	CAP REL COSTS-BEDG & TTXT	0	}		0 2, 922, 653		2. 00
3.00	Total (sum of lines 1-2)	0	1		0 5, 557, 868		3. 00
0.00	Total (Sam of Triles 1 2)	J	SI	JMMARY OF CAPI		712,000	0.00
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11.00	12. 00	13. 00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	1, 161, 209	148, 571	894, 77	0 0	4, 866, 017	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	1, 101, 207			o o	3, 818, 417	2. 00
3.00	Total (sum of lines 1-2)	1, 161, 209			-	8, 684, 434	
			1	1	1		

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0047 Peri od: Worksheet A-8 From 06/01/2018 05/31/2019 Date/Time Prepared: 10/30/2019 3:37 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basi s/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by -2, 250 CAP REL COSTS-BLDG & FIXT 6.00 1.00 10 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -8, 081 ADMINI STRATI VE AND GENERAL 7.00 5.03 7.00 stations excluded) (chapter

From 06/01/2018 | WUI NOTICE TO A-0
TO 05/31/2019 | Date/Time Prepared:

					o 05/31/2019	Date/Time Prep 10/30/2019 3:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
33. 01	MARKETING EXPENSE	A	-393, 199	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 01
33. 02	PENALTI ES	A	-17	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 02
33. 04	SENI OR CIRCLE	A	-197	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 04
33.06	PATIENT PHONE WAGE COSTS	A	-17, 014	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 06
33. 07	PATIENT PHONES BENEFITS	A	-3, 662	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 07
33. 08	PATIENT PHONE DEPRECIATION	A	-232	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 08
	COST						
33. 09	PATIENT TV DEPRECIATION	A	-5, 211	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 09
33. 11	PHYSICIAN RECRUITING	A	-91, 454	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 11
33. 12	LOBBYING EXPENSE IN DUES	A	-2, 683	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 12
33. 13	CHARITABLE CONTRIBUTIONS	A	-83, 895	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 13
33. 15	IMPUTED RENT	A	-18, 720	CAP REL COSTS-MVBLE EQUIP	2.00	10	33. 15
33. 16	NONALLOWABLE LEGAL EXPENSES	A	-62, 122	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 16
50.00	TOTAL (sum of lines 1 thru 49)		-4, 299, 561				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0047 | Period: From 06/01/2018 | To 05/31/2019 | Date/Time Prepared:

					10/30/2019 3:	37 pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		I		_	
1. 00	1		CAPITAL-RELATED INTEREST	1, 161, 209		1. 00
2.00		CAP REL COSTS-BLDG & FLXT	PASI CAPITAL COSTS - BLDG &	13, 424		2. 00
3.00		CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL			3. 00
4.00		REVENUE CYCLE	PASI OPERATING COSTS	211, 350	·	4. 00
4.04		ADMINISTRATIVE AND GENERAL	Shared Service Center Alloca		861, 971	4. 04
4.05		CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix			4. 05
4.06		CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm		0	4. 06
4.07	5. 03	ADMINISTRATIVE AND GENERAL	Non-Capital Home Office Cost	2, 849, 002	0	4. 07
4.08	5. 03	ADMINISTRATIVE AND GENERAL	Malpractice Costs	235, 002	942, 777	4. 08
4.09	2. 00	CAP REL COSTS-MVBLE EQUIP	CIG Leased Equipment	470, 490	306, 765	4. 09
4. 10	5. 03	ADMINISTRATIVE AND GENERAL	Management Fees	0	2, 354, 238	4. 10
4.11	5. 03	ADMINISTRATIVE AND GENERAL	401K Fees	0	4, 402	4. 11
4. 12	5. 03	ADMINISTRATIVE AND GENERAL	Audit Fees	0	41, 425	4. 12
4. 13	5. 03	ADMINISTRATIVE AND GENERAL	Corporate Overhead Allocatio	0	818, 548	4. 13
4.14	5. 03	ADMINISTRATIVE AND GENERAL	HIIM Allocation	0	283, 681	4. 14
4. 15	5. 03	ADMINISTRATIVE AND GENERAL	PASI Lien Unit Collection Fe	0	24, 473	4. 15
4. 16	5. 03	ADMINISTRATIVE AND GENERAL	PPSI Fees	0	17, 138	4. 16
4. 17	8. 00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES	342, 806	349, 153	4. 17
5.00	TOTALS (sum of lines 1-4).			6, 730, 511	6, 306, 449	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		
					l
					l
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	1
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, I NC 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 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.

0 4.07 2, 849, 002 4.07 4.08 -707, 775 0 4 08 4.09 163, 725 10 4.09 4.10 -2, 354, 238 0 4. 10 0 4.11 -4, 402 4.11 0 4 12 -41 425 4 12 4.13 -818, 548 4.13 -283, 681 0 4.14 -24, 473 0 4.15 4.15 0 4.16 -17, 138 4. 16 4.17 -6, 347 0 4. 17 5.00 424, 062 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as

4 05

4.06

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				
	Type of Business				
	Type of business				
	6. 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	OWNER		6. 00			
7.00	DEBT COLLECTION		7.00			
8.00	LAUNDRY		8.00			
9.00			9.00			
10.00			10.00			
9. 00 10. 00 100. 00			100.00			

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

9

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- 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.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

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44, 522

281, 259

| Period: | Worksheet A-8-2 | From 06/01/2018 | To 05/31/2019 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0047

						To 05/31/2019	Date/Time Pro 10/30/2019 3:	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	1, 332, 307			1		1
2.00	50.00	OPERATING ROOM	807, 864			0	0	2. 00
3.00		RADI OLOGY-DI AGNOSTI C	1, 139			0	0	
4.00		LABORATORY	800			0	0	
5.00		EMERGENCY	400, 938			1	0	0.00
6.00		ADMINISTRATIVE AND GENERAL	748, 753			0	0	0.00
7.00		WOUND CARE	5, 000			0	0	7. 00
8.00		SUBPROVIDER - IPF	509, 220			0	0	0.00
9.00		ELECTROCARDI OLOGY	35, 454			0	0	7.00
10. 00	0. 00		0	(,	1	0	1
200.00			3, 841, 475			1	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost	
		ldenti fi er	Limit		Memberships &		of Mal practice	1
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8.00	9. 00	Educati on 12.00	12 13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	0.00				14.00	1.00
2. 00		OPERATING ROOM		1		1	_	1
3. 00		RADI OLOGY-DI AGNOSTI C						1
4. 00		LABORATORY			-	1		1
5. 00		EMERGENCY	0				Ö	
6. 00		ADMINISTRATIVE AND GENERAL	0				0	1
7. 00		WOUND CARE	0				l o	1
8.00		SUBPROVIDER - IPF	0				Ō	8.00
9.00		ELECTROCARDI OLOGY	0				0	1
10.00	0.00		0				0	1
200.00			0			ol o	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0		-			1.00
2.00	50. 00 OPERATING ROOM		0	-	0			2. 00
3. 00	54. 00 RADI OLOGY-DI AGNOSTI C		0	1	0	.,	1	3. 00
4.00	60. 00 LABORATORY		0	(4. 00
5.00	91. 00 EMERGENCY		0	() (400, 938		5.00
6.00	5. 03 ADMINI STRATI VE AND GENERAL		0	(6.00
7.00	76. 03 WOUND CARE) (5,000		7. 00
8.00		SUBPROVIDER - IPF	0			007,220		8.00
9.00		ELECTROCARDI OLOGY) (35, 454		9.00
10.00	0. 00		0			1	1	10. 00 200. 00
200.00	ı		1 0	l c) (3, 841, 475	1	∠UU. UU

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 06/01/2018 o 05/31/2019		pared: 37 pm
	Cost Center Description	Net Expenses	CAPITAL REL	ATED COSTS MVBLE EQUIP	EMPLOYEE	REVENUE CYCLE	
	μ	for Cost Allocation (from Wkst A			BENEFI TS DEPARTMENT		
		col . 7)					
	JOSUS DAL OS DUAS DE CONTROLO DE LA CONTROLO DEL CONTROLO DEL CONTROLO DE LA CONTROLO DE LA CONTROLO DE LA CONTROLO DEL CONTROLO DE LA CONTROLO DEL CONTROLO DEL CONTROLO DE LA CONTROLO DEL LA CONTROLO DE LA CONTROLO DEL LA CONTROLO D	0	1. 00	2. 00	4. 00	5. 01	
1 00	GENERAL SERVICE COST CENTERS	4 0// 017	4 0// 017				1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	4, 866, 017 3, 818, 417	4, 866, 017	3, 818, 417			1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 478, 350	55, 076		4, 576, 645		4.00
5. 01	00590 REVENUE CYCLE	5, 537, 000	195, 362		288, 383		5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	221, 427	135, 688		9, 160		5. 02
5.03	00591 ADMINISTRATIVE AND GENERAL	14, 258, 874	105, 565	82, 838	237, 315		5. 03
7.00	00700 OPERATION OF PLANT	4, 709, 974	1, 323, 949	1, 038, 916	172, 863	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	317, 982	43, 241		181	0	8. 00
9. 00	00900 HOUSEKEEPI NG	908, 781	654, 678		102, 014		9. 00
10.00	01000 DI ETARY	988, 250	204, 513		0	- 1	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	945, 451 2, 198, 540	0 74, 928	0 58. 797	304, 138	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	615, 282	74, 920	30, 797	36, 080		14. 00
15. 00	01500 PHARMACY	1, 570, 720	0	0	233, 565		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	536, 771	122, 546	96, 164	22, 433		16. 00
17. 00	01700 SOCIAL SERVICE	858, 515	0	0	128, 219		17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	468, 734	0	0	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	5, 334, 465	435, 460		727, 318		30.00
33.00	03300 BURN INTENSIVE CARE UNIT	3, 061, 443	81, 849		309, 577	210, 199	33. 00
40. 00 44. 00	04000 SUBPROVIDER - IPF 04400 SKILLED NURSING FACILITY	1, 718, 495 1, 235, 030	62, 195	· ·	250, 483 174, 020		40. 00 44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	1, 233, 030	114, 458	09, 017	174, 039	50, 559	44.00
50. 00	05000 OPERATI NG ROOM	1, 423, 229	200, 521	157, 351	115, 073	443, 413	50. 00
51.00	05100 RECOVERY ROOM	263, 712	75, 220		39, 992		51.00
53.00	05300 ANESTHESI OLOGY	1, 284, 254	0	0	0	48, 158	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 309, 725	192, 363	150, 949	271, 852	906, 862	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 59. 00	05700 CT SCAN 05900 CARDI AC CATHETERI ZATI ON	1, 750, 685	0 21, 428	0 16, 815	0 146, 898	0 266, 326	57. 00 59. 00
60.00	06000 LABORATORY	2, 834, 016	164, 644		299, 067	762, 539	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	156, 911	9, 022		277, 007	20, 414	•
65. 00	06500 RESPIRATORY THERAPY	713, 071	66, 899		96, 141	167, 259	
66.00	06600 PHYSI CAL THERAPY	431, 349	86, 926	68, 212	64, 326	51, 544	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	328, 428	33, 274		49, 375		67. 00
68. 00	06800 SPEECH PATHOLOGY	42, 440	12, 815		6, 145		68. 00
69. 00	06900 ELECTROCARDI OLOGY	62, 906	12, 196		14, 253		69. 00 71. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	636, 114 2, 837, 664	0	0	0	422, 183 263, 379	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 700, 722	28, 828	22, 621	0	867, 827	
74. 00	07400 RENAL DIALYSIS	262, 854	23, 459		0	18, 709	74. 00
76.00	03950 MISC ANCILLARY	0	0	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	330, 161	38, 024		63, 880		76. 02
76. 03	03952 WOUND CARE	960, 069	100, 243	78, 662	106, 730	57, 653	76. 03
00 00	OUTPATIENT SERVICE COST CENTERS	10 017	24 012	10 471	2.0(0	1 041	90. 00
90.00	09000 CLI NI C 09100 EMERGENCY	19, 817 2, 854, 388	24, 813 154, 023		2, 968 304, 177		•
92. 00		2, 034, 300	134, 023	120, 004	304, 177	021, 737	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		80, 851, 033	4, 854, 206	3, 809, 149	4, 576, 645	6, 174, 048	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	57	11, 811	9, 268	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
194. 00 200. 00	007950 MEALS ON WHEELS Cross Foot Adjustments		O	0	0		194. 00 200. 00
200.00			0	n	Ω		200.00
202.00	1 1 9	80, 851, 090	4, 866, 017	3, 818, 417	4, 576, 645		
50	1		., 220, 317	_, _,_,,,,,	.,		50

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 06/01/2018 Part I
To 05/31/2019 Date/Time Prepared: 10/30/2019 3:37 pm

				'	0 03/31/2017	10/30/2019 3:	
	Cost Center Description	PURCHASI NG	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	
	·	RECEIVING AND		AND GENERAL	PLANT	LINEN SERVICE	
		STORES					
		5. 02	5A. 02	5. 03	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01	00590 REVENUE CYCLE						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	472, 751					5. 02
5.03	00591 ADMINISTRATIVE AND GENERAL	1, 274	14, 685, 866	14, 685, 866			5. 03
7.00	00700 OPERATION OF PLANT	442	7, 246, 144	1, 608, 363	8, 854, 507		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	395, 336	87, 748	125, 519	608, 603	8. 00
9.00	00900 HOUSEKEEPI NG	16, 140	2, 195, 346	487, 272	1, 900, 369	0	9. 00
10.00	01000 DI ETARY	o	1, 353, 246	300, 362	593, 650	0	10. 00
11.00	01100 CAFETERI A	o	945, 451	209, 849	0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	710	2, 637, 113	585, 326	217, 499	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	12, 268	663, 630	147, 297	0	0	14. 00
15.00	01500 PHARMACY	1, 851	1, 806, 136	400, 885	0	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	165	778, 079	172, 700	355, 722	0	16. 00
17. 00	01700 SOCIAL SERVICE	113	986, 847	219, 038	0	0	17. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	o	468, 734	104, 039	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	19, 741	7, 240, 914	1, 607, 172	1, 264, 034	155, 196	30. 00
33.00	03300 BURN INTENSIVE CARE UNIT	13, 898	3, 741, 194	830, 384	237, 589	54, 899	33. 00
40.00	04000 SUBPROVI DER - I PF	3, 039	2, 534, 475	562, 544	180, 538	55, 285	40. 00
44.00	04400 SKILLED NURSING FACILITY	4, 077	1, 673, 980	371, 552	332, 245	49, 983	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	39, 058	2, 378, 645	527, 957	582, 064	43, 213	50. 00
51.00	05100 RECOVERY ROOM	41	483, 641	107, 348	218, 346	13, 898	51.00
53.00	05300 ANESTHESI OLOGY	7	1, 332, 419	295, 740	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 340	3, 840, 091	852, 335	558, 383	38, 893	54.00
54. 01	03630 ULTRA SOUND	o	0	0	0	0	54. 01
56.00	05600 RADI OI SOTOPE	o	0	0	0	0	56. 00
57.00	05700 CT SCAN	o	0	0	0	0	57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	25, 973	2, 228, 125	494, 548	62, 201	23, 335	59. 00
60.00	06000 LABORATORY	34, 609	4, 224, 073	937, 563	477, 922	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	10, 549	203, 975	45, 274	26, 188	0	62. 00
65.00	06500 RESPIRATORY THERAPY	5, 276	1, 101, 142	244, 406	194, 191	0	65. 00
66.00	06600 PHYSI CAL THERAPY	277	702, 634	155, 955	252, 326	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	54	490, 001	108, 759	96, 587	0	67. 00
68.00	06800 SPEECH PATHOLOGY	10	74, 397	16, 513	37, 198	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	250	144, 753	32, 129	35, 403	2, 576	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40, 179	1, 098, 476	243, 814	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	193, 855	3, 294, 898	1		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	3, 619, 998	1		0	73. 00
74.00	07400 RENAL DI ALYSI S	310	323, 740	1		0	74.00
76.00	03950 MISC ANCILLARY	o	0	0	0	0	76. 00
76. 01	03951 SLEEP LAB	o	0	0	0	0	76. 01
76. 02		550	468, 982	104, 094	110, 376	0	76. 02
76. 03	03952 WOUND CARE	14, 364	1, 317, 721	1		0	76. 03
	OUTPATIENT SERVICE COST CENTERS	<u> </u>					
90.00	09000 CLI NI C	10	69, 020	15, 319	72, 025	25, 084	90.00
91.00	09100 EMERGENCY	25, 317	4, 080, 728	905, 746	447, 092	146, 241	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0		·		92.00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>		,			
118.00		472, 747	80, 829, 950	14, 681, 174	8, 820, 222	608, 603	118. 00
	NONREI MBURSABLE COST CENTERS	· · ·					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4	21, 140	4, 692	34, 285	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	o		0	0		192. 00
	07950 MEALS ON WHEELS	o	0	o o	o.		194. 00
200.00]	0				200. 00
201.00		l ol	0	0	o	0	201. 00
202.00		472, 751	80, 851, 090	14, 685, 866	8, 854, 507	608, 603	
				•		•	

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 06/01/2018 | Part I | To 05/31/2019 | Date/Time Prepared: 10/30/2019 3: 37 pm

						10/30/2019 3:	37 pm
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	
		0.00	10.00	11 00	12.00	SUPPLY	
	GENERAL SERVICE COST CENTERS	9. 00	10.00	11. 00	13. 00	14. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
							•
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00590 REVENUE CYCLE						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5.03	00591 ADMINISTRATIVE AND GENERAL						5. 03
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	4 500 007					8. 00
9.00	00900 HOUSEKEEPI NG	4, 582, 987	2 (45 (02				9.00
10.00	01000 DI ETARY	398, 425	2, 645, 683	1 155 200			10.00
11. 00	01100 CAFETERIA	0	0	1, 155, 300	1		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	145, 973	0	72, 034		007.404	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	16, 174		827, 101	1
15. 00	01500 PHARMACY	000 744	0	49, 982		3, 464	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	238, 741	0	11, 349	1	309	16.00
17. 00	01700 SOCIAL SERVICE	0	0	35, 915	1	211	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	C)	0	22. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.40, 250	1 05/ 07/	250 553	1 101 140	27, 040	1 20 00
30.00	03000 ADULTS & PEDIATRICS	848, 350	1, 056, 276	250, 557		36, 948	30.00
33. 00	03300 BURN INTENSIVE CARE UNIT	159, 456	187, 803	86, 305		26, 013	33.00
40.00	04000 SUBPROVI DER - I PF	121, 167	396, 078	91, 232		5, 687	40.00
44. 00	04400 SKILLED NURSING FACILITY	222, 984	340, 847	49, 201	305, 309	7, 630	44. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	200 (40	ol	22 (72	128, 681	72 102	FO 00
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	390, 649 146, 542	0	33, 673 9, 276		73, 102 77	50. 00 51. 00
53. 00	05300 ANESTHESI OLOGY	140, 542	0	9, 270	1	14	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-1	0	87, 392	′I "I	15, 609	
54. 00		374, 755	0	87, 392			
	03630 ULTRA SOUND	0	0	(0	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	C		0	56.00
57. 00 59. 00	05700 CT SCAN	41 74	0	25 745	155 004		57. 00 59. 00
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	41, 746 320, 754	0	35, 745 106, 828		48, 612 64, 776	•
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	17, 576	0	100, 626	1	19, 744	62.00
65. 00	06500 RESPIRATORY THERAPY	130, 330	0	29, 867	1 1	9, 876	
66. 00	06600 PHYSI CAL THERAPY	169, 347	0	29, 607 17, 771	1	9, 676 518	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	64, 824	0	11, 791	1	102	67. 00
68. 00	06800 SPEECH PATHOLOGY	24, 965	0	1, 495	1	19	68. 00
69. 00	06900 ELECTROCARDI OLOGY	23, 760	0	3, 975		469	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	23, 700	0	3, 7/5		75, 201	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0			362, 819	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	56, 161	0			0	73. 00
74. 00	07400 RENAL DIALYSIS	45, 702	0			580	74. 00
76. 00	03950 MISC ANCILLARY	43, 702	0			0	76.00
76. 01	03951 SLEEP LAB	0	0			0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	74, 078	0	26, 265		1, 029	76. 02
	03952 WOUND CARE	195, 290	Ö	31, 124		26, 884	•
70.00	OUTPATIENT SERVICE COST CENTERS	1,0,2,0	<u> </u>	0.1, 1.2	102/07/	20,00.	70.00
90.00	09000 CLI NI C	48, 339	0	748	5, 373	18	90.00
91. 00	09100 EMERGENCY	300, 063	0	96, 601			•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					,	92.00
	SPECIAL PURPOSE COST CENTERS						ĺ
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 559, 977	1, 981, 004	1, 155, 300	3, 657, 945	827, 094	118. 00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	23, 010	O	C	0	7	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	403, 903	C	0		192.00
	07950 MEALS ON WHEELS	o	260, 776	C	I		194. 00
200.00			.]				200. 00
201.00		0	o	C	ol	0	201.00
202.00		4, 582, 987	2, 645, 683	1, 155, 300	3, 657, 945		
		. '			. '		

| Peri od: | Worksheet B | From 06/01/2018 | Part | | To 05/31/2019 | Date/Time Prepared: | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0047

				Т	o 05/31/2019	Date/Time Pre 10/30/2019 3:	
					INTERNS &	107 307 2017 3.	J7 piii
					RESI DENTS		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-OTHER	Subtotal	
			RECORDS &		PRGM COSTS		
		15. 00	16. 00	17. 00	APPRV 22. 00	24. 00	
	GENERAL SERVICE COST CENTERS	10.00	10.00	17.00	22.00	21.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	00590 REVENUE CYCLE 00560 PURCHASING RECEIVING AND STORES						5. 01 5. 02
5. 02	00591 ADMINISTRATIVE AND GENERAL			•			5. 02
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						10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			•			14. 00
15. 00	01500 PHARMACY	2, 308, 107					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	1, 556, 900				16. 00
17. 00	01700 SOCIAL SERVICE	0	0				17. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	572, 773		22. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	04 274	741 177	E72 772	1E 000 011	30. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	96, 374 53, 000			15, 080, 911 6, 064, 832	
40. 00	04000 SUBPROVI DER - I PF	o	113, 832	1		4, 686, 761	40. 00
44.00	04400 SKILLED NURSING FACILITY	0	14, 261	246, 561	0	3, 614, 553	44. 00
	ANCILLARY SERVICE COST CENTERS			1	1		
50.00	05000 OPERATING ROOM	0	111, 803			4, 269, 787	50.00
51. 00 53. 00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0	11, 510 12, 143	1		1, 061, 392 1, 640, 316	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	228, 819	1		5, 996, 277	54. 00
54. 01	03630 ULTRA SOUND	o	0	l .		0	
56.00	05600 RADI 0I SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0			0	57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	67, 152	l .	l l	3, 157, 458	
60. 00 62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	192, 269 5, 147			6, 324, 185 317, 904	
65. 00	06500 RESPIRATORY THERAPY	Ö	42, 173	l .		1, 751, 985	
66. 00	06600 PHYSI CAL THERAPY	O	12, 996	l .		1, 311, 547	
67. 00	06700 OCCUPATI ONAL THERAPY	0	13, 303	l .		785, 367	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	739	l .		155, 326	
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	11, 492 106, 451	l .		254, 557 1, 523, 942	69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATTENTS	0	66, 409	l .		4, 455, 452	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 308, 107	218, 816	ı		7, 090, 245	
74.00	07400 RENAL DIALYSIS	0	4, 717	1	0	514, 690	
	03950 MISC ANCILLARY	0	0			0	
	03951 SLEEP LAB	0	0	1	9	0	
76. 02 76. 03	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03952 WOUND CARE	0	1, 646 14, 537			786, 470 2, 321, 591	76. 02 76. 03
70.03	OUTPATIENT SERVICE COST CENTERS	U U	14, 557		U U	2, 321, 341	70.03
90.00	09000 CLI NI C	0	489	0	0	236, 415	90. 00
	09100 EMERGENCY	O	156, 822			6, 701, 314	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
110.00	SPECIAL PURPOSE COST CENTERS	2 200 107	1 557 000	1 425 020	F72 772	00 102 277	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 308, 107	1, 556, 900	1, 425, 020	572, 773	80, 103, 277	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0	ol	83, 134	190, 00
	19200 PHYSICIANS' PRIVATE OFFICES	o	0			403, 903	
	07950 MEALS ON WHEELS	О	0	0	0	260, 776	194. 00
200.00		_	=	_	0		200. 00
201.00		0 2, 308, 107	1 554 000	1 425 020	0 572 773	0 80, 851, 090	201. 00
202. 00	TOTAL (Suill TITIES TIS LITTOUGH 201)	2,308,107	1, 556, 900	1, 425, 020	572, 773	00, 851, 090	2U2. UU

ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0047 Peri od: Worksheet B From 06/01/2018 To 05/31/2019 Part I Date/Time Prepared: 10/30/2019 3: 37 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 26.00 25.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 1.00 1.00 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 00590 REVENUE CYCLE 5.01 5.02 00560 PURCHASING RECEIVING AND STORES 5. 02 5.03 00591 ADMINISTRATIVE AND GENERAL 5.03 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10. 00 01000 DI ETARY 10.00 11. 00 01100 CAFETERIA 11.00

11.00	UTTOO CAFETERIA				11.00
13. 00	01300 NURSING ADMINISTRATION				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00	01700 SOCIAL SERVICE				17. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV				22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS				1 22. 00
30. 00	03000 ADULTS & PEDIATRICS	-572, 773	14, 508, 138		30.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0,2,7,0	6, 064, 832	•	33. 00
40. 00	04000 SUBPROVI DER - I PF	٥	4, 686, 761	•	40.00
44. 00	04400 SKILLED NURSING FACILITY		3, 614, 553	•	44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	3,014,000		44.00
EO 00		ام	1 240 707		F0 00
50.00	05000 OPERATI NG ROOM	U	4, 269, 787		50.00
51.00	05100 RECOVERY ROOM	U	1, 061, 392		51.00
53. 00	05300 ANESTHESI OLOGY	0	1, 640, 316		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 996, 277		54.00
54. 01	03630 ULTRA SOUND	0	0		54. 01
56.00	05600 RADI OI SOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	l ol	3, 157, 458		59.00
60.00	06000 LABORATORY	ام	6, 324, 185	•	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	ام	317, 904		62.00
65. 00	06500 RESPIRATORY THERAPY	٥	1, 751, 985	•	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	1, 751, 765		66. 00
	1 1	U		•	
67. 00	06700 OCCUPATI ONAL THERAPY	U	785, 367	1	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	155, 326	•	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	254, 557	•	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 523, 942		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	4, 455, 452		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7, 090, 245		73. 00
74.00	07400 RENAL DIALYSIS	ol	514, 690		74.00
76.00	03950 MISC ANCILLARY	ol	0	1	76. 00
76. 01	03951 SLEEP LAB	أما	0		76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	ام	786, 470	l control of the cont	76. 02
76. 03	03952 WOUND CARE	ام	2, 321, 591	•	76. 03
70.03	OUTPATIENT SERVICE COST CENTERS	<u> </u>	2, 321, 371		70.03
90. 00	09000 CLINIC	O	236, 415		90.00
91.00	09100 EMERGENCY	0	6, 701, 314	•	91.00
	1 1	٥	0, 701, 314		•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	l U			92. 00
440.00	SPECIAL PURPOSE COST CENTERS	F70 770	70 500 504		140.00
118.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-572, 773	79, 530, 504		118. 00
400.00	NONREI MBURSABLE COST CENTERS	ا	00.404		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	83, 134	•	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	403, 903	•	192. 00
	07950 MEALS ON WHEELS	0	260, 776	•	194. 00
200.00		0	0		200. 00
201.00	Negative Cost Centers	O	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	-572, 773	80, 278, 317		202. 00
		'		•	•

| Peri od: | Worksheet B | From 06/01/2018 | Part II | To 05/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

				То	05/31/2019	Date/Time Pre 10/30/2019 3:	pared:
			CAPI TAL REI	LATED COSTS		10/30/2014 3.	37 pili
	Cook Cooks December	D:+1	DIDC & FLVT	MVBLE EQUIP	Culatatal	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MARTE EGOLA	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2.00	2.4	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2. 00	2A	4. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	OO400 EMPLOYEE BENEFITS DEPARTMENT	0	55, 076		98, 295		4.00
5. 01 5. 02	O0590 REVENUE CYCLE O0560 PURCHASING RECEIVING AND STORES	0	195, 362 135, 688		348, 665 242, 164	6, 195 197	
5. 03	00591 ADMINISTRATIVE AND GENERAL	0	105, 565		188, 403	5, 098	1
7.00	00700 OPERATION OF PLANT	0	1, 323, 949		2, 362, 865		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	43, 241		77, 173	4	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	654, 678 204, 513		1, 168, 411 364, 996	2, 191 0	9. 00 10. 00
11. 00	01100 CAFETERI A	0	0	0	0	Ö	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	74, 928	58, 797	133, 725	6, 533	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	-	0	775	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	122, 546	96, 164	0 218, 710	5, 017 482	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	0	70, 104	210, 710	2, 754	17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 0	405 4/0	0.44 74.0	777 470	45 (40	00.00
30. 00 33. 00	03000 ADULTS & PEDIATRICS 03300 BURN INTENSIVE CARE UNIT	0	435, 460 81, 849		777, 170 146, 077	15, 610 6, 650	1
40. 00	04000 SUBPROVI DER - I PF	0	62, 195		111, 000		1
44.00	04400 SKILLED NURSING FACILITY	0	114, 458		204, 275	3, 738	44. 00
F0 00	ANCILLARY SERVICE COST CENTERS		000 504	457.054	057.070	0. 470	1 50 00
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	0	200, 521 75, 220		357, 872 134, 246	2, 472 859	50. 00 51. 00
53. 00	05300 ANESTHESI OLOGY	0	75,220	37,020	134, 240	0.57	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	192, 363	150, 949	343, 312	5, 839	54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56. 00 57. 00	05600	0	0	0	0	0	56. 00 57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	21, 428	1	38, 243	3, 155	59. 00
60.00	06000 LABORATORY	0	164, 644		293, 842	6, 424	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	9, 022		16, 101	0	62.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	66, 899 86, 926		119, 395 155, 138	2, 065 1, 382	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	33, 274		59, 385	1, 061	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	12, 815		22, 871	132	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	12, 196		21, 767	306	69. 00
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	28, 828	-	51, 449	Ö	73. 00
74. 00	07400 RENAL DIALYSIS	0	23, 459	18, 408	41, 867	0	74.00
	03950 MI SC ANCI LLARY	0	0	1	0	0	1
	03951 SLEEP LAB 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0 38, 024	-	0 67, 862	0 1 372	76. 01 76. 02
	03952 WOUND CARE	0	100, 243		178, 905	2, 293	1
	OUTPATIENT SERVICE COST CENTERS			-, -	,	,	
	09000 CLI NI C	0			44, 284	64	ł
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	154, 023	120, 864	274, 887 0	6, 534	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS				<u> </u>		72.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	4, 854, 206	3, 809, 149	8, 663, 355	98, 295	118. 00
400.5	NONREI MBURSABLE COST CENTERS			2 2:=1	2. 2==	_	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	11, 811	9, 268	21, 079 0		190. 00 192. 00
	07950 MEALS ON WHEELS	0	0	0	0		194. 00
200.00					O		200. 00
201.00			0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	4, 866, 017	3, 818, 417	8, 684, 434	98, 295	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0047

Peri od: Worksheet B From 06/01/2018 Part II To 05/31/2019 Date/Time Prepared:

10/30/2019 3:37 pm Cost Center Description REVENUE CYCLE PURCHASI NG ADMINISTRATIVE OPERATION OF LAUNDRY & LINEN SERVICE RECEIVING AND AND GENERAL **PLANT STORES** 5. 01 5.03 7. 00 8. 00 5.02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00590 REVENUE CYCLE 354, 860 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 242, 361 5.02 5.03 00591 ADMINISTRATIVE AND GENERAL 0 653 194, 154 5.03 00700 OPERATION OF PLANT 0 21, 287 2, 388, 092 7.00 227 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 0 1, 160 33, 853 112, 190 8.00 9 00 00900 HOUSEKEEPI NG 0 8, 274 6, 441 512, 533 0 9 00 01000 DI ETARY 3, 970 10.00 10.00 160, 109 0 01100 CAFFTERIA 2,774 11.00 0 11.00 13.00 01300 NURSING ADMINISTRATION 0 0 0 364 7,737 58,660 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 6, 290 1, 947 0 14.00 01500 PHARMACY 5, 299 949 15.00 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 85 2, 283 95, 940 0 16.00 01700 SOCIAL SERVICE 2,895 17.00 17.00 58 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 1, 375 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 21.964 10, 121 21, 245 340, 915 28.609 30.00 03300 BURN INTENSIVE CARE UNIT 12,079 10, 120 33.00 7, 125 10, 977 64,079 33.00 04000 SUBPROVI DER - I PF 25, 943 7, 436 48, 692 10, 191 40.00 40.00 1, 558 04400 SKILLED NURSING FACILITY <u>2, 0</u>90 <u>4</u>, 911 9, 214 44.00 3, 250 89,608 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 25, 480 20, 024 6, 979 156, 985 7, 966 50.00 51 00 05100 RECOVERY ROOM 2 623 1.419 58, 889 2, 562 51 00 21 05300 ANESTHESI OLOGY 53.00 2,767 3, 909 Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 52, 187 4, 276 11, 267 150, 598 7, 170 54.00 54.01 03630 ULTRA SOUND 54.01 0 C C 0 0 05600 RADI OI SOTOPE 56.00 0 C 0 0 0 56.00 57.00 05700 CT SCAN 0 0 57.00 05900 CARDIAC CATHETERIZATION 59.00 15, 304 13, 315 6,537 16, 776 4, 301 59.00 60 00 06000 LABORATORY 43 819 17, 743 12 393 128 897 60 00 0 5, 408 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 1, 173 598 7,063 0 62.00 06500 RESPIRATORY THERAPY 9,611 2, 705 3, 231 52, 374 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 2,962 142 2,062 68,053 0 66.00 06700 OCCUPATIONAL THERAPY 3,032 26, 050 67 00 28 1, 438 67 00 0 68.00 06800 SPEECH PATHOLOGY 168 218 10,033 0 68.00 06900 ELECTROCARDI OLOGY 2,619 425 69.00 69.00 128 9, 548 475 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 24, 260 20, 599 3, 223 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 9, 667 72 00 72 00 15, 135 99, 378 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 49, 869 10, 621 22, 569 0 73.00 74.00 07400 RENAL DIALYSIS 1,075 159 950 18, 366 0 74.00 03950 MISC ANCILLARY 76.00 76.00 0 0 C C 76.01 03951 SLEEP LAB 0 C 0 0 0 76.01 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 375 282 1, 376 29, 769 0 76.02 76.03 03952 WOUND CARE 3, 313 7, 364 3,866 78, 479 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 112 203 19 425 4.624 90.00 09100 EMERGENCY 12, 979 11, 973 120, 582 26, 958 91.00 91.00 35, 740 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 354, 860 242, 359 194, 092 2, 378, 845 112, 190 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 62 9.247 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 194.00 07950 MEALS ON WHEELS 0 0 0 0 194.00 C 200.00 Cross Foot Adjustments 200.00 0 201.00 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) 354.860 242, 361 194, 154 2, 388, 092 112, 190 202. 00

				'	0 03/31/2019	10/30/2019 3:	
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	J
					ADMI NI STRATI ON	SERVICES &	
		0.00	10.00	11 00	12.00	SUPPLY	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	13. 00	14. 00	
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	00590 REVENUE CYCLE						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00591 ADMINISTRATIVE AND GENERAL						5. 03
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	1, 697, 850					9. 00
10.00	01000 DI ETARY	147, 604	676, 679				10.00
11.00	01100 CAFETERI A	o	0	2, 774			11. 00
13.00	01300 NURSING ADMINISTRATION	54, 078	0	173	261, 270		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	39	0	9, 051	14. 00
15. 00	01500 PHARMACY	0	0	120		38	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	88, 446	0	27	1	3	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	86	I	2	17. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	214 207	270 1/0	400	05.075	404	1 20 00
30.00	03000 ADULTS & PEDI ATRI CS	314, 287	270, 160	600	1	404	30.00
33. 00 40. 00	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	59, 073 44, 888	48, 034 101, 304	207 219		285	33. 00 40. 00
44. 00	04400 SKI LLED NURSI NG FACI LI TY	82, 608	87, 178	118	1	62 84	44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	82,000	07, 170	110	21,007	04	44.00
50. 00	05000 OPERATING ROOM	144, 723	ol	81	9, 191	800	50.00
51. 00	05100 RECOVERY ROOM	54, 289	o	22		1	51.00
53. 00	05300 ANESTHESI OLOGY	0 1, 20 7	0	0		0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	138, 835	o	210	ol	171	54. 00
54. 01	03630 ULTRA SOUND	0	O	C	I I	0	54. 01
56.00	05600 RADI 0I SOTOPE	o	0	C	o	0	56. 00
57.00	05700 CT SCAN	0	o	C	o	0	57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	15, 465	0	86	11, 142	532	59. 00
60.00	06000 LABORATORY	118, 829	0	257	0	709	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	6, 511	0	C	1	216	62. 00
65. 00	06500 RESPI RATORY THERAPY	48, 283	0	72	I I	108	1
66. 00	06600 PHYSI CAL THERAPY	62, 738	0	43		6	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	24, 015	0	28	0	1	67. 00
68. 00	06800 SPEECH PATHOLOGY	9, 249	0	4	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	8, 802	0	10	0	5	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		823 3, 971	71. 00 72. 00
73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	20, 806	ol	0		3, 9/1	73.00
74. 00	07400 RENAL DIALYSIS	16, 931	0	0		6	74.00
76. 00	03950 MISC ANCILLARY	10, 731	ő	0		0	76. 00
76. 01	03951 SLEEP LAB	0	0	Ö		0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	27, 444	o	63	o	11	ı
	03952 WOUND CARE	72, 349	o	75		294	1
	OUTPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	-,		, , , , ,		
90.00	09000 CLI NI C	17, 908	0	2	384	0	90. 00
91.00	09100 EMERGENCY	111, 164	o	232	37, 187	519	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	<u> </u>	1, 689, 325	506, 676	2, 774	261, 270	9, 051	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 525	0	C	I .		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	103, 305	C	=		192. 00
	07950 MEALS ON WHEELS	0	66, 698	C	0	0	194. 00
200.00	1 1			-		~	200. 00
201.00		1 407 050	674 470	2 774	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 697, 850	676, 679	2, 774	261, 270	9, 051	202. 00

| Peri od: | Worksheet B | From 06/01/2018 | Part II | To 05/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

				Т	o 05/31/2019	Date/Time Pre 10/30/2019 3:	
					INTERNS &	10/30/2019 3.	37 pili
					RESI DENTS		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-OTHER	Subtotal	
			RECORDS & LI BRARY		PRGM COSTS APPRV		
		15. 00	16. 00	17. 00	22.00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00590 REVENUE CYCLE			•			5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00591 ADMINISTRATIVE AND GENERAL					•	5. 03
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY	14, 826					15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	405, 976	1			16. 00
17. 00 22. 00	01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				17. 00 22. 00
22.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	l U		<u> </u> C	1, 375] 22.00
30. 00	03000 ADULTS & PEDI ATRI CS	0	25, 135	10, 079)	1, 921, 374	30. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	13, 823			419, 851	33. 00
40.00	04000 SUBPROVI DER - I PF	0	29, 689			414, 621	40. 00
44. 00	04400 SKILLED NURSING FACILITY	0	3, 719	3, 264		515, 864	44. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	O	29, 159	·I c		761, 732	50. 00
51. 00	05100 RECOVERY ROOM		3, 002	1		262, 987	51.00
53. 00	05300 ANESTHESI OLOGY	o	3, 167	1		9, 847	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	59, 600	o c)	773, 465	54.00
54. 01	03630 ULTRA SOUND	0	0	1		0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	1		0	56.00
57. 00 59. 00	05700 CT SCAN 05900 CARDI AC CATHETERI ZATI ON		0 17, 514	1		0 142, 370	57. 00 59. 00
60. 00	06000 LABORATORY		50, 146	l .		673, 059	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1, 342	l .)	38, 412	1
65.00	06500 RESPI RATORY THERAPY	0	10, 999	C)	248, 843	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	3, 390	1		295, 916	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	3, 469 193	l .		118, 507	1
69. 00	06900 ELECTROCARDI OLOGY		193 2, 997	l .		42, 873 47, 082	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		27, 763	l .		76, 668	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	17, 320	1)	145, 471	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	14, 826	57, 070	1		227, 210	1
74.00	07400 RENAL DIALYSIS	0	1, 230			80, 584	74.00
76. 00 76. 01	03950 MISC ANCILLARY 03951 SLEEP LAB		0			0	76. 00 76. 01
	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	0	429	1		128, 983	
	03952 WOUND CARE	o	3, 791	1		361, 627	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	128	1		87, 139	
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	40, 901	C		679, 656	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS	L					92.00
118.00		14, 826	405, 976	18, 867	0	8, 474, 141	118. 00
	NONREI MBURSABLE COST CENTERS					, ,	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 MEALS ON WHEELS		0	C		103, 305	1
200.00		"	U		1, 375	66, 698 1 375	200. 00
201.00		o	O	l c	0	0	201. 00
202.00		14, 826	405, 976	18, 867	1, 375		202. 00

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047 Peri od: Worksheet B From 06/01/2018 Part II 05/31/2019 Date/Time Prepared: 10/30/2019 3:37 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 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 00590 REVENUE CYCLE 5. 01 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00591 ADMINISTRATIVE AND GENERAL 5.03 5.03 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 01000 DI ETARY 10.00 10.00 11. 00 01100 CAFETERIA 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 921, 374 30.00 03300 BURN INTENSIVE CARE UNIT 0 33 00 33 00 419, 851 04000 SUBPROVIDER - IPF 0 40.00 414, 621 40.00 04400 SKILLED NURSING FACILITY 44.00 44.00 515, 864 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 761, 732 50 00 05100 RECOVERY ROOM 0 51.00 262, 987 51.00 05300 ANESTHESI OLOGY 00000000000000000000 9, 847 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 773, 465 54.00 54.01 03630 ULTRA SOUND Ω 54.01 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 57.00 57.00 59.00 05900 CARDIAC CATHETERIZATION 142.370 59.00 06000 LABORATORY 60 00 673.059 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 38, 412 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 248, 843 65.00 06600 PHYSI CAL THERAPY 295, 916 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 118, 507 67.00 68.00 06800 SPEECH PATHOLOGY 42, 873 68.00 69.00 06900 ELECTROCARDI OLOGY 47, 082 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 76, 668 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 145, 471 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 227, 210 73.00 07400 RENAL DIALYSIS 74.00 80, 584 74.00 03950 MISC ANCILLARY 76.00 C 76.00 76.01 03951 SLEEP LAB 76.01 0 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 128, 983 76.02 03952 WOUND CARE 0 76.03 361, 627 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 87, 139 90.00 0 91.00 09100 EMERGENCY 91.00 679, 656 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00

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0 0 0

8, 474, 141

38, 915

66, 698

1, 375

103, 305

8, 684, 434

118.00

190.00

192. 00

194.00

200 00

201.00

202.00

118.00

200 00

201.00

202.00

SPECIAL PURPOSE COST CENTERS

NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

Cross Foot Adjustments

Negative Cost Centers

192.00 19200 PHYSICIANS' PRIVATE OFFICES

194.00 07950 MEALS ON WHEELS

SUBTOTALS (SUM OF LINES 1 through 117)

TOTAL (sum lines 118 through 201)

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0047 Peri od: Worksheet B-1 From 06/01/2018 05/31/2019 Date/Time Prepared: 10/30/2019 3:37 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** REVENUE CYCLE **PURCHASI NG** Cost Center Description (SQUARE FOO (GROSS CHAR RECEIVING AND (SQUARE FOO BENEFITS TAGE) TAGE) DEPARTMENT STORES. GES) (GROSS (COSTED REQUIS.) SALARI ES) 1.00 2.00 5. 01 4.00 5.02 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 416 929 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 416, 929 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4,719 4, 719 28, 176, 466 4.00 00590 REVENUE CYCLE 1, 775, 452 16, 739 16, 739 5 01 5 01 423, 362, 560 5.02 00560 PURCHASING RECEIVING AND STORES 11,626 11,626 56, 393 7, 017, 107 5.02 5.03 00591 ADMINISTRATIVE AND GENERAL 9,045 9, 045 1, 461, 049 18, 913 5.03 7.00 00700 OPERATION OF PLANT 113, 438 113, 438 1,064,243 0 6, 564 7.00 00800 LAUNDRY & LINEN SERVICE 0 3.705 3, 705 8 00 1.114 0 8 00 9.00 00900 HOUSEKEEPI NG 56,094 56, 094 628, 059 0 239, 566 9.00 01000 DI ETARY 17, 523 0 10.00 17, 523 C 0 10.00 0 01100 CAFETERI A 11.00 11.00 0 01300 NURSING ADMINISTRATION 10, 546 13.00 6.420 6, 420 1, 872, 448 13.00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 222, 127 182, 103 14.00 01500 PHARMACY 15.00 1, 437, 960 27, 472 15.00 01600 MEDICAL RECORDS & LIBRARY 0 10, 500 10,500 138, 109 2, 451 16,00 16,00 17 00 01700 SOCIAL SERVICE 789, 392 1,671 17 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDLATRICS 37, 311 37, 311 4, 477, 791 26, 209, 952 293, 021 30.00 33.00 03300 BURN INTENSIVE CARE UNIT 7,013 7,013 1, 905, 934 14, 413, 967 206, 297 33.00 04000 SUBPROVIDER - IPF 1, 542, 117 30, 957, 832 45, 104 40.00 40.00 5, 329 5, 329 04400 SKILLED NURSING FACILITY 60, 514 9,807 9,807 1, 071, 481 3, 878, 425 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 181 17, 181 708, 457 30, 406, 145 579, 740 50.00 05100 RECOVERY ROOM 51.00 6, 445 6, 445 246, 216 3, 130, 379 610 51.00 53.00 05300 ANESTHESI OLOGY 3, 302, 370 108 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 16, 482 16, 482 1, 673, 675 62, 175, 916 123, 788 54.00 03630 ULTRA SOUND 54.01 54.01 56.00 05600 RADI OI SOTOPE 0 0 Ω 56.00 05700 CT SCAN 57 00 Ω \cap Λ 57 00 59.00 05900 CARDI AC CATHETERI ZATI ON 1,836 1,836 904, 390 18, 262, 740 385, 520 59.00 06000 LABORATORY 52, 289, 561 60.00 14, 107 14, 107 1, 841, 228 513, 714 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 773 1, 399, 853 62.00 773 156, 584 62.00 78, 320 06500 RESPIRATORY THERAPY 591.898 11, 469, 460 65.00 5, 732 5, 732 65.00 66.00 06600 PHYSI CAL THERAPY 7,448 7, 448 396, 030 3, 534, 530 4, 112 66.00 67.00 06700 OCCUPATI ONAL THERAPY 2,851 2, 851 303, 978 3, 617, 813 805 67.00 37, 834 06800 SPEECH PATHOLOGY 68 00 1 098 1 098 200, 967 148 68 00 69.00 06900 ELECTROCARDI OLOGY 1,045 1, 045 87, 752 3, 125, 356 3, 716 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 28, 950, 381 596, 391 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 18, 060, 682 2, 877, 386 72.00 07300 DRUGS CHARGED TO PATIENTS 2 470 2 470 0 59 509 499 73 00 73 00 0 74.00 07400 RENAL DIALYSIS 2,010 2,010 0 1, 282, 924 4,601 74.00 03950 MISC ANCILLARY 0 76.00 76.00 0 03951 SLEEP LAB 76.01 76.01 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 393, 279 76.02 3 258 3.258 447, 706 8, 160 76.02 76.03 03952 WOUND CARE 8,589 8, 589 657, 094 3, 953, 416 213, 205 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 2, 126 2. 126 18, 275 133, 124 142 90.00 09100 EMERGENCY 1, 872, 691 375, 778 91.00 13, 197 13, 197 42, 649, 562 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 415, 917 415, 917 28, 176, 466 423, 362, 560 7, 017, 050 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1.012 1,012 C 57 190, 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 0 0 O 01194.00 194.00 07950 MEALS ON WHEELS 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 3, 818, 417 4, 576, 645 6, 174, 048 472, 751 202. 00 4, 866, 017 Part I) 0. 067371 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 11.671093 9.158435 0.162428 0.014583 204.00 Cost to be allocated (per Wkst. B, 242, 361 204. 00 98, 295 354, 860 Part II) 0.003489 0. 034539 205. 00

0.000838

206.00

II)

(per Wkst. B-2)

Unit cost multiplier (Wkst. B, Part

NAHE adjustment amount to be allocated

205.00

206.00

Health Financial Systems	ST JOSEPH MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der Co	Provider CCN: 15-0047		Worksheet B-1		
				From 06/01/2018 To 05/31/2019			
	CAPITAL REL	ATED COSTS					
Cost Center Description	BLDG & FIXT (SQUARE FOO TAGE)	MVBLE EQUIP (SQUARE FOO TAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHAR GES)	PURCHASI NG RECEI VI NG AND STORES (COSTED REQUI S.)		
	1.00	2.00	4.00	5. 01	5. 02		
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Peri od: From 06/01/2018 To 05/31/2019 Date/Ti me Prepared:

	Cost Center Description	Reconciliation	ADMINI STRATI VE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FOO TAGE)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	10/30/2019 3: HOUSEKEEPING (SOUARE FOO TAGE)	
0.5	NEDAL CEDILLOS COCT CENTEDO	5A. 03	5. 03	7. 00	8. 00	9. 00	
1. 00	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 1200 CAP REL COSTS-BLDG & FIXT 1200 CAP REL COSTS-BVBLE EQUIP 1400 EMPLOYEE BENEFITS DEPARTMENT 1590 REVENUE CYCLE 1560 PURCHASING RECEIVING AND STORES 1591 ADMINISTRATIVE AND GENERAL 1700 OPERATION OF PLANT 1800 LAUNDRY & LINEN SERVICE 1900 HOUSEKEEPING 100 OD IETARY 100 CAFETERIA 300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY 1700 SOCIAL SERVICE	-14, 685, 866 0 0 0 0 0 0 0 0	7, 246, 144 395, 336 2, 195, 346 1, 353, 246 945, 451 2, 637, 113 663, 630 1, 806, 136 778, 079 986, 847	261, 362 3, 705 56, 094 17, 523 0 6, 420 0 10, 500	666, 125 0 0 0 0 0 0 0	201, 563 17, 523 0 6, 420 0 10, 500	1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 22. 00
	PATIENT ROUTINE SERVICE COST CENTERS OOO ADULTS & PEDIATRICS	1 0	7, 240, 914	37, 311	169, 865	37, 311	30.00
33. 00 03 40. 00 04 44. 00 04	ADDLIS & PEDIATRICS 300 BURN INTENSIVE CARE UNIT 000 SUBPROVIDER - IPF 400 SKILLED NURSING FACILITY CILLARY SERVICE COST CENTERS	0 0 0	3, 741, 194 2, 534, 475	7, 013 5, 329	60, 088	7, 013 5, 329 9, 807	33. 00 40. 00 44. 00
50. 00 05	000 OPERATING ROOM	0				17, 181	50. 00
53. 00 05 54. 00 05 54. 01 03	100 RECOVERY ROOM 300 ANESTHESI OLOGY 400 RADI OLOGY-DI AGNOSTI C 630 ULTRA SOUND	0 0 0 0		6, 445 0 16, 482	0	6, 445 0 16, 482 0	51. 00 53. 00 54. 00 54. 01
	600 RADI OI SOTOPE 700 CT SCAN	0 0	0	0	0	0	56. 00 57. 00
	900 CARDI AC CATHETERI ZATI ON 000 LABORATORY	0	2, 228, 125		25, 540	1, 836	59.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	4, 224, 073 203, 975		0	14, 107 773	60. 00 62. 00
	500 RESPI RATORY THERAPY	0	1, 101, 142		0	5, 732	65. 00
	600 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY	0	702, 634 490, 001	7, 448 2, 851	0	7, 448 2, 851	66. 00 67. 00
	800 SPEECH PATHOLOGY	0	74, 397	1, 098		1, 098	68. 00
	900 ELECTROCARDIOLOGY 100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	144, 753 1, 098, 476		2, 819 0	1, 045 0	69. 00 71. 00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 294, 898	0	0	0	72. 00
	300 DRUGS CHARGED TO PATIENTS 400 RENAL DIALYSIS	0	3, 619, 998 323, 740			2, 470 2, 010	73. 00 74. 00
76. 00 03	950 MISC ANCILLARY	0	0	0	0	2,010	76. 00
	951 SLEEP LAB 550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 0	0 468, 982	0 3, 258	0	0 3, 258	76. 01 76. 02
76. 02 03	952 WOUND CARE	0		8, 589			
	TPATIENT SERVICE COST CENTERS	0	40.020	2 124	27, 455	2 124	90.00
	100 EMERGENCY	0				2, 126 13, 197	•
	200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
118. 00	ECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	-14, 685, 866	66, 144, 084	260, 350	666, 125	200, 551	118. 00
	NREIMBURSABLE COST CENTERS OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	T 0	21, 140	1, 012	O	1 012	190. 00
192. 00 19	200 PHYSI CLANS' PRI VATE OFFI CES	Ö	ľ	0	o	0	192. 00
194. 00 07 200. 00	950 MEALS ON WHEELS Cross Foot Adjustments	0	0	0	0	0	194. 00 200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)		14, 685, 866	8, 854, 507	608, 603	4, 582, 987	202. 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)		0. 221957 194, 154			22. 737243 1, 697, 850	1
205. 00	Unit cost multiplier (Wkst. B, Part		0. 002934	9. 137105	0. 168422	8. 423421	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
I	Parts III and IV)	I	I	I	ı l	l	I

		ncial Systems TION - STATISTICAL BASIS	ST JOSEPH MEDI	CAL CENTER Provider C	CN: 15-0047 P	In Lieu eriod:	u of Form CMS-: Worksheet B-1	<u> 2552-10</u>
					F	rom 06/01/2018 o 05/31/2019	Date/Time Pre	
		Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (GROSS	SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	37 piii
			10.00	11.00	13. 00	REQUIS.) 14. 00	15. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00 5. 01 5. 02 5. 03 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 22. 00	00200 00400 00590 00560 00591 00700 00800 01000 01100 01300 01400 01500 01600 01700 02200	CAP REL COSTS-BUBLE EQUIP CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT REVENUE CYCLE PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE L&R SERVICES-OTHER PRGM COSTS APPRV IENT ROUTINE SERVICE COST CENTERS	116, 307 0 0 0 0 0 0 0	3, 400, 100 212, 000 47, 600 147, 100 33, 400 105, 700	10, 677, 225 0 139, 058 0 534, 187	6, 559, 415 27, 472 2, 451 1, 671	2, 688, 280 0 0 0	2. 00 4. 00 5. 01 5. 02 5. 03 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
30. 00		ADULTS & PEDIATRICS	46, 435	737, 400	3, 476, 831	293, 021	0	30. 00
33. 00 40. 00		BURN INTENSIVE CARE UNIT SUBPROVIDER - IPF	8, 256 17, 412	254, 000 268, 500			0	33. 00 40. 00
44. 00	04400	SKILLED NURSING FACILITY	14, 984	144, 800			0	44. 00
50. 00 51. 00 53. 00 54. 00 54. 01 56. 00 57. 00 59. 00 60. 00	05000 05100 05300 05400 03630 05600 05700 05900	LARY SERVICE COST CENTERS OPERATING ROOM RECOVERY ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C ULTRA SOUND RADI OI SOTOPE CT SCAN CARDI AC CATHETERI ZATI ON LABORATORY	0 0 0 0 0 0 0	99, 100 27, 300 0 257, 200 0 0 105, 200 314, 400	206, 524 0 0 0 0 0 0 0 455, 332	610 108 123, 788 0 0 0 0 385, 520	0 0 0 0 0 0 0	50. 00 51. 00 53. 00 54. 00 54. 01 56. 00 57. 00 59. 00 60. 00
72. 00 73. 00 74. 00 76. 00 76. 01 76. 02	06500 06600 06700 06800 07100 07200 07300 07400 03950 03951 03550	WHOLE BLOOD & PACKED RED BLOOD CELL RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS RENAL DIALYSIS MISC ANCILLARY SLEEP LAB PSYCHIATRIC/PSYCHOLOGICAL SERVICES WOUND CARE TIENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0	0 87, 900 52, 300 34, 700 4, 400 11, 700 0 0 0 0 0 77, 300 91, 600		78, 320 4, 112 805 148 3, 716 596, 391 2, 877, 386 0 4, 601 0	0 0 0 0 0 0 0 2, 688, 280 0 0 0	72. 00 73. 00 74. 00 76. 00
90.00	09000	CLI NI C	0	2, 200			0	1
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	0	284, 300	1, 519, 699	375, 778	0	91. 00 92. 00
118. 00	SPECI	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	87, 087	3, 400, 100	10, 677, 225	6, 559, 358	2, 688, 280	
192.00	19000 19200 07950	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES MEALS ON WHEELS Cross Foot Adjustments Negative Cost Centers	0 17, 756 11, 464	0 0 0	0 0	0	0	190. 00 192. 00 194. 00 200. 00 201. 00
202. 00		Cost to be allocated (per Wkst. B,	2, 645, 683	1, 155, 300	3, 657, 945	827, 101	2, 308, 107	•
203. 00 204. 00		Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	22. 747410 676, 679	0. 339784 2, 774	1		0. 858581 14, 826	203. 00 204. 00
205.00		Unit cost multiplier (Wkst. B, Part	5. 818042	0. 000816	0. 024470	0. 001380	0. 005515	205. 00
206. 00		NAHE adjustment amount to be allocated						206. 00
207. 00		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0047

				Ic	05/31/2019 Date/lime P 10/30/2019	
				INTERNS &		
	Cook Cooks Doors at the	MEDICAL	COCLAL CEDVICE	RESI DENTS		
	Cost Center Description	MEDICAL RECORDS &	SOCIAL SERVICE	PRGM COSTS		
		LI BRARY	(TOTAL PATIENT	APPRV		
		(GROSS CHAR	DAYS)	(ROTATIONS)		
		GES)	17.00	22.22		
	GENERAL SERVICE COST CENTERS	16. 00	17. 00	22. 00		
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	00590 REVENUE CYCLE					5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES					5. 02
5. 03 7. 00	00591 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT					5. 03 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10. 00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					13.00
14. 00 15. 00	01500 PHARMACY					14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LI BRARY	423, 362, 560				16. 00
17. 00	01700 SOCIAL SERVICE	0	1			17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	100		22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	0, 000 050	1 44 070			
30.00	03000 ADULTS & PEDI ATRI CS	26, 209, 952		100		30.00
33. 00 40. 00	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	14, 413, 967 30, 957, 832		0		33. 00 40. 00
44. 00	04400 SKILLED NURSING FACILITY	3, 878, 425				44. 00
	ANCILLARY SERVICE COST CENTERS		,	·		
50. 00	05000 OPERATING ROOM	30, 406, 145		0		50. 00
51.00	05100 RECOVERY ROOM	3, 130, 379		0		51.00
53.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	3, 302, 370		0		53. 00 54. 00
54. 00 54. 01	03630 ULTRA SOUND	62, 175, 916	0	0		54. 00
56. 00	05600 RADI OI SOTOPE	0	0			56. 00
57. 00	05700 CT SCAN	0	0	0		57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	18, 262, 740		0		59. 00
60.00	06000 LABORATORY	52, 289, 561	0	0		60.00
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	1, 399, 853 11, 469, 460		0		62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 534, 530		0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	3, 617, 813		Ö		67. 00
68. 00	06800 SPEECH PATHOLOGY	200, 967	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 125, 356	0	0		69. 00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	28, 950, 381	0	0		71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	18, 060, 682 59, 509, 499		0		72. 00 73. 00
	07400 RENAL DIALYSIS	1, 282, 924		- 1		74. 00
	03950 MISC ANCILLARY	0	0	0		76. 00
76. 01	03951 SLEEP LAB	0	0	0		76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	447, 706		0		76. 02
76. 03	03952 WOUND CARE OUTPATIENT SERVICE COST CENTERS	3, 953, 416	0	0		76. 03
90. 00	09000 CLINIC	133, 124	0	0		90.00
91. 00	09100 EMERGENCY	42, 649, 562		o		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
	SPECIAL PURPOSE COST CENTERS					
118. 00		423, 362, 560	26, 719	100		118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			O		190, 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0		190.00
	07950 MEALS ON WHEELS	0		0		194. 00
200.00		_		_		200.00
201.00						201. 00
202.00		1, 556, 900	1, 425, 020	572, 773		202. 00
203.00	Part I)	0 002677	E2 222E02	5 727 720000		202 00
203.00		0. 003677 405, 976		5, 727. 730000 1, 375		203. 00 204. 00
20 7. 00	Part II)	155, 770	10,007	1, 5, 5		201.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000959	0. 706127	13. 750000		205. 00
20/ 22	NAUE adjustment amount to be all control					207.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206. 00
	1 (poi moc. 5 2)	I	1	ı		1

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od: From 06/01/2018	Worksheet B-1	
				To 05/31/2019	Date/Time Pre 10/30/2019 3:	
			INTERNS &			
	MEDIONI	COOLAL CEDVIOL	RESI DENTS	<u> </u>		
Cost Center Description		SOCIAL SERVICE		K		
	RECORDS &		PRGM COSTS			
	LI BRARY	(TOTAL PATIENT	APPRV			
	(GROSS CHAR	DAYS)	(ROTATIONS)			
	GES)	,	, ,			
	16. 00	17. 00	22.00			
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0047	Period: Worksheet C From 06/01/2018 Part I		

				From 06/01/2018 To 05/31/2019	Part I Date/Time Pre 10/30/2019 3:	pared: 37 pm
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost 1	herapy 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 CENT						
30. 00 03000 ADULTS & PEDI ATRI CS	14, 508, 138		14, 508, 13		14, 508, 138	ł
33.00 03300 BURN INTENSIVE CARE UNIT	6, 064, 832		6, 064, 83		6, 064, 832	•
40. 00 04000 SUBPROVI DER - I PF	4, 686, 761		4, 686, 76		4, 686, 761	40. 00
44.00 04400 SKILLED NURSING FACILITY	3, 614, 553		3, 614, 55	3 0	3, 614, 553	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 269, 787		4, 269, 78		4, 269, 787	
51.00 05100 RECOVERY ROOM	1, 061, 392		1, 061, 39		1, 061, 392	51. 00
53. 00 05300 ANESTHESI OLOGY	1, 640, 316		1, 640, 31		1, 640, 316	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 996, 277		5, 996, 27	7 0	5, 996, 277	54.00
54.01 03630 ULTRA SOUND	0			0	0	54. 01
56. 00 05600 RADI OI SOTOPE	0			0	0	56. 00
57.00 05700 CT SCAN	0			0	0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 157, 458		3, 157, 45		3, 157, 458	59. 00
60. 00 06000 LABORATORY	6, 324, 185		6, 324, 18	5 0	6, 324, 185	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOO	DD CELL 317, 904		317, 90	0	317, 904	62.00
65. 00 06500 RESPIRATORY THERAPY	1, 751, 985	0	1, 751, 98	5 0	1, 751, 985	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 311, 547	0	1, 311, 54	.7	1, 311, 547	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	785, 367	0	785, 36	7 0	785, 367	67. 00
68. 00 06800 SPEECH PATHOLOGY	155, 326	0	155, 32	6 0	155, 326	68. 00
69. 00 06900 ELECTROCARDI OLOGY	254, 557		254, 55	7 0	254, 557	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO P	PATI ENT 1, 523, 942		1, 523, 94	.2 0	1, 523, 942	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	S 4, 455, 452		4, 455, 45	2 0	4, 455, 452	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 090, 245		7, 090, 24	5 0	7, 090, 245	73. 00
74.00 07400 RENAL DIALYSIS	514, 690		514, 69	0 0	514, 690	74. 00
76.00 03950 MISC ANCILLARY	o			0 0	0	76. 00
76. 01 03951 SLEEP LAB	o			0 0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SER	RVI CES 786, 470		786, 47	0	786, 470	76. 02
76. 03 03952 WOUND CARE	2, 321, 591		2, 321, 59	0 1	2, 321, 591	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	236, 415		236, 41		236, 415	90. 00
91. 00 09100 EMERGENCY	6, 701, 314		6, 701, 31	4 0	6, 701, 314	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTING	T PART 1, 491, 218		1, 491, 21	8	1, 491, 218	92.00
200.00 Subtotal (see instructions)	81, 021, 722	0	81, 021, 72	2 0	81, 021, 722	200. 00
201.00 Less Observation Beds	1, 491, 218		1, 491, 21	8	1, 491, 218	201. 00
202.00 Total (see instructions)	79, 530, 504	0	79, 530, 50	0	79, 530, 504	202. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0047	Period: Worksheet C From 06/01/2018 Part I		

00	3.7 3.7 10.1.7 3.7 33.5 13.5 3.1 11.0.2 3				From 06/01/2018 To 05/31/2019	Part I Date/Time Pre	nared:
						10/30/2019 3:	37 pm
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	21, 359, 682		21, 359, 68			30. 00
	300 BURN INTENSIVE CARE UNIT	14, 413, 967		14, 413, 96			33. 00
	000 SUBPROVI DER - I PF	30, 957, 832		30, 957, 83			40. 00
	400 SKILLED NURSING FACILITY	3, 878, 425		3, 878, 42	5		44. 00
	CILLARY SERVICE COST CENTERS						
	000 OPERATING ROOM	12, 962, 438	17, 443, 707				
	100 RECOVERY ROOM	1, 538, 780	1, 591, 599			0. 000000	
	300 ANESTHESI OLOGY	1, 603, 066	1, 699, 304			0. 000000	
	400 RADI OLOGY-DI AGNOSTI C	15, 336, 634	46, 839, 282	62, 175, 91		0. 000000	
	630 ULTRA SOUND	0	0		0. 000000	0. 000000	
	600 RADI OI SOTOPE	0	0		0. 000000	0. 000000	
	700 CT SCAN	0	0		0. 000000	0. 000000	
	900 CARDI AC CATHETERI ZATI ON	7, 839, 191	10, 423, 549			0. 000000	
	000 LABORATORY	21, 908, 971	30, 380, 590			0. 000000	
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 225, 456	174, 397			0. 000000	
	500 RESPI RATORY THERAPY	9, 641, 184	1, 828, 276			0. 000000	
	600 PHYSI CAL THERAPY	3, 469, 094	65, 436			0. 000000	
	700 OCCUPATI ONAL THERAPY	3, 567, 727	50, 086			0. 000000	
	800 SPEECH PATHOLOGY	194, 058	6, 909			0. 000000	
	900 ELECTROCARDI OLOGY	1, 225, 568	1, 899, 788			0. 000000	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 687, 005	17, 263, 376			0. 000000	
	200 I MPL. DEV. CHARGED TO PATIENTS	8, 269, 854	9, 790, 828			0. 000000	
	300 DRUGS CHARGED TO PATIENTS	43, 607, 744	15, 901, 755			0.000000	
	400 RENAL DIALYSIS	1, 235, 872	47, 052	1, 282, 92		0. 000000	
	950 MISC ANCILLARY	0	0		0.000000	0. 000000	
76. 01 03	951 SLEEP LAB	0	0	(0.000000	0.000000	76. 01
76. 02 03	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	27, 920	419, 786	447, 70	1. 756666	0.000000	76. 02
76. 03 03	952 WOUND CARE	812, 058	3, 141, 358	3, 953, 41	0. 587237	0. 000000	76. 03
	TPATIENT SERVICE COST CENTERS						
	000 CLI NI C	15, 706	117, 418	133, 12	1. 775901	0. 000000	
	100 EMERGENCY	8, 597, 288	34, 052, 274	42, 649, 56	0. 157125	0. 000000	
92. 00 09	200 OBSERVATION BEDS (NON-DISTINCT PART	1, 162, 609	3, 687, 661	4, 850, 27	0. 307451	0. 000000	92.00
200. 00	Subtotal (see instructions)	226, 538, 129	196, 824, 431	423, 362, 56	o		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	226, 538, 129	196, 824, 431	423, 362, 56	o		202. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN:		From 06/01/2018 To 05/31/2019	Worksheet C Part I Date/Time Prepared:	

			10 03/31/2019	10/30/2019 3: 37	
		Title XVIII	Hospi tal	PPS	-
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					0. 00
33.00 03300 BURN INTENSIVE CARE UNIT					3. 00
40. 00 04000 SUBPROVI DER - I PF					0. 00
44.00 04400 SKILLED NURSING FACILITY				4	4. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 140425			l l	0. 00
51.00 05100 RECOVERY ROOM	0. 339062				1. 00
53. 00 05300 ANESTHESI OLOGY	0. 496709				3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 096441			l l	4. 00
54.01 03630 ULTRA SOUND	0. 000000				4. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000				6. 00
57.00 05700 CT SCAN	0. 000000				7. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 172891				9. 00
60. 00 06000 LABORATORY	0. 120945				0. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 227098				2. 00
65. 00 06500 RESPI RATORY THERAPY	0. 152752			65	5. 00
66. 00 06600 PHYSI CAL THERAPY	0. 371067			66	6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 217083				7. 00
68. 00 06800 SPEECH PATHOLOGY	0. 772893				8. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 081449				9. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 052640				1. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 246693				2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 119145				3. 00
74. 00 07400 RENAL DI ALYSI S	0. 401185			l l	4. 00
76.00 03950 MISC ANCILLARY	0. 000000				6. 00
76. 01 03951 SLEEP LAB	0. 000000				6. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 756666			76	6. 02
76. 03 03952 WOUND CARE	0. 587237			76	6. 03
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	1. 775901				0. 00
91. 00 09100 EMERGENCY	0. 157125				1. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 307451				2. 00
200.00 Subtotal (see instructions)					0. 00
201.00 Less Observation Beds				l l	1. 00
202.00 Total (see instructions)				202	2. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0047	Period: Worksheet C From 06/01/2018 Part I		

					From 06/01/2018 To 05/31/2019	Part I Date/Time Pre 10/30/2019 3:	pared: 37 pm
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 ADULTS & PEDI ATRI CS	14, 508, 138		14, 508, 1	38 0	14, 508, 138	30. 00
33.00	03300 BURN INTENSIVE CARE UNIT	6, 064, 832		6, 064, 8	32 0	6, 064, 832	33. 00
40.00	04000 SUBPROVI DER - I PF	4, 686, 761		4, 686, 70	51 0	4, 686, 761	40.00
44.00	04400 SKILLED NURSING FACILITY	3, 614, 553		3, 614, 5	53 0	3, 614, 553	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 269, 787		4, 269, 78	37 0	4, 269, 787	50. 00
51.00	05100 RECOVERY ROOM	1, 061, 392		1, 061, 39	92 0	1, 061, 392	51.00
53.00	05300 ANESTHESI OLOGY	1, 640, 316		1, 640, 3	16 0	1, 640, 316	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 996, 277		5, 996, 2	77 0	5, 996, 277	54. 00
54. 01	03630 ULTRA SOUND	0			0 0	0	54. 01
56.00	05600 RADI OI SOTOPE	0			0 0	0	56. 00
57.00	05700 CT SCAN	0			0 0	0	57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 157, 458		3, 157, 4!	58 0	3, 157, 458	59. 00
60.00	06000 LABORATORY	6, 324, 185		6, 324, 18	35 0	6, 324, 185	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	317, 904		317, 90	04	317, 904	62.00
65.00	06500 RESPIRATORY THERAPY	1, 751, 985	0	1, 751, 98	35 0	1, 751, 985	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 311, 547	0	1, 311, 5	17 0	1, 311, 547	66.00
67.00	06700 OCCUPATI ONAL THERAPY	785, 367	0	785, 30	57 0	785, 367	67.00
68.00	06800 SPEECH PATHOLOGY	155, 326	0	155, 3	26 0	155, 326	68. 00
69.00	06900 ELECTROCARDI OLOGY	254, 557		254, 5	57 0	254, 557	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 523, 942		1, 523, 9	12 0	1, 523, 942	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 455, 452		4, 455, 4	52 0	4, 455, 452	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 090, 245		7, 090, 2	15 0	7, 090, 245	73. 00
74.00	07400 RENAL DIALYSIS	514, 690		514, 69	90 0	514, 690	74. 00
76.00	03950 MISC ANCILLARY	O			0 0	0	76. 00
76. 01	03951 SLEEP LAB	o			0 0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	786, 470		786, 4 ⁻	70 0	786, 470	76. 02
76. 03	03952 WOUND CARE	2, 321, 591		2, 321, 59	91 0	2, 321, 591	76. 03
	OUTPATIENT SERVICE COST CENTERS				-		
90.00	09000 CLI NI C	236, 415		236, 4	15 0	236, 415	90.00
91.00	09100 EMERGENCY	6, 701, 314		6, 701, 3 ⁻	14 0	6, 701, 314	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 491, 218		1, 491, 2 ⁻	18	1, 491, 218	92.00
200.00		81, 021, 722	0			81, 021, 722	
201.00	Less Observation Beds	1, 491, 218		1, 491, 2 ⁻	18	1, 491, 218	201.00
202.00	Total (see instructions)	79, 530, 504	0				

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0047	Period: Worksheet C From 06/01/2018 Part I		

					rom 06/01/2018 o 05/31/2019	Part I Date/Time Pre 10/30/2019 3:	pared: 37 pm
			Titl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
			7.00	0.00		Rati o	
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00	03000 ADULTS & PEDIATRICS	21, 359, 682		21, 359, 682			30.00
33. 00	03300 BURN INTENSIVE CARE UNIT	14, 413, 967		14, 413, 967			33.00
40. 00	04000 SUBPROVI DER – I PF	30, 957, 832		30, 957, 832			40.00
44. 00	04400 SKILLED NURSING FACILITY	3, 878, 425		3, 878, 425			44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	3, 676, 425		3, 070, 420	<u>'</u>		44.00
50.00	05000 OPERATING ROOM	12, 962, 438	17, 443, 707	30, 406, 145	0. 140425	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	1, 538, 780	1, 591, 599			0. 000000	
53. 00	05300 ANESTHESI OLOGY	1, 603, 066	1, 699, 304	3, 302, 370		0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	15, 336, 634	46, 839, 282	62, 175, 916		0. 000000	1
54. 01	03630 ULTRA SOUND	0	0	(0. 000000	0. 000000	
56. 00	05600 RADI OI SOTOPE	0	0	Ċ		0.000000	
57. 00	05700 CT SCAN	0	0	Ċ		0.000000	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	7, 839, 191	10, 423, 549	18, 262, 740	0. 172891	0.000000	59. 00
60.00	06000 LABORATORY	21, 908, 971	30, 380, 590	52, 289, 561	0. 120945	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 225, 456	174, 397	1, 399, 853	0. 227098	0.000000	62.00
65.00	06500 RESPI RATORY THERAPY	9, 641, 184	1, 828, 276	11, 469, 460	0. 152752	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	3, 469, 094	65, 436	3, 534, 530		0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	3, 567, 727	50, 086	3, 617, 813		0.000000	
68. 00	06800 SPEECH PATHOLOGY	194, 058	6, 909			0.000000	
69. 00	06900 ELECTROCARDI OLOGY	1, 225, 568	1, 899, 788			0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 687, 005	17, 263, 376	28, 950, 381		0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	8, 269, 854	9, 790, 828	18, 060, 682		0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	43, 607, 744	15, 901, 755	59, 509, 499		0. 000000	
74.00	07400 RENAL DIALYSIS	1, 235, 872	47, 052	1, 282, 924		0. 000000	
76. 00	03950 MISC ANCILLARY	0	0	(0. 000000	
76. 01	03951 SLEEP LAB	0	0	(0.00000	0. 000000	1
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	27, 920	419, 786	447, 706		0. 000000	
76. 03	03952 WOUND CARE	812, 058	3, 141, 358	3, 953, 416	0. 587237	0. 000000	76. 03
00.00	OUTPATIENT SERVICE COST CENTERS	15 70/	117 410	122 12	1 775001	0.000000	00.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	15, 706 8, 597, 288	117, 418 34, 052, 274			0. 000000 0. 000000	90. 00 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		34, 052, 274	42, 649, 562			1
92. 00 200. 00		1, 162, 609 226, 538, 129	196, 824, 431	4, 850, 270 423, 362, 560		0. 000000	200. 00
200.00		220, 330, 129	190, 024, 431	423, 302, 500	ή		200.00
201.00		226, 538, 129	196, 824, 431	423, 362, 560			201.00
202.00	Total (300 Histi doti olis)	220, 330, 129	170,024,431	125, 502, 500	1		1202.00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0047	Peri od: Worksheet C From 06/01/2018 Part I To 05/31/2019 Date/Time Prepared:		

IMPATIENT ROUTINE SERVICE COST CENTERS 11.00				10 05/31/2019	10/30/2019 3: 37 p	
Ratio 11.00 10.0			Title XIX	Hospi tal		
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 33000 ADULTS & PEDIATRICS 30.00 33000 ADULTS & PEDIATRICS 30.00 33000 BURN INTENSIVE CARE UNIT 40.00 44.00 044000 SWIBPROVIDER - I PF 40.00 0550000 0550000 0550000 0550000 0550000 05500000 055000000 055000000 0550000000 05500000	Cost Center Description	PPS Inpatient				
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 330.						
30.00		11. 00				
33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 34.0						
40.00 04400 SUBPROVI DER - I PF 40.00 04400 SKILLED NURSI NG FACILITY 44.00 NAILLED NU						
44. 00 04400 SKI LLEDN WIRSI NG FACILITY						
ANCILLARY SERVICE COST CENTERS 50.00						
50. 00 05000 OPERATI NG ROOM 0. 140425 51. 00 51. 00 05100 RECOVERY ROOM 0. 339062 51. 00 51. 00 05300 ARESTHESI OLOGY 0. 496709 53. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 096441 54. 01 05430 ULTRA SOUND 0. 000000 54. 01 05400 RADI OLOGY-DI AGNOSTI C 0. 000000 54. 01 05400 RADI OLOGY-DI AGNOSTI C 0. 000000 54. 01 05600 RADI OLOGY-DI AGNOSTI C 0. 000000 54. 01 05600 RADI OLOGY-DI AGNOSTI C 0. 000000 55. 00 05600 RADI OLOGY-DI AGNOSTI C 0. 000000 55. 00 05600 RADI OLOGY-DI AGNOSTI C 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 00000 0. 00000 0. 00000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000					44	r. 00
51.00 05100 RECOVERY ROOM 0.339062 51.00 05300 ANESTHESI OLOGY 0.496709 53.00 05300 ANESTHESI OLOGY 0.96441 54.00 05400 RADI OLOCY-DI AGNOSTI C 0.996441 54.00 05400 RADI OLOCY-DI AGNOSTI C 0.000000 54.01 03630 ULTRA SQUND 0.000000 55.00 05700 CT SCAN 0.000000 57.00 05900 CARDI AC CATHETERI ZATI ON 0.172891 69.00 06000 LABORATORY 69.00 06000 LABORATORY 69.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.227098 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.227098 65.00 06500 RESPI RATORY THERAPY 0.371067 66.00 06600 PHYSI CAL THERAPY 0.371067 66.00 06600 PHYSI CAL THERAPY 0.371067 66.00 06900 06000 PHYSI CAL THERAPY 0.217083 67.00 06700 06700 06700 0CCUPATI ONAL THERAPY 0.217083 68.00 06800 SPEECH PATHOLOGY 0.081449 69.00 06900 ELECTROCARDI OLOGY 0.081449 69.00 06900 ELECTROCARDI OLOGY 0.081449 69.00 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.246693 72.00 07200 MPUL DEV. CHARGED TO PATI ENTS 0.246693 72.00 07300 DRUGS CHARGED TO PATI ENTS 0.119145 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.119145 73.00 74.00 07400 RENAL DI ALYSI S 0.401185 74.00 0.00000 76.00 0.00000 76.00 0.00000 76.00 0.00000 76.00 0.00000 76.00 0.00000 76.00 0.00000 76.00 0.00000 76.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000						
53. 00 05300 ANESTHESI OLOGY 0. 496709 53. 00 54. 00 05400 RADI OLOGY-DIAGNOSTI C 0. 096441 54. 00 54. 01 03630 ULTRA SOUND 0. 000000 55. 00 57. 00 05700 CT SCAN 0. 000000 56. 00 57. 00 05700 CT SCAN 0. 000000 57. 00 60. 00 06900 CARDI AC CATHETERI ZATI ON 0. 172891 59. 00 60. 00 06000 LABORATORY 0. 120945 60. 00 62. 00 06200 MHOLE BLOOD & PACKED RED BLOOD CELL 0. 227098 62. 00 65. 00 06500 RESPIRATORY THERAPY 0. 152752 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 3172893 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 217083 67. 00 68. 00 08600 SPEECH PATHOLOGY 0. 712893 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 081449 69. 00 71. 00 07100 IMEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 246693 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 246693 73. 00 76. 00 03950 I SC ANCI LLARY 0. 000000		I I				
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.096441 54. 00 54. 01 03600 ULTRA SOUND 0.000000 55. 00 56. 00 05600 RADI OL SOTOPE 0.000000 55. 00 57. 00 05700 CT SCAN 0.000000 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.172891 59. 00 60. 00 06000 LABORATORY 0.120945 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.227098 62. 00 65. 00 06500 RESPI RATORY THERAPY 0.152752 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.371067 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.217083 67. 00 68. 00 06800 SPECEN PATHOLOGY 0.77283 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.081449 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.246693 72. 00 72. 00 07200 INPL. DEV. CHARGED TO PATI ENTS 0.19145 73. 00						
54. 01 0.3630 ULTRA SOUND 0.000000 54. 01		I I				
56. 00 05600 RADI OI SOTOPE 0.000000 57. 00 5700 CT SCAN 0.000000 57. 00 5700 CT SCAN 0.000000 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.172891 59. 00 06000 LABORATORY 0.120945 60. 00 06200 LABORATORY 0.120945 62. 00 06500 RESPI RATORY THERAPY 0.5152752 65. 00 06500 PHYSI CAL THERAPY 0.371067 66. 00 06600 PHYSI CAL THERAPY 0.217083 67. 00 06700 0CCUPATI ONAL THERAPY 0.217083 67. 00 06900 ELECTROCARDI OLOGY 0.081449 69. 00 06900 ELECTROCARDI OLOGY 0.081449 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.052640 71. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0.246693 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.119145 73. 00 74. 00 07400 RENAL DI ALYSIS 0.401185 74. 00 76. 00 03951 SLEEP LAB 0.000000 76. 00 03951 SLEEP LAB 0.000000 0.5500 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1.756666 0.5500 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1.756666 0.000000 0.000000 0.0000000 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 0.00000000		I I				
57. 00 05700 CT SCAN 0.000000 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.172891 59. 00 60. 00 06000 LABORATORY 0.12945 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.227098 62. 00 65. 00 06500 RESPI RATORY THERAPY 0.152752 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.371067 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.217083 67. 00 68. 00 06800 SPECH PATHOLOGY 0.772893 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.772893 68. 00 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.052640 71. 00 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.246693 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.191145 73. 00 74. 00 07400 RENAL DI ALYSI S 0.401185 74. 00 76. 01 03950 MI SC ANCI LLARY 0.000000 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1.756666 76. 02 76. 03 099000 CLI NI C		· ·				
59. 00 05900 CARDIAC CATHETERIZATION 0. 172891 59. 00 60. 00 06000 LABORATORY 0. 120945 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 227098 62. 00 65. 00 06500 RESPI RATORY THERAPY 0. 152752 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 371067 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 217083 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 7172893 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 081449 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 052640 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 246693 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 119145 73. 00 74. 00 07400 RENAL DI ALYSI S 0. 401185 74. 00 76. 01 03951 SLEEP LAB 0. 000000 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1. 756666 76. 02 76. 03 09000 CLI NI C 1. 775901 90. 00 91. 00 09000 OBSERVATI						
60. 00 06000 LABORATORY 0. 120945 62. 00 6200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 227098 62. 00 66. 00 06500 RESPI RATORY THERAPY 0. 152752 65. 00 06600 PHYSI CAL THERAPY 0. 371067 66. 00 06700 0CCUPATI ONAL THERAPY 0. 217083 67. 00 06700 0CCUPATI ONAL THERAPY 0. 722893 67. 00 06900 ELECTROCARDI OLOGY 0. 081449 68. 00 06900 ELECTROCARDI OLOGY 0. 081449 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 052640 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 246693 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 246693 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 401185 73. 00 07400 RENAL DI ALYSI S 0. 401185 74. 00 07400 RENAL DI ALYSI S 0. 401185 74. 00 07400 RENAL DI ALYSI S 0. 401185 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1. 756666 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1. 756666 76. 02 03950 MI SC ANCI LLARY 0. 000000 76. 01 03950 MI SC ANCI LLARY 0. 0000000 76. 01 03950 MI SC ANCI LLARY 0. 0000000 MI SC ANCI LLARY 0. 00000		•				
62. 00		•				
65. 00 06500 RESPIRATORY THERAPY 0. 152752 66. 00 06600 PHYSI CAL THERAPY 0. 371067 66. 00 06700 0CCUPATI ONAL THERAPY 0. 217083 67. 00 06800 SPEECH PATHOLOGY 0. 772893 68. 00 06800 SPEECH PATHOLOGY 0. 081449 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 052640 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 246693 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 246693 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 119145 73. 00 07400 RENAL DIALYSI S 0. 401185 74. 00 07400 RENAL DIALYSI S 0. 401185 74. 00 076. 01 03951 SLEEP LAB 0. 000000 76. 01 03951 SLEEP LAB 0. 000000 76. 01 03952 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1. 756666 76. 02 03952 WOUND CARE 0. 587237 76. 03 00000 09100 EMERGENCY 0. 0157125 90. 00 09100 EMERGENCY 0. 0157125 91. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 0. 307451 0						
66. 00					· · · · · · · · · · · · · · · · · · ·	
67. 00						
68. 00		•				
69. 00						
71. 00						
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 246693 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 119145 73. 00 74. 00 07400 RENAL DI ALYSI S 0. 401185 74. 00 76. 00 03950 MI SC ANCI LLARY 0. 0. 000000 76. 00 76. 01 03951 SLEEP LAB 0. 000000 76. 00 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1. 756666 76. 02 76. 03 03952 WOUND CARE 0. 587237 76. 03 000000 09100 CLI NI C 0. 1. 775901 90. 00 91. 00 09100 BERRGENCY 0. 157125 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 307451 200. 00 201. 00 Less Observati on Beds 201. 00 200. 00 201.						
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 119145 73. 00 07400 RENAL DI ALYSI S 0. 401185 74. 00 03950 MI SC ANCI LLARY 0. 000000 76. 01 03951 SLEEP LAB 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000		•				
74. 00 07400 RENAL DI ALYSI S 0. 401185 74. 00 76. 00 03950 MI SC ANCI LLARY 0. 000000 76. 01 03951 SLEEP LAB 0. 000000 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1. 756666 76. 02 03952 WOUND CARE 0. 587237 76. 03 0017PATI ENT SERVI CE COST CENTERS 09000 CLI NI C 90. 00 91. 00 09100 EMERGENCY 0. 157125 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 307451 92. 00 200. 00 Less Observati on Beds 200. 00 201. 00 0000000000000000000000000000000						
76. 00 03950 MI SC ANCI LLARY 0. 000000 76. 01 03951 SLEEP LAB 0. 0000000 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1. 756666 0. 587237 76. 03 03952 WOUND CARE 0. 587237 76. 03 09000 CLI NI C 76. 00 09000 CLI NI C 90. 00 09100 EMERGENCY 0. 157125 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 307451 92. 00 09000 Less Observati on Beds 200. 00 201. 00 Less Observati on Beds 200. 00 201. 00		· ·				
76. 01 03951 SLEEP LAB 0. 000000 76. 02 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 1. 756666 76. 02 03952 WOUND CARE 0. 587237 76. 03 000000 CLI NI C 76. 00 09000 CLI NI C 76. 00 09100 EMERGENCY 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 200. 00 00000 CLI SS 00000 CLI SS 00000 CLI SS 00000 CLI SS 00000 CLI SI (see i nstructi ons) 200. 00 201. 00 Less Observati on Beds 201. 00 201. 00		· ·			• • • • • • • • • • • • • • • • • • •	
76. 02 76. 03 76						
76. 03 03952 WOUND CARE 0. 587237 70UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 1. 775901 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 307451 92. 00 0000 Subtotal (see instructions) 200. 00 Less Observation Beds 201. 00 201. 00		· · · · · · · · · · · · · · · · · · ·				
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 91.00 09100 EMERGENCY 0.157125 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						
90. 00 9000 CLINIC 1.775901 90. 00 91. 00 92. 00 92. 00 92. 00 Subtotal (see instructions) Less Observation Beds 1.875901 92. 00 9		0. 587237			76	. 03
91.00 09100 EMERGENCY 0.157125 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 201.00 Less Observation Beds 0.157125 0.307451 92.00 200.00 201.00						
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 307451 92. 00 200. 00 201. 00 Less Observation Beds 92. 00 201. 00						
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						
201.00 Less Observation Beds 201.00	· ·	0. 307451				
202.00 Total (see instructions)						
	202.00 Total (see instructions)				202	00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE CO	ST TO CHARGE RATIOS NET OF	Provider CCN: 15-0047	Peri od:	Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 06/01/2018	

REDUCTIONS FOR MEDICALD ONLY				To 05/31/2019		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	(Wkst. B, Part				Reduction	
	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						
50.00 05000 OPERATING ROOM	4, 269, 787	761, 732			0	
51.00 05100 RECOVERY ROOM	1, 061, 392	262, 987	·		0	
53. 00 05300 ANESTHESI OLOGY	1, 640, 316	9, 847			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 996, 277	773, 465	5, 222, 812	2 0	0	54. 00
54.01 03630 ULTRA SOUND	0	0	(0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	(0	0	56. 00
57. 00 05700 CT SCAN	0	0	(0	0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 157, 458	142, 370	3, 015, 088	3 0	0	59. 00
60. 00 06000 LABORATORY	6, 324, 185	673, 059	5, 651, 126	5 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	317, 904	38, 412	279, 492	2 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	1, 751, 985	248, 843	1, 503, 142	2 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 311, 547	295, 916	1, 015, 63	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	785, 367	118, 507	666, 860	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	155, 326	42, 873	112, 453	3 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	254, 557	47, 082	207, 475	5 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 523, 942	76, 668	1, 447, 274	1 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 455, 452	145, 471	4, 309, 98	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 090, 245	227, 210	6, 863, 035	5 0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	514, 690	80, 584	434, 106	0	0	74. 00
76.00 03950 MISC ANCILLARY	0	0	(0	0	76. 00
76. 01 03951 SLEEP LAB	0	0		o	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	786, 470	128, 983	657, 487	7 0	0	76. 02
76. 03 03952 WOUND CARE	2, 321, 591	361, 627	1, 959, 964	1 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS			<u> </u>	<u>'</u>		
90. 00 09000 CLI NI C	236, 415	87, 139	149, 276	5 0	0	90. 00
91. 00 09100 EMERGENCY	6, 701, 314	679, 656	6, 021, 658	3 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 491, 218	197, 488		o o	0	92.00
200.00 Subtotal (sum of lines 50 thru 199)	52, 147, 438				0	200.00
201.00 Less Observation Beds	1, 491, 218	197, 488	1, 293, 730	o	0	201. 00
202.00 Total (line 200 minus line 201)	50, 656, 220					202. 00
			•	•	•	•

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COS REDUCTIONS FOR MEDICALD ONLY	T TO CHARGE RATIOS NET OF	Provider CCN: 15-0047	From 06/01/2018	Worksheet C Part II Date/Time Prepared:

						10/30/2019 3	: 37 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Total Charges	Outpati ent			
				Cost to Charge			
		Operating Cost					
		Reducti on	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	ILLARY SERVICE COST CENTERS				_		
4	OO OPERATING ROOM	4, 269, 787	30, 406, 145				50. 00
	OO RECOVERY ROOM	1, 061, 392	3, 130, 379	•			51. 00
4	00 ANESTHESI OLOGY	1, 640, 316	3, 302, 370	•			53. 00
	OO RADI OLOGY-DI AGNOSTI C	5, 996, 277	62, 175, 916				54. 00
	30 ULTRA SOUND	0	0	0. 000000			54. 01
1	00 RADI 0I SOTOPE	0	0	0.000000			56. 00
	00 CT SCAN	0	0	0.000000			57. 00
59. 00 059	OO CARDI AC CATHETERI ZATI ON	3, 157, 458	18, 262, 740	0. 172891			59. 00
	00 LABORATORY	6, 324, 185	52, 289, 561				60.00
62. 00 062	00 WHOLE BLOOD & PACKED RED BLOOD CELL	317, 904	1, 399, 853	0. 227098	3		62. 00
65. 00 065	00 RESPI RATORY THERAPY	1, 751, 985	11, 469, 460	0. 152752	2		65. 00
66. 00 066	00 PHYSI CAL THERAPY	1, 311, 547	3, 534, 530	0. 371067	'		66. 00
67. 00 067	00 OCCUPATI ONAL THERAPY	785, 367	3, 617, 813	0. 217083	3		67. 00
68. 00 068	00 SPEECH PATHOLOGY	155, 326	200, 967	0. 772893	3		68. 00
69. 00 069	00 ELECTROCARDI OLOGY	254, 557	3, 125, 356	0. 081449			69. 00
71. 00 071	OO MEDICAL SUPPLIES CHARGED TO PATIENT	1, 523, 942	28, 950, 381	0. 052640			71. 00
72. 00 072	00 IMPL. DEV. CHARGED TO PATIENTS	4, 455, 452	18, 060, 682	0. 246693	3		72. 00
73.00 073	OO DRUGS CHARGED TO PATIENTS	7, 090, 245	59, 509, 499	0. 119145	5		73. 00
74.00 074	00 RENAL DIALYSIS	514, 690	1, 282, 924	0. 401185	5		74.00
76.00 039	50 MISC ANCILLARY	0	0	0.000000)		76. 00
76. 01 039	51 SLEEP LAB	0	0	0.000000			76. 01
76. 02 035	50 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	786, 470	447, 706	1. 756666	b		76. 02
76. 03 039	52 WOUND CARE	2, 321, 591	3, 953, 416	0. 587237	7		76. 03
OUT	PATIENT SERVICE COST CENTERS						
90.00 090	OO CLI NI C	236, 415	133, 124	1. 775901			90. 00
91. 00 091	OO EMERGENCY	6, 701, 314	42, 649, 562	0. 157125	5		91. 00
92. 00 092	OO OBSERVATION BEDS (NON-DISTINCT PART	1, 491, 218	4, 850, 270	0. 307451			92.00
200. 00	Subtotal (sum of lines 50 thru 199)	52, 147, 438	352, 752, 654				200. 00
201. 00	Less Observation Beds	1, 491, 218	0				201. 00
202. 00	Total (line 200 minus line 201)	50, 656, 220	352, 752, 654				202. 00

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 06/01/2018 To 05/31/2019	Date/Time Pre	pared:
-		Title	e XVIII	Hospi tal	10/30/2019 3: PPS	37 piii
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capi tal Related Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	Part II, col. 26)		(col . 1 - col 2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 921, 374	0	1, 921, 37	4 15, 907	120. 79	30. 00
33.00 BURN INTENSIVE CARE UNIT	419, 851		419, 85			33. 00
40. 00 SUBPROVI DER - I PF	414, 621	0	414, 62	1 5, 300		
44.00 SKILLED NURSING FACILITY	515, 864		515, 86	4 4, 623	111. 59	44. 00
200.00 Total (lines 30 through 199)	3, 271, 710		3, 271, 71	0 28, 354		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	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	2, 754	332, 656	,			30.00
33. 00 BURN INTENSIVE CARE UNIT	458				ļ	33.00
40. 00 SUBPROVI DER - PF	2, 882					40.00
44.00 SKILLED NURSING FACILITY	1, 695					44. 00
200.00 Total (lines 30 through 199)	7, 789					200. 00

Heal th Financial	Systems		ST JOSEPH MED	I CAL	CENTER		In Li€	eu of Form CMS-	2552-10
APPORTI ONMENT OF	INPATIENT ANCILLARY SERVICE CA	API TAL	_ COSTS	ſ	Provi der C	CN: 15-0047	Peri od: From 06/01/2018 To 05/31/2019	Worksheet D Part II Date/Time Pre 10/30/2019 3:	
					Ti tl e	XVIII	Hospi tal	PPS	
Cost	Center Description		Capital Related Cost (from Wkst. B, Part II, col.	(fro Par	m Wkst. C,		Program	Capital Costs (column 3 x column 4)	

				10 05/31/2019	10/30/2019 3:	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal		Ratio of Cost	I npati 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		T	T		1	
50. 00 05000 OPERATI NG ROOM	761, 732					
51. 00 05100 RECOVERY ROOM	262, 987		1	· ·		
53. 00 05300 ANESTHESI OLOGY	9, 847					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	773, 465	62, 175, 916	1			
54. 01 03630 ULTRA SOUND	0	0	0. 000000		0	54. 01
56. 00 05600 RADI OI SOTOPE	0	0	0. 000000		0	56. 00
57. 00 05700 CT SCAN	0	0	0. 000000		0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	142, 370			· · ·		
60. 00 06000 LABORATORY	673, 059					
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	38, 412			· ·		1
65. 00 06500 RESPI RATORY THERAPY	248, 843					
66. 00 06600 PHYSI CAL THERAPY	295, 916			· ·		
67. 00 06700 OCCUPATI ONAL THERAPY	118, 507					
68. 00 06800 SPEECH PATHOLOGY	42, 873		1	· ·		68. 00
69. 00 06900 ELECTROCARDI OLOGY	47, 082			· ·		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 668		1			71. 00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	145, 471		1			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	227, 210					73. 00
74. 00 07400 RENAL DI ALYSI S	80, 584	1, 282, 924			25, 084	74. 00
76. 00 03950 MISC ANCILLARY	0	0	0.00000		0	76. 00
76. 01 03951 SLEEP LAB	0	0	0.00000	0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	128, 983	447, 706				76. 02
76. 03 03952 WOUND CARE	361, 627	3, 953, 416	0. 091472	148, 576	13, 591	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	87, 139	133, 124	0. 654570		333	90.00
91. 00 09100 EMERGENCY	679, 656	42, 649, 562	0. 01593	1, 434, 651	22, 863	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	197, 488	4, 850, 270	0. 04071	331, 543		
200.00 Total (lines 50 through 199)	5, 399, 919	352, 752, 654		32, 828, 688	446, 135	200. 00

	CT LOCEDII MEI	NI OAL OENTED			6.5 046	0550 40
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ST JOSEPH MED SS THROUGH COS			In Lie Period: From 06/01/2018 Fo 05/31/2019		pared:
		Title	e XVIII	Hospi tal	PPS	07 piii
Cost Center Description	Post-Stepdown Adjustments		Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
LANDATI ENT. DOUTLAND DEDVI OF COOT OFFITEDO	1A	1.00	2A	2. 00	3. 00	
30.00 03000 ADULTS & PEDLATRICS 33.00 03300 BURN INTENSIVE CARE UNIT 40.00 04400 SUBPROVIDER - IPF 44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description	Swing-Bed Adjustment Amount (see	Total Costs (sum of cols. 1 through 3,	Total Patient Days	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 Inpatient Program Days	33. 00
	instructions)					
LANDATI ENT. DOUTLAND DEDVI OF COOT OFFITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	C	0 0 0	15, 90 2, 52 5, 30 4, 62 28, 35	0.00 0.00 3 0.00	458 2, 882 1, 695	33. 00 40. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					

30. 00 33. 00

40. 00 44. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 33. 00 03300 BURN INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 44. 00 04400 SKILLED NURSING FACILITY 200. 00 Total (lines 30 through 199)
 Heal th Financial
 Systems
 ST JOSEPH MEDICAL

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS
 ST JOSEPH MEDICAL CENTER Provider CCN: 15-0047

THROUGH COSTS

Non Physician Non Physicia							10/30/2019 3:	37 pm
Anesthetist Cost And justments Anesthetist Cost And justments Anesthetist Cost Cos				Title	XVIII	Hospi tal	PPS	
Cost Adj ustments Adj ustments Adj ustments Cost Adj ustments Cost Adj ustments Cost Adj ustments Cost C		Cost Center Description		Nursing School	Nursing Schoo	Allied Health	Allied Health	
1.00 2A 2.00 3A 3.00			Anestheti st	Post-Stepdown				
ANCI LLARY SERVICE COST CENTERS								
50.00			1.00	2A	2. 00	3A	3. 00	
51. 00 05100 RECOVERY ROOM 0 0 0 0 0 0 51. 00 53. 00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 53. 00 0 0 0 0 0 0 0 0 0								
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 54. 00 54. 01 03630 ULTRA SOUND 0 0 0 0 0 0 54. 01 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATI ENTS 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 0 0 0 0 0 0 76. 03 03952 WOUND CARE 0 0 0 0 0 76. 04 03952 WOUND CARE 0 0 0 0 0 76. 05 00 09000 CLINIC C 0 0 0 0 79. 00 09000 CLINIC C 0 0 0 0 0 79. 00 09000 CLINIC C 0 0 0 0 79. 00 09000 CLINIC C 0 0 0 0 79. 00 09000 CLINIC C 0 0 0 0 79. 00 09000 CLINIC C 0 0 0 0 79. 00 09000 CLINIC C 0 0 0 0 79. 00 09000 CLINIC C 0 0 0 0 79. 00 09000 CLINIC C 0 0 0 0 79. 00 09000 CLINIC C 0 0 0 0 79. 00 09000 CLINIC C 0 0 0 79. 00 09000		l l	0	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 54. 00 54. 01 03830 ULTRA SOUND 0 0 0 0 0 54. 01 55. 00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 54. 01 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 55. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 76. 01 03951 SLEEP LAB 0 0 0 0 0 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76. 03 00TPATI ENT SERVI CE COST CENTERS 0 0 0 0 90. 00 09000 CLINI C 0 0 0 0 91. 00 09000 CLINI C 0 0 0 0 91. 00 09000 CLINI C 0 0 92. 00 09000 O0200 O0200 O0200 O0200 O0200 O0200 92. 00 09000 CLINI C 0 0 0 0 92. 00 09000 CLINI C 0 0 92. 00 09000 O0200 O0200 O0200 O0200 O0200 O0200 O0200 92. 00 09000 O0200 O0200 O0200 O0200 O0200 O0200 92. 00 09000 O0200	51.00	05100 RECOVERY ROOM	0	0		0	0	51. 00
54. 01 03630 ULTRA SOUND 0 0 0 0 0 0 54. 01 56. 00 05600 RADI DI SOTOPE 0 0 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 57. 00 59. 00 05700 CT SCAN 0 0 0 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 76. 01 03951 SLEEP LAB 0 0 0 0 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 76. 03 03952 WOUND CARE 0 0 0 0 76. 03 0000 0000 CLI NI C 0 0 79. 00 09000 CLI NI C 0 0 0 79. 00 09000 CLI NI C 0 0 79. 00 09000 09000 CLI NI C 0 0 79. 00 09000 CLI NI C 0 0 79. 00	53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 55. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 57. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 65. 00 05500 RESPI RATORY THERAPY 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06800 SPECCH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 671. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 74. 00 07400 RENAL DI ALYSIS S 0 0 0 0 76. 01 03951 MISC ANCI LLARY 0 0 0 0 76. 02 03952 MISC ANCI LLARY 0 0 0 0 76. 03 03952 WOUND CARE 0 0 0 0 76. 04 00 07400 RENAL DI ALYSIS 0 0 0 0 76. 07 07000 CLINIC 0 0 0 79. 00 07000 CLINIC 0 0 79. 00 07000 CLINIC 0 0 0 79. 00 07000 CLINIC 0 0 0 79. 00 07000 CLINIC 0 0 0 79. 00 07000 DRESENATION BEDS (NON-DISTINCT PART 0 0 0 79. 00 07000 DRESENATION BEDS (NON-DISTINCT PART 0 0 0 79. 00 07000 DRESENATION BEDS (NON-DISTINCT PART 0 0 0 79. 00 07000 DRESENATION BEDS (NON-DISTINCT PART 0 0 0 79. 00 07000 DRESENATION BEDS (NON-DISTINCT PART 0 0 0 70. 00 07000 DRESENATION BEDS (NON-DISTINCT PART 0 0 0 70. 00 07000 DRESENATION BEDS (NON-DISTINCT PART 0 0 0 70. 00 07000 DRESENATION BEDS (NON-DISTINCT PART 0 0 0 70. 00 07000 DRESENATION BEDS (NON-DISTINCT PART 0 0 0 70. 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 66. 00 68. 00 06600 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 733. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 74. 00 76. 00 03950 MISC ANCI LLARY 0 0 0 0 0 0 0 76. 00 76. 01 03951 SLEEP LAB 0 0 0 0 0 0 0 76. 00 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 0 76. 02 76. 03 03952 WOUND CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 91. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54.01	03630 ULTRA SOUND	0	0		0	0	54. 01
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0	56.00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0 60. 00 62. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 0 62. 00 65. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 67. 00 68. 00 06900 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57.00	05700 CT SCAN	0	0		0	0	57. 00
62. 00	59.00	05900 CARDI AC CATHETERI ZATI ON	O	0		0	0	59. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 65. 00 66. 00 666. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 65. 00 66. 00 66. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 66. 00 67. 00 6800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 6800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 74. 00 76. 00 03950 MI SC ANCI LLARY 0 0 0 0 0 0 0 0 76. 01 76. 01 03951 SLEEP LAB 0 0 0 0 0 0 0 76. 01 76. 01 03951 SLEEP LAB 0 0 0 0 0 0 0 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 76. 02 76. 03 03952 WOUND CARE 0 0 0 0 0 0 0 0 76. 03 0900 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60.00	06000 LABORATORY	O	0		0	0	60.00
66. 00	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	O	0		0	0	62. 00
67. 00	65.00	06500 RESPI RATORY THERAPY	o	0		0	0	65. 00
68. 00	66.00	06600 PHYSI CAL THERAPY	o	0		0	0	66. 00
69. 00	67.00	06700 OCCUPATI ONAL THERAPY	o	0		0	0	67. 00
71. 00	68.00	06800 SPEECH PATHOLOGY	O	0		0	0	68. 00
72. 00	69.00	06900 ELECTROCARDI OLOGY	o	0		0 0	0	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 74. 00 76. 00 03950 MI SC ANCI LLARY 0 0 0 0 0 0 76. 00 76. 01 03951 SLEEP LAB 0 0 0 0 0 0 0 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 76. 02 03952 WOUND CARE 0 0 0 0 0 0 76. 03 0000 CLI NI C 0 0 0 0 76. 03 09000 CLI NI C 0 0 0 0 76. 03 09100 EMERGENCY 0 0 0 0 76. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 77. 00 0 0 0 0 78. 00 0 0 0 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 94. 00 0000 0000 00000 00000 00000 95. 00 00000 000000 000000000000000	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0		0 0	0	71. 00
74. 00	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0		0	0	72. 00
76. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		0	0	73. 00
76. 01	74.00	07400 RENAL DIALYSIS	o	0		0	0	74.00
76. 02	76.00	03950 MISC ANCILLARY	o	0		0	0	76. 00
76. 03 03952 WOUND CARE 0 0 0 0 0 0 76. 03 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92. 00	76. 01	03951 SLEEP LAB	o	0		0	0	76. 01
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92. 00	76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	0		0	0	76. 02
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92. 00	76. 03	03952 WOUND CARE	0	0		0	o	76. 03
91. 00 09100 EMERGENCY			-,					
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 92. 00	90.00	09000 CLI NI C	0	0		0 0	0	90.00
	91.00	09100 EMERGENCY	0	0		0 0	0	91. 00
200.00 Total (lines 50 through 199) 0 0 0 0 200.00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	200.00	Total (lines 50 through 199)	o	0		0	0	200. 00

Health Financial Systems	ST JOSEPH MEDICAL CEN	TER In L	ieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provi	der CCN: 15-0047 Peri od:	Worksheet D
THROUGH COSTS		From 06/01/20	18 Part IV

THROUG	H COSTS				From 06/01/2018 Fo 05/31/2019	Date/Time Pre	pared:
						10/30/2019 3:	37 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of	· ·	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
		4. 00	5. 00	and 4) 6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
50.00	05000 OPERATI NG ROOM	0	C) (30, 406, 145	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	O		3, 130, 379	0. 000000	51.00
53.00	05300 ANESTHESI OLOGY	0	Ö		3, 302, 370	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	Ö		62, 175, 916	0.000000	54. 00
54. 01	03630 ULTRA SOUND	0	Ö		0	0.000000	54. 01
56.00	05600 RADI 0I S0T0PE	0	Ö		0	0.000000	56. 00
57.00	05700 CT SCAN	0	0) (0	0.000000	57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0) (18, 262, 740	0.000000	59. 00
60.00	06000 LABORATORY	0	0) (52, 289, 561	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0) (1, 399, 853	0.000000	62.00
65.00	06500 RESPIRATORY THERAPY	0	0) (11, 469, 460	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0) (3, 534, 530	0.000000	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0	0) (3, 617, 813	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0) (200, 967	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0) (3, 125, 356	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0) (28, 950, 381	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	18, 060, 682	0. 000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) (59, 509, 499	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0)	1, 282, 924	0.000000	74. 00
76.00	03950 MISC ANCILLARY	0	0) (0	0.000000	76. 00
	03951 SLEEP LAB	0	0) (0	0.000000	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0) (447, 706	0.000000	76. 02
76. 03	03952 WOUND CARE	0	0)	3, 953, 416	0. 000000	76. 03
	OUTPATIENT SERVICE COST CENTERS				T		4
	09000 CLI NI C	0	0		133, 124		
	09100 EMERGENCY	0	0		42, 649, 562		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		4, 850, 270		
200.00	Total (lines 50 through 199)	0	0) (352, 752, 654	1	200. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER In Lieu					u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVI	CE OTHER PASS	Provi der	CCN: 15-0047	Peri od: From 06/01/2018	Worksheet D Part IV	
Inkough COSTS					To 05/31/2019		pared: 37 pm_
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	R	atio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	h Charges	Pass-Through	
	(0	col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12.00	13.00	

		1		******	noopi tai		
Cost	Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12.00	13. 00	
	SERVI CE COST CENTERS						
50. 00 05000 OPER	ATING ROOM	0. 000000	3, 529, 880	0	4, 527, 009	0	50.00
51. 00 05100 REC0	VERY ROOM	0. 000000	232, 092	0	550, 267	0	51. 00
53.00 05300 ANES	STHESI OLOGY	0. 000000	331, 366	0	380, 830	0	53.00
54. 00 05400 RADI	OLOGY-DI AGNOSTI C	0. 000000	3, 887, 596	0	6, 478, 370	0	54.00
54. 01 03630 ULTR	RA SOUND	0. 000000	0	0	0	0	54. 01
56. 00 05600 RADI	OI SOTOPE	0. 000000	0	o	0	0	56.00
57.00 05700 CT S	SCAN	0. 000000	0	О	0	0	57. 00
59. 00 05900 CARD	DI AC CATHETERI ZATI ON	0. 000000	1, 683, 748	o	2, 379, 235	0	59. 00
60. 00 06000 LABO	RATORY	0. 000000	3, 848, 893		1, 784, 199		60.00
62. 00 06200 WHOL	E BLOOD & PACKED RED BLOOD CELL	0. 000000	183, 177	l o	68, 831	l 0'	62.00
1 1	PI RATORY THERAPY	0. 000000	2, 263, 744		370, 126		65.00
	SI CAL THERAPY	0. 000000	222, 236		6, 451		66, 00
	IPATI ONAL THERAPY	0. 000000	173, 338		5, 388		67. 00
1 1	CH PATHOLOGY	0. 000000	41, 281		750		68. 00
	TROCARDI OLOGY	0. 000000	241, 515		370, 148		69. 00
	CAL SUPPLIES CHARGED TO PATIENT	0. 000000	3, 610, 869		6, 048, 659		71. 00
	. DEV. CHARGED TO PATIENTS	0. 000000	2, 512, 813		3, 355, 638		72.00
	S CHARGED TO PATIENTS	0. 000000	7, 749, 589		3, 516, 308		73. 00
74. 00 07400 RENA		0. 000000	399, 340		47, 051		74. 00
76. 00 03950 MI SC		0. 000000	0,,,0.10	0	.,,	0	76. 00
76. 01 03951 SLEE		0. 000000	0	0	0	0	76. 01
	CHIATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	1, 932	0	248, 720	0	76. 02
76. 03 03952 WOUN		0. 000000	148, 576		1, 271, 894		76. 03
	SERVICE COST CENTERS	0.00000	110,010	<u>ا</u>	1,2,1,0,1		70.00
90. 00 09000 CLIN		0. 000000	509	0	8, 070	0	90.00
91. 00 09100 EMER		0. 000000	1, 434, 651		2, 985, 173		
1 1	RVATION BEDS (NON-DISTINCT PART	0. 000000	331, 543		769, 328		ı
1 1	Il (lines 50 through 199)	3. 000000	32, 828, 688		35, 172, 445		200. 00
200.00 10ta	ii (iiiica ao tiii ougii 177)	1	32, 020, 000	١	33, 172, 443	, 0	1200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0047 Peri od: Worksheet D From 06/01/2018 Part V 05/31/2019 Date/Time Prepared: 10/30/2019 3:37 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed 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.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 140425 4, 527, 009 635, 705 50.00 51.00 05100 RECOVERY ROOM 0. 339062 550, 267 0 0 186, 575 51.00 05300 ANESTHESI OLOGY 0 53 00 0 496709 380, 830 189, 162 53 00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.096441 6, 478, 370 624, 780 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 Ω 0 05700 CT SCAN 0 57.00 0.000000 Λ 57.00 59.00 05900 CARDIAC CATHETERIZATION 0.172891 2, 379, 235 411, 348 59.00 06000 LABORATORY 0 60.00 0. 120945 1, 784, 199 0 215, 790 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 227098 0 62 00 68.831 15, 631 62 00 65.00 06500 RESPIRATORY THERAPY 0. 152752 370, 126 56, 537 65.00 06600 PHYSI CAL THERAPY 0.371067 6, 451 0 2, 394 66.00 0 66.00 06700 OCCUPATIONAL THERAPY 0 1, 170 0. 217083 67.00 67.00 5, 388 0 06800 SPEECH PATHOLOGY 68.00 0.772893 750 580 68 00 69.00 06900 ELECTROCARDI OLOGY 0.081449 370, 148 0 0 30, 148 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.052640 6,048,659 0 71.00 318, 401 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 355, 638 0 0 827, 812 72.00 0.246693 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0.119145 73.00 3, 516, 308 23, 434 418, 951 73.00 74.00 07400 RENAL DIALYSIS 0. 401185 47, 051 0 18, 876 74.00 03950 MISC ANCILLARY 0.000000 0 76.00 76.00 C 0 0 0 03951 SLEEP LAB 76.01 0.000000 0 76.01 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 436, 918 76.02 1.756666 248, 720 0 76.02 03952 WOUND CARE 0.587237 1, 271, 894 0 746, 903 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1.775901 90.00 8,070 0 348 14, 332 0 91.00 09100 EMERGENCY 0. 157125 2, 985, 173 469, 045 91.00 92.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.307451 769, 328 0 236, 531 0 200.00 Subtotal (see instructions) 35, 172, 445 23, 782 5, 857, 589 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges

35, 172, 445

0

23, 782

5, 857, 589 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	ST J	OSEPH MED	ICAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE		-		CCN: 15-0047	Peri od: From 06/01/2018	Worksheet D	pared:
			Ti tl	e XVIII	Hospi tal	PPS	•
		Cos	sts				
Cost Center Description		Cost	Cost Reimbursed				
		vi ces	Servi ces Not				
	Subj	ect To	Subject To				

		CO	SIS	
	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	
	ANCI LLARY SERVI CE COST CENTERS			4
50. 00		C	0	50. 00
51. 00		C	0	51. 00
53. 00		C	0	53. 00
54. 00		C	0	54. 00
54. 01		C	0	54. 01
56. 00		C	0	56. 00
57. 00	05700 CT SCAN	C	0	57.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	C	0	59. 00
60.00	06000 LABORATORY	C	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	0	62. 00
65.00	06500 RESPI RATORY THERAPY	C	0	65. 00
66.00	06600 PHYSI CAL THERAPY	C	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	C	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	C	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	C	o	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	o	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	o	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	2, 792	73. 00
74.00	07400 RENAL DIALYSIS	C	o	74. 00
76.00	03950 MISC ANCILLARY	C	o	76. 00
76. 01	03951 SLEEP LAB	C	o	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C	o	76. 02
76. 03	03952 WOUND CARE	C	o	76. 03
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLI NI C	C	618	90. 00
91.00	09100 EMERGENCY	C	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	C	0	92.00
200.0	Subtotal (see instructions)	C	3, 410	200. 00
201.0				201.00
	Only Charges			
202. 0		c	3, 410	202. 00

Health Financial Systems	ST JOSEPH MED			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	L COSTS	Provi der C	CN: 15-0047	Peri od:	Worksheet D	
		0	CON 15 CO 17	From 06/01/2018	Part II	
		Component	CCN: 15-S047	To 05/31/2019	Date/Time Pre 10/30/2019 3:	pared: 37 nm
		Ti tl e	xVIII	Subprovi der -	PPS	57 piii
		11 (1)	, XVIII	IPF	113	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
·		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col		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, 732	30, 406, 145	0. 0250	52 0	0	50.00
51.00 05100 RECOVERY ROOM	262, 987	3, 130, 379	0. 0840	17, 944	1, 507	51.00
53. 00 05300 ANESTHESI OLOGY	9, 847	3, 302, 370	0. 00298	32 4, 077	12	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	773, 465	62, 175, 916	0. 01244	462, 216	5, 750	54.00
54. 01 03630 ULTRA SOUND	0	0	0.00000	00	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0.00000	00	0	56.00
57. 00 05700 CT SCAN	0	0	0.00000	00	0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	142, 370	18, 262, 740	0. 00779	96 0	0	59.00
60. 00 06000 LABORATORY	673, 059	52, 289, 561	0. 01287	1, 199, 613	15, 441	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	38, 412	1, 399, 853	0. 0274	10 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	248, 843	11, 469, 460	0. 02169	165, 584	3, 593	65.00
66. 00 06600 PHYSI CAL THERAPY	295, 916	3, 534, 530	0. 08372	21 201, 854	16, 899	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	118, 507	3, 617, 813	0. 0327	269, 989	8, 844	67.00
68.00 06800 SPEECH PATHOLOGY	42, 873	200, 967	0. 21333	17, 650	3, 765	68. 00
69. 00 06900 ELECTROCARDI OLOGY	47, 082	3, 125, 356	0. 0150	67, 120	1, 011	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 668	28, 950, 381	0. 00264	17, 347	46	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	145, 471	18, 060, 682	0.0080	55 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	227, 210	59, 509, 499	0. 0038	1, 769, 257	6, 755	73. 00
74.00 07400 RENAL DIALYSIS	80, 584	1, 282, 924	0.0628	13 0	0	74.00
76.00 03950 MISC ANCILLARY	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	128, 983	447, 706	0. 2880	14, 980	4, 316	76. 02
76. 03 03952 WOUND CARE	361, 627	3, 953, 416	0. 09147	4, 507	412	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	87, 139	133, 124			0	
91. 00 09100 EMERGENCY	679, 656	42, 649, 562	0. 01593	379, 034	6, 040	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4, 850, 270	0.00000		0	
200.00 Total (lines 50 through 199)	5, 202, 431	352, 752, 654		4, 596, 212	74, 391	200. 00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0047	Peri od: From 06/01/2018	Worksheet D
TIROUGII CUSTS		Component CCN: 15-S047		
		Title XVIII	Subprovi der -	PPS

			litle	e XVIII	Subprovi der -	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursi na School		Allied Health	
	, , , , , , , , , , , , , , , , , , ,		Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	C	0	C	0	0	50.00
51.00	05100 RECOVERY ROOM	C	0	C	0	0	51.00
53.00	05300 ANESTHESI OLOGY	C	0	C	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	0	C	0	0	54. 00
54. 01	03630 ULTRA SOUND	C	0	C	0	0	54. 01
56.00	05600 RADI OI SOTOPE	C	0	C	0	0	56. 00
57.00	05700 CT SCAN	C	0	C	0	0	57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	C	0	C	0	0	59. 00
60.00	06000 LABORATORY	C	0	C	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	0	C	0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	C	0	C	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	C	0	C	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	C	0	C	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	C	0	C	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	C	0	C	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0	C	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0	C	0	0	73. 00
74.00	07400 RENAL DIALYSIS	C	0	C	0	0	74. 00
	03950 MISC ANCILLARY	C	0	C	0	0	76. 00
	03951 SLEEP LAB	C	0	C	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C	0	C	0	0	76. 02
76. 03	03952 WOUND CARE	C	0	C	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	C	0	C	0	0	90.00
	09100 EMERGENCY	C	0	C	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	C		0)	0	92. 00
200.00	Total (lines 50 through 199)	[C	0	(C	0	0	200. 00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS				From 06/01/2018	Part IV	
		Component	CCN: 15-S047	To 05/31/2019	Date/Time Prep 10/30/2019 3:	parea: 37 nm
		Title	XVIII	Subprovi der -	PPS	37 piii
				I PF		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				00 404 445		
50. 00 05000 OPERATI NG ROOM	0			0 30, 406, 145		
51. 00 05100 RECOVERY ROOM	0	0		0 3, 130, 379		
53. 00 05300 ANESTHESI OLOGY	0	0		0 3, 302, 370		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 62, 175, 916		
54. 01 03630 ULTRA SOUND	0	0		0	0. 000000	
56. 00 05600 RADI 01 SOTOPE	0	0		0	0. 000000	
57. 00 05700 CT SCAN	0	0		0	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 18, 262, 740		
60. 00 06000 LABORATORY	0	0	•	0 52, 289, 561	0.000000	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 1, 399, 853		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 11, 469, 460		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 3, 534, 530		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 617, 813		
68. 00 06800 SPEECH PATHOLOGY	0	0		0 200, 967		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 3, 125, 356		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 28, 950, 381	0.000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 18, 060, 682		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	l	0 59, 509, 499		
74. 00 07400 RENAL DI ALYSI S	0	0		0 1, 282, 924		
76. 00 03950 MISC ANCILLARY	0	0		0	0.000000	
76. 01 03951 SLEEP LAB	0	0		0 447 704	0.000000	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 447, 706 0 3 953 416		
76. 03 03952 WOUND CARE OUTPATIENT SERVICE COST CENTERS	0	0		0 3, 953, 416	0. 000000	76. 03
90. 00 O9000 CLINIC	0	0		0 133, 124	0.000000	90.00
91. 00 09100 EMERGENCY	0			0 42, 649, 562		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 42, 849, 562		
200.00 Total (lines 50 through 199)	0			0 352, 752, 654		200. 00
200.00 Total (Titles 50 till ough 199)	1	0	I	U ₁ 302, 702, 604	1	1200.00

Health Financial Systems	ST JOSEPH MEDI	_	ON 45 0047		u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE UTHER PASS	Provi der CO	JN: 15-0047	Peri od: From 06/01/2018	Worksheet D Part IV	
THROUGH COSTS		Component (CCN: 15-S047	To 05/31/2019	Date/Time Pre 10/30/2019 3:	pared: 37 pm
		Title	XVIII	Subprovi der – I PF	PPS	•
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	0		0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	17, 944		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	4, 077		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	462, 216		0 0	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000	0		0 0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	0		0 0	0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	1, 199, 613		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	165, 584		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	201, 854		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	269, 989		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	17, 650		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	67, 120		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	17, 347		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 769, 257		0 0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
76. 00 03950 MISC ANCILLARY	0. 000000	0		0 0	0	76.00
76. 01 03951 SLEEP LAB	0. 000000	0		0 0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	14, 980		0 0	0	76. 02
76. 03 03952 WOUND CARE	0. 000000	4, 507		0 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 756	0	90.00
91. 00 09100 EMERGENCY	0. 000000	379, 034		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	5, 040		0 0	0	92.00
200.00 Total (lines 50 through 199)		4, 596, 212		0 756	0	200. 00

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0047	Peri od:	Worksheet D	
					From 06/01/2018	Part V	
			Component	CCN: 15-S047	To 05/31/2019	Date/Time Pre 10/30/2019 3:	pared:
			Title	xVIII	Subprovi der -	PPS	37 pili
			11 11 0	, , , , , , , , , , , , , , , , , , , ,	IPF	113	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	,		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C.	inst.)	Servi ces	Services Not	(, , , , , , , , , , , , , , , , , , ,	
		Part I, col. 9	,	Subject To	Subject To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 140425	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 339062	0		0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0. 496709	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 096441	0		0 0	0	54.00
54. 01	03630 ULTRA SOUND	0. 000000	0		0 0	0	54. 01
56.00	05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56. 00
57.00	05700 CT SCAN	0. 000000	0		0 0	0	57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 172891	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 120945	0		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 227098	0		0 0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0. 152752	0		0 0	0	1
66. 00	06600 PHYSI CAL THERAPY	0. 371067	0		0 0	0	66, 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 217083	0		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 772893	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 081449	0		0 0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 052640	0		0 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 246693	0		0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0. 119145	0		0 4, 697	0	1
74. 00	07400 RENAL DI ALYSI S	0. 401185	0		0 0	0	74. 00
	03950 MISC ANCILLARY	0. 000000	0		0 0	0	
	03951 SLEEP LAB	0. 000000	0		0 0	0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 756666	0		0 0	0	76. 02
	03952 WOUND CARE	0. 587237	0		0 0	ľ	1
. 0. 00	OUTPATIENT SERVICE COST CENTERS	0.00,207				<u> </u>	1
90. 00	09000 CLINIC	1. 775901	756		ol o	1, 343	90.00
	09100 EMERGENCY	0. 157125	0	•	0 0	1	1
	00200 OBSERVATION DEDS (NON DISTINCT DART	0.107120	0	1	0		

0. 307451

756

756

0 0 0

4, 697

4, 697

0 92.00 1, 343 200.00 201.00

1, 343 202. 00

92.00 09700 EMERGENCY
92.00 09700 OBSERVATION BEDS (NON-DISTINCT PART
200.00 Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
202.00 Net Charges (line 200 - line 201)

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVI	CES AND VACCINE COST	Provider Component	CN: 15-0047 CCN: 15-S047	Peri od: From 06/01/2018 To 05/31/2019	Worksheet D Part V Date/Time Pre 10/30/2019 3:	epared:
		Title	xVIII	Subprovi der -	PPS	or piii
	Cos	sts		1111		
Cost Center Description		Cost Reimbursed Services Not Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCILLARY SERVICE COST CENTERS	6.00	7. 00				
50. 00 05000 0PERATI NG ROOM 05100 RECOVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OLOGY-DI AGNOSTI C 05600 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06000 LABORATORY 06500 RESPI RATORY THERAPY 06500 06500 RESPI RATORY THERAPY 06700 06CUPATI ONAL THERAPY 06700 06CUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07300 O7300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S	0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				50. 00 51. 00 53. 00 54. 00 54. 01 56. 00 60. 00 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00
74. 00 07400 RENAL DITALYSTS 76. 01 03950 MISC ANCILLARY 76. 02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVIC 76. 03 03952 WOUND CARE	0	0 0 0 0				74. 00 76. 00 76. 01 76. 02 76. 03

0

560

560

91.00

92. 00 200. 00

201. 00

202. 00

91. 00 09100 EMERGENCY

Health Financial Systems	ST JOSEPH	MEDICAL CENTER	In Lie	eu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER	PASS Provider CCN: 15-00		Worksheet D
THROUGH COSTS		0	From 06/01/2018	
		Component CCN: 15-5	56 10 05/31/2019	Date/Time Prepared:
				10/30/2019 3:37 pm
		Title XVIII	Skilled Nursing	PPS

			Title	: XVIII	Skilled Nursing	PPS	
		1			Facility		
	Cost Center Description			Nursing Schoo	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1		1			
	05000 OPERATING ROOM	0	0		0	0	50.00
	05100 RECOVERY ROOM	0	0	1	0	0	51.00
	05300 ANESTHESI OLOGY	0	0	1	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	0	54.00
54. 01	03630 ULTRA SOUND	0	0	1	0	0	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	1	0	0	56. 00
57. 00	05700 CT SCAN	0	0	1	0	0	57. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0	0	59. 00
	06000 LABORATORY	0	0	1	0	0	60. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	0	0	62. 00
	06500 RESPI RATORY THERAPY	0	0	1	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	1	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	1	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0)	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0)	0	0	74.00
76.00	03950 MISC ANCILLARY	0	0)	0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	1	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	1	0	0	76. 02
76. 03	03952 WOUND CARE	0	0	1	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0)	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			O	0	92. 00
200.00	Total (lines 50 through 199)	0	0		0	0	200. 00

Heal th Financial Systems ST JOSEPH MEDICAL CENTER Provider CD: 15-0047 Provider								
THROUGH COSTS								2552-10
Component COx: 15-5356 To O5/31/2019 Date/Time Prepared: 10/30/2019 3: 37 pm			RVICE OTHER PASS	S Provider C			Worksheet D	
Title XVIII Skilled Nursing Facility PPS	THROUG	GH COSTS		Component			Date/Time Pre	nared.
Cost Center Description			component con. To coop			10 00/01/201/	10/30/2019 3:	37 pm
Cost Center Description				Ti tl e	: XVIII	Skilled Nursing		•
Medical Education Cost Sum of cols. Cost (sum of cols. Cost (sum of cols. Cost (sum of cols. Cost (sum of cols. Sum of cols. Cost (sum of cols. Sum of co								
ANCILLARY SERVICE COST CENTERS		Cost Center Description						
ACCILLARY SERVICE COST CENTERS			Medi cal					
ANCILLARY SERVICE COST CENTERS			Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
A.00 5.00 6.00 7.00 8.00				4)		8)	7)	
ANCILLARY SERVICE COST CENTERS 50.00 0 0 30, 406, 145 0.000000 50.00 50.00 0.000000 50.00								
50. 00			4. 00	5. 00	6. 00	7. 00	8. 00	
51.00 05100 RECOVERY ROOM 0 0 3, 130, 379 0.000000 51.00 53.00 05300 AMESTHESI OLOGY 0 0 0 3, 302, 370 0.000000 53.00 54.01 03400 RADI OLOGY-DI AGNOSTI C 0 0 0 62, 175, 916 0.00000 54.01 54.01 03630 LUTRA SOUND 0 0 0 0 0.00000 54.01 56.00 05600 RADI OLSTOPE 0 0 0 0 0.00000 56.00 57.00 05700 CT SCAN 0 0 0 0 0.000000 57.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 18, 262, 740 0.000000 59.00 60.00 06000 LABORATORY 0 0 0 13, 399, 853 0.000000 66.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 11, 469, 460 0.000000 67.00								
53.00 05300 ANESTHESI OLOGY 0 0 3, 302, 370 0.000000 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 62, 175, 916 0.000000 54.00 0 0.000000 54.00 0 0.000000 54.00 0 0.000000 54.00 0 0.000000 54.00 0 0.000000 54.00 0 0.000000 54.00 0 0.000000 56.00 0 0.000000 56.00 0 0.000000 56.00 0 0 0.000000 56.00 0 0 0.000000 56.00 0 0 0.000000 57.00 0 0 0.000000 57.00 0 0 0 0 0.000000 57.00 0 0 0 0 0.000000 57.00 0 0 0 0 0.000000 57.00 0		l l	0		1			
54. 00 0 5400 RADI OLOGY-DI AGNOSTI C 0 0 0 62, 175, 916 0.000000 54. 00 54. 01 0 3630 ULTRA SOUND 0 0 0 0.000000 54. 00 56. 00 0 5600 RADI OL SOTOPE 0 0 0 0.000000 56. 00 57. 00 0 5700 CT SCAN 0 0 0 0.000000 57. 00 59. 00 0 5900 CARDI AC CATHETERI ZATI ON 0 0 0 18, 262, 740 0.000000 59. 00 60. 00 0 6000 LABORATORY 0 0 52, 289, 561 0.000000 60. 00			0	0)			
54. 01 03630 ULTRA SOUND 0 0 0 0 0.000000 54. 01 56. 00 05600 RADI OI SOTOPE 0 0 0 0 0.000000 55. 00 57. 00 05700 CT SCAN 0 0 0 0 0.000000 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 52, 289, 561 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 11, 399, 853 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 3, 534, 530 0.000000 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 3, 617, 813 0.000000 67. 00 68. 00 06600 SPEECH PATHOLOGY 0 0 0 3, 617, 813 0.000000 <td></td> <td></td> <td>0</td> <td>0</td> <td>)</td> <td></td> <td></td> <td></td>			0	0)			
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0.000000 56. 00 57. 00 05700 CT SCAN 0 0 0 0.000000 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 18, 262, 740 0.000000 57. 00 60. 00 06000 LABORATORY 0 0 0 52, 289, 561 0.000000 60.00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 1, 399, 853 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 11, 469, 460 0.00000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 3, 534, 530 0.000000 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 3, 617, 813 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 3, 617, 813 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>)</td> <td>0 62, 175, 916</td> <td></td> <td></td>			0	0)	0 62, 175, 916		
57. 00 05700 CT SCAN 0 0 0 0.000000 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 18, 262, 740 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 52, 289, 561 0.000000 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 1, 399, 853 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 11, 469, 460 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 3, 534, 530 0.000000 66. 00 67. 00 06700 06700 06700 0 3, 617, 813 0.000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 200, 967 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 3, 125, 356 0.0			0	0)	0		
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 18, 262, 740 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 52, 289, 561 0.000000 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 1, 399, 853 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 11, 469, 460 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 3, 534, 530 0.000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 3, 617, 813 0.000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 200, 967 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 3, 125, 356 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 28, 950, 381 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0	56.00		0	0)	0		
60. 00 06000 LABORATORY 0 0 0 52, 289, 561 0.000000 60. 00 62. 00 62. 00 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 1,399, 853 0.000000 62. 00 65. 00 65. 00 65. 00 66. 00 06600 RESPI RATORY THERAPY 0 0 0 0 3,534,530 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 3,534,530 0.000000 67. 00 68. 00 067. 00 07. 00			0	0)	-	l .	
62. 00			0	0	1	-, -, -, -,		
65. 00 06500 RESPI RATORY THERAPY 0 0 0 11, 469, 460 0.000000 65. 00 66. 00	60.00		0	0	1	0 52, 289, 561	0.000000	60.00
66. 00			0	0	1			
67. 00	65.00		0	0	1	0 11, 469, 460	0.000000	
68. 00			0	0	1			
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 3, 125, 356 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 28, 950, 381 0. 000000 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 18, 060, 682 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 59, 509, 499 0. 000000 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 1, 282, 924 0. 000000 74. 00 76. 00 03950 MI SC ANCI LLARY 0 0 0 0 1, 282, 924 0. 000000 76. 00 76. 01 03951 SLEEP LAB 0 0 0 0 0 0. 000000 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 447, 706 0. 000000 76. 02 76. 03 03952 WOUND CARE 0 0 0 0 133, 124 0. 000000 76. 03 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 42, 649, 562 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 4, 850, 270 0. 000000 92. 00			0	0)			
71. 00			0	0)			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 18,060,682 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 59,509,499 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 1,282,924 0.000000 74.00 76.00 03950 MISC ANCILLARY 0 0 0 0 0 0.000000 76.00 76.01 03951 SLEEP LAB 0 0 0 0 0 0.000000 76.01 76.02 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 447,706 0.000000 76.02 76.03 03952 WOUND CARE 0 0 0 3,953,416 0.000000 76.03 000000 76.03 000000 76.03 000000 000000 000000 0000000 000000			0	0)		l .	
73. 00			0	0)			
74. 00 07400 RENAL DI ALYSI S 0 0 1, 282, 924 0.000000 74. 00 76. 00 03950 MI SC ANCI LLARY 0 0 0 0 0.000000 76. 00 76. 01 03951 SLEEP LAB 0 0 0 0 0.000000 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 447, 706 0.000000 76. 02 76. 03 03952 WOUND CARE 0 0 0 3, 953, 416 0.000000 76. 03 90. 00 09000 CLI NI C 0 0 0 133, 124 0.000000 90. 00 91. 00 09100 EMERGENCY 0 0 0 42, 649, 562 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 4, 850, 270 0.000000 92. 00			0	0)			
76. 00			0	0)			
76. 01 03951 SLEEP LAB 0 0 0 0 0 0.000000 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 447, 706 0.000000 76. 02 76. 03 03952 WOUND CARE 0 0 0 3, 953, 416 0.000000 76. 03 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 133, 124 0.000000 90. 00 91. 00 09100 EMERGENCY 0 0 0 42, 649, 562 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 4, 850, 270 0.000000 92. 00			0	0)	0 1, 282, 924		
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 447, 706 0.000000 76. 02 76. 03 03952 WOUND CARE 0 0 0 3, 953, 416 0.000000 76. 03 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0)	0		
76. 03 03952 WOUND CARE 0 0 0 3,953,416 0.000000 76. 03 000000 000000000000000000000000000	76. 01		0	0)	٩		
OUTPATIENT SERVICE COST CENTERS 90.00 0 133,124 0.000000 90.00 91.00 91.00 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 4,850,270 0.000000 92.00 92.00 93.00 94.0			0					
90. 00	76. 03		0	0		0 3, 953, 416	0.000000	76. 03
91. 00 09100 EMERGENCY 0 0 42, 649, 562 0.00000 91. 00 92. 00 09200 09SERVATI ON BEDS (NON-DI STI NCT PART 0 0 4, 850, 270 0.000000 92. 00			_					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 4,850,270 0.000000 92.00			1					
		l l	0	0	1			
200.00 Total (lines 50 through 199) 0 0 352,752,654 200.00		,	0		1			
	200.00	Total (lines 50 through 199)	0	0	1	0 352, 752, 654		200. 00

	Financial Systems	ST JOSEPH MEDIC			In Lie	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der CO	CN: 15-0047	Peri od:	Worksheet D	
THROUG	GH COSTS			201 45 5057	From 06/01/2018		
			Component	CCN: 15-5356	To 05/31/2019	Date/Time Pre 10/30/2019 3:	
			Title	XVIII	Skilled Nursing		37 pili
			11116	AVIII	Facility	113	
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	9	Costs (col.		Costs (col. 9	
		7)		x col. 10)		x col . 12)	
		9.00	10. 00	11.00	12. 00	13.00	
	ANCILLARY SERVICE COST CENTERS	<u> </u>		•			
50.00	05000 OPERATING ROOM	0. 000000	538		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	71, 000		0 0	0	54.00
54. 01	03630 ULTRA SOUND	0. 000000	0		0 0	0	54. 01
56. 00	05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
57. 00	05700 CT SCAN	0. 000000	0		0 0	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 000000	380, 535		0 0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	19, 821		0 0	0	62.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	441, 324		0	0	1
66. 00	06600 PHYSI CAL THERAPY	0. 000000	854, 532		0 0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	963, 885		0 0	o o	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	8, 026		0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	4, 892		0 0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	99, 900		0 0	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	i	0 0	o o	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 917, 810		0 0	0	1
74. 00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74. 00
76. 00	03950 MISC ANCILLARY	0. 000000	0		0 0	0	
76. 01	03951 SLEEP LAB	0. 000000	0		0 0	0	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	76. 02
76. 03	03952 WOUND CARE	0. 000000	47, 011		0 0		
70.00	OUTPATIENT SERVICE COST CENTERS	0.00000	177011		<u> </u>		7 0. 00
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
91. 00	09100 EMERGENCY	0. 000000	0		0 0		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	o o	
200.00	,	0.00000	4, 809, 274		0 0		200.00
	1 1 1 1 (ı	.,,,	1	-1 -1		

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 06/01/2018 To 05/31/2019		narod:
				10 03/31/2019	10/30/2019 3:	37 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing 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		T				
30. 00 ADULTS & PEDI ATRI CS	1, 921, 374		1 1,72.,07			
33.00 BURN INTENSIVE CARE UNIT	419, 851		419, 85			1
40. 00 SUBPROVI DER - I PF	414, 621		414, 62			
44.00 SKILLED NURSING FACILITY	515, 864		515, 86			1
200.00 Total (lines 30 through 199)	3, 271, 710		3, 271, 71	0 28, 354		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	4			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	832		1		l	30.00
33.00 BURN INTENSIVE CARE UNIT	137		•		ļ	33. 00
40. 00 SUBPROVI DER – I PF	544				ļ	40.00
44.00 SKILLED NURSING FACILITY	279				ļ	44. 00
200.00 Total (lines 30 through 199)	1, 792	196, 977	Ί			200. 00

Health Financial Systems	ST JOSEPH MED	I CAL	CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	F	Provi der C	CN: 15-0047	Peri od: From 06/01/2018 To 05/31/2019	Worksheet D Part II Date/Time Pre 10/30/2019 3:	
			Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	(fror	n Wkst. C,		Program	Capital Costs (column 3 x column 4)	

					10/30/2019 3:	37 pm_
			e XIX	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,	Part I, col.	(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, 732	30, 406, 145	0. 025052	675, 298	16, 918	50.00
51.00 05100 RECOVERY ROOM	262, 987	3, 130, 379	0. 084011	53, 460	4, 491	51.00
53. 00 05300 ANESTHESI OLOGY	9, 847	3, 302, 370	0. 002982	81, 162	242	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	773, 465	62, 175, 916	0. 012440	987, 988	12, 291	54. 00
54. 01 03630 ULTRA SOUND	0	0	0.000000	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0.000000	0	0	56. 00
57. 00 05700 CT SCAN	0	0	0.000000	0	0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	142, 370	18, 262, 740	0. 007796	148, 173	1, 155	59. 00
60. 00 06000 LABORATORY	673, 059	52, 289, 561	0. 012872	1, 159, 359	14, 923	60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	38, 412	1, 399, 853	0. 027440	85, 223	2, 339	62. 00
65. 00 06500 RESPIRATORY THERAPY	248, 843	11, 469, 460	0. 021696	508, 802	11, 039	65. 00
66. 00 06600 PHYSI CAL THERAPY	295, 916	3, 534, 530	0. 083721	45, 939	3, 846	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	118, 507	3, 617, 813		46, 544	1, 525	67. 00
68. 00 06800 SPEECH PATHOLOGY	42, 873	200, 967	0. 213334	4, 562	973	68. 00
69. 00 06900 ELECTROCARDI OLOGY	47, 082	3, 125, 356	0. 015065	55, 675		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 668	28, 950, 381	0. 002648	389, 134	1, 030	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	145, 471	18, 060, 682	0. 008055	178, 363	1, 437	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	227, 210			2, 118, 649		73. 00
74. 00 07400 RENAL DIALYSIS	80, 584		0. 062813	118, 768	7, 460	74. 00
76. 00 03950 MISC ANCILLARY	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	128, 983	447, 706		0	0	76, 02
76. 03 03952 WOUND CARE	361, 627			37, 188	3, 402	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	87, 139	133, 124	0. 654570	1, 449	948	90.00
91. 00 09100 EMERGENCY	679, 656			479, 006		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	197, 488			49, 375		92.00
200.00 Total (lines 50 through 199)	5, 399, 919			7, 224, 117		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		,	1			

Health Financial Systems	ST JOSEPH MED	DICAL CENTER		In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PAS	SS THROUGH COS			Period: From 06/01/2018 To 05/31/2019		pared: 37 pm
			le XIX	Hospi tal	PPS	
Cost Center Description				Allied Health		
	Post-Stepdown		Post-Stepdowr	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0) (0	0	
33.00 03300 BURN INTENSIVE CARE UNIT	0) (0	0	
40. 00 04000 SUBPROVI DER - 1 PF	0) (0	0	40. 00
44.00 04400 SKILLED NURSING FACILITY	0) (0		44. 00
200.00 Total (lines 30 through 199)	0) ()	0 0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)					
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0) (15, 90			
33.00 03300 BURN INTENSIVE CARE UNIT			2, 52		137	33. 00
40. 00 04000 SUBPROVI DER - 1 PF	0) (5, 30			
44.00 04400 SKILLED NURSING FACILITY			4, 62	0.00	279	44. 00
200.00 Total (lines 30 through 199)		(28, 35	4	1, 792	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
INDATIENT DOUTING CEDVICE COCT CENTERS	9. 00					

30. 00 33. 00

40. 00 44. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 33. 00 03300 BURN INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 44. 00 04400 SKILLED NURSING FACILITY 200. 00 Total (lines 30 through 199)
 Heal th Financial
 Systems
 ST JOSEPH MEDICAL

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS
 ST JOSEPH MEDICAL CENTER Provider CCN: 15-0047

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 06/01/2018 | Part IV | To 05/31/2019 | Date/Time Prepared: | THROUGH COSTS

					10 00/01/201/	10/30/2019 3:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician N	lursing School	Nursing Schoo	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS				_		
	05000 OPERATI NG ROOM	0	0		0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0		0	0	51. 00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	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	0	57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0 0	0	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	O	0		0 0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	o	0		o o	0	65. 00
66.00	06600 PHYSI CAL THERAPY	o	0		o o	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		o o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	O	0		o o	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	0		o o	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0		o o	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0		o o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		ol o	ol	73. 00
74. 00	07400 RENAL DIALYSIS	o	0		o o	o	74. 00
	03950 MISC ANCILLARY	o	0		o o	o	76. 00
	03951 SLEEP LAB	o	0		o o	o	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	0		o o	o	76. 02
76. 03	03952 WOUND CARE	o	0		o o	o	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90. 00
91. 00	09100 EMERGENCY	o	0		o o	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			o	0	92.00
200.00	1	o	0		o o	0	200. 00
	1 1	-1	_	1	-1 -	-	

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0047	Peri od:	Worksheet D
THROUGH COSTS			From 06/01/2018	Part IV

THROUGH COSTS To 05/31/2019 Date/Time Prepared: 10/30/2019 3:37 pm Title XIX Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) col s. 2, 3, 8) 7) and 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 30, 406, 145 0.000000 50.00 00000000000000000000000 51.00 05100 RECOVERY ROOM 3, 130, 379 0.00000051.00 05300 ANESTHESI OLOGY 0 0 3, 302, 370 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 62, 175, 916 0.000000 54.00 54.00 03630 ULTRA SOUND OI 0 54.01 0.000000 54.01 0 56.00 05600 RADI OI SOTOPE 0 0 0.000000 56.00 57.00 05700 CT SCAN 0 0.000000 57.00 0 05900 CARDIAC CATHETERIZATION 0 18, 262, 740 0.000000 59 00 59 00 0 0 60.00 06000 LABORATORY 52, 289, 561 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 1, 399, 853 0.000000 62.00 06500 RESPIRATORY THERAPY 0 65.00 11, 469, 460 0.000000 65.00 06600 PHYSI CAL THERAPY 0 3, 534, 530 0.000000 66.00 66 00 67.00 06700 OCCUPATIONAL THERAPY 0 3, 617, 813 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 200, 967 68.00 06900 ELECTROCARDI OLOGY 3, 125, 356 69 00 0.000000 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 28, 950, 381 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 18, 060, 682 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 59, 509, 499 0.000000 73.00 07400 RENAL DIALYSIS 0 74 00 Ω 1, 282, 924 0.000000 74 00 76.00 03950 MISC ANCILLARY 0 0 0.000000 76.00 03951 SLEEP LAB 0.000000 76.01 76.01 0 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 447, 706 0.000000 76.02 0 03952 WOUND CARE 3, 953, 416 0.00000076.03 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 0 0 0 0.000000 90.00 09000 CLI NI C 133, 124 0 91. 00 09100 EMERGENCY 0 0 42, 649, 562 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 4, 850, 270 0 92.00 0 0.000000 200.00 Total (lines 50 through 199) 0 352, 752, 654 200.00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0047	Peri od: From 06/01/2018 To 05/31/2019	Worksheet D Part IV Date/Time Prepared: 10/30/2019 3:37 pm
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THROUGH COSTS				To 05/31/2019	Date/Time Pre 10/30/2019 3:	pared:
		Ti tl	e XIX	Hospi tal	PPS	37 piii
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
p	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	Ŭ	Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	675, 298	(0	0	50. 00
51.00 05100 RECOVERY ROOM	0. 000000	53, 460	(0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	81, 162	(0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	987, 988	(0	0	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
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	148, 173	(0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	1, 159, 359	(0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	85, 223	(0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	508, 802	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	45, 939	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	46, 544	(0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	4, 562	(o	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	55, 675	(0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	389, 134	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	178, 363	(0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 118, 649	(o	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	118, 768	(o	0	74.00
76.00 03950 MISC ANCILLARY	0. 000000	0	(o	0	76. 00
76. 01 03951 SLEEP LAB	0. 000000	0	(o	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	(o	0	76. 02
76. 03 03952 WOUND CARE	0. 000000	37, 188		o	0	76. 03
OUTPATIENT SERVICE COST CENTERS	<u> </u>					
90. 00 09000 CLI NI C	0. 000000	1, 449	(0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	479, 006	(0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	49, 375	(0	0	92.00
200.00 Total (lines 50 through 199)		7, 224, 117	(0	0	200. 00
	•		-			-

Health Financial Systems	ST JOSEPH MEDICAL CENTER			In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL.	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0047	Peri od:	Worksheet D

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0047	Peri od:	Worksheet D	
				From 06/01/2018	Part V	
				To 05/31/2019	Date/Time Pre 10/30/2019 3:	pared:
		T: ±1	- VIV	11: 4-1	10/30/2019 3:	37 pm
		1111	e XIX	Hospi tal	PPS	
0 1 0 1 0 11	0 1 1 01	DDC D ! I	Charges	0 1	Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C, Part I, col. 9	inst.)	Servi ces	Services Not		
	Part I, Cor. 9		Subject To Ded. & Coins.	Subject To Ded. & Coins.		
			(see inst.)			
	1. 00	2.00	3.00	(see inst.) 4.00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 140425			0 741, 157	0	50.00
	0. 140425				0	
				0 112, 932		51.00
53. 00 05300 ANESTHESI OLOGY	0. 496709			0 101, 521	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 096441		1	0 2, 048, 308	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000		1	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000		1	0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	0	1	0	0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 172891	0	1	0 156, 926	0	59. 00
60. 00 06000 LABORATORY	0. 120945			0 1, 272, 126	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 227098)	0 14, 294	0	62. 00
65. 00 06500 RESPI RATORY THERAPY	0. 152752	0	1	0 101, 638	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 371067	0	1	0 3, 682	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 217083	0		0 1, 178	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 772893	0)	0 3, 008	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 081449	0)	0 95, 700	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 052640	0)	0 271, 499	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 246693	0)	0 207, 404	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 119145	0	1	0 643, 589	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 401185	0	1	0 0	0	74. 00
76. 00 03950 MISC ANCILLARY	0. 000000	l o)	0 0	0	76. 00
76. 01 03951 SLEEP LAB	0. 000000		,	0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 756666		,	0 3, 329	0	76. 02
76. 03 03952 WOUND CARE	0. 587237		,	0 123, 386	0	76. 03
OUTPATIENT SERVICE COST CENTERS		_				
90. 00 09000 CLI NI C	1. 775901	0		0 4, 764	0	90.00
91. 00 09100 EMERGENCY	0. 157125		,	0 2, 281, 547	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 307451		,	0 224, 315	0	92.00
200.00 Subtotal (see instructions)		1	,	0 8, 412, 303		
201.00 Less PBP Clinic Lab. Services-Program]		0 0		201. 00
Only Charges				آ ا		
202.00 Net Charges (line 200 - line 201)		l o	,	0 8, 412, 303	0	202. 00
1 1 1 1 2 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ı		•	, . ,	_	

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDI CAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0047	Peri od: From 06/01/2018	

	·				From 06/01/2018 To 05/31/2019	Part V Date/Time Pre 10/30/2019 3:	epared: 37 pm
				e XIX	Hospi tal	PPS	
			sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
0.01	OLLIADY CEDYLOE COCT CENTERS	6. 00	7. 00				
	CILLARY SERVICE COST CENTERS		104.077				
	OOO OPERATING ROOM	0	104, 077				50.00
	100 RECOVERY ROOM	0	38, 291				51.00
	300 ANESTHESI OLOGY	0	50, 426				53.00
	400 RADI OLOGY-DI AGNOSTI C	0	197, 541	1			54.00
	630 ULTRA SOUND	0	0	•			54. 01
	6600 RADI OI SOTOPE	0	0				56. 00
	700 CT SCAN	0	0				57. 00
	900 CARDI AC CATHETERI ZATI ON	0	27, 131				59. 00
	000 LABORATORY	0	153, 857				60. 00
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 246				62. 00
	500 RESPI RATORY THERAPY	0	15, 525				65. 00
	600 PHYSI CAL THERAPY	0	1, 366				66. 00
	700 OCCUPATI ONAL THERAPY	0	256				67. 00
	800 SPEECH PATHOLOGY	0	2, 325				68. 00
	900 ELECTROCARDI OLOGY	0	7, 795				69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	14, 292				71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	51, 165				72. 00
	300 DRUGS CHARGED TO PATIENTS	0	76, 680)			73. 00
	400 RENAL DI ALYSI S	0	0)			74. 00
	950 MISC ANCILLARY	0	0				76. 00
	951 SLEEP LAB	0	0	1			76. 01
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0					76. 02
	952 WOUND CARE	0	72, 457				76. 03
	TPATIENT SERVICE COST CENTERS						
	000 CLI NI C	0	8, 460)			90. 00
	100 EMERGENCY	0	358, 488				91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART	0	68, 966				92. 00
200.00	Subtotal (see instructions)	0	1, 258, 192	1			200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	1, 258, 192	1			202. 00

Health Financial Systems	ST JOSEPH MED			In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-0047	Peri od:	Worksheet D	
		0	CON 15 CO 17	From 06/01/2018	Part II	
		Component	CCN: 15-S047	To 05/31/2019	Date/Time Pre 10/30/2019 3:	pared: 37 nm
		Ti +I	e XIX	Subprovi der -	PPS	37 piii
		11.61	CAIA	IPF	113	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
·		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(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, 732	30, 406, 145	0. 0250	52 0	0	50.00
51.00 05100 RECOVERY ROOM	262, 987	3, 130, 379	0. 0840	11 0	0	51. 00
53. 00 05300 ANESTHESI OLOGY	9, 847	3, 302, 370	0. 00298	32 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	773, 465	62, 175, 916	0. 01244	10 78, 549	977	54.00
54. 01 03630 ULTRA SOUND	0	0	0.00000	00	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0.00000	00	0	56.00
57. 00 05700 CT SCAN	0	0	0.00000	00	0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	142, 370	18, 262, 740	0. 00779	96 0	0	59.00
60. 00 06000 LABORATORY	673, 059	52, 289, 561	0. 01287	72 308, 683	3, 973	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	38, 412	1, 399, 853	0. 0274	40 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	248, 843	11, 469, 460	0. 02169	36, 995	803	65.00
66. 00 06600 PHYSI CAL THERAPY	295, 916	3, 534, 530	0. 08372	21 19, 774	1, 655	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	118, 507	3, 617, 813	0. 0327	57 24, 451	801	67.00
68. 00 06800 SPEECH PATHOLOGY	42, 873	200, 967	0. 21333	780	166	68. 00
69. 00 06900 ELECTROCARDI OLOGY	47, 082	3, 125, 356	0. 0150	13, 301	200	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 668	28, 950, 381	0. 00264	18 8, 804	23	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	145, 471	18, 060, 682	0.0080	55 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	227, 210	59, 509, 499	0. 0038	18 348, 442	1, 330	73. 00
74. 00 07400 RENAL DIALYSIS	80, 584	1, 282, 924	0. 0628	13 0	0	74. 00
76.00 03950 MISC ANCILLARY	0	0	0.00000	00	0	76. 00
76. 01 03951 SLEEP LAB	0	0	0.0000		0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	128, 983	447, 706	0. 2880	98 0	0	76. 02
76. 03 03952 WOUND CARE	361, 627	3, 953, 416	0. 09147	72 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	87, 139	133, 124			190	
91. 00 09100 EMERGENCY	679, 656					1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1			
200.00 Total (lines 50 through 199)	5, 202, 431	352, 752, 654		1, 009, 181	12, 811	200. 00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0047 Component CCN: 15-S047	Peri od: From 06/01/2018 To 05/31/2019	Date/Time Prepared:
				10/30/2019 3:37 pm
		Title XIX	Subprovi der -	PPS

			Ti tl	e XIX	Subprovi der -	PPS	
	Coot Conton Decement on	Non Dhyoi oi on	Nurai na Cabaal	Nuncina Cohool	I PF	Allied Health	
	Cost Center Description	Anesthetist	Post-Stepdown	nursing school	Allied Health Post-Stepdown	Allied Health	
		Cost	Adjustments		Adjustments		
		1, 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	JA.	3.00	
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	Ö	o d	o o	0	51.00
53. 00	05300 ANESTHESI OLOGY	0	0	o d	o o	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
54. 01	03630 ULTRA SOUND	0	0	d	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	l c	0	0	56.00
57.00	05700 CT SCAN	0	0	ol c	0	0	57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	ol c	0	0	59. 00
60.00	06000 LABORATORY	0	0	o c	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	o c	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	0	o c	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	O C	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
	07400 RENAL DI ALYSI S	0	0	C	0	0	74. 00
	03950 MISC ANCILLARY	0	0	C	0	0	76. 00
	03951 SLEEP LAB	0	0) C	0	0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(C	0	0	76. 02
76. 03	03952 WOUND CARE	0	0	0	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0) c	0	0	90. 00
	09100 EMERGENCY	0	0	C	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_			0	92. 00
200.00	Total (lines 50 through 199)	0	0	ll C	0	0	200. 00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF			CN: 15-0047	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S047	From 06/01/2018 To 05/31/2019		pared: 37 pm
		Ti tl	e XIX	Subprovi der – I PF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
		·	and 4)			
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0)	0 30, 406, 145	0. 000000	
51. 00 05100 RECOVERY ROOM	0	0	1	0 3, 130, 379		
53. 00 05300 ANESTHESI OLOGY	0	0	1	0 3, 302, 370	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 62, 175, 916	0. 000000	
54. 01 03630 ULTRA SOUND	0	0	1	0	0. 000000	
56. 00 05600 RADI 0I SOTOPE	0	0	1	0	0. 000000	
57. 00 05700 CT SCAN	0	0)	0	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1	0 18, 262, 740	0. 000000	
60. 00 06000 LABORATORY	0	0	1	0 52, 289, 561	0. 000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	0 1, 399, 853	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0)	0 11, 469, 460	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0)	0 3, 534, 530	0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0)	0 3, 617, 813	0. 000000	
68.00 06800 SPEECH PATHOLOGY	0	0)	0 200, 967	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0 3, 125, 356	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 28, 950, 381	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 18, 060, 682	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 59, 509, 499		
74. 00 07400 RENAL DI ALYSI S	0	0	1	0 1, 282, 924	0. 000000	
76. 00 03950 MISC ANCILLARY	0	0	1	0	0. 000000	
76. 01 03951 SLEEP LAB	0	0	1	0	0. 000000	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	l .	0 447, 706	0. 000000	
76. 03 03952 WOUND CARE	0	0		0 3, 953, 416	0. 000000	76. 03
OUTPATIENT SERVICE COST CENTERS	_	_	1	al 400 : - :	0.005	
90. 00 09000 CLI NI C	0	1	1	0 133, 124		
91. 00 09100 EMERGENCY	0	_		0 42, 649, 562		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1	0 4, 850, 270		
200.00 Total (lines 50 through 199)	0	0	11	0 352, 752, 654		200. 00

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI		Provider Co	CN: 15-0047	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-S047	From 06/01/2018 To 05/31/2019	Part IV Date/Time Pre 10/30/2019 3:	pared: 37 pm
	Title XIX Subprovider - PPS					
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	
51. 00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	78, 549		0 0	0	54. 00
54. 01 03630 ULTRA SOUND	0. 000000	0		0 0	0	
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	0		0 0	0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	
60. 00 06000 LABORATORY	0. 000000	308, 683	i	0 0	0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	36, 995		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	19, 774		0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	24, 451		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	780		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	13, 301		0 0	0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 000000	8, 804		0 0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	348, 442		0 0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	0		0	0	
76. 00 03950 MI SC ANCI LLARY	0. 000000	0		0 0	0	
76. 01 03951 SLEEP LAB	0. 000000	0		0 0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	
76. 03 03952 WOUND CARE	0. 000000	0		0 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS	0.000000	204		0 0	2	00.00
90. 00 09000 CLI NI C	0. 000000	291		0 0	0	
91. 00 09100 EMERGENCY	0. 000000	168, 985		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	126		0 0	0	
200.00 Total (lines 50 through 199)	1	1, 009, 181	I	0 0	l 0	200. 00

Health Financial Systems	ST JOSEPH	MEDICAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER	PASS Provider CCN: 15-0		Worksheet D
THROUGH COSTS		0 1 00N 45	From 06/01/2018	
		Component CCN: 15-	5356 To 05/31/2019	
				10/30/2019 3:37 pm
		Title XIX	Skilled Nursing	PPS

				Ti tl	e XIX	Skilled Nursing	PPS	
			I	h	h	Facility		
		Cost Center Description			Nursing School	Allied Health	Allied Health	
			Anesthetist	Post-Stepdown		Post-Stepdown		
			Cost	Adjustments	0.00	Adjustments	0.00	
	4410111	ADV. CEDVILOE COCT. CENTEDO	1.00	2A	2. 00	3A	3. 00	
FO 00		ARY SERVICE COST CENTERS			J		0	
		OPERATING ROOM	0	0		0	0	50.00
		RECOVERY ROOM	0	0		0	0	51.00
		ANESTHESI OLOGY	0	0		0	0	53.00
	1	RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
		ULTRA SOUND	0	0		0	0	54. 01
		RADI OI SOTOPE	0	0		0	0	56. 00
		CT SCAN	0	0	(0	0	57. 00
		CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
		LABORATORY	0	0	(0	0	60.00
		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0	0	62. 00
		RESPI RATORY THERAPY	0	0	(0	0	65. 00
		PHYSI CAL THERAPY	0	0	(0	0	66. 00
		OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
		SPEECH PATHOLOGY	0	0	(0	0	68. 00
		ELECTROCARDI OLOGY	0	0	(0	0	69. 00
	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
		IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
	1	DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
		RENAL DIALYSIS	0	0	(0	0	74. 00
		MISC ANCILLARY	0	0	(0	0	76. 00
		SLEEP LAB	0	0	(0	0	76. 01
76. 02	03550	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(0	0	76. 02
76. 03		WOUND CARE	0	0	(0	0	76. 03
		FLENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	(0	0	90.00
91.00	09100	EMERGENCY	0	0	(0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0				0	92. 00
200.00		Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	ST JOSEPH MED			In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS			OON 15 5057	From 06/01/2018 To 05/31/2019	Part IV	
		Component	CCN: 15-5356	To 05/31/2019	Date/Time Pre 10/30/2019 3:	pareu: 37 nm
		Ti tl	e XIX	Skilled Nursing		57 piii
			· //.	Facility		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	1	1	0 30, 406, 145		
51.00 05100 RECOVERY ROOM	0	0		0 3, 130, 379		
53. 00 05300 ANESTHESI OLOGY	0	0		0 3, 302, 370		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 62, 175, 916		
54. 01 03630 ULTRA SOUND	0	0)	0	0. 000000	
56. 00 05600 RADI 0I SOTOPE	0	0		0	0. 000000	
57. 00 05700 CT SCAN	0	0		0	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 18, 262, 740		
60. 00 06000 LABORATORY	0	0		0 52, 289, 561		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 1, 399, 853		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 11, 469, 460	l .	
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0 3, 534, 530		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	0 3, 617, 813		
68. 00 06800 SPEECH PATHOLOGY	0	0	1	0 200, 967		
69. 00 06900 ELECTROCARDI OLOGY	0	0	1	0 3, 125, 356		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0 28, 950, 381		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0 18, 060, 682		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 59, 509, 499	l .	
74. 00 07400 RENAL DI ALYSI S	0	0	1	0 1, 282, 924		
76. 00 03950 MI SC ANCI LLARY	0	0	1	0		
76. 01 03951 SLEEP LAB	0	0	1	0 0	0.000000	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 447, 706		
76. 03 03952 WOUND CARE	0	0		0 3, 953, 416	0. 000000	76. 03
OUTPATIENT SERVICE COST CENTERS				100 101	0.00000	00.00
90. 00 09000 CLI NI C	0			0 133, 124		
91. 00 09100 EMERGENCY	0			0 42, 649, 562		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1		0 4, 850, 270 0 352, 752, 654		
200.00 Total (lines 50 through 199)	1	0	"	0 352, 752, 654	I	200. 00

	Financial Systems	ST JOSEPH MEDI	_			u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der CO	CN: 15-0047	Peri od:	Worksheet D	
THROUG	SH COSTS		Component (CCN: 15-5356	From 06/01/2018 To 05/31/2019	Part IV Date/Time Pre	parod:
			Component	JCIN. 13-3330	03/31/2019	10/30/2019 3:	37 pm
			Titl	e XIX	Skilled Nursing	PPS	о, р
					Facility		
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	h Charges	Pass-Through	
		(col. 6 ÷ col.	Ü	Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12. 00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	2, 972		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	39, 217		0 0	0	54.00
54. 01	03630 ULTRA SOUND	0. 000000	0		0 0	0	54. 01
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56. 00
57.00	05700 CT SCAN	0. 000000	0		0 0	0	57.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60.00	06000 LABORATORY	0. 000000	62, 303		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	159, 376		0 0	0	66, 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	88, 669		0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	121, 740		0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	780		0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	2, 252		0	Ō	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	23, 594		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	513, 289		0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000	0		0	0	74. 00
76. 00	03950 MI SC ANCI LLARY	0. 000000	0		0	Ō	
76. 01	03951 SLEEP LAB	0. 000000	0		0 0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	76. 02
76. 02	03952 WOUND CARE	0. 000000	6, 974		0 0	Ö	
, 0. 00	OUTPATIENT SERVICE COST CENTERS	0.000000	5, 714	l	9, 0		1 . 0. 00
90.00	09000 CLINI C	0. 000000	0		0 0	0	90.00
91. 00	09100 EMERGENCY	0. 000000	0		0 0	Ö	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	Ö	
200.00		0.000000	1, 021, 166		0 0	-	200. 00
	1 1 2 1 (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	.,, .00	1	٠,١	ŭ	

Health Financial Systems	ST JOSEPH MEDICA	L CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0047	Peri od: From 06/01/2018	Worksheet D-1
				Date/Time Prepared: 10/30/2019 3:37 pm
		Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	10/30/2019 3: PPS	37 pm
	Cost Center Description	IT LITE AVITT	110Spi tai	FF3	
	DADT I ALL DROWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		15, 907	1.00
2.00	Inpatient days (including private room days, excluding swing-	ped and newborn days)		15, 907	
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		14, 272	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	14, 2/2	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om 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 roor	m days) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	ii days) tiii ougii beceiibei	31 Of the Cost	l	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	m 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	swing-bed and	2, 754	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	oom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)		oom days)	l	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, en				10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	confy (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including privat	e room davs)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15. 00 16. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period	G			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es 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
19.00	reporting period	s till ough becember 31 of	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
21 00	reporting period	- >		14 500 120	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing period (line	14, 508, 138 0	1
22.00	5 x line 17)	or or the cost report	ring perrod (rrine	l	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24.00	x line 18)	- 21 -6 -1	(1:		24.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (iine	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	(1: 21 -: 1: 2/)		0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		14, 508, 138	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d 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 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	: Tine 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		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 a 27 minus line 36)	and private room cost di	rrerential (line	14, 508, 138	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	•		912.06	
39.00	Program general inpatient routine service cost (line 9 x line	•		2, 511, 813	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 2, 511, 813	
11.00	1.0ta ogram gonerar impatront routine service cost (Tine 37		ı	2,011,013	, 55

Heal th	Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0047	Peri od: From 06/01/2018 To 05/31/2019	Worksheet D-1	pared:
	Cost Center Description	Total Inpatient Costl	Total			PPS Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00 44. 00 45. 00 46. 00 47. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	6, 064, 832	2, 524	2, 402. 8	87 458	1, 100, 514	43. 00 44. 00 45. 00 46. 00 47. 00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wk:	st. D-3, col. 3,	, line 200)			1. 00 4, 741, 965	48. 00
	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	V , ,		•		8, 354, 292	
50. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	WKST. D, Sur	m of Parts I and	408, 840	50.00
51. 00	Pass through costs applicable to Program inpand IV)	•	y services (fr	om Wkst. D, s	sum of Parts II	446, 135	
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclumedical education costs (line 49 minus line !	ding capital rel	lated, non-phy	sician anesth	hetist, and	854, 975 7, 499, 317	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tai	rget amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00						0 0.00	
60. 00 61. 00	60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	1
42.00	amount (line 56), otherwise enter zero (see				3	0	62. 00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payments PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of the	cost reporti	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	er 31 of the c	ost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line d	64 plus line 6	5)(title XVII	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 c	f the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)		•			72. 00
73. 00 74. 00	Medically necessary private room cost applications Total Program general inpatient routine servi						73. 00 74. 00
75. 00	Capital related cost allocated to inpatient Capital - related cost allocated to inpatient 26. Ine 45)				Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on			,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (:						82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•	*				85. 00 86. 00
00.00	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	ough 00)				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			1, 635 912. 06	1
	Observation bed cost (line 87 x line 88) (see		/			1, 491, 218	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 CC		Peri od:	Worksheet D-1	
				From 06/01/2018 To 05/31/2019	Date/Time Pre 10/30/2019 3:	pared: 37 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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	1, 921, 374	14, 508, 138	0. 13243	4 1, 491, 218	197, 488	90.00
91.00 Nursing School cost	0	14, 508, 138	0.00000	0 1, 491, 218	0	91.00
92.00 Allied health cost	0	14, 508, 138	0.00000	0 1, 491, 218	0	92.00
93.00 All other Medical Education	0	14, 508, 138	0. 00000	0 1, 491, 218	0	93. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047	Peri od:	Worksheet D-1
	Component CCN: 15-S047	From 06/01/2018 To 05/31/2019	
	Title XVIII	Subprovi der -	PPS

		litle XVIII	I PF	PPS	
	Cost Center Description				
	DADT I ALL DOOM DED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		5, 300	1. 00
2.00	Inpatient days (including private room days, excluding swing-			5, 300	
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.			5 000	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room		r 21 of the cost	5, 300 0	4. 00 5. 00
5.00	reporting period	on days) through becembe	i 31 of the cost	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	m 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	o the Program (excluding	swing-bed and	2, 882	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including privato r	room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		oon days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, en				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	Confy (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	Konly (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)		
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
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				10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	f the cost	0.00	17. 00
18. 00	reporting period	as after December 21 of	the cost	0.00	10.00
16.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es arter becember 31 or	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s 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 21 of t	ho cost	0.00	20. 00
20.00	reporting period	s arter becember 31 or t	THE COST	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			4, 686, 761	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23. 00
	x line 18)		9	_	
24. 00	Swing-bed cost applicable to NF type services through December	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 3	31 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the dost reporting	perrod (rriie e	Ü	20.00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 686, 761	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)		3,1,	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	: line 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 min		tions)	0.00	•
35. 00	Average per diem private room cost differential (line 34 x line 35)	ie 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fforontial (line	0 4 696 761	36. 00 37. 00
37.00	27 minus line 36)	and private room cost or	Trefelitial (TIME	4, 686, 761	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			884. 29	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			2, 548, 524 0	
	Total Program general inpatient routine service cost (line 39	,		2, 548, 524	
		,	'		

MPLITA	Financial Systems TION OF INPATIENT OPERATING COST	ST JOSEPH MEDIC	Provider CO	:N: 15-0047	Period:	u of Form CMS- Worksheet D-1	
WI OTA	THE OF THE ATTENT OF EIGHT NO GOOT			CCN: 15-S047	From 06/01/2018 To 05/31/2019	Date/Time Pro	epare
			Title	XVIII	Subprovi der -	10/30/2019 3: PPS	37 p
	Cost Center Description	Total Inpatient Costlr	Total patient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	NURSERY (title V & XIX only)			3. 3.9			42.
	ntensive Care Type Inpatient Hospital Units						
	INTENSIVE CARE UNIT						43.
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0	00 0	C	44. 45.
	SURGICAL INTENSIVE CARE UNIT	١	U	0.	00		46.
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description	<u> </u>					
						1. 00	
	Program inpatient ancillary service cost (Wk					677, 465	
	Total Program inpatient costs (sum of lines	41 through 48)(se	e instructio	ns)		3, 225, 989	49
_	PASS THROUGH COST ADJUSTMENTS			Wi+ D	Dt- 1	225 450	
	Pass through costs applicable to Program inp III)	attent routine se	ervices (iron	WKSt. D, Su	III OI PAILS I AND	225, 459	50
1	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst D	sum of Parts II	74, 391	51
	and IV)					, 371	"
00	Total Program excludable cost (sum of lines	50 and 51)				299, 850	52
	Total Program inpatient operating cost exclu		ited, non-phy	sician anest	hetist, and	2, 926, 139	53
	medical education costs (line 49 minus line	52)					
-	FARGET AMOUNT AND LIMIT COMPUTATION Program discharges					C	54
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operat	ing cost and targ	get amount (I	ine 56 minus	line 53)	C	
	Bonus payment (see instructions)					C	58
	Lesser of lines 53/54 or 55 from the cost re	porting period er	ndi ng 1996, u	pdated and c	ompounded by the	0.00	59
1	market basket					0.00	
	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0. 00 0	1
	which operating costs (line 53) are less tha						′ ′
	amount (line 56), otherwise enter zero (see		(,,	g		
00 1	Relief payment (see instructions)					C	
	Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)			C	63
	PROGRAM INPATIENT ROUTINE SWING BED COST	4- 4	21 -6 +		!!! (C		
	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	is through becenik	er 31 or the	cost report	ing period (see	C	64
	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reportin	a period (See	C	65
	instructions)(title XVIII only)				5 (
	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 6	5)(title XVI	ll only). For	C	66
	CAH (see instructions)			6.11			,,
	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through L	ecember 31 o	r the cost r	eporting period	C	67
1	Title V or XIX swing-bed NF inpatient routin	e costs after Dec	ember 31 of	the cost ren	orting period	C	68
	(line 13 x line 20)	c costs arter bec	CIIIDOI OI OI	the cost rep	or tring period		
00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	68)		C	69
	PART III - SKILLED NURSING FACILITY, OTHER N						
	Skilled nursing facility/other nursing facil)		70
	Adjusted general inpatient routine service c		ie 70 ÷ Tine	2)			71
	Program routine service cost (line 9 x line Medically necessary private room cost applic		line 14 v li	ne 35)			72
	Total Program general inpatient routine serv	9	•	110 30)			74
	Capital -related cost allocated to inpatient	•		orksheet B,	Part II, column		75
:	26, line 45)		•				
	Per diem capital-related costs (line 75 ÷ li	. *					76
	Program capital-related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		vider record	s)			78
	Total Program routine service costs for comp				nus line 79)		80
1	Inpatient routine service cost per diem limi			(z /o iiii			81
	Inpatient routine service cost limitation (82
. 00	Reasonable inpatient routine service costs (see instructions)					83
1	Program inpatient ancillary services (see in						84
	Utilization review - physician compensation						85
_	Total Program inpatient operating costs (sum		ougn 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PAS: Total observation bed days (see instructions					C	87
. 00	Adjusted general inpatient routine cost per	•	ine 2)			0.00	
00						0.00	, ,,

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 06/01/2018 To 05/31/2019		
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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	414, 621	4, 686, 761	0. 08846	6 0	0	90. 00
91.00 Nursing School cost	0	4, 686, 761	0. 00000	0 0	0	91. 00
92.00 Allied health cost	0	4, 686, 761	0. 00000	0 0	0	92. 00
93.00 All other Medical Education	0	4, 686, 761	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 CCN: 15-0047	Peri od:	Worksheet D-1
	Component CCN: 15-5356	From 06/01/2018 To 05/31/2019	
	Title XVIII	Skilled Nursing	PPS
		Eocility	

		litie XVIII	Facility	PPS	
	Cost Center Description		rucirity		
	DART I ALL DROWLDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		4, 623	1. 00
2.00	Inpatient days (including private room days, excluding swing-			4, 623	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only p	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		4, 623	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	0	5. 00
/ 00	reporting period		21 -6 -1	0	
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	m days) through Decembe	r 31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	m days) after December	31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excludin	g swing-bed and	1, 695	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instructions)		room days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	Conly (including priva	te room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including priva	te room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this li	ne)		
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00 15. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWI NG BED ADJUSTMENT		1		
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31	of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 o	f the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of	the cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		3, 614, 553	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost repor	ting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporti	ng poriod (line 6	0	23. 00
23.00	x line 18)	or the cost reporti	ng perrou (rine o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost report	ing period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reportin	g period (line 8	0	25. 00
0, 00	x line 20)				0, 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 3, 614, 553	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(11110 21 1111103 11110 20)	I	0, 011, 000	27.00
	General inpatient routine service charges (excluding swing-bed	d and observation bed c	harges)		28. 00
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)	,		0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	11 00) (0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		ctions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	10 31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost d	ifferential (line	3, 614, 553	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)			38. 00
39. 00	Program general inpatient routine service cost (line 9 x line				39. 00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,			40. 00 41. 00
- 1. 00	Trotal Trogram general impatrent routine service cost (Title 37		ļ	ļ	- 1.00

	Financial Systems	ST JOSEPH MED				u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C Component	CN: 15-0047 CCN: 15-5356	Period: From 06/01/2018 To 05/31/2019	Worksheet D-1 Date/Time Pre	pared:
			Title	e XVIII	Skilled Nursing	10/30/2019 3: PPS	37 pm
	Cost Center Description	Total	Total	Average Per	Facility Program Days	Program Cost	
	cost center bescription	Inpatient Cost		Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)		2.00	0.00	11 00	3. 33	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units	; 		I			43.00
44.00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
							47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1.00	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)			49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	patient routine	services (from	n Wkst. D. sui	m of Parts I and		50.00
	111)		•				
51. 00	Pass through costs applicable to Program inpland IV)	oatient ancillar	y services (fr	om Wkst. D,	sum of Parts II		51. 00
52. 00	Total Program excludable cost (sum of lines						52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	sician anest	hetist, and		53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
54. 00 55. 00	Program discharges Target amount per discharge						54. 00 55. 00
56. 00	Target amount (line 54 x line 55)						56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)		57. 00
58. 00 59. 00	Bonus payment (see instructions)	enorting period	endina 1996 ı	indated and co	omnounded by the		58. 00 59. 00
market basket				37.00			
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see	es 55, 59 or 60 an expected cost	enter the Less	ser of 50% of	the amount by		60.00
62. 00	Relief payment (see instructions)	riisti ucti olis)					62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see instru	ctions)				63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of the	cost report	ing period (See		64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	rost reporting	n neriod (See		65. 00
00.00	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	55)(title XVI	II only). For		66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 d	of the cost r	eporting period		67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost ren	orting period		68. 00
00.00	(line 13 x line 20)	10 00313 41101 1		the cost rep	or tring period		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						69. 00
70. 00	Skilled nursing facility/other nursing facil)	3, 614, 553	70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71.00
73. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)		1, 325, 253 0	1
74.00	Total Program general inpatient routine serv	vice costs (line	72 + line 73)		D+ 11 '	1, 325, 253	74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from V	Vorksheet B, I	Part II, column	0	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					0	
79. 00	Aggregate charges to beneficiaries for exces	ss costs (from p				0	79. 00
80.00	Total Program routine service costs for comp		ost limitation	n (line 78 mi	nus line 79)	0	1
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)			0. 00 0	1
83.00	Reasonable inpatient routine service costs (see instruction				1, 325, 253	83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)			919, 157 0	1
86. 00	Total Program inpatient operating costs (sum	of lines 83 th				2, 244, 410	1
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					0	87. 00
88. 00	1	•	line 2)				88. 00
	Observation bed cost (line 87 x line 88) (se						89. 00

Health Financial Systems	ST JOSEPH ME	DI CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	
		Component		From 06/01/2018 To 05/31/2019		nared:
		Component	CCN. 13-3330	10 03/31/2017	10/30/2019 3:	
		Ti tl e	× XVIII	Skilled Nursing	PPS	
				Facility -		
Cost Center Description	Cost	Routine Cost		Total	Observation	
		(from line 21)	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	(0.00000	0 0	0	90.00
91.00 Nursing School cost			0.00000	0 0	0	91.00
92.00 Allied health cost		o c	0. 00000	0 0	0	92.00
93.00 All other Medical Education		ol c	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 CCN: 15-0047	Peri od: From 06/01/2018	Worksheet D-1
			Date/Time Prepared: 10/30/2019 3:37 pm
	Title XIX	Hospi tal	PPS

		Title XIX	Hospi tal	10/30/2019 3:: PPS	37 pm
	Cost Center Description		·	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
4 00	I NPATI ENT DAYS			45.007	4 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			15, 907 15, 907	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.		vate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation be	ed days)		14, 272	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period		31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	832	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private ro	oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	after December 31 of t	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions			14, 508, 138	
22. 00	Swing-bed cost applicable to SNF type services through Decembe 5×1 ine 17)	·		0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)		, , , ,	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3×1 ine $20)$	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		0 14, 508, 138	26. 00 27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		, ,		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0	28. 00 29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	- line 28)		0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir		tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)		SS	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	unu private room cost di	TEPENTIAL (TINE	14, 508, 138	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ISTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			912. 06	38. 00
39. 00	Program general inpatient routine service cost per drem (see			758, 834	39. 00
40. 00	Medically necessary private room cost applicable to the Progra			0	40. 00
41. 00		•		758, 834	41. 00

Heal th	Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0047	Peri od: From 06/01/2018 To 05/31/2019	Worksheet D-1	pared:
	Cost Center Description	Total Inpatient Cost I	Total	e XIX Average Per Diem (col. 1		PPS Program Cost (col. 3 x col.	97 piii
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42.00	NURSERY (title V & XIX only)						42. 00
43. 00 44. 00 45. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	6, 064, 832	2. 524	2, 402.	87 137	329, 193	43. 00 44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description	0,001,002	2, 02 1	2, 102.	107	327, 173	46. 00 47. 00
		-				1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ns)		1, 026, 089 2, 114, 116	
50. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, su	m of Parts I and	123, 286	50.00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	102, 590	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line	ding capital rel	ated, non-phy	sician anest	hetist, and	225, 876 1, 888, 240	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57.00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59. 00	
60. 00 61. 00	61.00 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				0.00	1	
62. 00 63. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ŕ	tions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decembe	er 31 of the c	ost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	•				0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			·	orting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70. 00 71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	(lino 14 v li	no 25)			72. 00 73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	ice costs (line	72 + line 73)		Part II, column		74. 00 74. 00 75. 00
76. 00 77. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider record	s)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the co			nus 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 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 00 84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	(see instruction					85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	ough ou)				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	diem (line 27 ÷	line 2)			1, 635 912. 06 1, 491, 218	88. 00

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 06/01/2018 To 05/31/2019	Date/Time Pre 10/30/2019 3:	pared: 37 pm_
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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	1, 921, 374	14, 508, 138	0. 13243	4 1, 491, 218	197, 488	90.00
91.00 Nursing School cost	0	14, 508, 138	0.00000	0 1, 491, 218	0	91.00
92.00 Allied health cost	0	14, 508, 138	0.00000	0 1, 491, 218	0	92.00
93.00 All other Medical Education	0	14, 508, 138	0. 00000	0 1, 491, 218	0	93. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047	Peri od: From 06/01/2018	Worksheet D-1
	Component CCN: 15-S047	To 05/31/2019	Date/Time Prepared: 10/30/2019 3:37 pm
	Title XIX	Subprovi der -	PPS

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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) 481,054 41.00		Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)			
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)	Ţ	481, 054	41. 00

()[()[()	Financial Systems ATION OF INPATIENT OPERATING COST	ST JOSEPH MEDIC	Provi der C	CN: 15_0047	Peri od:	u of Form CMS Worksheet D-1	
OWPUT	ATION OF INPATIENT OPERATING COST			CCN: 15-5047	From 06/01/2018 To 05/31/2019	Date/Time Pre 10/30/2019 3:	pared
			Ti tl	e XIX	Subprovi der -	PPS	37 pii
	Cost Center Description	Total	Total	Average Pe	r Program Days	Program Cost	
		Inpatient Costlr		col . 2)		(col. 3 x col. 4)	
2 00	NUDCEDY (+: +1 - V o VIV1)	1.00	2. 00	3. 00	4. 00	5. 00	42
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	,					42.
3. 00	INTENSIVE CARE UNIT						43.
4. 00	CORONARY CARE UNIT						44.
5. 00	BURN INTENSIVE CARE UNIT	0	0	0.	00 0	0	45.
5. 00	SURGICAL INTENSIVE CARE UNIT						46.
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	_
2 00	Dragger i proti est ancil lagu convice cost (W	(at D.2 and 2	line 200)			1.00	40
	Program inpatient ancillary service cost (Wh Total Program inpatient costs (sum of lines			inc)		133, 977 615, 031	1
7. 00	PASS THROUGH COST ADJUSTMENTS	41 till ough 40) (Se	e mstructio	1115)		015, 031	47.
0. 00	Pass through costs applicable to Program in	patient routine se	ervices (from	ı Wkst. D. su	m of Parts I and	42, 557	50.
						,	
1. 00	Pass through costs applicable to Program in	patient ancillary	services (fr	om Wkst. D,	sum of Parts II	12, 811	51.
	and IV)						
2. 00	Total Program excludable cost (sum of lines					55, 368	1
3. 00	Total Program inpatient operating cost exclu		ited, non-phy	sician anest	hetist, and	559, 663	53.
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
00	Program di scharges					0	54.
	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operation	ting cost and tard	et amount (I	ine 56 minus	line 53)	0	1
. 00	Bonus payment (see instructions)					0	58.
00 .	Lesser of lines 53/54 or 55 from the cost re	eporting period er	nding 1996, ι	pdated and c	ompounded by the	0.00	59
	market basket						١
0. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
1. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.
	amount (line 56), otherwise enter zero (see		(TTTICS ST X	00), 01 1% 0	Tile target		
2. 00	Relief payment (see instructions)	,				0	62.
3. 00	Allowable Inpatient cost plus incentive payr	ment (see instruct	ions)			0	63.
	PROGRAM INPATIENT ROUTINE SWING BED COST						1
4. 00	Medicare swing-bed SNF inpatient routine cos	sts through Decemb	er 31 of the	cost report	ing period (See	0	64.
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ste after December	21 of the c	oct roportin	a pariod (Saa	0	65.
3. 00	instructions)(title XVIII only)	sts after beceiiber	31 Of the C	ost reportin	g perrou (see	0	05.
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	l plus line 6	5)(title XVI	II only). For	0	66.
	CAH (see instructions)	·	•	, ,	•		
7. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through [December 31 c	of the cost r	eporting period	0	67.
	(line 12 x line 19)						
8. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after Dec	cember 31 of	the cost rep	orting period	0	68.
2 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs (Li	no 47 : Line	. 40)		0	69.
7. 00	PART III - SKILLED NURSING FACILITY, OTHER N	•				0	09.
0.00	Skilled nursing facility/other nursing facil)		70.
1. 00	Adjusted general inpatient routine service of	,		•	,		71.
2. 00	Program routine service cost (line 9 x line						72.
3. 00	Medically necessary private room cost applic	cable to Program ([line 14 x li	ne 35)			73.
1. 00	Total Program general inpatient routine serv	•					74.
5. 00	Capital-related cost allocated to inpatient	routine service o	costs (from W	orksheet B,	Part II, column		75.
5. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.
7. 00	Program capital-related costs (line 9 x line						77.
3. 00	Inpatient routine service cost (line 74 minu						78.
. 00	Aggregate charges to beneficiaries for excess		ovi der record	ls)			79.
. 00	Total Program routine service costs for comp		st limitation	(line 78 mi	nus line 79)		80.
. 00	Inpatient routine service cost per diem limi						81.
2. 00	Inpatient routine service cost limitation (,					82.
3.00	Reasonable inpatient routine service costs	•					83.
4. 00 5. 00	Program inpatient ancillary services (see in		:)				84.
6. 00 6. 00	Utilization review - physician compensation Total Program inpatient operating costs (sur						85. 86.
5. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS		ragii 00)				1 30.
7. 00	Total observation bed days (see instructions					0	87.
	Adjusted general inpatient routine cost per		ine 2)			0.00	1
3. 00	rajusted general impatreme routine cost per						

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component (From 06/01/2018 To 05/31/2019		pared·
		oomponone (3011. 10 0017		10/30/2019 3:	
		Ti tl	e XIX	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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	414, 621	4, 686, 761	0. 08846	6 0	0	90. 00
91.00 Nursing School cost	0	4, 686, 761	0.00000	0	0	91.00
92.00 Allied health cost	0	4, 686, 761	0.00000	0	0	92.00
93.00 All other Medical Education	0	4, 686, 761	0. 00000	0	l 0 ¹	93. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047		Worksheet D-1
	Component CCN: 15-5356	From 06/01/2018	
	Component CCN: 15-5356	10 05/31/2019	10/30/2019 3: 37 pm
	Title XIX	Skilled Nursing	PPS
		Facility	

		Title XIX	Skilled Nursing Facility	PPS	
Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)			4, 623 4, 623	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,			4, 023	3. 00
	do not complete this line.	, , , , , , , , , , , , , , , , , , , ,			
4.00	Semi-private room days (excluding swing-bed and observation be		24 6 11	4, 623	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			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 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 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and		279	9. 00	
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)			0	10.00
10. 00	through December 31 of the cost reporting period (see instructions)			0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ei 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 after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)		-	0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	as after December 31 of	the cost	0.00	18. 00
10.00	reporting period	es arter becember 51 or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)		3, 614, 553	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December	er 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	31 of the cost reportin	g period (line 6	0	23. 00
	x line 18)	·			
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	⁻ 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December : x line 20)	31 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	(line 21 minus line 26)		3, 614, 553	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation hed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bearing	ai ges)	0	29. 00
30.00	Semi-private 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)			0. 00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
34. 00	Average per diem private room charge differential (line 32 min	, ,	tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 25)	ne 31)		0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforontial (line	2 614 552	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	rrerentral (Trie	3, 614, 553	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line				38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra				40.00
	Total Program general inpatient routine service cost (line 39 + line 40)				41. 00
		,	'	'	

1PUT/	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0047	Peri od:	Worksheet D-1	
			Component	CCN: 15-5356	From 06/01/2018 To 05/31/2019	Date/Time Pre	
			Titl	e XIX	Skilled Nursing	10/30/2019 3: PPS	37 p
					Facility		
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1	9 9	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42.
	Intensive Care Type Inpatient Hospital Units	5					
	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.
	BURN INTENSIVE CARE UNIT						44
	SURGI CAL INTENSIVE CARE UNIT						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1 00	
00	Program inpatient ancillary service cost (W	cst. D-3. col. 3.	line 200)			1. 00	48
	Total Program inpatient costs (sum of lines			ons)			49
	PASS THROUGH COST ADJUSTMENTS						
00	Pass through costs applicable to Program in	patient routine s	services (from	n Wkst. D, sui	m of Parts I and		50
00	III) Pass through costs applicable to Program in	patient ancillary	services (fr	om Wkst. D. :	sum of Parts II		51
	and IV)		(1)				
	Total Program excludable cost (sum of lines	,					52
00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	sician anesti	netist, and		53
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges						54
	Target amount per discharge						55
1	Target amount (line 54 x line 55) Difference between adjusted inpatient opera-	ting cost and tar	raet amount (1	ine 56 minus	line 53)		56 57
	Bonus payment (see instructions)	tring cost and tar	get amount (i	1110 30 1111 1103	11116 33)		58
	Lesser of lines 53/54 or 55 from the cost re	eporting period e	endi ng 1996, ເ	updated and co	ompounded by the		59
00	market basket						١,,
	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by		60
	which operating costs (line 53) are less that						"
	amount (line 56), otherwise enter zero (see	instructions)			Ü		
	Relief payment (see instructions)						62
	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instruc	tions)				63
	Medicare swing-bed SNF inpatient routine cos	sts through Decem	ber 31 of the	cost report	ing period (See		64
	instructions)(title XVIII only)						
00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts after Decembe	er 31 of the d	cost reportin	g period (See		65
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	55)(title XVI	ll only). For		66
	CAH (see instructions)	`	·	, ,	3,		
00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	ne costs through	December 31 d	of the cost r	eporting period		67
00	Title V or XIX swing-bed NF inpatient routing	ne costs after De	ecember 31 of	the cost rep	ortina period		68
	(line 13 x line 20)				, , , , , , , , , , , , , , , , , , ,		
	Total title V or XIX swing-bed NF inpatient						69
	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)	3, 614, 553	70
	Adjusted general inpatient routine service	,		•	,	781. 86	
	Program routine service cost (line 9 \times line					218, 139	
	Medically necessary private room cost applic	•	•			210 120	73
- 1	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II column	218, 139 515, 864	
	26, line 45)	Toutine Service	00313 (110 1	ior Rancet B,	are rr, corumn	010,001	l '`
	Per diem capital-related costs (line 75 ÷ li					111. 59	
1	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu					31, 134 187, 005	
	Aggregate charges to beneficiaries for exces		ovi der record	ls)		187,005	
	Total Program routine service costs for comp				nus line 79)	187, 005	
- 1	Inpatient routine service cost per diem limi					0. 00	
1	Inpatient routine service cost limitation (I					21 124	82
- 1	Reasonable inpatient routine service costs Program inpatient ancillary services (see in		·)			31, 134 255, 468	
	Utilization review - physician compensation		ıs)			255, 408	85
00	Total Program inpatient operating costs (sur	m of lines 83 thr				286, 602	
	PART IV - COMPUTATION OF OBSERVATION BED PAS					_	
00	Total observation bed days (see instructions	S)				0	
- 1	Adjusted general inpatient routine cost per	diem (line 27 ±	line 2)		l	0. 00	l X

Health Financial Systems	ST JOSEPH ME	DI C	AL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der CO		Peri od:	Worksheet D-1	
					From 06/01/2018		
			Component	CCN: 15-5356	To 05/31/2019	Date/Time Prep 10/30/2019 3:3	
			Titl	e XIX	Skilled Nursing		07 piii
					Facility		
Cost Center Description	Cost	R	outine Cost	column 1 ÷	Total	Observation	
		(fi	rom line 21)	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	00	0	91. 00
92.00 Allied health cost		0	0	0.00000	00	0	92. 00
93.00 All other Medical Education		ol	0	0.00000	00	0	93. 00

	Financial Systems	ST JOSEPH MEDICAL CENTER			u of Form CMS-	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0047	Peri od:	Worksheet D-3	
				From 06/01/2018 To 05/31/2019	Date/Time Pre 10/30/2019 3:	
		Ti tle	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	The state of the s	Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
	INDATION DOUTING CEDVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS		1	7, 247, 345		30.00
33. 00	03300 BURN INTENSIVE CARE UNIT			2, 484, 758		33. 00
	04000 SUBPROVI DER - I PF			2, 464, 736		40.00
40.00	ANCI LLARY SERVI CE COST CENTERS					40.00
50. 00	05000 OPERATING ROOM		0. 1404	25 3, 529, 880	495, 683	50.00
51. 00	05100 RECOVERY ROOM		0. 3390		78, 694	1
53. 00	05300 ANESTHESI OLOGY		0. 4967		164, 592	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 0964		374, 924	
54. 01	03630 ULTRA SOUND		0.0000		0,1,,21	
56. 00	05600 RADI OI SOTOPE		0.0000		Ö	
57. 00	05700 CT SCAN		0.0000		o o	1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 1728		291, 105	
60.00	06000 LABORATORY		0. 1209		465, 504	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2270		41, 599	
65.00	06500 RESPI RATORY THERAPY		0. 1527	52 2, 263, 744	345, 791	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 3710	67 222, 236	82, 464	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0. 2170	83 173, 338	37, 629	67. 00
68.00	06800 SPEECH PATHOLOGY		0.7728	93 41, 281	31, 906	68. 00
69.00	06900 ELECTROCARDI OLOGY		0. 0814	49 241, 515	19, 671	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.0526	40 3, 610, 869	190, 076	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2466	93 2, 512, 813	619, 893	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1191	45 7, 749, 589	923, 325	73. 00
74.00	07400 RENAL DIALYSIS		0. 4011	85 399, 340	160, 209	74.00
76.00	03950 MISC ANCILLARY		0.0000	00 0	0	76. 00
76. 01	03951 SLEEP LAB		0.0000		0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		1. 7566			
76. 03	03952 WOUND CARE		0. 5872	37 148, 576	87, 249	76. 03
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		1. 7759			90. 00
01 00	00100 EMERCENCY		∩ 1571	25 1 /2/ 451	225 420	I 01 00

0. 157125

0. 307451

1, 434, 651 331, 543

32, 828, 688

32, 828, 688

4, 741, 965 200. 00

225, 420 101, 933

91.00

92.00

201. 00

202. 00

91. 00 09100 EMERGENCY

200.00

201.00

202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems ST JOSE	EPH MEDICAL CENTER		In lie	u of Form CMS-2	2552_10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0047	Peri od:	Worksheet D-3	
	Component	CCN: 15-S047	From 06/01/2018 To 05/31/2019	Date/Time Pre 10/30/2019 3:	pared: 37 pm
	Ti tl e	xVIII	Subprovider -	PPS	
Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33.00
40. 00 04000 SUBPROVI DER - 1 PF			10, 200, 994		40.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 14042		0	
51. 00 05100 RECOVERY ROOM		0. 33906		6, 084	
53. 00 05300 ANESTHESI OLOGY		0. 49670	·	2, 025	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.09644		44, 577	
54. 01 03630 ULTRA SOUND 56. 00 05600 RADI OI SOTOPE		0.00000		0	
57. 00 05700 CT SCAN		0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 17289		0	1
60. 00 06000 LABORATORY		0. 12094		-	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 22709		0	1
65. 00 06500 RESPIRATORY THERAPY		0. 15275		25, 293	
66. 00 06600 PHYSI CAL THERAPY		0. 37106	7 201, 854	74, 901	66.00
67. 00 06700 OCCUPATIONAL THERAPY		0. 21708	269, 989	58, 610	67.00
68.00 06800 SPEECH PATHOLOGY		0. 77289	17, 650	13, 642	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 08144			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 05264		913	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24669		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 11914		210, 798	
74. 00 07400 RENAL DI ALYSI S		0. 40118		0	1
76. 00 03950 MI SC ANCI LLARY 76. 01 03951 SLEEP LAB		0.00000		0	1
76. 01 03951 SLEEP LAB 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 00000 1. 75666		0 26, 315	1
76. 03 03952 WOUND CARE		0. 58723		26, 313	
OUTPATIENT SERVICE COST CENTERS		0.56723	4, 507	2, 047	70.03
90. 00 09000 CLI NI C		1. 77590	11 0	0	90.00
91. 00 09100 EMERGENCY		0. 15712		59, 556	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 30745			
200.00 Total (sum of lines 50 through 94 and 96 through	gh 98)		4, 596, 212	677, 465	
201.00 Less PBP Clinic Laboratory Services-Program onl	y charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			4, 596, 212		202.00

Health Financial Systems ST JOSEPH MEDI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0047	Peri od:	worksheet D-3	
	Component	CCN: 15-5356	From 06/01/2018 To 05/31/2019	Date/Time Pre 10/30/2019 3:	pared:
	Ti tl e	e XVIII	Skilled Nursing Facility		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INDATIENT DOUTINE CEDVICE COCT CENTEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		I	0	I	30.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0	l	33.00
40. 00 04000 SUBPROVI DER - PF			0		40.00
ANCI LLARY SERVI CE COST CENTERS				l	10.00
50. 00 05000 OPERATING ROOM		0.1404	25 538	76	50.00
51. 00 05100 RECOVERY ROOM		0. 3390		1	
53. 00 05300 ANESTHESI OLOGY		0. 4967	09 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0964	41 71, 000	6, 847	54.00
54. 01 03630 ULTRA SOUND		0.0000		0	54. 0°
56. 00 05600 RADI OI SOTOPE		0.0000	00	0	56.00
57. 00 05700 CT SCAN		0.0000		0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1728		0	59.00
60. 00 06000 LABORATORY		0. 1209			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2270		4, 501	
65. 00 06500 RESPI RATORY THERAPY		0. 1527			
66. 00 06600 PHYSI CAL THERAPY		0. 3710			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2170			
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 7728 0. 0814			
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0.0526			
72. 00 07200 MPL. DEV. CHARGED TO PATTENT		0.0320		0, 239	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1191			
74. 00 07400 RENAL DI ALYSI S		0. 4011		0	1
76. 00 03950 MI SC ANCI LLARY		0.0000		Ö	
76. 01 03951 SLEEP LAB		0.0000		ő	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		1. 7566	66 0	0	76. 02
76. 03 03952 WOUND CARE		0. 5872	37 47, 011	27, 607	76. 0
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		1. 7759		1	
91. 00 09100 EMERGENCY		0. 1571		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3074		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			4 809 274	919 157	1

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

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

0 91.00 0 92.00 919, 157 200.00

201. 00 202. 00

4, 809, 274

200.00

201.00 202.00

Health Financial Systems	ST JOSEPH MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co		Peri od:	Worksheet D-3	
			From 06/01/2018 To 05/31/2019	Date/Time Pre 10/30/2019 3:	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		4.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			2, 065, 284		30.00
33. 00 03300 BURN INTENSIVE CARE UNIT			840, 964		33.00
40. 00 04000 SUBPROVI DER - 1 PF			040, 704		40.00
ANCILLARY SERVICE COST CENTERS			0		40.00
50. 00 05000 OPERATING ROOM		0. 14042	.5 675, 298	94, 829	50.00
51. 00 05100 RECOVERY ROOM		0. 33906		18, 126	
53. 00 05300 ANESTHESI OLOGY		0. 49670		40, 314	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 09644		· ·	
54. 01 03630 ULTRA SOUND		0. 00000		0	54. 01
56. 00 05600 RADI OI SOTOPE		0. 00000	00	0	56. 00
57.00 05700 CT SCAN		0. 00000	00	0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 17289	148, 173	25, 618	59. 00
60. 00 06000 LABORATORY		0. 12094	1, 159, 359	140, 219	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 22709	85, 223	19, 354	
65. 00 06500 RESPIRATORY THERAPY		0. 15275			
66. 00 06600 PHYSI CAL THERAPY		0. 37106			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 21708		10, 104	
68. 00 06800 SPEECH PATHOLOGY		0. 77289			
69. 00 06900 ELECTROCARDI OLOGY		0. 08144			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 05264		20, 484	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 24669		44, 001	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 11914		· ·	
74. 00 07400 RENAL DI ALYSI S		0. 40118		47, 648	
76. 00 03950 MI SC ANCI LLARY		0.00000		0	76.00
76. 01 03951 SLEEP LAB		0.00000		0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		1. 75666		0	76. 02
76. 03 03952 WOUND CARE		0. 58723	37, 188	21, 838	76. 03
90. 00 09000 CLI NI C		1. 77590	1 440	2 572	90.00
90. 00 09000 CLINI C		1. //590 0. 15713			90.00

91.00

92. 00

201.00

202. 00

75, 264 15, 180

1, 026, 089 200. 00

1, 449 479, 006 49, 375

7, 224, 117

7, 224, 117

0. 157125

0. 307451

91. 00 09100 EMERGENCY

200.00

201.00

202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

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

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0047 F	Peri od:	eu of Form CMS-2 Worksheet D-3	
		F	From 06/01/2018		
	Component	CCN: 15-S047	Го 05/31/2019	Date/Time Pre 10/30/2019 3:	pare
	Ti tl	e XIX	Subprovi der - I PF	PPS	
Cost Center Description	'	Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS			0		30.
3.00 03300 BURN INTENSIVE CARE UNIT			0		33.
D. 00 04000 SUBPROVIDER - IPF			1, 494, 845		40.
ANCILLARY SERVICE COST CENTERS		,			
0.00 05000 OPERATING ROOM		0. 140425			
I. 00 05100 RECOVERY ROOM		0. 339062		-	
3. 00 05300 ANESTHESI OLOGY		0. 496709		0	
1. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 096441	· ·		
4. 01 03630 ULTRA SOUND		0.000000		0	
5. 00 05600 RADI OI SOTOPE		0.000000		0	1
7. 00 05700 CT SCAN 9. 00 05900 CARDI AC CATHETERI ZATI ON		0.000000		0	
		0. 172891		1	1 0,
D. 00 06000 LABORATORY D. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 120945 0. 227098		37, 334	1 .
5. 00 06500 RESPI RATORY THERAPY		0. 227090		1	1 .
6. 00 06600 PHYSI CAL THERAPY		0. 132732			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 217083		5, 308	
3. 00 06800 SPEECH PATHOLOGY		0. 772893			
P. 00 06900 ELECTROCARDI OLOGY		0. 081449		1, 083	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 052640		463	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 246693	3 0	0	72
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 119145	348, 442	41, 515	73
1.00 07400 RENAL DIALYSIS		0. 401185	5 0	0	74
5. 00 03950 MISC ANCILLARY		0.000000	0	0	76
5. 01 03951 SLEEP LAB		0.000000	0	0	76
5. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		1. 756666			
5. 03 03952 WOUND CARE		0. 587237	7 0	0	」76
OUTPATIENT SERVICE COST CENTERS			.1		4
0. 00 09000 CLI NI C		1. 775901		517	
I. 00 09100 EMERGENCY		0. 157125		26, 552	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 307451			
70.00 Total (sum of lines 50 through 94 and 96 through 94 and 96 through 94 and 96 through 99 and 99 through			1, 009, 181	133, 977	
01.00 Less PBP Clinic Laboratory Services-Program or	ny charges (line 61)	1	1 0	1	201

Health Financial Systems	ST JOSEPH MEDICAL CENTER			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
	Component	CCN: 15-5356	From 06/01/2018 To 05/31/2019		
	Ti tl	e XIX	Skilled Nursing Facility		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LNDATI ENT. DOUTLING CERVILOE COCT. CENTERS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		I	20.00
30. 00 03000 ADULTS & PEDIATRICS 33. 00 03300 BURN INTENSIVE CARE UNIT			0	l	30.00
			0	l	40.00
40. 00 04000 SUBPROVI DER - I PF ANCI LLARY SERVI CE COST CENTERS			1 0		40.00
50. 00 05000 OPERATING ROOM		0. 14042	2, 972	417	50.00
51. 00 05100 RECOVERY ROOM		0. 33906			51.00
53. 00 05300 ANESTHESI OLOGY		0. 49670		0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 09644		3, 782	
54. 01 03630 ULTRA SOUND		0.00000		1	1
56. 00 05600 RADI OI SOTOPE		0. 00000		0	
57. 00 05700 CT SCAN		0. 00000		0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 17289		0	59.00
60. 00 06000 LABORATORY		0. 12094		7, 535	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 22709		1	62.00
65. 00 06500 RESPIRATORY THERAPY		0. 15275	52 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 37106	7 159, 376	59, 139	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 21708	88, 669	19, 249	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 77289		94, 092	
69. 00 06900 ELECTROCARDI OLOGY		0. 08144			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 05264			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 24669			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 11914		61, 156	
74. 00 07400 RENAL DI ALYSI S		0. 40118		0	
76. 00 03950 MI SC ANCI LLARY		0. 00000		0	
76. 01 03951 SLEEP LAB		0.00000		0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		1. 75666		0	1 , 0. 02
76. 03 03952 WOUND CARE		0. 58723	6, 974	4, 095	76. 03
OUTPATIENT SERVICE COST CENTERS		1 77500	.1	_	00.00
90. 00 09000 CLI NI C		1. 77590			90.00

0. 157125

0. 307451

1, 021, 166

1, 021, 166

201. 00 202. 00

0 91.00 0 92.00 255, 468 200.00

91.00

92.00

200.00

201.00 202.00

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	Peri od: Worksheet E From 06/01/2018 Part A To 05/31/2019 Date/Time Prepared: 10/30/2019 3:37 pm			

			10 05/31/2019	10/30/2019 3:3	
		Title XVIII	Hospi tal	PPS	<u>07 p</u>
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (see	0 1, 892, 245	1. 00 1. 01
1. 02	<pre>instructions) DRG amounts other than outlier payments for discharges occurri instructions)</pre>	3, 439, 273	1. 02		
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	or discharges occurring	orior to October	0	1. 03
1.04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			187, 239	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2.01
3.00	Managed Care Simulated Payments	0113)		3, 901, 000	3. 00
4. 00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	rting period (see instru	ctions)	100. 91	1
5.00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996 (see instructions)	t recent cost reporting	period ending on	8. 95	5. 00
6.00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	ne criteria for an add-o	n to the cap for	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified u ACA § 5503 reduction amount to the IME cap as specified under			1. 89 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopate			-6. 37	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.1998), and 67 FR 50069 (August 1, 2002).	79(c)(2)(i v), 64 FR 2634	Ö (May 12,		
8. 01	The amount of increase if the hospital was awarded FTE cap sld report straddles July 1, 2011, see instructions.			0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)				8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	es (8, 8,01 and 8,02) (see	0. 69	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs.	ent year from your recor	ds	0. 50 0. 00	ł
	Current year allowable FTE (see instructions)				12.00
	Total allowable FTE count for the prior year.			0. 69	1
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ar ended on or after Sep	tember 30, 1997,	5. 29	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.				15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
	Adjusted rolling average FTE count				18.00
	Current year resident to bed ratio (line 18 divided by line 4)).		0. 021405	
	Prior year resident to bed ratio (see instructions)			0. 006759	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 006759	•
22. 00	IME payment adjustment (see instructions)			19, 663	1
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422	Onf the MMA		14, 387	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE reside (f)(1)(iv)(C).		FR 412. 105	4. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			-0. 19	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the linstructions)	ower of line 23 or line	24 (see	0. 00	ı
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
	IME payments adjustment factor. (see instructions)			0. 000000	ł
	IME add-on adjustment amount (see instructions)			0	28. 00
	IME add-on adjustment amount - Managed Care (see instructions))		0	28. 01
	Total IME payment (sum of lines 22 and 28)	,		19, 663	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0' Disproportionate Share Adjustment	1)		14, 387	1
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	13. 08	30.00
	Percentage of Medicaid patient days (see instructions)	acronic days (see institut	1 0113)	43. 47	1
	Sum of Lines 30 and 31			56. 55	1
	Allowable disproportionate share percentage (see instructions)	1		35. 87	
	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	,		478, 104	1
54.00	D Disproportionate share adjustment (see instructions)				

	Financial Systems ST JOSEPH MEDICATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2018 To 05/31/2019		
			10 03/31/2019	10/30/2019 3:	
		Title XVIII	Hospi tal	PPS 10 (1	
			1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment				
35. 00	Total uncompensated care amount (see instructions)		0 00000000		35. 00
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, ent	er zero on this line) (se	0. 000000000 e 1, 606, 994		•
00.02	instructions)	er 2010 on this ime, (30	1,000,771	1,000,127	00.02
35. 03	Pro rata share of the hospital uncompensated care payment am	ount (see instructions)	537, 133		
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.) Additional payment for high percentage of ESRD beneficiary di		1, 639, 040 ah 46)		36. 00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40. 00
	652, 682, 683, 684 and 685 (see instructions)		Dofono 1/1	On /Aften 1 /1	
			Before 1/1 1.00	0n/After 1/1 1.01	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41. 00
41. 01	<pre>instructions) Total ESRD Medicare covered and paid discharges excluding MS an 685. (see instructions)</pre>	-DRGs 652, 682, 683, 684	0	0	41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42. 00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6	82, 683, 684 an 685. (see	0		43. 00
44. 00	instructions) Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44. 00
	days)	3			
45. 00 46. 00	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line 4	•	0.00	0.00	45. 00 46. 00
47. 00	Subtotal (see instructions)	1.01)	7, 655, 564		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00
	only. (see instructions)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instruction			7, 669, 951	1
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I all Exception payment for inpatient program capital (Wkst. L, Pt.			530, 827	50. 00 51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4, I			67, 250	ł
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			0	54. 00 54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)			55.00
56. 00	Cost of physicians' services in a teaching hospital (see int	ructions)		0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	57. 00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0 8, 268, 028	58. 00 59. 00
60.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			4, 289	
61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		8, 263, 739	
62. 00	Deductibles billed to program beneficiaries			527, 204	
63.00	Coinsurance billed to program beneficiaries			13, 807	1
64. 00 65. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			167, 196 108, 677	1
66. 00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		84, 982	•
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		7, 831, 405	1
68. 00	Credits received from manufacturers for replaced devices for			0	68. 00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96)	.(For SCH see instruction	s)	0	69.00
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see	instructions)	0	70. 00 70. 50
70. 87	Demonstration payment adjustment amount before sequestration	, ,		Ö	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)			70. 89
70. 89	, ,			0	70. 90 70. 91
70. 90	THSP DODUS DAVMENT HER Additistment amount (see instructions)			. 0	, , , , , , ,
	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 92
70. 90 70. 91	, , , , , , , , , , , , , , , , , , , ,			0 2, 315 -5, 763	70. 92 70. 93

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER		In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der Co	CN: 15-0047	Peri od: From 06/01/2018 To 05/31/2019	Worksheet E Part A Date/Time Pre 10/30/2019 3:	pared: 37 pm
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	

			To 05/31/2019	Date/Time Pre 10/30/2019 3:	
-	Title	XVIII	Hospi tal	PPS	<u>о, р</u>
			(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70. 96
the corresponding federal year for the period prior to 10/1)					
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 97
the corresponding federal year for the period ending on or af	ter 10/1)				
70.98 Low Volume Payment-3				0	
70.99 HAC adjustment amount (see instructions)				0	
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			7, 827, 957	
71.01 Sequestration adjustment (see instructions)				156, 559	1
71.02 Demonstration payment adjustment amount after sequestration				0	71. 02
72.00 Interim payments				7, 324, 581	
73.00 Tentative settlement (for contractor use only)	0 70 1			0 4 4 0 1 7	73.00
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.0	2, 72, and			346, 817	74. 00
73)	noo wi +h			1 700 427	75 00
75.00 Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	nce with			1, 708, 437	75. 00
TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2 03			0	90.00
plus 2.04 (see instructions)	0. 2.00			· ·	70.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (see instr	uctions)			0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instruc				0	93. 00
94.00 The rate used to calculate the time value of money (see instr				0.00	94. 00
95.00 Time value of money for operating expenses (see instructions)				0	95. 00
96.00 Time value of money for capital related expenses (see instruc	tions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
HSP Bonus Payment Amount			_	_	
100.00 HSP bonus amount (see instructions)			0	0	100. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment					
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions)	6)		0. 0000000000	0. 0000000000	101. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction	s)			0. 0000000000	
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	s)		0. 0000000000	0. 0000000000	101. 00 102. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions)			0.0000000000	0. 0000000000 0	101. 00 102. 00 103. 00
100. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101. 00 HVBP adjustment factor (see instructions) 102. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103. 00 HRR adjustment factor (see instructions) 104. 00 HRR adjustment amount for HSP bonus payment (see instructions))	istment	0. 0000000000	0. 0000000000 0	101. 00 102. 00
100. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101. 00 HVBP adjustment factor (see instructions) 102. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103. 00 HRR adjustment factor (see instructions) 104. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst) ration) Adju		0.0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst) ration) Adju		0.0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00
100. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101. 00 HVBP adjustment factor (see instructions) 102. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103. 00 HRR adjustment factor (see instructions) 104. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst) ration) Adju		0.0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst 200.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.) ration) Adju riod under t		0.0000000000	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00
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100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see inst 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions) 100 Total adjustment to Medicare IPPS payments (see instructions) 101 Comparision of PPS versus Cost Reimbursement 102 Comparision of PPS versus Cost Reimbursement 103.00 Low-volume adjustment (see instructions)	ration) Adjuriod under te 49) first year ructions) line 59)	of the currer	0.000000000	0. 0000000000 0 0. 00000 0 cration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER			u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CCN: 15-0047	Peri od: From 06/01/2018 To 05/31/2019	Worksheet E Part B Date/Time Prepared: 10/30/2019 3:37 pm

		10 03/31/2019	10/30/2019 3:	
		Title XVIII Hospital	PPS	07 piii
		THE ATTENDED	1	
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
1.00	Medical and other services (see instructions)		3, 410	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	tions)	5, 857, 589	
3. 00	OPPS payments		3, 697, 114	
4.00	Outlier payment (see instructions)		97, 030	
4.01	Outlier reconciliation amount (see instructions)		0	
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)	0.000	5. 00
6.00	Line 2 times line 5	•	0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7. 00
8.00	Transitional corridor payment (see instructions)		0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200	0	9. 00
10.00	Organ acqui si ti ons		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3, 410	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonabl e charges			
12.00	Ancillary service charges		23, 782	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		23, 782	14.00
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for p	payment for services on a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	. ,	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e	e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	
18. 00	Total customary charges (see instructions)		23, 782	
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds line 11) (see	20, 372	19. 00
	instructions)			
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds line 18) (see	0	20. 00
21 00	instructions)		2 410	21. 00
21. 00	Lesser of cost or charges (see instructions)			
22. 00	Interns and residents (see instructions)	custions)	0	22. 00 23. 00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instituted prespective payment (sum of lines 2, 4, 4,01, 8, and 0)	uctions)	3, 794, 144	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT		3, 174, 144	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	2)	10, 421	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line		628, 456	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p		3, 158, 677	
27.00	instructions)	or as the sam of fires 22 and 20] (see	0, 100, 077	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 50)	29, 011	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,	0	
30.00	Subtotal (sum of lines 27 through 29)		3, 187, 688	
31.00	Primary payer payments		163	
32.00	Subtotal (line 30 minus line 31)		3, 187, 525	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33. 00
34.00	Allowable bad debts (see instructions)		255, 718	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		166, 217	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)	177, 169	36. 00
37.00	Subtotal (see instructions)		3, 353, 742	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R		0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		39. 50
39. 97	Demonstration payment adjustment amount before sequestration		0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	39. 99
40. 00	Subtotal (see instructions)		3, 353, 742	
40. 01	Sequestration adjustment (see instructions)		67, 075	
40. 02	Demonstration payment adjustment amount after sequestration	0 3, 369, 958		
41. 00	· ·			
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)	' II ONO DI 15 O I I 1	-83, 291	
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, chapter 1,	0	44. 00
	§115. 2			
00.00	TO BE COMPLETED BY CONTRACTOR			00 00
90.00	Original outlier amount (see instructions)		0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money		0.00	91. 00 92. 00
92.00	Time Value of Money (see instructions)		0.00	1
	Total (sum of lines 91 and 93)		0	
, 1. 00	1.00a. (Sam of 111105 /1 and /0)		1	, , , , , , ,

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2018	Worksheet E
	Component CCN: 15-S047		
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der – I PF	PPS	
			111	1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			560	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruc-	ti ons)		1, 343	
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			193 0	3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)		Ö	4. 01	
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV. col. 13. line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			560	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			4, 697	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			4, 697	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for patients liable for patients liable for patients.	navment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			Ö	16. 00
	had such payment been made in accordance with 42 CFR §413.13(3		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	vifline 18 exceeds li	ne 11) (see	4, 697 4, 137	18. 00 19. 00
	instructions)	. ,	, (555	.,	. , , , ,
20. 00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			560	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			193	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	=)		11	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line	•	uctions)	0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	olus the sum of lines 22	and 23] (see	742	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, li</pre>	no EO)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	THE 50)		0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)			742	30. 00
31. 00	Primary payer payments			0	31. 00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	res)		742	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,,,,		0	33. 00
34.00	Allowable bad debts (see instructions)			0	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	uctions)		0 742	36. 00 37. 00
	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50 39. 97	Prioneer ACO demonstration payment adjustment (see instructions	5)		0	39. 50 39. 97
39. 97	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(((,	0	39. 99
40. 00	Subtotal (see instructions)			742	•
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	15 0	40. 01 40. 02		
41. 00	Interim payments			1, 099	
42.00	, ,				42. 00
43.00	Balance due provider/program (see instructions)				43.00
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2, (unapter I,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90. 00
	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)			0	

Health Financial Systems ST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 06/01/2018 | Part I | To 05/31/2019 | Date/Time Prepared: Provider CCN: 15-0047

	Title Inpatien	XVIII t Part A	Hospi tal	10/30/2019 3: 3 PPS	57 p
	Inpatien	t Part A			
			Par	rt B	
-					
	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1.00 T.	1. 00	2.00	3. 00	4. 00	4 00
1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either		7, 324, 581 (3, 369, 958 0	1. 00 2. 00
submitted or to be submitted to the contractor for		C	'		2.00
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		C	1	0	3. 01
3. 02					3. 02
3. 03		C			3. 03
3. 04		Ċ		0	3. 04
3. 05		C)	0	3. 05
Provider to Program					
3. 50 ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51		(0	3. 51
3. 52 3. 53		(0 0	3. 52 3. 53
3. 54		(3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines		(3. 99
3. 50-3. 98)					0. ,,
4.00 Total interim payments (sum of lines 1, 2, and 3.99)		7, 324, 581		3, 369, 958	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
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		C		0	5. 02
5.03 Provider to Program		C	'	0	5. 03
5. 50 TENTATIVE TO PROGRAM		C	\	0	5. 50
5. 51					5. 51
5. 52					5. 52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
5. 50-5. 98)					
6.00 Determined net settlement amount (balance due) based on					6. 00
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER		244 017	,	0	6. 01
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM		346, 817 (83, 291	6. 01
7.00 Total Medicare program liability (see instructions)		7, 671, 398		3, 286, 667	7. 00
100 100 100 100 100 110 100 110 100 110 100 110 100 110 100 110 100 1		7, 0, 1, 0, 0	Contractor	NPR Date	7. 00
			Number	(Mo/Day/Yr)	
	()	1. 00	2. 00	
8.00 Name of Contractor					8. 00

Provider CCN: 15-0047 Component CCN: 15-S047 Subprovi der -Title XVIII

Inpatient Part A Part B mm/dd/yyyy	0	1. 00
1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 2, 283, 703 1, 0 2.00 Interim payments payable on individual bills, either 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 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 0	- 1	
1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either 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 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 0 2, 283, 703 1,00	- 1	
2.00 Interim payments payable on individual bills, either 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 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 0	- 1	
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 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 0	0	2. 00
services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0		
write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0		
3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0		
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 0		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 0		3.00
payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0		
Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0		
3 02	0	3. 01
	0	3. 02
3.03	0	3. 03
3.04	0	3. 04
3.05 Provi der to Program	0	3. 05
3. 50 ADJUSTMENTS TO PROGRAM 0	0	3. 50
3. 51	ol	3. 51
3. 52	0	3. 52
3.53	0	3. 53
3.54	0	3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0	0	3. 99
3. 50-3. 98)		
4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,283,703 1,0 (transfer to Wkst. E or Wkst. E-3, line and column as)99	4. 00
appropriate)		
TO BE COMPLETED BY CONTRACTOR		
5.00 List separately each tentative settlement payment after		5. 00
desk review. Also show date of each payment. If none,		
write "NONE" or enter a zero. (1)		
Program to Provider		
5.01 TENTATIVE TO PROVIDER 0	0	5. 01
5. 02 5. 03	0	5. 02 5. 03
Provider to Program	-0	5. 03
5.50 TENTATI VE TO PROGRAM	0	5. 50
5.51	0	5. 51
5. 52	0	5. 52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0	0	5. 99
5. 50-5. 98)		
6.00 Determined net settlement amount (balance due) based on		6. 00
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 845	0	6. 01
	372	6. 01
	727	7. 00
Contractor NPR Date		00
Number (Mo/Day/Yr))	
0 1.00 2.00		
8.00 Name of Contractor		8. 00

Provider CCN: 15-0047 Component CCN: 15-5356 Title XVIII Skilled Nursing

		Title	XVIII	Skilled Nursing Facility	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		572, 93	6 0	0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3. 04				0	0	3. 04
3. 05				0	0	3. 05
3.03	Provider to Program		'	0	U	3.03
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				Ö	o	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		572, 93	6	0	4. 00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider			_		
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5. 03				0	0	5. 03
F 50	Provider to Program					F 50
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 52 5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on		' 	O		6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			o O	0	6. 02
7. 00	Total Medicare program liability (see instructions)		572, 93	~	Ö	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems ST JOSEPH MEDIC	AL CENTER	In Lie	u of Form CMS-	2552-10
From 06/01/2018 To 05/31/2019				epared:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1. 00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	1-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7. 00					7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00					10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31. 00
22.00	Polones due provider (line 0 (en line 10) minus line 20 and l	ing 21) (and instruction	20)		22.00

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

30. 00 31. 00 32. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od:	Worksheet E-3
	Component CCN: 15-S047	From 06/01/2018	
	Component Gon. 13 3047	03/31/2017	10/30/2019 3: 37 pm
	Title XVIII	Subprovi der -	PPS
		IPF	

	The Airr	IPF	113	
	DART LL MEDICARE BART A CERVICEC LIFE DEC		1. 00	
1. 00	PART II - MEDICARE PART A SERVICES - IPF PPS Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	T	2, 526, 959	1. 00
2.00	Net IPF PPS Outlier Payments		2, 526, 959 5, 977	2.00
3.00	Net IPF PPS ECT Payments		1, 207	3. 00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or befor	e November	0.00	4. 00
4.00	15, 2004. (see instructions)			4.00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were di		0. 00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	under 42		
5.00	New Teaching program adjustment. (see instructions)		0. 00	5. 00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth perio	d of a "new	0. 00	6. 00
	teaching program" (see instuctions)			
7.00	Current year's unweighted I&R FTE count for residents within the new program growth perio	d of a "new	0. 00	7. 00
	teaching program" (see instuctions)			
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0. 00	
9.00	Average Daily Census (see instructions)		14. 520548	
10.00			0. 000000	
11. 00			0	11. 00
12.00			2, 534, 143	
13.00			0	13.00
14.00				14. 00
15.00			0 524 142	15. 00
16.00			2, 534, 143 0	
17. 00 18. 00		+	ŭ	17. 00 18. 00
19. 00		+	2, 534, 143 171, 164	
20.00			2, 362, 979	
21. 00			32, 663	
22. 00			2, 330, 316	
23. 00			1, 316	
24. 00			855	
25. 00	· · · · · · · · · · · · · · · · · · ·		1, 316	
26. 00			2, 331, 171	
27. 00			0	27. 00
28. 00			0	
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	Demonstration payment adjustment amount before sequestration		0	30. 99
31.00	Total amount payable to the provider (see instructions)		2, 331, 171	31. 00
31. 01			46, 623	
31. 02			0	
32. 00			2, 283, 703	
33. 00	, , , , , , , , , , , , , , , , , , , ,		0	33. 00
34. 00			845	
35. 00		ter 1,	0	35. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR			
50. 00			5, 977	50. 00
51.00			3, 477	51. 00
52. 00	· · · · · · · · · · · · · · · · · · ·			52. 00
	Time Value of Money (see instructions)			53. 00
		'	- 1	

	Financial Systems	ST JOSEPH MEDICAL CENTER		u of Form CMS-2	
CALCUL	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od:	Worksheet E-3	
		Component CCN: 15-5356	From 06/01/2018 To 05/31/2019		narod:
		Component Con. 15-5556	10 03/31/2019	10/30/2019 3:3	
		Title XVIII	Skilled Nursing		
			Facility		
				1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTL	EMEMENT - ALL OTHER HEALTH SERVICES FOR T	ITLE XVIII PART A	A PPS SNF	
	SERVI CES				
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS				
1.00	Resource Utilization Group Payment (RUGS)			689, 080	1. 00
2.00	Routine service other pass through costs			0	2. 00
3.00	Ancillary service other pass through costs			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			689, 080	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this	line as vaccine costs are included in lin	e 1 of W/S E,		5. 00
	Part B. This line is now shaded.)				
6.00	Deducti bl e			0	6. 00
7.00	Coi nsurance			104, 451	7. 00
8.00	Allowable bad debts (see instructions)			0	8. 00
9.00	Reimbursable bad debts for dual eligible ben	neficiaries (see instructions)		0	9. 00
	1		1		

Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)

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

0 10.00

0 11.00

0

0

0 14.50

0 14.99

0 15.02

0 17.00

0

0 19.00

12.00

13.00

14.00

15.00

15.01

16.00

18.00

584, 629

584, 629

11, 693

572, 936

10.00 Adjusted reimbursable bad debts (see instructions)

Sequestration adjustment (see instructions)

Tentative settlement (for contractor use only)

Pioneer ACO demonstration payment adjustment (see instructions)

Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)

Demonstration payment adjustment amount before sequestration

Demonstration payment adjustment amount after sequestration

Inpatient primary payer payments

Subtotal (see instructions

11.00 Utilization review

OTHER ADJUSTMENTS

Interim payments

§115. 2

12.00

13.00

14.00

14.50

14.99

15.00

15. 01

15.02

16.00

17.00

18.00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	Peri od: From 06/01/2018 To 05/31/2019 Worksheet E-3 Part VII Date/Time Prepared:

		-	Го 05/31/2019	Date/Time Pre 10/30/2019 3:	
		Title XIX	Hospi tal	PPS	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR XI)	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			1, 258, 192	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	1, 258, 192	1
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpati ent pri mary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	1, 258, 192	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges				0.00
8. 00 9. 00	Routine service charges Ancillary service charges		7 224 117	0 412 202	8. 00 9. 00
10.00	Organ acquisition charges, net of revenue		7, 224, 117	8, 412, 303	10.00
	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		7, 224, 117	8, 412, 303	1
12.00	CUSTOMARY CHARGES		7,227,117	0, 412, 303	12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis	g-			
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	1
16. 00	Total customary charges (see instructions)		7, 224, 117	8, 412, 303	1
17. 00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	7, 224, 117	7, 154, 111	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	y IT Tine 4 exceeds Tine	0	0	18. 00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 10		0	_	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of			1, 200, 172	21.00
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25.00	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
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	1, 258, 192	29. 00
00.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				00.00
30.00	Excess of reasonable cost (from line 18)		0	1 250 103	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		0	1, 258, 192	
32. 00 33. 00			0	0	
34. 00			0	0	
35. 00	Utilization review		0	U	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	1, 258, 192	1
	ELIMINATE SETTLEMENT	33)	0	-1, 258, 192	
	Subtotal (line 36 ± line 37)		0	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	_	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	1
41. 00	Interim payments		0	0	1
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	ce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od: From 06/01/2018	Worksheet E-3
	Component CCN: 15-S047	To 05/31/2019	
	Title XIX	Subprovi der -	PPS

		II ti e xi x	I PF	PPS	
			Inpati ent	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	S FOR TITLES V OR XI)		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	0 1 011 11 1220 1 011 71.7	. 02.111.020		
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)		0	_	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		o	0	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)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		-1		
	Reasonable Charges				
8. 00	Routine service charges		0		8. 00
9. 00	Ancillary service charges		1, 009, 181	0	9. 00
10. 00	Organ acquisition charges, net of revenue		0	Ü	10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		1, 009, 181	0	12. 00
	CUSTOMARY CHARGES		.,,,		
13. 00	Amount actually collected from patients liable for payment for ser	vices on a charge	0	0	13. 00
	basis	g-			
14.00	Amounts that would have been realized from patients liable for pay	ment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CF				
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)		1, 009, 181	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	1, 009, 181	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	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instructi	ons)	0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	leted for PPS provide			
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 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	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	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31. 00
32. 00	Deducti bl es		0	0	32. 00
33. 00	Coinsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review		0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40. 00
41. 00	Interim payments		0	0	41. 00
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 w	ith CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	From 06/01/2018	
	Component CCN: 15-5356	10 05/31/2019	Date/II me Prepared: 10/30/2019 3:37 pm
	Title XIX	Skilled Nursing	PPS

	'	I LI E AIA	Facility	PPS	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FO	D TITLES V OD VI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	K IIILLS V OK XIZ	SERVICES		
1. 00	Inpatient hospital/SNF/NF services		286, 602		1.00
2. 00	Medical and other services		200, 002	0	2.00
3.00	Organ acquisition (certified transplant centers only)			U	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		204 402	0	4. 00
5.00	Inpatient primary payer payments		286, 602	U	5.00
6. 00			٩	0	6. 00
7. 00	Outpatient primary payer payments		204 402	0	7.00
7.00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		286, 602	U	7.00
	Reasonable Charges				
0.00	y .				0 00
8.00	Routine service charges		0	0	8. 00 9. 00
9.00	Ancillary service charges		1, 021, 166	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		1 001 1//	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		1, 021, 166	0	12. 00
40.00	CUSTOMARY CHARGES				40.00
13. 00	Amount actually collected from patients liable for payment for service	s on a charge	0	0	13. 00
14 00	basis	for compless on	0	0	14 00
14. 00	Amounts that would have been realized from patients liable for payment		٩	U	14. 00
15. 00	a charge basis had such payment been made in accordance with 42 CFR §4	13. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0.000000	16.00
	Total customary charges (see instructions)	o 1/ overede	1, 021, 166	0	
17. 00	Excess of customary charges over reasonable cost (complete only if lin line 4) (see instructions)	e to exceeds	734, 564	U	17. 00
18. 00		o 1 ovecede Line		0	18. 00
10.00	Excess of reasonable cost over customary charges (complete only if lin 16) (see instructions)	e 4 exceeds fille	١	U	16.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		286, 602	0	21. 00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete	d for DDC provide		0	21.00
22. 00	Other than outlier payments	u toi 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	Capital exception payments (see instructions)		0		25. 00
26. 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			204 402	0	29.00
29.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		286, 602	0	29.00
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)		286, 602	0	31.00
31.00			280, 602	0	
	Deductibles		0		32.00
33. 00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34. 00 35. 00
35. 00	Utilization review		207 (02	0	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		286, 602	0	36. 00
37. 00	SETTLEMENT ADJ		-286, 602	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	_	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41. 00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	CMC Duk 45 0	0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance with	UNIS PUD 15-2,	0	0	43. 00
	chapter 1, §115.2		1		

	Financial Systems ST JOSEPH MEDICA		ov. 45 oo 45		u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provi der C	CN: 15-0047	Peri od: From 06/01/2018 To 05/31/2019	Worksheet E-4 Date/Time Prep	
		Title	e XVIII	Hospi tal	10/30/2019 3:3 PPS	37 piii
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1.00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	7. 63	1. 00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CF		1) (see instr	uctions)	0.00	2. 00
3. 00 3. 01	Amount of reduction to Direct GME cap under section 422 of MM Direct GME cap reduction amount under ACA §5503 in accordance		8 §413.79 (m).	(see	0. 00 0. 00	3. 00 3. 01
4. 00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	-6. 94	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		cost reporti	ng periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (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 pl	us or minus	line 4 plus l	ines 4.01 and	0. 69	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	0. 50	6. 00
7. 00	Enter the lesser of line 5 or line 6		1		0. 50	7. 00
			Primary Care	0ther 2.00	<u>Total</u> 3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	0. 5		0. 50	8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		0.5	0.00	0. 50	9. 00
10. 00 10. 01 11. 00 12. 00	6. Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions)	rrent year	0. § 0. ¢			10. 00 10. 01 11. 00 12. 00
13. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	5. 2	0.00		13. 00
14. 00 15. 00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	by 3).	2. 7			14. 00 15. 00
15. 01	Unweighted adjustment for residents in initial years of new p	rograms	0.0			15. 01
16. 00 16. 01	Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h		0. 0 0. 0			16. 00 16. 01
17. 00	closure Adjusted rolling average FTE count		2. 1			17. 00
	Per resident amount Approved amount for resident costs		102, 134. 5 220, 61		220, 611	18. 00 19. 00
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots red	eived under 42		20. 00
21. 00 22. 00	Direct GME FTE unweighted resident count over cap (see instru Allowable additional direct GME FTE Resident Count (see instr	uctions)			0.00 0.00	22. 00
23. 00	Enter the locality adjustment national average per resident a Multiply line 22 time line 23 Tatal direct CME amount (sum of lines 19 and 24)	mount (see i	nstructions)		101, 570. 05 0	23. 00 24. 00
25. 00	Total direct GME amount (sum of lines 19 and 24)		Inpatient Par	t Managed care	220, 611	25. 00
			1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
26. 00 27. 00 28. 00 29. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount		6, 09 22, 09 0. 27579 60, 8 ²	26 22, 096 27 0. 186957 44 41, 245		26. 00 27. 00 28. 00 29. 00
30. 00 31. 00	Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount			5, 828	96, 261	30. 00 31. 00

Heal th	Financial Systems ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2	2552-10	
DI REC	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0047	Peri od:	Worksheet E-4		
MEDI CA	AL EDUCATION COSTS		From 06/01/2018 To 05/31/2019	Date/Time Prep 10/30/2019 3:		
		Title XVIII	Hospi tal	PPS		
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLIEDUCATION COSTS)	`		CAL		
32. 00		Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00	
	and 94)					
33. 00	Transaction and transaction an		74 and 94)	1, 282, 924		
34. 00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0. 000000	1	
	Medicare outpatient ESRD charges (see instructions)	24 1: 25)		0		
36.00						
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII Part A Reasonable Cost	UNLY				
37. 00				13, 594, 614	27 00	
38. 00	,			13, 394, 014	ı	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0		
	Primary payer payments (see instructions)	ructions)		4, 289	1	
	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)		13, 590, 325		
11.00	Part B Reasonable Cost					
42.00				5, 862, 902	42. 00	
43.00	,			163	•	
44.00	Total Part B reasonable cost (line 42 minus line 43)			5, 862, 739	44. 00	
45.00	Total reasonable cost (sum of lines 41 and 44)			19, 453, 064	45. 00	
46.00	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line 45)		0. 698621	46. 00	
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin	e 44 ÷ line 45)		0. 301379	47. 00	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAI	RT B				
	Total program GME payment (line 31)			96, 261	1	
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			67, 250	49. 00	
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		29, 011	50.00	

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

Provi der CCN: 15-0047 Pe

oni y)				0 00/01/201/	10/30/2019 3:	37 pm
		General Fund	Specific	Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	I	1			
1.00	Cash on hand in banks	-978, 825	l .	0	0	
2. 00 3. 00	Temporary investments Notes receivable	0	C	-	0	
4. 00	Accounts receivable	39, 972, 210	1		0	
5. 00	Other recei vabl e	0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		o o	0	
6.00	Allowances for uncollectible notes and accounts receivable	-15, 399, 728	c	0	0	
7.00	Inventory	3, 053, 590	C	0	0	
8. 00	Prepai d expenses	1, 650, 580	l .	0	0	
9.00	Other current assets	569, 640	1	1	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	28, 867, 467		-	0	1
11.00	FIXED ASSETS	20, 007, 407) 0	0	11.00
12.00	Land	1, 010, 000	C	0	0	12. 00
13.00	Land improvements	412, 126	1	0	0	
14.00	Accumulated depreciation	-316, 600	1			1
15.00	Bui I di ngs	28, 363, 799	1	_	0	
16.00	Accumulated depreciation	-20, 111, 861	C	_	0 0	1
17. 00 18. 00	Leasehold improvements Accumulated depreciation	23, 328, 864 -8, 336, 829	1	1		
19. 00	Fi xed equipment	1, 569, 517	1	1	0	
20. 00	Accumulated depreciation	0	l c	o o	Ö	
21.00	Automobiles and trucks	0	ol c	0	0	21. 00
22. 00	Accumul ated depreciation	0	C	0	0	
23. 00	Major movable equipment	22, 591, 480	l .	_	0	
24. 00	Accumulated depreciation	-17, 595, 552	l .	_	0	
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation	8, 355, 514 -7, 245, 004	l .	1	0 0	
27. 00	HIT designated Assets	-7, 243, 004			0	
28. 00	Accumulated depreciation	ĺ		o o	Ö	
29.00	Mi nor equi pment-nondepreci abl e	0	d	0	0	
30.00	Total fixed assets (sum of lines 12-29)	32, 025, 454	<u> </u> c	0	0	30.00
	OTHER ASSETS	1	1			
31.00	Investments	0	C	-	0 0	
32. 00 33. 00	Deposits on leases Due from owners/officers	0		_	0	
34. 00	Other assets	8, 923, 261	1	_	0	1
35. 00	Total other assets (sum of lines 31-34)	8, 923, 261	1	o o	Ö	•
36.00	Total assets (sum of lines 11, 30, and 35)	69, 816, 182	c	0	0	36. 00
	CURRENT LI ABILITIES		1			
37. 00	Accounts payable	1, 901, 536	1	-		1
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	2, 174, 793	1	_	0	
40. 00	Notes and Loans payable (short term)	245, 940 238, 034				
41. 00	Deferred income	230,034		0	Ö	
42.00	Accel erated payments	0			_	42. 00
43.00	Due to other funds	44, 481, 087	c	0	0	43.00
44. 00	Other current liabilities	1, 689, 510	1	1	-	
45. 00	Total current liabilities (sum of lines 37 thru 44)	50, 730, 900	<u>C</u>	0	0	45. 00
44 00	LONG TERM LIABILITIES	1 0	1 0	0	0	144 00
46. 00 47. 00	Mortgage payable Notes payable	-1		1		
48. 00	Unsecured Loans	-1		-	0	1
49. 00	Other long term liabilities	Ö	i c	-	Ö	
50.00	Total long term liabilities (sum of lines 46 thru 49)	-1	c	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	50, 730, 899	C	0	0	51.00
	CAPI TAL ACCOUNTS		1			
52. 00	General fund balance	19, 085, 283	l .			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		C	,		53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted		•	0		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
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	19, 085, 283	l .	0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	69, 816, 182		,	0	60. 00
	''	I	I	T	ı	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0047

					To	05/31/2019	Date/Time Pre 10/30/2019 3:	
		General	l Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		33, 547, 476			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		-14, 462, 193 19, 085, 283			0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	0	19, 000, 203		0	U	0	4. 00
5. 00	Additions (credit adjustments) (specify)	l o			0		0	5. 00
6. 00		0			0		0	6. 00
7.00		0			0		0	7. 00
8.00		0			0		0	8. 00
9.00	T + 1 - 11111 (C + 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	0	Ō		0		0	9. 00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 19, 085, 283			0		10. 00 11. 00
12. 00	Deductions (debit adjustments) (specify)	0	19, 000, 203		0	U	0	12.00
13. 00	beddetrons (debrt day dstmerts) (speerry)	l o			0		l ő	13. 00
14. 00		0			0		0	14. 00
15.00		O			0		0	15. 00
16. 00		0			0		0	16. 00
17. 00	T	0	Ō		0		0	17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		19, 085, 283			0		18. 00 19. 00
17.00	sheet (line 11 minus line 18)		17, 003, 203			0		17.00
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1. 00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5. 00 6. 00			0					5. 00 6. 00
7. 00			0					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	Subtotal (line 3 plus line 10)	0	Ō		0			11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)		0					12. 00 13. 00
14. 00			0					14. 00
15. 00			0					15. 00
16.00			0					16. 00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	0			0			18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19. 00
	Isheer (Line II milius IIIe 10)	1		I	- 1			I

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0047

			То	05/31/2019	Date/Time Prep 10/30/2019 3:3	
	Cost Center Description	Inpatie	nt	Outpati ent	Total	57 p
		1.00		2.00	3. 00	
	PART I - PATIENT REVENUES				0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	21, 658	, 560		21, 658, 560	1.00
2.00	SUBPROVI DER - I PF	28, 566			28, 566, 134	2.00
3.00	SUBPROVI DER - I RF				., ,	3. 00
4.00	SUBPROVI DER	İ				4.00
5.00	Swing bed - SNF	İ	0		ol	5. 00
6.00	Swing bed - NF	İ	0		0	6. 00
7.00	SKILLED NURSING FACILITY	3, 878	. 425		3, 878, 425	7. 00
8.00	NURSING FACILITY				., ,	8. 00
9. 00	OTHER LONG TERM CARE	1				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	54, 103	. 119		54, 103, 119	
	Intensive Care Type Inpatient Hospital Services	1	,		2.1, 1.20, 1.1.	
11. 00	INTENSIVE CARE UNIT					11. 00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT	14, 494	, 928		14, 494, 928	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	ines 14, 494	, 928		14, 494, 928	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	68, 598	, 047		68, 598, 047	17.00
18.00	Ancillary services	148, 039	, 073	158, 985, 517	307, 024, 590	18.00
19.00	Outpatient services	9, 868	, 123	37, 871, 802	47, 739, 925	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	o	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 Wkst. 226,505	, 243	196, 857, 319	423, 362, 562	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			85, 150, 651		29.00
30.00	ROUNDI NG ADJUSTMENT		6			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)			6		36.00
37.00	ROUNDI NG ADJUSTMENT		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		85, 150, 657		43.00
	to Wkst. G-3, line 4)					

		MEDICAL CENTER		u of Form CMS-2	
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0047	Peri od: From 06/01/2018	Worksheet G-3	
			To 05/31/2019	Date/Time Pre	nared.
			10 00, 01, 201,	10/30/2019 3:	
			,	1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			423, 362, 562	
2.00	Less contractual allowances and discounts on patients' ad	ccounts		352, 771, 039	
3.00	Net patient revenues (line 1 minus line 2)			70, 591, 523	
4.00	Less total operating expenses (from Wkst. G-2, Part II, I			85, 150, 657	
5.00	Net income from service to patients (line 3 minus line 4))		-14, 559, 134	5. 00
	OTHER INCOME				
6. 00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous communica	ation services		0	
9.00	Revenue from television and radio service			0	,,,,,
10.00	Purchase di scounts			0	1 .0.00
11. 00	Rebates and refunds of expenses			0	1
	Parking Lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	
14.00	Revenue from meals sold to employees and guests			0	
15. 00	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to oth	her than patients			16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	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	
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER MISC INCOME			96, 941	24. 00
25.00	Total other income (sum of lines 6-24)			96, 941	
26.00	Total (line 5 plus line 25)			-14, 462, 193	26. 00
27.00	OTHER EXPENSES (SPECIFY)			0	
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29.00	Net income (or loss) for the period (line 26 minus line 2	28)		-14, 462, 193	29.00

Health Financial Systems ST JOSEPH MEDICA CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 15-0047	Peri od:	u of Form CMS-2 Worksheet L	
			From 06/01/2018 To 05/31/2019	Parts I-III Date/Time Pre	
		Title XVIII	Hospi tal	10/30/2019 3: PPS	3/ pm
	DADT I FILLY PROOPERTIVE METURE			1. 00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				
. 00	Capital DRG other than outlier			428, 328	1.0
. 01	Model 4 BPCI Capital DRG other than outlier			420, 320	1.0
. 00	Capital DRG outlier payments			44, 846	
. 01	Model 4 BPCI Capital DRG outlier payments			0	2.0
. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			46. 16	3.0
. 00	Number of interns & residents (see instructions)			2. 16	4.0
. 00	Indirect medical education percentage (see instructions)			1. 33	5.0
. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)			5, 697	6.0
. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			13. 08	7. C
. 00	Percentage of Medicaid patient days to total days (see instructions)			43. 47	8.0
. 00	Sum of lines 7 and 8			56. 55	
0. 00 1. 00	Allowable disproportionate share percentage (see instructions Disproportionate share adjustment (see instructions)	S)		12. 13	
	Total prospective capital payments (see instructions)			51, 956 530, 827	
2.00	Total prospective capital payments (see That detrois)			330, 027	12.0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
. 00	Program inpatient routine capital cost (see instructions)			0	1.0
. 00	Program inpatient ancillary capital cost (see instructions)			0	2.0
. 00 . 00	Total inpatient program capital cost (line 1 plus line 2)			0	3. C
. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
00	Total impatrent program capital cost (iiiic 3 x iiiic 4)			0	3. 0
	DADT LLL COMPUTATION OF EVERDION DAVMENTS			1. 00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1. (
00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	2.0
00	Net program inpatient capital costs (line 1 minus line 2)	(555 11.51. 451. 51.5)		0	3. 0
. 00	Applicable exception percentage (see instructions)			0.00	4.0
00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 0
00	Percentage adjustment for extraordinary circumstances (see in	,		0.00	
00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2 >	(line 6)	0	
00	Capital minimum payment level (line 5 plus line 7)			0	8. (
00	Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to o		loss lino ()	0	9. 10.
. 00	Carryover of accumulated capital minimum payment level over of worksheet L. Part III, line 14)			0	11. (
2. 00	Net comparison of capital minimum payment level to capital pa	avments (line 10 plus lir	ne 11)	0	12. (
3. 00	Current year exception payment (if line 12 is positive, enter the amount on this line)			0	13. (
1. 00	Carryover of accumulated capital minimum payment level over capital payment for the following period			0	14.
	(if line 12 is negative, enter the amount on this line)				
5. 00	Current year allowable operating and capital payment (see ins	structions)		0	15. (
5. 00	Current year operating and capital costs (see instructions) Current year exception offset amount (see instructions)			0	16. 17.