Health Financial Systems ST. JOSEPHS REG MED CENTER	PLYMOUTH In Lieu of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to	o report can result in all interim FORM APPROVED
payments made since the beginning of the cost reporting period being deeme	
	EXPI RES 09-30-2025
	der CCN: 15-0076 Period: Worksheet S
AND SETTLEMENT SUMMARY	From 07/01/2022 Parts I-III To 06/30/2023 Date/Time Prepared:
	11/29/2023 2:02 pm
PART I - COST REPORT STATUS	
Provider 1. [X] Electronically prepared cost report	Date: 11/29/2023 Time: 2:02 pm
use only 2. [] Manually prepared cost report	
3.[0]If this is an amended report enter the number of tim 4.[F]Medicare Utilization. Enter "F" for full, "L" for I	nes the provider resubmitted this cost report low, or "N" for no.
Contractor 5. [1] Cost Report Status 6. Date Received:	10. NPR Date:
use only (1) As Submitted 7, Contractor No.	11. Contractor's Vendor Code: 4
(2) Settled without Audit 8. [N] Initial Report for this	s Provider CCN 12. [0]If line 5, column 1 is 4: Enter
(3) Settled with Audit 9. [N]Final Report for this P	Provider CCN number of times reopened = 0-9.
(4) Reopened	
(5) Amended	
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR P	PROVI DER(S)
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COM	ST REPORT MAY BE PUNI SHABLE BY CRIMINAL, CIVIL AND
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHE	RMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKB.	ACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVI	DER(S)
I HEREBY CERTIFY that I have read the above certification statemen	nt and that I have examined the accompanying
electronically filed or manually submitted cost report and submitt	ted cost report and the Balance Sheet and
Statement of Revenue and Expenses prepared by ST. JOSEPHS REG MED	
reporting period beginning 07/01/2022 and ending 06/30/2023 and to	
report and statement are true, correct, complete and prepared from	
accordance with applicable instructions, except as noted. I furthe	
regulations regarding the provision of health care services, and t report were provided in compliance with such laws and regulations.	

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1		2	SI GNATURE STATEMENT	
1	Melis	sa Lukasick	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Melissa Lukasick			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	291, 436	-32, 851	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER – 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
200.00	TOTAL	0	291, 436	-32, 851	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi d	er CCN:		Period: From 07/01/		Workshe Part I	et S-2	
						To 06/30/	2023	Date/Ti 11/29/2		
	1.00	2.00		3.00		L	. 00	11/27/2	025 2.	
	Hospital and Hospital Health Care Co		-							4
0	Street: 1915 LAKE AVENUE	PO Box:670 State: IN	Zip Cod	- 14E43	Count					1
0	City: PLYMOUTH	Component Name	Zip Code	CBSA		y: MARSHALL Date	Payme	nt Syst	om (P	2
		component Mame	Number	Number		Certified		0, or		
							V	XVIII	XIX	1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componen		1	1						4
0	Hospi tal	ST. JOSEPHS REG MED	150076	99915	5 1	07/01/1996	Ν	P	Р	3
0	Subprovider - IPF	CENTER PLYMOUTH								4
0	Subprovider - IRF									5
0	Subprovider - (Other)									6
0	Swing Beds - SNF									7
0	Swing Beds - NF									8
0	Hospital-Based SNF									9
00	Hospital-Based NF									10
00	Hospital-Based OLTC Hospital-Based HHA									11
	Separately Certified ASC									12
	Hospi tal -Based Hospi ce									14
00	Hospital -Based Health Clinic - RHC									15
	Hospital-Based Health Clinic - FQHC									16
00	Hospital-Based (CMHC) I									17
	Renal Dialysis									18
00	Other									19
						From: 1.00				+
00	Cost Reporting Period (mm/dd/yyyy)					07/01/20	122	06/30/		20
	Type of Control (see instructions)					1		00,00,	2020	21
					1.00	2.00		3.0	0	
~~	Inpatient PPS Information				Y	N				
00	Does this facility qualify and is it disproportionate share hospital adju				ř	N				22
	§412.106? In column 1, enter "Y" fo			·						
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo									
01	Did this hospital receive interim UC				Y	Y				22
	this cost reporting period? Enter in									
	for the portion of the cost reporting 1. Enter in column 2, "Y" for yes or									
	cost reporting period occurring on o									
	i nstructi ons)									
02	Is this a newly merged hospital that	requires a final UCP t	to be		Ν	N				22
	determined at cost report settlement			umn						
	1, "Y" for yes or "N" for no, for the	e portion of the cost r	reporting							
	period prior to October 1. Enter in f			no,						
03 03	for the portion of the cost reporting Did this hospital receive a geograph				Ν	N		N		22
	rural as a result of the OMB standard				14	IN IN		IN IN		~~
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reporting	g period prior to Octob	oer 1. Ente							
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or after									
	Does this hospital contain at least counted in accordance with 42 CFR 41.		•							
	yes or "N" for no.	2. 100): LITTER TH COLUMN	13, T IU	"						
04	Did this hospital receive a geograph	ic reclassification fro	om urban to	,		1				22
	rural as a result of the revised OMB									
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reporting			r						
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or after Does this hospital contain at least			_						
	counted in accordance with 42 CFR 41.									
	yes or "N" for no.			- I						
						1				1
00	Which method is used to determine Me	dicaid days on lines 24	and/or 25			3 N				23
00	5					3 N				23
00	Which method is used to determine Me	of admission, 2 if cens of identifying the days	sus days, o s in this c	r 3		3 N				23

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	TH CN: 15-0076		ri od:			neet S-2	
					Fr To	om 07/0 06/3	0/2023		ime Pre 2023 2:	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	S Mec eli	ut-of tate di cai d gi bl e npai d	Medicai HMO day	/s Me	Other edi cai d days	
4 00	If this provider is an LDDC beenited optor the	1.00	2.00	3.00		4.00	5.00		6.00	24.0
	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 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					1 0		0	47	24. (
	Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.									
						Urban/R	Rural S		f Geogr 00	-
6.00	Enter your standard geographic classification (not wa		at the beg	jinning of t	the	1. 1	2	۷.	00	26. (
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassifi If this is a call community hereital (CCU)	age) status r "2" for r ication in	ural. If ap column 2.	pl i cabl e,			2			27.0
5.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number or	periods su	H Status Ir	n		0			35.
					-	Begi ni 1. (i ng: 00	-
5.00	Enter applicable beginning and ending dates of SCH s		cript line	36 for numb	ber	1. \	00	۷.	00	36.
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	us		0			37.
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo	he MDH tran	sitional pa	ayment in						37.
. 00	instructions) [f line 37 is 1, enter the beginning and ending date:	5		•						
	greater than 1, subscript this line for the number o									38.
						Y/	ΎΝ	Y	/N	38.
	greater than 1, subscript this line for the number o enter subsequent dates.	f periods i	n excess of	fone and	-	1. (00	2.	00	38.
9. 00	greater than 1, subscript this line for the number or enter subsequent dates. 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 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol	f periods i l payment a), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente	n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y	for low volu for low volu er in colur nts in 2 "Y" for ye (" for yes o	mn es or		00	2.		38. 39. 40.
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0.00	greater than 1, subscript this line for the number or enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "V" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment	f periods i l payment a), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente . (see inst	n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions)	[™] one and for low volu cer in colur its in 2 "Y" for yes /" for yes o /es or "N" 1	mn es or for	1. (Y	00 1 V	2.	00 Y N XI X	39. 40.
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2. 00 3. 00 5. 00 5. 00 5. 00	greater than 1, subscript this line for the number or enter subsequent dates. 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 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octoon no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals	f periods i payment a), (ii), or the mileage ii)? Enter n adjustmen ber 1. Enter . (see inst . (see inst . (see inst . L, Pt. I capital? E t? Enter "	n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes	For Low volu er in colur hts in ? "Y" for yes (" for yes of ves or "N" 1 e share in ary circumst L-1, Pt. r yes or "N" or "N" for	mn es for for acco tance I th " for no.	1.0 Y N prdance es nrough r no.	00 1 1.00 N N	2. XVI I I 2. 00 N N	00 Y N 3.00	39.
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. 00 . 00 . 00 . 00 . 00 . 00	greater than 1, subscript this line for the number or enter subsequent dates. 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 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octoon in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter " cost reporting periods beginning on or after December the instructions. For column 2, if the response to cc involved in training residents in approved GME program	f periods i I payment a), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente . (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRS) MA dir er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e on duty, i	n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina 11 and Wkst nter "Y for Y" for yes ME programs or "N" for year ect GME pay , if line 5 in approved If column ing period? E-4. If co S. For cost)(1)(iv) ar f the respon	F one and For low volu ter in colur ter in colur ter in colur try for yes of (" for yes of " N" for ter share in ary circumst C. L-1, Pt. - yes or "N" or "N" for S? For cost CFR 413.78(t this hospit or penultir ment reduct 56, column 2 is "Y", co 2 Enter "Y' olumn 2 is " reporting p od (v), regonse to line	mn es or for for acccc accc accc accc accc accc accc a	1.0 Y Pordance es hrough r no. Orting 1. For year, ? Enter s year, ? Enter s year, ? Enter s yeas, trained r yes of is "Y"	00 1 1 1 0 1 0 1 0 1 0 1 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0	2. XVIII 2.00 N N N	00 Y N <u>XIX</u> 3.00 N N	39 40 45 46 47 48

IOSPI TAI	L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 07/01/2022 o 06/30/2023	Worksheet S-2 Part I Date/Time Pre 11/29/2023 2: XVIII XIX	pared:
					1.00		
9.00 A	re costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,		N		59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
a i i	Are you claiming nursing and allied health education ny programs that meet the criteria under 42 CFR 413. nstructions) Enter "Y" for yes or "N" for no in col s "Y", are you impacted by CR 11642 (or subsequent C djustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. R) NAHE	see If column 1	N			60.0
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
s 51.01 E F e	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care ETEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see nstructions)	N	2.00	3.00	0.00		61.0
F A 1.03 E	Inter the current year total unweighted primary care TE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of NCA). (see instructions) Inter the base line FTE count for primary care and/or general surgery residents, which is used for						61. C
d i 1.04 E s	Netermining compliance with the 75% test. (see nstructions) Enter the number of unweighted primary care/or Surgery allopathic and/or osteopathic FTEs in the						61. (
1.05 E a p 6	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line pl. 04 minus line 61.03). (see instructions)						61. (
u	Inter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. (
		Pro	ogram Name			Direct GME FTE Count	
1 10 0) of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.1
s f c p u F 1. 20 0	special ty, 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 inweighted count. Enter in column 4, the direct GME FTE unweighted count. of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE				0.00		61. 2
i E 3	residents for each expanded program. (see nstructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 8, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
	CA Dravisiona Affaation the Unity D		Administry to			1.00	
2.00 E	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	traineo tions)	d in this cost	reporting peri		0.00	62.0
2.01 Ē	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	Teachi			your hospital	0.00	62.0

alth Financial Systems)SPITAL AND HOSPITAL HEALTH CARE COMPL		REG MED CENTER PLYMO TA Provider C		eriod:	u of Form CMS- Worksheet S-2	
SFITE AND HOSFITE HEALTH CARE COMPL	LX TUENTITICATION DA			rom 07/01/2022	Part I	pared:
			Unweighted	Unweighted	Ratio (col. 1/	
			FTES	FTEs in	(col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te	2.00	2.00	-
Section 5504 of the ACA Base Year	ETE Posidonts in No	opprovidor Sottings	1.00	2.00	<u>3.00</u>	
period that begins on or after Ju			ini s base year	is your cost i	eportring	
4.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you	yes, or your facilit per of unweighted non ations occurring in number of unweighted ur hospital. Enter in	y trained residents n-primary care all nonprovider non-primary care column 3 the ratio	0.00	O. OC	0. 000000	0 64. OC
of (column 1 divided by (column 1						
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
			Nonprovi der	Hospital	(cor. 3 + cor. 4))	
			Si te	nospi tai	4))	
-	1.00	2.00	3.00	4.00	5.00	-
5.00 Enter in column 1, if line 63	1.00	2.00	0.00			65 00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovider Site 1.00	FTEs in Hospital	(col. 1 + col. 2))	
Section 5504 of the ACA Current Y	lear FTF Residents in	Nonnrovider Setting		2.00	3.00	
beginning on or after July 1, 201		r Nonprovider Setting	J3Litective it		ng perious	
b. 00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u	nweighted non-primar curring in all nonpr	ovider settings.	0.00	0. 00	0. 000000	66.00
FTEs that trained in your hospita	l. Enter in column 3	the ratio of				
(column 1 divided by (column 1 +				llowol	Datio (0)	
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	0.00	Site		5.05	-
	1.00	2.00	3.00	4.00	5.00	17.07
7.00 Enter in column 1, the program 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			0.00	0. 00	0. 000000	0 67.00

	l l l l l l l l l l l l l l l l l l l	Period: From 07/01/20		eet S-2		
		o 06/30/20	23 Date/Ti 11/29/2			
			1. (00		
68.00	<u>Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10</u> For a cost reporting period beginning prior to October 1, 2022, did you obtain permissi MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR (August 10, 2022)?	on from your	N	1	68.00	
		1	. 00 2. 00	3.00		
70.00	<u>Inpatient Psychiatric Facility PPS</u> Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub	provi der?	N		70.00	
71.00		0	71.00			
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		N		75.00	
76.00	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 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o no. Column 2: Did this facility train residents in a new teaching program in accordance 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)	r "N" for with 42		0	76.00	
			1.0	00		
	Long Term Care Hospital PPS				00.00	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no. TEFRA Providers	period? Ente	er N		80. 00 81. 00	
	 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 					
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	I	87.00	
		Approved for Permanent Adjustmen (Y/N) 1.00	Appro	oved nent ments		
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions)			0	88.00	
	Column 2: Enter the number of approved permanent adjustments. Wkst. A Line	Effective Da				
	No.		Perma Adjus Amoun Disch	tment t Per		
89 00	1.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0.0	2.00	3. (89.00	
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the	_				
	TEFRA target amount per discharge.	V	XI			
	Title V and XIX Services	1.00	2.0			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00	
93.00	"Y" for yes or "N" for no in the applicable column.	N	N		93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N		94.00	
	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. (N		95. 00 96. 00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.0	00	97.00	

	ENTIFICATION DATA	D CENTER PLYMOL Provider CO		Peri od:	eu of Form CMS Worksheet S	
				From 07/01/2022 To 06/30/2023	2 Part I	repared:
				V	XI X	<u>2.02 piii</u>
				1.00	2.00	
3.00 Does title V or XIX follow Medicare (t stepdown adjustments on Wkst. B, Pt. I column 1 for title V, and in column 2	, col. 25? Enter "Y"			Y	Y	98.0
B. 01 Does title V or XIX follow Medicare (t C, Pt. I? Enter "Y" for yes or "N" for title XIX.	itle XVIII) for the m				Y	98.0
B. 02 Does title V or XIX follow Medicare (t bed costs on Wkst. D-1, Pt. IV, line 8 for title V. and in column 2 for title	9? Enter "Y" for yes			Y	Y	98.0
8.03 Does title V or XIX follow Medicare (t reimbursed 101% of inpatient services		Ν	98. C			
for title V, and in column 2 for title 0.04 Does title V or XIX follow Medicare (t outpatient services cost? Enter "Y" fo	itle XVIII) for a CAH			N	N	98.0
in column 2 for title XIX. 5.05 Does title V or XIX follow Medicare (t Wkst. C, Pt. I, col. 4? Enter "Y" for relevant of the title XIX					Y	98. C
column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (t Pts. I through IV? Enter "Y" for yes o column 2 for title XIX.	Y	Y	98.0			
Rural Providers 05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, h	as it elected the all	-inclusive meth	nod of paymen	t		105. 0 106. 0
for outpatient services? (see instruct 7.00 Column 1: If line 105 is Y, is this fa training programs? Enter "Y" for yes o Column 2: If column 1 is Y and line 7 approved medical education program in	cility eligible for o r "N" for no in colur O or line 75 is Y, do the CAH's excluded J	nn 1. (see inst you train I&Rs PF and/or IRF u	tructions) s in an			107. C
Enter "Y" for yes or "N" for no in col 8.00 Is this a rural hospital qualifying fo CFR Section §412.113(c). Enter "Y" for	r an exception to the	e CRNA fee sched				108.0
		Physi cal	Occupationa		Respi ratory	<u>/</u>
09.00 f this hospital qualifies as a CAH or therapy services provided by outside s for yes or "N" for no for each therapy	upplier? Enter "Y"	1.00	2.00	3.00	4.00	109. 0
					1.00	_
0.00 Did this hospital participate in the R Demonstration)for the current cost rep complete Worksheet E, Part A, lines 20 applicable.	orting period? Enter	"Y" for yes or	"N" for no.	lf yes,	1.00 N	110. 0
Demonstration)for the current cost rep complete Worksheet E, Part A, lines 20	orting period? Enter	"Y" for yes or	"N" for no.	lfyes, ugh 215, as	N	110. 0
Demonstration)for the current cost rep complete Worksheet E, Part A, lines 20 applicable.	orting period? Enter 0 through 218, and Wo id it participate in onstration for this o If the response to o which this CAH is pa	"Y" for yes or prksheet E-2, li the Frontier Co cost reporting p column 1 is Y, e articipating in	"N" for no. nes 200 thro ommunity period? Enter enter the column 2.	If yes, ugh 215, as 1.00 N		110. 0 111. 0
Demonstration) for the current cost rep complete Worksheet E, Part A, lines 20 applicable. 1.00 If this facility qualifies as a CAH, d Health Integration Project (FCHIP) dem "Y" for yes or "N" for no in column 1. integration prong of the FCHIP demo in Enter all that apply: "A" for Ambulanc	orting period? Enter 0 through 218, and Wo id it participate in onstration for this o If the response to o which this CAH is pa	"Y" for yes or prksheet E-2, li the Frontier Co cost reporting p column 1 is Y, e articipating in	"N" for no. nes 200 thro pommunity period? Enter enter the column 2. and/or "C"	If yes, ugh 215, as 1.00 N	N 2.00	
Demonstration) for the current cost rep complete Worksheet E, Part A, lines 20 applicable. 1.00 If this facility qualifies as a CAH, d Health Integration Project (FCHIP) dem "Y" for yes or "N" for no in column 1. integration prong of the FCHIP demo in Enter all that apply: "A" for Ambulanc for tele-health services. 2.00 Did this hospital participate in the P (PARHM) demonstration for any portion period? Enter "Y" for yes or "N" for "Y", enter in column 2, the date the h demonstration. In column 3, enter the	orting period? Enter 0 through 218, and Wo id it participate in onstration for this of If the response to of which this CAH is pa e services; "B" for a ennsylvania Rural Hea of the current cost n no in column 1. If of ospital began partici date the hospital co	"Y" for yes or orksheet E-2, li the Frontier Co cost reporting p column 1 is Y, e articipating in additional beds; alth Model reporting column 1 is pating in the	"N" for no. nes 200 thro ommunity period? Enter enter the column 2.	If yes, ugh 215, as 1.00 N	N	111. 0
Demonstration) for the current cost rep complete Worksheet E, Part A, lines 20 applicable. 1.00 If this facility qualifies as a CAH, d Health Integration Project (FCHIP) dem "Y" for yes or "N" for no in column 1. integration prong of the FCHIP demo in Enter all that apply: "A" for Ambulanc for tele-health services. 2.00 Did this hospital participate in the P (PARHM) demonstration for any portion period? Enter "Y" for yes or "N" for "Y", enter in column 3, enter the participation in the demonstration, if Miscellaneous Cost Reporting Informati	orting period? Enter 0 through 218, and Wo id it participate in onstration for this of If the response to of which this CAH is pa e services; "B" for a ennsylvania Rural Hea of the current cost r no in column 1. If of ospital began partici date the hospital co <u>applicable</u> . on	"Y" for yes or prksheet E-2, li the Frontier Co cost reporting p column 1 is Y, o urticipating in additional beds; alth Model reporting column 1 is pating in the eased	"N" for no. nes 200 thro pommuni ty peri od? Enter enter the column 2. and/or "C" 1.00	If yes, ugh 215, as 1.00 N	N 2.00	
 Demonstration) for the current cost repcomplete Worksheet E, Part A, lines 20 applicable. 1.00 If this facility qualifies as a CAH, d Health Integration Project (FCHIP) dem "Y" for yes or "N" for no in column 1. integration prong of the FCHIP demo in Enter all that apply: "A" for Ambulanc for tele-health services. 2.00 Did this hospital participate in the P (PARHM) demonstration for any portion period? Enter "Y" for yes or "N" for yes or "N" for sort the head the head monstration. In column 3, enter the participation in the demonstration, if Miscellaneous Cost Reporting Informati 5.00 Is this an all-inclusive rate provider in column 1. If column 1 is yes, enter for short term hospital or "98" percen psychiatric, rehabilitation and long t 	orting period? Enter 0 through 218, and Wo id it participate in onstration for this of If the response to of which this CAH is pa e services; "B" for a e services; "B" for a of the current cost n no in column 1. If of ospital began partici date the hospital co applicable. on ? Enter "Y" for yes of the method used (A, in column 3 either ' t for long term care erm hospitals provide	"Y" for yes or orksheet E-2, li the Frontier Co cost reporting p column 1 is Y, e riticipating in additional beds; alth Model reporting column 1 is pating in the based or "N" for no B, or E only) 93" percent (includes	"N" for no. nes 200 thro pommuni ty peri od? Enter enter the column 2. and/or "C" 1.00	If yes, ugh 215, as 1.00 N	N 2.00	111. C
Demonstration) for the current cost rep complete Worksheet E, Part A, lines 20 applicable.	orting period? Enter 0 through 218, and Wo id it participate in onstration for this of If the response to of which this CAH is part e services; "B" for a e services; "B" for a of the current cost r no in column 1. If of ospital began partici date the hospital co applicable. on ? Enter "Y" for yes of the method used (A, in column 3 either ' t for long term care erm hospitals provide r 22, §2208.1. ral center? Enter "Y"	"Y" for yes or prksheet E-2, li the Frontier Co cost reporting p column 1 is Y, of articipating in additional beds; alth Model reporting column 1 is pating in the eased or "N" for no B, or E only) 93" percent (includes ers) based on for yes or	"N" for no. nes 200 thro pommuni ty peri od? Enter enter the col umn 2. and/or "C" 1.00 N	If yes, ugh 215, as 1.00 N	N 2.00	0115. C
<pre>complete Worksheet E, Part A, lines 20 applicable. 11.00 If this facility qualifies as a CAH, d Health Integration Project (FCHIP) dem "Y" for yes or "N" for no in column 1. integration prong of the FCHIP demo in Enter all that apply: "A" for Ambulanc for tele-health services. 12.00 Did this hospital participate in the P (PARHM) demonstration for any portion period? Enter "Y" for yes or "N" for "Y", enter in column 2, the date the h demonstration. In column 3, enter the participation in the demonstration, if Miscellaneous Cost Reporting Informati 15.00 Is this an all-inclusive rate provider in column 1. If column 1 is yes, enter for short term hospital or "98" percen psychiatric, rehabilitation and long t the definition in CMS Pub. 15-1, chapte 16.00 Is this facility classified as a refer</pre>	orting period? Enter 0 through 218, and Wo id it participate in onstration for this of If the response to of which this CAH is pa e services; "B" for a e services; "B" for a of the current cost n no in column 1. If of ospital began partici date the hospital co applicable. on ? Enter "Y" for yes of the method used (A, in column 3 either ' t for long term care erm hospitals provide r 22, §2208.1. ral center? Enter "Y'	"Y" for yes or orksheet E-2, li the Frontier Co cost reporting p column 1 is Y, e rrticipating in additional beds; alth Model reporting column 1 is pating in the passed or "N" for no B, or E only) 93" percent (includes ers) based on for yes or urance? Enter	"N" for no. nes 200 thro pommuni ty peri od? Enter enter the col umn 2. and/or "C" 1.00 N	If yes, ugh 215, as 1.00 N	N 2.00	111. C

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCI		Period: From 07/01/2022 To 06/30/2023	Date/Time Pr 11/29/2023 2	repared
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
8.01 List amounts of malpractice premiums and paid losses:			0 (0	0118.
			1.00	2.00	-
8.02 Are malpractice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.			N		118.
9.00 D0 NOT USE THIS LINE 0.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Has \$3121 and applicable amendments? (see instructions) Enter in cc "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA \$3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.	lumn 1, "Y" fies for the	for yes or e Outpatient		N	119. (120. (
1.00Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.	able devices	charged to	Y		121.
2.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.					122.
3.00 Did the facility and/or its subproviders (if applicable) purchas services, e.g., legal, accounting, tax preparation, bookkeeping management/consulting services, from an unrelated organization for yes or "N" for no.	, payroll, a 'In column	and/or 1, enter "Y"			123.
If column 1 is "Y", were the majority of the expenses, i.e., gr professional services expenses, for services purchased from unr located in a CBSA outside of the main hospital CBSA? In column "N" for no. Certified Transplant Center Information	elated organ	ni zati ons			
5.00 Does this facility operate a Medicare-certified transplant cent		Y" for yes	N		125.
and "N" for no. If yes, enter certification date(s) (mm/dd/yyy 6.00 f this is a Medicare-certified kidney transplant program, enter for the second s		fication dat	e		126.
in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare-certified heart transplant program, enter	the certifi	cation date			127.
in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare-certified liver transplant program, enter	the certifi	cation date			128.
in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare-certified lung transplant program, enter in column 1 and termination date, if applicable, in column 2.	the certifi	cation date			129.
0.00 f this is a Medicare-certified pancreas transplant program, er date in column 1 and termination date, if applicable, in column		ti fi cati on			130.
1.00 f this is a Medicare-certified intestinal transplant program, date in column 1 and termination date, if applicable, in column	enter the co	erti fi cati on			131
2.00 If this is a Medicare-certified islet transplant program, enter in column 1 and termination date, if applicable, in column 2.		cation date			132. 133.
 OO Removed and reserved OO If this is a hospital-based organ procurement organization (OPC in column 1 and termination date, if applicable, in column 2. All Providers)), enter the	e OPO number			133.
0.00 Are there any related organization or home office costs as defi chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes are claimed, enter in column 2 the home office chain number. (s 1.00 2.00	s, and home of	office costs	Y 3.00	15H034	140.
If this facility is part of a chain organization, enter on line				of the	
home office and enter the home office contractor name and contractor. 1. 00 Name: SAINT JOSEPH REG MEDICAL CTR Contractor's Name: WISCO SERVI			or's Number: 0800	01	141.
2.00 Street: 5215 HOLY CROSS PARKWAY PO Box: 3.00 City: MI SHAWAKA State:		Zip Code	: 4654	45	142. 143.
4.00 Are provider based physicians' costs included in Worksheet A?				1.00 Y	144.
T. COMPLET PROVIDED DASED PHYSICIANS COSTS FICTURED FIT WORKSHEEL A?				1	144.
5.00 f costs for renal services are claimed on Wkst. A, line 74, and			1.00	2.00	145.
inpatient services only? Enter "Y" for yes or "N" for no in col no, does the dialysis facility include Medicare utilization for period? Enter "Y" for yes or "N" for no in column 2.	this cost	reporting			
6.00 Has the cost allocation methodology changed from the previously Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2	filed cost	report?	N		146

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider C	CN: 15-0076	From	od: 07/01/2022 06/30/2023		epared:
						1.00	_
147.00Was there a change in the statisti	cal basis? Enter "Y" fo	or yes or "N" for	no.			N	147.00
48.00 Was there a change in the order of						N	148.00
49.00 Was there a change to the simplifi	ed cost finding method				T ' 11 1/	N N	149.00
		Part A 1.00	Part 2.00		Title V 3.00	Title XIX 4.00	-
Does this facility contain a provi	der that qualifies for						
or charges? Enter "Y" for yes or '							
55. 00 Hospi tal		N	N		N	N	155. 0
56.00 Subprovider - IPF		N	N		N	N	156.0
57.00 Subprovider – IRF		N	N		N	N	157.0
58. 00 SUBPROVI DER							158. 0
59. 00 SNF	N	N N		N	N	159. 0	
60. 00 HOME HEALTH AGENCY		N	N		N	N	160. C
61.00 CMHC			N		N	N	161.0
						1.00	_
Multicampus							
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has	one or more camp	uses in di	fferent	CBSAs?	N	165. 0
	Name	County	State	Zip Code	e CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	00 166. C
						1.00	_
Health Information Technology (HI) incentive in the Ame	rican Recovery an	d Reinvest	ment Act	:		
67.00 Is this provider a meaningful user						Y	167. C
68.00 f this provider is a CAH (line 10			e 167 is "	Y"), ente	er the		168. 0
reasonable cost incurred for the H				- ·			
58.01 If this provider is a CAH and is r					rdshi p		168. 0
exception under §413.70(a)(6)(ii); 69.00 f this provider is a meaningful u transition factor. (see instruction	ıser (line 167 is "Y") a				enter the	9. 9	99169. 0
	///3 <i>/</i>			F	Begi nni ng	Endi ng	
					1.00	2.00	1
70.00 Enter in columns 1 and 2 the EHR k period respectively (mm/dd/yyyy)	eginning date and endin	ng date for the r	eporting				170. 0
					1.00	2.00	_
71.00 fline 167 is "Y", does this prov	ider have any days for	individuals enro	lledin		N	2.00	0171.0
section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, I mn 1. If column 1 is ye	Pt. I, line 2, co	I. 6? Ente				

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0076	Period: From 07/01/2022 To 06/30/2023		
				10 00/ 30/ 2023	11/29/2023 2	
				Y/N	Date	
				1.00	2.00	_
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in [.]	the	
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in c	corumn 2. (see	Y/N) Date	V/I	
			1.00	2.00	3.00	+
. 00	Has the provider terminated participation in the Medicare F	Program? If	N	2.00	0.00	2.0
	yes, enter in column 2 the date of termination and in colum					
. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug der or its of the board	N			3. 0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
. 00 . 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	for Compiled, ailable in erent from	Y N	A		4. (
	those on the filed financial statements? If yes, submit rec	conciliation.				_
				Y/N	Legal Oper.	
	Approved Educational Activition			1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If ves is	the provide	r N		6.0
. 00	the legal operator of the program?	2. 11 900, 10				0.,
. 00	Are costs claimed for Allied Health Programs? If "Y" see ir			Ν		7. (
. 00 . 00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		0			9. (
	program in the current cost report? If yes, see instruction	is.				
0. 00	Was an approved Intern and Resident GME program initiated of	or renewed in 1	the current	N		10.0
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& Pin an Anr	broved	Ν		11. (
1.00	Teaching Program on Worksheet A? If yes, see instructions.		or oved	IN		
	,			L.	Y/N	
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.
3.00	If line 12 is yes, did the provider's bad debt collection p	oolicy change o	during this c	ost reporting	N	13.0
4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions.	ance amounts wa	aived? If yes	see	Ν	14.
	Bed Complement					
5.00	Did total beds available change from the prior cost reporti	ng period?lf	yes, see ins	tructions.	N	15. (
			rt A		t B	
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
6. 00	Was the cost report prepared using the PS&R Report only?	Y	10/23/2023	Y	10/23/2023	16.0
0.00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		10/23/2023		10/23/2023	
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		Ν		18.
9. 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		Ν		19.

Health Financial Systems

|--|

In Lieu of Form CMS-2552-10

lealth Financial Systems ST. JOSEPHS REG MED) CENTER PLYMOL	JIH	In Lie	u of Form CM	S-2552-1
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider CO		Period: From 07/01/2022		
			To 06/30/2023	Date/Time P 11/29/2023	
	Descri	ption	Y/N	Y/N	2.02 pm
)	1.00	3.00	
0.00 If line 16 or 17 is yes, were adjustments made to PS&R		<u>,</u>	N	N	20.00
Report data for Other? Describe the other adjustments:	V /N	Dete	V /N	Data	_
	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 1.00	2.00		4.00	21.00
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
				1.00	_
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPLTALS)			
Capital Related Cost					
2.00 Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 0
3.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made duri	ng the cost		23.0
4.00 Were new leases and/or amendments to existing leases entered	d into during	this cost rep	orting period?		24.0
If yes, see instructions (5.00 Have there been new capitalized leases entered into during	the cost repor	ting period?	lf yes, see		25.0
instructions. 6.00 Were assets subject to Sec.2314 of DEFRA acquired during th	e cost reporti	ng period? If	ves, see		26.0
instructions. 27.00 Has the provider's capitalization policy changed during the		•	-		27.00
сору.			yes, submit		
8.00 Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporti ng		28.0
period? If yes, see instructions. 9.00 Did the provider have a funded depreciation account and/or 1	bond funds (De	bt Service Re	serve Fund)		29.0
treated as a funded depreciation account? If yes, see instr 0.00 Has existing debt been replaced prior to its scheduled matu		debt?lf.ves	See		30.0
instructions. 1.00 Has debt been recalled before scheduled maturity without is	5	5			31.0
instructions.		debt? IT yes,	366		
2.00 Have changes or new agreements occurred in patient care services		d through con	tractual		32.0
arrangements with suppliers of services? If yes, see instru- 3.00 If line 32 is yes, were the requirements of Sec. 2135.2 app		g to competit	ive bidding? If		33. 0
no, see instructions. Provider-Based Physicians					_
4.00 Were services furnished at the provider facility under an a	rrangement wit	h provider-ba	sed physicians?		34.0
If yes, see instructions.	J				
5.00 If fine 34 is yes, were there new agreements or amended exi- physicians during the cost reporting period? If yes, see in		ts with the p	rovi der-based		35.0
physicians during the cost reporting period: in yes, see in			Y/N	Date	
			1.00	2.00	
Home Office Costs				2.00	
6.00 Were home office costs claimed on the cost report?	ionorod by the	hama offica?			36.0
7.00 If line 36 is yes, has a home office cost statement been pro- If yes, see instructions.					37.0
3.00 If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	of the home o	ffi ce.			38.0
9.00 If line 36 is yes, did the provider render services to othe see instructions.	r chain compon	ents? If yes,			39. (
0.00 If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see			40. 0
	1.	00	2.	00	
Cost Report Preparer Contact Information					
	Tracy Workman		WORKMAN		41.0
respecti vel y.	St Jos Health	System			42.0
2 00 Enter the employer/company name of the cost report			1		4 <u>2</u> . (
preparer.	5743354652		workmantsjrmc.		43.

Heal th	Financial Systems	ST. JOSEPHS REG MED	CENTER PLYM	NOUTH		In Lie	u of Form CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	F QUESTI ONNAI RE	Provi der	CCN: 15-007		eri od:	Worksheet S-2	
					To	rom 07/01/2022 06/30/2023	Part II Date/Time Pre 11/29/2023 2:	pared: 02 pm
				3.00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the	title/position	SENIOR REIMB	URSEMENT ANA	ALYST			41.00
	held by the cost report preparer in colu	imns 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the c	ost report						42.00
	preparer.							
43.00	Enter the telephone number and email add	lress of the cost						43.00
	report preparer in columns 1 and 2, resp	ecti vel y.						

	Financial Systems ST AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	JOSEPHS REG MED AL DATA	Provi der CC	CN: 15-0076 F	Period:	u of Form CMS-2 Worksheet S-3	
					From 07/01/2022 Fo 06/30/2023	Part I Date/Time Pre	
						11/29/2023 2:0 /P Days / 0/P	02 pm
						Visits / Trips	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I – STATISTICAL DATA	1100	2100	0100		0100	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	38	13, 870	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		38	13, 870	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	7	(0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T	34.00	0	(0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		45	13, 870	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						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)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	45			0	26.25
27.00	Total (sum of lines 14-26)		45			0	27.00
28.00	Observation Bed Days					0	
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		0				31.00
32.00	Labor & delivery days (see instructions)		0	(32.00
32.01	Total ancillary labor & delivery room						32.01
33.00	outpatient days (see instructions) LTCH non-covered days						33.00
33.00 33.01	LTCH site neutral days and discharges						33.00 33.01
	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	(0	34.00
54.00	remporary Expansion COVID-17 FIL ACULE Calle	30.00	U	l (U	54.00

In Lieu of Form CMS-2552-10 Worksheet S-3

		JOSEPHS REG MEL				eu of Form CMS-	
IOSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C		Period: From 07/01/2022	Worksheet S-3 Part I	5
					To 06/30/2023		pare
						11/29/2023 2:	
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns		
				Patients	& Residents	Payrol I	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA				-1		1 .
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 052	77	3, 35	5		1.
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
00	for the portion of LDP room available beds)	1 050	F//				
00	HMO and other (see instructions)	1, 053 0	566				2
. 00	HMO I PF Subprovi der	0	0				3
. 00	HMO IRF Subprovider	0	0		0		4
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5
. 00 . 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	1, 052	77	3, 35	-		
. 00	beds) (see instructions)	1,032	//	3, 30	5		'
. 00	INTENSI VE CARE UNI T	0	0		0		8
. 00	CORONARY CARE UNIT	0	0		0		9
0.00	BURN INTENSIVE CARE UNIT						10
1.00	SURGI CAL I NTENSI VE CARE UNI T	0	0		0		11
2.00	OTHER SPECIAL CARE (SPECIFY)	0	0		0		12
3.00	NURSERY		216	33	2		13
4.00	Total (see instructions)	1,052	293			261.29	
5.00	CAH visits	1,032	2,3	5,00	0.00	201.27	115
5.10	REH hours and visits	Ŭ	0				15
6.00	SUBPROVIDER - IPF						16
7.00	SUBPROVIDER - IRF						17
8.00	SUBPROVI DER						18
9.00	SKILLED NURSING FACILITY						19
0. 00	NURSING FACILITY						20
	OTHER LONG TERM CARE						21
2.00	HOME HEALTH AGENCY						22
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23
4.00	HOSPICE						24
4.10	HOSPICE (non-distinct part)				0		24
5.00	CMHC - CMHC						25
6.00	RURAL HEALTH CLINIC						26
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26
7.00	Total (sum of lines 14-26)				0.00	261.29	27
8.00	Observation Bed Days		5	1, 21	2		28
9.00	Ambulance Trips	0					29
0. 00	Employee discount days (see instruction)			3			30
1. 00	Employee discount days - IRF				0		31
2.00	Labor & delivery days (see instructions)	0	47	6			32
2. 01	Total ancillary labor & delivery room				0		32
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33
3.01	LTCH site neutral days and discharges	0			_		33
4.00	Temporary Expansion COVID-19 PHE Acute Care	0	0		0		34

HOSPI T	Financial Systems ST AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0076	Peri od:	Worksheet S-3	2552-10
					From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 11/29/2023 2:0	pared:
		Full Time		Di so	charges		
		Equivalents			T		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I – STATISTICAL DATA	11.00	12.00	10.00	11.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	38	12	1, 403	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			31			2.00
3.00	HMO I PF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	100. 00	0	38	12 12	1, 403	14.00
15.00	CAH visits						15.00
15. 10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY OTHER LONG TERM CARE						20.00
21.00 22.00	HOME HEALTH AGENCY						21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)						22.00
24.00	HOSPICE						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)	100.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance Trips						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
22 00	outpatient days (see instructions)						22.00
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges				0		33. 00 33. 01

ST. JOSEPHS REG MED CENTER PLYMOUTH

. WAGE INDEX INFORMATION ART II - WAGE DATA ALARIES otal salaries (see nstructions) on-physician anesthetist Part on-physician anesthetist Part	Wkst. A Line Number 1.00 200.00		Provider CC Reclassificati on of Salaries (from Wkst. A-6) 3.00	Adjusted	Paid Hours		eparo 02
ALARIES otal salaries (see nstructions) on-physician anesthetist Part on-physician anesthetist Part	Number 1.00	Reported	on of Salaries (from Wkst. A-6)	Salaries (col.2 ± col. 3)	Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	'
ALARIES otal salaries (see nstructions) on-physician anesthetist Part on-physician anesthetist Part			3.00	4.00	5.00	6 00	
ALARIES otal salaries (see nstructions) on-physician anesthetist Part on-physician anesthetist Part	200. 00	18, 790, 300				0.00	-
otal salaries (see nstructions) on-physician anesthetist Part on-physician anesthetist Part	200. 00	18, 790, 300					1
on-physician anesthetist Part on-physician anesthetist Part			0	18, 790, 300	543, 486. 00	34.57	7 1
on-physician anesthetist Part	1	0	0	0	0.00	0. 00	
		0	0	0	0.00	0.00	1 1
		0	0	0	0.00	0. 00	
hysician-Part A -		20, 860	0	20, 860	149.00	140.00	
dmi ni strati ve		20, 800	0	20, 000	149.00	140.00	1
hysicians - Part A - Teaching		0	0	0			
hysician and Non hysician-Part B		118, 696	0	118, 696	1, 873. 00	63.37	1 !
on-physician-Part B for		0	0	0	0.00	0. 00	
ospital-based RHC and FQHC							
ervices nterns & residents (in an	21.00	0	0	0	0.00	0. 00	
pproved program)	21.00	0	0	0	0.00	0.00	1
ontracted interns and		0	0	0	0.00	0.00	
esidents (in an approved rograms)							
ome office and/or related		0	0	0	0.00	0. 00	
rganization personnel		0			0.00		
NF xcluded area salaries (see	44.00	0 1, 601, 976	0	-	0. 00 60, 326. 40		
nstructions)		1,001,770	Ĭ	1,001,770	00, 020. 10	20.00	
THER WAGES & RELATED COSTS		045 005		015 005	0,000,00	00.00	
ontract labor: Direct Patient are		815, 885	0	815, 885	9, 922. 00	82. 23	3 1
ontract labor: Top level anagement and other anagement and administrative		15, 440	0	15, 440	74.00	208.65	1:
ervices ontract labor: Physician-Part		184, 223	0	184, 223	1, 216. 00	151. 50) 1
- Administrative ome office and/or related rganization salaries and		0	0	0	0.00	0. 00) 1
age-related costs							
		4,170,795	1	4, 170, 795			
ome office: Physician Part A		14, 108	-	14, 108			
Admi ni strati ve							
		0	0	0	0.00	0.00	11
ome office Physicians Part A		0	0	0	0.00	0. 00	1
Teachi ng		0			0.00	0.00	
hysicians Part A - Teaching AGE-RELATED COSTS				0	0.00	0.00	
age-related costs (core) (see		6,005,362	0	6, 005, 362			1
age-related costs (other)							1
see instructions)							
xcluded areas on-physician anesthetist Part		752, 736	0	752, 736			10
		0		0			2
on physionan anesthetist rai t		0		0			 ²
hysician Part A -		1, 652	0	1, 652			22
		Ο	0	0			2
hysician Part B		23, 374	Ő	23, 374			2
age-related costs (RHC/FQHC)		0	0	0			24
		0	0	0			2
nterns & residents (in an	1						2
nterns & residents (in an pproved program) ome office wage-related		1, 141, 811	0	1, 141, 811			
pproved program) ome office wage-related core)		1, 141, 811					
pproved program) ome office wage-related		1, 141, 811 0	0				2!
aoeo oho o <u>ha(</u> anasxo o hdhh	ge-related costs me office salaries lated organization salaries me office: Physician Part A Administrative me office and Contract ysicians Part A - Teaching me office Physicians Part A Teaching me office contract ysicians Part A - Teaching <u>SE-RELATED COSTS</u> ge-related costs (core) (see structions) ge-related costs (other) ee instructions) cluded areas n-physician anesthetist Part n-physician anesthetist Part ministrative ysician Part A - Teaching ysician Part B ge-related costs (RHC/FOHC) terns & residents (in an	ge-related costs me office salaries lated organization salaries me office: Physician Part A Administrative me office and Contract ysicians Part A - Teaching me office Physicians Part A Teaching me office contract ysicians Part A - Teaching SE-RELATED COSTS ge-related costs (core) (see structions) ge-related costs (other) ee instructions) cluded areas n-physician anesthetist Part n-physician anesthetist Part n-physician Part A - Teaching ysician Part A - Teaching ysician Part B ge-related costs (RHC/FQHC) terns & residents (in an	ge-rel ated costs4,170,795me office salaries0me office: Physician Part A14,108Administrative14,108me office and Contract0ysicians Part A - Teaching0me office contract0ge-rel ated costs (core) (see6,005,362structions)ge-rel ated costs (other)ce instructions)752,736n-physician anesthetist Part0n-physician Part A - Teaching0ge-rel ated costs (other)0geinal anesthetist Part0n-physician anesthetist Part0n-physician Part A - Teaching0ysician Part A -1,652ministrative0ysician Part A -0n-physician anesthetist Part0ysician Part A -1,652ministrative0ysician Part B23,374ge-rel ated costs (RHC/FOHC)0terns & residents (in an0	ge-rel ated costs me office sal aries4,170,795I ated organization sal aries0I ated organization0I ated organizations0I ated	ge-rel ated costs me office sal aries4, 170, 79504, 170, 795I ated organization sal aries000me office: Physician Part A14, 108014, 108Administrative0000me office and Contract000me office contract000me office contract000me office contract000ge-rel ated costs (core) (see6, 005, 36206, 005, 362structions)ge-rel ated costs (other)00ee instructions)000n-physician anesthetist Part000n-physician Part A - Teaching000ge-rel ated costs (other)000on physician anesthetist Part000n-physician Part A -1, 65201, 652on physician Part A -1, 65200on physician Part A - Teaching000ysician Part A -1, 65200on physician Part A -23, 374023, 374on physician Part B23, 374023, 374on physician Part B23, 374023, 374on physician Part B000on physician Part B000on physician Part B000on physician Part B000on physician Part B000<	ge-related costs 4, 170, 795 0 4, 170, 795 91, 626.00 me office salaries 0 0 0 0 0 me office: Physician Part A 14, 108 0 14, 108 0 14, 108 109.00 Administrative 0 <td< td=""><td>ge-related costs 4, 170, 795 0 4, 170, 795 91, 626, 00 45.52 me office salaries 0</td></td<>	ge-related costs 4, 170, 795 0 4, 170, 795 91, 626, 00 45.52 me office salaries 0

Health Financial Systems

ST. JOSEPHS REG MED CENTER PLYMOUTH

In Lieu of Form CMS-2552-10

	AL WAGE INDEX INFORMATION			Provider C	CN: 15-0076 P F	eriod: rom 07/01/2022 o 06/30/2023		pared:
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.		Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	A-6) 3.00	4,00	<u>col.4</u> 5.00	6,00	
25. 53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0	3.00	0.00	25. 53
26.00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4.00	57, 462	0	57, 462	1, 539. 10	27.22	26.00
28.00	Administrative & General	4.00 5.00	1, 093, 424					
27.00	Administrative & General under	5.00	308, 502		308, 502			27.00
20.00	contract (see inst.)		500, 502	0	500, 502	2,017.00	117.77	20.00
29.00	Maintenance & Repairs	6, 00	0	0	0	0.00	0.00	29.00
30,00	Operation of Plant	7.00	479, 026	0	479, 026			
31.00	Laundry & Linen Service	8.00	0	0	0	0.00		31.00
32.00	Housekeepi ng	9.00	320, 792	0	320, 792	18, 070. 62	17.75	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	341, 485	0	341, 485	17, 101. 25	19.97	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteri a	11.00	45, 940	0	45, 940	1, 881. 75	24. 41	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	652, 357	0	652, 357	12, 149. 31	53.69	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	684, 147	0	684, 147	13,065.00	52.36	40.00
41.00	Medical Records & Medical Records Library	16. 00	369, 467	0	369, 467	13, 152. 97	28.09	41.00
42.00	Soci al Servi ce	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

	Financial Systems		JOSEPHS REG MEI	Provider CC		eriod:	u of Form CMS-2 Worksheet S-3	
103111	AL WAGE HIDEX HIN ORWATTON					rom 07/01/2022		
					T			pared:
							11/29/2023 2:	02 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid 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						
. 00	Net salaries (see		18, 980, 106	0	18, 980, 106	544, 232. 00	34.88	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 601, 976	0	1, 601, 976	60, 326. 40	26. 56	2.00
	instructions)							
. 00	Subtotal salaries (line 1		17, 378, 130	0	17, 378, 130	483, 905. 60	35. 91	3.00
	minus line 2)							
l. 00	Subtotal other wages & related		5, 200, 451	0	5, 200, 451	102, 947. 00	50. 52	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		7, 148, 825	0	7, 148, 825	0.00	41.14	5.00
	(see inst.)							
. 00	Total (sum of lines 3 thru 5)		29, 727, 406	0	29, 727, 406	586, 852. 60	50.66	6.00
. 00	Total overhead cost (see		4, 352, 602	-64, 302	4, 288, 300	142, 856. 75	30. 02	7.00
	instructions)							

OSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0076	Peri od: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part IV Date/Time Pre 11/29/2023 2:	pare
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				-
	Part A - Core List				-
~~	RETIREMENT COST			014 404	
00	401K Employer Contributions			814, 496	
00	Tax Sheltered Annuity (TSA) Employer Contribution			0	
00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3
00	Qualified Defined Benefit Plan Cost (see instructions)			114, 837	4
~ ~	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				1.
00	401K/TSA Plan Administration fees			0	
00	Legal /Accounting/Management Fees-Pension Plan			0	6
00	Employee Managed Care Program Administration Fees			107, 954	7
	HEALTH AND INSURANCE COST				
00	Health Insurance (Purchased or Self Funded)			0	
01	Health Insurance (Self Funded without a Third Party Administr			0	
02	Health Insurance (Self Funded with a Third Party Administrate	or)		2, 982, 932	
03	Heal th Insurance (Purchased)			0	
00	Prescription Drug Plan			812, 616	
. 00	Dental, Hearing and Vision Plan			95, 383	
. 00	Life Insurance (If employee is owner or beneficiary)			23, 984	
2.00	Accident Insurance (If employee is owner or beneficiary)			0	
8.00	Disability Insurance (If employee is owner or beneficiary)			333, 461	13
. 00	Long-Term Care Insurance (If employee is owner or beneficiary	()		0	
. 00	'Workers' Compensation Insurance			126, 153	
. 00	Retirement Health Care Cost (Only current year, not the extra	aordinary accrual require	ed by FASB 106.	0	16
	Noncumulative portion)				
	TAXES			4 055 440	1
. 00	FICA-Employers Portion Only			1, 355, 413	
8.00	Medicare Taxes - Employers Portion Only			0	
. 00	Unemployment Insurance			468	
. 00	State or Federal Unemployment Taxes			0	20
. 00	OTHER Executive Deferred Compensation (Other Than Retirement Cost R	Reported on lines 1 throu	ugh 4 above. (see	0	21
	instructions))		~ · · · ·		
. 00	Day Care Cost and Allowances			0	22
. 00	Tuition Reimbursement			13, 776	23
. 00	Total Wage Related cost (Sum of lines 1 -23)			6, 781, 473	24
	Part B - Other than Core Related Cost		· · · · · · · · ·		1

	Financial Systems AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0076	Peri od:	Worksheet S-3	
103211	AL CUNTRACT LADOR AND DENEFTT COST		PLOVIDEL CCN. 15-0078	From 07/01/2022	Part V	
				To 06/30/2023		pared:
					11/29/2023 2:	
	Cost Center Description			Contract Labor	Benefit Cost	
				1.00	2.00	
	PART V - Contract Labor and Benefit Co	st				
	Hospital and Hospital-Based Component	l denti fi cati on:				
1.00	Total facility's contract labor and be	enefit cost		815, 885	6, 781, 473	1.00
2.00	Hospi tal			815, 885	6, 781, 473	2.00
3.00	SUBPROVIDER - IPF					3.00
4.00	SUBPROVIDER - IRF					4.00
5.00	Subprovider - (Other)			0	0	5.00
5.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
3.00	SKILLED NURSING FACILITY					8.00
9.00	NURSING FACILITY					9.00
10.00	OTHER LONG TERM CARE I					10.00
11.00	Hospital-Based HHA					11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I					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	Hospital-Based-CMHC					16.00
17.00	RENAL DIALYSIS I					17.00
18.00	Other			0	0	18.00

Heal	th	Fi	nanci a	l System	ns	

ST. JOSEPHS REG MED CENTER PLYMOUTH In Lieu of Form CMS-2552-10

HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-0076	Period:	Worksheet S-1	0
				From 07/01/2022 To 06/30/2023		
					11/29/2023 2:	02 pm
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by lin	ne 202 colum	18)	0. 203006	1.00
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid				10, 934, 650	2.00
2.00 3.00	Did you receive DSH or supplemental payments from Medicaid?				10, 934, 650 Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	al navments	s from Medic	ai d?	Ý	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr				0	5.00
6.00	Medi cai d charges				40, 511, 560	6.00
7.00	Medicaid cost (line 1 times line 6)				8, 224, 090	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minu	us sum of li	nes 2 and 5; if	0	8.00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line	e)		-	
9.00	Net revenue from stand-alone CHLP Stand-alone CHLP charges				0	
10.00	0	10.00				
11.00 Stand-alone CHIP cost (line 1 times line 10)12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then						11.00 12.00
12.00	enter zero)		nus i ne 🧃		0	12.00
	Other state or local government indigent care program (see inst	ructions fo	or each line)		
13.00	9)	0	13.00			
14.00	in lines 6 or	0	14.00			
45 00		0	15 00			
15.00 State or local indigent care program cost (line 1 times line 14)16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus li						15.00
16.00	13; if < zero then enter zero)	igent care	program (III	ne 15 minus line	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indi	pent care program	ns (see	
	instructions for each line)			J J J		
17.00	Private grants, donations, or endowment income restricted to fu				0	
18.00	Government grants, appropriations or transfers for support of h				0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent o	care program	s (sum of lines	0	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line)	: 1 : + 1	2 ((0 4	51 224, 592	2 002 042	20.00
20.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	iiity	2, 668, 4	224, 392	2, 893, 043	20.00
21.00	Cost of patients approved for charity care and uninsured discou	nts (see	541, 7	12 224, 592	766, 304	21.00
	instructions)	(,	
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00
~~ ~~	charity care		F 4 4 - 7		7// 00/	
23.00	Cost of charity care (line 21 minus line 22)		541, 7	12 224, 592	766, 304	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	t days bey	ond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care					
25.00	If line 24 is yes, enter the charges for patient days beyond th	e indigent	care progra	n's length of	0	25.00
26.00	stay limit Total bad debt expense for the entire hospital complex (see ins	tructions)			4, 988, 084	26.00
28.00	Medicare reimbursable bad debts for the entire hospital complex (see his		ructions)		4, 988, 084 69, 454	
27.00	Medicare allowable bad debts for the entire hospital complex (s				106, 851	
28.00	Non-Medicare bad debt expense (see instructions)				4, 881, 233	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	instructions)	1, 028, 317	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 794, 621	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			1, 794, 621	31.00

	Financial Systems ST SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	JOSEPHS REG MED	CENTER PLYMOL		In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
NEGEAS	STITEATION AND ADJUSTMENTS OF TREAD DELANCE O			F	rom 07/01/2022 o 06/30/2023	Date/Time Pre	pared [.]
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	11/29/2023 2: Recl assi fi ed	02 pm
	cost center bescription	54141163	other	+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		0		2, 068, 872	2, 068, 872	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	C C	314	314	2.00
3.00 4.00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	57, 462	0 208, 856	0 C 266, 318	0	0 266, 318	3.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 093, 424	18, 172, 346			20, 071, 619	5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 479, 026	0 2, 719, 474	-	0 -1, 085, 902	0 2, 112, 598	6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	154, 004	154, 004	-447	153, 557	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	320, 792 341, 485	227, 878 317, 928			547, 508 634, 467	9.00 10.00
11.00	01100 CAFETERIA	45, 940	53, 116			96, 387	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0	0	12.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	652, 357 0	253, 860 0		-130, 563 0	775, 654 0	13.00 14.00
15.00	01500 PHARMACY	684, 147	2, 152, 147			611, 953	15.00
16.00 17.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	369, 467	95, 923 0	465, 390	0	465, 390	16.00 17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	19.00
20. 00 21. 00	02000 NURSING PROGRAM 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	20.00
21.00	02200 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	21.00 22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	C	0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 183, 219	1, 245, 576	4, 428, 795	-862, 969	3, 565, 826	30.00
31.00	03100 I NTENSI VE CARE UNI T	0,100,217	0			14, 789	
34.00 43.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04300 NURSERY	0	0		0 369, 575	0 240 E7E	34.00 43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	0	0	/C	309, 375	369, 575	43.00
50.00	05000 OPERATING ROOM	2, 267, 449	2, 825, 173			4, 110, 888	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0 1, 195, 686	0 451, 526	-	0077070	369, 575 1, 457, 050	
55.00	05500 RADI OLOGY-THERAPEUTI C	308, 948	587, 387	896, 335	-55, 596	840, 739	55.00
57.00 59.00	05700 CT SCAN 05900 CARDI AC CATHETERI ZATI ON	106, 204 73, 539	94, 510 166, 673			167, 836 107, 369	
60.00	06000 LABORATORY	1, 718, 412	2, 699, 812			4, 287, 965	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C 750.000	0	0	62.30
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	372, 863 43, 665	380, 417 29, 004			722, 056 71, 105	
66.00	06600 PHYSI CAL THERAPY	849, 001	333, 823	1, 182, 824	-9, 683	1, 173, 141	66.00
66. 01 66. 02	06601 PHYSI CAL THERAPY – LI FEPLEX 06602 PHYSI CAL THERAPY – CULVER MI LI TARY	109, 313 0	202, 550 0			308, 357 0	66. 01 66. 02
67.00	06700 OCCUPATI ONAL THERAPY	150, 796	32, 846		-	180, 116	
68.00	06800 SPEECH PATHOLOGY	100, 762	19, 894			120, 656	
69.00 71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	189, 266 0	91, 367 -42, 338			243, 888 0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	802, 838	802, 838	72.00
73.00 76.97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	0	-	2, 288, 113	2, 288, 113 0	1
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0		7, 219	7, 219	
76.99	07699 LI THOTRI PSY 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0		0	0	
77.00	OUTPATIENT SERVICE COST CENTERS	0	0	<u>/</u>	0	0	77.00
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	7,646	1, 243			8, 889	
90. 02 90. 03	09002 ATHLETI C TRAI NERS 09003 SAI NT JOSEPH HEALTH CENTER	61, 395 0	18, 542 0			79, 937 0	90. 02 90. 03
90.04	09004 WOUND CARE	183, 913	689, 337	873, 250	-184, 143	689, 107	90.04
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 222, 147	2, 211, 694	4, 433, 841	-516, 055	3, 917, 786	
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	17, 188, 324	36, 394, 568	53, 582, 892	126, 565	53, 709, 457	118.00
	NONREI MBURSABLE COST CENTERS			1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 LIFEPLEX FITNESS FORUM	0 467, 422	18, 228 3, 021, 200			18, 228 3, 440, 153	
	19200 PHYSI CLANS' PRI VATE OFFICES	821, 317	336, 293			1, 153, 977	
	19201 FOUNDATI ON ADMI NI STATI ON	0	0		0		192.01
	2 19202 HOSPI TALI ST 3 19203 I NTENSI VI ST	0	0		0		192. 02 192. 03
192.04	19204 FOOT & ANKLE SPORTS MED PLY	211, 712	706, 434			914, 782	192.04
194.00	07950PLYMOUTH MOB-4	0	133, 908	133, 908	-71, 099	62, 809	194.00

Health Financial Systems ST.	JOSEPHS REG MED	CENTER PLYMOL	JTH	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Period: From 07/01/2022	Worksheet A	
				To 06/30/2023		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194. 01 07951 COMMUNI TY OUTREACH & PARTNERSHIP	101, 525	35, 430	136, 955	5 0	136, 955	194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	18, 790, 300	40, 646, 061	59, 436, 36	0	59, 436, 361	200. 00

In Lieu of Form CMS-2552-10 Worksheet A

RECLAS	STFICATION AND ADJUSIMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-0076	From 07/01/2022 To 06/30/2023 I	Worksheet A Date/Time Prepared:
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	_		11/29/2023 2:02 pm
	GENERAL SERVICE COST CENTERS		1	1		
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 046, 101				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0				2.00
3.00	00300 OTHER CAP REL COSTS	0	-			3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-65, 639				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-6, 922, 178				5.00
6.00	00600 MAINTENANCE & REPAIRS	0				6.00
7.00		0				7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE	-2, 875				8.00
9.00 10.00	00900 HOUSEKEEPING	0				9.00
	01000 DI ETARY	-				10.00
11.00	01100 CAFETERIA	-153, 919		1		11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0				13.00
	01400 CENTRAL SERVICES & SUPPLY	0				14.00
	01500 PHARMACY	-12, 137				15.00
	01600 MEDICAL RECORDS & LIBRARY	-12, 137				16.00
	01700 SOCIAL SERVICE	-34				17.00
	01900 NONPHYSI CI AN ANESTHETI STS	0				19.00
	02000 NURSI NG PROGRAM	0	0			20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	-			20.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0				21.00
	02200 PARAMED ED PRGM-(SPECIFY)	0				22.00
25.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0			23.00
30.00	03000 ADULTS & PEDI ATRI CS	-528	3, 565, 298			30.00
31.00	03100 I NTENSI VE CARE UNI T	0				31.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0				34.00
43.00	04300 NURSERY	0				43.00
101.00	ANCI LLARY SERVI CE COST CENTERS		007,070			
50.00	05000 OPERATI NG ROOM	-124,672	3, 986, 216			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	-482, 205				55.00
57.00	05700 CT SCAN	0				57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0				59.00
60.00	06000 LABORATORY	-920				60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0			62.30
65.00	06500 RESPI RATORY THERAPY	-2, 393	719, 663			65.00
65.01	06501 SLEEP LAB	_, 0		1		65.01
66.00	06600 PHYSI CAL THERAPY	0				66.00
66.01	06601 PHYSI CAL THERAPY - LI FEPLEX	0				66.01
66.02	06602 PHYSICAL THERAPY - CULVER MILITARY	0	0			66.02
67.00	06700 OCCUPATI ONAL THERAPY	0	180, 116			67.00
68.00	06800 SPEECH PATHOLOGY	0	120, 656			68.00
	06900 ELECTROCARDI OLOGY	0				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	802, 838			72.00
	07300 DRUGS CHARGED TO PATIENTS	0				73.00
	07697 CARDI AC REHABI LI TATI ON	0				76.97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	7, 219			76. 98
76.99	07699 LI THOTRI PSY	0	0			76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0			77.00
	OUTPATIENT SERVICE COST CENTERS					
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	8, 889			90. 01
90. 02	09002 ATHLETI C TRAI NERS	-68, 119	11, 818			90. 02
90.03	09003 SAINT JOSEPH HEALTH CENTER	0	0			90. 03
90.04	09004 WOUND CARE	0	689, 107			90.04
	09100 EMERGENCY	-30, 722				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
	OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0			102.00
	SPECIAL PURPOSE COST CENTERS					
118.00		-6, 820, 260	46, 889, 197			118.00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 228			190. 00
	19001 LIFEPLEX FITNESS FORUM	-536, 850	2, 903, 303			190. 01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 153, 977			192.00
192.01	19201 FOUNDATI ON ADMI NI STATI ON	0	0			192. 01
192.02	19202 HOSPI TALI ST	0	0			192. 02
	19203 I NTENSI VI ST	0	0			192. 03
	19204 FOOT & ANKLE SPORTS MED PLY	0	914, 782			192.04
	07950 PLYMOUTH MOB-4	0	62, 809			194.00
	07951 COMMUNI TY OUTREACH & PARTNERSHI P	0				194.01
200.00		-7, 357, 110				200.00
			, =0			1

	Financial Systems SIFICATIONS	ST.	JOSEPHS REG MED	CENTER PLYMOUTH	15-0076	In Lie	u of Form CMS- Worksheet A-6	
NEGENS.				Trovider con.	13 0070	From 07/01/2022 To 06/30/2023	Date/Time Pre	epared:
		Increases					11/29/2023 2:	02 pm
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00				
	A - Negative Balances	3.00	4.00	5.00				
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENT	71.00	0	42, 338				1.00
	B - Implantable Devices	I	0	42, 330				
1.00	I MPL. DEV. CHARGED TO PATIENTS	72.00	0	802, 838				1.00
2.00 3.00		0.00 0.00	0	0 0				2.00 3.00
4.00		0.00	0	0				4.00
5.00 6.00		0.00 0.00	0	0				5.00 6.00
0.00	TOTALS			802, 838				0.00
1.00	C - Drugs Charged to Patients DRUGS CHARGED TO PATIENTS	73.00	0	2, 288, 113				1.00
2.00	DRUGS CHARGED TO PATTENTS	0.00	0	2, 288, 113				2.00
3.00		0.00	О	0				3.00
4.00 5.00		0.00 0.00	0	0				4.00 5.00
5.00 6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00 10.00		0.00 0.00	0	0				9. 00 10. 00
11.00		0.00	0	0				11.00
12.00			0	0				12.00
	TOTALS E - Building Depreciation		0	2, 288, 113				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 786, 892				1.00
2.00		0.00	0	0				2.00
3.00 4.00		0.00 0.00	0	0				3.00 4.00
5.00		0.00	0	0				5.00
6.00 7.00		0.00 0.00	0	0				6.00 7.00
8.00		0.00	0	0				8.00
9.00		0.00	О	0				9.00
10. 00 11. 00		0.00 0.00	0	0				10. 00 11. 00
12.00		0.00	0	0				12.00
13.00		0.00	О	0				13.00
14.00 15.00		0.00 0.00	0	0				14. 00 15. 00
16.00		0.00	0	0				16.00
17.00		0.00	О	0				17.00
18. 00 19. 00		0.00 0.00	0	0				18. 00 19. 00
20.00		0.00	0	0				20.00
21.00		0.00	0	0				21.00
	TOTALS F - Equipment Depreciation		0	1, 786, 892				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	314				1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 511, 978				2.00
3.00 4.00		0.00 0.00	0	0				3.00 4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00 8.00		0.00 0.00	0	0				7.00 8.00
9.00		0.00	Ö	Ö				9.00
10.00		0.00	0	0				10.00
11. 00 12. 00		0.00 0.00	0	0				11. 00 12. 00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15. 00 16. 00		0.00 0.00	0	0				15. 00 16. 00
17.00		0.00	0	0				17.00
18.00		0.00	0	0				18.00
19.00 20.00		0.00 0.00	0	0				19.00 20.00
20.00 21.00		0.00	0	0				20.00
22.00		0.00	0	0				22.00
23.00		0.00	0	0				23.00

ST. JOSEPHS REG MED CENTER PLYMOUTH Provider CCN: 15-0076 Period:

In Lieu of Form CMS-2552-10 Worksheet A-6

RECLAS.	SEFECATIONS			Provider d	CN. 15-0076	From 07/01/2022 To 06/30/2023	Date/Time Pr 11/29/2023 2	epared:
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
24.00		0.00	0	0				24.00
25.00		0.00	0	0				25.00
	TOTALS		0	1, 512, 292				
	I - Nursery and Labor/Deliver							
1.00	NURSERY	43.00	249, 384	120, 191				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	24 <u>9, 3</u> 84	12 <u>0, 1</u> 91				2.00
	TOTALS		498, 768	240, 382				
	K - Interest Expense							_
1.00	CAP REL COSTS-BLDG & FIXT	1.00		281, 980				1.00
2.00								2.00
			0	281, 980				_
	N - Hyperbaric Oxygen	T						_
1.00	HYPERBARIC OXYGEN THERAPY	<u>76.</u> 98	<u>3, 9</u> 55	<u>3, 2</u> 64				1.00
			3, 955	3, 264				_
	0 - COVID-19 Dept Reclass							_
1.00	ADULTS & PEDIATRICS	30.00	49, 513	0				1.00
2.00	I NTENSI VE_CARE_UNI T		<u> </u>	0				2.00
			64, 302	0				_
	P - Contr Labor Reclass							_
1.00	ADULTS & PEDIATRICS	30.00	0	41, 108				1.00
2.00	RADI OLOGY-THERAPEUTI C	55.00	0	3,575				2.00
	TOTALS		0	44, 683				1
500.00	Grand Total: Increases		567, 025	7, 002, 782				500.00

Health Financial Systems RECLASSIFICATIONS

ST.	JOSEPHS	REG	MED	CENTER	PLYMOUTH

Provider CCN: 15-0076 Period:

In Lieu of Form CMS-2552-10 Worksheet A-6

RECLAS	SIFICATIONS			Provider (me Prepared:
		Decreases				023 2:02 pm
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - Negative Balances					
1.00	ADMI NI STRATI VE & GENERAL		0	42, 338		1.00
	TOTALS B - Implantable Devices		0	42, 338		
1.00	ADULTS & PEDIATRICS	30.00	0	219		1.00
2.00	OPERATING ROOM	50.00	0	662, 411		2.00
3.00 4.00	RADI OLOGY-THERAPEUTI C ELECTROCARDI OLOGY	55.00 69.00	0	172 94		3.00
5.00	WOUND CARE	90.04	Ö	139, 895		5.00
6.00	EMERGENCY	91.00	0	47		6.00
	TOTALS C - Drugs Charged to Patients	<u> </u>	0	802, 838		
1.00	PHARMACY	15.00	0	1, 997, 719		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	24, 754		2.00
3.00 4.00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	0	47, 850 130, 985		3.00 4.00
5.00	RADI OLOGY - THERAPEUTI C	55.00	0	230		5.00
6.00	CT SCAN	57.00	0	25, 458		6.00
7.00 8.00	CARDIAC CATHETERIZATION RESPIRATORY THERAPY	59.00 65.00	0	609 8		7.00 8.00
9.00	PHYSICAL THERAPY	66.00	0	371		9.00
10.00	ELECTROCARDI OLOGY	69.00	0	402		10.00
11.00	WOUND CARE	90.04	0	14, 973		11.00
12.00	EMERGENCY	91.00	0	4 <u>4, 7</u> 54 2, 288, 113		12.00
	E - Building Depreciation	· ·				
1.00		0.00 5.00	0	0		1.00 2.00
2.00 3.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	7.00	0	276, 138 752, 909		3.00
4.00	HOUSEKEEPING	9.00	Ō	1, 162		4.00
5.00	DIETARY	10.00	0	3, 010		5.00
6.00 7.00	CAFETERIA NURSING ADMINISTRATION	11.00 13.00	0	443 55, 235		6.00 7.00
8.00	PHARMACY	15.00	0	200, 386		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	20, 817		9.00
10. 00 11. 00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	0	36, 427 10, 929		10.00
12.00	RADI OLOGY-THERAPEUTI C	55.00	0	12, 671		12.00
13.00	LABORATORY	60.00	О	1, 122		13.00
14.00 15.00	RESPI RATORY THERAPY SLEEP LAB	65.00 65.01	0	4, 852 408		14.00 15.00
16.00	PHYSICAL THERAPY	66.00	0	3, 354		16.00
17.00	WOUND CARE	90.04	0	22, 056	0	17.00
18.00		91.00	0	322, 986		18.00
19.00 20.00	LIFEPLEX FITNESS FORUM FOOT & ANKLE SPORTS MED PLY	190. 01 192. 04	0	362 1, 743		19.00 20.00
21.00	PLYMOUTH MOB-4	194.00	0	59,882		21.00
	TOTALS		0	1, 786, 892		
1.00	F - Equipment Depreciation	0.00	0	0	9	1.00
2.00	OPERATION OF PLANT	7.00	0	329, 681	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	447		3.00
4.00 5.00	DI ETARY CAFETERI A	10.00 11.00	0	21, 936 2, 226		4.00 5.00
6.00	NURSING ADMINI STRATI ON	13.00	0	75, 328		6.00
7.00	PHARMACY	15.00	0	26, 236		7.00
8.00 9.00	ADULTS & PEDIATRICS OPERATING ROOM	30.00 50.00	0	168, 650 235, 046		8.00 9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	48, 248		10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	0	46, 098		11.00
12. 00 13. 00	CT SCAN CARDIAC CATHETERIZATION	57.00 59.00	0	7, 420 132, 234		12.00 13.00
14.00	LABORATORY	60.00	0	129, 137		14.00
15.00	RESPI RATORY THERAPY	65.00	Ō	26, 364	0	15.00
16.00 17.00	SLEEP LAB	65.01	0	1, 156		16.00
17.00 18.00	PHYSICAL THERAPY PHYSICAL THERAPY - LIFEPLEX	66. 00 66. 01	0	5, 958 3, 506		17.00 18.00
19.00	OCCUPATI ONAL THERAPY	67.00	Ō	3, 526	0	19.00
20.00	ELECTROCARDI OLOGY	69.00	0	36, 249		20.00
21.00 22.00	EMERGENCY LIFEPLEX FITNESS FORUM	91.00 190.01	0	148, 268 48, 107		21.00 22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3, 633		23.00
24.00	FOOT & ANKLE SPORTS MED PLY	192.04	0	1, 621		24.00
25.00	PLYMOUTH MOB-4	194.00	0	11, 217	0	25.00

	Financial Systems	51.	JOSEPHS REG MED		-	-	u of Form CMS	
RECLAS	SIFICATIONS			Provider (CCN: 15-0076	Period: From 07/01/2022	Worksheet A-	6
						To 06/30/2023	Date/Time Pr 11/29/2023 2	epared: :02 pm
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Re	f.		
	6.00	7.00	8.00	9.00	10.00			
	TOTALS		0	1, 512, 292				
	I - Nursery and Labor/Delive							
1.00	ADULTS & PEDIATRICS	30.00	498, 768	240, 382		0		1.00
2.00		0.00	0	0		0		2.00
	TOTALS		498, 768	240, 382				
	K - Interest Expense							
1.00						11		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00		28 <u>1, 9</u> 80				2.00
			0	281, 980				
	N - Hyperbaric Oxygen							
1.00	WOUND CARE	90.04	3, 955	3, 264				1.00
			3, 955	3, 264				
	0 - COVID-19 Dept Reclass	1 1			1			
1.00	ADMI NI STRATI VE & GENERAL	5.00	64, 302	0				1.00
2.00								2.00
			64, 302	0				
	P - Contr Labor Reclass							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	41, 371		0		1.00
2.00	OPERATION OF PLANT	7.00	0	<u>3, 3</u> 12		0		2.00
	TOTALS		o	44,683				
500.00	Grand Total: Decreases		567, 025	7,002,782				500.00

ST. JOSEPHS REG MED CENTER PLYMOUTH In Provider CCN: 15-0076 Period:

In Lieu of Form CMS-2552-10 Worksheet A-7

					From 07/01/2022 To 06/30/2023		pared: 02_pm
				Acqui si ti on	S		
		Begi nni ng	Purchases	Donation	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	477, 930			0 0	0	1.00
2.00	Land Improvements	2, 348, 695			0 151, 375		2.00
3.00	Buildings and Fixtures	42, 715, 411			0 146, 013		3.00
4.00	Building Improvements	22, 694	3, 216, 889		0 3, 216, 889	42, 621	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	28, 096, 320	3, 614, 498		0 3, 614, 498	360, 261	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	73, 661, 050	7, 128, 775		0 7, 128, 775	556, 733	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	73, 661, 050	7, 128, 775		0 7, 128, 775	556, 733	10.00
		Endi ng Bal ance					
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	477, 930					1.00
2.00	Land Improvements	2, 477, 011	1, 724, 862				2.00
3.00	Buildings and Fixtures	42, 730, 632	19, 251, 750				3.00
4.00	Building Improvements	3, 196, 962	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	31, 350, 557	20, 271, 823				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	80, 233, 092	41, 248, 435				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	80, 233, 092	41, 248, 435				10.00

Heal th	Fi nanci al	Systems	
DECONC			COCTO

Health Financial Systems SI.	JUSEPHS REG MEI	D CENTER PLINU	UIN	IN LIE	U OF FORM CMS-2	2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0076	Period: From 07/01/2022 To 06/30/2023	Worksheet A-7 Part II Date/Time Pre 11/29/2023 2:	pared:		
		SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)				
	9.00	10.00	11.00	12.00	13.00			
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	NN 2, LINES 1 a	and 2					
1.00 CAP REL COSTS-BLDG & FIXT	0	()	0 0	0	1.00		
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00		
3.00 Total (sum of lines 1-2)	0	(0 0	0	3.00		
		OF CAPITAL						
Cost Center Description	Other	Total (1) (sun	n					
	Capi tal -Rel ate	of cols. 9						
	d Costs (see	through 14)						
	instructions)							
	14.00	15.00						
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	and 2					
1.00 CAP REL COSTS-BLDG & FIXT	0	0	D			1.00		
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0			2.00		
3.00 Total (sum of lines 1-2)	0	(c	p			3.00		

PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS O O O O Insurance Insurance 0	Health Financial Systems	ST. JOSEPHS REG MED) CENTER PLYMOU	JTH	In Lie	u of Form CMS-2	2552-10
Cost Center Description Gross Assets Capitalized Leases Gross Assets for Ratio (col. 1 - col. Insurance PART 111 - RECONCLILATION OF CAPITAL COSTS CENTERS 0	RECONCILIATION OF CAPITAL COSTS CENTERS			F	From 07/01/2022 To 06/30/2023	Part III Date/Time Prep 11/29/2023 2:0	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS for Ratio (col. 1 - col. 2) instructions) 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00 3.00 1.00 2.00 0.00 0.00000 0.00 3.00 1.000000 0.00 3.00 1.00 2.00 0.00 0.00000 0.00 3.00 1.00 2.00 0.00 0.00 0.00 0.00 0.00 2.00 3.00		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 0.00 0 1.000000 0 1.00 0	Cost Center Description	Gross Assets	Leases	for Ratio (col. 1 - col.	instructions)	Insurance	
0.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1.00 0.00 0 1.000000 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0		1.00	2.00	3.00	4.00	5.00	
2.00 CAP REL COSTS-MVBLE EQUIP 0	PART III - RECONCILIATION OF CAPITAL COS	TS CENTERS					
3.00 Total (sum of lines 1-2) 0 0 0 0 1.000000 0 3.00 3.00 Cost Center Description ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Capital-Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 1.00 CAP REL COSTS-BLOG & FIXT 0 0 0 2.861,148 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 2.00 2.861,462 0 3.00 3.00 Total (sum of lines 1-2) 0 0 0 2.861,462 0 3.00 3.00 Total (sum of lines 1-2) 0 0 0 2.861,462 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Other instructions) Total (costs (see instructions) Other instructions) Interest<		0	0	(-	1.00 2.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Capital-Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease 1.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 2.00 314 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 2.861, 148 0 1.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other of cols. 9 through 14) Total (2) (sum of Cost. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 0 3,114,973 0 0 11.00 12.00 13.00 14.00 15.00 10.00 CAP REL COSTS-BLDG & FIXT 253,825 0 0 0 3,114,973 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 3,114,973 1.00 </td <td></td> <td>0</td> <td>0</td> <td>(</td> <td></td> <td></td> <td></td>		0	0	(
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Capital -Relate d Costs col s. 5 through 7) col s. 5 through 7) col s. 5 through 7) 1.00 CAP REL COSTS-BLDG & FIXT 6.00 7.00 8.00 9.00 10.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 2.00 314 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 2.861,462 0 3.00 2.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other capital -Relate instructions) Total (2) (sum of col s. 9 through 14) 11.00 12.00 13.00 14.00 15.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-BLDG & FIXT 253,825 0 0 0 3,114,973 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 3,114,973 1.00		ALLOCAT	TION OF OTHER O	CAPI TAL			
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 2,861,148 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 314 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2,861,462 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other instructions Total (2) (sum of cols. 9 Intrough 14) Instructions	Cost Center Description		Capi tal -Rel ate	cols. 5	Depreciation	Lease	
1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 2,861,148 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 314 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2,861,148 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2,861,462 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Total -Rel ate of Costs (see instructions) 0		6.00	7.00	8.00	9.00	10.00	
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 3.14 0 2.00 3.14 0 2.00 3.14 0 2.00 3.14 0 2.00 3.00 70tal (sum of lines 1-2) 0 0 0 0 0 2.861,462 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other d Costs (see instructions) Total (2) (sum of cols. 9 through 14) PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 3.14, 973 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 3.14 2.00	PART III - RECONCILIATION OF CAPITAL COS	TS CENTERS					
3.00 Total (sum of lines 1-2) 0 0 0 2,861,462 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other capital -Rel ate d Costs (see instructions) Total (2) (sum of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 253,825 0 0 0 3,114,973 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 314 2.00		0	0	(2, 861, 148	0	1.00
SUMMARY OF CAPITAL SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Capital -Relate d Costs (see through 14) Total (2) (sum of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS O O 0 3, 114, 973 1.00 2.00 CAP REL COSTS-BLDG & FIXT 253, 825 0 0 0 3, 114, 973 1.00		0	0	(2.00
Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other capital -Relate d Costs (see instructions) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 253,825 0 0 0 3,114,973 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 314 2.00	3.00 Total (sum of lines 1-2)	0	0	(0	3.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.00 15.00 100 CAP REL COSTS-BLDG & FIXT 253,825 0 0 0 3,114,973 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 314 2.00			SL	JMMARY OF CAPI	TAL		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 0 0 0 0 0 0 0 11.00 12.00 13.00 14.00 15.00 1.00 CAP REL COSTS-BLDG & FIXT 253,825 0 0 0 3,114,973 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 314 2.00	Cost Center Description	Interest					
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.00 15.00 1.00 CAP REL COSTS-BLDG & FIXT 253,825 0 0 0 3,114,973 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 314 2.00			instructions)	instructions)	d Costs (see		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 253, 825 0 0 0 3, 114, 973 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 314 2.00		11 00	12 00	13 00		15 00	
1.00 CAP_REL_COSTS-BLDG & FIXT 253,825 0 0 3,114,973 1.00 2.00 CAP_REL_COSTS-MVBLE_EQUIP 0 0 0 314 2.00	PART III - RECONCILIATION OF CAPITAL COS		12.00	10.00	11.00	10.00	
2. 00 CAP REL COSTS-MVBLE EQUI P 0 0 0 314 2. 00			0	(0 0	3, 114, 973	1.00
3.00 Total (sum of lines 1-2) 253,825 0 0 3,115,287 3.00	2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(0 0		2.00
	3.00 Total (sum of lines 1-2)	253, 825	0	(0 0	3, 115, 287	3.00

Health Financial Systems ADJUSTMENTS TO EXPENSES	ST	JOSEPHS REG MEI	D CENTER PLYMOUTH Provider CCN: 15-0076	In Lie Period: From 07/01/2022 To 06/30/2023	wof Form CMS-2 Worksheet A-8 Date/Time Pre 11/29/2023 2:0	pared:
			Expense Classification of To/From Which the Amount is			<u>52 pm</u>
				s to be Adjusted		
Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00 Investment income - CAP REL	В		CAP REL COSTS-BLDG & FIXT	1.00		1.00
2.00 COSTS-BLDG & FIXT (chapter 2) 1 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7.00 Tel ephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21) 10.00 Provider-based physician adjustment	A-8-2	0 -1, 899, 457		0.00	0 0	
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	309, 249			0	12.00
13.00 Laundry and Linen service 14.00 Cafeteria-employees and guests	В	0 -150 943	CAFETERI A	0.00 11.00		
15.00 Rental of quarters to employee and others		0		0.00		
16.00 Sale of medical and surgical supplies to other than		0		0.00	0	16.00
patients 17.00 Sale of drugs to other than patients	В	-12, 137	PHARMACY	15.00	0	17. 00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19. 00
20.00 Vending machines 21.00 Income from imposition of	В	-2, 976 0	CAFETERI A	11.00 0.00		
interest, finance or penal ty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23.00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25.00 limitation (chapter 14) utilization review - physicians' compensation		0	*** Cost Center Deleted **;	* 114.00		25.00
(chapter 21) 26.00 Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of 	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00		29. 00 30. 00
30.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
instructions) 31.00 Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31. 00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	Ο	32. 00

cт

leal th	Financial Systems	ST	JOSEPHS REG MEI	D CENTER PLYMOUTH	In Lie	u of Form CMS-2	2552-1
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 07/01/2022		
					To 06/30/2023	Date/Time Pre 11/29/2023 2:0	
				Expense Classification o	n Worksheet A	11/2//2020 21	
				To/From Which the Amount is			
	Cont Conton Decemintion		A	Cost Costor	1.1.7.7.1		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY)	1.00	2.00		4.00	5.00	33. C
53.00	(3)		0		0.00	0	33.0
33. 01	Other Operating Rev -	В	0	RESPI RATORY THERAPY	65.00	0	33.0
0.01	Respiratory Care - Rent	D	0		05.00	0	00.0
33. 02	Other Operating Rev -	В	-136.015	RADI OLOGY-THERAPEUTI C	55.00	0	33.0
	Radiation Oncology - Rent	_	,			-	
3. 03	Other Operating Rev - Physical	В	0	PHYSICAL THERAPY	66.00	0	33.0
	Therapy						
3. 04	Other Operating Rev - Athletic	В	-68, 119	ATHLETIC TRAINERS	90.02	0	33.0
	Trainers						
3.05	Other Operating Rev -	В	0	HOUSEKEEPI NG	9.00	0	33. (
	Housekeeping	_				-	
3.06	Other Operating Rev -	В	-38, 452	ADMI NI STRATI VE & GENERAL	5.00	0	33.
	Administration	_			10.00		
3.07	Other Operating Rev - Vending	В		DIETARY	10.00	0	33.
3.08	OTHER REVENUE	В			60.00	0	33.
3.09	OTHER REVENUE	В		RESPIRATORY THERAPY	65.00	0	33.
3. 10	Other Operating Rev - Saint	В	0	SAINT JOSEPH HEALTH CENTER	90.03	0	33.
3. 11	Joseph Health Center Other Operating Rev - Foot &	В	0	FOOT & ANKLE SPORTS MED PLY	192.04	0	33.
5.11	Ankle Sports Med	D	0	FOUL & ANKLE SPORTS MED PLT	192.04	0	33.
3. 12	Other Operating Revenue -	В	0	CARDIAC REHABILITATION	76.97	0	33.
5. 12	Cardi ac Rehab Li fePl ex	D	0		70.77	0	55.
3. 13	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
00	(3)		0		0.00	0	00.
3.14	Other Revenue - LifePlex	В	-536, 850	LIFEPLEX FITNESS FORUM	190.01	0	33. '
3. 15	Other Revenue - Lab	В		LABORATORY	60.00	0	33.
3. 16	Other Revenue - Med Records	В	-54	MEDICAL RECORDS & LIBRARY	16.00	9	33.
	and HIM						
3.17	Other Operating Rev -	В	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.
	Physician Offices-Clinics						
3. 18	Other Revenue - Laundry -	В	-2, 875	LAUNDRY & LINEN SERVICE	8.00	0	33.
	Linen						
4.00	PROVI DER TAX	A		ADMI NI STRATI VE & GENERAL	5.00	0	
4.10	Provider Tax	A		ADMI NI STRATI VE & GENERAL	5.00	0	34.
5.00	Donations	A		ADMI NI STRATI VE & GENERAL	5.00	0	35.
5.10	Property Tax	A		ADMINISTRATIVE & GENERAL	5.00	0	35.
0.00	TOTAL (sum of lines 1 thru 49)		-7, 357, 110				50. (
	(Transfer to Worksheet A,						
	<u> column 6, line 200.)</u> scription - all chapter referen						I

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.

Heal th	Financial Systems	ST. JOSEPHS REG M	ED CENTER PLYMOUTH	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 07/01/2022 To 06/30/2023		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	2.00	3.00	4.00	5	
				4.00	5.00	
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED	
1.00		ADMINISTRATIVE & GENERAL	HO NON CAPITAL COSTS	7, 957, 414	8, 762, 394	1.00
2.00			WORKERS COMP	101, 908		
3.00			INSURANCE	145, 109		
3.01			PENSION	0	-327,603	
3.02	5.00	ADMINISTRATIVE & GENERAL	RETIREE HEALTH COSTS	0	138, 563	3. 02
3.03	1.00	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS	1, 074, 256	0	3. 03
3.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	Emp Health Stop Loss	0	65, 639	3. 04
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			9, 278, 687	8, 969, 438	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

				Related Organization(s) and/	or Home Office				
				-					
	Symbol (1)	Name	Percentage of	Name	Percentage of				
	Symbol (1)	Name		Name					
			Ownership		Ownership				
	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.

1 Of Inio al						
6.00	G		100.00	TRINITY HEALTH	100.00	6.00
7.00	G		100.00	SJRMC – INC	100.00	7.00
8.00	G	SJRMC - SB	100.00		100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	FINANCIAL				100.00
	non-financial) specify:					1

(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.

MCRI F32 - 21. 2. 177. 0

Health Financial Systems	ST. JOSEPHS REG MED C	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM REL	LATED ORGANIZATIONS AND HOME	Provider CCN: 15-0076		Worksheet A-8-1
OFFICE COSTS			From 07/01/2022	
			To 06/30/2023	Date/Time Prepared:

					11/29/2023	2:02 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTME	INTS REQUIRED AS A RESULT OF TRAI	NSACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	-804, 980	0				1.00
2.00	5, 646	0				2.00
3.00	-89, 074	0				3.00
3.01	327, 603	0				3. 01
3.02	-138, 563	0				3. 02
3.03	1, 074, 256	9				3. 03
3.04	-65, 639	0				3. 04
4.00	0	0				4.00
5.00	309, 249					5.00

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 allowable should be indicated columns

nas no	t been posted to worksheet A,	corumns r and/or 2, the amount arrowable should be indicated in corumn 4 of this part.	
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	51		
	6,00		
		TED ORGANIZATION(S) AND/OR HOME OFFICE:	
-			

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

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

reimbur	rsement under title XVIII.	
6.00	HO OF PARENT CO	6.00
7.00	PARENT COMPANY	7.00
8.00	HOSPI TAL	8.00
9.00		9.00
10. 00 100. 00		10.00
100.00		100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related

organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

In Lieu of Form CMS-2552-10 Worksheet A-8-2

PROVIDER BASED PHYSICIAN ADJUSTMENT					Provider (Period:	Worksheet A-8	3-2
							From 07/01/2022 To 06/30/2023		narad
							10 06/30/2023	11/29/2023 2:	
	Wkst. A Li	ne #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	02 pm
		ne "	I denti fi er	Remuneration	Component	Component	ROL ANOUNT	ider Component	
			ruchtinici	Remarker at rom	component	component		Hours	
	1.00		2.00	3.00	4.00	5.00	6.00	7.00	
1.00		0.00	2.00	0	4.00	0.00			1.00
2.00			OPERATING ROOM	124, 672	124, 672	(-	Ŭ Ŭ	2.00
3.00		0.00	OF ERATTING ROOM	124,072	124,072			0	3.00
3.00 4.00			RADI OLOGY-THERAPEUTI C	347, 395	245 045	1, 450	1 0		
					345, 945				4.00
5.00			LABORATORY	5, 550	0	5, 550			5.00
6.00		0.00		0	0	0		0	6.00
7.00			EMERGENCY	66, 522	0	66, 522			7.00
8.00			ADMINISTRATIVE & GENERAL	76, 139	46, 979	29, 160			8.00
9.00			ADMINISTRATIVE & GENERAL	1, 336, 481	1, 336, 481	0			9.00
10.00	3	0. 00	ADULTS & PEDIATRICS	-14, 672	528	-15, 200	179,000	80	10.00
11.00	6	5.00	RESPI RATORY THERAPY	4, 200	0	4,200	179,000	21	11.00
200.00				1, 946, 287	1, 854, 605	91, 682		784	200.00
	Wkst. A Li	ne #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
			I denti fi er		Unadjusted RCE	Memberships &	Component	of Malpractice	
					Limit	Continuing	Share of col.	Insurance	
						Educati on	12		
	1.00		2.00	8.00	9.00	12.00	13.00	14.00	
1.00		0.00		0	0	(0	0	1.00
2.00	5	0.00	OPERATING ROOM	0	0	C C	0	0	2.00
3.00		0.00		0	0	(0	3.00
4.00			RADI OLOGY - THERAPEUTI C	1, 205	60		0	0	4.00
5.00			LABORATORY	4, 630	232	(0	0	5.00
6.00		0.00	EADORATORT	4,000	232		0	0	6.00
7.00			EMERGENCY	35, 800	1, 790		0	0	7.00
8.00			ADMI NI STRATI VE & GENERAL	18, 588	929		0	0	8.00
9.00			ADMINISTRATIVE & GENERAL	10, 568	929 0		0	0	8.00 9.00
				Ű	-		0		
10.00			ADULTS & PEDIATRICS	6, 885	344		0	0	10.00
11.00	6	5.00	RESPI RATORY THERAPY	1,807	90		0	0	11.00
200.00				68, 915	3, 445	(0	0	200.00
	Wkst. A Li	ne #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
			Identi 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		0.00		0	0				1.00
2.00			OPERATING ROOM	0	0	0	124, 672	l I	2.00
3.00		0.00		0	0	0	0	l I	3.00
4.00	5	5.00	RADI OLOGY-THERAPEUTI C	0	1, 205	245	346, 190		4.00
5.00	60. 00 LABORATORY		0	4, 630	920	920		5.00	
6.00		0.00		0	0	0	0		6.00
7.00	9	1.00	EMERGENCY	0	35, 800	30, 722	30, 722		7.00
8.00			ADMINISTRATIVE & GENERAL	0	18, 588	10, 572			8.00
9.00			ADMI NI STRATI VE & GENERAL	0	.0,000	10, 0/2			9,00
10.00			ADULTS & PEDIATRICS	0	6, 885				10.00
11.00			RESPI RATORY THERAPY	0	1, 807	2, 393			11.00
200.00		,5.00	NEGETIATORI HIERAFI	0					200.00
200.00	I			I U	00, 915	44, 852	1,077,457	i I	200.00

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CO	F	Period: rom 07/01/2022 o 06/30/2023	Worksheet B Part I Date/Time Pre 11/29/2023 2:	pared:
			CAPI TAL REL	ATED COSTS		11/29/2023 2.	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		col. 7)	1.00	2.00	4.00	4.0	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
1.00	00100 CAP REL COSTS-BLDG & FIXT	3, 114, 973	3, 114, 973				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	314		314			2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATIVE & GENERAL	200, 679	0 347, 009	C 35			4.00 5.00
5.00 6.00	00600 MAINTENANCE & REPAIRS	13, 149, 441	347,009	30		13, 507, 510 0	6.00
7.00	00700 OPERATION OF PLANT	2, 112, 598	656, 286	68	5, 132	2, 774, 084	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	150, 682	11, 750	1	0	162, 433	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	547, 508 634, 467	5, 817 40, 659	1	3, 437 3, 658	556, 763 678, 788	9.00 10.00
11.00	01100 CAFETERIA	-57, 532	40, 839 38, 934		492	-18, 102	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	C	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	775, 654	0	C	6, 989	782, 643	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0 599, 816	90, 567 24, 062		0 2 7,329	90, 576 631, 209	
16.00	01600 MEDICAL RECORDS & LIBRARY	465, 336	48, 744	5	3, 958		
17.00	01700 SOCIAL SERVICE	0	0	C	0	0	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	(0	0	19.00
20. 00 21. 00	02000 NURSING PROGRAM 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	20.00 21.00
21.00	02200 I &R SERVICES-SALART & FRINGES APPRV	0	0			0	21.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	C	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 565, 298 14, 789	375, 918 72, 089	38	-		30.00 31.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	14, 789	72,089			07,043	34.00
43.00	04300 NURSERY	369, 575	0	C	2, 672	372, 247	43.00
F0 00	ANCI LLARY SERVICE COST CENTERS		000 (75		04.004	4 000 010	50.00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	3, 986, 216 369, 575	282, 675 0			4, 293, 210 372, 247	50.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 457, 050	140, 843				
55.00	05500 RADI OLOGY-THERAPEUTI C	358, 534	175, 472	18	3, 310		
57.00	05700 CT SCAN	167, 836	8, 124	1	1, 138		
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	107, 369 4, 287, 045	41, 163 84, 265	2	788 18, 409		
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	01,200	0	0 0	0	
65.00	06500 RESPI RATORY THERAPY	719, 663	64, 314	6	3, 994	787, 977	65.00
65. 01 66. 00	06501 SLEEP LAB	71, 105	0 113, 369	(11) 468 9, 095	71, 573 1, 295, 616	
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 PHYSI CAL THERAPY - LI FEPLEX	1, 173, 141 308, 357	113, 369	11	-	309, 528	
	06602 PHYSI CAL THERAPY - CULVER MI LI TARY	0	0	-			
67.00	06700 OCCUPATI ONAL THERAPY	180, 116	0	C	1, 615		
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	120, 656 243, 888	0) 1, 079 2, 028		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	243, 888	0		0 2,028	243, 910	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	802, 838	0	C	0	802, 838	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 288, 113	0	(0	2, 288, 113	
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C 0XYGEN THERAPY	0 7, 219	0		42	0 7, 261	
76.99	07699 LI THOTRI PSY	, 217	0		0 42	0	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
00 01	OUTPATIENT SERVICE COST CENTERS	0.000	0	(0.071	00.01
90. 01 90. 02	09001 OUTPATIENT TREATMENT & INFUSION CTR 09002 ATHLETIC TRAINERS	8, 889 11, 818	0) 82) 658	8, 971 12, 476	
90.03	09003 SAINT JOSEPH HEALTH CENTER	0	0	0	0 0	0	
90.04	09004 WOUND CARE	689, 107	60, 611	6	1, 928		
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 887, 064	142, 297	14	23, 806	4, 053, 181 0	
92.00	OTHER REIMBURSABLE COST CENTERS	I				0	92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	() 0	0	102.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	46, 889, 197	2, 824, 968	284	183, 517	46, 582, 000	118 00
	NONREI MBURSABLE COST CENTERS	40,007,197	2, 024, 700	204	103, 517		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18, 228	5, 313	1	0		190.00
	19001 LIFEPLEX FITNESS FORUM 19200 PHYSICIANS' PRIVATE OFFICES	2, 903, 303 1, 153, 977	0 284, 692	29	5, 007 8, 799	2, 908, 310 1, 447, 497	
	19201 FOUNDATION ADMINISTATION	0	204, 092	(-		192.00
192.02	2 19202 HOSPI TALI ST	0	0	C	0	0	192. 02
192.03	3 19203 INTENSI VI ST	0	0	(0 0	0	192.03

Health Financial Systems	ST. JOSEPHS REG MED	CENTER PLYMOL	JTH	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	
				From 07/01/2022 To 06/30/2023	Part I	narodi
				10 00/30/2023	Date/Time Pre 11/29/2023 2:	pareu. 02 pm
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP		Subtotal	
	for Cost			BENEFITS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	<u>col.7)</u>	1.00	2.00	4, 00	4A	
192.04 19204 FOOT & ANKLE SPORTS MED PLY	914, 782		2.00	0 2, 268		192 04
194. 00 07950 PLYMOUTH_MOB-4	62, 809			0 0	62,809	
194. 01 07951 COMMUNITY OUTREACH & PARTNERSHIP	136, 955			0 1,088		
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	52, 079, 251	3, 114, 973	31	4 200, 679	52, 079, 251	202.00
			1			

	LLOCATION - GENERAL SERVICE COSTS	JOSEPHS REG MEL	Provider CC	N: 15-0076 Pe	eriod: com 07/01/2022	u of Form CMS- Worksheet B Part I Date/Time Pre	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATI ON OF	LAUNDRY &	11/29/2023 2: HOUSEKEEPI NG	02 pm
		& GENERAL 5.00	REPAI RS 6.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS	1 0.00			0.00		
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	13, 507, 510	1				5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	971,007	0	3, 745, 091			6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	56, 856	0	20, 839	240, 128		8.00
9.00	00900 HOUSEKEEPI NG	194, 883	0	10, 316	0	761, 962	
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	237, 595	0	72, 110 69, 049	17 0	14, 794 14, 166	1
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	09,049	0	14, 100	1
13.00	01300 NURSI NG ADMI NI STRATI ON	273, 947	0	0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	31, 704		160, 622	0	32, 954	1
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	220, 941 181, 330	0	42, 674 86, 449	0	8, 755 17, 736	
17.00	01700 SOCIAL SERVICE	0	Ő	0	0	0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
20.00 21.00	02000 NURSI NG PROGRAM 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0	0	0	0	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	1
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 389, 799	0	666, 695	14, 470	136, 782	30.00
30.00	03100 I NTENSI VE CARE UNI T	30, 467	0	127, 851	14, 470	26, 230	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
43.00	04300 NURSERY	130, 297	0	0	762	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	1, 502, 744	0	501, 328	39, 984	102, 854	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	130, 297		0	1, 538	02,034	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	563, 796		249, 787	22, 607	51, 247	
55.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	188, 082	0	311, 203	8, 967	63, 847	
57.00 59.00	05900 CARDI AC CATHETERI ZATI ON	61, 990 52, 268	0	14, 408 73, 004	36, 298 1, 269	2, 956 14, 978	
60.00	06000 LABORATORY	1, 536, 510	0	149, 446	47, 121	30, 661	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	1
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	275, 814 25, 053	0	114, 062	2, 629 454	23, 401 0	
66.00	06600 PHYSI CAL THERAPY	453, 502	0	201, 061	5, 586	41, 250	
66. 01	06601 PHYSI CAL THERAPY - LI FEPLEX	108, 343		0	1, 099	0	
66. 02 67. 00	06602 PHYSICAL THERAPY - CULVER MILITARY 06700 OCCUPATIONAL THERAPY	63, 611	0	0	0 1, 100	0	
68.00	06800 SPEECH PATHOLOGY	42, 611	0	0	293	0	1
69.00	06900 ELECTROCARDI OLOGY	86, 077	0	0	8, 798	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0		0	0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	281, 016 800, 904	0	0	2, 374 15, 975	0	
76.97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	1
76.98	07698 HYPERBARI C OXYGEN THERAPY	2, 542	0	0	106	0	
76. 99 77. 00	07699 LI THOTRI PSY 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS	,					
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	3, 140		0	0	0	
90. 02 90. 03	09002 ATHLETIC TRAINERS 09003 SAINT JOSEPH HEALTH CENTER	4, 367	0	0	0	0	
90.04	09004 WOUND CARE	263, 099	0	107, 494	2, 756	22, 054	1
91.00	09100 EMERGENCY	1, 418, 727	0	252, 366	21, 735	51, 776	
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	11, 583, 319	0	3, 230, 764	235, 938	656, 441	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 240	0	9, 422	0	1, 933	190.00
	19001 LIFEPLEX FITNESS FORUM	1, 017, 990		0	0		190.01
	19200 PHYSI CI ANS' PRI VATE OFFI CES	506, 664	0	504, 905	1, 410	103, 588	
	19201 FOUNDATI ON ADMI NI STATI ON 19202 HOSPI TALI ST			0	0 1, 624		192. 01 192. 02
	19203 NTENSI VI ST	0	0	0	0		192.02
192.04	19204 FOOT & ANKLE SPORTS MED PLY	320, 993		0	1, 156		192.04
	07950 PLYMOUTH MOB-4 07951 COMMUNI TY OUTREACH & PARTNERSHIP	21, 985		0	0		194.00 194.01
200.00		48, 319	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00

Health Financial Systems	ST. JOSEPHS REG MED	D CENTER PLYMOU	ІТН	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	F	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/29/2023 2:	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6.00	7.00	8.00	9.00	
202.00 TOTAL (sum lines 118 through 201)	13, 507, 510	0	3, 745, 091	240, 128	761, 962	202.00

	LLOCATION - GENERAL SERVICE COSTS	JOSEPHS REG MED	Provider C	CN: 15-0076	Period: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 2:	epared:
	Cost Center Description	DI ETARY		MAI NTENANCE (PERSONNEL	ADMI NI STRATI ON	SUPPLY	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00 \end{array}$	ODIOD CAP REL COSTS-BLDG & FIXT O0200 CAP REL COSTS-BLDG & FIXT O0200 CAP REL COSTS-BLDG & FIXT O0400 EMPLOYEE BENEFITS DEPARTMENT O0500 ADMI NI STRATI VE & GENERAL O0600 MAI NTENANCE & REPAIRS O0700 OPERATION OF PLANT O0800 LAUNDRY & LI NEN SERVICE O0900 HOUSEKEEPING 01000 DI ETARY 011000 CAFETERIA 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVICES & SUPPLY	1,003,304 0 0 0 0	65, 113 0 1, 780		0 0 1, 058, 370 0 0	315, 856	1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
15.00 16.00 17.00 19.00 20.00 21.00 22.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS		1, 918 1, 901 0 0 0 0 0 0 0 0		0 32,056 0 31,767 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		15.00 16.00 17.00 19.00 20.00 21.00 22.00
30.00	03000 ADULTS & PEDI ATRI CS	755, 506	10, 360		0 173, 161	19, 041	30.00
	03100 I NTENSI VE CARE UNI T	160, 913	0		0 0	-	
	03400 SURGI CAL I NTENSI VE CARE UNI T 04300 NURSERY	0	0 961		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0	
43.00	ANCI LLARY SERVI CE COST CENTERS	0	701		10,007	1,003	45.00
50.00	05000 OPERATING ROOM	78, 022	7, 936		0 132, 614		
	05200 DELIVERY ROOM & LABOR ROOM	0	961		0 16,057		
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	4, 749 988		0 79, 360 0 16, 519		
57.00	05700 CT SCAN	0	456		0 7,624		1
	05900 CARDI AC CATHETERI ZATI ON	0	311		0 5, 198		1
	06000 LABORATORY	0	8, 896	,	0 148, 671		
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	-	
65.00	06500 RESPI RATORY THERAPY	0	1, 262		0 21, 082		
	06501 SLEEP LAB	0	187		0 3, 119		
	06600 PHYSI CAL THERAPY 06601 PHYSI CAL THERAPY - LI FEPLEX	0	3, 263 525		0 54, 524 0 8, 779		1
	06602 PHYSI CAL THERAPY - CULVER MILITARY	0	525		0 0,779		1
	06700 OCCUPATI ONAL THERAPY	0	453		0 7, 566		67.00
68.00	06800 SPEECH PATHOLOGY	0	277		0 4, 621		68.00
	06900 ELECTROCARDI OLOGY	0	774	1	0 12, 938	11, 578	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			3, 123 3, 123 21, 022	
	07697 CARDI AC REHABI LI TATI ON	0	0			0	
	07698 HYPERBARI C OXYGEN THERAPY	0	14		0 231		
	07699 LI THOTRI PSY	0	0		0 0	-	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0 0	77.00
90. 01	OUTPATIENT SERVICE COST CENTERS 09001 OUTPATIENT TREATMENT & INFUSION CTR		28		0 462	2 0	90.01
	09002 ATHLETI C TRAI NERS	0	422		0 7,047	-	
	09003 SAINT JOSEPH HEALTH CENTER	0	0		0 0	0	
90.04	09004 WOUND CARE	0	646		0 10, 801	3, 627	90.04
	09100 EMERGENCY	8, 863	7,037		0 117, 597	28, 602	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
102 00	OTHER REIMBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM	0	0		0 0		102.00
102.00	SPECIAL PURPOSE COST CENTERS		0	1	0 0	<u>, </u>	102.00
118.00		1, 003, 304	56, 105		0 907, 851	310, 342	2 118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19001 LI FEPLEX FI TNESS FORUM	0	4, 127		0 68, 964		190.01
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 083		0 51, 521		192.00
	19201 FOUNDATI ON ADMI NI STATI ON 19202 HOSPI TALI ST		0				192.01
197 117		0	0		0 0		192.02
	19203 I NI ENSI VI SI						
192.03	19203 INTENSIVIST 19204 FOOT & ANKLE SPORTS MED PLY	0	1, 103		0 18, 425		192.04
192. 03 192. 04 194. 00	19204 FOOT & ANKLE SPORTS MED PLY 07950 PLYMOUTH MOB-4	0	0		0 0	0	192.04 194.00
192. 03 192. 04 194. 00	19204 FOOT & ANKLE SPORTS MED PLY 07950 PLYMOUTH MOB-4 07951 COMMUNI TY OUTREACH & PARTNERSHIP	0 0 0	1, 103 0 695		0 18, 425 0 0 0 11, 609	0	192. 04

Health Financial Systems	ST.	JOSEPHS REG MED	CENTER PLYMOL	JTH	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL	SERVICE COSTS		Provider CO		Period:	Worksheet B	
					From 07/01/2022		
					To 06/30/2023	Date/Time Pre 11/29/2023 2:	
Cost Center D	escription	DI ETARY	CAFETERI A	MAINTENANCE C	F NURSI NG	CENTRAL	
				PERSONNEL	ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
201.00 Negative Cost	Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum li	nes 118 through 201)	1,003,304	65, 113		0 1, 058, 370	315, 856	202.00

Heal th	Fi nanci al	Systems	
COST A		CENEDAL	SED/

	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2022 Fo 06/30/2023	Worksheet B Part I Date/Time Pro 11/29/2023 2	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICI	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
		15.00	16.00	17.00	19.00	20.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.0
00	00200 CAP REL COSTS-MUBLE EQUIP						2.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
00	00500 ADMINI STRATI VE & GENERAL						5.0
00	00600 MAINTENANCE & REPAIRS						6. (
00	00700 OPERATION OF PLANT						7.0
00	00800 LAUNDRY & LINEN SERVICE						8.
00	00900 HOUSEKEEPI NG						9.0
0.00	01000 DI ETARY						10.
1.00 2.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL						11.
2.00	01300 NURSI NG ADMI NI STRATI ON						13.0
4.00	01400 CENTRAL SERVICES & SUPPLY						14.
	01500 PHARMACY	937, 553					15.0
	01600 MEDICAL RECORDS & LIBRARY	0	837, 226				16.
7.00	01700 SOCIAL SERVICE	0	0		D		17.0
	01900 NONPHYSICIAN ANESTHETISTS	0	0	(0 0		19.0
	02000 NURSING PROGRAM	0	0	(D	(20.
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		D I		21.
2.00 3.00	02200 I & SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0				22. 23.
5.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0				23.
0. 00	03000 ADULTS & PEDI ATRI CS	0	50, 471	(0 0	(30.
	03100 I NTENSI VE CARE UNI T	0	0		0		31.
4.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	(o o	(34.
3.00	04300 NURSERY	0	2, 659	(0 0	(3 43.
	ANCI LLARY SERVI CE COST CENTERS						
). 00	05000 OPERATING ROOM	0	139, 470		0 0	(
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	5, 364		0		52.
. 00	05400 RADI OLOGY-DI AGNOSTI C	0	78, 856		0) 54.
5.00 7.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	31, 277 126, 612) 55.) 57.
7.00 7.00	05900 CARDI AC CATHETERI ZATI ON	0	4, 428				5 59.
). 00	06000 LABORATORY	o	164, 053		0		0 60.
2.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	() 62.
6. 00	06500 RESPI RATORY THERAPY	0	9, 169		0 0	() 65.
5. 01	06501 SLEEP LAB	0	1, 585		0 0	() 65.
5.00	06600 PHYSI CAL THERAPY	0	19, 483		0 0) 66.
b. 01	06601 PHYSI CAL THERAPY - LI FEPLEX	0	3, 833		0 0) 66.
b. 02	06602 PHYSI CAL THERAPY - CULVER MILITARY	0	0		0		0 66.
2.00 3.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	3, 838 1, 022) 67.) 68.
	06900 ELECTROCARDI OLOGY	0	30, 689) 68.) 69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0,007) 71.
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8, 279		0 0		0 72.
. 00	07300 DRUGS CHARGED TO PATIENTS	927, 101	55, 722		0 0	(J 73.
	07697 CARDI AC REHABI LI TATI ON	0	0	(0 0	() 76.
	07698 HYPERBARI C OXYGEN THERAPY	0	371		0 0) 76.
		0	0		0) 76.
. 00	07700 ALLOGENEI C HSCT ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	(0 0	(<u> </u>
0. 01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0			(9 0.
	09002 ATHLETI C TRAI NERS	0	0) 90.) 90.
	09003 SAINT JOSEPH HEALTH CENTER	Ő	0		ol ol) 90.
	09004 WOUND CARE	0	9, 614	(90.
	09100 EMERGENCY	0	75, 813		0 0	() 91.
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
	OTHER REIMBURSABLE COST CENTERS						1100
2.00	10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	(0 0	(102.
8.00		927, 101	822, 608		0 0	(0 118.
5.00	NONREI MBURSABLE COST CENTERS	727,101	022,000			(
0. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	(0 190.
	19001 LI FEPLEX FI TNESS FORUM	0	0				0 190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 530	4, 919	(0 0		0 192.
	19201 FOUNDATION ADMINISTATION	0	0		0 0		3 192.
	19202 HOSPI TALI ST	0	5, 665	(0 0		D 192.
	19203 I NTENSI VI ST	0	1		0 0		0 192.
2.04	19204 FOOT & ANKLE SPORTS MED PLY	8, 922	4, 033	(0 0		0 192.
		0	0	1 (ם ור	(0 194.
	07950 PLYMOUTH MOB-4 07951 COMMUNITY OUTREACH & PARTNERSHIP	0	-				0 194.

Health Financial Systems	ST. JOSEPHS REG MED	CENTER PLYMOL	JTH	In Lie	u of Form CMS	6-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				rom 07/01/2022 o 06/30/2023	Part I Date/Time Pr	conarod.
				0 00/30/2023	11/29/2023	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG	
		RECORDS &		ANESTHETI STS	PROGRAM	
		LI BRARY				
	15.00	16.00	17.00	19.00	20.00	
201.00 Negative Cost Centers	0	0	C	0 0		0 201.00
202.00 TOTAL (sum lines 118 through 201)	937, 553	837, 226	C	0		0 202. 00

DST ALLO	OCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2022 To 06/30/2023		eparec 02 pm
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PRGM		Intern & Residents Cost & Post Stepdown Adjustments	
GEN	NERAL SERVICE COST CENTERS	21.00	22.00	23.00	24.00	25.00	
	100 CAP REL COSTS-BLDG & FIXT						1.1
	200 CAP REL COSTS-MVBLE EQUIP						2.
00 004	400 EMPLOYEE BENEFITS DEPARTMENT						4.
00 00	500 ADMI NI STRATI VE & GENERAL						5.
00 000	600 MAINTENANCE & REPAIRS						6.
	700 OPERATION OF PLANT						7.
	800 LAUNDRY & LINEN SERVICE						8.
	900 HOUSEKEEPI NG						9.
							10.
							11.
	200 MAI NTENANCE OF PERSONNEL 300 NURSI NG ADMI NI STRATI ON						12. 13.
	400 CENTRAL SERVICES & SUPPLY						14.
	500 PHARMACY						15.
	600 MEDICAL RECORDS & LIBRARY						16.
	700 SOCIAL SERVICE						17.
	900 NONPHYSI CI AN ANESTHETI STS						19.
0. 00 020	000 NURSI NG PROGRAM						20.
1.00 02'	100 I &R SERVICES-SALARY & FRINGES APPRV	0					21.
2.00 022	200 I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.
3.00 023	300 PARAMED ED PRGM-(SPECIFY)				0		23.
	PATIENT ROUTINE SERVICE COST CENTERS				_		
	000 ADULTS & PEDIATRICS	0	0		0 7, 186, 823	0	
	100 I NTENSI VE CARE UNI T	0	0		0 432, 504	0	
	400 SURGICAL INTENSIVE CARE UNIT	0	0		0 0	0	
	300 NURSERY	0	0		0 523, 986	0	43.
	CILLARY SERVICE COST CENTERS	0			0 6 050 770	0	I FO
	000 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	0			0 6, 850, 779 0 528, 488	0	
	400 RADI OLOGY-DI AGNOSTI C	0	0		0 528, 488 0 2, 690, 868	0	
	500 RADI OLOGY-THERAPEUTI C	0	0		0 1, 170, 017	0	
	700 CT SCAN	0	0		0 475, 209	0	
1	900 CARDI AC CATHETERI ZATI ON	0	0		0 302, 450	0	
	000 LABORATORY	0	0		0 6, 536, 978	0	60.
2.30 062	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.
5.00 065	500 RESPI RATORY THERAPY	0	0		0 1, 238, 855	0	65.
. 01 06	501 SLEEP LAB	0	0		0 102, 569	0	
	600 PHYSI CAL THERAPY	0	0		0 2, 081, 635	0	
	601 PHYSI CAL THERAPY - LI FEPLEX	0			0 433, 553	0	
	602 PHYSI CAL THERAPY - CULVER MILITARY	0	0		0 0	0	
	700 OCCUPATIONAL THERAPY	0	0		0 259, 747	0	
	800 SPEECH PATHOLOGY	0	0		0 170, 944	0	
	900 ELECTROCARDI OLOGY 100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 396, 770	0	
	200 IMPL. DEV. CHARGED TO PATIENT				0 1, 097, 630	0	
	300 DRUGS CHARGED TO PATIENTS	0 0	0		0 4, 108, 837	0	
	697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	
	698 HYPERBARI C OXYGEN THERAPY	0	o o		0 10, 665	0	
	699 LI THOTRI PSY	0	0		0 0	0	
. 00 07	700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.
OUT	TPATIENT SERVICE COST CENTERS						
	001 OUTPATIENT TREATMENT & INFUSION CTR	0	0		0 12, 601	0	
	002 ATHLETI C TRAI NERS	0	0		0 24, 312	0	
	003 SAINT JOSEPH HEALTH CENTER	0	0		0 0	0	
	004 WOUND CARE	0	0		0 1, 171, 743	0	
	100 EMERGENCY	0	0		0 6, 035, 697	0	
	200 OBSERVATION BEDS (NON-DISTINCT PART HER REIMBURSABLE COST CENTERS					0	92.
	200 OPIOID TREATMENT PROGRAM	0	0		0 0	0	102.
	ECIAL PURPOSE COST CENTERS	0	0		<u> </u>	0	1'02.
B. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 43, 843, 660	0	118.
	NREIMBURSABLE COST CENTERS	0	. 0		- 10, 040, 000	0	1
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 43, 137	0	190.
	001 LI FEPLEX FI TNESS FORUM	0	0		0 3, 999, 391		190.
	200 PHYSI CLANS' PRI VATE OFFI CES	0	o o		0 2, 626, 973		192.
	201 FOUNDATION ADMINISTATION	0	Ő		0 0		192.
2.011174					0 0 4 2 4		192.
	202 HOSPI TALI ST	0	0		0 9,426	0	192.

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0076	Period: From 07/01/2022 To 06/30/2023		
	INTERNS &	RESI DENTS				
Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post	
					Stepdown Adjustments	
	21.00	22.00	23.00	24.00	25.00	
192.04 19204 FOOT & ANKLE SPORTS MED PLY	0	0		0 1, 273, 203	0	192.04
194.0007950 PLYMOUTH MOB-4	0	0		0 84, 794	0	194.00
194. 01 07951 COMMUNI TY OUTREACH & PARTNERSHI P	0	0		0 198, 666	0	194.01
200.00 Cross Foot Adjustments	0	0		0 0	0	200. 00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	0		0 52, 079, 251	0	202.00

In Lieu of Form CMS-2552-10 Worksheet B

LUSI F	ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0076	From 07/01/2022 Par To 06/30/2023 Dat	e/Time Prepared
	Cost Center Description	Total		/ /	29/2023 2:02 pm
	GENERAL SERVICE COST CENTERS	26.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT				1. (
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 0
5.00	00500 ADMINISTRATIVE & GENERAL				5.0
6.00	00600 MAI NTENANCE & REPAI RS				6.0
7.00	00700 OPERATION OF PLANT				7.0
8.00	00800 LAUNDRY & LINEN SERVICE				8.0
9.00	00900 HOUSEKEEPI NG				9. (
10. 00	01000 DI ETARY				10. 0
11. 00	01100 CAFETERI A				11. (
12.00	01200 MAINTENANCE OF PERSONNEL				12. (
	01300 NURSI NG ADMI NI STRATI ON				13. (
	01400 CENTRAL SERVICES & SUPPLY				14. (
	01500 PHARMACY				15.0
	01600 MEDI CAL RECORDS & LI BRARY				16. 0
	01700 SOCI AL SERVI CE				17. (
	01900 NONPHYSI CI AN ANESTHETI STS				19. (
	02000 NURSI NG PROGRAM				20.0
					21.0
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV				22.0
23.00					23. 0
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	7, 186, 823			30.0
	03100 I NTENSI VE CARE UNI T	432, 504			31. (
	03400 SURGICAL INTENSIVE CARE UNIT	0			34.0
13.00	04300 NURSERY	523, 986			43. (
	ANCI LLARY SERVI CE COST CENTERS				
50.00	05000 OPERATI NG ROOM	6, 850, 779			50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	528, 488			52.0
	05400 RADI OLOGY-DI AGNOSTI C	2, 690, 868			54.0
5.00	05500 RADI OLOGY-THERAPEUTI C	1, 170, 017			55.0
57.00	05700 CT SCAN	475, 209			57.0
59.00	05900 CARDI AC CATHETERI ZATI ON	302, 450			59.0
	06000 LABORATORY	6, 536, 978			60.0
52.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			62.3
65.00	06500 RESPI RATORY THERAPY	1, 238, 855			65.0
55.01	06501 SLEEP LAB	102, 569			65.0
56.00	06600 PHYSI CAL THERAPY	2, 081, 635			66.0
56. 01	06601 PHYSI CAL THERAPY - LI FEPLEX	433, 553			66.0
	06602 PHYSI CAL THERAPY - CULVER MILITARY	0			66.0
	06700 OCCUPATI ONAL THERAPY	259, 747			67.0
	06800 SPEECH PATHOLOGY	170, 944			68.0
	06900 ELECTROCARDI OLOGY	396, 770			69. (
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71. (
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 097, 630			72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 108, 837			73.0
	07697 CARDI AC REHABI LI TATI ON	0			76. 9
	07698 HYPERBARI C OXYGEN THERAPY	10, 665			76. 9
	07699 LI THOTRI PSY	0			76. 9
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0			
	OUTPATIENT SERVICE COST CENTERS				
	09001 OUTPATIENT TREATMENT & INFUSION CTR	12, 601			90.0
	09002 ATHLETI C TRAI NERS	24, 312			90.0
	09003 SAINT JOSEPH HEALTH CENTER	0			90.0
	09004 WOUND CARE	1, 171, 743			90.0
	09100 EMERGENCY	6, 035, 697			91. (
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.0
	OTHER REIMBURSABLE COST CENTERS				
02.00	10200 OPI OI D TREATMENT PROGRAM	0			102. (
	SPECIAL PURPOSE COST CENTERS	-			
18.00		43, 843, 660			118. (
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	43, 137			190. (
	19001 LIFEPLEX FITNESS FORUM	3, 999, 391			190. (
	19200 PHYSICIANS' PRIVATE OFFICES	2, 626, 973			192. (
	19201 FOUNDATI ON ADMI NI STATI ON	0			192. (
	19202 HOSPI TALI ST	9, 426			192. (
92.03	19203 I NTENSI VI ST	1			192. (
	19204 FOOT & ANKLE SPORTS MED PLY	1, 273, 203			192. (
	07950 PLYMOUTH MOB-4	84, 794			194. (
	07951 COMMUNI TY OUTREACH & PARTNERSHI P	198, 666			194. (
		0			200. 0
200.00		-			
200.00 201.00	Negative Cost Centers	0			201.0

	TION OF CAPITAL RELATED COSTS		Provider CC	Fi	eriod: rom 07/01/2022 p 06/30/2023	Worksheet B Part II Date/Time Pre 11/29/2023 2:	pared: 02 pm
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						1 1 00
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	
00	00500 ADMI NI STRATI VE & GENERAL	0	347, 009	35	347, 044	0	
00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6.00
00	00700 OPERATION OF PLANT	0	656, 286	68	656, 354	0	7.0
00	00800 LAUNDRY & LINEN SERVICE	0	11, 750	1	11, 751	0	
00 . 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	5, 817 40, 659	1	5, 818 40, 663	0	9.0 10.0
	01100 CAFETERIA	0	38, 934	4	38, 938	0	11.0
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.0
	01300 NURSING ADMINISTRATION	0	0	0	0	0	13.0
	01400 CENTRAL SERVICES & SUPPLY	0	90, 567	9	90, 576	0	14.0
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	24, 062 48, 744	2	24, 064 48, 749	0	15.0
	01700 SOCIAL SERVICE	0	40, 744	5	40, 749	0	17.0
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.0
	02000 NURSI NG PROGRAM	0	0	0	0	0	20.0
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.0
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.0
8.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.0
0. 00	03000 ADULTS & PEDIATRICS	0	375, 918	38	375, 956	0	30.0
	03100 I NTENSI VE CARE UNI T	0	72, 089	7	72, 096	0	
	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
. 00	04300 NURSERY	0	0	0	0	0	43.0
	ANCI LLARY SERVICE COST CENTERS		202 (75	20	202 702	0	1 50 0
0. 00 . 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	282, 675	28 0	282, 703 0	0	50.0 52.0
	05400 RADI OLOGY-DI AGNOSTI C	0	140, 843	14	140, 857	0	54.0
. 00	05500 RADI OLOGY-THERAPEUTI C	0	175, 472	18	175, 490	0	55.0
. 00	05700 CT SCAN	0	8, 124	1	8, 125	0	57.0
. 00	05900 CARDI AC CATHETERI ZATI ON	0	41, 163	4	41, 167	0	59.0
. 00 . 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	84, 265	8	84, 273	0	60.0
. 00	06500 RESPIRATORY THERAPY	0	64, 314	6	64, 320	0	65.0
. 01	06501 SLEEP LAB	0	0	0	0 1/ 020	0	65.0
. 00	06600 PHYSI CAL THERAPY	0	113, 369	11	113, 380	0	66.0
	06601 PHYSI CAL THERAPY - LI FEPLEX	0	0	0	0	0	66.0
	06602 PHYSI CAL THERAPY - CULVER MI LI TARY	0	0	0	0	0	
. 00 . 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.0
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.0
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.9
	07699 LI THOTRI PSY	0	0	0	0	0	76.9
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	1
	OUTPATIENT SERVICE COST CENTERS						
	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0	0	
	09002 ATHLETIC TRAINERS	0	0	0	0	0	
	09003 SAINT JOSEPH HEALTH CENTER 09004 WOUND CARE	0	60, 611	0	60, 617	0	90. C
	09100 EMERGENCY	0	142, 297	14	142, 311	0	91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. C
	OTHER REIMBURSABLE COST CENTERS						
2.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. C
	SPECIAL PURPOSE COST CENTERS	0	2 924 049	204	2 025 252	0	1110 0
		0	2, 824, 968	284	2, 825, 252	0	118.0
3. 00	NONREL MBURSABLE COST CENTERS		E 212	1	5, 314	0	190. 0
	NONREIMBURSABLE COST CENTERS	0	5.31.31				1
0. 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 LIFEPLEX FITNESS FORUM	0	5, 313 0	0	0	0	190. C
0. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 0 0	5, 313 0 284, 692	0 29	0 284, 721	0	190. 0 192. 0
0. 00 0. 01 2. 00 2. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 LIFEPLEX FITNESS FORUM 19200 PHYSICIANS' PRIVATE OFFICES 19201 FOUNDATION ADMINISTATION	0 0 0	0	0 29 0	0	0 0	192. 0 192. 0
0. 00 0. 01 2. 00 2. 01 2. 02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 LIFEPLEX FITNESS FORUM 19200 PHYSICIANS' PRIVATE OFFICES		0	0 29 0 0	0	0 0 0	192.0

Health Financial Systems	ST. JOSEPHS REG MEL) CENTER PLYMOL	JTH	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre	nared [.]
				10 00/00/2020	11/29/2023 2:	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Di rectl y Assi gned New Capi tal Rel ated Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
194.0007950 PLYMOUTH MOB-4	0	0		0 0		194.00
194. 01 07951 COMMUNI TY OUTREACH & PARTNERSHI P	0	0		0 0	0	194.01
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	3, 114, 973	31	4 3, 115, 287	0	202.00

	TION OF CAPITAL RELATED COSTS	JOSEPHS REG MEL	Provi der CC		eri od:	Worksheet B	2552-10
	ITUN OF CAPITAL RELATED COSTS				rom 07/01/2022	Part II	pared: 02 pm
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS		LINEN SERVICE	0.00	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
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
5.00	00500 ADMINI STRATI VE & GENERAL	347,044					5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	0				6.00
7.00	00700 OPERATION OF PLANT	24, 947	0	681, 301			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1,461	0	3, 791	17, 003		8.00
9.00	00900 HOUSEKEEPING	5,007	0	1,877	0	12, 702	•
	01000 DI ETARY 01100 CAFETERI A	6, 104 0	0	13, 118	0	247	•
	01200 MAINTENANCE OF PERSONNEL	0	0	12, 561 0	0	236	1
	01300 NURSI NG ADMI NI STRATI ON	7,038	0	0	0	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	815	0	29, 220	0	549	•
	01500 PHARMACY	5, 676	-	7, 763	0	146	1
	01600 MEDICAL RECORDS & LI BRARY	4,659	0	15, 727	0	296	1
	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	35, 707	0	101 005	1 020	2 290	20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	783	0	121, 285 23, 258	1, 020 0	2, 280 437	30.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	23, 258	0	437	34.00
	04300 NURSERY	3, 348	0	0	54	0	43.00
10.00	ANCI LLARY SERVI CE COST CENTERS	0,010	<u> </u>		01		10.00
50.00	05000 OPERATI NG ROOM	38, 609	0	91, 201	2, 819	1, 715	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 348	0	0	108		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 485	0	45, 441	1, 594	854	54.00
	05500 RADI OLOGY-THERAPEUTI C	4, 832	0	56, 613	632	1, 064	55.00
	05700 CT SCAN	1, 593		2, 621	2, 560		•
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 343	0	13, 281	90	250	•
	06000 LABORATORY	39, 482	0	27, 187	3, 395		•
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	7,086	0	20, 750	185		
	06600 PHYSI CAL THERAPY	644 11, 651	0	36, 577	32 394	0 688	65.01 66.00
	06601 PHYSICAL THERAPY - LIFEPLEX	2, 784	0	30, 377	77	0000	66.01
	06602 PHYSI CAL THERAPY - CULVER MILITARY	2,704	0	0	0	0	66.02
	06700 OCCUPATI ONAL THERAPY	1, 634	0	0	78	0	67.00
68.00	06800 SPEECH PATHOLOGY	1, 095	0	0	21	0	68.00
69.00	06900 ELECTROCARDI OLOGY	2, 212	0	0	620	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	7, 220		0	167	0	
	07300 DRUGS CHARGED TO PATIENTS	20, 577	0	0	1, 126		73.00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.97
	07698 HYPERBARI C OXYGEN THERAPY	65	0	0	/	0	76.98
	07699 LI THOTRI PSY 07700 ALLOGENEI CHSCT ACQUI SI TI ON	0	0	0	0	0	77.00
77.00	OUTPATIENT SERVICE COST CENTERS	0	<u> </u>	0	0	0	//.00
90. 01	09001 OUTPATIENT TREATMENT & INFUSION CTR	81	0	0	0	0	90.01
	09002 ATHLETI C TRAI NERS	112	0	0	0	0	90.02
	09003 SAINT JOSEPH HEALTH CENTER	0	0	0	0	0	90.03
90.04	09004 WOUND CARE	6, 760	0	19, 555	194	368	90.04
	09100 EMERGENCY	36, 450	0	45, 910	1, 533	863	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	-					
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	297, 608	0	587, 736	16, 707	10, 943	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	0	1, 714	0	22	190.00
	19001 LIFEPLEX FITNESS FORUM	26, 154		0	0		190.01
	19200 PHYSI CLANS' PRI VATE OFFI CES	13, 017	o o	91, 851	99		192.00
	19201 FOUNDATION ADMINISTATION	0	0	0	0		192.01
192.00		1	0	0	115	0	192.02
192.00 192.01	19202 HOSPI TALI ST	0	, °	1			
192.00 192.01 192.02 192.03	19202 HOSPI TALI ST 19203 I NTENSI VI ST	0	0	0	0		192.03
192.00 192.01 192.02 192.03 192.04	19202 HOSPI TALI ST 19203 I NTENSI VI ST 19204 FOOT & ANKLE SPORTS MED PLY	0 0 8, 247	0	0 0	0 82	0	192.04
192.00 192.01 192.02 192.03 192.04 194.00	19202 HOSPI TALI ST 19203 I NTENSI VI ST 19204 FOOT & ANKLE SPORTS MED PLY 07950 PLYMOUTH MOB-4	565	0 0 0	0 0 0	-	0 0	192. 04 194. 00
192.00 192.01 192.02 192.03 192.04 194.00 194.01	19202 HOSPI TALI ST 19203 I NTENSI VI ST 19204 FOOT & ANKLE SPORTS MED PLY 07950 PLYMOUTH MOB-4 07951 COMMUNI TY OUTREACH & PARTNERSHI P		0 0 0	0 0 0 0	-	0 0	192. 04 194. 00 194. 01
192.00 192.01 192.02 192.03 192.04 194.00	19202 HOSPI TALI ST 19203 I NTENSI VI ST 19204 FOOT & ANKLE SPORTS MED PLY 07950 PLYMOUTH MOB-4 07951 COMMUNI TY OUTREACH & PARTNERSHI P Cross Foot Adj ustments	565	000000000000000000000000000000000000000	0 0 0 0	-	0 0 0	192. 04 194. 00

Health Financial Systems	ST. JOSEPHS REG MEI	D CENTER PLYMOU	JTH	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 07/01/2022	Worksheet B	
					Date/Time Pre 11/29/2023 2:	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6.00	7.00	8.00	9.00	
202.00 TOTAL (sum lines 118 through 201)	347,044	0	681, 301	17, 003	12, 702	202.00

Heal th	Fina	nci	al S	yste	ems		
		OF	CADI	TAI	DEL	ATED	

		JOSEPHS REG MED				u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 07/01/2022 o 06/30/2023	Worksheet B Part II Date/Time Pre 11/29/2023 2:	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL	
		10.00	11.00	12.00	13.00	14.00	
1 00	GENERAL SERVICE COST CENTERS			1			1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP					1	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					1	4.00
5.00	00500 ADMINI STRATI VE & GENERAL					1	5.00
6.00	00600 MAI NTENANCE & REPAI RS					1	6.00
7.00	00700 OPERATION OF PLANT					1	7.00
8.00	00800 LAUNDRY & LINEN SERVICE					1	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	60, 133				1	9.00 10.00
11.00	01100 CAFETERI A	00, 135	27, 466			1	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	,			1	12.00
13.00	01300 NURSING ADMINISTRATION	0	751	0	7, 789	1	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	C		0	121, 160	
15.00		0	809		236	0	
16.00 17.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	802 (234	0	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	1
20.00	02000 NURSI NG PROGRAM	0	C	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	C	0	0	0	
22.00	02200 I & R SERVICES-OTHER PRGM COSTS APPRV	0	0	-	0	0	1
23.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0 0	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	45, 282	4, 371	0	1, 275	7, 301	30, 00
31.00	03100 I NTENSI VE CARE UNI T	9,644	., ., .			0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	C	0 0	0	0	34.00
43.00	04300 NURSERY	0	405	ō 0	118	385	43.00
		4 (7)	2.24	1	07/	20.175	1 50 00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	4, 676 0	3, 347 405			20, 175 776	1
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	2,003		584	11, 407	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	417		122	4, 524	
57.00	05700 CT SCAN	0	192	2 0	56	18, 315	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	131		38	640	1
60.00	06000 LABORATORY	0	3, 753			23, 782	1
62.30 65.00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0	532	-	0 155	0 1, 326	
65.01	06501 SLEEP LAB	0	79		23	229	
66.00	06600 PHYSI CAL THERAPY	0	1, 376	0	401	2, 818	66.00
66. 01	06601 PHYSI CAL THERAPY - LI FEPLEX	0	222		65	554	1
66.02	06602 PHYSI CAL THERAPY - CULVER MILITARY	0	0		0	0	1
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	191 117		56 34	555 148	1
	06900 ELECTROCARDI OLOGY	0	327		95	4, 439	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	0	0	1, 198	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	8, 061	
76.97 76.98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0			0	0 54	1
	07699 LI THOTRI PSY	0	(-	2	0	1
	07700 ALLOGENEIC HSCT ACQUISITION	0	C		0	0	1
	OUTPATIENT SERVICE COST CENTERS			1	11		
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	12			0	
	09002 ATHLETI C TRAI NERS 09003 SAI NT JOSEPH HEALTH CENTER	0	178			0	
90. 03 90. 04	09003 SAINT JUSEPH HEALTH CENTER	0	273	-	0 79	0 1, 391	90.03 90.04
	09100 EMERGENCY	531	2, 968		865	10, 967	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS			1	1		
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	00	0	0	102.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	60, 133	23, 667	7 0	6, 681	119, 045	1110 00
110.00	NONREIMBURSABLE COST CENTERS	00, 133	23,007	ч <u></u>	0,001	119,045	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0 0	0	0	190.00
190.01	19001 LIFEPLEX FITNESS FORUM	0	1, 741		508	0	190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 300		379		192.00
	19201 FOUNDATI ON ADMI NI STATI ON	0	0		0		192.01
	19202 HOSPI TALI ST 19203 I NTENSI VI ST	0			0		192. 02 192. 03
	19203 INTENSIVISI 19204 FOOT & ANKLE SPORTS MED PLY	0	465		136		192.03
	07950 PLYMOUTH MOB-4	0	400		0		192.04
194.01	07951 COMMUNI TY OUTREACH & PARTNERSHI P	0	293	3 0	85		194.01
200.00	Cross Foot Adjustments						200.00

Health Fina	ncial Systems ST.	JOSEPHS REG MED	CENTER PLYMOU	JTH	In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	
					From 07/01/2022		
					To 06/30/2023	Date/Time Pre	
						11/29/2023 2:	<u>02 pm</u>
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
				PERSONNEL	ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
201.00	Negative Cost Centers	0	24, 269	(0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	60, 133	51, 735		7, 789	121, 160	202.00

Heal th	Financial Systems	ST	JOSEPHS REG MED	CENTER PLYMOU	JTH	In Lie	eu of Form CMS	-2552-10
	ATION OF CAPITAL RELATED COSTS			Provider C	F	veriod: rom 07/01/2022 o 06/30/2023	Worksheet B Part II	repared:
	Cost Center Description		PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
	Г		15.00	16.00	17.00	19.00	20.00	
1 00	GENERAL SERVICE COST CENTERS	-			1			1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP							4.00
5.00	00500 ADMI NI STRATI VE & GENERAL							5.00
6.00	00600 MAI NTENANCE & REPAI RS							6.00
7.00	00700 OPERATION OF PLANT						ĺ	7.00
8.00	00800 LAUNDRY & LINEN SERVICE						ĺ	8.00
9.00	00900 HOUSEKEEPI NG							9.00
10.00	01000 DI ETARY							10.00
11.00								11.00
	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON							12.00
	01400 CENTRAL SERVICES & SUPPLY	,						14.00
15.00	01500 PHARMACY		38, 694				ĺ	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	,	0	70, 467			1	16.00
17.00	01700 SOCIAL SERVICE		0	0	C			17.00
	01900 NONPHYSICIAN ANESTHETISTS		0	0	C	0		19.00
			0	0	C		(0 20.00
	02100 I &R SERVICES-SALARY & FRI		0	0	C C			21.00
			0	0 0				22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST		U U	0	η C	1	l	_ 23.00
30.00	03000 ADULTS & PEDIATRICS		0	4, 253	C)		30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	c		ĺ	31.00
	03400 SURGI CAL INTENSI VE CARE U	INI T	0	0				34.00
43.00	04300 NURSERY		0	224	C		<u>i</u>	43.00
E0 00	ANCI LLARY SERVICE COST CENTERS		0	11 754	C			- EO 00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	NA	0	11, 754 452				50.00 52.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	111	0	6, 646				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C		0	2,636			İ	55.00
57.00	05700 CT SCAN		0	10, 670	c		ĺ	57.00
	05900 CARDI AC CATHETERI ZATI ON		0	373				59.00
60.00	06000 LABORATORY		0	13, 736				60.00
62.30 65.00	06250 BLOOD CLOTTING FOR HEMOPH 06500 RESPIRATORY THERAPY	IT LT ACS	0	0 773				62.30 65.00
65.00	06501 SLEEP LAB		0	134				65.00
66.00	06600 PHYSI CAL THERAPY		0	1, 642			l	66.00
66.01	06601 PHYSI CAL THERAPY - LI FEPL	.EX	0	323			ĺ	66. 01
66. 02	06602 PHYSI CAL THERAPY - CULVER	MI LI TARY	0	0	C			66. 02
67.00	06700 OCCUPATI ONAL THERAPY		0	323				67.00
	06800 SPEECH PATHOLOGY		0	86				68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED		0	2, 586 0				69.00 71.00
			0	698				72.00
			38, 263	4, 696			ĺ	73.00
	07697 CARDI AC REHABI LI TATI ON		0	0	C		ĺ	76.97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	,	0	31	C		ĺ	76. 98
	07699 LI THOTRI PSY		0	0				76.99
77.00	07700 ALLOGENEI C HSCT ACQUI SI TI		0	0	C		<u> </u>	77.00
90. 01	OUTPATIENT SERVICE COST CENTERS		0	0	C			90.01
	09002 ATHLETIC TRAINERS	I JJION CIK	0	0			1	90.01
	09003 SAINT JOSEPH HEALTH CENTE	R	0	0			1	90.02
			0	810			1	90.04
91.00	09100 EMERGENCY		0	6, 389			1	91.00
92.00							<u> </u>	92.00
100.00	OTHER REIMBURSABLE COST CENTERS	5	d			1		-
102.00	DIO200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS		0	0	C)	i	102. 00
110 00		through 117)	38, 263	69, 235	C	0	1	0 118.00
118.00		«g/)	55,200	37,200				
118.00	SUBTOTALS (SUM OF LINES 1 NONREIMBURSABLE COST CENTERS					1	1	190.00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP	& CANTEEN	0	0	1			
190. 00 190. 01	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP I 19001 LIFEPLEX FITNESS FORUM		0	0	C			190. 01
190. 00 190. 01 192. 00	NONREI MBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOF I 19001 LI FEPLEX FI TNESS FORUM D 19200 PHYSI CI ANS' PRI VATE OFFI C		0 0 63		C			190. 01 192. 00
190. 00 190. 01 192. 00 192. 01	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP 19001 LIFEPLEX FITNESS FORUM 19200 PHYSICIANS' PRIVATE OFFIC 19201 FOUNDATION ADMINISTATION		0	0 415 0				190. 01 192. 00 192. 01
190. 00 190. 01 192. 00 192. 01 192. 02	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP 19001 LI FEPLEX FI TNESS FORUM 19200 PHYSI CI ANS' PRI VATE OFFI C 19201 FOUNDATI ON ADMI NI STATI ON 219202 HOSPI TALI ST		0	0				190. 01 192. 00 192. 01 192. 02
190. 00 190. 01 192. 00 192. 01 192. 02 192. 03	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOF 19001 LIFEPLEX FITNESS FORUM 19200 PHYSI CI ANS' PRI VATE OFFIC 19201 FOUNDATION ADMI NI STATI ON 219202 HOSPI TALI ST 319203 I NTENSI VI ST	ES	0	0 415 0				190. 01 192. 00 192. 01 192. 02 192. 03
190.00 190.01 192.00 192.01 192.02 192.03 192.04 194.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOF 19001 LIFEPLEX FITNESS FORUM 19200 PHYSICIANS' PRIVATE OFFIC 19201 FOUNDATION ADMINISTATION 219202 HOSPITALIST 319203 INTENSIVIST 419204 FOOT & ANKLE SPORTS MED F 07950 PLYMOUTH MOB-4	ΈS PLY	0 63 0 0 0	0 415 0 477 0				190. 01 192. 00 192. 01 192. 02
190.00 190.01 192.00 192.01 192.02 192.03 192.04 194.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP 19001 LIFEPLEX FITNESS FORUM 19200 PHYSI CIANS' PRI VATE OFFIC 19201 FOUNDATI ON ADMI NI STATI ON 219202 HOSPI TALI ST 319203 INTENSI VI ST 419204 FOOT & ANKLE SPORTS MED F 07950 PLYMOUTH MOB-4 07951 COMMUNI TY OUTREACH & PART	ΈS PLY	0 63 0 0 0	0 415 0 477 0				190. 01 192. 00 192. 01 192. 02 192. 03 192. 04

Health Fina	ancial Systems ST.	JOSEPHS REG MED	CENTER PLYMOU	JTH	In Lie	u of Form CMS	S-2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
					From 07/01/2022		ronorod.
					To 06/30/2023	Date/Time P 11/29/2023	
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVIC	E NONPHYSI CI AN	NURSI NG	
			RECORDS &		ANESTHET I STS	PROGRAM	
			LI BRARY				
		15.00	16.00	17.00	19.00	20.00	
201.00	Negative Cost Centers	0	0		0 0		0 201.00
202.00	TOTAL (sum lines 118 through 201)	38, 694	70, 467		0 0		0 202. 00

LOCATION OF CAPIT		JUSEPHS REG MEL	Provider CC		Peri od:	Worksheet B	
					From 07/01/2022 To 06/30/2023	Date/Time Pre	
		INTERNS &	RESI DENTS			11/29/2023 2:	02 p
Cost Ce	nter Description	SERVI CES-SALAR			Subtotal	Intern &	
		Y & FRI NGES	PRGM COSTS	PRGM		Residents Cost	
		APPRV	APPRV			& Post Stepdown	
						Adjustments	
		21.00	22.00	23.00	24.00	25.00	-
GENERAL SERVI	CE COST CENTERS						
00 00100 CAP REL	COSTS-BLDG & FIXT						1 1
00 00200 CAP REL	COSTS-MVBLE EQUIP						2
00400 EMPLOYE	E BENEFITS DEPARTMENT						4
00 00500 ADMI NI S	TRATIVE & GENERAL						5
1 1	ANCE & REPAIRS						6
0 00700 OPERATI							7
1 1	& LINEN SERVICE						8
							9
00 01000 DI ETARY 00 01100 CAFETER							10
	ANCE OF PERSONNEL						12
	ADMI NI STRATI ON						13
	SERVICES & SUPPLY						14
00 01500 PHARMAC							15
1 1	RECORDS & LI BRARY						16
00 01700 SOCI AL							17
	ICIAN ANESTHETISTS						19
00 02000 NURSI NO	PROGRAM						20
	VICES-SALARY & FRINGES APPRV	0					21
	VICES-OTHER PRGM COSTS APPRV		0				22
	ED PRGM-(SPECIFY)				0		23
	ITINE SERVICE COST CENTERS				500 700		1
00 03000 ADULTS					598, 730		
00 03100 I NTENSI 00 03400 SURGI CA					106, 218		
00 04300 NURSERY	L INTENSIVE CARE UNIT				0 4, 534		
	VICE COST CENTERS				4, 554	1 0	43
00 05000 OPERATI					457, 975	0	50
	Y ROOM & LABOR ROOM				5, 207	0	
	GY-DI AGNOSTI C				223, 871		
	GY-THERAPEUTI C				246, 330		
00 05700 CT SCAN					44, 181	0	57
00 05900 CARDI AC	CATHETERI ZATI ON				57, 313	0	59
00 06000 LABORAT	ORY				197, 213	0	60
	LOTTING FOR HEMOPHILIACS				0		
00 06500 RESPI RA					95, 517		
01 06501 SLEEP L					1, 141		
00 06600 PHYSI CA					168, 927		
	L THERAPY - LIFEPLEX				4, 025		
	L THERAPY - CULVER MILITARY IONAL THERAPY				2, 837	0	
00 06800 SPEECH					1, 501	0	
00 06900 ELECTRO					10, 279		
	SUPPLIES CHARGED TO PATIENT				0,277		
	EV. CHARGED TO PATIENTS				9, 283		
	HARGED TO PATIENTS				72, 723		
1 1	REHABI LI TATI ON				0		
98 07698 HYPERBA	RIC OXYGEN THERAPY				165	0	
99 07699 LI THOTE					0		
	EIC HSCT ACQUISITION				0	0	77
	RVICE COST CENTERS	1	I			1	
	ENT TREATMENT & INFUSION CTR				96		
02 09002 ATHLETI					342		
	OSEPH HEALTH CENTER				0 047	-	
04 09004 WOUND 0 00 09100 EMERGEN					90, 047 248, 787		
	TION BEDS (NON-DISTINCT PART				240, /8/	0	
	SABLE COST CENTERS					0	1 72
	TREATMENT PROGRAM				0		102
	ISE COST CENTERS	I					1.02
	LS (SUM OF LINES 1 through 117)	0	0		0 2, 647, 242	0	118
	LE COST CENTERS						
	LOWER, COFFEE SHOP & CANTEEN				7, 272	0	190
). 01 19001 LI FEPLE					28, 403		190
	ANS' PRIVATE OFFICES				394, 284		192
	I ON ADMINISTATION				0		192
2. 02 19202 HOSPI TA					1, 412		192
	VIST				0	0	192

ST. JOSEPHS REG MED CENTER PLYMOUTH In Lieu of Form CMS-2552-10 Worksheet B Part II Date/Time Prepared: 11/29/2023 2:02 pm ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0076 Peri od: From 07/01/2022 To 06/30/2023 INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Subtotal Intern & Y & FRINGES PRGM COSTS PRGM Residents Cost APPRV APPRV & Post Stepdown Adj ustments 21.00 22.00 23.00 24.00 25.00 10, 221 192.04 19204 FOOT & ANKLE SPORTS MED PLY 0 192.04 194. 00 07950 PLYMOUTH MOB-4 194. 01 07951 COMMUNI TY OUTREACH & PARTNERSHI P 0 194.00 565 1,619 0 194.01 Cross Foot Adjustments Negative Cost Centers 0 200. 00 0 201. 00 200.00 0 0 0 0 0 0 0 0 0 201.00 24, 269 0 202.00 TOTAL (sum lines 118 through 201) 0 202.00 3, 115, 287

In Lieu of Form CMS-2552-10 Worksheet B

ALLOON		OF CAPITAL RELATED COSTS		Provider CCN: 15-0076	Period: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Pr	
		Cost Center Description	Total 26.00		11/29/2023 2	2:02 p
	GENER	AL SERVICE COST CENTERS	20.00			
1.00	00100	CAP REL COSTS-BLDG & FIXT				1
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4
5.00		ADMINISTRATIVE & GENERAL				5
6.00	1	MAINTENANCE & REPAIRS				6
		OPERATION OF PLANT				7
		LAUNDRY & LINEN SERVICE				8
	1	HOUSEKEEPING				9
	1	DIETARY				10
						11
		MAINTENANCE OF PERSONNEL				12
						13
		CENTRAL SERVICES & SUPPLY PHARMACY				14
		MEDICAL RECORDS & LIBRARY				16
		SOCIAL SERVICE				17
		NONPHYSICIAN ANESTHETISTS				19
		NURSI NG PROGRAM				20
		I &R SERVICES-SALARY & FRINGES APPRV				21
		I &R SERVICES-OTHER PRGM COSTS APPRV				22
		PARAMED ED PRGM-(SPECIFY)				23
		I ENT ROUTI NE SERVI CE COST CENTERS				- ٦
30. 00		ADULTS & PEDIATRICS	598, 730			30
		INTENSIVE CARE UNIT	106, 218			31
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0			34
	1	NURSERY	4, 534			43
	ANCI L	LARY SERVICE COST CENTERS				
60.00	05000	OPERATING ROOM	457, 975			50
52.00	05200	DELIVERY ROOM & LABOR ROOM	5, 207			52
54.00	05400	RADI OLOGY-DI AGNOSTI C	223, 871			54
5.00	05500	RADI OLOGY-THERAPEUTI C	246, 330			55
7.00	05700	CT SCAN	44, 181			57
		CARDI AC CATHETERI ZATI ON	57, 313			59
	1	LABORATORY	197, 213			60
	1	BLOOD CLOTTING FOR HEMOPHILIACS	0			62
		RESPI RATORY THERAPY	95, 517			65
		SLEEP LAB	1, 141			65
		PHYSICAL THERAPY	168, 927			66
		PHYSICAL THERAPY - LIFEPLEX	4, 025			66
		PHYSI CAL THERAPY - CULVER MILITARY OCCUPATI ONAL THERAPY	0			66
		SPEECH PATHOLOGY	2, 837 1, 501			67
		ELECTROCARDI OLOGY	10, 279			68
		MEDICAL SUPPLIES CHARGED TO PATIENT	10, 279			71
		IMPL. DEV. CHARGED TO PATIENTS	9, 283			72
		DRUGS CHARGED TO PATIENTS	72, 723			73
		CARDI AC REHABI LI TATI ON	0			76
		HYPERBARI C OXYGEN THERAPY	165			76
		LI THOTRI PSY	0			76
		ALLOGENEIC HSCT ACQUISITION	Ő			77
		TIENT SERVICE COST CENTERS				
0. 01		OUTPATIENT TREATMENT & INFUSION CTR	96			90
		ATHLETI C TRAI NERS	342			90
0. 03	09003	SAINT JOSEPH HEALTH CENTER	0			90
0. 04	09004	WOUND CARE	90, 047			90
		EMERGENCY	248, 787			91
		OBSERVATION BEDS (NON-DISTINCT PART				92
	OTHER	REIMBURSABLE COST CENTERS				
02.00		OPIOID TREATMENT PROGRAM	0			102
		AL PURPOSE COST CENTERS				
18.00		SUBTOTALS (SUM OF LINES 1 through 117)	2, 647, 242			118
		MBURSABLE COST CENTERS				
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,272			190
		LIFEPLEX FITNESS FORUM	28, 403			190
		PHYSICIANS' PRIVATE OFFICES	394, 284			192
		FOUNDATION ADMINISTATION	0			192
		HOSPI TALI ST	1, 412			192
			0			192
		FOOT & ANKLE SPORTS MED PLY	10, 221			192
		PLYMOUTH MOB-4	565			194
94.01		COMMUNITY OUTREACH & PARTNERSHIP	1, 619			194
100 00	i -	Cross Foot Adjustments	0			200
200.00 201.00		Negative Cost Centers	24, 269			201

ST INSERHS REG MED CENTER PLYMOUTH

		JOSEPHS REG MEI	CENTER PLYMOU		In Lie	u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provider CC	F	eriod: rom 07/01/2022 o 06/30/2023	Worksheet B-1 Date/Time Pre	
			_ATED COSTS		00,00,2020	11/29/2023 2:	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	& GENERAL	
				DEPARTMENT (GROSS		(ACCUM COST)	
		1.00	2.00	SALARI ES) 4. 00	5A	5.00	
	GENERAL SERVICE COST CENTERS					0100	
	00100 CAP REL COSTS-BLDG & FIXT	160, 655	1 1				1.00
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	160, 655 0	18, 732, 838			2.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	17, 897	17, 897	1, 029, 122		38, 589, 843	
	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6.0
	00700 OPERATION OF PLANT	33, 848	33, 848	479, 026	0	2, 774, 084	
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	606 300	606 300	0 320, 792	0	162, 433 556, 763	
	01000 DI ETARY	2, 097	2,097	341, 485		678, 788	
	01100 CAFETERI A	2,008		45, 940		0	
	01200 MAINTENANCE OF PERSONNEL	0	0	0	-	0	
	01300 NURSI NG ADMI NI STRATI ON	0	0	652, 357		782, 643	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	4, 671 1, 241	4, 671 1, 241	0 684, 147	-	90, 576 631, 209	
	01600 MEDICAL RECORDS & LIBRARY	2, 514	2, 514	369, 467		518, 043	
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.0
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
	02000 NURSING PROGRAM 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	-	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	L					
	03000 ADULTS & PEDIATRICS	19, 388		2, 733, 964		3, 970, 538	
	03100 I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T	3, 718	3, 718 0	14, 789 0	0	87, 043 0	
	04300 NURSERY	0	Ő	249, 384	0	372, 247	
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	14, 579		2, 267, 449		4, 293, 210	
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	0 7, 264	249, 384 1, 195, 686		372, 247 1, 610, 716	
	05500 RADI OLOGY-THERAPEUTI C	9,050	9, 050	308, 948		537, 334	
	05700 CT SCAN	419		106, 204		177, 099	
	05900 CARDI AC CATHETERI ZATI ON	2, 123		73, 539		149, 324	
	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	4, 346	4, 346	1, 718, 412	0	4, 389, 727 0	
	06500 RESPIRATORY THERAPY	3, 317	3, 317	372, 863	-	787, 977	
	06501 SLEEP LAB	0	0	43, 665	0	71, 573	
6.00	06600 PHYSI CAL THERAPY	5,847	5, 847	849, 001		1, 295, 616	
	06601 PHYSI CAL THERAPY - LI FEPLEX 06602 PHYSI CAL THERAPY - CULVER MI LI TARY	0	0	109, 313 0		309, 528 0	
	06700 OCCUPATI ONAL THERAPY	0	0	150, 796	Ű	181, 731	
68.00	06800 SPEECH PATHOLOGY	0	0	100, 762		121, 735	
	06900 ELECTROCARDI OLOGY	0	0	189, 266		245, 916	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 802, 838	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	2, 288, 113	
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	3, 955	0	7, 261	
		0	0	0	0	0	
	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77.0
	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0	7, 646	0	8, 971	90.0
90. 02	09002 ATHLETI C TRAI NERS	0	0	61, 395		12, 476	90.0
	09003 SAINT JOSEPH HEALTH CENTER	0	0	0	0	0	
		0.407		470 000		751, 652	90.0
0. 04	09004 WOUND CARE	3, 126 7, 339		179, 958 2 222 147			
90. 04 91. 00		3, 126 7, 339		179, 958 2, 222, 147		4, 053, 181	91.0
90.04 91.00 92.00	09004 WOUND CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	7, 339	7, 339	2, 222, 147	0	4, 053, 181	91. C 92. C
90.04 91.00 92.00	09004 WOUND CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM		7, 339		0	4, 053, 181	91.0 92.0
90. 04 91. 00 92. 00 02. 00	09004 WOUND CARE 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	7, 339	7, 339	2, 222, 147	0	4, 053, 181	91. 0 92. 0 102. 0
90. 04 91. 00 92. 00 102. 00 118. 00 190. 00	09004 WOUND CARE 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LI NES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	7, 339	7, 339	2, 222, 147	0	4, 053, 181	91. 0 92. 0 102. 0 118. 0
90. 04 91. 00 92. 00 102. 00 118. 00 190. 00 190. 01	09004 WOUND CARE 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LI NES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 LI FEPLEX FI TNESS FORUM	7, 339 0 145, 698 274 0	7, 339 0 145, 698 274 0	2, 222, 147 0 17, 130, 862 0 467, 422	0 0 -13, 489, 408 0 0	4, 053, 181 0 33, 092, 592 23, 542 2, 908, 310	91. 00 92. 00 102. 00 118. 00 190. 00 190. 0
90. 04 91. 00 92. 00 102. 00 118. 00 190. 00 190. 01 192. 00	09004 WOUND CARE 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 LIFEPLEX FITNESS FORUM 19200 PHYSICIANS' PRIVATE OFFICES	7, 339	7, 339 0 145, 698 274 0	2, 222, 147 0 17, 130, 862 0 467, 422 821, 317	0 0 -13, 489, 408 0 0	4, 053, 181 0 33, 092, 592 23, 542 2, 908, 310 1, 447, 497	91. 0 92. 0 102. 0 118. 0 190. 0 190. 0 192. 0
 90. 04 91. 00 92. 00 102. 00 118. 00 190. 00 190. 01 192. 00 192. 01 	09004 WOUND CARE 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LI NES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 LI FEPLEX FI TNESS FORUM	7, 339 0 145, 698 274 0	7, 339 0 145, 698 274 0	2, 222, 147 0 17, 130, 862 0 467, 422	0 0 -13, 489, 408 0 0	4, 053, 181 0 33, 092, 592 23, 542 2, 908, 310 1, 447, 497 0	91. 0 92. 0 102. 0 118. 0 190. 0 190. 0

ST. JOSEPHS REG MED CENTER PLYMOUTH Provider CCN: 15-0076 Period:

In Lieu of Form CMS-2552-10 Worksheet B-1

Cost Center Description CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE & GENERAL (ACCUM COST) 192.04 FOOT & ANKLE SPORTS MED PLY 194.00 0 0 210.7 5A 5.00 192.04 FOOT & ANKLE SPORTS MED PLY 194.00 0 0 211.712 0 917.050 192.04 192.04 FOOT & ANKLE SPORTS MED PLY 194.00 0 0 0 211.712 0 917.050 192.04 192.04 FOOT & ANKLE SPORTS MED PLY 194.00 0 0 0 101.525 0 917.050 192.04 192.04 COMUNI TY OUTREACH & PARTNERSHIP 200.00 0 <th>COST ALL</th> <th>LOCAI</th> <th>ION - STATISTICAL BASIS</th> <th></th> <th>Provider C</th> <th></th> <th>eriod: From 07/01/2022</th> <th>Worksheet B-1</th> <th></th>	COST ALL	LOCAI	ION - STATISTICAL BASIS		Provider C		eriod: From 07/01/2022	Worksheet B-1	
Cost Center Description BLDG & FIXT (SOUARE FEET) MVBLE EQUIP (SOUARE FEET) EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) Reconciliation & ADMINISTRATIVE & GENERAL (ACCUM COST) 192. 04/19204 FOOT & ANKLE SPORTS MED PLY 0 0 5A 5.00 192. 04/19204 FOOT & ANKLE SPORTS MED PLY 0 0 0 211, 712 0 977, 050 192. 04 194. 0107950 PLYMOUTH MOB-4 0 0 0 0 62, 809 194. 00 200. 00 Cross Foot Adjustments 0 0 0 101, 525 0 138, 043 194. 01 200. 00 Cost to be allocated (per Wkst. B, Part I) 3, 114, 973 314 200, 679 13, 507, 510 202. 00 201. 00 202. 00 347, 044 204. 00 347, 044 204. 00 205. 00 347, 044 204. 00 205. 00 0. 000000 0. 000000 0. 008993 205. 00 206. 00 206. 00 206. 00 206. 00 207. 00								Date/Time Pre	
BLDG & FLXT (SQUARE FEET) NVBLE EQUIP (SQUARE FEET) EMPLOYEE (SQUARE FEET) Reconciliation ADMINISTRATIVE & GENERAL (ACCUM COST) 192.04/19204 FOOT & ANKLE SPORTS MED PLY 0 0 2.00 4.00 5A 5.00 194.00/07950 PLYMOUTH MOB-4 0 0 211,712 0 917,050 192.04 100 Cross Foot Adjustments 0 0 0 0 200.00 201.01,525 0 138,043 194.01 200.00 Cross Foot Adjustments 3,114,973 314 200,679 13,507,510 202.00 201.00 Negative Cost Centers 3,114,973 314 200,679 13,507,510 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.001954 0.010713 0.350028 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.001954 0.000000 0.008993 205.00 11) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0 0.000000 0.008993 205.00 20								11/29/2023 2:	02 pm
Image: Source of the second				CAPITAL REL	LATED COSTS				
Image: Source of the second							L		
Image: Note of the second state of the seco			Cost Center Description				Reconciliation		
Image: Construction of the second systems				(SQUARE FEET)	(SQUARE FEET)				
Image: Note of the second se								(ACCUM COST)	
I.00 2.00 4.00 5A 5.00 192.04 FOOT & ANKLE SPORTS MED PLY 0 0 211,712 0 917,050 192.04 194.00 07950 PLYMOUTH MOB-4 0 0 0 0 62,809 194.00 194.01 07951 COMMUNI TY OUTREACH & PARTNERSHI P 0 0 0 0 62,809 194.00 200.00 Cross Foot Adjustments 0 0 0 101,525 0 138,043 194.01 200.00 Cost to be allocated (per Wkst. B, Part I) 0 0 0 0 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 19.389207 0.001954 0.010713 0.350028 203.00 204.00 Part II) 19.389207 0.001954 0.010713 0.008993 205.00 205.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.000000 0.008993 205.00 206.00 What adjustment amount to be allocated (per Wkst. B, Part II) 0.0000000 0.008993									
192. 04 192.04 FOOT & ANKLE SPORTS MED PLY 0 0 0 0 171, 712 0 917, 050 192. 04 194. 00 07950 PLYMOUTH MOB-4 0 0 0 0 0 62, 809 194. 00 194. 01 07951 COMMUNI TY OUTREACH & PARTNERSHIP 0 0 0 101, 525 0 138, 043 194. 01 200. 00 Cross Foot Adjustments 0 0 0 0 101, 525 0 138, 043 194. 01 200. 00 Cost to be allocated (per Wkst. B, Part I) 0 314 200, 679 13, 507, 510 202. 00 203. 00 Unit cost multiplier (Wkst. B, Part I) 19. 389207 0. 001954 0. 010713 0. 350028 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part I) 19. 389207 0. 001954 0. 010713 0. 350028 203. 00 205. 00 Unit cost multiplier (Wkst. B, Part I) 19. 389207 0. 000000 0. 008993 205. 00 10 NAHE adjustment amount to be allocated (per				1.00	2.00	<i>(</i>		F 00	
194.00 07950 PLYMOUTH MOB-4 0 0 0 62,809 194.00 194.01 07951 COMMUNI TY OUTREACH & PARTNERSHIP 0 0 101,525 0 138,043 194.01 200.00 Cross Foot Adjustments 200.00 201.00 202.00 205 to be allocated (per Wkst. B, Part I) 314 200,679 13,507,510 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.001954 0.010713 0.350028 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 19.389207 0.001954 0.010713 0.350028 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.000000 0.000000 0.008993 205.00 11) Unit cost multiplier (Wkst. B, Part I) 19.389207 0.000000 0.000000 0.008993 205.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.008993 205.00 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 207.00 207.00 207.00	100.044	0004	FOOT & ANIXI E COORTE MED DI V	1.00	2.00				100.01
194.01 07951 COMMUNITY OUTREACH & PARTNERSHIP 0 0 101,525 0 138,043 194.01 200.00 200.00 Cross Foot Adjustments Negative Cost Centers 201.00 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 3114,973 314 200,679 13,507,510 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.001954 0.010713 0.350028 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 19.389207 0.001954 0.000000 0.350028 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.001954 0.000000 0.008993 205.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 0.008993 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 0 0 206.00 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0 0 207.00 207.00				0	0	211, /1.	2 0		
200.00 Cross Foot Adjustments 200.00 200.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 3, 114, 973 314 200, 679 13, 507, 510 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.001954 0.010713 0.350028 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 19.389207 0.001954 0.010713 0.350028 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.001954 0 0.000000 0.008993 205.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.008993 205.00 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 207.00 207.00 207.00				0	0		0		
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 3,114,973 314 200,679 13,507,510 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.001954 0.010713 0.350028 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 19.389207 0.001954 0.010713 0.350028 203.00 205.00 Unit cost multiplier (Wkst. B, Part II) 19.389207 0.001954 0.000000 0.008993 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 0.000000 206.00 206.00 206.00 206.00 207.00 207.00 207.00				0	0	101, 52	0		
202.00 Cost to be allocated (per Wkst. B, Part I) 3, 114, 973 314 200, 679 13, 507, 510 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.001954 0.010713 0.350028 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 19.389207 0.001954 0.010713 0.350028 203.00 205.00 Unit cost multiplier (Wkst. B, Part II) 19.389207 0.001954 0 0.000000 205.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.000000 205.00 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 206.00 206.00 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.00 207.00			3						
Part I) Part I) 19.389207 0.001954 0.010713 0.350028 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 19.389207 0.001954 0.010713 0.350028 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.001954 0 0 347,044 204.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.008993 205.00 0 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0 207.00 207.00 207.00			8						
203.00 Unit cost multiplier (Wkst. B, Part I) 19.389207 0.001954 0.010713 0.350028 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 19.389207 0.001954 0 0 347,044 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0 0.000000 0.008993 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0 0 0 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0 0 207.00 207.00	202.00			3, 114, 973	314	200, 679	9	13, 507, 510	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) 0 347,044 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.008993 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00									
Part II) 0.000000 0.008993 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.008993 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00				19. 389207	0. 001954	0. 010713	3		
205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.008993 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	204.00)	347, 044	204.00
206.00II) NAHE adjustment amount to be allocated (per Wkst. B-2)206.00207.00NAHE unit cost multiplier (Wkst. D,207.00			· · ·						
206.00NAHE adjustment amount to be allocated (per Wkst. B-2)206.00207.00NAHE unit cost multiplier (Wkst. D,207.00	205.00					0.00000)	0. 008993	205.00
(per Wkst. B-2)207.00NAHE unit cost multiplier (Wkst. D,207.00	001 00								001 00
207.00 NAHE unit cost multiplier (Wkst. D, 207.00	206.00								206.00
	207 00								207 00
	207.00								207.00
				1	l	I	1	l	

Heal th Financial	Systems
COCT ALLOCATION	

Heal th	Financial Systems ST.	JOSEPHS REG ME	D CENTER PLYMOU	JTH	In Lie	u of Form CMS-	2552-10
	ALLOCATION - STATISTICAL BASIS		Provider C		eriod:	Worksheet B-1	
					rom 07/01/2022 o 06/30/2023	Date/Time Pre 11/29/2023 2:	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (GROSS REVE	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	
		(00	7.00	NUE)	0.00	10.00	
	GENERAL SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
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
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	109 010				6.00 7.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	0	108, 910 606				8.00
9.00	00900 HOUSEKEEPI NG	0	300		108, 004		9.00
10.00	01000 DI ETARY	0	2, 097			16, 074	10.00
11.00	01100 CAFETERI A	0	2, 008	0	2,008	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	4,671	0		0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 241 2, 514		1, 241 2, 514	0	
17.00	01700 SOCIAL SERVICE	0	2, 314	0	2, 314	0	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22.00	02200 I & R SERVICES-OTHER PRGM COSTS APPRV	0		0	-	0	
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	19, 388	13, 250, 485	19, 388	12, 104	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	3, 718		3, 718	2, 578	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0,710	0	0	0	
43.00	04300 NURSERY	0	0	698, 100	0	0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	,		14, 579	1, 250	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	-	.,		0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	7, 264 9, 050			0	
57.00	05700 CT SCAN		419			0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	2, 123			-	1
60.00	06000 LABORATORY	0	4, 346			0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
65.00	06500 RESPI RATORY THERAPY	0	3, 317	2, 407, 269		0	
65.01	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	0	0	416, 036		0	
66. 00 66. 01	06601 PHYSICAL THERAPY	0	5, 847	5, 115, 051 1, 006, 220	5, 847	0	66.00 66.01
66. 02	06602 PHYSI CAL THERAPY - CULVER MILLITARY	0	0	1,000,220	0	0	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1, 007, 688	0	0	
68.00	06800 SPEECH PATHOLOGY	0	0	268, 257		0	
	06900 ELECTROCARDI OLOGY	0	0	8, 056, 872	0	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	2, 173, 620		0	
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	0	14, 629, 042	0	0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	97, 320	0	0	
	07699 LI THOTRI PSY	0	0	0	0	0	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0	0	
	09002 ATHLETIC TRAINERS	0	0	0	0	0	
	09003 SAINT JOSEPH HEALTH CENTER		3, 126	2, 523, 948	3, 126	0	
	09100 EMERGENCY		7, 339		7, 339		90.04
	09200 OBSERVATION BEDS (NON-DISTINCT PART		1		,,,		92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS	_					
118.00		0	93, 953	215, 988, 220	93, 047	16,074	118.00
190 00	NONREIMBURSABLE COST CENTERS	0	274	0	274	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2/4		2/4		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	14, 683	1, 291, 299	14, 683		192.00
	19201 FOUNDATION ADMINISTATION	0	0	0	0		192.01
192.02	19202 HOSPI TALI ST	0	0	1, 487, 357	0	0	192.02
	19203 I NTENSI VI ST	0	0	316			192.03
	19204 FOOT & ANKLE SPORTS MED PLY	0	0	1, 058, 685	0		192.04
	07950 PLYMOUTH MOB-4 07951 COMMUNITY OUTREACH & PARTNERSHIP	0	0		0		194.00 194.01
194.01	UT751 COMMUNITY OUTREACH & PARTNERSHIP	0	'I U	I U	0	0	1194.01

Health Financial Systems ST. JOSEPHS REG MED CENTER PLYMOUTH In Lieu of Form CMS-2552-10

COST AL	LOCATION - STATISTICAL BASIS		Provider C		Period: From 07/01/2022	Worksheet B-1	
					To 06/30/2023	Date/Time Pre 11/29/2023 2:	pared: 02 pm
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS REVE			
				NUE)			
		6.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	0	3, 745, 091	240, 128	3 761, 962	1, 003, 304	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	34. 387026	0. 001092	2 7.054942	62. 417818	203.00
204.00	Cost to be allocated (per Wkst. B,	0	681, 301	17, 003	3 12, 702	60, 133	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	6. 255633	0.000077	0. 117607	3. 741010	205.00
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Heal th Financial	Systems			
MOLTADOLIA T200				

ealth Financial Systems ST.	JOSEPHS REG MEI) CENTER PLYM	OUTH	ln Li€	eu of Form CMS-	2552-
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 15-0076	Peri od:	Worksheet B-1	
				From 07/01/2022		
				To 06/30/2023	Date/Time Pre 11/29/2023 2:	
Cost Center Description	CAFETERI A	MAINTENANCE C	OF NURSI NG	CENTRAL	PHARMACY	
	(MEALS SERVED)		ADMI NI STRATI		(COSTED	
	,	(NUMBER		SUPPLY	REQUIS.)	
		HOUSED)	(DI RECT NRSI		, í	
		,	HRS)	REQUIS.)		
	11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS	·				•	
. 00 00100 CAP REL COSTS-BLDG & FIXT						1.
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.
1.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.
5. 00 00500 ADMINISTRATIVE & GENERAL						5.
0.00 00600 MAINTENANCE & REPAIRS						6.
2.00 00700 OPERATION OF PLANT						7.
3.00 00800 LAUNDRY & LINEN SERVICE						8.
2. 00 00900 HOUSEKEEPI NG						9.
0. 00 01000 DI ETARY						10.
1.00 01100 CAFETERIA	18, 839					11.
2.00 01200 MAINTENANCE OF PERSONNEL	0		0			12.
3. 00 01300 NURSING ADMINISTRATION	515		0 18, 3			13.
4.00 01400 CENTRAL SERVICES & SUPPLY	0		0	0 219, 809, 875		14.
5. 00 01500 PHARMACY	555			55 0	2, 168, 153	
6.00 01600 MEDICAL RECORDS & LIBRARY	550		0 5	50 0	0	
7.00 01700 SOCIAL SERVICE	0		0	0 0	0	
9.00 01900 NONPHYSI CLAN ANESTHETI STS	0		0	0 0	0	
20. 00 02000 NURSI NG PROGRAM	0		0	0 0	0	
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0		0	0 0	0	
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0		0	0 0	0	
3. 00 02300 PARAMED ED PRGM-(SPECIFY)	0		0	0 0	0	23.
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.000					
0.00 03000 ADULTS & PEDIATRICS	2, 998		0 2,9			
1. 00 03100 INTENSIVE CARE UNIT	0		0	0 0	-	
4.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0		0	0 0	-	
3. 00 04300 NURSERY	278		0 2	78 698, 100	0	43.
ANCI LLARY SERVI CE COST CENTERS	0.00(0/ 0/ /45 007		5
0.00 05000 OPERATING ROOM	2, 296		0 2, 2			
2. 00 05200 DELIVERY ROOM & LABOR ROOM	278			78 1, 408, 294		
4. 00 05400 RADI OLOGY -DI AGNOSTI C	1, 374		0 1, 3			
5. 00 05500 RADI OLOGY-THERAPEUTI C	286			86 8, 211, 293		
77.00 05700 CT SCAN	132			32 33, 240, 332		
9. 00 05900 CARDI AC CATHETERI ZATI ON 0. 00 06000 LABORATORY	90			90 1, 162, 386		
	2, 574		0 2,5			
	-				-	
5. 00 06500 RESPI RATORY THERAPY 5. 01 06501 SLEEP LAB	365			65 2, 407, 269 54 416, 036		
6. 00 06600 PHYSI CAL THERAPY	54			54 416, 036 44 5, 115, 051		
6. 01 06601 PHYSICAL THERAPY - LIFEPLEX	152				-	
	0		0			
6. 02 06602 PHYSI CAL THERAPY - CULVER MILLITARY						
7. 00 06700 OCCUPATI ONAL THERAPY	131			31 1, 007, 688		
8. 00 06800 SPEECH PATHOLOGY 9. 00 06900 ELECTROCARDI OLOGY	80			80 268, 257		
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		2	24 8, 056, 872 0 0		
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0			
3. 00 07200 TMPL. DEV. CHARGED TO PATTENTS 3. 00 07300 DRUGS CHARGED TO PATTENTS	0		0	0 2, 173, 620 0 14, 629, 042		
6. 97 07697 CARDI AC REHABI LI TATI ON	0		0	0 14, 029, 042	2, 143, 981	
6. 98 07698 HYPERBARI C OXYGEN THERAPY	1		0	4 97, 320		
6. 99 07699 LI THOTRI PSY	4		0	4 97, 320	0	
7. 00 07700 ALLOGENEIC HSCT ACQUISITION	0		0		0	
OUTPATIENT SERVICE COST CENTERS	0		9	0 0	0	· / · ·
D. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	8		0	8 0	0	90.
0. 02 09002 ATHLETIC TRAINERS	122		0 1	22 0	0	
0. 03 09003 SAINT JOSEPH HEALTH CENTER	0		ŏ	0 0		
0. 04 09004 WOUND CARE	187		0 1	87 2, 523, 948	, °	
1. 00 09100 EMERGENCY	2,036		0 2,0		0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,000		2,0		Ĭ	92.
OTHER REIMBURSABLE COST CENTERS						1
D2. 00 10200 OPI OI D TREATMENT PROGRAM	0		0	0 0	0	102.
SPECIAL PURPOSE COST CENTERS			-1			1
18.00 SUBTOTALS (SUM OF LINES 1 through 117)	16, 233		0 15, 7	18 215, 972, 218	2, 143, 981	1118
NONREI MBURSABLE COST CENTERS			,	,,,,		1
90. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0 0		190.
90. 01 19001 LI FEPLEX FI TNESS FORUM	1, 194		0 1, 1	-		190.
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	892			92 1, 291, 299		
92. 01 19201 FOUNDATION ADMINISTATION	072		ő	0 0		192.
92. 02 19201 FOUNDATION ADMINISTRITION 92. 02 19202 HOSPI TALI ST			ő	0 1, 487, 357		192.
92. 03 19202 HOSPITALIST 92. 03 19203 I NTENSI VI ST			ő	0 1, 487, 357		192.
92.04 19203 INTENSIVIST 92.04 19204 FOOT & ANKLE SPORTS MED PLY	319		0 2	19 1, 058, 685		
					. /// D133	117/
94. 00 07950 PLYMOUTH MOB-4	0			0 0		194.

Health Financial Systems

ST. JOSEPHS REG MED CENTER PLYMOUTH

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 15-0076			Worksheet B-1	
					From 07/01/2022 To 06/30/2023		
	Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
		(MEALS SERVED)		ADMI NI STRATI O		(COSTED	
			(NUMBER		SUPPLY	REQUIS.)	
			HOUSED)	(DIRECT NRSIN	G (COSTED		
				HRS)	REQUIS.)		
		11.00	12.00	13.00	14.00	15.00	
194.010795	1 COMMUNI TY OUTREACH & PARTNERSHIP	201	0	20	1 0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	65, 113	0	1, 058, 37	0 315, 856	937, 553	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3. 456287	0. 000000	57.75867	7 0. 001437	0. 432420	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	51, 735	0	7, 78	9 121, 160	38, 694	204.00
205.00	Unit cost multiplier (Wkst. B, Part	1. 457933	0. 000000	0. 42507	1 0. 000551	0. 017847	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Heal th	Financial Systems ST.	JOSEPHS REG ME	D CENTI	ER PLYMOU	JTH		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Pr	ovider C	CN: 15-0076		ri od:	Worksheet B-1	
						Fro	om 07/01/2022 06/30/2023	Date/Time Pre	nared
							00/ 30/ 2023	11/29/2023 2:	
								INTERNS &	
		MEDLOAL	600L AL					RESI DENTS	
	Cost Center Description	MEDI CAL RECORDS &	SUCTAL	SERVI CE	NONPHYSI CI A ANESTHETI ST		NURSI NG PROGRAM	SERVICES-SALAR Y & FRINGES	
		LI BRARY		SPENT)	(ASSI GNED	3	(ASSI GNED	APPRV	
		(GROSS REVE		_ JILINI)	TIME)		TIME)	(ASSI GNED	
		NUE)						TIME)	
		16.00	1	7.00	19.00		20.00	21.00	
	GENERAL SERVICE COST CENTERS				1				
1.00	00100 CAP REL COSTS-BLDG & FIXT								1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP								2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT								4.00
5.00	00500 ADMINI STRATI VE & GENERAL								5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT								6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE								8.00
9.00	00900 HOUSEKEEPING								9.00
10.00	01000 DI ETARY								10.00
11.00	01100 CAFETERIA								11.00
12.00	01200 MAINTENANCE OF PERSONNEL								12.00
13.00	01300 NURSI NG ADMI NI STRATI ON								13.00
14.00	01400 CENTRAL SERVICES & SUPPLY								14.00
15.00	01500 PHARMACY								15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	219, 809, 875							16.00
17.00	01700 SOCIAL SERVICE	0		0					17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0		0		0			19.00
20.00	02000 NURSI NG PROGRAM	0		0			0	0	20.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV			0				0	21.00 22.00
22.00	02300 PARAMED ED PRGM-(SPECIFY)			0					22.00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		<u>′</u>	0	1				23.00
30.00	03000 ADULTS & PEDIATRICS	13, 250, 485	1	0		0	0	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	0		0		0	0	0	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0)	0	0	0	34.00
43.00	04300 NURSERY	698, 100		0		0	0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS		1		1				
50.00	05000 OPERATING ROOM	36, 615, 827		0		0	0	0	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 408, 294		0		0	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 702, 569		0		0	0	0	54.00
55.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	8, 211, 293 33, 240, 332		0		0	0	0	55.00 57.00
57.00	05900 CARDI AC CATHETERI ZATI ON	1, 162, 386		0		0	0	0	59.00
60.00	06000 LABORATORY	43, 077, 838		0		0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0		0	0	0	62.30
65.00	06500 RESPI RATORY THERAPY	2, 407, 269		0)	0	0	0	65.00
65.01	06501 SLEEP LAB	416, 036		0)	0	0	0	65.01
66.00	06600 PHYSI CAL THERAPY	5, 115, 051		0		0	0	0	66.00
66. 01	06601 PHYSI CAL THERAPY - LI FEPLEX	1,006,220		0		0	0	0	66. 01
66. 02	06602 PHYSI CAL THERAPY - CULVER MILITARY	0	1	0		0	0	0	66. 02
67.00	06700 OCCUPATIONAL THERAPY	1,007,688		0		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	268, 257		0		0	0	0	
	06900 ELECTROCARDI OLOGY	8, 056, 872	1	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1	0		0	0	0	71.00
72.00 73.00	07200 TMPL. DEV. CHARGED TO PATIENTS	2, 173, 620 14, 629, 042		0		0	0	0	72.00 73.00
76.97	07697 CARDI AC REHABI LI TATI ON	14, 029, 042		0		0	0	0	76.97
	07698 HYPERBARI C OXYGEN THERAPY	97, 320		0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0		0	0	0	1
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		0)	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0		0)	0	0	0	90.01
90.02	09002 ATHLETI C TRAI NERS	0		0		0	0	0	1
	09003 SAINT JOSEPH HEALTH CENTER	0		0		0	0	0	90.03
90.04		2, 523, 948		0		0	0	0	90.04
91.00	09100 EMERGENCY	19, 903, 771		0		0	0	0	91.00
92.00									92.00
100.00	OTHER REIMBURSABLE COST CENTERS				1			0	102.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	2	0	1	0	0	0	102.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	215, 972, 218		0		0	0	^	118.00
110.00	NONREIMBURSABLE COST CENTERS	213, 7/2, 218	1	0	1	J	0	0	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0		0	0	0	190.00
	19001 LIFEPLEX FITNESS FORUM	1 0		0		õ	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 291, 299		0		0	0		192.00
	19201 FOUNDATI ON ADMINI STATI ON	0		0		0	0	0	192.01
	19202 HOSPI TALI ST	1, 487, 357		0		0	0		192. 02
192.03	3 19203 I NTENSI VI ST	316		0	1	0	0	0	192.03

near th i mai	ici ai 5ystellis 51.	JUSEI IIS KEU WE					2552-10
COST ALLOCATION - STATISTICAL BASIS			Provider CO		Peri od:	Worksheet B-1	
					From 07/01/2022		
					To 06/30/2023		pared:
						11/29/2023 2:	02 pm
						INTERNS &	
						RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL SERVI CE			SERVI CES-SALAR	
		RECORDS &		ANESTHETI STS	PROGRAM	Y & FRINGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
		(GROSS REVE		TIME)	TIME)	(ASSI GNED	
		NUE)				TIME)	
		16.00	17.00	19.00	20.00	21.00	
192.04 19204	FOOT & ANKLE SPORTS MED PLY	1, 058, 685	0		0 0	0	192.04
194.0007950	PLYMOUTH MOB-4	C	0		0 0	0	194.00
194.0107951	COMMUNI TY OUTREACH & PARTNERSHIP	C	0		0 0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	837, 226	0		0 0	0	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 003809	0. 000000	0. 00000	0.000000	0. 000000	203.00
204.00	Cost to be allocated (per Wkst. B,	70, 467	0		0 0	0	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000321	0. 000000	0. 00000	0 0.00000	0.000000	205.00
	11)						
206.00	NAHE adjustment amount to be allocated				0		206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,	1			0.00000		207.00
	Parts III and IV)						
			•	•		•	•

Health Financial Systems		JOSEPHS REG MED				u of Form CMS-2552-
COST ALLOCATION - STATI	STI CAL BASI S		Provider C	CN: 15-0076	Period: From 07/01/2022 To 06/30/2023	Worksheet B-1 Date/Time Prepared
Cost Center	Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV (ASSI GNED TIME)	PRGM (ASSI GNED TI ME)	_		<u>11/29/2023 2:02 pm</u>
GENERAL SERVICE C	OST CENTERS	22.00	23.00			
GENERAL SERVICE C 1.00 00100 CAP REL COS 2.00 00200 CAP REL COS	TS-BLDG & FIXT					1. (
4. 00 00400 EMPLOYEE BE 5. 00 00500 ADMI NI STRAT						4. (
6. 00 00600 MAI NTENANCE						6. (
7.00 00700 OPERATION 0						7. (
8.00 00800 LAUNDRY & L 9.00 00900 HOUSEKEEPIN						8. (
10. 00 01000 DI ETARY	5					10. (
11. 00 01100 CAFETERI A						11. (
12.00 01200 MAI NTENANCE 13.00 01300 NURSI NG ADM						12. (
14.00 01400 CENTRAL SER						13.0
15.00 01500 PHARMACY						15. (
16.00 01600 MEDI CAL REC						16. (
17.00 01700 SOCIAL SERV 19.00 01900 NONPHYSICIA						17. (19. (
20. 00 02000 NURSI NG PRO						20. 0
	S-SALARY & FRINGES APPRV					21. (
22.00 02200 I &R SERVICE 23.00 02300 PARAMED ED	S-OTHER PRGM COSTS APPRV	0	0			22. (
	SERVICE COST CENTERS		0	/		23.0
30.00 03000 ADULTS & PE	DI ATRI CS	0	0	1		30. (
31.00 03100 I NTENSI VE C		0	0	•		31. (
34.00 03400 SURGI CAL IN 43.00 04300 NURSERY	TENSIVE CARE UNIT	0	0			34. (
ANCI LLARY SERVI CE	COST CENTERS					
50.00 05000 OPERATING R		0	0			50.0
52.00 05200 DELIVERY R0 54.00 05400 RADIOLOGY-D		0	0	•		52. (54. (
55. 00 05500 RADI 0L0GY-T		0	0			55.0
57.00 05700 CT SCAN		0	0			57.0
59.00 05900 CARDI AC CAT	HETERI ZATI ON	0	0			59. (60. (
60. 00 06000 LABORATORY 62. 30 06250 BLOOD CLOTT	ING FOR HEMOPHILIACS	0	0			62.3
65. 00 06500 RESPI RATORY		0	0			65.0
65. 01 06501 SLEEP LAB		0	0	1		65. (
66. 00 06600 PHYSI CAL TH 66. 01 06601 PHYSI CAL TH		0	0			66. 0 66. 0
66. 02 06602 PHYSI CAL TH		0	0			66. (
67.00 06700 OCCUPATI ONA		0	0			67.0
68.00 06800 SPEECH PATH 69.00 06900 ELECTROCARD		0				68. (69. (
	PLIES CHARGED TO PATIENT	0	0			71.0
72.00 07200 I MPL. DEV.		0	0			72. (
73.00 07300 DRUGS CHARG 76.97 07697 CARDI AC REH		0	0			73.0
76. 97 07697 CARDIAC REH 76. 98 07698 HYPERBARI C		0				76.9
76. 99 07699 LI THOTRI PSY		0	0			76.9
77.00 07700 ALLOGENEI C		0	0			77. (
90 01 00001 0UTPATI ENT SERVIC	E COSI CENIERS TREATMENT & INFUSION CTR	0	0			90.0
90. 02 09002 ATHLETIC TR		0	0	•		90.0
90. 03 09003 SAI NT JOSEP	H HEALTH CENTER	0	0			90. (
90.04 09004 WOUND CARE		0	0			90. (
91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON	BEDS (NON-DISTINCT PART	0	0			91. (92. (
OTHER REI MBURSABL		1		1		
102.00 10200 OPI OI D TREA		0	0			102. (
	SUM OF LINES 1 through 117)	0	0			118. (
NOUDELING	UNI CENTERS			J		100 /
NONREI MBURSABLE C			∩)		
190.00 19000 GIFT, FLOWE	R, COFFEE SHOP & CANTEEN	0	0			190. (190. (
190. 00 19000 GI FT, FLOWE 190. 01 19001 LI FEPLEX FI 192. 00 19200 PHYSI CI ANS'	R, COFFEE SHOP & CANTEEN TNESS FORUM PRIVATE OFFICES	0 0 0	0 0 0			190. (192. (
190. 00 19000 GIFT, FLOWE 190. 01 19001 LIFEPLEX FI	R, COFFEE SHOP & CANTEEN TNESS FORUM PRI VATE OFFI CES ADMI NI STATI ON	0 0 0 0	0 0 0 0			190. (

Health Financial Systems ST. JOSEPHS REG MED CENTER PLYMOUTH In Lieu of Form CMS-2552-10

COST A	COST ALLOCATION - STATISTICAL BASIS			Provider CC	CN: 15-0076	Period: From 07/01/2022	Worksheet B-1
						To 06/30/2023	Date/Time Prepared: 11/29/2023 2:02 pm
			INTERNS &				
			RESI DENTS				
		Cost Center Description	SERVI CES-OTHER	PARAMED ED			
			PRGM COSTS	PRGM			
			APPRV	(ASSI GNED			
			(ASSI GNED	TIME)			
			TIME)	00.00			
100.01	10001	FOOT & ANKLE COODEC MED DUV	22.00	23.00			100.04
		FOOT & ANKLE SPORTS MED PLY	0	0			192.04
		PLYMOUTH MOB-4	0	0			194.00
		COMMUNITY OUTREACH & PARTNERSHIP	0	0			194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0			202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000			203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0			204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0. 000000	0. 000000			205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0. 000000			207.00

Health Financial Systems SI.	JOSEPHS REG MEI	D CENTER PLYMOU	ЛН	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2022	Worksheet C Part I	
				To 06/30/2023	Date/Time Pre 11/29/2023 2:	
		Title	× XVIII	Hospi tal	PPS	uz pili
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance	iotal oboto	
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 186, 823		7, 186, 82	3 0	7, 186, 823	30.00
31.00 03100 INTENSIVE CARE UNIT	432, 504		432, 50	4 0	432, 504	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	34.00
43. 00 04300 NURSERY	523, 986		523, 98	6 0	523, 986	43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	6, 850, 779		6, 850, 77	9 0	6, 850, 779	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	528, 488		528, 48	8 0	528, 488	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 690, 868		2, 690, 86	8 0	2, 690, 868	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 170, 017		1, 170, 01	7 245	1, 170, 262	55.00
57.00 05700 CT SCAN	475, 209		475, 20	9 0	475, 209	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	302, 450		302, 45	0 0	302, 450	59.00
60. 00 06000 LABORATORY	6, 536, 978		6, 536, 97	8 920	6, 537, 898	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	1, 238, 855	0	1, 238, 85	5 2, 393	1, 241, 248	65.00
65. 01 06501 SLEEP LAB	102, 569	0	102, 56	9 0	102, 569	65.01
66.00 06600 PHYSI CAL THERAPY	2,081,635	0	2, 081, 63	5 0	2, 081, 635	66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	433, 553	0	433, 55	3 0	433, 553	66.01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0	0		0 0	0	66.02
67.00 06700 OCCUPATIONAL THERAPY	259, 747	0	259, 74	7 0	259, 747	67.00
68.00 06800 SPEECH PATHOLOGY	170, 944	0	170, 94	4 0	170, 944	68.00
69. 00 06900 ELECTROCARDI OLOGY	396, 770		396, 77	0 0	396, 770	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1,097,630		1, 097, 63	0 0	1, 097, 630	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 108, 837		4, 108, 83	7 0	4, 108, 837	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	10, 665		10, 66	5 0	10, 665	76.98
76. 99 07699 LI THOTRI PSY	0			0 0	0	76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	12, 601		12, 60		12, 601	
90. 02 09002 ATHLETIC TRAINERS	24, 312		24, 31		24, 312	•
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0			0 0	0	90.03
90. 04 09004 WOUND CARE	1, 171, 743		1, 171, 74		1, 171, 743	
91.00 09100 EMERGENCY	6, 035, 697		6, 035, 69		6, 066, 419	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 907, 252		1, 907, 25	2	1, 907, 252	92.00
OTHER REIMBURSABLE COST CENTERS		1	1			
102.00 10200 OPIOID TREATMENT PROGRAM	0			0		102.00
200.00 Subtotal (see instructions)	45, 750, 912					
201.00 Less Observation Beds	1, 907, 252		1, 907, 25		1, 907, 252	
202.00 Total (see instructions)	43, 843, 660	0	43, 843, 66	0 34, 280	43, 877, 940	202.00

Heal th Fi	nancial Systems ST.	JOSEPHS REG MED	CENTER PLYMOL	JTH	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CO	Provider CCN: 15-0076		Period: Worksheet C	
					From 07/01/2022	Part I	
					To 06/30/2023	Date/Time Pre 11/29/2023 2:	epared:
			Titlo	XVIII	Hospi tal	PPS	02 pili
			Charges	AVI I I		PP3	
	Cost Center Description	Inpatient	Outpati ent	Total (col	6 Cost or Other	TEFRA	
	cost center bescription	Therefic	outpatrent	+ col. 7	Ratio	Inpatient	
				+ COL. 7)	Ratio	Ratio	
		6.00	7.00	8.00	9.00	10.00	
LN	PATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
	BOOO ADULTS & PEDIATRICS	9, 994, 915		9, 994, 91	5		30.00
	100 I NTENSI VE CARE UNI T	0		,,,,,,,,,,	0		31.00
	400 SURGI CAL I NTENSI VE CARE UNI T	0			0		34.00
	300 NURSERY	698, 100		698, 10	0		43.00
	CILLARY SERVICE COST CENTERS	070,100		070, 10			40.00
	0000 OPERATI NG ROOM	5, 030, 039	31, 585, 788	36, 615, 82	0. 187099	0.00000	50.00
	5200 DELIVERY ROOM & LABOR ROOM	1, 338, 847	69, 447			0. 000000	
	5400 RADI OLOGY-DI AGNOSTI C	1, 875, 223	18, 827, 346			0.000000	•
	5500 RADI OLOGY-THERAPEUTI C	32, 296	8, 178, 997	8, 211, 29		0.000000	•
	5700 CT SCAN	4, 275, 692	28, 964, 641	33, 240, 33		0. 000000	•
	5900 CARDI AC CATHETERI ZATI ON	31,855	1, 130, 531	1, 162, 38		0.000000	
	000 LABORATORY	5, 459, 051	37, 618, 787			0.000000	•
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0,407,001	0,010,707	45, 077, 00	0 0.00000	0. 000000	•
	5500 RESPIRATORY THERAPY	1, 449, 555	957, 714	2, 407, 26		0. 000000	
	501 SLEEP LAB	1, 449, 333	416, 036			0.000000	
	600 PHYSI CAL THERAPY	358, 317	4, 756, 734			0.000000	
	601 PHYSI CAL THERAPY - LI FEPLEX	0	1,006,220			0.000000	
	602 PHYSI CAL THERAPY - CULVER MILITARY	0	1,000,220	1,000,22	0 0.00000	0.000000	
	700 OCCUPATI ONAL THERAPY	219, 593	788, 095	1, 007, 68		0. 000000	
	800 SPEECH PATHOLOGY	53, 568	214, 689	268, 25		0. 000000	
	900 ELECTROCARDI OLOGY	1, 528, 242	6, 528, 630			0. 000000	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0, 020, 000	0,000,07	0 0.000000	0. 000000	
	200 IMPL. DEV. CHARGED TO PATIENTS	274, 680	1, 898, 939	2, 173, 61		0. 000000	
	300 DRUGS CHARGED TO PATIENTS	2, 329, 055	12, 299, 987	14, 629, 04		0. 000000	
	7697 CARDI AC REHABI LI TATI ON	0	0	11/02//0	0 0.000000	0. 000000	
	7698 HYPERBARI C OXYGEN THERAPY	0	97, 320	97, 32		0. 000000	
	7699 LI THOTRI PSY	0	0	,,,	0 0.00000	0. 000000	
	700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0.000000	0. 000000	
	TPATIENT SERVICE COST CENTERS			<u> </u>	0 0.00000	0.00000	11.00
	2001 OUTPATIENT TREATMENT & INFUSION CTR	0	0		0 0.00000	0.00000	90.01
	2002 ATHLETI C TRAI NERS	0	0		0 0.000000	0. 000000	
	2003 SAINT JOSEPH HEALTH CENTER	0	0		0 0.000000	0. 000000	
	2004 WOUND CARE	5, 389	2, 518, 559	2, 523, 94		0. 000000	•
	100 EMERGENCY	2,072,876	17, 830, 895			0. 000000	
	2200 OBSERVATION BEDS (NON-DISTINCT PART	1, 115, 559	2, 140, 011			0. 000000	
	HER REIMBURSABLE COST CENTERS	., 110, 007	2, 110, 011	5,200,01	- 0.00040	0.000000	1
	2200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
200.00	Subtotal (see instructions)	38, 142, 852	177, 829, 366		-		200.00
201.00	Less Observation Beds	33, 1.2, 002	, 62., 666	2.0,	-		201.00
202.00	Total (see instructions)	38, 142, 852	177, 829, 366	215, 972, 21	8		202.00
_02.00		00, 1.2, 002	, 02., 000		-1	I	

Health Financial Systems ST.	JOSEPHS REG MED	CENTER PLYMOUTH	In Lieu	u of Form CMS-2	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0076	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prep 11/29/2023 2:0	ared: 2 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	· · ·				
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 187099				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 375268				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 129977				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 142519				55.00
57.00 05700 CT SCAN	0.014296				57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 260198				59.00
60. 00 06000 LABORATORY	0. 151769				60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.30
65. 00 06500 RESPI RATORY THERAPY	0. 515625				65.00
65. 01 06501 SLEEP LAB	0. 246539				65.01
66. 00 06600 PHYSI CAL THERAPY	0. 406963				66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	0. 430873				66. 01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILI TARY	0. 000000				66. 02
67.00 06700 OCCUPATI ONAL THERAPY	0. 257765				67.00
68.00 06800 SPEECH PATHOLOGY	0. 637240				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 049246				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 504978				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 280868				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 109587				76. 98
76. 99 07699 LI THOTRI PSY	0. 000000				76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
OUTPATIENT SERVICE COST CENTERS					
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0.000000				90.01
90. 02 09002 ATHLETI C TRAI NERS	0.000000				90. 02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0. 000000				90.03
90. 04 09004 WOUND CARE	0. 464250				90.04
91.00 09100 EMERGENCY	0. 304787				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 585843				92.00
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPI OI D TREATMENT PROGRAM				1	102.00
200.00 Subtotal (see instructions)				2	200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Heal th Finan	ncial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMOL	JTH	In Lie	u of Form CMS-:	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
					From 07/01/2022		
					To 06/30/2023		
			T; +1	e XIX	Hospi tal	11/29/2023 2: PPS	uz pili
			1111		Costs	PP3	
	Cost Coston Deceminting	Tatal Cast	The surgery set 1 is mit at	Tatal Casta		Tatal Casta	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	0.00	0.00	4 00	F 00	
LNDAT		1.00	2.00	3.00	4.00	5.00	
	I ENT ROUTI NE SERVI CE COST CENTERS	7 404 000		7 404 00		7 404 000	
	ADULTS & PEDIATRICS	7, 186, 823		7, 186, 82			
	INTENSIVE CARE UNIT	432, 504		432, 50			
	SURGICAL INTENSIVE CARE UNIT	0			0 0		
	NURSERY	523, 986		523, 98	6 0	523, 986	43.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	6, 850, 779		6, 850, 77	9 0	6, 850, 779	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	528, 488		528, 48	8 0	528, 488	52.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	2, 690, 868		2, 690, 86	0 8	2, 690, 868	54.00
55.00 05500	RADI OLOGY-THERAPEUTI C	1, 170, 017		1, 170, 01	7 245	1, 170, 262	55.00
57.00 05700	CT SCAN	475, 209		475, 20	9 0	475, 209	57.00
	CARDI AC CATHETERI ZATI ON	302, 450		302, 45		302, 450	
	LABORATORY	6, 536, 978		6, 536, 97		6, 537, 898	
	BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
	RESPIRATORY THERAPY	1, 238, 855		1, 238, 85	0	-	
	SLEEP LAB	102, 569		102, 56		102, 569	
	PHYSI CAL THERAPY	2, 081, 635		2, 081, 63			
	PHYSICAL THERAPY - LIFEPLEX	433, 553		433, 55		433, 553	
	PHYSICAL THERAPY - CULVER MILITARY	433, 553			0 0	433, 553	
		Ŭ	Ű		0	-	
	OCCUPATIONAL THERAPY	259, 747		259, 74		259, 747	
	SPEECH PATHOLOGY	170, 944		170, 94		170, 944	
	ELECTROCARDIOLOGY	396, 770		396, 77		396, 770	
	MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	
	IMPL. DEV. CHARGED TO PATIENTS	1, 097, 630		1, 097, 63		1, 097, 630	
	DRUGS CHARGED TO PATIENTS	4, 108, 837		4, 108, 83		4, 108, 837	
	CARDIAC REHABILITATION	0			0 0	0	
	HYPERBARIC OXYGEN THERAPY	10, 665		10, 66	5 0	10, 665	
76.99 07699	LI THOTRI PSY	0			0 0	0	76.99
	ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
OUTPA	TI ENT SERVICE COST CENTERS						
90.01 09001	OUTPATIENT TREATMENT & INFUSION CTR	12, 601		12,60	0	12, 601	90.01
90.02 09002	ATHLETI C TRAI NERS	24, 312		24, 31	2 0	24, 312	90.02
90.03 09003	SAINT JOSEPH HEALTH CENTER	0			0 0	0	90.03
	WOUND CARE	1, 171, 743		1, 171, 74	3 0	1, 171, 743	
	EMERGENCY	6, 035, 697		6, 035, 69			
	OBSERVATION BEDS (NON-DISTINCT PART	1, 907, 252		1, 907, 25		1, 907, 252	
	REIMBURSABLE COST CENTERS	1,701,202	<u> </u>	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		., , , , , , , , 202	1
	OPIOID TREATMENT PROGRAM	0			0		102.00
200.00	Subtotal (see instructions)	45, 750, 912					
200.00	Less Observation Beds	1, 907, 252		1, 907, 25		1, 907, 252	
202.00	Total (see instructions)	43, 843, 660	o				
202.00		45, 045, 000	0	1 43, 043, 00	54, 200	45, 077, 740	202.00

Health Financial Systems ST.	JOSEPHS REG MED	CENTER PLYMOL	ITH	In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-0076	Peri od:	Worksheet C	
				From 07/01/2022	Part I	
				To 06/30/2023		epared:
					11/29/2023 2:	02 pm
			e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	9, 994, 915		9, 994, 91	5		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0	Í	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0	1	34.00
43. 00 04300 NURSERY	698, 100		698, 10	-		43.00
ANCI LLARY SERVI CE COST CENTERS	070,100		070, 10		·	45.00
50. 00 05000 OPERATING ROOM	5, 030, 039	31, 585, 788	36, 615, 82	0. 187099	0.00000	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 338, 847	69, 447	1, 408, 29			
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 875, 223	18, 827, 346	20, 702, 56			
55. 00 05500 RADI OLOGY-THERAPEUTI C	32, 296	8, 178, 997	8, 211, 29			
57.00 05700 CT SCAN	4, 275, 692	28, 964, 641	33, 240, 33			
59. 00 05900 CARDI AC CATHETERI ZATI ON	31, 855	1, 130, 531	1, 162, 38			
60. 00 06000 LABORATORY	5, 459, 051	37, 618, 787	43,077,83	8 0. 151748	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.000000	0.000000	62.30
65. 00 06500 RESPI RATORY THERAPY	1, 449, 555	957, 714	2, 407, 26	0. 514631	0.000000	65.00
65. 01 06501 SLEEP LAB	0	416, 036	416, 03	6 0. 246539	0.000000	65.01
66. 00 06600 PHYSI CAL THERAPY	358, 317	4, 756, 734	5, 115, 05	0. 406963	0.000000	66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	0	1,006,220	1,006,22			
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0	., 000, 220	1,000,22	0 0.000000		
67. 00 06700 OCCUPATI ONAL THERAPY	219, 593	788, 095	1, 007, 68			
68. 00 06800 SPEECH PATHOLOGY	53, 568	214,689	268, 25			
69. 00 06900 ELECTROCARDI OLOGY						
	1, 528, 242	6, 528, 630	8, 056, 87			
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	o 470 (4	0 0.00000		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	274, 680	1, 898, 939	2, 173, 61			
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 329, 055	12, 299, 987	14, 629, 04			
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	97, 320	97, 32			
76. 99 07699 LI THOTRI PSY	0	0		0 0.000000		76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0.000000	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0		0 0.000000	0.000000	90.01
90. 02 09002 ATHLETI C TRAI NERS	0	0		0 0.000000	0.000000	90.02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0	0		0 0.000000		
90. 04 09004 WOUND CARE	5, 389	2, 518, 559	2, 523, 94			
91. 00 09100 EMERGENCY	2,072,876	17, 830, 895	19, 903, 77			
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	1, 115, 559	2, 140, 011	3, 255, 57	0 0.000843	0.00000	92.00
	0	0		0		102.00
102.00 10200 OPI OI D TREATMENT PROGRAM	Ŭ	0		0	1	102.00
200.00 Subtotal (see instructions)	38, 142, 852	177, 829, 366	215, 972, 21	ö		200.00
201.00 Less Observation Beds			o		1	201.00
202.00 Total (see instructions)	38, 142, 852	177, 829, 366	215, 972, 21	8	l –	202.00

Health Financial Systems ST.	JOSEPHS REG MED	CENTER PLYMOUTH	In Lie	u of Form CMS-25	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0076	Peri od:	Worksheet C	
			From 07/01/2022	Part I	
			To 06/30/2023	Date/Time Prepa 11/29/2023 2:02	ared:
		Title XIX	Hospi tal	PPS	<u>z μιι</u>
Cost Center Description	PPS Inpatient		nospi tui	113	
oost oontor beschiption	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				
50. 00 05000 OPERATI NG ROOM	0. 187099				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 375268				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 129977				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 142519				55.00
57.00 05700 CT SCAN	0.014296				57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 260198				59.00
60. 00 06000 LABORATORY	0. 151769				60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.30
65. 00 06500 RESPI RATORY THERAPY	0. 515625				65.00
65. 01 06501 SLEEP LAB	0. 246539				65.01
66. 00 06600 PHYSI CAL THERAPY	0. 406963				66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	0. 430873				66. 01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0. 000000				66. 02
67.00 06700 OCCUPATIONAL THERAPY	0. 257765				67.00
68.00 06800 SPEECH PATHOLOGY	0. 637240				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 049246				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 504978				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 280868				73.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 109587				76. 98
76. 99 07699 LI THOTRI PSY	0. 000000				76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000				77.00
OUTPATIENT SERVICE COST CENTERS					
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0. 000000				90.01
90. 02 09002 ATHLETI C TRAI NERS	0. 000000				90. 02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0. 000000				90.03
90. 04 09004 WOUND CARE	0. 464250				90.04
91. 00 09100 EMERGENCY	0. 304787				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 585843				92.00
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPI OI D TREATMENT PROGRAM					02.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)				2	202.00

Heal th	Financial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMOL	JTH	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF OUTPATIENT SERVICE COST TO CHARGE RA IONS FOR MEDICAID ONLY		Provider CO	CN: 15-0076	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part II	pared:
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost		t Capital	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	I Reduction	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						
	05000 OPERATING ROOM	6, 850, 779				0	
	05200 DELIVERY ROOM & LABOR ROOM	528, 488		523, 28		0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 690, 868	223, 871	2, 466, 99		0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 170, 017	246, 330	923, 68	7 0	0	55.00
57.00	05700 CT SCAN	475, 209	44, 181	431, 02	8 0	0	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	302, 450	57, 313	245, 13	7 0	0	59.00
60.00	06000 LABORATORY	6, 536, 978	197, 213	6, 339, 76	5 0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65.00	06500 RESPI RATORY THERAPY	1, 238, 855	95, 517	1, 143, 33	8 0	0	65.00
65.01	06501 SLEEP LAB	102, 569		101, 42		0	65.01
	06600 PHYSI CAL THERAPY	2,081,635		1, 912, 70		0	66.00
	06601 PHYSI CAL THERAPY - LI FEPLEX	433, 553		429, 52		0	66.01
	06602 PHYSI CAL THERAPY - CULVER MILLI TARY	0			0 0	0	66.02
	06700 OCCUPATI ONAL THERAPY	259.747	-	256, 91		0	67.00
	06800 SPEECH PATHOLOGY	170, 944		169, 44		0	68.00
	06900 ELECTROCARDI OLOGY	396, 770				0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0,0,7,0			0 0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	1,097,630	j v		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	4, 108, 837				0	73.00
	07697 CARDI AC REHABI LI TATI ON	4, 100, 037	0	4,030,11	4 0 0 0	0	76.97
	07698 HYPERBARI C OXYGEN THERAPY	10, 665	-	10, 50	0 0	0	76.98
	07699 LI THOTRI PSY	10,005	0		0 0	0	76.99
	07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
77.00	OUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	0 0	0	//.00
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	12,601	96	12, 50	5 0	0	90.01
	09002 ATHLETIC TRAINERS					0	
		24, 312		23, 97			
	09003 SAINT JOSEPH HEALTH CENTER		j ő		0	0	
	09004 WOUND CARE	1, 171, 743		1,081,69		0	90.04
	09100 EMERGENCY	6,035,697				0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 907, 252	158, 891	1, 748, 36	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						100.00
	10200 OPI OI D TREATMENT PROGRAM	0	, o		0 0	-	102.00
200.00		37, 607, 599					200.00
201.00		1,907,252					201.00
202.00	Total (line 200 minus line 201)	35, 700, 347	1, 937, 760	33, 762, 58	0	0	202.00

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE I EDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet C Part II Date/Time Pre 11/29/2023 2:	epared
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges				
		(Worksheet C,				
	Operating Cost	Part I, column		6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
0. 00 05000 OPERATING ROOM	6, 850, 779	36, 615, 827	0. 1870	99		50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	528, 488	1, 408, 294	0. 3752	68		52.0
. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 690, 868	20, 702, 569	0. 1299	77		54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	1, 170, 017	8, 211, 293	0. 1424	89		55.
2.00 05700 CT SCAN	475, 209	33, 240, 333		96		57.
0. 00 05900 CARDI AC CATHETERI ZATI ON	302, 450	1, 162, 386		98		59.
0. 00 06000 LABORATORY	6, 536, 978	43, 077, 838				60.
2. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0,000,770	0				62.
6. 00 06500 RESPI RATORY THERAPY	1, 238, 855	2, 407, 269				65.
5. 01 06501 SLEEP LAB	102, 569	416, 036				65.
00 06600 PHYSI CAL THERAPY	2, 081, 635	5, 115, 051				66.
						66.
	433, 553	1, 006, 220				
0.02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0	0				66.
7. 00 06700 OCCUPATI ONAL THERAPY	259, 747	1,007,688				67.
8. 00 06800 SPEECH PATHOLOGY	170, 944	268, 257				68.
P. 00 06900 ELECTROCARDI OLOGY	396, 770	8, 056, 872				69.
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 097, 630	2, 173, 619				72.
8. 00 07300 DRUGS CHARGED TO PATIENTS	4, 108, 837	14, 629, 042				73.
o. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.0000	00		76.
. 98 07698 HYPERBARI C OXYGEN THERAPY	10, 665	97, 320	0. 1095	87		76.
. 99 07699 LI THOTRI PSY	0	0	0.0000	00		76.
. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.0000	00		77.
OUTPATIENT SERVICE COST CENTERS			·			
0. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	12,601	0	0.0000	00		90.
0. 02 09002 ATHLETI C TRAI NERS	24, 312	0				90.
. 03 09003 SAINT JOSEPH HEALTH CENTER	24, 312	0	0.0000			90.
0. 04 09004 WOUND CARE	1, 171, 743	2, 523, 948				90.
. 00 09100 EMERGENCY	6, 035, 697	19, 903, 771				91.
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	1, 907, 252	3, 255, 570	0. 5858	43		92.
OTHER REIMBURSABLE COST CENTERS			0.0077	20		-
2.00 10200 OPI OI D TREATMENT PROGRAM	0	0		00		102.
0.00 Subtotal (sum of lines 50 thru 199)	37, 607, 599	205, 279, 203				200.
1.00 Less Observation Beds	1, 907, 252	0				201.
2.00 Total (line 200 minus line 201)	35, 700, 347	205, 279, 203				202.

Health Financial Systems	ST. JOSEPHS REG MEI	D CENTER PLYMOU	JTH	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	TAL COSTS	Provider C		Period: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 2:	
		Title	XVIII	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						
30. 00 ADULTS & PEDIATRICS	598, 730	0	598, 73	0 4, 567	131.10	30.00
31.00 INTENSIVE CARE UNIT	106, 218		106, 21	8 0	0.00	31.00
34.00 SURGI CAL I NTENSI VE CARE UNI T	0			0 0	0.00	34.00
43.00 NURSERY	4, 534		4, 53	4 332	13.66	43.00
200.00 Total (lines 30 through 199)	709, 482		709, 48			200.00
Cost Center Description	Inpati ent	I npati ent		-+ · ·		
	Program days	Program				
	0 5	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	·					
30. 00 ADULTS & PEDI ATRI CS	1,052	137, 917				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
43. 00 NURSERY	0	Ö				43.00
200.00 Total (lines 30 through 199)	1, 052	137, 917				200.00

Health Financial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMOL	ITH	Inlie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part II Date/Time Pre 11/29/2023 2:	pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(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	457, 975	36, 615, 827	0. 01250	1, 072, 961	13, 421	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 207	1, 408, 294	0.00369	97 61	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	223, 871	20, 702, 569	0. 0108	4 622, 277	6, 729	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	246, 330	8, 211, 293	0.02999	09 0	0	55.00
57.00 05700 CT SCAN	44, 181	33, 240, 333	0.00132	1, 352, 077	1, 797	57.00
59.00 05900 CARDI AC CATHETERI ZATI ON	57, 313					59.00
60, 00 06000 LABORATORY	197, 213				7, 812	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0				0	62.30
65. 00 06500 RESPI RATORY THERAPY	95, 517	-			20, 102	65.00
65. 01 06501 SLEEP LAB	1, 141				20, 102	65.01
66. 00 06600 PHYSI CAL THERAPY	168, 927				4, 838	66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	4, 025				4,000	66.01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	4, 025				0	66.02
67. 00 06700 OCCUPATI ONAL THERAPY	2,837				254	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 501				106	68.00
69. 00 06900 ELECTROCARDI OLOGY	10, 279				703	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 279				0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 283	-			228	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	72, 723				3, 486	
76. 97 07697 CARDI AC REHABI LI TATI ON	12, 123				3, 460 0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	165	-			0	76.97
					-	
76. 99 07699 LI THOTRI PSY	0				0	76.99
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	0.0000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS	0(0.0000		0	00.01
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	96				-	90.01
90. 02 09002 ATHLETI C TRAI NERS	342		0.00000		0	90.02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0	-			0	90.03
90. 04 09004 WOUND CARE	90, 047					1
91. 00 09100 EMERGENCY	248, 787					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	158, 891					
200.00 Total (lines 50 through 199)	2, 096, 651	205, 279, 203	1	7, 932, 860	86, 468	200.00

Health Financial Systems ST APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER		CENTER PLYMOU		Period:	u of Form CMS-: Worksheet D	2332-1
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS INKUUGH CUS			From 07/01/2022		
				To 06/30/2023	Date/Time Pre	
					11/29/2023 2:	02 pm
	N1 1		XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdowr	n Cost	Medical Education Cost	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments 1A	1.00	2A	2.00	3, 00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	ZA	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	1		0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			0 0	0	31.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0			0	
43. 00 04300 NURSERY	0	0				
200.00 Total (lines 30 through 199)	0	0			-	200.0
Cost Center Description	Swing-Bed	Total Costs	Total Dation	Per Diem (col.	Inpati ent	200. 0
Cost center bescription	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Days	5 ÷ cor. 0)		
	i nstructi ons)	minus col. 4)				
	4.00	5.00	6,00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0.00	1100	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	4, 56	7 0.00	1, 052	1 30. 00
31.00 03100 INTENSIVE CARE UNIT		0		0.00		31.0
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0		0.00	0	34.0
43. 00 04300 NURSERY		0	33			
200.00 Total (lines 30 through 199)		0				200. 0
Cost Center Description	I npati ent					
•	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.0
31. 00 03100 I NTENSI VE CARE UNI T	0					31.0
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.0
43. 00 04300 NURSERY	0					43.0
						200. 0

Health Financial Systems ST.	JOSEPHS REG MED	CENTER PLYMOU	JTH	In L	ieu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			Period: From 07/01/202 To 06/30/202	23 Date/Time Pre 11/29/2023 2:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments		Post-Stepdow Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS			1			
50.00 OPERATING ROOM	0	0		0	0 0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0 0	55.00
57.00 05700 CT SCAN	0	0		0	0 0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0 0	
60. 00 06000 LABORATORY	0	0		0	0 0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0 0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0 0	
65. 01 06501 SLEEP LAB	0	0		0	0 0	65.01
66.00 06600 PHYSI CAL THERAPY	0	0		0	0 0	66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	0	0		0	0 0	
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0	0		0	0 0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0 0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0 0	
69. 00 06900 ELECTROCARDI OLOGY	0	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 PATIENTS	0	0		0	0 0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0 0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0 0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0 0	
76. 99 07699 LI THOTRI PSY	0	0		0	0 0	
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0	0		0	0 0	77.00
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0		0	0 0	90.01
90. 02 09002 ATHLETIC TRAINERS	0	0		0		
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0	0		0		
90. 04 09004 WOUND CARE	0	0		0		90.03
91. 00 09100 EMERGENCY	0	0		0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	
200.00 Total (lines 50 through 199)	0	0		0		200.00

Health Financial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMO	JTH	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 07/01/2022 To 06/30/2023	Date/Time Pre	pared:
			e XVIII	Hospi tal	11/29/2023 2: PPS	02 pm
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
oust center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost	•	Cost (sum of		$(col. 5 \div col.$	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-				•	
50. 00 05000 OPERATI NG ROOM	0	C		0 36, 615, 827	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 408, 294	0.000000	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 20, 702, 569	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 8, 211, 293	0. 000000	55.00
57.00 05700 CT SCAN	0	0		0 33, 240, 333	0. 000000	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 1, 162, 386	0. 000000	59.00
60. 00 06000 LABORATORY	0	C		0 43, 077, 838	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0)	0 0	0. 000000	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 407, 269	0.000000	65.00
65.01 06501 SLEEP LAB	0	0)	0 416, 036	0. 000000	65.01
66. 00 06600 PHYSI CAL THERAPY	0	0		0 5, 115, 051	0.000000	66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	0	0		0 1, 006, 220	0. 000000	66. 01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0	0		0 0	0. 000000	66. 02
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 007, 688	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 268, 257	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 8, 056, 872	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 2, 173, 619	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 14, 629, 042	0.000000	73.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0.000000	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 97, 320	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0.000000	76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0)	0 0	0.000000	90.01
90. 02 09002 ATHLETI C TRAI NERS	0	0)	0 0	0. 000000	90. 02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0	0		0 0	0.000000	
90. 04 09004 WOUND CARE	0	0		0 2, 523, 948	0.000000	90.04
91. 00 09100 EMERGENCY	0	0		0 19, 903, 771	0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 3, 255, 570	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0		0 205, 279, 203		200. 00

ealth Financial Systems ST. PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	JOSEPHS REG MED	Provider C		Peri		u of Form CMS-: Worksheet D	2002-1
HROUGH COSTS	INVIOL OTHER TROO		. 10 0070		n 07/01/2022	Part IV	
				То	06/30/2023	Date/Time Pre	pared:
		Title	XVIII		Hospi tal	11/29/2023 2: PPS	uz pili
Cost Center Description	Outpati ent	Inpati ent	Inpatient		Outpatient	Outpati ent	
	Ratio of Cost	Program	Program		Program	Program	
	to Charges	Charges	Pass-Throug	h	Charges	Pass-Through	
	(col. 6 ÷ col.	Ũ	Costs (col.	8	Ũ	Costs (col. 9	
	7)		x col. 10)			x col. 12)	
	9.00	10.00	11.00		12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
D. 00 05000 OPERATI NG ROOM	0. 000000	1, 072, 961		0	5, 648, 591	0	50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	61		0	57	0	52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	622, 277		0	3, 085, 235	0	54.C
5. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	0	1	0	1, 966, 110	0	55. C
7.00 05700 CT SCAN	0. 000000	1, 352, 077	1	0	6, 461, 006	0	57. C
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	9, 018	1	0	324, 253	0	59.0
D. 00 06000 LABORATORY	0. 000000	1, 706, 424		0	2, 364, 085	0	60.0
2.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	0	62.3
5. 00 06500 RESPI RATORY THERAPY	0. 000000	506, 604		0	169, 722	0	65.0
5. 01 06501 SLEEP LAB	0. 000000	0		0	63, 443	0	65. (
6. 00 06600 PHYSI CAL THERAPY	0. 000000	146, 504		0	2, 708	0	66.0
6. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	0. 000000	0		0	584	0	66. (
6. 02 06602 PHYSI CAL THERAPY - CULVER MILI TARY	0. 000000	0		0	0	0	66. (
7.00 06700 OCCUPATI ONAL THERAPY	0. 000000	90, 138		0	141	0	67.0
8.00 06800 SPEECH PATHOLOGY	0. 000000	18, 871		0	2, 839	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	0. 000000	550, 845		0	1, 533, 499	0	69.1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	0	71. (
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	53, 485		0	351, 437	0	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	701, 171		0	4,012,043	0	73.0
5. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	0	76. 9
5. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	0	76. 9
5. 99 07699 LI THOTRI PSY	0. 000000	0		0	0	0	76.
7.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	0	77. (
OUTPATIENT SERVICE COST CENTERS	•			-			
D. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0. 000000	0		0	0	0	90.0
D. 02 09002 ATHLETIC TRAINERS	0. 000000	0		0	0	0	90.
D. 03 09003 SAINT JOSEPH HEALTH CENTER	0. 000000	0		0	0	0	90.
D. 04 09004 WOUND CARE	0. 000000	3, 038		0	841, 785	0	90.
1. 00 09100 EMERGENCY	0. 000000	749, 654		0	2, 486, 687	0	91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	349, 732		0	376, 768	0	92.0
00.00 Total (lines 50 through 199)		7, 932, 860		0	29, 690, 993	0	200.0

Health Financial Systems	ST. JOSEPHS REG ME			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE	S AND VACCINE COST	Provider C	CN: 15-0076	Peri od:	Worksheet D	
				From 07/01/2022 To 06/30/2023		nared
				10 00/ 30/ 2023	11/29/2023 2:	
		Title	× XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(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	
ANCI LLARY SERVI CE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	0. 187099			0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 375268			0 0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 129977			0 0		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 142489			0 0	280, 149	
57.00 05700 CT SCAN	0. 014296			0 0	92, 367	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 260198			0 0	84, 370	
60. 00 06000 LABORATORY	0. 151748			0 0		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0 0		
65. 00 06500 RESPI RATORY THERAPY	0. 514631			0 0	87, 344	
65.01 06501 SLEEP LAB	0. 246539			0 0	15, 641	
66. 00 06600 PHYSI CAL THERAPY	0. 406963			0 0	1, 102	
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	0. 430873			0 0	252	
66. 02 06602 PHYSICAL THERAPY - CULVER MILITARY				0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 257765			0 0	36	
68.00 06800 SPEECH PATHOLOGY	0. 637240			0 0	1, 809	•
69. 00 06900 ELECTROCARDI OLOGY	0. 049246			0 0		•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN				0 0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 504978			0 0	177, 468	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 280868			0 960	1, 126, 854	•
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			0 0		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 109587			0 0	-	
76. 99 07699 LI THOTRI PSY	0. 000000			0 0		
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT TREATMENT & INFUSION CT				0 0		
90. 02 09002 ATHLETI C TRAI NERS	0. 000000			0 0		
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0. 000000			0 0	0	
90. 04 09004 WOUND CARE	0. 464250			0 0		
91.00 09100 EMERGENCY	0. 303244			0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T 0. 585843			0 0		
200.00 Subtotal (see instructions)		29, 690, 993		0 960		
201.00 Less PBP Clinic Lab. Services-Prog	ram			0 0		201.00
		1	1	1	1	1
0nl y Charges 202.00 Net Charges (line 200 - line 201)		29, 690, 993		0 960	5, 125, 132	000 00

Heal th	Financial Systems ST.	JOSEPHS REG ME	D CENTER PLYMO	JTH	In Lie	u of Form CMS-	-2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0076	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pro 11/29/2023 2:	epared: :02 pm
			Title	e XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	4			
	ANCIAL ADV. CEDVILOE, COCT, CENTERC	6.00	7.00				-
F0 00	ANCI LLARY SERVICE COST CENTERS	0	0	N.			50.00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM						50.00
52.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	0		•			52.00
54.00 55.00	05500 RADI OLOGY - DI AGNOSTI C	0					54.00
55.00	05700 CT SCAN	0					57.00
57.00	05900 CARDI AC CATHETERI ZATI ON	0					59.00
60.00	06000 LABORATORY	0		•			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0					62.30
65.00	06500 RESPIRATORY THERAPY	0		1			65.00
65.00	06501 SLEEP LAB	0		•			65.00
66,00	06600 PHYSI CAL THERAPY	0		•			66.00
66.01	06601 PHYSICAL THERAPY - LIFEPLEX	0		•			66.01
66. 02	06602 PHYSICAL THERAPY - CULVER MILITARY			•			66.02
67.00	06700 OCCUPATI ONAL THERAPY			•			67.00
	06800 SPEECH PATHOLOGY			•			68.00
	06900 ELECTROCARDI OLOGY	0					69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		•			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	•			72.00
	07300 DRUGS CHARGED TO PATIENTS	0	270				73.00
	07697 CARDI AC REHABI LI TATI ON	0	C	•			76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	C				76.98
	07699 LI THOTRI PSY	0	C				76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	c c				77.00
	OUTPATIENT SERVICE COST CENTERS						
90.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	C)			90.01
90.02	09002 ATHLETI C TRAI NERS	0	C				90.02
90.03	09003 SAINT JOSEPH HEALTH CENTER	0	C				90.03
90.04	09004 WOUND CARE	0	C				90.04
91.00	09100 EMERGENCY	0	C				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C				92.00
200.00		0	270				200. 00
201.00	5	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	270	0			202.00

Health Financial Systems S	T. JOSEPHS REG ME	D CENTER PLYMO	UTH	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	AL COSTS			Period: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 2:	
			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						
30. 00 ADULTS & PEDIATRICS	598, 730	C	598, 73	0 4, 567	131.10	30.00
31.00 INTENSIVE CARE UNIT	106, 218		106, 21	в	0.00	31.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
43.00 NURSERY	4, 534		4, 53	4 332	13.66	43.00
200.00 Total (lines 30 through 199)	709, 482		709, 48	2 4, 899		200.00
Cost Center Description	I npati ent	Inpati ent			•	
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	77	10, 095	5			30.00
31.00 INTENSIVE CARE UNIT	0	C				31.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	C				34.00
43.00 NURSERY	216	2, 951				43.00
200.00 Total (lines 30 through 199)	293		5			200.00

Health Financial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMO	JTH	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part II Date/Time Pre 11/29/2023 2:	pared:
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(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	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	457, 975	36, 615, 827			13, 941	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 207	1, 408, 294	0.00369	97 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	223, 871	20, 702, 569	0. 0108	4 242, 392	2, 621	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	246, 330	8, 211, 293	0. 02999	99 0	0	55.00
57.00 05700 CT SCAN	44, 181	33, 240, 333	0.00132	633, 652	842	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	57, 313	1, 162, 386	0.04930	6, 172	304	59.00
60. 00 06000 LABORATORY	197, 213	43,077,838	0.00457	8 814, 799	3, 730	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0					62.30
65. 00 06500 RESPI RATORY THERAPY	95, 517	2, 407, 269			6, 025	65.00
65. 01 06501 SLEEP LAB	1, 141				0	65.01
66.00 06600 PHYSI CAL THERAPY	168, 927					66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	4,025					66.01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0					66.02
67.00 06700 OCCUPATI ONAL THERAPY	2,837	1,007,688			37	67.00
68.00 06800 SPEECH PATHOLOGY	1,501					68.00
69. 00 06900 ELECTROCARDI OLOGY	10, 279					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 283	2, 173, 619			0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	72, 723				1, 334	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0				0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	165	97, 320			0	76.98
76. 99 07699 LI THOTRI PSY	0				0	76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	-			-	77.00
OUTPATIENT SERVICE COST CENTERS			0.00000			
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	96	0	0.0000	0 00	0	90.01
90. 02 09002 ATHLETIC TRAINERS	342				0	90.02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0				0	90.03
90. 04 09004 WOUND CARE	90,047	-			0	90.04
91. 00 09100 EMERGENCY	248, 787				4, 564	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	158, 891				0	92.00
200.00 Total (lines 50 through 199)	2, 096, 651			3, 800, 957		200.00
		,,	•			

Health Financial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMOU	UTH	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		Period: From 07/01/2022 To 06/30/2023		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	l a		0 0	0	31.00
34.00 03400 SURGI CAL INTENSI VE CARE UNI T	0			0 0	0	34.00
43. 00 04300 NURSERY	0			0 0	0	
200.00 Total (lines 30 through 199)	0					200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
oost oontor bescription	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	buys		l l l ogi am bays	
		minus col. 4)				
	4.00	5.00	6,00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDIATRICS	0	C	4, 56	7 0.00	77	7 30.00
31.00 03100 INTENSIVE CARE UNIT				0.00	0	31.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T				0.00		
43. 00 04300 NURSERY			33			
200.00 Total (lines 30 through 199)						200.00
Cost Center Description	I npati ent		1,07	/	270	200.00
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS			-		-	
30. 00 03000 ADULTS & PEDIATRICS	0					30. 00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
						34.00
34 OO TO34OO SURGECAL ENTENSIVE CARE UNLE						
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0					
34.00 O3400 SURGICAL INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0					43.00

APPORTLONMENT OF INPATIENT/AUTPATIENT ANCILLARY SERVICE OTHER PASS. THROUGH COSTS Provider CCN: 15-0076 Period: From 07/07/2022 To 06/30/2020 Worksheet D Part IV Date/Time Prepared: TO 06/30/2020 Cost Center Description Non Physician Anesthetist ZA ZA	Health Financial Systems ST.	JOSEPHS REG MED	CENTER PLYMO	JTH	In Lie	eu of Form CMS-:	2552-10
Cost Center Description Non Physician Anesthetist Cost Nursing Program Post-Stepdom Adjustments Nursing Program Post-Stepdom Adjustments All ied Heal th All ied Heal th Post-Stepdom Adjustments 0.00 05000 (PERCEC COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 (PERCEC COST CENTERS 0 <td></td> <td>VICE OTHER PASS</td> <td>S Provider C</td> <td>CN: 15-0076</td> <td>From 07/01/2022</td> <td>Part IV</td> <td></td>		VICE OTHER PASS	S Provider C	CN: 15-0076	From 07/01/2022	Part IV	
Cost Center Description Norsing Anesthetist Cost Nursing Program Hursing Program All I el Health Post-Stepdown Adjustments All I el Health Post-Stepdown Adjustments 50.00 0000 0000 0000 00000 00000 00000 00000 000000 000000 000000000000000000000000000000000000					10 06/30/2023	11/29/2023 2:	pared: 02 pm
Anesthetist Program Cost Program Adjustments Program Adjustments Program Adjustments 1.00 2A 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS 0			Ti tl	e XIX	Hospi tal		
Adj ustments Adj ustments 1.00 2A 2.00 3A 3.00 50.00 05000 (PERATI NC ROOM 0	Cost Center Description					Allied Health	
Adj ustments - - - ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 (DEPLATING ROM 0							
I.00 2A 2.00 3A 3.00 50.00 05000 OPERATING ROOM 0		Cost			Adjustments		
ANCILLARY SERVICE COST CENTERS - - 50.00 05000 (DPERATI NG ROOM) 0		1.00		2 00	3 \	3 00	
50. 00 05000 0PERATI NG ROOM 0 0 0 0 0 0 0 0 0 50. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 <td>ANCI LLARY SERVI CE COST CENTERS</td> <td>1.00</td> <td>25</td> <td>2.00</td> <td>34</td> <td>3.00</td> <td></td>	ANCI LLARY SERVI CE COST CENTERS	1.00	25	2.00	34	3.00	
54.00 05400 RADI OLOGY - JI AGNOSTI C 0		0	C		0 0	0	50.00
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55.00 57.00 05700 CT SCAN 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
57.00 05700 CT SCAN 0 0 0 0 0 57.00 59.00 05900 CARDIAC CATHETERIZATION 0	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0	55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	55.00
60.00 06000 LABORATORY 0	57. 00 05700 CT SCAN	0	C		0 0	0	57.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 65.00 65.01 06501 SLEEP LAB 0 0 0 0 0 65.01 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.01 66.01 06601 PHYSI CAL THERAPY - LIFEPLEX 0 0 0 0 66.02 67.00 06700 0CCUPATI ONAL THERAPY - LIFEPLEX 0 0 0 0 66.02 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 66.02 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 0 0 68.00 69.00 0 68.00 69.00 69.00 71.00 0 0 0 0 0 71.00 0 0 0 0 71.00 71.00 71.00 71.00 72.00 72.00 72.0		0	C		0 0	0	59.00
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 65.01 06501 SLEEP LAB 0 0 0 0 65.01 66.00 06501 PHYSI CAL THERAPY LI FEPLEX 0 0 0 0 66.01 66.01 0600 PHYSI CAL THERAPY LI FEPLEX 0 0 0 0 66.01 66.02 0602 PHYSI CAL THERAPY CULVER MI LI TARY 0 0 0 0 66.02 67.00 0CCUPATI ONAL THERAPY CULVER MI LI TARY 0 0 0 0 66.02 67.00 0CCUPATI ONAL THERAPY CULVER MI LI TARY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 67.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 07401 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 73.00 76.97 CARDI AC REHABI LI TATI ON		0	0		0 0	0	60.00
65.01 06501 SLEEP LAB 0 0 0 0 0 65.01 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66.01 66.01 06602 PHYSI CAL THERAPY - LI FEPLEX 0 0 0 0 66.01 66.02 0602 PHYSI CAL THERAPY - LI FEPLEX 0 0 0 0 66.02 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 0 66.02 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 SPEECH PATHOLOGY 0 0 0 0 0 68.00 69.00 G6900 ELECTROCARDI OLOGY 0 0 0 0 71.00 71.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.98 07699 LTHOTRI PSY 0		0	0		0 0	0	
66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 66.01 06601 PHYSI CAL THERAPY LIFEPLEX 0 0 0 0 66.01 66.02 PHYSI CAL THERAPY LIFEPLEX 0 0 0 0 66.02 67.00 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0 0 0 72.00 73.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0 73.00 73.00 76.98 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 76.99		0	C		0 0		
66.01 06601 PHYSI CAL THERAPY - LIFEPLEX 0		0	C		0 0		
66.02 06602 PHYSI CAL THERAPY - CULVER MI LI TARY 0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>Ŭ</td><td></td></td<>		0	0		0 0	Ŭ	
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.00 71.00 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 76.97 CARDIAC REHABILITATION 0 0 0 0 76.97 76.98 07699 LITHOTRIPSY 0 0 0 0 76.98 77.00 70700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 76.99 77.00 07409 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 90.01 90.01 09001 0UTPATIENT TREATMENT & INFUSION CTR 0 0 0<		0	0		0 0		
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72.00 73.00 73.00 70.07 CARDI AC REHABI LI TATI ON 0 0 0 0 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 90.01 90.01 90.01 90.01 90.01 90.01 90.02 90.02 ATHLETI C TRAI NERS 0 0 0 90.02 90.03 90.04 90.		0	0		0 0		
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 76.98 07598 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 76.99 07699 LITHOTRIPSY 0 0 0 0 76.98 77.00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 77.00 01 09001 OUTPATIENT TREATMENT & INFUSION CTR 0 0 0 0 90.01 90.02 09002 ATHLETI C TRAINERS 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td></td></t<>		0	0		0 0		
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 76.98 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 77.00 0010 09001 OUTPATI ENT TREATMENT & INFUSION CTR 0		0	0		0 0		
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 0 73.00 76.97 07697 CARDIA C. REHABILITATION 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C. OXYGEN THERAPY 0 0 0 0 76.98 76.99 07699 LI THOTRIPSY 0 0 0 0 76.99 77.00 07700 ALLOGENEI C. HSCT. ACQUI SI TI ON 0 0 0 0 77.00 00 07700 ALLOGENEI C. HSCT. ACQUI SI TI ON 0 0 0 0 77.00 01 09001 OUTPATI ENT TREATMENT & INFUSION CTR 0 0 0 0 0 0 90.01 90.01 09002 ATHLETI C. TRAI NERS 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>		0	0		0 0		
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.97 07697 CARDI AC REHABILITATION 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.99 76.99 07609 LI THOTRI PSY 0 0 0 0 0 76.99 77.00 0700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 77.00 01 09001 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 90.01 90.01 09002 ATHLETI C TRAINERS 0 0 0 0 90.02 90.02 09003 SAINT JOSEPH HEALTH CENTER 0 0 0 0 90.02 90.04 09004 WOUND CARE 0 0 0 0 90.04 91.00 09100 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>-</td><td></td></t<>		0	0		0 0	-	
76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 99 76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 99 77. 00 07700 ALLOGENEI C HSCT ACOUI SI TI ON 0 0 0 0 77. 00 01 09001 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 90. 01 90. 01 09001 OUTPATI ENT TREATMENT & INFUSION CTR 0 0 0 0 90. 01 90. 02 09002 ATHLETI C TRAI NERS 0 0 0 0 90. 02 90. 03 09003 SAI NT JOSEPH HEALTH CENTER 0 0 0 0 90. 03 90. 04 90. 04 09004 WOUND CARE 0 0 0 0 0 90. 04 91. 00 09100 EMERGENCY 0<		0	0		0 0	-	
76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 0 76.99 76.99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 76.99 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0		0	0				
76. 99 07699 LI THOTRI PSY 0 0 0 0 0 76. 99 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 77. 00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 90. 01 90. 01 0UTPATI ENT TREATMENT & INFUSION CTR 0 0 0 0 90. 01 90. 02 09002 ATHLETI C TRAINERS 0 0 0 0 90. 02 90. 03 09003 SAINT JOSEPH HEALTH CENTER 0 0 0 0 90. 03 90. 04 09004 WOUND CARE 0 0 0 0 90. 04 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 92. 00		0	0			-	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 90. 01 90.01 0UTPATI ENT TREATMENT & INFUSION CTR 0 0 0 0 0 90. 01 90. 02 90.02 ATHLETI C TRAINERS 0 0 0 0 90. 02 90. 03 90. 03 SAINT JOSEPH HEALTH CENTER 0 0 0 0 90. 03 90. 04 90.04 WOUND CARE 0 0 0 0 90. 04 90. 04 90.04 WOUND CARE 0 0 0 0 90. 04 91. 00 91. 00 91. 00 92.		0	0		0 0		
OUTPATI ENT SERVICE COST CENTERS 90.01 09001 OUTPATI ENT TREATMENT & INFUSION CTR 0 0 0 0 90.01 90.02 09002 ATHLETI C TRAINERS 0 0 0 0 90.02 90.03 09003 SAINT JOSEPH HEALTH CENTER 0 0 0 0 90.03 90.04 09004 WOUND CARE 0 0 0 0 90.04 91.00 09100 EMERGENCY 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 92.00		0	0				
90. 02 09002 ATHLETI C TRAI NERS 0 0 0 0 90. 02 90. 03 09003 SAI NT JOSEPH HEALTH CENTER 0 0 0 0 90. 03 90. 04 09004 WOUND CARE 0 0 0 0 90. 04 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 92. 00				1			
90.03 09003 SAINT JOSEPH HEALTH CENTER 0 0 0 0 90.03 90.04 09004 WOUND CARE 0 0 0 0 90.04 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00	90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	C		0 0	0	90.01
90. 04 09004 WOUND CARE 0 0 0 0 90. 04 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 92. 00	90. 02 09002 ATHLETI C TRAI NERS	0	C		0 0	0	90.02
91.00 09100 EMERGENCY 0 0 0 91.00 91.00 91.00 92.00 0 92.00 0 0 0 0 92.00 0 92.00 0 0 0 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00	90. 03 09003 SAINT JOSEPH HEALTH CENTER	0	C		0 0	0	90.03
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92. 00	90. 04 09004 WOUND CARE	0	C		0 0	0	90.04
		0	C		0 0	0	91.00
200.00 Total (lines 50 through 199) 0 0 0 0 0 200.00		0			0	-	
	200.00 Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

	JOSEPHS REG ME		JTH	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS			Period: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 2:	pared: 02 pm
			e XIX	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)	
			and 4)		(see	
		5.00	(7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-	-	1			
50.00 05000 OPERATING ROOM	0	-		0 36, 615, 827		1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C)	0 1, 408, 294		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C	0	0 20, 702, 569		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 8, 211, 293		
57.00 05700 CT SCAN	0	C)	0 33, 240, 333		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C)	0 1, 162, 386		
60. 00 06000 LABORATORY	0	C		0 43, 077, 838		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0 0	01000000	62.30
65. 00 06500 RESPI RATORY THERAPY	0	C		0 2, 407, 269		
65. 01 06501 SLEEP LAB	0	C)	0 416, 036	0.000000	65.01
66. 00 06600 PHYSI CAL THERAPY	0	C)	0 5, 115, 051	0.000000	66.00
66. 01 06601 PHYSI CAL THERAPY – LI FEPLEX	0	C)	0 1, 006, 220	0.000000	66. 01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILI TARY	0	C)	0 0	0.000000	66. 02
67.00 06700 OCCUPATI ONAL THERAPY	0	C)	0 1,007,688	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 268, 257	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 8, 056, 872	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	c c		0 0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	c c		0 2, 173, 619	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	c c		0 14, 629, 042	0.000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C C		0 0	0.000000	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C		0 97, 320	0.000000	76.98
76. 99 07699 LI THOTRI PSY	0	c c		0 0	0.000000	76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	c c		0 0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	C)	0 0	0.00000	90.01
90. 02 09002 ATHLETIC TRAINERS	0			0 0	0.000000	
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0	c		0 0	0.000000	
90. 04 09004 WOUND CARE	0			0 2, 523, 948		
91.00 09100 EMERGENCY	0			0 19, 903, 771		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 3, 255, 570		
200.00 Total (lines 50 through 199)	0	-		0 205, 279, 203		200.00
······································			I.		1	

	JOSEPHS REG MED			In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0076	Period: From 07/01/2022 To 06/30/2023		pared:
					11/29/2023 2:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	L
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	TT		1		1	4
50. 00 05000 OPERATI NG ROOM	0. 000000	1, 114, 528		0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	242, 392		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
57.00 05700 CT SCAN	0. 000000	633, 652		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	6, 172		0 0	0	
60. 00 06000 LABORATORY	0. 000000	814, 799		0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 000000	151, 846		0 0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	27, 330		0 0	0	66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	0. 000000	0		0 0	0	66. 01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0. 000000	0		0 0	0	66. 02
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	13, 233		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	9, 758		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	153, 732		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	268, 388		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0	1	0 0	0	76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	1	0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS			•		•	1
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0. 000000	0		0 0	0	90.01
90. 02 09002 ATHLETI C TRAI NERS	0. 000000	0		0 0	0	90.02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0. 000000	0		0 0	0	90.03
90. 04 09004 WOUND CARE	0. 000000	0		0 0	0	90.04
91.00 09100 EMERGENCY	0. 000000	365, 127		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)	1	3, 800, 957		0 0	0	200.00

	Financial Systems ST. JOSEPHS REG MED ATION OF INPATIENT OPERATING COST <td< th=""><th>Provider CCN: 15-0076</th><th>Peri od:</th><th>u of Form CMS-2 Worksheet D-1</th><th></th></td<>	Provider CCN: 15-0076	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2022 To 06/30/2023	Date/Time Pre	
		Title XVIII	Hospi tal	11/29/2023 2: PPS	02 pii
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			4, 567	1.0
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da do not complete this line.		ivate room days,	4, 567 0	2. 3.
. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	3, 355 0	4. 5.
. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.
. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	-		0	
3. 00	reporting period Total swing-bed NF type inpatient days (including private roo			0	8.
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	5		1, 052	9.
0. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	room days)	0	
1.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of	ctions)	•	0	11.
	December 31 of the cost reporting period (if calendar year, of Swing-bed NF type inpatient days applicable to titles V or XI	enter 0 on this line)	5	0	
	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	3	5 /	0	13.
4.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	year, enter O on this lir ram (excluding swing-bed	ne) days)	0	14.
5.00	Total nursery days (title V or XIX only)			0	15.
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				1
	Medicare rate for swing-bed SNF services applicable to service reporting period	C C		0.00	
8.00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0.00	18.
	Medicaid rate for swing-bed NF services applicable to service reporting period	<u> </u>		0.00	
	Medicaid rate for swing-bed NF services applicable to service reporting period		he cost	0.00	
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)		ing period (line	7, 186, 823 0	
3. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportir	ng period (line 6	0	23.
4. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	er 31 of the cost reporti	ng period (line	0	24.
5.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25.
6. 00 7. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 7, 186, 823	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	· · ·			
8.00 9.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed cr	larges)	0	28. 29.
0. 00	Semi-private room charges (excluding swing-bed charges)			0	30.
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		cuons)	0.00	
	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	
5.00 7.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 77 minute line 24)	and private room cost di	fferential (line	0 7, 186, 823	36. 37.
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
0 0-	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				-
	Adjusted general inpatient routine service cost per diem (see			1,573.64	
	Program general inpatient routine service cost (line 9 x line Medically person private room cost applicable to the Progr			1, 655, 469 0	39. 40.
n n n	Medically necessary private room cost applicable to the Progr	iam (IIIIC 14 X IIIIC 33)		0	1 40.

	ST.	JOSEPHS	REG	MED	CENTER	PLYMOUTH
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Heal th	Financial Systems ST.	JOSEPHS REG ME	D CE	NTER PLYMO	UTH		ln Li€	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			Provider C	CN: 15-	0076 P	eriod:	Worksheet D-1	
							rom 07/01/2022		
						T	06/30/2023		
				Ti +1 4	e XVIII		Hospi tal	11/29/2023 2: PPS	uz pili
	Cost Center Description	Total		Total		age Per	Program Days	Program Cost	
		Inpatient Cost	Inpa		sDiem (col. 1 ÷		(col. 3 x col.	
		•				. 2)		4)	
		1.00		2.00	_	. 00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0)	C		0.00	0	0	42.00
40.00	Intensive Care Type Inpatient Hospital Units	400 504			1	0.00			40.00
43.00		432, 504		C	2	0.00	0	0	
44.00	CORONARY CARE UNIT								44.00 45.00
45.00 46.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0		C		0.00	0	0	45.00
	OTHER SPECIAL CARE (SPECIFY)	0	Ί	C		0.00	0	0	40.00
47.00	Cost Center Description								47.00
								1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, I	ine 200)				1, 604, 266	48.00
48.01	Program inpatient cellular therapy acquisiti	on cost (Worksh	neet	D-6, Part	111, 1	ine 10,	column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines -	11 through 48.0	D1) (:	see instruc	ctions)			3, 259, 735	49.00
	PASS THROUGH COST ADJUSTMENTS							1	
50.00	Pass through costs applicable to Program inpa	atient routine	ser	vices (from	n Wkst.	D, sum	of Parts I and	137, 917	50.00
51.00	<pre>III) Pass through costs applicable to Program inpa</pre>	tiont oncillor		orvione (fr	com Wkc	+ D cu	m of Dorte II	86, 468	51.00
51.00	and IV)		y s	ervices (II	UIII WKS	ι. D, Su	III UI PALLS II	00, 400	51.00
52.00	Total Program excludable cost (sum of lines !	50 and 51)						224, 385	52.00
53.00	Total Program inpatient operating cost exclusion		elat	ed. non-phy	vsi ci an	anesthe	tist. and	3, 035, 350	
	medical education costs (line 49 minus line				, = : = : = : :				
	TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges								54.00
55.00	Target amount per discharge							0.00	
55.01	Permanent adjustment amount per discharge								55.01
55.02	Adjustment amount per discharge (contractor							0.00	
56.00	Target amount (line 54 x sum of lines 55, 55			t amount (l	ing E4	mi nuc i	ing 52)	0	
57.00 58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ng cost and ta	ar ge	t amount (i	The so	minus i	The 53)	0	
59.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n th	e cost rend	ortina	neriod e	nding 1996	0.00	1
57.00	updated and compounded by the market basket)				Sitting	periodie	narng 1770,	0.00	57.00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om p	rior year o	cost re	port, up	dated by the	0.00	60.00
	market basket)		•	5			5		
61.00	Continuous improvement bonus payment (if line							0	61.00
	55.01, or line 59, or line 60, enter the less								
	53) are less than expected costs (lines 54 x	60), or 1 % of	f th	e target an	mount (line 56)	, otherwise		
62.00	enter zero. (see instructions) Relief payment (see instructions)							0	62.00
	Allowable Inpatient cost plus incentive payme	ont (see instru	icti	nns)				0	
05.00	PROGRAM INPATIENT ROUTINE SWING BED COST			51137					05.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	embe	r 31 of the	e cost	reportin	g period (See	0	64.00
	instructions)(title XVIII only)	5				•	51 (
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 3	31 of the c	cost re	porti ng	period (See	0	65.00
	instructions)(title XVIII only)								
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64	plus line 6	55)(ti t	le XVIII	only); for	0	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	costs through		combor 21 c	of tho	cost ron	orting poriod	0	67.00
07.00	(line 12 x line 19)	e costs through	I Dei		JI LIIE	cust rep	or tring period	0	07.00
68.00	Title V or XIX swing-bed NF inpatient routing	e costs after [Dece	mber 31 of	the co	st repor	ting period	0	68.00
	(line 13 x line 20)					•	0.		
69.00	Total title V or XIX swing-bed NF inpatient							0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU								
70.00	Skilled nursing facility/other nursing facili	5				ıne 37)			70.00
71.00 72.00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line)		ine	/U ÷ IIne	2)				71.00
72.00	Program routine service cost (line 9 x line Medically necessary private room cost application		n (1	ine 14 v li	NG 321				72.00
74.00	Total Program general inpatient routine service								74.00
75.00	Capital -related cost allocated to inpatient	•				et B. Pa	rt II. column		75.00
	26, line 45)			(···-··			,		
76.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)							76.00
77.00	Program capital-related costs (line 9 x line	76)							77.00
78.00	Inpatient routine service cost (line 74 minus								78.00
79.00	Aggregate charges to beneficiaries for excess					70 .			79.00
80.00	Total Program routine service costs for comparison to a limit		cost	ıımı tati or	n (line	/8 minu	s line /9)		80.00
81.00 82.00	Inpatient routine service cost per diem limi		1)						81.00 82.00
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:		13)						84.00
85.00	Utilization review - physician compensation		ons)						85.00
86.00	Total Program inpatient operating costs (sum			gh 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS								
87.00	Total observation bed days (see instructions)							1, 212	
88.00	Adjusted general inpatient routine cost per			ne 2)				1, 573. 64	
89.00	Observation bed cost (line 87 x line 88) (see	e instructions))					1, 907, 252	89.00

Health Financial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMOU	ITH	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2022	Worksheet D-1	
				To 06/30/2023	Date/Time Pre 11/29/2023 2:	
	_	Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	598, 730	7, 186, 823	0. 08330	9 1, 907, 252	158, 891	90.00
91.00 Nursing Program cost	0	7, 186, 823	0.00000	0 1, 907, 252	0	91.00
92.00 Allied health cost	0	7, 186, 823	0.00000	0 1, 907, 252	0	92.00
93.00 All other Medical Education	0	7, 186, 823	0.00000	0 1, 907, 252	0	93.00

ST.	JOSEPHS	REG	MED	CENTER	PLYMOUTH	

		Provi der CCN: 15-0076	Peri od:	Worksheet D-1	
			To 06/30/2023		
		Title XIX	Hospi tal	11/29/2023 2:0 PPS	02
	If row 07/07/2022 To 06/30/2022 Data / Time Preserved: 11/20/202 / 20 2 mini- 10/2020 Cost Center Description Title XIX Hespital Pre- 10/2020 PART 1 - ALL PROVIDER COMPONENTS 1.00 IMPATIENT DAYS 1.00 1.00 INPATIENT DAYS 1.00 4.567 1.00 Inpatient days (including private room days, excluding swing-bed and observation bed days). 1.00 4.567 2.00 Coals sing-bed SMF type inpatient days (including private room days) for December 31 of the cost 0 6.00 7.00 Coals sing-bed SMF type inpatient days (including private room days) after December 31 of the cost 0 7.00 Coals sing-bed SMF type inpatient days (including private room days) after December 31 of the cost 0 7.00 Coals sing-bed SMF type inpatient days (including private room days) after December 31 of the cost 0 1.00 December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 1.00 Swing				
	PART I - ALL PROVIDER COMPONENTS			1.00	
		o ovoluding nowhorn)		4 5 4 7	
00 00					
	Private room days (excluding swing-bed and observation bed da		rivate room days,		
0	I I I I I I I I I I I I I I I I I I I	od dave)		2 255	
0			er 31 of the cost		
00		om days) after December	31 of the cost	0	
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	- 31 of the cost	0	7
0		m dayc) aftar Dacambar (1 of the cost	0	
00		in days) arter beceniber .	ST OF THE COST	0	
00		o the Program (excluding	g swing-bed and	77	9
00		nlv (including private u	room days)	0	10
	through December 31 of the cost reporting period (see instruc	tions)	5 1	0	
00			room days) after	0	11
00			te room days)	0	12
	through December 31 of the cost reporting period		5 -		
				0	13
00	Medically necessary private room days applicable to the Progr			0	14
00				216	1 16
00		es through December 31 d	of the cost	0.00	17
00		os after December 21 of	the cost	0.00	10
	reporting period			0.00	
00		s through December 31 of	f the cost	0.00	19
00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20
00		c)		7 104 000	21
00			ting period (line		
	5 x line 17)		0 1 1		
00		31 of the cost reportin	ng period (line 6	0	23
00	· · · · · · · · · · · · · · · · · · ·	r 31 of the cost reporti	ng period (line	0	24
00		21 of the cost reporting	n pariod (line 9	0	2
00			period (inte o	0	20
		(line 01 minute line 04)		-	
		(TTHE 21 minus TINE 26)		7, 186, 823	2
00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)		
		÷line 28)			
00	Average private room per diem charge (line 29 ÷ line 3)	,			32
		nuc line 22) (and instant	ations)		
00	Private room cost differential adjustment (line 3 x line 35)			0	36
00		and private room cost di	fferential (line	7, 186, 823	37
					1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			121, 170 0	
	Total Program general inpatient routine service cost (line 39	· , ,		121, 170	

	Financial Systems ST. ATION OF INPATIENT OPERATING COST	JOSEPHS REG MEI		UTH CN: 15-0076	Period:	eu of Form CMS-2 Worksheet D-1	
					From 07/01/2022 To 06/30/2023		
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	523, 986	332	2 1, 578.	27 216	340, 906	42.00
42 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	422 504	0		00 0	0	1 42 00
43.00 44.00	CORONARY CARE UNIT	432, 504		0.	JU U	, 0	43.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGI CAL I NTENSI VE CARE UNI T	0	C	0.	00 C	0 0	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						<u> </u>
48.00	Program inpatient ancillary service cost (Wk		2 Lino 200)			1.00	48.00
48.00	Program inpatient cellular therapy acquisition			III line 10	column 1)	007,044	48.00
49.00	Total Program inpatient costs (sum of lines					1, 129, 720	
	PASS THROUGH COST ADJUSTMENTS	9					
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	า Wkst. D, sur	n of Parts I and	13, 046	50.00
51.00) Pass through costs applicable to Program inpa	tiont oncillor	n consider (fr	om Wkot D	our of Dorto II	24 552	51.00
51.00	and IV)		y services (II	UIII WKSL. D, S	Sum OF Parts II	34, 552	51.00
52.00	Total Program excludable cost (sum of lines !	50 and 51)				47, 598	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-phy	/sician anest!	netist, and	1, 082, 122	53.00
	medical education costs (line 49 minus line	52)					_
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
54.00 55.00	Target amount per discharge					0.00	
55.01	Permanent adjustment amount per discharge					0.00	
55.02	Adjustment amount per discharge (contractor	use only)				0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55					0	
57.00	Difference between adjusted inpatient operation	ng cost and ta	arget amount (I	ine 56 minus	line 53)	0	
58.00 59.00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from	the cost rong	orting poriod	onding 1006	0.00	
57.00	updated and compounded by the market basket)		i the cost rept	n tring period	enurny 1990,	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year o	cost report, i	updated by the	0.00	60.00
	market basket)						
61.00	Continuous improvement bonus payment (if line					0	61.00
	55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)		the target an		J), otherwise		
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Door	mbor 21 of the		ing partial (Saa	0	64.00
04.00	instructions) (title XVIII only)	is through bece		: cost report	ng period (see	0	04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the o	cost reportin	g period (See	0	65.00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	o5)(title XVI	il only); for	0	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 (of the cost n	enorting period	0	67.00
07.00	(line 12 x line 19)				sporting period		07.00
68.00	Title V or XIX swing-bed NF inpatient routing	e costs after D	December 31 of	the cost rep	orting period	0	68.00
(0.00	(line 13 x line 20)						(0.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facil)		70.00
71.00	Adjusted general inpatient routine service of						71.00
72.00	Program routine service cost (line 9 x line		<u></u>	0-1			72.00
73.00	Medically necessary private room cost applicated	0	•				73.00
74.00 75.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient				Part II column		74.00
75.00	26, line 45)	outine service		ior Kaneet D, I			/ 0.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line						77.00
78.00 79.00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovidor roos	46)			78.00
79.00 80.00	Total Program routine service costs for compa	• •			nus line 79)		80.00
81.00	Inpatient routine service cost per diem limit						81.00
82.00	Inpatient routine service cost limitation (I	ne 9 x line 81					82.00
83.00	Reasonable inpatient routine service costs (ıs)				83.00
84.00	Program inpatient ancillary services (see in:		nc)				84.00
85.00 86.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00 86.00
30.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1	00.00
87.00	Total observation bed days (see instructions))				1, 212	
	1 A 14						
88. 00 89. 00	Adjusted general inpatient routine cost per o Observation bed cost (line 87 x line 88) (see		,			1, 573. 64 1, 907, 252	

Health Financial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMOU	JTH	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2022	Worksheet D-1	
				To 06/30/2023	Date/Time Pre 11/29/2023 2:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	598, 730	7, 186, 823	0.08330	9 1, 907, 252	158, 891	90.00
91.00 Nursing Program cost	0	7, 186, 823	0.00000	0 1, 907, 252	0	91.00
92.00 Allied health cost	0	7, 186, 823	0.00000	0 1, 907, 252	0	92.00
93.00 All other Medical Education	0	7, 186, 823	0. 00000	0 1, 907, 252	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0076	Period: From 07/01/2022 To 06/30/2023		pared:
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 O3000 ADULTS & PEDI ATRI CS		T	2 025 (25	1	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T			2, 935, 635		30.00 31.00
			0		
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 18709	9 1, 072, 961	200, 750	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 37526		200, 750	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 37520		80, 882	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 12997		00,002	55.00
57. 00 05700 CT SCAN		0. 01425		19, 329	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON					
		0. 26019		2, 346	
		0. 15176		258, 982	
		0.0000			62.30
65. 00 06500 RESPIRATORY THERAPY		0. 51562		261, 218	65.00
		0. 24653		-	65.01 66.00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX		0. 40696		59, 622 0	66.00
66. 02 06602 PHYSICAL THERAPY - CULVER MILITAR	/	0. 00000			66.02
67. 00 06700 OCCUPATIONAL THERAPY	1	0. 25776		-	
68. 00 06800 SPEECH PATHOLOGY					
		0. 63724		12,025	
69. 00 06900 ELECTROCARDI OLOGY	IT	0.04924		27, 127	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI EN		0.00000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 50497			
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDIAC REHABILITATION		0. 28086		196, 936	
76. 98 07698 HYPERBARIC OXYGEN THERAPY		0.00000		0	76.97
76. 99 07699 LI THOTRI PSY		0. 10958		-	76.98
		0.00000		0	76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS		0.00000	0 0	0	77.00
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CT	rp.	0.0000	0 0	0	90.01
90. 02 09002 ATHLETI C TRAI NERS		0.00000		0	90.02
90. 03 09003 SAINT JOSEPH HEALTH CENTER		0.00000		0	90.02
90. 04 09004 WOUND CARE		0. 46425		-	
91. 00 09100 EMERGENCY		0. 30478		228, 485	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	9T	0. 58584			
200.00 Total (sum of lines 50 through 94		0.0004	7, 932, 860		
201.00 Less PBP Clinic Laboratory Service			, 732, 000 Λ	1,004,200	200.00
202.00 Net charges (line 200 minus line 2			7, 932, 860		201.00
		1	,, 752, 500	I	1202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-0076	Peri od: From 07/01/2022 To 06/30/2023		pared:
	Title	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			2 002 040		20.00
30. 00 03000 ADULTS & PEDIATRICS			2, 992, 040		30.00
31. 00 03100 INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT			0		31.00 34.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS			0		43.00
50. 00 05000 OPERATI NG ROOM		0. 18709	9 1, 114, 528	208, 527	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 37526		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12997		31, 505	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 14251		0 0	55.00
57. 00 05700 CT SCAN		0. 01429		9,059	•
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 26019		1, 606	•
60. 00 06000 LABORATORY		0. 15176			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	62.30
65. 00 06500 RESPI RATORY THERAPY		0. 51562		78, 296	•
65. 01 06501 SLEEP LAB		0.24653		0	65.01
66. 00 06600 PHYSI CAL THERAPY		0.40696		11, 122	66.00
66. 01 06601 PHYSI CAL THERAPY – LI FEPLEX		0.43087		0	66.01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILI TARY		0.0000		0	66. 02
67.00 06700 OCCUPATI ONAL THERAPY		0. 25776	13, 233	3, 411	67.00
68.00 06800 SPEECH PATHOLOGY		0. 63724	9, 758	6, 218	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 04924	153, 732	7, 571	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.0000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 50497	78 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 28086	268, 388	75, 382	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 10958		0	
76. 99 07699 LI THOTRI PSY		0.00000		0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000	0 0	0	77.00
OUTPATI ENT SERVI CE COST CENTERS				1	
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR		0.0000		0	
90. 02 09002 ATHLETI C TRAI NERS		0.0000		0	
90. 03 09003 SAINT JOSEPH HEALTH CENTER		0.0000		0	90.03
90. 04 09004 WOUND CARE		0. 46425		0	
91.00 09100 EMERGENCY		0. 30478			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 58584		0	1 2.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	aa (lina (1)		3, 800, 957	667, 644	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line ol)				201.00
202.00 Net charges (line 200 minus line 201)	I		3, 800, 957	I	202.00

Health Financial Systems ST. JOSEPHS REG MED CENTER PLYMOUTH In Lieu of Form CMS-2552-10 CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0076 Peri od: Worksheet E From 07/01/2022 Part A Date/Time Prepared: То 06/30/2023 11/29/2023 2:02 pm Title XVIII Hospi tal PPS 1.00 PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG Amounts Other than Outlier Payments 0 1.00 2, 890, 171 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 1.01 instructions) 1.02 1 02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 0 instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1.03 0 1.03 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 1.04 October 1 (see instructions) 2 00 Outlier payments for discharges. (see instructions) 2 00 2.01 Outlier reconciliation amount 0 2.01 2.02 Outlier payment for discharges for Model 4 BPCI (see instructions) 0 2.02 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.03 2.03 0 2 04 Outlier payments for discharges occurring on or after October 1 (see instructions) 0 2 04 3.00 Managed Care Simulated Payments 2,679,898 3.00 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 34.68 4.00 Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on 0 00 5.00 or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 0.00 5.01 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for 6.00 0.00 6.00 new programs in accordance with 42 CFR 413.79(e) Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of 0.00 6.26 6.26 the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1) 7.00 0.00 7.00 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2) If the 0.00 7.01 cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural 0.00 7 02 7 02 track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for 0.00 8.00 affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8 01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost 0 00 8.01 report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital 8.02 0.00 8.02 under § 5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see 8.21 0.00 8.21 instructions) 9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or 0.00 9 00 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 Current year allowable FTE (see instructions) 0.00 12.00 12.00 Total allowable FTE count for the prior year. 13.00 0.00 13.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 otherwise enter zero. Sum of lines 12 through 14 divided by 3. 15.00 15.00 0.00 Adjustment for residents in initial years of the program (see instructions) 0.00 16.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjusted rolling average FTE count 0.00 18.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 19.00 20 00 Prior year resident to bed ratio (see instructions) 0 000000 20 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 IME payment adjustment - Managed Care (see instructions) 22.01 0 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 23.00 0.00 23.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 28 00 0 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 28.01 0 Total IME payment (sum of lines 22 and 28) 29.00 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 29.01 0 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.15 30.00 31.00 Percentage of Medicaid patient days (see instructions) 23.92 31.00 Sum of lines 30 and 31 25.07 32.00 32.00 9.90 33.00 Allowable disproportionate share percentage (see instructions) 33.00 71, 532 34.00

Heal th Financial Systems

ST.	JOSEPHS	REG	MED	CENTER	PLYMOUTH

CAL CULATION OF RETURBUSESMENT STITLINENT Provider CD2 15-0076 Period arrow to the part of the propured to the part of the part of the propured to the part of the pa	Hear th	FINANCIAI SYSTEMS SI. JUSEPHS REG MED CEN	NIER PLYMUUIH	In Lie	U OI FORM CMS-2	2552-10
Title XVIII Hospital 11/29/2033 2:02 pm Uncompensated Care Payment Adjustment Prior 13 10/1 backfree 10/1 0.00 2.00 35:00 Total uncompensated Care Payment Adjustment 0.00 0.00 0.00 0.00 35:01 Factor 3 (see instructions) 0.00000000 0.000000000 0.000000000 0.000000	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0076	From 07/01/2022	Part A	oared:
Prior to 10.71 Description 100 2.00 100 2.00 100 2.00 100 0.000000 100 0.0000000 100 0.0000000 100 0.0000000 100 0.0000000 100 0.0000000 100 0.0000000 100 0.0000000 100 0.0000000 100 0.0000000 100 0.0000000 100 0.0000000 100 0.0000000 100 0.0000000 100 0.00000000 100 0.0000000000 100 0.00000000000000000000000000000000000					11/29/2023 2:	D2 pm
Uncompensated Care Payment Adjustment 1.00 2.00 35.00 Total uncompensated care amount (see instructions) 0 0.00000000 35.00 36.00 Total uncompensated care amount (see instructions) 0.00000000 0.00000000 35.01 37.00 Case instructions) 0.00000000 0.00000000 35.01 37.01 Case instructions) 0.00000000 0.00000000 35.01 37.01 Including supplemental UCP (see instructions) 0.00000000 68.00 68.00 40.00 Intal Bed care discharges (see instructions) 0 0.00000000 41.00 41.00 Intal ESD Medicare covered and paid discharges (see instructions) 0 0 41.00 41.00 Intal ESD Medicare covered and paid discharges (see instructions) 0 0 41.00 42.00 Intal Medicare ESD Medicare covered and paid discharges (see instructions) 0 0 41.00 43.00 Intal Medicare ESD Medicare covered and paid discharges (see instructions) 0 0 42.00 44.00 Istal for Average length of stay to one week (line 43 divided by 1 re 41 divided by			Title XVIII			
Incompensated Care Payment Adjustment 0				Prior to 10/1	On/After 10/1	
95.00 Total uncompensated care amount (see instructions) 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0				1.00	2.00	
35.01 Factor 3 (see instructions) 0.00000000 0.0000000 0.0000000 0.00000000 0.0000000 0.00000000 0.0000000 0.00000000 0.00000000 0.00000000 0.0000000 0.00000000 0.00000000 0.00000000 0.00000000 0.00000000 0.0000000000 0.000000000 0.000000000 0.000000000 0.000000000 0.000000000 0.000000000 0.000000000 0.000000000000 0.00000000000000000000000000000000000						
Issis Instructions) Instructions Issist Solution 56.03 Profile Solution So	35.01	Factor 3 (see instructions)	enter zero on this line	0. 00000000	0. 000000000	35.01
Add It onal psyment for inplayment for inplay percentage of ESRD beneficiary discharges (lines 40 through 46) 40.00 Ital Medicare discharges (see instructions) 0 41.00 Total ESRD Medicare discharges (see instructions) 0 41.00 Total ESRD Medicare discharges (see instructions) 0 0 41.00 Total ESRD Medicare SRD (see instructions) 0 0 41.00 41.00 Total ESRD Medicare SRD (see instructions) 0 0 41.00 42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 0.00 0 43.00 43.00 Addicare ESRD for dial ysis (see instructions) 0 0 44.00 44.00 Initial specific psyments (to be completed by SCH and MDH, small rural hospitals 0 0 46.00 47.00 Motol (see instructions) 3, 620, 665 47.00 48.00 49.00 Total payment for inpatient operating costs (see instructions) 3, 620, 665 45.00 51.00 Exception payment for inpatient operating costs (see instructions) 3, 620, 665 45.00 51.00 Exception payment for inpatient operating costs (see instructions) 3, 620, 665 40.00		(see instructions)				
Answer Deferre 1/1 On After 1/1 41.00 Total ESR0 Medicare discharges (see instructions) 1.00 1.01 1.00 1.00 1.00 1.00 41.01 Total ESR0 Medicare covered and paid discharges (see instructions) 0 0 0 0.00 0 41.00 42.00 Divide line 41 by line 40 (if less than 10%, you do not quality for adjustment) 0.00 0.00 42.00 43.00 Total Medicare ESR0 Medicare Covered and sky (see instructions) 0 0.00 44.00 44.00 Netrage weekly cost for dialysis treatments (see instructions) 0.00 0.00 45.00 45.00 Average weekly cost for dialysis treatments (see instructions) 0.00 0.00 46.00 46.00 Total payment for inpatient operating costs (see instructions) 3.620.665 44.00 47.00 Total payment for inpatient operating costs (see instructions) 3.620.665 45.00 51.00 Rexement for inpatient program capital (from Wkst. L, Pt. 11, see instructions). 3.620.665 50.00 52.00 Direct graduate medical educating payment for ingay talog specific on thapay acqital (the deta) the congr		Additional payment for high percentage of ESRD beneficiary disc	harges (lines 40 throug	jh 46)		
1.00 Total ESRD Medicare discharges (see instructions) 1.00 41.01 01.01 Total ESRD Medicare discharges (see instructions) 0 41.00 01.01 Total ESRD Medicare discharges (see instructions) 0 0 41.00 02.00 Divide line 41 bit line 43 (line 183 divided by line 41 divided by 7 0 0 43.00 03.00 Total Medicare ESRD inpatient days (see instructions) 0.00 0 43.00 04.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 0.000 0.00 45.00 04.00 Total additional payment (line 45 times line 44 times line 41.01) 0 0.00 46.00 10.01 Use Instructions) 0.00 0.00 46.00 46.00 10.02 Total payment for inpatient operating costs (see instructions) 3.620.665 49.00 216.566 50.00 10.00 Execution payment for inpatient program capital (from Wkst. L. Pt. Lin. see instructions) 0 216.566 50.00 51.00 51.00 51.00 52.00 51.00 52.00 51.00 51.00 51.00	40.00	Total Medicare discharges (see instructions)				40.00
11.00 Total ESBD Medicare discharges (see instructions) 0						
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60.00Primary payer payments060.0061.00Total amount payable for program beneficiaries (line 59 minus line 60)3,845,13561.0062.00Deductibles billed to program beneficiaries436,73262.0063.00Coinsurance billed to program beneficiaries3,54563.0064.00Allowable bad debts (see instructions)10,92164.0065.00Adjusted reimbursable bad debts (see instructions)66.007,09965.0066.00Subtotal (line 61 plus line 65 minus lines 62 and 63)66.003,411,95767.0067.00Subtotal (line 61 plus line 65 minus lines 93, 95 and 96). (For SCH see instructions)068.0070.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)64.10A Demonstration) adjustment (see instructions)070.0070.50Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)070.5070.75N95 respirator payment adjustment amount (see instructions)070.8770.88SCH or MDH volume decrease adjustment (contractor use only)70.8970.8970.99HSP bonus payment HRR adjustment amount (see instructions)070.9070.91HSP bonus payment HRR adjustment amount (see instructions)070.9170.92Bundled Model 1 discount amount (see instructions)070.9270.93HRR adjustment amount (see instructions)070.9370.94HRR adjustment amount (see instructions)070.9370.93HRR Adjustment amount (se	59.00				3, 845, 135	59.00
61.00Total amount payable for program beneficiaries (line 59 minus line 60)3,845,13561.0062.00Deductibles billed to program beneficiaries436,73262.0063.00Coinsurance billed to program beneficiaries3,54563.0064.00Allowable bad debts (see instructions)0,92164.0065.00Adjusted reimbursable bad debts (see instructions)10,92164.0066.00Allowable bad debts for dual eligible beneficiaries (see instructions)7,09965.0067.00Subtotal (line 61 plus line 65 minus lines 62 and 63)7,09965.0068.00Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)068.0069.00Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)069.0070.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)070.0070.50Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)070.9070.87Demonstration payment adjustment amount before sequestration070.8770.88SCH or MDH volume decrease adjustment (contractor use only)070.9070.91HSP bonus payment HVBP adjustment amount (see instructions)070.9070.92Bundled Model 1 di scount amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.9270.94HRR Adjustment amount (see instructions)070.92	60.00	Primary payer payments			0	60.00
62.00Deductibles billed to program beneficiaries436,73262.0063.00Coinsurance billed to program beneficiaries3,54563.0064.00Allowable bad debts (see instructions)10,92164.0065.00Adjusted reimbursable bad debts (see instructions)7,09965.0066.00Allowable bad debts for dual eligible beneficiaries (see instructions)6,47366.0067.00Subtotal (line 61 plus line 65 minus lines 62 and 63)3,411,95767.0068.00Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)068.0069.00Ottler payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)069.0070.00Ottler payments reconciliation Project (§410A Demonstration) adjustment (see instructions)070.5070.75N95 respirator payment adjustment amount (see instructions)070.8770.87Demonstration payment adjustment amount (see instructions)070.8770.90HSP bonus payment HVBP adjustment amount (see instructions)070.9070.91HSP bonus payment HRR adjustment amount (see instructions)070.9170.92HVBP payment adjustment amount (see instructions)070.9270.93HVBP payment adjustment amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.9370.94HRR adjustment amount (see instructions)070.9370.94HRR adjustment amount (see instructions)<	61.00	Total amount payable for program beneficiaries (line 59 minus l	ine 60)		3, 845, 135	61.00
64.00Allowable bad debts (see instructions)10,92164.0065.00Adjusted reimbursable bad debts (see instructions)7,09965.0066.00Allowable bad debts for dual eligible beneficiaries (see instructions)6,47366.0067.00Subtotal (line 61 plus line 65 minus lines 62 and 63)3,411,95767.0068.00Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)068.0069.00Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)069.0070.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)070.0070.50Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)070.0070.75N95 respirator payment adjustment amount (see instructions)070.75070.88SCH or MDH volume decrease adjustment (contractor use only)070.88070.8970.90HSP bonus payment HVBP adjustment amount (see instructions)070.9070.9070.91HSP bonus payment HVBP adjustment amount (see instructions)070.9170.93HVBP payment adjustment amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.9270.94HRR adjustment amount (see instructions)-2,09670.94	62.00				436, 732	62.00
65.00Adjusted reimbursable bad debts (see instructions)7,09965.0066.00Allowable bad debts for dual eligible beneficiaries (see instructions)6,47366.0067.00Subtotal (line 61 plus line 65 minus lines 62 and 63)3,411,95767.0068.00Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)068.0069.00Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)068.0070.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)070.0070.50Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)070.5070.75N95 respirator payment adjustment amount before sequestration070.8770.88SCH or MDH volume decrease adjustment (contractor use only)070.8970.99HSP bonus payment HVBP adjustment amount (see instructions)070.9070.91HSP bonus payment HRR adjustment amount (see instructions)070.9070.93HVBP payment adjustment amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.93	63.00	Coinsurance billed to program beneficiaries			3, 545	63.00
66.00Allowable bad debts for dual eligible beneficiaries (see instructions)6,47366.0067.00Subtotal (line 61 plus line 65 minus lines 62 and 63)3,411,95767.0068.00Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)068.0069.00Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)069.0070.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)070.0070.50Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)070.5070.75N95 respirator payment adjustment amount (see instructions)070.7570.87Demonstration payment adjustment amount (see instructions)070.8770.88SCH or MDH volume decrease adjustment (contractor use only)070.8870.90HSP bonus payment HVBP adjustment amount (see instructions)070.9070.91HSP bonus payment HRR adjustment amount (see instructions)070.9170.92Bundled Model 1 discount amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.92	64.00	Allowable bad debts (see instructions)			10, 921	64.00
67.00Subtotal (line 61 plus line 65 minus lines 62 and 63)3, 411, 95767.0068.00Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)068.0069.00Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)069.0070.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)070.0070.50Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)070.5070.75N95 respirator payment adjustment amount (see instructions)070.7570.87Demonstration payment adjustment amount (see instructions)070.8770.88SCH or MDH volume decrease adjustment (contractor use only)070.8870.90HSP bonus payment HVBP adjustment amount (see instructions)070.9070.91HSP bonus payment HRR adjustment amount (see instructions)070.9170.92Bundle Model 1 discount amount (see instructions)070.9370.94HRR adjustment amount (see instructions)070.9370.94HRR adjustment amount (see instructions)070.94	65.00	Adjusted reimbursable bad debts (see instructions)			7, 099	65.00
68.00Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)068.0069.00Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)069.0070.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)070.0070.50Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)070.5070.75N95 respirator payment adjustment amount (see instructions)070.5070.88SCH or MDH volume decrease adjustment (contractor use only)070.8870.90HSP bonus payment HVBP adjustment amount (see instructions)070.9070.91HSP bonus payment HRR adjustment amount (see instructions)070.9170.92Bundled Model 1 discount amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.9370.94HRR adjustment amount (see instructions)070.94	66.00	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		6, 473	66.00
69.00Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)069.0070.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)070.0070.50Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)070.0070.75N95 respirator payment adjustment amount (see instructions)070.5070.87Demonstration payment adjustment amount before sequestration070.8770.88SCH or MDH volume decrease adjustment (contractor use only)070.8870.90HSP bonus payment HVBP adjustment amount (see instructions)070.9070.91HSP bonus payment HRR adjustment amount (see instructions)070.9070.92Bundled Model 1 discount amount (see instructions)070.9270.93HVBP payment adjustment amount (see instructions)070.9370.94HRR adjustment amount (see instructions)070.94	67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3, 411, 957	67.00
70.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)070.0070.50Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)070.5070.75N95 respirator payment adjustment amount (see instructions)070.7570.87Demonstration payment adjustment amount before sequestration070.8770.88SCH or MDH volume decrease adjustment (contractor use only)070.8870.99Pioneer ACO demonstration payment adjustment amount (see instructions)070.9070.91HSP bonus payment HVBP adjustment amount (see instructions)070.9070.92Bundled Model 1 discount amount (see instructions)070.9270.93HVBP payment adjustment amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.92	68.00	Credits received from manufacturers for replaced devices for ap	plicable to MS-DRGs (se	e instructions)	0	68.00
70. 50Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)070. 5070. 75N95 respirator payment adjustment amount (see instructions)070. 7570. 87Demonstration payment adjustment amount before sequestration070. 8770. 88SCH or MDH volume decrease adjustment (contractor use only)070. 8870. 99Pioneer ACO demonstration payment adjustment amount (see instructions)070. 8970. 91HSP bonus payment HVBP adjustment amount (see instructions)070. 9070. 92Bundled Model 1 discount amount (see instructions)070. 9270. 93HVBP payment adjustment amount (see instructions)070. 9270. 94HRR adjustment amount (see instructions)070. 9270. 94HRR adjustment amount (see instructions)070. 93	69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (F	or SCH see instructions	3)	0	
70.75N95 respirator payment adjustment amount (see instructions)070.7570.87Demonstration payment adjustment amount before sequestration070.8770.88SCH or MDH volume decrease adjustment (contractor use only)070.8870.89Pioneer ACO demonstration payment adjustment amount (see instructions)070.8970.90HSP bonus payment HVBP adjustment amount (see instructions)070.9070.91HSP bonus payment HRR adjustment amount (see instructions)070.9170.93HVBP payment adjustment amount (see instructions)070.9270.94HRR adjustment amount (see instructions)070.9370.94HRR adjustment amount (see instructions)070.9370.94HRR adjustment amount (see instructions)070.93		OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70. 87Demonstration payment adjustment amount before sequestration070. 8770. 88SCH or MDH volume decrease adjustment (contractor use only)070. 8870. 89Pioneer ACO demonstration payment adjustment amount (see instructions)070. 8970. 90HSP bonus payment HVBP adjustment amount (see instructions)070. 9070. 91HSP bonus payment HRR adjustment amount (see instructions)070. 9170. 92Bundled Model 1 discount amount (see instructions)070. 9370. 94HRR adjustment amount (see instructions)070. 9370. 94HRR adjustment amount (see instructions)070. 9370. 94HRR adjustment amount (see instructions)070. 93			ition) adjustment (see i	nstructions)	0	
70. 88 70. 89SCH or MDH volume decrease adjustment (contractor use only)070. 88 70. 8970. 89 70. 90Pioneer ACO demonstration payment adjustment amount (see instructions)070. 89 						
70. 89Pioneer ACO demonstration payment adjustment amount (see instructions)70. 8970. 90HSP bonus payment HVBP adjustment amount (see instructions)070. 91HSP bonus payment HRR adjustment amount (see instructions)070. 92Bundl ed Model 1 discount amount (see instructions)070. 93HVBP payment adjustment amount (see instructions)070. 94HRR adjustment amount (see instructions)070. 94HRR adjustment amount (see instructions)0					-	
70. 90HSP bonus payment HVBP adjustment amount (see instructions)070. 9070. 91HSP bonus payment HRR adjustment amount (see instructions)070. 9170. 92Bundled Model 1 discount amount (see instructions)070. 9270. 93HVBP payment adjustment amount (see instructions)070. 9270. 94HRR adjustment amount (see instructions)070. 93		SCH or MDH volume decrease adjustment (contractor use only)			0	
70. 91HSP bonus payment HRR adjustment amount (see instructions)070. 9170. 92Bundled Model 1 discount amount (see instructions)070. 9270. 93HVBP payment adjustment amount (see instructions)070. 9370. 94HRR adjustment amount (see instructions)070. 94			icti ons)			
70.92Bundled Model 1 discount amount (see instructions)070.9270.93HVBP payment adjustment amount (see instructions)070.9370.94HRR adjustment amount (see instructions)-2,09670.94	70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
70. 93HVBP payment adjustment amount (see instructions)070. 9370. 94HRR adjustment amount (see instructions)-2, 09670. 94		HSP bonus payment HRR adjustment amount (see instructions)			0	
70. 94 HRR adjustment amount (see instructions) -2,096 70. 94		Bundled Model 1 discount amount (see instructions)			-	
70. 95 Recovery of accelerated depreciation 0 70. 95		, , , , , , , , , , , , , , , , , , ,				
	70.95	Recovery of accel erated depreciation			0	70. 95

ST. JOSEPHS REG MED CENTER PLYMOUTH

ealth Financial Systems ST. JOSEPHS REG MED C	CENTER PLYMOL	JTH	In Lie	u of Form CMS-2	2552-1
ALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CO	F	veriod: rom 07/01/2022 o 06/30/2023	Worksheet E Part A Date/Time Pre	narod
		1	0 00/30/2023	11/29/2023 2:	
	Title	XVIII	Hospi tal	PPS	
			уууу)	Amount	
0.96 Low volume adjustment for federal fiscal year (vvvv) (Enter i			0)22	1.00	70.9
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n corumn u	20)22	487, 583	10.9
0.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af		20	023	73, 461	70.9
0.98 Low Volume Payment-3	-		0	0	70.9
0.99 HAC adjustment amount (see instructions)				0	
1.00 Amount due provider (line 67 minus lines 68 plus/minus lines 6	69 & 70)			3, 970, 905	
1.01 Sequestration adjustment (see instructions)				79, 418	
1.02 Demonstration payment adjustment amount after sequestration				0	
1.03 Sequestration adjustment-PARHM pass-throughs				2 (00 051	71.0
2.00 Interim payments				3, 600, 051	
2.01 Interim payments-PARHM 3.00 Tentative settlement (for contractor use only)				0	72.0
3.01 Tentative settlement-PARHM (for contractor use only)				0	73.0
4.00 Balance due provider/program (line 71 minus lines 71.01, 71.0)	12 72 and			291, 436	
73)	2, 72, 414			271,430	/ 4. 0
4.01 Balance due provider/program-PARHM (see instructions)					74.0
5.00 Protested amounts (nonallowable cost report items) in accorda	nce with			162, 334	75.0
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum (of 2.03			0	90.0
plus 2.04 (see instructions)				0	01
1.00 Capital outlier from Wkst. L, Pt. I, line 2 2.00 Operating outlier reconciliation adjustment amount (see instru	wati ana)			0	
				0	
3.00 Capital outlier reconciliation adjustment amount (see instruc 4.00 The rate used to calculate the time value of money (see instru				0.00	
5.00 Time value of money for operating expenses (see instructions)				0.00	
6.00 Time value of money for capital related expenses (see instruct				0	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount			1		
00.00 HSP bonus amount (see instructions)			0	0	100. (
HVBP Adjustment for HSP Bonus Payment			0.0000000000	0.000000000	101 /
01.00 HVBP adjustment factor (see instructions)			0.0000000000000000000000000000000000000	0.000000000	101.0
02.00 HVBP adjustment amount for HSP bonus payment (see instruction: HRR Adjustment for HSP Bonus Payment	15)		U U	0	102.
03.00 HRR adjustment factor (see instructions)			0.0000	0.0000	103
04.00 HRR adjustment amount for HSP bonus payment (see instructions)	;)		0.0000		104.
Rural Community Hospital Demonstration Project (§410A Demonstr		stment	-		
00.00 Is this the first year of the current 5-year demonstration pe					200.
Century Cures Act? Enter "Y" for yes or "N" for no.					
Cost Reimbursement			1		
01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	ie 49)				201. (
02.00 Medicare discharges (see instructions)					202. (
03.00 Case-mix adjustment factor (see instructions)	£:		E		203. (
Computation of Demonstration Target Amount Limitation (N/A in period)	TITSt year	or the current	5-year demonst	ration	
04.00 Medicare target amount					204.
05.00 Case-mix adjusted target amount (line 203 times line 204)					205.
06.00 Medicare inpatient routine cost cap (line 202 times line 205)					206.
Adjustment to Medicare Part A Inpatient Reimbursement					
07.00 Program reimbursement under the §410A Demonstration (see inst					207.
	ructions)				208.
					209.
08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,					
 08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 09.00 Adjustment to Medicare IPPS payments (see instructions) 00.00 Reserved for future use 					
08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 09.00 Adjustment to Medicare IPPS payments (see instructions) 10.00 Reserved for future use 11.00 Total adjustment to Medicare IPPS payments (see instructions)					
 008.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, D9.00 Adjustment to Medicare IPPS payments (see instructions) 10.00 Reserved for future use 11.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 	line 59)				211.
 008.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 09.00 Adjustment to Medicare IPPS payments (see instructions) 10.00 Reserved for future use 11.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 12.00 Total adjustment to Medicare Part A IPPS payments (from line 1 	line 59)				211. 212.
 08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 09.00 Adjustment to Medicare IPPS payments (see instructions) 10.00 Reserved for future use 11.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 12.00 Total adjustment to Medicare Part A IPPS payments (from line 13.00 Low-volume adjustment (see instructions) 	line 59) 211)				210. 211. 212. 212. 213.
 08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 09.00 Adjustment to Medicare IPPS payments (see instructions) 10.00 Reserved for future use 11.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 12.00 Total adjustment to Medicare Part A IPPS payments (from line 1 	line 59) 211)	bursement)			211 212

	Financial Systems		JOSEPHS REG MED	Provider CO	CN: 15-0076 F	Period: From 07/01/2022 To 06/30/2023	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Pre 11/29/2023 2:0	t 4 pared
			Amounts (from	Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	<u>through 4)</u> 5.00	
00	DRG amounts other than outlier	1.00	0	0			0	1.
01	payments DRG amounts other than outlier payments for discharges	1. 01	2, 890, 171	0	2, 890, 171		2, 890, 171	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	О	0		0	0	1.
)3	1 DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1. 03	0	0	C		0	1
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	О	0		0	0	1
00	Outlier payments for	2.00						2
)1	discharges (see instructions) Outlier payments for	2. 02		Δ	(0	0	2
	di scharges for Model 4 BPCI	2.02	0	0			0	2
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	C		0	2
)3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2
00	Operating outlier	2. 01	О	0	C	0	0	3
00	reconciliation Managed care simulated payments	3.00	2, 679, 898	0	2, 679, 898	3 0	2, 679, 898	4
	Indirect Medical Education Adju							
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0.00000	0. 000000		5
00	IME payment adjustment (see instructions)	22.00	О	0	C	0 0	0	6
)1	IME payment adjustment for managed care (see instructions)	22.01	O	0	C	0 0	0	6
	Indirect Medical Education Adju							_
00	IME payment adjustment factor (see instructions) IME adjustment (see	27.00 28.00	0. 000000	0. 000000			0	7
)1	instructions) IME payment adjustment add on for managed care (see	28.01	о	0	C	o o	0	8
00	instructions) Total IME payment (sum of	29.00	о	0	C	o o	0	9
)1	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29.01	о	0	C	0 0	0	9
	8.01)							
00	Disproportionate Share Adjustme Allowable disproportionate share percentage (see	33.00	0. 0990	0. 0990	0. 0990	0. 0990		10
00	instructions) Disproportionate share adjustment (see instructions)	34.00	71, 532	0	71, 532	2 0	71, 532	11
01	Uncompensated care payments	36.00	658, 962	0	155, 494	503, 468	658, 962	11
00	Additional payment for high per Total ESRD additional payment (see instructions)	centage of ESF 46.00	D beneficiary d 0	li scharges 0	C	0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	3, 620, 665 0	0 0	3, 117, 197 C	503, 468 0 0	3, 620, 665 0	13 14
00	(see instructions) Total payment for inpatient operating costs (see	49.00	3, 620, 665	0	3, 117, 197	503, 468	3, 620, 665	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	216, 546	0	216, 546	0	216, 546	16

OW VO	LUME CALCULATION EXHIBIT 4			Provider CC		Period: From 07/01/2022 To 06/30/2023		pared
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
7.00	Special add-on payments for	54.00	7, 924	0	7, 92	4 0	7, 924	17.
	new technol ogi es							
7.01	Net organ aquisition cost					_	_	17.0
7.02	Credits received from	68.00	0	0		0 0	0	17.
	manufacturers for replaced							
0 00	devices for applicable MS-DRGs	00.00					0	1 1 0 1
8. 00	Capital outlier reconciliation adjustment amount (see	93.00	0	0		0 0	0	18. (
	instructions)							
9 00	SUBTOTAL			0	3, 341, 66	503, 468	3, 845, 135	19
// 00	oob to the	W/S L, line	(Amounts from		0,011,00		0,010,100	
			L)					
		0	1.00	2.00	3.00	4.00	5.00	
0.00	Capital DRG other than outlier	1.00	216, 546	0	216, 54			
0. 01	Model 4 BPCI Capital DRG other	1. 01	0	0		0 0	0	20.
	than outlier							
1.00	Capital DRG outlier payments	2.00	0	0		0 0	0	
1. 01	Model 4 BPCI Capital DRG	2.01	0	0		0 0	0	21.
2 00	outlier payments	F 00	0,0000	0,0000	0.000	0 0000		22
2.00	Indirect medical education	5.00	0. 0000	0.0000	0.000	0.0000		22.
3.00	percentage (see instructions) Indirect medical education	6.00	0	0		0 0	0	23.
3.00	adjustment (see instructions)	0.00	0	0		0 0	0	23.
4.00	Allowable disproportionate	10.00	0. 0000	0.0000	0.000	0.0000		24.
1.00	share percentage (see	10.00	0.0000	0.0000	0.000	0.0000		2
	i nstructi ons)							
5.00	Disproportionate share	11.00	О	0		0 0	0	25.
	adjustment (see instructions)		-					
6.00	Total prospective capital	12.00	216, 546	0	216, 54	6 0	216, 546	26.
	payments (see instructions)							
		W/S E, Part A	• ·					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
7.00	Low volume adjustment factor	70.0/			0. 14591			27.
8. 00	Low volume adjustment	70.96			487, 58	3	487, 583	28.
	(transfer amount to Wkst. E,							
9.00	Pt. A, line) Low volume adjustment	70. 97				70 4/1	72 //1	29.
7.00	Low volume adjustment (transfer amount to Wkst. E,	10.91				73, 461	73, 461	29.
	Pt. A, Line)							
00 00	Transfer low volume		Y					100.
00.00	adjustments to Wkst. E, Pt. A.		'					100.

			D CENTER PLYMOL			eu of Form CMS-2	2552-10
HOSPI -	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 07/01/2022 To 06/30/2023		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)				
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for	1.01	2, 890, 171	2, 890, 17	1	2, 890, 171	1.01
	discharges occurring prior to October 1						
1.02	DRG amounts other than outlier payments for	1.02	0		0	0	1. 02
	discharges occurring on or after October 1						
1.03	DRG for Federal specific operating payment	1.03	0		0	0	1.03
	for Model 4 BPCI occurring prior to October						
1.04	DRG for Federal specific operating payment	1.04	0		0	0	1.04
	for Model 4 BPCI occurring on or after October 1						
2.00	Outlier payments for discharges (see	2.00					2.00
2.00	instructions)	2.00					2.00
2. 01	Outlier payments for discharges for Model 4	2.02	0		0	0	2.01
2.01	BPCI	2.02	0		0		2.01
2.02	Outlier payments for discharges occurring	2.03	0		n	0	2.02
	prior to October 1 (see instructions)	2.00	Ū				2.02
2.03	Outlier payments for discharges occurring on	2.04	0		0	0	2.03
2.00	or after October 1 (see instructions)	2.01					2.00
3.00	Operating outlier reconciliation	2.01	0		o o	0	3.00
1.00	Managed care simulated payments	3.00	2, 679, 898	2, 679, 89	8 0	2, 679, 898	4.00
	Indirect Medical Education Adjustment				-		1
5.00	Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0.00000	0.00000)	5.00
	(see instructions)						

	Indiffect medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0.00000	0.00000		5.00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see	22.01	0	0	0	0	6.01
	instructions)						
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of th	he MMA			
7.00	IME payment adjustment factor (see	27.00	0. 000000	0.00000	0.000000		7.00
	instructions)						
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed	28.01	0	0	0	0	8.01
	care (see instructions)						
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of	29.01	0	0	0	0	9.01
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 0990	0.0990	0. 0990		10.00
	(see instructions)						
11.00	Disproportionate share adjustment (see	34.00	71, 532	71, 532	0	71, 532	11.00
	instructions)						
11.01	Uncompensated care payments	36.00	658, 962	155, 521	503, 468	658, 989	11.01
	Additional payment for high percentage of ESR	D beneficiary	di scharges				
12.00	Total ESRD additional payment (see	46.00	0	0	0	0	12.00
	instructions)						
13.00		47.00	3, 620, 665	3, 117, 197	503, 468	3, 620, 665	13.00
14.00	Hospital specific payments (completed by SCH	48.00	0	0	0	0	14.00
	and MDH, small rural hospitals only.) (see						
	instructions)						
15.00		49.00	3, 620, 665	3, 117, 197	503, 468	3, 620, 665	15.00
	(see instructions)						
16.00		50.00	216, 546	216, 546	0	216, 546	16.00
	Wkst. L, Pt. I, if applicable)						
	Special add-on payments for new technologies	54.00	7, 924	7, 924	0	7, 924	17.00
17.01							17.01
17.02	Credits received from manufacturers for	68.00	0	0	0	0	17.02
	replaced devices for applicable MS-DRGs						
18.00		93.00	0	0	0	0	18.00
	amount (see instructions)						
19.00	SUBTOTAL			3, 341, 667	503, 468	3, 845, 135	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC	CN: 15-0076	Period: From 07/01/2022 To 06/30/2023		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	216, 546	216, 5	46 0	216, 546	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.0
21.00 Capital DRG outlier payments	2.00	0		0 0	0	21.0
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.0
22.00 Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.0
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.0
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0. 0000		24.0
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.0
26.00 Total prospective capital payments (see instructions)	12.00	216, 546	216, 54	46 0	216, 546	26.0
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.0
28.00 Low volume adjustment prior to October 1	70.96	487, 583	487, 58		487, 583	28.0
29.00 Low volume adjustment on or after October 1	70.97	73, 461		73, 461	73, 461	
30.00 HVBP payment adjustment (see instructions)	70. 93	0		0 0	0	
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30.0
31.00 HRR adjustment (see instructions)	70. 94	-2, 096	-2, 0	96 0	-2, 096	
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.0
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
82.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. (

2.00 Wellcal and other services 'reinforced under OPS (see instructions) 5,125,132 2.00 0.00 OPS: of Rei payment's (see instructions) 4,265,133 4,00 0.00 Unit is repayment' (see instructions) 4,000 0,000 5,000 0.00 Line 2 times in the situations 0,000 5,000 0,000 5,000 0.00 Sam of lines 3, 4, and 4,01, divided by line 6 0,000 5,000 0,000 5,000 0.00 Diransi tines 1, and 1,001 (see instructions) 0,000 5,000 0,000 5,000 0,000 5,000 0,000 5,000 0,000 5,000 0,000 5,000 0,000 5,000 0,000 5,000 0,000 5,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,0000 0,0000 1,000 0,0000 1,000 0,0000 1,000 0,00000 1,000 0,00000 1,000 0,00000 1,00	Heal th	Financial Systems ST. JOSEPHS REG MED C	ENTER PLYMOUTH	In Lie	eu of Form CMS-2	2552-10
THE 2011 Respital PPS 1.00 Mail 24. No. Of HER HEALTH SERVICES 1.00 270 1.00 0.00 5.00 1.00 5.00 1.00 5.00 1.00 0.00 5.00 1.00 0.00 5.00 1.00 0.00 5.00 1.00 0.00 9.00	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0076	From 07/01/2022	Part B Date/Time Pre	
Model B - Boal CA. AND OTHER THEALT SERVICES 100 0 Mail data of horth services (see instructions) 5,1220 100 0 Mail data of horth services (see instructions) 4,728,133 00 0 Outling regenerations (see instructions) 4,728,133 00 0 Outling regenerations (see instructions) 4,728,133 00 0 Outling regenerations (see instructions) 0,03 0,03 0 Outling regenerations (see instructions) 0,03 0,03 0 Trans Store (see instructions) 0,00 0,00 1 Trans Store (see instructions) 0,00 0,00 1 Trans Store (see instructions			Title XVIII	Hospi tal		02 pm
Model B - Boal CA. AND OTHER THEALT SERVICES 100 0 Mail data of horth services (see instructions) 5,1220 100 0 Mail data of horth services (see instructions) 4,728,133 00 0 Outling regenerations (see instructions) 4,728,133 00 0 Outling regenerations (see instructions) 4,728,133 00 0 Outling regenerations (see instructions) 0,03 0,03 0 Outling regenerations (see instructions) 0,03 0,03 0 Trans Store (see instructions) 0,00 0,00 1 Trans Store (see instructions) 0,00 0,00 1 Trans Store (see instructions					1.00	
1.00 Kedi cal and other services (see Instructions) 2200 1.00 0.00 Kedi cal and other services (inkervice under GPP (see Instructions) 4,725,153 20 0.00 Comparison of the provide of		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	-
6.00 Line 2 times 1 ines 3, 4, and 4.01, divide by line 6 0.00 <td>2.00 3.00 4.00</td> <td>Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc OPPS or REH payments Outlier payment (see instructions)</td> <td>ti ons)</td> <td></td> <td>5, 125, 132 4, 725, 513 4, 036</td> <td>2.00 3.00 4.00</td>	2.00 3.00 4.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc OPPS or REH payments Outlier payment (see instructions)	ti ons)		5, 125, 132 4, 725, 513 4, 036	2.00 3.00 4.00
2.00 Sum of Lines 3, 4, and 4.01, divided by Line 6 0.00 <td></td> <td></td> <td>ctions)</td> <td></td> <td></td> <td></td>			ctions)			
8.00 Transitional corridor payment (see instructions) 0 0.00 0.01 Intradiational corridor pass through costs from West. D. Pt. IV, col. 13, line 200 0 0.00 0.10 Intradiational corridor pass through costs from West. D. Pt. IV, col. 13, line 200 0 0.00 0.10 Intradiational corridor pass through costs from West. D. Pt. IV, col. 13, line 200 0 0.00 0.10 Intradiational corridor pass through costs from West. D. Pt. III, col. 4, line 69) 0 0.00 0.10 Intradiation charges (can of lines 12 and 13) 0 0.00 0.00 0.11 Intel intradiation charges (can of lines 12 and 13) 0 0.00 0.000000 0.11 Intradiation cost over customary charges (cost over custover custover customary charges (cost over customary c					-	•
9.00 Ancillary service other pass timungh costs from Wist. D. Pt. IV, col. 13, line 200 0						
11.00 Total cost (sum of Lines 1 and 10) (see instructions) 270 110 12.00 Ancil Targes 120 110 12.00 Ancil Targes 120 110 12.00 Ancil Targes 120 120 12.00 Total restonable charges 90 120 12.00 Total restonable charges 90 120 13.00 Total restonable charges 01 00 14.00 Total restonable charges 01 00 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 10.00 Total sch payment been medic in accordance with 42 CFR §413.13(2) 0 0.000000 10 10.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0 21 02 20.00 Excess of restonable cost over customary charges (complete instructions) 0 22 0 22 0 22 0 22 0 22 0 22 0 22 0 22<			IV, col. 13, line 200		0	
COMPUTATION OF LISSER OF COST DO CHARGES Reasonable charges 12.00 Ancilliary service charges (from Rkst. D-4, Pt. 111, col. 4, line 69) 0 13.00 10.01 recession colspan="2">recession colspan="2" 10.01 recession colspan="2"		0			-	
Beasonable charges Percent (a) Percent (a) <td>11.00</td> <td></td> <td></td> <td></td> <td>270</td> <td>11.00</td>	11.00				270	11.00
12:00 Ancill ary service charges 960 12:00 13:00 Organ acquisition charges (from Wist. D.4, Pt. 111, col. 4, line 69) 00 13:00 14:00 Lotal reasonable charges (from Wist. D.4, Pt. 111, col. 4, line 69) 00 13:00 14:00 Manuarts that would have been nealized from patients linelic for payment for services on a chargebasis 0 15:00 10:00 Advaurts that would have been nealized from patients linelic for payment for services on a chargebasis 0 16:00 10:00 Total custemary charges (see instructions) 0 0.000000 17:00 10:00 Total custemary charges (see instructions) 0 0 0 0 10:00 Excess of customary charges (see instructions) 0<						-
13:00 Organ acquisition charges (sum of lines 12 and 13) 0 13:00 Organ acquisition charges (sum of lines 12 and 13) 0 14:00 0	12.00				960	12.00
Customary charges			ine 69)		0	13.00
1:00 Aggregate amount actually collected from patients liable for payment for services on a charge basis not be that would have been realized from patients liable for payment for services on a charge basis not be that would have been realized from patients liable for payment for services on a charge basis not be that would have been realized from patients liable for payment for services on a charge basis not be that would have been realized from patients liable for payment for services on a charge basis not be that would have been realized from patients liable for payment for services on a charge basis not be that would have been realized from patients liable for services on a charge basis not be that would have been realized from patients liable for services on a charge basis not be that the services in a transmither that the services of the services of reasonable cost complete only if line 18 exceeds line 18) (see instructions) 0.0000001 1:00 Lesser of cost or charges (see instructions) 270 270 1:00 Lesser of cost or charges services in a tracking hospital (see instructions) 0 23.00 1:00 Total coursence amounts (for CAH, see instructions) 0 25.00 2:00 DeductIbles and Col naurance amounts (from Wkst. E-4, line 20) 0 28.00 2:00 Direct graduate medical education payments (from Wkst. E-4, line 20) 3.87.008 27.02 2:00 Subtotal (lines 2:1 and 2:4 in CALUE on MAST (SON MKSt. E-4, line 20) 3.87.008 3.87.008 3:00 Subtotal (line 3:0 and 2:2)	14.00				960	14.00
16.00 Amounts that would have been realized from patients ii able for payment for services on a chargebasis 0 16.00 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 18.00 Total customary charges (see instructions) 0.000000 17.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0.00000 17.00 10.00 Entertortics 0.01 18.00 0.02 0.00000 17.00 10.01 Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 18) (see 0.00000 17.00 10.02 Excess of customary charges (see instructions) 0.00000 27.00 0.000000 27.00 0.0000000000 27.00 0.00000000000000000000000000000000000	15 00		normant for complete on	a abanga baala	0	1 15 00
In ad such payment been made in accordance with 42 CFR \$413.13(e) 0 10.00 Ratio of line 15 to line 16 (not to exced 1.000000) 0.000000 0.000000 11.00 Ratio of line 15 to line 16 (not to exced 1.000000) 0.000000 0.000000 12.00 Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 11) (see instructions) 0.000000 0.000000 20.01 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.000000 0.000000 20.01 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.000000 0.000000 20.01 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.00000 0.000000 20.01 Excess of reasonable cost over customary charges (see instructions) 0.000000 0.000000 0.000000 20.00 Eductibles and coinsurance amounts (for CAH, see instructions) 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000000 0.0000000000000 0					-	
17.00 Ratia of Line 15 to Line 16 (not to exceed 1.00000) 0.000000 17.00 18.00 Total customary charges (see instructions) 0.000000 17.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0.00 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0.20 20.01 Lesser of cost or charges (see instructions) 0.21 0.00 20.01 Instructions 0.22 0.00 20.02 Intermandin real data (see instructions) 0.22 0.00 20.01 Deductible sand coinsurance ancounts (ror CAH, see instructions) 0.22 0.00 20.00 Deductible sand coinsurance ancounts relating to anount on line 24 (for CAH, see instructions) 0.28 0.28 21.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 2.8 0.28 </td <td>10.00</td> <td></td> <td>1 5</td> <td>n a chargebasis</td> <td>0</td> <td>10.00</td>	10.00		1 5	n a chargebasis	0	10.00
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 600 19.00 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 21.00 22.00 21.00 Lesser of cost or charges (see instructions) 22.00 22.00 21.00 Lesser of cost or charges (see instructions) 0.22.00 21.00 Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9) 4, 722.91 21.00 Deductive set of cost or charges (see instructions) 0.23.00 20.00 Deductive set of cost or charges arounds (for fML see instructions) 0.07.07 21.00 Deductive and cost of graduate medical education payments (from Wkst. E-4, line 50) 0.28.00 22.00 Subtotal (sum of lines 27.28.28.50 and 29) 0.28.00 0.29.00 20.00 Subtotal (sum of lines 37.28.28.50 and 29) 0.28.00 0.29.00 2.07.31.00 20.00 Subtotal (sum of lines 37.78.28.50 and 29) 0.28.57.30.00 2.8.57.30.00 2.9.07.31.30.00 21.00 Subtotal (sum of lines 37.78.28.50 and 29) 0.3.860,025 3.00.00 2.9.07.31.00 21.00 Subtotal (sum of lines 37.78.28.50 and 29) 3	17.00				0. 000000	17.00
Instructions) Instructions) 20.00 Instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00 10 Lesser of cost or charges (see instructions) 0 22.00 11 27.00 12.00 23.00 21.00 Lesser of cost or charges (see instructions) 0 22.00 23.00 22.00 Interns and residents (see instructions) 0 23.00 22.00 Deductibles and coinsurance amounts relating hospital (see instructions) 0 27.07 25.00 25.00 Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 0 27.07 28.00 28.00 28.00 28.00 28.00 28.00 29.00						•
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions) 20.0 21.00 Lesser of cost or charges (see instructions) 27.0 21.00 Lesser of cost or charges (see instructions) 0.2.00 22.01 Ottal rest (see instructions) 0.2.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0.2.00 24.00 Total prospective payment (sum of lines 2.4.4.01, 8 and 9) 4.7.29.549 24.00 Deductibles and coinsurance amounts (for CAH, see instructions) 8.77.74 26.00 Deductibles and coinsurance amounts (for Mikst. E-4, line 30) 0.8.50.025 27.00 Distortal (line 3.2 and 2.4 ninus the sum of lines 2.2 and 2.3] (see Instructions) 0.8.50.025 28.00 Direct medical education payments (from Wikst. E-4, line 30) 0.8.50.025 30.00 Direct medical education costs (from Wikst. E-4, line 30) 0.8.50.025 30.01 Definitions (See Instructions) 2.9.07 31.00 Subtotal (see instructions) 3.8.60.025 32.01 Ret facility payment amount 95.93.60 32.02 Subtotal (see instructions) 4.7.38.28.60 32.01 Compo	19.00		ly if line 18 exceeds li	ne 11) (see	690	19.00
Instructions)220100Lesser of cost or charges (see instructions)02100Losser of physicians' services in a teaching hospital (see instructions)02200Cost of physicians' services in a teaching hospital (see instructions)02300Cost of physicians' services in a teaching hospital (see instructions)02500Deductibles and coinsurance amounts (for CAH, see instructions)02500Deductibles and coinsurance amounts (for CAH, see instructions)02600Diductibles and coinsurance amounts (from Wkst. E-4, line 50)02800Diductibles and coinsurance amounts (from Wkst. E-4, line 50)02800Direct graduate medical education costs (from Wkst. E-4, line 36)02900ESR0 direct medical education costs (from Wkst. E-4, line 36)02900Subtotal (sum of lines 27, 28, 28, 50 and 29)3, 847,0082000Subtotal (sum of lines 31)3, 847,0082000Subtotal (sum of lines 31)3, 847,0082001Subtotal (see instructions)62, 353300Allowable bad debts (see instructions)62, 353300Allowable bad debts (see instructions)62, 353300Other erit maturations)0, 9, 933300Other erit discuster at amount from PS&R-643100Other erit discuster amount after sequestration3, 909, 513300Other erit discuster amount after sequestration3, 909, 517300Other erit sequestration adjustment amount face instructions)3, 909, 517	20 00	,	lvifline 11 exceeds li	ne 18) (see	0	20 00
22.00 Interns and residents (see instructions) 0 22.00 23.00 Cost of physic clars' services in a teaching hospital (see instructions) 0 23.00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 4, 729,549 24.00 COMPUTATION OF RELNDENEEDED SETTLEMENT 0 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 87,774 26.00 25.00 Deductibles and coinsurance amounts (from Wkst. E-4, line 50) 87,774 26.00 26.01 Direct graduate medical education payments (from Wkst. E-4, line 36) 28.00 28.00 27.00 Subtotal (sum of lines 27, 28, 25.50 and 29) 3,850,025 30.00 29.00 20.00 Subtotal (sum of lines 27, 28, 25.50 and 29) 3,850,025 30.00 29.00 20.01 Subtotal (sum of nucus line 31) 3,847,008 32.00 20.02 Butotal (sum of nucus line 31) 3,847,008 32.00 20.03 Distotal (see instructions) 62,325 33.00 34.00 34.00 35.00 34.00 34.00 34.00 35.00 35.00 35.07	20.00				, , , , , , , , , , , , , , , , , , ,	20.00
22.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 23.00 Columna (See Instructions) 0 23.00 20.00 Total prospective payment (sum of lines 3, 4, 4, 0, 8 and 9) 4, 729, 549 24.00 20.00 Deductibles and coinsurance amounts (For CAH, see instructions) 879, 794 26.00 20.00 Ductor prospective payment (sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 879, 794 26.00 20.00 Direct graduate medical education payments (from Wst. E-4, line 50) 0 28.00 0 28.00 0 29.00						•
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COMPUTATION OF RELIMBURST SETTLEMENT Computation Computation <thcomputation< th=""> Computation <t< td=""><td></td><td></td><td>ructions)</td><td></td><td>-</td><td>•</td></t<></thcomputation<>			ructions)		-	•
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instructions) [100] [101] [102	26.00	Deductibles and Coinsurance amounts relating to amount on lin	e 24 (for CAH, see inst	ructions)	879, 794	26.00
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41.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)42.0042.01Tentative settlement -PARHM (for contractor use only)42.0043.00Balance due provider/program (see instructions)-32,85143.01Balance due provider/program-PARHM (see instructions)-32,85144.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2070BE COMPLETED BY CONTRACTOR090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0					2 861 170	•
42.00 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) -32,851 43.00 43.01 Balance due provider/program-PARHM (see instructions) -32,851 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 5115.2					3, 004, 170	41.00
43.00 Balance due provider/program (see instructions) -32,851 43.00 43.01 Balance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 §115.2 TO BE COMPLETED BY CONTRACTOR 0 90.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00					0	•
43.01 Balance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, structions 44.00 70 BE COMPLETED BY CONTRACTOR 90.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00						42.01
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u> <u>TO BE COMPLETED BY CONTRACTOR</u> 90.00 0 90.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00					-32, 851	
§115.2TO BE COMPLETED BY CONTRACTOR90.000riginal outlier amount (see instructions)0 utlier reconciliation adjustment amount (see instructions)92.0093.00Time Value of Money (see instructions)093.00			nce with CMS Dub 15 2	chanter 1	_	•
TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00	44.00		nee writh GWB FUD. 19-2,			44.00
91.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00						1
92.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00		b			-	
93.00 Time Value of Money (see instructions) 0 93.00						
						•
						•

Health Financial Systems	ST. JOSEPHS REG MED	CENTER PLYMOUTH	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0076	Period: From 07/01/2022	Worksheet E	
				Date/Time Pre	
				11/29/2023 2:	<u>02 pm</u>
		Title XVIII	Hospi tal	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	F	eriod: rom 07/01/2022 o 06/30/2023	Worksheet E-1 Part I Date/Time Prep 11/29/2023 2:0	barec D2 pr
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		3, 600, 051		3, 864, 178	1.
00	Interim payments payable on individual bills, either		0		0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~~	write "NONE" or enter a zero					~
00	List separately each retroactive lump sum adjustment					3.
	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					
01	ADJUSTMENTS TO PROVIDER		0		0	3.
02			0		0	3
03			0		0	3
04			0		0	3
05			0		0	3
	Provider to Program			1		
50	ADJUSTMENTS TO PROGRAM		0		0	3
51			0		0	3
52			0		0	3 3
53 54			0		0	3 3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3
,,	3. 50-3. 98)		0		Ŭ	5
00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 600, 051		3, 864, 178	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVIDER		0		0	5
02			0		0	5
03			0		0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM		0		0	5
51			0		0	5
52			0		0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on					6
50	the cost report. (1)					0
01	SETTLEMENT TO PROVIDER		291, 436		0	6
02	SETTLEMENT TO PROGRAM		0		32, 851	6
00	Total Medicare program liability (see instructions)		3, 891, 487		3, 831, 327	7
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1.00	2.00	

Heal th	Financial Systems ST. JOSEPHS REG MED C	ENTER PLYMOUTH	In Lie	u of Form CMS-	2552-10				
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0076 Period: Wo								
	From 07/01/2022 Part								
			To 06/30/2023	Date/Time Pre 11/29/2023 2:					
		Title XVIII	Hospi tal	PPS	02 pm				
				1.00					
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1.00				
2.00	Medicare days (see instructions)				2.00				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00				
4.00	Total inpatient days (see instructions)				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				6.00				
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00				
	line 168								
8.00	Calculation of the HIT incentive payment (see instructions)				8.00				
9.00	Sequestration adjustment amount (see instructions)				9.00				
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00				
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				-				
	Initial/interim HIT payment adjustment (see instructions)				30.00				
	Other Adjustment (specify)				31.00				
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32.00				

Health Financial Systems ST. JO	OSEPHS REG MED CENTER PLYMOUTH	In Lieu	u of Form CMS-2	552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Worksheet E-5			
	Date/Time Prep 11/29/2023 2:0			
	Title XVIII		PPS	
			1.00	
TO BE COMPLETED BY CONTRACTOR				
1.00 Operating outlier amount from Wkst. E, Pt. A,	line 2, or sum of 2.03 plus 2.04 (see instruct	tions)	0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00 Operating outlier reconciliation adjustment am	nount (see instructions)		0	3.00
4.00 Capital outlier reconciliation adjustment amou	unt (see instructions)		0	4.00
5.00 The rate used to calculate the time value of m	noney (see instructions)		0.00	5.00
6.00 Time value of money for operating expenses (se	ee instructions)		0	6.00
7.00 Time value of money for capital related expens			0	7.00
	· ·		,	

	<u>Financial Systems</u> E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 07/01/2022	Worksheet G	
na-t il y)	ype accounting records, comprete the General Fund corumn			To 06/30/2023	Date/Time Pre 11/29/2023 2:	pare 02 p
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
00	Cash on hand in banks	83, 043		0 0	0	1 1
00	Temporary investments	0		0 0	0	2
00	Notes receivable	0		0 0	0	3
00	Accounts receivable	231, 388, 949		0 0	0	
00	Other receivable	0		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	0		0 0	0	
00 00	Inventory Prepaid expenses	1, 474, 021		0 0	0	
00	Other current assets	4, 758		0 0	0	
. 00	Due from other funds	4,730		0 0	0	
. 00	Total current assets (sum of lines 1-10)	232, 950, 771		0 0		
	FI XED ASSETS		1			
. 00	Land	477, 930	r	0 0	0	12
. 00	Land improvements	2, 096, 101		0 0		
. 00	Accumulated depreciation	-1, 695, 588		0 0	0	
	Buildings	45, 927, 594		0 0	0	
. 00	Accumulated depreciation Leasehold improvements	-34, 078, 522		0 0	0	
	Accumulated depreciation	380, 910 -380, 910	1	0 0 0 0	0	
	Fixed equipment	-360, 910		0 0	0	
	Accumul ated depreciation	0		0 0	0	
	Automobiles and trucks	220, 814		0 0	0	
. 00	Accumulated depreciation	-164, 987		0 0	0	22
. 00	Major movable equipment	31, 129, 743		0 0	0	23
	Accumulated depreciation	-26, 616, 571		0 0	0	
	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation Minor equipment-nondepreciable	0		0 0		
	Total fixed assets (sum of lines 12-29)	17, 296, 514		0 0		
	OTHER ASSETS	11/2/0/011	1	<u> </u>		
. 00	Investments	0		0 0	0	31
. 00	Deposits on Leases	0	,	0 0	0	32
. 00	Due from owners/officers	0		0 0	0	33
	Other assets	6, 394, 777	1	0 0	0	
	Total other assets (sum of lines 31-34)	6, 394, 777		0 0		
. 00	Total assets (sum of lines 11, 30, and 35)	256, 642, 062		0 0	0	36
00	CURRENT LI ABI LI TI ES Accounts payable	167, 617, 358	1	0 0	0	37
	Salaries, wages, and fees payable	9, 166, 315	1	0 0		
. 00	Payrol I taxes payable	0		0 0		
. 00	Notes and Loans payable (short term)	404, 364		0 0	0	
. 00	Deferred income	166, 110		0 0	0	
2. 00	Accelerated payments	0	,		l	42
	Due to other funds	0		0 0		
	Other current liabilities	105, 892	1	0 0		
6. 00	Total current liabilities (sum of lines 37 thru 44)	177, 460, 039		0 0	0	45
. 00	LONG TERM LIABILITIES Mortgage payable	0		0 0	0	46
. 00 . 00	Notes payable	0		0 0	0	
	Unsecured Loans	0	,	0 0	0	
. 00	Other long term liabilities	5, 699, 807		0 0		
. 00	Total long term liabilities (sum of lines 46 thru 49)	5, 699, 807		0 0	0	
. 00	Total liabilities (sum of lines 45 and 50)	183, 159, 846		0 0	0	51
	CAPI TAL ACCOUNTS					1
. 00	General fund balance	73, 482, 216				52
. 00	Specific purpose fund			0		53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00 . 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55
. 00 . 00	Plant fund balance - invested in plant			0	0	
. 00 3. 00	Plant fund balance - reserve for plant improvement,				0	
20	replacement, and expansion				j j	
	Total fund balances (sum of lines 52 thru 58)	73, 482, 216		0 0	0	59
9.00		10, 102, 210				

STATEMENT OF CHANGES IN FUND BALANCES		Provider CCN	N: 15-0076	Period: From 07/01/202 To 06/30/202		pared
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 Intraco equity transfers 5.00 7.00 3.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 	1.00 0 1,187,000 0 0 0 0 0 0 0 0 0 0 0 0	2.00 71,404,048 891,171 72,295,219 1,187,000 73,482,219 0 73,482,219	3.00		5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. (6. (7. (8. (9. (10. (11. (12. (13. (14. (15. (16. (
	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00			
 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 Intraco equity transfers 5.00 7.00 3.00 00 	0	0 0 0 0		0		1. (2. (3. (4. (5. (6. (7. (8. (9. (
0.00 Total additions (sum of line 4-9) 1.00 Subtotal (line 3 plus line 10) 2.00 Deductions (debit adjustments) (specify) 3.00 4.00 5.00 6.00 7.00	0			0		10. 11. 12. 13. 14. 15. 16. 17.
 8.00 Total deductions (sum of lines 12-17) 9.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 	0 0			0 0		18. 19.

TATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	rovi der			Worksheet G-2 Parts I & II Date/Time Pre 11/29/2023 2:0	pared
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
00	General Inpatient Routine Services		10 (02 015		10 (02 015	1 1
. 00	Hospi tal SUBPROVIDER - IPF		10, 693, 015		10, 693, 015	1. 2.
. 00	SUBPROVIDER - IRF					3.
. 00	SUBPROVIDER - TRF					3. 4.
. 00	Swing bed - SNF		0		0	
. 00	Swing bed - NF		0		0	
. 00	SKILLED NURSING FACILITY		0		0	7.
. 00	NURSI NG FACILITY					8.
. 00	OTHER LONG TERM CARE					9.
0.00	Total general inpatient care services (sum of lines 1-9)		10, 693, 015		10, 693, 015	
0.00	Intensive Care Type Inpatient Hospital Services		10,070,010		10, 070, 010	10.
1.00	I NTENSI VE CARE UNI T		0		0	11.
2.00	CORONARY CARE UNI T					12.
3.00						13.
4.00	SURGI CAL I NTENSI VE CARE UNI T		0		0	14.
5.00	OTHER SPECIAL CARE (SPECIFY)					15.
6. 00	Total intensive care type inpatient hospital services (sum of li 11-15)	nes	0		0	16.
7.00	Total inpatient routine care services (sum of lines 10 and 16)		10, 693, 015		10, 693, 015	17.
8.00	Ancillary services		24, 256, 013	155, 339, 900	179, 595, 913	18.
9.00	Outpatient services		3, 193, 824	22, 489, 465	25, 683, 289	19.
0. 00	RURAL HEALTH CLINIC		0	0	0	20.
	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	
	HOME HEALTH AGENCY					22.
3.00	AMBULANCE SERVICES					23.
4.00	СМНС					24.
5.00	AMBULATORY SURGICAL CENTER (D. P.)					25.
	HOSPI CE		17 / 0 /	4 954 949	4 994 543	26
7.00	PHYSI CI AN' S PRI VATE OFFI CES		47,624	1, 256, 943	1, 304, 567	
7.02			986, 365	500, 992	1, 487, 357	
7.03			316	0	316	
7.04 7.99	FOOT & ANKLE SPORTS MED PLY REVENUE ADJUSTMENTS		43, 835 321, 708	1,014,850	1,058,685	
7.99 8.00		Wkct	39, 542, 700	3, 252, 993 183, 855, 143	3, 574, 701 223, 397, 843	
5.00	G-3, line 1)	WKSL.	39, 342, 700	103, 000, 143	223, 397, 043	20.
	PART II - OPERATING EXPENSES					
9. 00	Operating expenses (per Wkst. A, column 3, line 200)			59, 436, 361		29.
). 00	ADD (SPECIFY)		0	07, 100, 001		30.
. 00			0			31.
2.00			0			32
3.00			0			33
1.00			0			34
5.00			0			35
5.00	Total additions (sum of lines 30-35)			0		36
7.00	DEDUCT (SPECIFY)		0	-		37
3.00			0			38
9.00			0			39
0. 00			0			40
1 00						

41.00

42.00

43.00

0

0

59, 436, 361

Total deductions (sum of lines 37-41) 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)

41.00

	Financial Systems ST. JOSEPHS REG M	IED CENTER PLYMOUTH	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0076	Peri od:	Worksheet G-3	
			From 07/01/2022		
			To 06/30/2023	Date/Time Prep 11/29/2023 2:0	
				11/2//2023 2.0	<u>52 pm</u>
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		223, 397, 843	1.00
2.00	Less contractual allowances and discounts on patients' ac			165, 137, 565	2.00
3.00	Net patient revenues (line 1 minus line 2)			58, 260, 278	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		59, 436, 361	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-1, 176, 083	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communica	tion services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			57, 315	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to othe	er than patients		0	16.00
	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			36, 267	
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
	Other specify			1, 973, 672	24.00
24.50	COVI D-19 PHE Fundi ng			0	24.50
25.00	Total other income (sum of lines 6-24)			2, 067, 254	25.00
26.00	Total (line 5 plus line 25)			891, 171	26.00
	Other expenses specify			0	27.00
	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	8)		891, 171	29.00

Health Financial Systems

ST.	JOSEPHS	REG	MED	CENTER	PLYN	IOUTH		
				Drov	idar	CON	15	007

Title XVIII Hospital PPS EART 1 - FULLY PROSPECTIVE ME(HOD CAPITAL FEORAL MADAT 1.00 1.00 CAPITAL FEORAL MADAT 216,546 1.00 100 Capital D60 other than Guiler payments 0 0 101 Capital D60 other than Guiler payments 0 2.01 101 Capital D60 other than Guiler payments 0 2.01 101 Capital D60 other than Guiler payments 0 2.01 102 Indirect medical education agruement (see instructions) 0.04 0.00 100 Indirect medical education agruement (see instructions) 0.00 0.00 5.00 101 (See instructions) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 <t< th=""><th>CALCUL</th><th>ATI ON OF CAPITAL PAYMENT</th><th>Provider CCN: 15-0076</th><th>Period: From 07/01/2022 To 06/30/2023</th><th>Worksheet L Parts I-III Date/Time Pre 11/29/2023 2:0</th><th></th></t<>	CALCUL	ATI ON OF CAPITAL PAYMENT	Provider CCN: 15-0076	Period: From 07/01/2022 To 06/30/2023	Worksheet L Parts I-III Date/Time Pre 11/29/2023 2:0	
PART 1 - FULLY PROSPECTIVE METHOD 216,546 Capital DRC other than outlier 216,546 1.00 Capital DRC other than outlier 0 2.01 Model 4 PPCI Capital DRC other than outlier 0 2.01 Model 4 PPCI Capital DRC outlier payments 0 2.01 Model 4 PPCI Capital DRC outlier payments 0 2.00 Indicated 4 PPCI Capital DRC outlier payments 0 0.00 Indicate A PPCI Capital DRC outlier payments 0 0.00 Indirect medical education adjustment (mult lip) Line 5 by the sum of Lines 1 and 1.01, columns 1 and 0 0.00 restructions) 0.00 0.00 0.00 restructions) 0.00 0.00 0.00 seinstructions) 0.00 0.00 0.00 Sum of Lines 7 and 8 0.00 0.00 0.00 Nowelle disproportionate share aprecentage (see instructions) 0.00 0.00 1.00 Percentage of Medicaid patient acost (see instructions) 0.00 1.00 1.00 Disproportionate share adjustment (see instructions) 0 1.00 <t< td=""><td></td><td></td><td>Title XVIII</td><td>Hospi tal</td><td>PPS</td><td></td></t<>			Title XVIII	Hospi tal	PPS	
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