Heal th Financia	al Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2552-10
This report is	required by law (42 USC 1395g; 42	CFR 413.20(b)). Failu	re to report can re	esult in all interim	FORM APPROVED
payments made	since the beginning of the cost re	porting period being d	eemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
HOSPI TAL AND H AND SETTLEMENT	IOSPITAL HEALTH CARE COMPLEX COST R SUMMARY	EPORT CERTIFICATION	Provider CCN: 1500	47 Peri od: From 06/01/2015 To 05/31/2016	
PART I - COST	REPORT STATUS				
Provi der	1. [ X ] Electronically filed cost	report		Date: 10/31/2	016 Time: 8:25 am
use only	2. [ ] Manually submitted cost re	eport			
	3. [ 0 ] If this is an amended repo 4. [ F ] Medicare Utilization. Ente			r resubmitted this c	ost report
Contractor use only	(1) As Submitted 7. Co (2) Settled without Audit 8. [	ite Received: ntractor No. N ]Initial Report for N ]Final Report for th	this Provider CCN		
PART II - CERT	I FI CATI ON		· · · · · ·		
MI SREPRESENTAT	ION OR FALSIFICATION OF ANY INFORM	ATION CONTAINED IN THI	S COST REPORT MAY E	BE PUNISHABLE BY CRIM	AINAL, CIVIL AND
ADMI NI STRATI VE	ACTION, FINE AND/OR IMPRISONMENT	UNDER FEDERAL LAW. FU	RTHERMORE, IF SERVI	CES IDENTIFIED IN TH	IS REPORT WERE
PROVIDED OR PR	COCURED THROUGH THE PAYMENT DIRECTL	Y OR INDIRECTLY OF A K	ICKBACK OR WERE OTH	HERWISE ILLEGAL, CRIM	/INAL, CIVIL AND

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

ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST JOSEPH MEDICAL CENTER (150047) for the cost reporting period beginning 06/01/2015 and ending 05/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Officer or Administrator of Provider(s)

SR VICE PRESIDENT-REVENUE MANAGEMENT Title

10/31/2016

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	225, 853	-32, 694	0	0	1.00
2.00	Subprovider - IPF	0	9, 079	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
7.00	SKILLED NURSING FACILITY	0	85	0		0	7.00
200.00	Total	0	235, 017	-32, 694	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX I		EPH MEDICAL TA	CENTER Provi der	CCN: 150	0047	Peri od:			eet S-2	2552-10
1105111	AL AND HOST THE HEALTH CARE COMPLEX I	DENTITICATION DA		TTOVIGET	00M. 130		From 06/01		Part I	ime Pre	
							10 05/31			2016 8:	
	1.00 Hospital and Hospital Health Care Co		00	3.00	)			4.00			
1.00	Street: 700 BROADWAY STREET	P0 Box:									1.00
2.00	City: FORT WAYNE	State: I Component Na		p Code: 46 CCN CE		Count ovi der	y: ALLEN Date	Davmo	nt Sys	tom (D	2.00
						Туре	Certi fi ed		0, or		
		1.00				1 00	F 00	V	XVIII	-	
	Hospital and Hospital-Based Componen	1.00 t Identification:		. 00 3.	00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospi tal	ST JOSEPH MEDICA	L 15	0047 23	060	1	07/01/1996	N	Р	Р	3.00
4.00	Subprovider - IPF	CENTER ST JOSPEH GENERA	TLONS 15	S047 23	060	4	06/01/2003	B N	Р	P	4.00
5.00	Subprovider - IRF										5.00
5.00 7.00	Subprovider - (Other) Swing Beds - SNF										6.00 7.00
3.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF	SKILLED NURSING		5356 23	060		04/01/1990	N	P	N	9.00
10.00	Hospi tal -Based NF	FACILITY ST JOSE	PH								10.00
11.00	Hospi tal -Based OLTC										11.00
12.00	Hospi tal-Based HHA Separately Certified ASC										12.00 13.00
14.00	Hospi tal -Based Hospi ce										14.00
15.00 16.00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FOHC										15.00 16.00
17.00	Hospi tal -Based (CMHC) I										17.00
18.00 19.00	Renal Dialysis Other										18.00
19.00	lotner						From	:	T	):	19.00
							1.00			00	
20.00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						06/01/2	2015	05/31	/2016	20.00
	Inpatient PPS Information										1
22.00	Does this facility qualify and is it share hospital adjustment, in accord						Y		1	N	22.00
	for yes or "N" for no. Is this facil	ity subject to 42	CFR Section	on §412.10			e				
22. 01	amendment hospital?) In column 2, en Did this hospital receive interim un				st renor	ctina	Y		`	ł	22. 01
22.01	period? Enter in column 1, "Y" for y	es or "N" for no	for the por	tion of t	he cost	0				•	22.01
	reporting period occurring prior to for no for the portion of the cost r										
	(see instructions)	eporting period c	ccurring of		october	1.					
22. 02	Is this a newly merged hospital that determined at cost report settlement						N		1	N	22.02
	or "N" for no, for the portion of th	•				2	5				
	in column 2, "Y" for yes or "N" for	no, for the porti	on of the o	cost repor	ting per	ri od or	ר				
22.03	or after October 1. Did this hospital receive a geograph	ic reclassificati	on from urb	oan to rur	al as a	resul	t N		1	N	22.03
	of the OMB standards for delineating	statistical area	ns adopted b	by CMS in	FY2015?	Enter					
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column						e				
	cost reporting period occurring on o	r after October 1	. (see inst	tructions)	Does th	ni s					
	hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,			unted in a	ccordanc	ce with	ר				
23.00	Which method is used to determine Me	dicaid days on li	nes 24 and/					3	1	N	23.00
	1, enter 1 if date of admission, 2 i method of identifying the days in th										
	used in the prior cost reporting per		2, enter "Y	for yes	<u>or "N" f</u>	for no.					
			In-State Medicaid	In-State Medicaid	Out-o Stat			Medicai HMO dav		)ther di cai d	
			paid days	eligible	Medica	aid 🛛 🕅	ledi cai d	uay		days	
				unpai d days	paid d	lays   e	eligible unpaid				
			1.00	2.00	3.00	0	4. 00	5.00		6.00	-
24.00	If this provider is an IPPS hospital		2, 943	2, 25		28	44		364		24.00
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c	olumn 3,									
	out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in	column 6.									
25.00	If this provider is an IRF, enter th Medicaid paid days in column 1, the		0	(	D	0	0		0		25.00
	Medicaid eligible unpaid days in col										
						1					
	out-of-state Medicaid days in column										
		umn 4, Medicaid									

HOSPI T.	Financial Systems ST JOSE AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		CAL CENTER		eriod: rom 06/01/201!		t S-2	
						10/31/20	16 8:	
					Urban/Rural 3 1.00	2.00		-
26.00	Enter your standard geographic classification (not wa	ge) sta	atus at the beg	inning of the		1		26.00
27. 00	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 or	ge) sta "2" fo	atus at the end or rural. If ap			1		27.00
35. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0		35.00
					Begi nni ng:	Endi n	<u> </u>	
36.00	Enter applicable beginning and ending dates of SCH st	atus 🤇	Subscript line	36 for number	1.00	2.00		36.00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	S.	·			0		37.00
37.01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo				N			37.01
38.00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.							38.00
	enter subsequent dates.				Y/N	Y/N		
20.00	Does this facility qualify for the inpatient hospital	001/202	adiuctment f	or low volum-	1.00 N	2.00		20.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	)? Ente uiremer or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ce with 42 nstructions)		N		39.00
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. E	Enter "Y" for y		N	Y		40.00
					V 1. (		XI X 3. 00	
45.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	t for c	li sproporti onat	e share in acc	cordance N	I Y	N	45.00
46. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					I N	Ν	46.00
	ls this a new hospital under 42 CFR §412.300 PPS capi <u>Is the facility electing full federal capital payment</u> Teaching Hospitals				no. N		N N	47.00 48.00
56.00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" f	for yes Y	′		56.00
57.00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th ", comp	"N" for no in his cost report plete Worksheet	column 1. If ing period? E	column 1 Enter "Y"			57.00
58.00	If line 56 is yes, did this facility elect cost reimb	ursemer	nt for physicia	ns' services a	is N	I		58.00
59 00	defined in CMS Pub. 15–1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			Pt I	N			59.00
	Are you claiming nursing school and/or allied health	costs f	°or a program t	hat meets the	N			60.00
	provider-operated criteria under §413.85? Enter "Y"	for yes Y/N	<u>s or "N" for no</u> IME	. <u>(see instruc</u> Direct GME	tions)	Direct	GME	
(1.00		1.00	2.00	3.00	4.00	5.00		(1.00
51.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.0		0.00	61.00
51. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00				61.01
51. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00				61. 02
51. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.00				61.03
61.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0.00				61.04
	current cost reporting period.(see instructions). Enter the difference between the baseline primary		0.00	0.00				61.05

IOSPI TAL	AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	ТА	Provider (		ri od:	Worksheet S-2	
					To	06/01/2015 05/31/2016	Part I Date/Time Pre 10/31/2016 8:	
			Y/N	IME	Direct GME	IME	Direct GME	
1 0/ 5			1.00	2.00	3.00	4.00	5.00	
us	nter the amount of ACA §5503 aw sed for cap relief and/or FTEs are or general surgery. (see in	that are nonprimary		0.00	0.00			61.0
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
sp fo co pr un	<sup>5</sup> the FTEs in line 61.05, speci- becial ty, if any, and the numbe or each new program. (see instr- blumn 1, the program name, ente rogram code, enter in column 3, weighted count and enter in co IE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.1
1.20 Of pr re in en 3,	<sup>7</sup> the FTEs in line 61.05, speci- rogram specialty, if any, and t esidents for each expanded prog- nstructions) Enter in column 1, nter in column 2, the program c the IME FTE unweighted count direct GME FTE unweighted count	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61.2
							1.00	
	CA Provisions Affecting the Hea					od for which		62.0
yo 2. 01 En	your hospital received HRSA PCRE funding (see instructions)							62.0
Те	eaching Hospitals that Claim Re	sidents in Nonprovide	er Setti	ngs				
	as your facility trained reside (" for yes or "N" for no in col					eriod? Enter	N	63. (
					Unwei ghted FTEs Nonprovi der	9	Ratio (col. 1/ (col. 1 + col. 2))	
				-	Si te	•		
	ection 5504 of the ACA Base Yea				1.00 his base year	2.00 is your cost r	3.00 reporting	
4.00 En in re se re	riod that begins on or after July 1, 2009 and before June 30, 2010. ter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 the base year period, the number of unweighted non-primary care sident FTEs attributable to rotations occurring in all nonprovider ttings. Enter in column 2 the number of unweighted non-primary care sident FTEs that trained in your hospital. Enter in column 3 the ratio (column 1 divided by (column 1 + column 2)). (see instructions)					0. 000000	64. (	
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site		Ratio (col. 3/ (col. 3 + col. 4))	
	-	1.00		2.00	3.00	4.00	5.00	
is tr ye as FT pr co un re ro no co un	hter in column 1, if line 63 syes, or your facility rained residents in the base ear period, the program name sociated with primary care regram in which you trained esidents. Enter in column 2, he program code, enter in olumn 3, the number of mweighted primary care FTE esidents attributable to obtations occurring in all on-provider settings. Enter in olumn 4, the number of mweighted primary care esident FTEs that trained in our hospital. Enter in column				0.00	0.00	0. 000000	65.0

Health Financial Sys	tems	ST JOSI	EPH MEDICAL	CENTER		I	n Lie	u of For	m CMS-2	2552-10
HOSPI TAL AND HOSPI TA	AL HEALTH CARE COMP	LEX IDENTIFICATION DA	ΤA	Provi der	F	Period: From 06/01. To 05/31.		Workshe Part I Date/Ti 10/31/2	me Pre	
					Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs Hospi t	i n al	Ratio (c (col. 1 2))	+ col.)	
Section 5504	of the ACA Current	Year FTE Residents in	n Nonprovide	er Settino	1.00 IsEffective f	2.00		<u>3.0</u> na perio		
beginning on	or after July 1, 20	)10	•	0			·	<u> </u>		
FTEs attribut: Enter in colu FTEs that tra	able to rotations o mn 2 the number of ined in your hospit	unweighted non-primar accurring in all nonpr unweighted non-primar al. Enter in column 3 column 2)). (see ins	rovider sett ry care resi 3 the ratio	i ngs. dent	0.0		0. 00	0.	000000	66.00
		Program Name	Program	Code	Unweighted FTEs Nonprovider Site	Unwei gh FTEs Hospi t	in	Ratio (c (col. 3 4))	+ col.	
		1.00	2.0	0	3.00	4.00	)	5.0	0	
your primary of which you trail Enter in colu code. Enter in number of unwo care FTE resid to rotations of non-provider s column 4, the unweighted pri resident FTEs your hospital 5, the ratio	ed with each of care programs in ined residents. mn 2, the program n column 3, the eighted primary dents attributable occurring in all settings. Enter in number of imary care that trained in . Enter in column of (column 3 olumn 3 + column			_	0.0		0.00		000000	67.00
					1		1.00	0.00	0.00	
Inpatient Psy	chiatric Facility F	PPS					1.00	2.00	3.00	
	ity an Inpatient Ps yes or "N" for no	ychiatric Facility (I	PF), or doe	s it cont	ain an IPF sub	provi der?	Y			70.00
71.00 If line 70 yes recent cost r 42 CFR 412.42 program in ac Column 3: If 0 (see instruct	s: Column 1: Did th eport filed on or b 4(d)(1)(iii)(c)) Co cordance with 42 CF column 2 is Y, indi	e facility have an ap refore November 15, 20 Jumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	D04? Enter lity train (D)? Enter	"Y" for y residents "Y" for y	es or "N" for in a new teac es or "N" for	no. (see hi ng no.	N	N	0	71.00
75.00 Is this facili	ity an Inpatient Re	habilitation Facility	y (IRF), or	does it c	ontain an IRF		N			75.00
76.00 If line 75 yes recent cost re no. Column 2: CFR 412.424 (d	eporting period end Did this facility d)(1)(iii)(D)? Ente	and "N" for no. ne facility have an ap ling on or before Nové train residents in a er "Y" for yes or "N" n during this cost re	ember 15, 20 new teachin for no. Col	04? Enter g program umn 3: If	"Y" for yes o in accordance column 2 is Y	r "N" for with 42	N	N	0	76.00
								1.0	0	
80.00 Is this a long 81.00 Is this a LTC	H co-located within nd "N" for no.	I (LTCH)? Enter "Y" another hospital for				period? E	nter	N		80. 00 81. 00
85.00 Is this a new 86.00 Did this faci	hospital under 42 lity establish a ne	CFR Section §413.40(f w Other subprovider ( or yes and "N" for no.	(excl uded un				no.	N		85. 00 86. 00
	tal a "subclause (I	I)" LTCH classified u		n 1886(d)	(1)(B)(iv)(II)	? Enter "Y		Ν		87.00
	101 110.					V		XL		
Title V and X	IX Services					1.00	)	2.0	0	
90.00 Does this fac	ility have title V	and/or XIX inpatient	hospital se	rvi ces? E	nter "Y" for	N		Y		90.00
91.00 Is this hospi		title V and/or XIX th				N		Y		91.00
		ves or "N" for no in t ving title XVIII SNF b						N		92.00
instructions)	Enter "Y" for yes	or "N" for no in the F/IID facility for pu	appl i cabl e	column.		N		N		93.00
"Y" for yes o	r "N" for no in the	applicable column.								
94.00 Does title V o applicable co		al cost? Enter "Y" fo	or yes, and	"N" for n	o in the	N		N		94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	L CENTER Provider	CCN: 150047	Peri od:	n Lieu	u of Form Workshee		52-10
	11001 del	con. 100047	From 06/01 To 05/31		Part I Date/Tim 10/31/20	e Prepar	
			V		XI X		am
95.00 If line 94 is "Y", enter the reduction percentage in the applic	cable colum	2	1.00		2.00		95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes of applicable column.			N N	,	N 0.00		96. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the applic Rural Providers		٦.	0.00	)	0.00		97.00
105.00 Does this hospital qualify as a critical access hospital (CAH)' 106.00 If this facility qualifies as a CAH, has it elected the all-ind for outpatient services? (see instructions)		nod of paymer	nt N				)5. 00 )6. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost retraining programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2! reimbursed. If yes complete Wkst. D-2, Pt. II.	. (see insti	ructions) If	it			10	07.00
108.00 Is this a rural hospital qualifying for an exception to the CRI CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							08. 00
	Physi cal 1.00	Occupationa 2.00	1 Speed 3.00		Respi ra 4.00		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00	2.00	3.00	5	4.00		9. 00
				-	1.00	)	
110.00 Did this hospital participate in the Rural Community Hospital I the current cost reporting period? Enter "Y" for yes or "N" for		on project (4	10A Demo)fc	or	N	11	10.00
Miscellaneous Cost Reporting Information				1.00	2.00	3.00	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "I is yes, enter the method used (A, B, or E only) in column 2. It 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers)	f column 2 i for long ter	s "E", enter rm care (incl	in column udes	N		0 11	15.00
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for 117.00 Is this facility legally-required to carry malpractice insurance no.			"N" for	N N			6.00  7.00
118.00 Is the malpractice insurance a claims-made or occurrence policy claim-made. Enter 2 if the policy is occurrence.	y? Enter 1 i	f the policy	is	1		11	8.00
		Durantiuma					
		Premi ums	Losse	es	l nsurar	nce	
118.01 List amounts of malpractice premiums and paid losses:		1.00 34,4	2.00		I nsurar 3. 00	)	18. 01
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	) 0	3.00	0 11	18. 01
118.02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.		1.00 34,4 than the	2.00	) 0		) 0 11 ) 11	18. 02
<ul> <li>118.02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in cc "N" for no. Is this a rural hospital with &lt; 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments?</li> </ul>	e listing co armless prov olumn 1, "Y' ifies for th	1.00 34,4 than the ost centers /ision in ACA ' for yes or ne Outpatient	2.00 33 1.00 N	) 0	3.00	0 11	
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha \$3121 and applicable amendments? (see instructions) Enter in cc "N" for no. Is this a rural hospital with &lt; 100 beds that qualified Hard Hard Hard Hard Hard Hard Hard Har</li></ul>	e listing co armless prov olumn 1, "Y" ifies for th ? (see instr	1.00 34,4 than the ost centers vision in ACA ' for yes or ne Outpatient ructions)	2.00 33 1.00 N	) 0	3.00	0 11	18. 02
<ul> <li>118.02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with &lt; 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? Enter for no in column 1. If column 1 is "Y", enter in column 2 the N</li> </ul>	e listing co armless prov olumn 1, "Y ifies for th ? (see instr able devices ter "Y" for	1.00 34,4 than the ost centers ' for yes or ne Outpatient ructions) s charged to yes or "N"	2.00 33 1.00 N	) 0	3.00	0 11 0 11 11 12 12	18. 02 19. 00 20. 00
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in cc "N" for no. Is this a rural hospital with &lt; 100 beds that qualified Hard Hard Hard Hard Hard Hard Hard Har</li></ul>	e listing co armless prov olumn 1, "Y" ifies for th ? (see instr able devices ter "Y" for Worksheet A	1.00 34,4 than the ost centers ' for yes or he Outpatient ructions) s charged to yes or "N" line number	2.00 33 1.00 N N Y	) 0	3.00	0 11 0 11 11 12 12	18. 02 19. 00 20. 00 21. 00
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in cer "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies that qualifies for the outpatient amendments?</li> <li>121. 00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>122. 00 Does the cost report contain state health or similar taxes? Enter these taxes are included.</li> </ul>	e listing co armless prov olumn 1, "Y" ifies for th ? (see instr able devices ter "Y" for Worksheet A	1.00 34,4 than the ost centers ' for yes or he Outpatient ructions) s charged to yes or "N" line number	2.00 33 1.00 N N Y	) 0	3.00	0 11 0 11 11 12 12 12	18. 02 19. 00 20. 00 21. 00
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in com "N" for no. Is this a rural hospital with &lt; 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.</li> <li>121. 00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>122. 00 Does the cost report contain state health or similar taxes? Enter these taxes are included. Transplant Center Information</li> <li>125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126. 00 If this is a Medicare certified kidney transplant center, enter</li> </ul>	e listing co armless prov olumn 1, "Y ifies for th ? (see instr able devices ter "Y" for Worksheet A yes and "N"	1.00 34,4 than the ost centers ' for yes or ne Outpatient ructions) s charged to yes or "N" line number	2.00 33 1.00 N N Y N	) 0	3.00	0 11 0 11 11 12 12 12 12	18. 02 19. 00 20. 00 21. 00 22. 00
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in cc "N" for no. Is this a rural hospital with &lt; 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in col umn 2, "Y" for yes or "N" for no.</li> <li>121. 00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>122. 00 Does the cost report contain state heal th or similar taxes? Enter these taxes are included. Transplant Center Information</li> <li>125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> </ul>	e listing co armless prov olumn 1, "Y" ifies for th ? (see instr able devices ter "Y" for Worksheet A yes and "N" r the certifi	1.00 34,4 than the ost centers ' for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date	2.00 33 1.00 N N Y N	) 0	3.00	0 11 0 11 11 12 12 12 12 12 12 12 12	18. 02         19. 00         20. 00         21. 00         22. 00         25. 00         26. 00         27. 00
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in com "N" for no. Is this a rural hospital with &lt; 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in com 2, "Y" for yes or "N" for no.</li> <li>121. 00 Did this facility incur and report costs for high cost implants patients? Enter "Y" for yes or "N" for no.</li> <li>122. 00 Does the cost report contain state health or similar taxes? Enter for no in column 1. If column 1 is "Y", enter in column 2 the Where these taxes are included.</li> <li>Transplant Center Information</li> <li>125. 00 Does this facility operate a transplant center? Enter, enter in column 1. and termination date, if applicable, in column 2.</li> <li>127. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> </ul>	e listing co armless prov olumn 1, "Y' ifies for th ? (see instr able devices ter "Y" for Worksheet A yes and "N" r the certifi the certifi	1.00 34,4 than the post centers vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date	2. 00 33 1. 00 N N Y N	) 0	3.00	0 11 0 11 11 12 12 12 12 12 12 12 12	<ol> <li>18. 02</li> <li>19. 00</li> <li>20. 00</li> <li>21. 00</li> <li>22. 00</li> <li>25. 00</li> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> </ol>
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost cere Administrative and General? If yes, submit supporting scheduled and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Has \$3121 and applicable amendments? (see instructions) Enter in cere "N" for no. Is this a rural hospital with &lt; 100 beds that quali Hold Harmless provision in ACA \$3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.</li> <li>121. 00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>122. 00 Does the cost report contain state health or similar taxes? Enter for no in column 1. If column 1 is "Y", enter in column 2 the Where these taxes are included.</li> <li>Transplant Center Information</li> <li>125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>129. 00 If this is a Medicare certified liver transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>129. 00 If this is a Medicare certified liver transplant center, enter column 1 and termination date, if applicable, in column 2.</li> </ul>	e listing co armless prov olumn 1, "Y" ifies for th ? (see instr able devices ter "Y" for Worksheet A yes and "N" r the certifi the certific the certific	1.00 34,4 than the ost centers ' for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date cation date i	2. 00 33 1. 00 N N Y N	) 0	3.00	0 11 0 11 11 12 12 12 12 12 12 12 12	18. 02         19. 00         20. 00         21. 00         22. 00         25. 00         26. 00         27. 00         28. 00         29. 00
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in cer "N" for no. Is this a rural hospital with &lt; 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.</li> <li>121. 00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>122. 00 Does the cost report contain state health or similar taxes? Enter for no in column 1. If column 1 is "Y", enter in column 2 the Where these taxes are included.</li> <li>Transplant Center Information</li> <li>125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>127. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>129. 00 If this is a Medicare certified liver transplant center, enter</li> </ul>	e listing co armless prov olumn 1, "Y ifies for th ? (see instr able devices ter "Y" for Worksheet A yes and "N" r the certifi the certifi the certific the certific ter the certific	1.00 34,4 than the ost centers ' for yes or ne Outpatient 'uctions) s charged to yes or "N" line number for no. If fication date cation date cation date itification	2. 00 33 1. 00 N N Y N	) 0	3.00	0 11 0 11 11 12 12 12 12 12 12 12 12	<ol> <li>18. 02</li> <li>19. 00</li> <li>20. 00</li> <li>21. 00</li> <li>22. 00</li> <li>25. 00</li> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> </ol>

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA       Provider CCN: 150047       Period: From 06/01/2015 To 05/31/2016       Worksheet S-2 Part I Date/Time Prepared: 10/31/2016 8: 18 am         133.00       If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.       1.00       2.00         134.00       If this is an organ procurement organization (0P0), enter the 0P0 number in column 1       134.00       134.00	
To 05/31/2016 Date/Time Prepared: 10/31/2016 8: 18 am 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 1.00 2.00 1.00 1.00 1.00 1.00 1.00 1	
10/31/2016 8: 18 am       133.00       If this is a Medicare certified other transplant center, enter the certification date       1 and termination date, if applicable, in column 2.       134.00       If this is an organ procurement organization (OPO), enter the OPO number in column 1	d.
133.00If this is a Medicare certified other transplant center, enter the certification date133.0in column 1 and termination date, if applicable, in column 2.134.00134.00134.00If this is an organ procurement organization (OPO), enter the OPO number in column 1134.00	
133.00If this is a Medicare certified other transplant center, enter the certification date133.0in column 1 and termination date, if applicable, in column 2.134.00134.00134.00If this is an organ procurement organization (OPO), enter the OPO number in column 1134.00	
in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 134.0	
134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 134.0	00
	00
and termination date, if applicable, in column 2.	
All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Y 679005 140.0	00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs	00
are claimed, enter in column 2 the home office chain number. (see instructions)	
1.00 2.00 3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.	
141.00 Name: COMMUNITY HEALTH SYSTEMS Contractor's Name: WPS, INC. Contractor's Number: 10301 141.0	. 00
142. 00 Street: 4000 MERIDIAN BLVD PO Box: 142. 0	
143. 00  City:         FRANKLIN         State:         TN         Zip Code:         37067         143. 0	00
1.00	
144.00 Are provider based physicians' costs included in Worksheet A? Y 144.0	00
1.00     2.00       145.00     If costs for renal services are claimed on Wkst. A, line 74, are the costs for     Y     145.0	
inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is	00
no, does the dialysis facility include Medicare utilization for this cost reporting	
period? Enter "Y" for yes or "N" for no in column 2.	
146.00       Has the cost allocation methodology changed from the previously filed cost report?       N       146.0         Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If       N       146.0	00
yes, enter the approval date (mm/dd/yyyy) in column 2.	
1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.N147.0148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.N148.0	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.0	
Part A Part B Title V Title XIX	
1.00 2.00 3.00 4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)	
155. 00 Hospi tal	. 00
156.00 Subprovider - IPF N N N 156.0	00
157.00 Subprovider - IRF N N N 157.0	
158. 00 SUBPROVIDER   158. 0 159. 00 SNF N N N 159. 0	
160. 00 HOME HEALTH AGENCY N N N 160. 0	
161. 00 CMHC N N 161. 0	
1.00	
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.0	.00
Enter "Y" for yes or "N" for no.	
Name County State Zip Code CBSA FTE/Campus	
0         1.00         2.00         3.00         4.00         5.00           166.00         If line 165 is yes, for each         0         0.00         166.00	00
campus enter the name in column	00
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)	
1.00	
Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act           167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.         N         167.00	00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 0168.0	
reasonable cost incurred for the HIT assets (see instructions)	
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship	01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00(169.0	00
	20

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA	Provider CCN: 150047	Peri od:	Worksheet S-2	
			From 06/01/2015 To 05/31/2016		narod
			To 05/31/2016	Date/Time Pre 10/31/2016 8:	<u>18 am</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	g date and ending date	for the reporting			170.00
				1.00	
171.00 If line 167 is "Y", does this provider hav Medicare cost plans reported on Wkst. S-3,				Ν	171.00
(see instructions)		5			

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016	Worksheet S- Part II Date/Time Pro 10/31/2016 8	epared:
				Y/N	Date	
		<u> </u>		1.00	2.00	_
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	TOT ALL NU TE	esponses. Ente	er all dates in t	ine	
	COMPLETED BY ALL HOSPITALS					-
	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 co	olumn 2. (see				_
			Y/N 1.00	Date 2.00	V/I 3.00	_
2.00	Has the provider terminated participation in the Medicare Pr	rogram2 lf	1.00 N	2.00	3.00	2.0
. 00	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.					2.0
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	Y			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		1			
. 00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled, lable in	N			4.0
6.00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N			5.0
				Y/N	Legal Oper.	
				1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider is	s N		6.0
	the legal operator of the program?					
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		during the	N N		7.0 8.0
. 00	Are costs claimed for Interns and Residents in an approved of program in the current cost report? If yes, see instructions		cal education	Y		9.0
0. 00	Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		he current	N		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.0
					Y/N 1.00	-
	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes,	see instruct	i ons.		Y	12.0
3.00	If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.	olicy change o	luring this co	ost reporting	Ν	13.0
4.00	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	nts waived? If	<sup>-</sup> yes, see ins	structions.	N	14.0
5.00	Did total beds available change from the prior cost reportin	<u>v</u> 1	yes, see ins t A	tructions. Par	N t B	15.0
		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? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	09/23/2016	Y	09/23/2016	16.0
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.0
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.	Ν		Ν		19. (

03711	Financial Systems ST JOSEPH MED AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016	u of Form CMS- Worksheet S-2 Part II Date/Time Pre 10/31/2016 8:	2 epared:
		Descri	pti on	Y/N	Y/N	
		C	)	1.00	3.00	
0.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00
		Y/N	Date	Y/N	Date	_
		1.00	2.00	3.00	4.00	
1.00	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)		1.00	
	Capital Related Cost		501111120)			
2.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			Ν	22.00
3.00	Have changes occurred in the Medicare depreciation expense		als made dur	ing the cost	Ν	23.00
	reporting period? If yes, see instructions.			0		
4.00	Were new leases and/or amendments to existing leases entered	ed into during	this cost re	porting period?	Ν	24.00
	If yes, see instructions					
5.00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25.00
	instructions.			c		
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	r yes, see	Ν	26.00
7.00	Has the provider's capitalization policy changed during the	a cost reportin	a period2 lf	vos submit	Ν	27.00
7.00	copy.		g period: Ti	yes, subili t	IN IN	27.00
	Interest Expense					
8.00	Were new loans, mortgage agreements or letters of credit er	ntered into dur	ing the cost	reporting	N	28.00
	period? If yes, see instructions.		0			
9.00	Did the provider have a funded depreciation account and/or		bt Service R	eserve Fund)	Ν	29.0
	treated as a funded depreciation account? If yes, see instr					
0.00	Has existing debt been replaced prior to its scheduled matu	urity with new o	debt? If yes	, see	N	30.00
1.00	instructions. Has debt been recalled before scheduled maturity without is	scuence of new	dobt2 If you	600	Ν	31.00
1.00	instructions.	ssuance of new i	Jebt? IT yes	, See	IN	31.00
	Purchased Servi ces					
2.00	Have changes or new agreements occurred in patient care ser	rvi ces furni she	d through cc	ntractual	N	32.00
	arrangements with suppliers of services? If yes, see instru		5			
3.00	If line 32 is yes, were the requirements of Sec. 2135.2 app	plied pertaining	g to competi	tive bidding? If	Ν	33.00
	no, see instructions.					
	Provi der-Based Physi ci ans				••	-
4.00	Are services furnished at the provider facility under an ar	rrangement with	provi der-ba	sed physicians?	Ν	34.00
E 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	icting agroomon	to with the	providor bacad	Ν	35.00
5.00	physicians during the cost reporting period? If yes, see in		ts with the	pi ovi dei -based	IN	35.00
	The cost reporting porrod. In yes, see in			Y/N	Date	
				1.00	2.00	
	Home Office Costs					
6.00	Were home office costs claimed on the cost report?			Y		36. 00
7.00	If line 36 is yes, has a home office cost statement been pr	repared by the I	home office?	Y		37.00
	If yes, see instructions.				40 (04 (	
8.00	If line 36 is yes, was the fiscal year end of the home off			Ý	12/31/2015	38.00
0 00	the provider? If yes, enter in column 2 the fiscal year end			, N		39.00
7.00	If line 36 is yes, did the provider render services to othe see instructions.		ents: IT yes	, IN		39.00
0.00	If line 36 is yes, did the provider render services to the	home office?	lfves see	Ν		40.00
5.00	instructions.		. ,00, 300	TN .		
		1.0	00	2.	00	
	Cost Report Preparer Contact Information	L				-
		KUZI WA		TSI GA		41.00
1. 00						1
1. 00	held by the cost report preparer in columns 1, 2, and 3,					
	held by the cost report preparer in columns 1, 2, and 3, respectively.		TH SVSTEMS			12 00
	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	COMMUNI TY HEAL	TH SYSTEMS			42.00
2.00	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	COMMUNITY HEAL	TH SYSTEMS	KUZI WA_TSI GA@CI	HS. NET	42.00

Heal th	Financial Systems	ST JOSEPH MED	I CAL	CENTER			In Lie	eu of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	UESTI ONNAI RE		Provi der	CCN: 1		Period:	Worksheet S-2	
							From 06/01/2015 To 05/31/2016		pared: 18 am
					00		_		
	Cost Depart Droparan Contact Information			3.	00				
	Cost Report Preparer Contact Information								-
	Enter the first name, last name and the tit		MANGE	R, REVENU	E MANA	GEMENT			41.00
	held by the cost report preparer in columns	s 1, 2, and 3,							
	respectively.								
42.00	Enter the employer/company name of the cost	t report							42.00
	preparer.								
	Enter the telephone number and email addres	ss of the cost							43.00
	report preparer in columns 1 and 2, respect								101.00
	report preparer in corumns ranu z, respec	u very.	1				1		1

	Financial Systems			CENTER Provider CCN: 150047				In Lieu of Form CMS-2552-10			
HOSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 150047		eriod: com 06/01/2015	Worksheet S-3			
						Tc			pared:		
						L,		10/31/2016 8:			
								I/P Days / O/P			
								Visits / Trips			
	Component	Worksheet A Line Number	NO.	of Beds	Bed Days Available		CAH Hours	Title V			
		1.00		2.00	3.00	_	4.00	5.00			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		<u>2.00</u> 72		52	0.00	5.00	1.00		
1.00	8 exclude Swing Bed, Observation Bed and	30.00		12	20, 3	52	0.00	0	1.00		
	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 I RF Subprovi der								4.00		
5.00	Hospital Adults & Peds. Swing Bed SNF							0			
6.00	Hospital Adults & Peds. Swing Bed NF							0			
7.00	Total Adults and Peds. (exclude observation			72	26, 3	52	0.00	0			
7.00	beds) (see instructions)			12	20,0	02	0.00	0	/		
8.00	INTENSIVE CARE UNIT	31.00		19	6,9	54	0.00	0	8.00		
8.01	NEONATAL INTENSIVE CARE UNIT	31.01		8			0.00	0			
9.00	CORONARY CARE UNIT	01.01		0	2, ,	20	0.00	0	9.00		
10.00	BURN I NTENSI VE CARE UNI T	33.00		12	4,3	92	0.00	0			
11.00	SURGI CAL I NTENSI VE CARE UNI T	00.00		12	1,0	12	0.00	0	11.00		
12.00	OTHER SPECIAL CARE (SPECIFY)								12.00		
13.00	NURSERY	43.00						0			
14.00	Total (see instructions)	10.00		111	40, 6	26	0.00	0			
15.00	CAH visits				10,0	20	0.00	0			
16.00	SUBPROVIDER - IPF	40.00		30	10, 9	80		0			
17.00	SUBPROVIDER - IRF	10.00		00	10, 7	00		0	17.00		
18.00	SUBPROVI DER								18.00		
19.00	SKILLED NURSING FACILITY	44.00		21	7,6	86		0			
20.00	NURSI NG FACILITY	44.00		21	,,0	00		0	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	00.00							25.00		
26.00	RURAL HEALTH CLINIC								26.00		
26.25	FEDERALLY QUALIFIED HEALTH CENTER								26.25		
27.00	Total (sum of lines 14-26)			162					27.00		
28.00	Observation Bed Days			102				0			
29.00	Ambul ance Trips							0	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)			0		0			32.00		
32.00	Total ancillary labor & delivery room			0		U			32.00		
JZ. UI	outpatient days (see instructions)								32.01		
33.00	LTCH non-covered days								33.00		

HOSPI T	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der	CCN: 150047	Peri Froi To	iod: m 06/01/2015 05/31/2016	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 10/31/2016 8:	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		otal Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	5, 711	1, 332	20, 68	80			1.00
2.00	HMO and other (see instructions)	3, 516	7, 364					2.00
3.00	HMO IPF Subprovider	1, 026	0					3.00
4.00	HMO IRF Subprovider	0	0					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5, 711	1, 332	20, 68				7.00
8.00	INTENSIVE CARE UNIT	166	82	47	79			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	510	90	08			8.01
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT	211	65	1, 51	11			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		279	78	83			13.00
14.00	Total (see instructions)	6, 088	2, 268			5.13	526.55	14.00
15.00	CAH visits	0	0		0			15.00
16.00	SUBPROVIDER - IPF	3, 790	226	6, 04	48	0.00	28.85	
17.00	SUBPROVIDER - IRF			-, -				17.00
18.00	SUBPROVIDER							18.00
19.00	SKILLED NURSING FACILITY	2,026	0	4, 88	88	0.00	16.95	
20.00	NURSING FACILITY	2/ 020	0	.,		01.00	10170	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)	0	0		0			24.10
25.00	CMHC - CMHC	0	0		0			25.00
26.00	RURAL HEALTH CLINIC							26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00	Total (sum of lines 14-26)					5.13	572.35	
28.00	Observation Bed Days		0	3, 24	10	5.15	572.55	27.00
29.00	Ambulance Trips	0	0	3, 24	47			28.00
30.00	Employee discount days (see instruction)	0			0			30.00
					0			30.00
31.00	Employee discount days - IRF	0	107	47	-			
32.00	Labor & delivery days (see instructions)	0	127	1.	38			32.00
32.01	Total ancillary labor & delivery room				0			32.01
22.02	outpatient days (see instructions)							
JJ. UU	LTCH non-covered days	0						33.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016	Worksheet S-3 Part I Date/Time Pre 10/31/2016 8:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	11.00	0	1, 1	23 1, 886	4, 824	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider			6	39 0 0 0		2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						5.00 6.00 7.00
8.00 8.01 9.00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT						8. 00 8. 01 9. 00
10.00 11.00 12.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						10.00 11.00 12.00
13.00 14.00	NURSERY Total (see instructions)	0. 00	0	1, 1	23 1, 886	4, 824	13.00 14.00
15.00 16.00 17.00	CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF	0.00	0	2	66 69	422	15.00 16.00 17.00
18.00 19.00	SUBPROVI DER SKI LLED NURSI NG FACI LI TY	0. 00					17.00 18.00 19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00 21. 00
22.00 23.00 24.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						22.00 23.00 24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC						24.10 25.00
26.00 26.25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER						26.00 26.25
27.00 28.00 29.00	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0.00					27.00 28.00 29.00
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF						30.00 31.00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)						32. 00 32. 01
33.00	LTCH non-covered days						33.00

	Financial Systems AL WAGE INDEX INFORMATION		ST JOSEPH MEL		F	Period: From 06/01/2015 To 05/31/2016		pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	(col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
. 00	Total salaries (see	200. 00	32, 106, 637	0	32, 106, 637	1, 190, 477. 72	26. 97	1.00
00	instructions)					0.00	0.00	2.00
. 00	Non-physician anesthetist Part A		C	0	C	0.00	0.00	2.00
. 00	Non-physician anesthetist Part		C	0	C	0.00	0.00	3.00
. 00	B Dhuci ci ch Dant A		C	0		0.00	0.00	1 00
. 00	Physician-Part A - Administrative		Ĺ			0.00	0.00	4.00
. 01	Physicians - Part A - Teaching		C	0	C	0.00	0.00	4.01
. 00	Physician-Part B		C	0	0	0.00		
	Non-physician-Part B	21.00	C	0		0.00		
. 00	Interns & residents (in an approved program)	21.00	C	0		0.00	0.00	7.00
. 01	Contracted interns and		C	0	0	0.00	0.00	7.01
	residents (in an approved							
00	programs)		0			0.00	0.00	8.00
. 00 . 00	Home office personnel SNF	44.00	1,059,579	0	1, 059, 579	0.00 35,259.75		
0.00	Excluded area salaries (see	44.00	1, 467, 761					
	instructions)					-		
	OTHER WAGES & RELATED COSTS		F1 F74			700.00	(5.07	11 00
1.00	Contract Labor: Direct Patient Care		51, 574	0	51, 574	789.00	65.37	11.00
2.00	Contract Labor: Top Level		216, 000	0	216, 000	1, 440. 00	150.00	12.00
	management and other							
	management and administrative services							
3. 00	Contract Labor: Physician-Part		83, 748	0	83, 748	606.75	138 03	13.00
	A - Administrative		,	_				
4.00	Home office salaries &		2, 848, 223	0	2, 848, 223	80, 205. 00	35. 51	14.00
5.00	wage-related costs Home office: Physician Part A		C	0		0.00	0.00	15.00
5.00	- Administrative		C			0.00	0.00	15.00
6. 00	Home office and Contract		C	0	C	0.00	0.00	16.00
	Physicians Part A - Teaching WAGE-RELATED COSTS							-
	Wage-related costs (core) (see		6, 576, 982	0	6, 576, 982	2		17.00
	instructions)		-,,					
8.00	Wage-related costs (other)		C	0	C	)		18.00
9 00	(see instructions) Excluded areas		622, 417	0	622, 417	,		19.00
	Non-physician anesthetist Part		022, 11, C	-				20.00
	A							
1.00	Non-physician anesthetist Part		C	0	0	)		21.00
2.00	Physician Part A -		C	0	0			22.00
	Admi ni strati ve							
2.01	Physician Part A - Teaching		C	0	0			22.01
	Physician Part B Wage-related costs (RHC/FQHC)			0				23.00 24.00
	Interns & residents (in an		C	-				24.00
	approved program)							
( 00	OVERHEAD COSTS - DIRECT SALARIE		220.070		220.070		20 55	1 24 00
	Employee Benefits Department Administrative & General	4.00 5.00	229, 979 4, 291, 776					
	Administrative & General under	5.00	4, 271, 770 C	00,101	4, 377, 077	0.00		
	contract (see inst.)							
	Maintenance & Repairs	6.00	1 000 700	0	1 000 700	0.00		
	Operation of Plant Laundry & Linen Service	7.00 8.00	1, 002, 782 1, 817		1, 002, 782	47, 175. 00 0. 00		
	Housekeeping	9.00	650, 155		650, 155			
3.00	Housekeeping under contract		C	0	C	0.00	0.00	33.00
4 00	(see instructions)	10.00	~	_				24.00
4.00 5.00	Dietary Dietary under contract (see	10.00	C	0		0.00		34.00 35.00
5.00	instructions)		C			, 0.00	0.00	33.00
	Cafeteri a	11.00	C	0	( C	0.00		
	Maintenance of Personnel	12.00	C	0	(	0.00		37.00
	Nursing Administration	13.00	1,723,340	92, 628	1, 815, 968	3 51, 655. 76	35.16	38.00
	Central Services and Supply	14.00	343, 191	-343, 191		0.00	0.00	39.00

Health Financial Systems		ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					rom 06/01/2015		
				1	o 05/31/2016		pared:
						10/31/2016 8:	<u>18 am</u>
	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	
41.00 Medical Records & Medical	16.00	168, 968	0	168, 968	3 11, 765. 00	14.36	41.00
Records Library							
42.00 Social Service	17.00	C	0	(	0.00	0.00	42.00
43.00 Other General Service	18.00	C	0	(	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION         Provider CCN: 150047         Period: From 06/01/2015 To 05/31/2016         Worksheet S-3 Part III Dat IIII Dat III Dat IIII DAT III DAT III DAT III DAT IIII DAT IIII DAT III DAT IIII DAT IIII DAT III DAT III DAT IIII DAT III DAT III DAT IIII DAT III DAT III DAT III DAT IIII DAT IIIII DAT IIIII DAT IIIII DAT IIIII DAT IIIIIIIII DAT IIIIIIII DAT IIIII DAT IIIII DAT IIIII DAT IIIIIIIIIIIII	Heal th	Financial Systems		ST JOSEPH MED	OLCAL CENTER		In Lie	eu of Form CMS-2	2552-10
$\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$	HOSPI T	AL WAGE INDEX INFORMATION			Provi der				
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$								Date/Time Pre	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$			Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours		
PART 111 - HOSPITAL WAGE INDEX SUMMARY         3.00         4.00         5.00         6.00           1.00         2.00         3.00         4.00         5.00         6.00           PART 111 - HOSPITAL WAGE INDEX SUMMARY         32,106,637         0         32,106,637         1,190,477.72         26.97         1.00           2.00         Excluded area salaries (see instructions)         2,527,340         164,279         2,691,619         101,117.50         26.62         2.00           3.00         Subtotal salaries (line 1         29,579,297         -164,279         29,415,018         1,089,360.22         27.00         3.00           4.00         Subtotal other wages & related costs (see inst.)         3,199,545         0         3,199,545         83,040.75         38.53         4.00           5.00         Subtotal wage-related costs (see inst.)         6,576,982         0         6,576,982         0.00         22.36         5.00           6.00         Total (sum of lines 3 thru 5)         39,355,824         -164,279         39,191,545         1,172,400.97         33.43         6.00           7.00         Total overhead cost (see         9,758,814         -164,279         9,594,535         381,835.00         25.13         7.00 <td></td> <td></td> <td>Line Number</td> <td>Reported</td> <td>on of Salaries</td> <td></td> <td></td> <td></td> <td></td>			Line Number	Reported	on of Salaries				
PART 111 - HOSPITAL WAGE INDEX SUMMARY         32, 106, 637         0         32, 106, 637         1, 190, 477. 72         26. 97         1. 00           1.00         Excluded area salaries (see instructions)         32, 106, 637         0         32, 106, 637         1, 190, 477. 72         26. 97         1. 00           2.00         Excluded area salaries (see instructions)         2, 527, 340         164, 279         2, 691, 619         101, 117. 50         26. 62         2. 00           3.00         Subtotal salaries (line 1 minus line 2)         29, 579, 297         -164, 279         29, 415, 018         1, 089, 360. 22         27. 00         3. 00           4.00         Subtotal other wages & related costs (see inst.)         3, 199, 545         0         3, 199, 545         83, 040. 75         38. 53         4. 00           5.00         Subtotal wage-related costs (see inst.)         6, 576, 982         0         6, 576, 982         0. 00         22. 36         5. 00           6.00         Total (sum of lines 3 thru 5)         39, 355, 824         -164, 279         39, 191, 545         1, 172, 400. 97         33. 43         6. 00           7.00         Total overhead cost (see         9, 758, 814         -164, 279         9, 594, 535         381, 835. 00         25. 13         7. 00					(from	(col.2 ± col.	Salaries in	col. 5)	
PART 111 - HOSPITAL WAGE INDEX SUMMARY           1.00         Net salaries (see instructions)         32, 106, 637         0         32, 106, 637         1, 190, 477. 72         26. 97         1. 00           2.00         Excluded area salaries (see instructions)         2, 527, 340         164, 279         2, 691, 619         101, 117. 50         26. 62         2. 00           3.00         Subtotal salaries (line 1 minus line 2)         29, 579, 297         -164, 279         29, 415, 018         1, 089, 360. 22         27. 00         3. 00           4.00         Subtotal other wages & related costs (see inst.)         3, 199, 545         0         3, 199, 545         83, 040. 75         38. 53         4. 00           5.00         Subtotal wage-related costs (see inst.)         6, 576, 982         0         6, 576, 982         0. 00         22. 36         5. 00           6.00         Total (sum of lines 3 thru 5)         39, 355, 824         -164, 279         39, 191, 545         1, 172, 400. 97         33. 43         6. 00           7.00         Total overhead cost (see         9, 758, 814         -164, 279         9, 594, 535         381, 835. 00         25. 13         7. 00					Worksheet A-6)	3)	col. 4		
1.00       Net salaries (see instructions)       32, 106, 637       0       32, 106, 637       1, 190, 477. 72       26. 97       1.00         2.00       Excluded area salaries (see instructions)       2, 527, 340       164, 279       2, 691, 619       101, 117. 50       26. 62       2.00         3.00       Subtotal salaries (line 1 minus line 2)       29, 579, 297       -164, 279       29, 415, 018       1, 089, 360. 22       27. 00       3.00         4.00       Subtotal other wages & related costs (see inst.)       3, 199, 545       0       3, 199, 545       83, 040. 75       38. 53       4.00         5.00       Subtotal wage-related costs (see inst.)       6, 576, 982       0       6, 576, 982       0.00       22. 36       5.00         6.00       Total (sum of lines 3 thru 5)       39, 355, 824       -164, 279       39, 191, 545       1, 172, 400. 97       33. 43       6.00         7.00       Total overhead cost (see       9, 758, 814       -164, 279       9, 594, 535       381, 835. 00       25. 13       7. 00			1.00	2.00	3.00	4.00	5.00	6.00	
2.00       instructions)       2,527,340       164,279       2,691,619       101,117.50       26.62       2.00         3.00       Subtotal salaries (line 1 minus line 2)       29,579,297       -164,279       29,415,018       1,089,360.22       27.00       3.00         4.00       Subtotal other wages & related costs (see inst.)       3,199,545       0       3,199,545       83,040.75       38.53       4.00         5.00       Subtotal wage-related costs (see inst.)       6,576,982       0       6,576,982       0.00       22.36       5.00         6.00       Total (sum of lines 3 thru 5)       39,355,824       -164,279       39,191,545       1,172,400.97       33.43       6.00         7.00       Total overhead cost (see       9,758,814       -164,279       9,594,535       381,835.00       25.13       7.00		PART III - HOSPITAL WAGE INDEX	SUMMARY						
2.00       Excluded area salaries (see instructions)       2,527,340       164,279       2,691,619       101,117.50       26.62       2.00         3.00       Subtotal salaries (line 1 minus line 2)       29,579,297       -164,279       29,415,018       1,089,360.22       27.00       3.00         4.00       Subtotal other wages & related costs (see inst.)       3,199,545       0       3,199,545       83,040.75       38.53       4.00         5.00       Subtotal wage-related costs (see inst.)       6,576,982       0       6,576,982       0.00       22.36       5.00         6.00       Total (sum of lines 3 thru 5)       39,355,824       -164,279       39,191,545       1,172,400.97       33.43       6.00         7.00       Total overhead cost (see       9,758,814       -164,279       9,594,535       381,835.00       25.13       7.00	1.00	Net salaries (see		32, 106, 637	0	32, 106, 63	7 1, 190, 477. 72	26.97	1.00
instructions)       3.00       Subtotal salaries (line 1 minus line 2)       29,579,297       -164,279       29,415,018       1,089,360.22       27.00       3.00         4.00       Subtotal other wages & related costs (see inst.)       3,199,545       0       3,199,545       83,040.75       38.53       4.00         5.00       Subtotal wage-related costs (see inst.)       6,576,982       0       6,576,982       0.00       22.36       5.00         6.00       Total (sum of lines 3 thru 5)       39,355,824       -164,279       39,191,545       1,172,400.97       33.43       6.00         7.00       Total overhead cost (see       9,758,814       -164,279       9,594,535       381,835.00       25.13       7.00		instructions)							
3.00       Subtotal salaries (line 1 minus line 2)       29, 579, 297       -164, 279       29, 415, 018       1, 089, 360, 22       27.00       3.00         4.00       Subtotal other wages & related costs (see inst.)       3, 199, 545       0       3, 199, 545       83, 040, 75       38.53       4.00         5.00       Subtotal wage-related costs (see inst.)       6, 576, 982       0       6, 576, 982       0.00       22.36       5.00         6.00       Total (sum of lines 3 thru 5)       39, 355, 824       -164, 279       39, 191, 545       1, 172, 400, 97       33.43       6.00         7.00       Total overhead cost (see       9, 758, 814       -164, 279       9, 594, 535       381, 835.00       25.13       7.00	2.00	Excluded area salaries (see		2, 527, 340	164, 279	2, 691, 61	9 101, 117. 50	26.62	2.00
# in us line 2)minus line 2)3, 199, 54503, 199, 54583, 040. 7538. 534. 004. 00Subtotal other wages & related costs (see inst.)3, 199, 54503, 199, 54583, 040. 7538. 534. 005. 00Subtotal wage-related costs (see inst.)6, 576, 98206, 576, 9820.0022. 365. 006. 00Total (sum of lines 3 thru 5) Total overhead cost (see39, 355, 824 9, 758, 814-164, 279 -164, 27939, 191, 545 9, 594, 5351, 172, 400. 97 381, 835. 0033. 43 25. 136. 00		instructions)							
4.00       Subtotal other wages & related costs       3, 199, 545       0       3, 199, 545       83, 040. 75       38. 53       4. 00         5.00       Subtotal wage-related costs (see inst.)       6, 576, 982       0       6, 576, 982       0.00       22. 36       5. 00         6.00       Total (sum of lines 3 thru 5)       39, 355, 824       -164, 279       39, 191, 545       1, 172, 400. 97       33. 43       6. 00         7.00       Total overhead cost (see       9, 758, 814       -164, 279       9, 594, 535       381, 835. 00       25. 13       7. 00	3.00			29, 579, 297	-164, 279	29, 415, 01	8 1, 089, 360. 22	27.00	3.00
costs (see inst.)6.00Subtotal wage-related costs (see inst.)6.576,98206.576,9820.0022.365.006.00Total (sum of lines 3 thru 5)39,355,824-164,27939,191,5451,172,400.9733.436.007.00Total overhead cost (see9,758,814-164,2799,594,535381,835.0025.137.00		minus line 2)							
5. 00       Subtotal wage-related costs (see inst.)       6, 576, 982       0       6, 576, 982       0.00       22.36       5.00         6. 00       Total (sum of lines 3 thru 5)       39, 355, 824       -164, 279       39, 191, 545       1, 172, 400. 97       33. 43       6.00         7. 00       Total overhead cost (see       9, 758, 814       -164, 279       9, 594, 535       381, 835. 00       25. 13       7. 00	4.00	Subtotal other wages & related		3, 199, 545	0	3, 199, 54	5 83, 040. 75	38. 53	4.00
(see inst.)(see inst.)39, 355, 824-164, 27939, 191, 5451, 172, 400. 9733. 436. 007. 00Total overhead cost (see9, 758, 814-164, 2799, 594, 535381, 835. 0025. 137. 00		costs (see inst.)							
6.00         Total (sum of lines 3 thru 5)         39, 355, 824         -164, 279         39, 191, 545         1, 172, 400. 97         33. 43         6.00           7.00         Total overhead cost (see         9, 758, 814         -164, 279         9, 594, 535         381, 835. 00         25. 13         7.00	5.00	Subtotal wage-related costs		6, 576, 982	0	6, 576, 98	2 0.00	22.36	5.00
7.00         Total overhead cost (see         9, 758, 814         -164, 279         9, 594, 535         381, 835.00         25.13         7.00									
	6.00	Total (sum of lines 3 thru 5)		39, 355, 824	-164, 279	39, 191, 54	5 1, 172, 400. 97	33. 43	6.00
	7.00	Total overhead cost (see		9, 758, 814	-164, 279	9, 594, 53	5 381, 835. 00	25. 13	7.00
instructions)		instructions)							

Heal th	Financial Systems ST JOSEP	PH MEDICAL CENTE	R		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Provi	der CCN	: 150047	Period: From 06/01/2015 To 05/31/2016		pared:
						Amount	
						Reported	
	PART IV - WAGE RELATED COSTS					1.00	
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					539, 842	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution					037,042	2.00
3.00	Nongualified Defined Benefit Plan Cost (see instruction	)				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)					0	4.00
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External Organizati					0	4.00
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan					0	6.00
7.00	Employee Managed Care Program Administration Fees					0	7.00
	HEALTH AND INSURANCE COST					_	
8.00	Health Insurance (Purchased or Self Funded)					3, 549, 637	8.00
9.00	Prescription Drug Plan					0	9.00
10.00	Dental, Hearing and Vision Plan					46, 950	10.00
11.00	Life Insurance (If employee is owner or beneficiary)					23, 732	11.00
12.00	Accident Insurance (If employee is owner or beneficiar	~v)				2, 786	12.00
13.00	Disability Insurance (If employee is owner or benefici	ary)				15, 138	13.00
14.00	Long-Term Care Insurance (If employee is owner or bene	eficiary)				0	14.00
15.00	'Workers' Compensation Insurance					476, 616	15.00
16.00	Retirement Health Care Cost (Only current year, not th	ne extraordi nary	accrua	l require	d by FASB 106.	0	16.00
	Non cumulative portion)			-			
	TAXES						
	FICA-Employers Portion Only					1, 853, 808	
18.00	Medicare Taxes - Employers Portion Only					433, 552	
19.00	Unemployment Insurance					0	
20.00	State or Federal Unemployment Taxes					151, 535	20.00
	OTHER						
21.00	Executive Deferred Compensation (Other Than Retirement instructions))	t Cost Reported	on line:	s 1 throu	gh 4 above. (see	0	
22.00	Day Care Cost and Allowances					0	
23.00	Tuition Reimbursement					0	
24.00	Total Wage Related cost (Sum of lines 1 -23)					7, 093, 596	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER BENEFITS					105, 803	25.00

Heal th Fi	inancial Systems	ST JOSEPH MEDICAL	CENTER		In Lie	eu of Form CMS-2	2552-10
HOSPI TAL	CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150047	Peri od:	Worksheet S-3	
					From 06/01/2015		
					To 05/31/2016		
	Cast Captor Decarintian				Contract Lobar	10/31/2016 8:	18 am
	Cost Center Description				Contract Labor 1.00	Benefit Cost 2.00	
DA	NDT V Contract Lober and Departit Cost				1.00	2.00	
	ART V - Contract Labor and Benefit Cost	lootion.					-
	ospital and Hospital-Based Component Identif				0	0	1 00
1	otal facility's contract labor and benefit c	ost			0	0	1.00
	ospi tal				0	0	2.00
1	ubprovider - IPF				0	0	3.00
	ubprovider - IRF						4.00
	ubprovider - (Other)				0	0	5.00
	wing Beds - SNF				0	0	6.00
	wing Beds - NF				0	0	7.00
	ospital-Based SNF				0	0	8.00
	ospital-Based NF						9.00
	ospital-Based OLTC						10.00
	ospital-Based HHA						11.00
	eparately Certified ASC						12.00
	ospital-Based Hospice						13.00
	ospital-Based Health Clinic RHC						14.00
15.00 Ho	ospital-Based Health Clinic FQHC						15.00
16.00 Ho	ospital-Based-CMHC					1	16.00
17.00 Re	enal Dialysis				0	0	17.00
18.00 01	ther				0	0	18.00

	Financial Systems CTIVE PAYMENT FOR SNF STATISTICAL DATA	ST JOSEPH MEDICAL		CCN: 150047	In Lie Period:	u of Form CMS-2 Worksheet S-7	
PRUSPE	CITVE PATMENT FOR SNF STATISTICAL DATA		Provider		From 06/01/2015 To 05/31/2016		
						10/31/2016 8:	18 am
	1				1.00	2.00	
1.00	If this facility contains a hospital-base or was there no Medicare utilization? En- complete the rest of this worksheet.	er "Y" for yes in colu	mn 1 and c	do not	N		1.00
2.00	Does this hospital have an agreement under swing beds? Enter "Y" for yes or "N" for date (mm/dd/yyyy) in column 2.				Ν		2.00
			Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
			1.00	2.00	3.00	4.00	
3.00 4.00			RUX RUL		0 0 0 0	-	3.00 4.00
5.00			RVX		0 0	0	5.00
6.00 7.00			RVL RHX		0 0	-	6.00 7.00
7.00 8.00			RHL		0 0	-	8.00
9.00			RMX		0 0	-	1
10.00 11.00			RML RLX		0 0 0 0	0	10.00
12.00			RUC	1	-	-	
13.00			RUB	2	8 0	28	13.00
14.00			RUA	1			
15.00 16.00			RVC RVB	25 29			
17.00			RVA	18	3 0	183	17.00
18.00 19.00			RHC RHB	13		139 381	
20.00			RHA	28			
21.00			RMC	1	5 0	15	21.00
22.00			RMB	9		93	
23.00 24.00			RMA RLB	1			23.00 24.00
25.00			RLA		0 0	-	25.00
26.00 27.00			ES3 ES2		0 0 8 0	0	
27.00			ES2 ES1			0	
29.00			HE2		0 0	0	29.00
30.00 31.00			HE1 HD2	1	0 0		1
32.00			HD1		6 0		
33.00			HC2		0 0	0	
34.00 35.00			HC1 HB2	1	4 0	4	34.00 35.00
36.00			HB2 HB1	3		38	
37.00			LE2	1			
38.00 39.00			LE1 LD2	1	4 0 0 0		38.00 39.00
40.00			LD1		3 0	-	
41.00			LC2		0 0	-	
42.00 43.00			LC1 LB2	2	8 0 0 0	28	
44.00			LB1	3		35	44.00
45.00			CE2		0 0	0	
46.00 47.00			CE1 CD2		0 0 5 0	05	
48.00			CD1		0 0	0	48.00
49.00			CC2		0 0	0	
50.00 51.00			CC1 CB2	3	7 0 0 0	37	50.00 51.00
52.00			CB1	2	3 0	23	52.00
53.00 54.00			CA2 CA1	7	0 0	0	
54.00 55.00			SE3		8 0 0 0	/8	
56.00			SE2		0 0	0	56.00
57.00			SE1		0 0	-	
58.00 59.00			SSC SSB			0	1
60.00			SSA		0 0	0	60.00
			IB2		0 0	0	61.00
61.00			I B1		uj 0	0	
61.00 62.00					0 0		0,3.00
61.00 62.00 63.00 64.00			I A2 I A1		0 0 0 0	0	64.00
61.00 62.00 63.00 64.00 65.00			I A2 I A1 BB2			0	64.00 65.00
61.00 62.00 63.00 64.00			I A2 I A1		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0	64.00 65.00 66.00

Health Financial Systems	ST JOSEPH MEDICAL CENTEI	)		Inlie	u of Form CMS-	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		der CCN: 150047	Peri od:	TH EFG	Worksheet S-7	
			From 06/0	01/2015 31/2016	Date/Time Pre 10/31/2016 8:	pared:
	Group	SNF Days			Total (sum of	
	1.00	2.00	Da		<u>col. 2 + 3)</u>	
69.00	1.00 PE2	2.00	0	00	4.00	69.00
70.00	PE2 PE1		0	0	0	
70.00	PD2		0	0	0	
72.00	PD1		0	0	0	
73.00	PC2		0	0	0	
74.00	PC1		0	0	0	10.00
75.00	PB2		0	0	0	
76.00	PB1		0	0	0	
77.00	PA2		0	0	0	
78.00	PA1		0	0	0	
199.00	AAA		0	0		199.00
200. 00 TOTAL	7000	2	026	0		200.00
			CBSA	at 1	CBSA on/after	200100
			Begi nn		October 1 of	
			Cost Re		the Cost	
			Per	iod	Reporting	
					Period (if	
					appl i cabl e)	
			1.0	00	2.00	
SNF SERVICES						
201.00 Enter in column 1 the SNF CBSA code or 5 cha				-	23060	201.00
in effect at the beginning of the cost repor in effect on or after October 1 of the cost			•			
	reporting period (ir appr	Expenses	s Perce	opeta	Associ ated	
		Lypenses		intage	with Direct	
					Patient Care	
					and Related	
					Expenses?	
		1.00	2.	00	3.00	
A notice published in the Federal Register V						
payments beginning 10/01/2003. Congress expe						
expenses. For lines 202 through 207: Enter i						
column 2 the percentage of total expenses fo						
line 7, column 3. In column 3, enter "Y" for			ects increas	ses asso	ci ated	
with direct patient care and related expense	<u>s for each category. (see</u>	instructions)	0	0.00		
202.00 Staffing			0	0.00		202.00
203.00 Recruitment			U	0.00		203.00
204.00 Retention of employees			U	0.00		204.00
			U	0.00		205.00
206.00 OTHER (SPECIFY)		2 554	0	0.00		206.00
207.00 Total SNF revenue (Worksheet G-2, Part I, li	ne /, corumn 3)	3, 551,	300			207.00

Heal th	Financial Systems ST JOSEPH MEDICAL C	CENTER		In Lie	eu of Form CMS	-2552-10
HOSPI 1	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150047	Peri od:	Worksheet S-	10
				From 06/01/2015		onorod.
				To 05/31/2016	Date/Time Pr 10/31/2016 8	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by li	ne 202 columr	18)	0. 15207	9 1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				26, 404, 26	1 2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p		from Medicaic	1?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from M	Medi cai d			9, 585, 62	
6.00	Medi cai d charges				171, 321, 22	
7.00	Medicaid cost (line 1 times line 6)				26, 054, 36	
8.00	Difference between net revenue and costs for Medicaid program (li	ine 7 min	us sum of lir	nes 2 and 5; if		0 8.00
	< zero then enter zero)					_
0.00	State Children's Health Insurance Program (SCHIP) (see instruction	ons tor e	ach line)			
9.00	Net revenue from stand-al one SCHIP					0 9.00
10.00	Stand-alone SCHIP charges					0 10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	1 : ma 11 m	inua lina O.	if , zama than		0 11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (I enter zero)	ine n m	inus iine 9;	TT < Zero then		0 12.00
	Other state or local government indigent care program (see instru	uctions f	or each line)		1	-
13.00	Net revenue from state or local indigent care program (Not includ				453.22	2 13.00
14.00	Charges for patients covered under state or local indigent care p				3, 864, 86	
11.00	10)	or ogram (			0,001,00	/ 11.00
15.00	State or local indigent care program cost (line 1 times line 14)				587, 76	5 15.00
16.00	Difference between net revenue and costs for state or local indig	gent care	program (lir	ne 15 minus line		
	13; if < zero then enter zero)	5	1 3 (			
	Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to fund	ding char	ity care		,	0 17.00
18.00	Government grants, appropriations or transfers for support of hos					0 18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local	i ndi gent	care program	ns (sum of lines	134, 54	3 19.00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	_
20.00	Total initial obligation of patients approved for charity care (a	at full	1.00 931,19	2.00 23 49,898	3.00 981,09	1 20.00
20.00	charges excluding non-reimbursable cost centers) for the entire f		931, 19	49,898	981,09	1 20.00
21.00	Cost of initial obligation of patients approved for charity care		141, 61	15 7, 588	149, 20	3 21.00
21.00	times line 20)		111,0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	117,20	21.00
22.00	Partial payment by patients approved for charity care		1, 81	4, 967	6, 78	4 22.00
23.00	Cost of charity care (line 21 minus line 22)		139, 79			
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient of	days beyo	nd a length o	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care pr	rogram?	0	5		
25.00	If line 24 is "yes," charges for patient days beyond an indigent	t care pr	ogram's lengt	h of stay limit	,	0 25.00
26.00	Total bad debt expense for the entire hospital complex (see instr				23, 966, 03	
27.00	Medicare bad debts for the entire hospital complex (see instructi	,			320, 09	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		,		23, 645, 94	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper	nse (line	1 times line	28)	3, 596, 05	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				3, 738, 47	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			3, 873, 01	4  31.00

LASSITI	ICATION AND ADJUSTMENTS OF TRIAL BALANCE (	JF EXPENSES	Provi der	F	Period: From 06/01/2015 To 05/31/2016	Worksheet A Date/Time Pre	narr
						10/31/2016 8:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ERAL SERVICE COST CENTERS	-					
1	00 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP		1, 990, 758				
	00 EMPLOYEE BENEFITS DEPARTMENT	229, 979	4, 093, 564 149, 057	4, 093, 564 379, 036		5, 437, 868 5, 133, 130	
	60 OTHER ADMINISTRATIVE AND GENERAL	4, 291, 776	22, 895, 395			0, 133, 130	
	550 DATA PROCESSING	0	0	C		1, 822, 981	
	91 PURCHASING AND RECEIVING	0	0	( c	1, 171, 785	1, 171, 785	5
	40 CENTRAL SCHEDULING	0	0	0		1, 322, 427	
	80 CASHI ERI NG/ACCOUNTS RECEI VABLE 90 OTHER ADMINI STRATI VE AND GENERAL	0	0		1 - 1 - 1 - 1	2, 285, 594 14, 537, 664	
	OO OPERATION OF PLANT	1,002,782	2, 480, 229			3, 570, 976	
	BOO LAUNDRY & LINEN SERVICE	1,817	453, 181	454, 998		377, 252	
	000 HOUSEKEEPI NG	650, 155	421, 589	1, 071, 744		1, 077, 078	
	DOO DI ETARY	0	2, 138, 004	2, 138, 004		1, 288, 662	
		0	0		848, 352	848, 352	
	00 NURSI NG ADMI NI STRATI ON 350 PASTORAL CARE	1, 664, 180 59, 160	244, 483 15, 725	1, 908, 663 74, 885		2, 216, 841 74, 885	
	00 CENTRAL SERVICES & SUPPLY	343, 191	7, 117, 482	7, 460, 673		0	
	OO PHARMACY	1, 346, 806	4, 337, 437	5, 684, 243		1, 854, 289	
	00 MEDICAL RECORDS & LIBRARY	168, 968	197, 928	366, 896	5 O	366, 896	16
	00 I &R SERVICES-SALARY & FRINGES APPRV	0	2, 174, 023	2, 174, 023		0	2
	200 I & R SERVICES-OTHER PRGM COSTS APPRV	0	0	(	2, 174, 023	2, 174, 023	22
	ATIENT ROUTINE SERVICE COST CENTERS	6, 673, 015	2, 829, 608	9, 502, 623	-1, 420, 738	8, 081, 885	30
	00 I NTENSI VE CARE UNI T	310, 512	112, 694	423, 206		423, 206	
	060 NEONATAL INTENSIVE CARE UNIT	679, 004	163, 056			842, 060	
	OO BURN INTENSIVE CARE UNIT	0	0	C	.,	1, 660, 128	
	000 SUBPROVIDER - IPF	1, 465, 484	196, 005	1, 661, 489		1, 661, 489	
	00 NURSERY 00 SKILLED NURSING FACILITY	0 1, 059, 579	0	1 202 000	273, 026	273, 026	
	ILLARY SERVICE COST CENTERS	1,039,379	144, 310	1, 203, 889	<u> </u>	1, 203, 889	44
00 050	OO OPERATI NG ROOM	1, 312, 218	1,807,523	3, 119, 741	-494, 770	2, 624, 971	50
	30 ENDOSCOPY	0	0	( C		494, 631	
	OO RECOVERY ROOM	429, 063	36, 760			465, 823	
	200 DELIVERY ROOM & LABOR ROOM	856, 941	515, 136	1, 372, 077		857,888	
	000 ANESTHESI OLOGY 000 RADI OLOGY-DI AGNOSTI C	0 1, 202, 017	1, 168, 979 1, 144, 102	1, 168, 979 2, 346, 119		1, 168, 979 3, 124, 949	
	30 ULTRA SOUND	340, 494	34, 433			3, 124, 949	
-	000 RADI OI SOTOPE	87, 395	289, 037	376, 432		0	
	OO CT SCAN	191, 567	29, 900	221, 467	-221, 467	0	
		0	0	0		0	
	000 CARDI AC CATHETERI ZATI ON 000 LABORATORY	0 2, 044, 554	0	4, 195, 160		1, 329, 169 3, 520, 364	
	00 WHOLE BLOOD & PACKED RED BLOOD CELL	2,044,554	2, 150, 606	4, 195, 100	0 -674, 796 519, 383	519, 383	
	000 RESPIRATORY THERAPY	672, 194	170, 660	842, 854		825, 182	
	00 PHYSI CAL THERAPY	558, 828	164, 653	723, 481		626, 886	60
	OO OCCUPATIONAL THERAPY	323, 547	34, 091	357, 638		357, 638	
	SOO SPEECH PATHOLOGY	77, 213	7,406			84, 619	
	00 ELECTROCARDI OLOGY 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	868, 383	575, 592	1, 443, 975	5 -1, 329, 169 3, 917, 815	114, 806 3, 917, 815	
	OO IMPL. DEV. CHARGED TO PATIENTS	0	0		1, 952, 808	1, 952, 808	
	OO DRUGS CHARGED TO PATIENTS	0	0		3, 619, 995	3, 619, 995	
00 074	OO RENAL DI ALYSI S	0	359, 244	359, 244		359, 244	74
	50 OTHER ANCI LLARY SERVICE COST CENTER	0	0	C	0 0	0	
1		0	0	(	0	0	1
1	50 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 952 WOUND CARE	386, 379 775, 064	36, 231 176, 531	422, 610 951, 595		422, 554 951, 046	
	PATIENT SERVICE COST CENTERS	110,001	170,001	,,,,,,	5 017	,,,,,,,	1
	DOO CLINIC	160, 314	28, 787	189, 101	-3	189, 098	90
	00 EMERGENCY	1, 871, 781	696, 934	2, 568, 715	5 0	2, 568, 715	
	OOOOOBSERVATION BEDS (NON-DISTINCT PART						92
3. 00	CIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	32, 104, 360	61, 581, 133	93, 685, 493	-846, 512	92, 838, 981	1110
	REIMBURSABLE COST CENTERS	52, 104, 300	01, 001, 133	75, 065, 493	-040, 312	72, 030, 981	1,16
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 277	27, 495	29, 772	2 0	29, 772	190
	00 RESEARCH	0	0	,			191
	200 PHYSI CLANS' PRI VATE OFFI CES	0	365	365	ō 0	365	
	DO OTHER NONREI MBURSABLE COST CENTERS	0	0		0		194
	251 MARKETING 252 SENIOR CIRCLE	0	0		846, 512	846, 512	194 194
	952 SENTOR CIRCLE 953 SELECT SPECIALTY	0	0				194
		J	0		. 0	0	194

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der		Period: From 06/01/2015	Worksheet A	
				o 05/31/2016		
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	
200.00 TOTAL (SUM OF LINES 118-199)	32, 106, 637	61, 608, 993	93, 715, 630	0 0	93, 715, 630	200. 00

	<u>Financial Systems</u> SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	ST JOSEPH MEDI OF EXPENSES		CCN: 150047		u of Form CMS-2552 Worksheet A
					From 06/01/2015 To 05/31/2016	Date/Time Prepare 10/31/2016 8:18 a
	Cost Center Description		Net Expenses For Allocation 7.00			
	GENERAL SERVICE COST CENTERS					
. 00 . 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	3, 163, 150 -930, 499	6, 199, 182 4, 507, 369			1.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-4, 440	5, 128, 690			4.
. 01	00560 OTHER ADMINI STRATI VE AND GENERAL	4, 440 0	3, 120, 070			5.
. 02	00550 DATA PROCESSI NG	0	1, 822, 981			5.
. 03	00591 PURCHASING AND RECEIVING	0	1, 171, 785			5.
. 04	00540 CENTRAL SCHEDULI NG	0	1, 322, 427			5.
. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-23, 614	2, 261, 980			5.
. 06	00590 OTHER ADMINI STRATI VE AND GENERAL	-1, 980, 612	12, 557, 052			5.
. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-30, 752	3, 540, 224			7.
9.00 9.00	00900 HOUSEKEEPING	27, 500 0	404, 752 1, 077, 078			8. 9.
0.00	01000 DI ETARY	0	1, 288, 662			10.
1.00	01100 CAFETERI A	-166, 413	681, 939			11.
3.00	01300 NURSI NG ADMI NI STRATI ON	-2, 130	2, 214, 711			13.
3. 01	01850 PASTORAL CARE	0	74, 885			13.
	01400 CENTRAL SERVICES & SUPPLY	0	0			14.
5.00		0	1,854,289			15.
6.00 1.00		-2, 351 0	364, 545 0			16. 21.
	02200 I & SERVICES-SALARI & TRINGES AFFRV	0	2, 174, 023			21.
2.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	2, 174, 023	<u> </u>		
30.00	03000 ADULTS & PEDI ATRI CS	-1, 237, 314	6, 844, 571			30.
31.00		0	423, 206			31.
1. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	842, 060			31.
3. 00		-505, 594	1, 154, 534			33.
0.00	04000 SUBPROVIDER - IPF	0	1,661,489			40.
3.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	273, 026 1, 203, 889			43. 44.
4.00	ANCI LLARY SERVICE COST CENTERS	0	1,203,009			44.
0. 00		-698, 903	1, 926, 068			50.
50. 01	03330 ENDOSCOPY	0	494, 631			50.
1. 00	05100 RECOVERY ROOM	0	465, 823			51.
2.00	05200 DELIVERY ROOM & LABOR ROOM	-375, 977	481, 911			52.
3.00	05300 ANESTHESI OLOGY	-1, 167, 506	1, 473			53.
4.00	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	-1, 193	3, 123, 756			54.
54.01 56.00		0	0			54. 56.
57.00	05700 CT SCAN	0	0			57.
8.00		0	0			58.
9.00	05900 CARDI AC CATHETERI ZATI ON	0	1, 329, 169			59.
0.00	06000 LABORATORY	0	3, 520, 364			60.
2. 00		0	519, 383			62.
5.00		0	825, 182			65.
6.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	626, 886			66.
7.00	06800 SPEECH PATHOLOGY	0	357, 638 84, 619			67. 68.
9.00		0	114, 806			69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-360	3, 917, 455			71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 952, 808			72.
	07300 DRUGS CHARGED TO PATIENTS	0	3, 619, 995			73.
	07400 RENAL DI ALYSI S	0	359, 244			74.
	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0			76.
6.01		0	400 554			76. 76.
6.02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03952 WOUND CARE	0	422, 554 951, 046			76.
0.00	OUTPATIENT SERVICE COST CENTERS	0	731, 040			, 0.
0.00	09000 CLI NI C	0	189, 098			90.
	09100 EMERGENCY	0	2, 568, 715			91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.
10 0	SPECIAL PURPOSE COST CENTERS	0.007.05-	00 001 075			
18.00		-3, 937, 008	88, 901, 973			118.
90 00	NONREI MBURSABLE COST CENTERS	0	29, 772			190.
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29, 772			190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	365			191.
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0			194.
	107951 MARKETI NG	0	846, 512			194.
	2 07952 SENI OR CI RCLE	0	0			194.
	3 07953 SELECT SPECIALTY	0	0			194.
94.04	4 07954 FREE MEALS	0	0			194.
200.00	D TOTAL (SUM OF LINES 118-199)	-3, 937, 008	89, 778, 622	1		200.

Financial Systems IFICATIONS			Provider CC	From 06/01	
				To 05/31	/2016 Date/Time Pr 10/31/2016 8
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - EMPLOYEE BENEFITS	4.00		4 754 004		
EMPLOYEE BENEFITS DEPARTMENT		0	<u>4, 754, 094</u> 4, 754, 094		
B - OXYGEN		0	4, 754, 074		
MEDICAL SUPPLIES CHARGED TO	71.00	0	47, 853		
PATIENT					
	0.00	0	0		
TOTALS	0.00	0	47, 853		
C - LEASE AND RENTAL			17,000		
CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 330, 832		
LAUNDRY & LINEN SERVICE	8.00	0	2, 812		
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	o	o		
	0.00	Ö	0		
	0.00	О	0		
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	0	0		
TOTALS		— — — <u>o</u>	1, 333, 644		
D - OTHER CAPITAL COSTS					
CAP REL COSTS-BLDG & FIXT	1.00	0	147, 249		
CAP REL COSTS-BLDG & FIXT	1.00	0	898, 025		
CAP_REL_COSTS-MVBLE_EQUIP		0	1 <u>3, 4</u> 72 1, 058, 746		
E - MARKETING			1,000,740		
MARKETING	194.01	164, 279	682, 233		
TOTALS		164, 279	682, 233		
F - CNO	40.00	00 (00	01( 000		
NURSI NG ADMI NI STRATI ON	<u>13.00</u>	<u>92, 628</u> 92, 628	<u>216,000</u> 216,000		
G - MEDICAL SUPPLIES		92, 020	210,000		
MEDICAL SUPPLIES CHARGED TO	71.00	0	3, 869, 962		
PATI ENT					
IMPL. DEV. CHARGED TO	72.00	0	1, 952, 808		
PATIENTS	0.00	0	0		
	0.00	0	0		
TOTALS		0	5, 822, 770		
H - DRUGS AND IV COSTS		I			
DRUGS_CHARGED_TO_PATIENTS	73.00	0	<u>3, 619, 995</u>		
I - A&G COSTS		U	3, 619, 995		
DATA PROCESSING	5.02	733, 927	1, 089, 054		
PURCHASING AND RECEIVING	5.03	409, 940	761, 845		
CENTRAL SCHEDULING	5.04	1, 176, 827	145, 600		
CASHI ERI NG/ACCOUNTS RECEI VABLE	5.05	10, 764	2, 274, 830		
OTHER ADMINISTRATIVE AND	5.06	2, 305, 326	19, 226, 628		
GENERAL	5.00	2,000,020	, , , 220, 020		
TOTALS		4, 636, 784	23, 497, 957		
J - RADIOLOGY	Et ool	(10.15)	050.070		
RADI OLOGY-DI AGNOSTI C	54.00	619, 456	353, 370		
	0.00 0.00	0	0		
TOTALS		619, 456	353, 370		
K – DIETARY			1		
		0	848, 352		
		Ō	848, 352		
L - MISC DEPARTMENTS BURN INTENSIVE CARE UNIT	33.00	953, 886	706, 242		
CARDIAC CATHETERIZATION	59.00	953, 888 767, 534	561, 635		
	0.00	0,01,004	0		
ENDOSCOPY	50.01	275, 016	219, 615		
WHOLE BLOOD & PACKED RED	62.00	0	519, 383		
BLOOD CELL	+				
TOTALS M - UTILITIES RECLASS		1, 996, 436	2,006,875		
OPERATION OF PLANT	7.00	0	91, 166		
HOUSEKEEPING	9.00	0	5, 334		
	0.00	0	0		

Heal th	Financial Systems		ST JOSEPH MEI	DICAL CENTER		In Lie	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016	Worksheet A- Date/Time Pr 10/31/2016 8	epared:
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	TOTALS		0	96, 500				
	N - INTERNS AND RESIDENT COST	S						1
1.00	I&R SERVICES-OTHER PRGM	22.00	0	2, 174, 023				1.00
	COSTS_APPRV							
	TOTALS		0	2, 174, 023				
	O - OB/GYN COSTS							
1.00	ADULTS & PEDIATRICS	30.00	214, 972	26, 191				1.00
2.00	NURSERY	43.00	232, 171	40, 855				2.00
	TOTALS		447, 143	67, 046				
500.00	Grand Total: Increases		7, 956, 726	46, 579, 458				500.00

LASS	SI FI CATI ONS			Provi der	CCN: 150047	Period:	Worksheet A-6
						From 06/01/2015 To 05/31/2016	Date/Time Prepare
		Decreases					<u>10/31/2016 8: 18 a</u>
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref	.	
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS				1	1	
	OTHER ADMINI STRATI VE AND	5.06	0	4, 754, 094		0	1.
	GENERAL	+		4, 754, 094	<u> </u>	-	
	B - OXYGEN		UU	4, 754, 074			
	OPERATION OF PLANT	7.00	0	2, 107		0	1.
0	CENTRAL SERVICES & SUPPLY	14.00	0	28, 512		0	2
	RESPIRATORY_THERAPY		0	1 <u>7,2</u> 34		o	3.
	TOTALS		0	47, 853			
	C – LEASE AND RENTAL OTHER ADMINISTRATIVE AND	5.06	0	25 954	1	ol	1
	GENERAL	5.00	0	25, 856	) I'	0	1.
	OPERATION OF PLANT	7.00	o	1, 094		o	2
	DI ETARY	10.00	0	990		0	3
0	NURSING ADMINISTRATION	13.00	0	450	)	o	4
	CENTRAL SERVICES & SUPPLY	14.00	0	711, 130		0	5
		15.00	0	209, 959		0	6
	ADULTS & PEDIATRICS RADIOLOGY-DIAGNOSTIC	30.00 54.00	U U	1, 773 129, 779		0	8
	LABORATORY	54.00 60.00		129, 779		0	12
	PHYSICAL THERAPY	66.00	0	96, 595		ŏ	13
	PSYCHI ATRI C/PSYCHOLOGI CAL	76.02	õ	56		0	15
	SERVICES						
	WOUND_CARE		<u>o</u>	549		<u>0</u>	16
	TOTALS		0	1, 333, 644			
	D - OTHER CAPITAL COSTS OTHER ADMINISTRATIVE AND	5.06	0	1, 058, 746	1	2	1
	GENERAL	5.00	U	1, 036, 740	1.	<u> </u>	
0		0.00	о	C	1	3	2
0		0.00	0	C	1		3
	TOTALS		0	1, 058, 746			
	E - MARKETING	E orl	1/4 070	(00,000	i	0	
	OTHER ADMINISTRATIVE AND GENERAL	5.06	164, 279	682, 233	1	0	1
	TOTALS	+	164, 279	682, 233		1	
	F - CNO						
	OTHER ADMINISTRATIVE AND	5.06	92, 628	216, 000		0	1
	GENERAL		+		<u> </u>	4	
	TOTALS G - MEDI CAL SUPPLI ES		92, 628	216, 000			
	G - MEDICAL SUPPLIES CENTRAL SERVICES & SUPPLY	14.00	0	5, 822, 190		0	1
	OPERATING ROOM	50.00	ő	139		0	2
-	RESPI RATORY THERAPY	65.00	ō	438		0	3
0	CLINIC	90.00	o	3		o	4
	TOTALS		0	5, 822, 770			
	H - DRUGS AND IV COSTS	45 00		2 (10 005	1	0	
0	PHARMACY	<u>15.00</u>	— — — <u>0</u>	<u>3, 619, 995</u> 3, 619, 995		0	1
	I - A&G COSTS		J	5,017,990			
0	OTHER ADMINISTRATIVE AND	5.01	4, 291, 776	22, 895, 395	i	0	1
	GENERAL						
	LAUNDRY & LINEN SERVICE	8.00	1, 817	46, 912		0	2
	CENTRAL SERVICES & SUPPLY	14.00	343, 191	555, 650		0	3
0		0.00 0.00	0	C		0	4
	TOTALS		4, 636, 784	23, 497, 957			5
	J - RADI OLOGY		1, 000, 704	20, 177, 707			
	ULTRA SOUND	54.01	340, 494	34, 433		0	1
	RADI OI SOTOPE	56.00	87, 395	289, 037		o	2
	CT_SCAN	<u>57.00</u>		29,900		<u>o</u>	3
	TOTALS		619, 456	353, 370			
	K – DI ETARY DI ETARY	10.00	0	848, 352		0	1
	TOTALS		— — — <del>)</del>	<u>848, 352</u>			
	L - MISC DEPARTMENTS			510, 002	<u> </u>		
0		0.00	0	C		0	1
	ADULTS & PEDIATRICS	30.00	953, 886	706, 242		o	2
	LABORATORY	60.00	0	519, 383		0	3
	ELECTROCARDI OLOGY	69.00	767, 534	561, 635		0	4
	OPERATING ROOM	50.00	275, 016	219, 615	1	0	5.

Heal th	Financial Systems		ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-	-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 150047	Peri od:	Worksheet A-	6
						From 06/01/2015 To 05/31/2016	Date/Time Pr 10/31/2016 8	epared: 18 am
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	M - UTILITIES RECLASS							
1.00	OTHER ADMI NI STRATI VE AND GENERAL	5.06	0	454		0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	o	31, 829		0		2.00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	64, 217		0		3.00
	TOTALS	+	d	96, 500		7		
	N - INTERNS AND RESIDENT COST	ſS						1
1.00	I &R SERVICES-SALARY &	21.00	0	2, 174, 023		0		1.00
	FRINGES APPRV							
	TOTALS		0	2, 174, 023		7		
	O - OB/GYN COSTS							1
1.00	DELIVERY ROOM & LABOR ROOM	52.00	447, 143	67, 046		0		1.00
2.00		0.00	0	0		0		2.00
	TOTALS		447, 143	67,046		7		1
500.00	Grand Total: Decreases		7, 956, 726	46, 579, 458				500.00

Health Financial Systems	ST JOSEPH MED				u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150047	Period: From 06/01/2015	Worksheet A-7 Part I	
				To 05/31/2016	Date/Time Pre 10/31/2016 8:	pared:
			Acqui si ti on	IS	10/31/2010 0.	
	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	Bal ances				Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00 Land	9, 348, 028	0		0 0	0	1.00
2.00 Land Improvements	1, 764, 690	0		0 0	0	2.00
3.00 Buildings and Fixtures	28, 514, 428	17, 577		0 17, 577	0	3.00
4.00 Building Improvements	27, 253, 709	2, 356, 296		0 2, 356, 296		4.00
5.00 Fixed Equipment	17, 597, 484	61, 484		0 61, 484		5.00
6.00 Movable Equipment	50, 007, 431	1, 612, 469		0 1, 612, 469		
7.00 HIT designated Assets	2, 834, 603			0 0	790	
8.00 Subtotal (sum of lines 1-7)	137, 320, 373	4, 047, 826		0 4, 047, 826	2, 419, 122	
9.00 Reconciling Items	0	0		0 0	0	9.00
10.00 Total (line 8 minus line 9)	137, 320, 373	4, 047, 826		0 4, 047, 826	2, 419, 122	10.00
	Endi ng Bal ance	Fully				
		Depreci ated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE			1			
1.00 Land	9, 348, 028	0				1.00
2.00 Land Improvements	1, 764, 690	0				2.00
3.00 Buildings and Fixtures	28, 532, 005	0				3.00
4.00 Building Improvements	29, 610, 005	0				4.00
5.00 Fixed Equipment	17, 657, 206	0				5.00
6.00 Movable Equipment	49, 203, 330	0				6.00
7.00 HIT designated Assets	2, 833, 813	0				7.00
8.00 Subtotal (sum of lines 1-7)	138, 949, 077	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	138, 949, 077	0				10.00

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150047	Peri od:	Worksheet A-7	
					From 06/01/2015 To 05/31/2016		pared:
						10/31/2016 8:	
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00		11.00		instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 990, 758	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 093, 564	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	6, 084, 322			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORE	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 990, 758				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4, 093, 564				2.00
3.00	Total (sum of lines 1-2)	0	6, 084, 322				3.00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 06/01/2015 To 05/31/2016	Worksheet A-7 Part III Date/Time Prep 10/31/2016 8:	pared:
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		_				
1.00 CAP REL COSTS-BLDG & FIXT	69, 254, 728				0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	69, 694, 350	0	69, 694, 35	0 0. 501582	0	2.00
3.00 Total (sum of lines 1-2)	138, 949, 078		138, 949, 07			3.00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-	1	1			
1.00 CAP REL COSTS-BLDG & FIXT	0			0 3, 188, 428		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	-		0 3, 163, 065		2.00
3.00 Total (sum of lines 1-2)	0	9		0 6, 351, 493	1, 263, 886	3.00
			JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				-	( 100 100	
1.00 CAP REL COSTS-BLDG & FIXT	2,032,426				6, 199, 182	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0			0 0	4, 507, 369	2.00
3.00  Total (sum of lines 1-2)	2, 032, 426	160, 721	898, 02	5 0	10, 706, 551	3.00

	Financial Systems MENTS TO EXPENSES			F	<u>In Lie</u> Period: From 06/01/2015	Worksheet A-8	
					o 05/31/2016	Date/Time Pre 10/31/2016 8:	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
	COSTS-BLDG & FIXT (chapter 2)						
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	
3.00	Investment income - other (chapter 2)		0		0.00	0	
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)	В	-66, 946	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-14, 842	OTHER ADMINI STRATI VE AND GENERAL	5.06	0	7.00
8.00	Television and radio service (chapter 21)	А	-30, 752	OPERATION OF PLANT	7.00	0	8.00
	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -4, 534, 363		0.00	0 0	
11. 00	Sale of scrap, waste, etc.	В	-1, 154	RADI OLOGY-DI AGNOSTI C	54.00	0	11.00
	(chapter 23) Related organization transactions (chapter 10)	A-8-1	1, 611, 700	5		0	12.00
	Laundry and linen service Cafeteria-employees and guests	В	0 -166, 413	) CAFETERI A	0.00 11.00	0	
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16. 00	Sale of medical and surgical supplies to other than patients		C		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18. 00	Sale of medical records and abstracts	В	-2, 351	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20. 00	Vending machines	В	-2, 592	OTHER ADMINISTRATIVE AND	5.06	0	20.00
21.00	Income from imposition of interest, finance or penalty		O	GENERAL	0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		O		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPIRATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL	А	951, 160	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL	А	-859, 774	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29.00 30.00
	therapy costs in excess of limitation (chapter 14)		Ū				
30. 99	Hospice (non-distinct) (see instructions)		C	ADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
32. 00	Limitation (chapter 14) CAH HIT Adjustment for		C		0.00	0	32.00
	Depreciation and Interest INSERVICE EDUCATION REVENUE	В		NURSING ADMINISTRATION	13.00		33.00

Health Financial Systems		ST JOSEPH MEDI	ICAL CENTER	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Period: From 06/01/2015 Fo 05/31/2016	Date/Time Pre	pared:
				Wavely a state	10/31/2016 8:	18 am
			Expense Classification on To/From Which the Amount is			
			Torrow which the Anount 13	to be Aujusteu		
Cost Conton Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
Cost Center Description	1.00	Amount 2.00	3. 00	4,00	5.00	
33. 01 FI TNESS REVENUE	B		OTHER ADMINISTRATIVE AND	4.00		33.01
	U		GENERAL	0.00	Ŭ	00.01
33. 02 TELEPHONE COMMISSION	В	-1, 080	OTHER ADMINISTRATIVE AND	5.06	0	33.02
			GENERAL			
33.03 SALE OF SUPPLIES	В		MEDICAL SUPPLIES CHARGED TO	71.00	0	33.03
			PATI ENT			
33. 04 MI SC REVENUE	В		OTHER ADMINISTRATIVE AND	5.06	0	33.04
	^			E 0(	0	22.05
33. 05 CLUB DUES	A		OTHER ADMINISTRATIVE AND GENERAL	5.06	U	33.05
33.06 PATIENT PHONE WAGE COSTS	А		OTHER ADMINI STRATI VE AND	5.06	0	33.06
33.00 TATTENT THONE WADE COSTS			GENERAL	5.00	Ŭ	33.00
33.07 PATIENT PHONES BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08 PATIENT TV DEPRECIATION COSTS	A	-259	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09 PATIENT TV DEPRECIATION	A	-4, 827	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10 NONALLOWABLE MARKETING	A		OTHER ADMINISTRATIVE AND	5.06	0	33.10
			GENERAL			
33.11 PHYSICIAN RECRUITING	A		OTHER ADMINISTRATIVE AND	5.06	0	33. 11
	•			F 0/		22.12
33.12 LOBBYING EXPENSE IN DUES	A		OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33. 12
33. 13 CHARI TABLE CONTRI BUTI ONS	А		OTHER ADMINI STRATI VE AND	5.06	0	33, 13
			GENERAL	5.00	Ŭ	55.15
33. 14 PENALTI ES	А		OTHER ADMINISTRATIVE AND	5.06	0	33.14
			GENERAL			
33.15 IMPUTED RENT	A		OTHER ADMINISTRATIVE AND	5.06	0	33. 15
			GENERAL			
33.16 NONALLOWABLE LEGAL EXPENSES	A		OTHER ADMINISTRATIVE AND	5.06	0	33.16
			GENERAL			
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-3, 937, 008				50.00
column 6, line 200.)						
				1	L	

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

(2) basis for adjustment (see first definitions).
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 JOSEPH ME	DI CAL CENTER	In Lie	eu of Form CMS-	2552-10
STATEME OFFICE	COSTS	RELATED ORGANIZATIONS AND HON		Period: From 06/01/2015 To 05/31/2016		pared:
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL-	2,009,530	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	19, 790	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - MOVEABL	3, 106	0	3.00
4.00	5.05	CASHI ERI NG/ACCOUNTS RECEI VAB	PASI OPERATING COSTS	294, 321	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	5.06	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE CENTER ALLOCA	310, 239	0	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	16, 640	0	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - MOVABLE EQUIPM	229, 870	0	4.05
4.06	5.06	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	2, 766, 934	0	4.06
4.07	5.06	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS (SEE EXHIE	121, 383	0	4.07
4.08	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT (SEE EX	47, 467	0	4.08
4.09	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES (S	446, 721	0	4.09
4.10	5.06	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	2, 136, 367	4.10
4.11	5.06	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	6, 208	4.11
4.12	5.06	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	58, 076	4.12
4.13	5.06	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIC	0	1, 309, 017	4.13
4.14	5.06	OTHER ADMINISTRATIVE AND GEN	PPSI FEES	0	25, 245	4.14
4.15	5. 05	CASHI ERI NG/ACCOUNTS RECEI VAB	PASI COLLECTION FEES	0	317, 935	4.15
4.16	5.06	OTHER ADMINISTRATIVE AND GEN	EBOS FEES	0	4, 459	4.16
4.17	5.06	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	32, 618	4.17
4.18	5.06	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE ALLOCATIONS (PER	0	232, 049	4. 18
4.19	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT (PER EX	0	113, 106	4.19
4.20	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES (F	0	419, 221	4.20
5.00	TOTALS (sum of lines 1-4).			6, 266, 001	4, 654, 301	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.

nas not	been posted to worksheet A,	corumns r anu/or z, the amoun	it allowable si	ouru be murcateu mi corumn 4	or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	1
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
	B INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFLCE			

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

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

6.00	В	0.00/CHS, INC 100.00	6.00
7.00	В	0.00 PASI 100.00	7.00
8.00	С	33.00 SHARED LAUNDRY 33.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		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.

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELAT	ED ORGANIZATIONS AND HOME Provider CCN: 15004	7 Period: Worksheet A-8-1 From 06/01/2015
UTTEL COSTS		To 05/31/2016 Date/Time Prepared:

Not Adjustments (col. 4 mi nus col. 5)*         West. A-7 Ref.           6.00         7.00           A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:         1.00           1.00         2.009, 530         11         1.00           2.00         19, 790         11         3.00           3.00         3, 106         11         4.00           4.01         0         0         4.00           4.02         0         0         4.00           4.02         0         0         4.03           4.04         16, 640         9         4.03           4.05         2.29, 870         9         4.05           4.08         47, 467         9         4.07           4.08         47, 467         9         4.07           4.10         -2.766, 934         0         4.07           4.11         -5.20         0         4.07           4.11         -2.766, 934         0         4.07           4.11         -2.766, 934         0         4.07           4.11         -2.766, 934         0         4.10           4.11         4.12         4.13							Date/IIme Pre 10/31/2016 8:	
(col. 4 minus col. 5)*         7.00           A. COSTS INCURED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:         1.00           1.00         2,009,530         11         2.00           3.00         3,106         11         2.00           4.01         0         0         4.01           4.02         0         0         4.02           4.03         310,239         0         4.02           4.04         16,640         9         4.02           4.05         229,870         9         4.02           4.06         2,766,934         0         4.07           4.08         47,467         9         4.06           4.09         44,07         4.07           4.08         47,467         9           4.09         44,07         4.07           4.09         44,07         4.08           4.10         -2,136,367         0         4.08           4.11         -6,208         0         4.10           4.11         -6,208         0         4.12           4.13         -1,309,017         0         4.13           4.16         -4,459 </td <td></td> <td>Net</td> <td>Wkst. A-7 Ref.</td> <td></td> <td></td> <td>· · · ·</td> <td></td> <td></td>		Net	Wkst. A-7 Ref.			· · · ·		
Col. 5)*		Adjustments						
6.00         7.00           A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED           HOME OFFICE COSTS:         1.00           2.000         19, 790         11         2.00           3.00         3, 106         11         3.00           4.00         294, 321         0         4.00           4.01         0         0         0         4.00           4.02         0         0         0         4.02           4.02         0         0         4.02         0         4.03           4.04         16, 640         9         4.03         4.03         4.04           4.05         229, 870         9         4.05         4.05         4.05           4.06         2.766, 934         0         4.05         4.07         4.08           4.07         121, 383         0         4.05         4.07         4.08           4.07         121, 383         0         4.07         4.08         4.07           4.08         47, 467         9         4.07         4.08         4.07           4.10         -2.136, 367         0         4.10         4.10         4.11 </td <td></td> <td>(col. 4 minus</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		(col. 4 minus						
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:           1.00         2.009,530         11         2.00           3.00         3,106         11         2.00           4.01         0         0         4.00           4.02         0         0         4.00           4.03         310,239         0         4.03           4.05         229,870         9         4.06           4.06         2.766,934         0         4.06           4.09         446,721         0         4.07           4.10         -2.08         0         4.01           4.11         -2.58,076         0         4.02           4.11         -2.29,870         9         4.06           4.06         2.766,934         0         4.06           4.09         446,721         0         4.07           4.11         -2.29,875         0         4.11           4.12         -58,076         0         4.10           4.11         -1.13,09,017         0         4.12           4.13         -1.309,017         0         4.14           4.15         -317,935 <td></td> <td>col. 5)*</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		col. 5)*						
HOME OFFICE COSTS: $1.00$ $2,009,530$ $11$ $1.00$ $2.00$ $19,790$ $11$ $3.00$ $3.00$ $3,106$ $11$ $3.00$ $4.00$ $294,321$ $0$ $4.01$ $4.01$ $0$ $0$ $4.02$ $4.02$ $0$ $0$ $4.02$ $4.03$ $310,239$ $0$ $4.04$ $16,640$ $9$ $4.05$ $229,870$ $9$ $4.06$ $2,766,934$ $0$ $4.08$ $47,467$ $9$ $4.09$ $446,721$ $0$ $4.11$ $-6,208$ $0$ $4.11$ $-6,208$ $0$ $4.14$ $-25,245$ $0$ $4.14$ $-25,245$ $0$ $4.14$ $-232,618$ $0$ $4.17$ $-322,618$ $4.19$ $4.19$ $-113,106$ $9$ $4.20$ $-419,221$ $0$								
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$				MENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED OF	RGANIZATIONS OR CL	_AI MED	
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$				1				
$ \begin{array}{cccccccccccccccccccccccccccccccccccc$								
$ \begin{array}{cccccccccccccccccccccccccccccccccccc$								
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$			11					
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$		294, 321	0					
$ \begin{array}{cccccccccccccccccccccccccccccccccccc$			0					
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$		-	0					
$ \begin{array}{cccccccccccccccccccccccccccccccccccc$			0					
$ \begin{array}{cccccccccccccccccccccccccccccccccccc$								4.04
$ \begin{array}{cccccccccccccccccccccccccccccccccccc$								
$ \begin{array}{cccccccccccccccccccccccccccccccccccc$		2, 766, 934	0					
$ \begin{array}{cccccccccccccccccccccccccccccccccccc$			0					
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$			9					
4. 11       -6, 208       0       4. 11         4. 12       -58, 076       0       4. 12         4. 13       -1, 309, 017       0       4. 13         4. 14       -25, 245       0       4. 14         4. 15       -317, 935       0       4. 15         4. 16       -4, 459       0       4. 16         4. 17       -32, 618       0       4. 18         4. 19       -113, 106       9       4. 19         4. 20       -419, 221       0       4. 20	4.09	446, 721	0					4.09
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	4.10	-2, 136, 367	0					4.10
4. 13       -1, 309, 017       0       4. 13         4. 14       -25, 245       0       4. 14         4. 15       -317, 935       0       4. 15         4. 16       -4, 459       0       4. 16         4. 17       -32, 618       0       4. 17         4. 18       -232, 049       0       4. 19         4. 19       -113, 106       9       4. 20			0					4.11
4. 14       -25, 245       0       4. 14         4. 15       -317, 935       0       4. 15         4. 16       -4, 459       0       4. 16         4. 17       -32, 618       0       4. 17         4. 18       -232, 049       0       4. 18         4. 19       -113, 106       9       4. 20	4.12	-58, 076	0					4.12
4. 15       -317, 935       0       4. 15         4. 16       -4, 459       0       4. 16         4. 17       -32, 618       0       4. 17         4. 18       -232, 049       0       4. 18         4. 19       -113, 106       9       4. 19         4. 20       -419, 221       0       4. 20			0					4.13
4. 16       -4, 459       0         4. 17       -32, 618       0         4. 18       -232, 049       0         4. 19       -113, 106       9         4. 20       -419, 221       0	4.14		0					4.14
4. 17       -32, 618       0       4. 17         4. 18       -232, 049       0       4. 18         4. 19       -113, 106       9       4. 19         4. 20       -419, 221       0       4. 20		-317, 935	0					4.15
4. 18       -232,049       0       4. 18         4. 19       -113,106       9       4. 19         4. 20       -419,221       0       4. 20		-4, 459	0					4.16
4. 19     -113, 106     9       4. 20     -419, 221     0	4.17	-32, 618	0					4.17
4. 20 -419, 221 0 4. 20			0					
			9					
5.00 1,611,700 5.00			0					
	5.00	1, 611, 700						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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office		
Type of Business		
 6.00		
 B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	OWNER	6.00
7.00	DEBT COLLECTION	7.00
	LAUNDRY	8.00
9. 00 10. 00		9.00
10.00		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 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.

Heal th	Financial Syste	ems	ST JOSEPH ME	DICAL CENTER		In Li	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi der		Peri od:	Worksheet A-8	-2
						From 06/01/2015		
						To 05/31/2016	5 Date/Time Pre 10/31/2016 8:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	intot. A Erno #	I denti fi er	Remuneration	Component	Component		ider Component	
			nomarior a crom	oomponone	oomportorre		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	OTHER ADMINISTRATIVE AND	549, 030	549, 030	C	C	0	1.00
		GENERAL						
2.00		ADULTS & PEDIATRICS	1, 237, 314	1, 237, 314	C	c c	0	2.00
3.00	33.00	BURN INTENSIVE CARE UNIT	505, 594	505, 594	C	C	0	3.00
4.00		OPERATING ROOM	698, 903	698, 903	C	c c	0	4.00
5.00		DELIVERY ROOM & LABOR ROOM	375, 977		C	c c	0	5.00
6.00		ANESTHESI OLOGY	1, 167, 506		C	c c	0	6.00
7.00		RADI OLOGY-DI AGNOSTI C	39		C	c c	0	7.00
8.00	0.00		0	0	C		0	8.00
9.00	0.00		0	0			0	9,00
10.00	0.00		0	0	C		0	10.00
200.00	0.00		4, 534, 363	4, 534, 363	-	-	0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	intot. A Erno #	I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
			2	Limit	Conti nui ng	Share of col.	Insurance	
				2.1.1.1	Educati on	12	i nour anos	
	1, 00	2.00	8,00	9.00	12.00	13.00	14.00	
1.00	5.06	OTHER ADMINISTRATIVE AND	0	0				1.00
		GENERAL	_					
2.00	30.00	ADULTS & PEDIATRICS	0	0	C	C	0	2.00
3.00		BURN INTENSIVE CARE UNIT	0	0	C	c c	0	3.00
4.00	50.00	OPERATING ROOM	0	0	C	c c	0	4.00
5.00		DELIVERY ROOM & LABOR ROOM	0	0	C	c c	0	5.00
6.00	53.00	ANESTHESI OLOGY	0	0	C	c c	0	6.00
7.00		RADI OLOGY-DI AGNOSTI C	0	0	C	c c	0	7.00
8.00	0.00		0	0	C	c c	0	8.00
9.00	0, 00		0	0	C		0	9.00
10.00	0.00		0	0	C		0	10.00
200.00			0	0				
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	_	
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.06	OTHER ADMINISTRATIVE AND	0	0	C	549,030	)	1.00
		GENERAL						
2.00	30.00	ADULTS & PEDIATRICS	0	0	C	1, 237, 314		2.00
3.00	33.00	BURN INTENSIVE CARE UNIT	0	0	C	505, 594		3.00
4.00	50.00	OPERATING ROOM	0	0	C	698, 903		4.00
5.00		DELIVERY ROOM & LABOR ROOM	0	0	C			5.00
6.00	53.00	ANESTHESI OLOGY	0	0	C	1, 167, 506		6.00
7.00		RADI OLOGY-DI AGNOSTI C	0	0	C			7.00
8.00	0.00		0	0	C			8.00
9.00	0.00		0	0	C	C		9.00
10.00	0.00		0	0				10.00
200.00			0	0	C	4, 534, 363		200.00

	Financial Systems	ST JOSEPH MED				eu of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	Period: From 06/01/2015 To 05/31/2016		pared:
			CAPI TAL REI	ATED COSTS		10/31/2016 8:	18 am
				<b>.</b>			
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS	OTHER ADMI NI STRATI VE	
		Allocation			DEPARTMENT	AND GENERAL	
		(from Wkst A					
		<u>col.7)</u> 0	1.00	2.00	4.00	5. 01	
1 00	GENERAL SERVICE COST CENTERS	( 100 100	( 400 400	1			1.00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	6, 199, 182 4, 507, 369		4, 507, 369			1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 128, 690	70, 165				4.00
5.01	00560 OTHER ADMINISTRATIVE AND GENERAL	0	0		-	0	5.01
5.02 5.03	00550 DATA PROCESSING 00591 PURCHASING AND RECEIVING	1, 822, 981 1, 171, 785	199, 686 172, 863			0	5.02 5.03
5.04	00540 CENTRAL SCHEDULING	1, 322, 427	49, 200				5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 261, 980		-			5.05
5.06 7.00	00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	12, 557, 052 3, 540, 224	134, 487 1, 055, 572			0	5.06 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	404, 752	55, 088			0	8.00
9.00	00900 HOUSEKEEPI NG	1,077,078					9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	1, 288, 662 681, 939	260, 544 0			0	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 214, 711	30, 020	-	-		13.00
13.01	01850 PASTORAL CARE	74, 885	34, 674				13.01
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0 1, 854, 289	0			0	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	364, 545	156, 121	-			16.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		°	0	21.00
22.00	02200 I & R SERVI CES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 174, 023	0	C	0 0	0	22.00
30.00	03000 ADULTS & PEDIATRICS	6, 844, 571	554, 765	403, 365	977, 314	0	30.00
31.00	03100 INTENSIVE CARE UNIT	423, 206	182, 929				31.00
31.01 33.00	02060 NEONATAL INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT	842, 060 1, 154, 534	40, 815 104, 274				31.01 33.00
40.00	04000 SUBPROVI DER – I PF	1, 661, 489					40.00
43.00	04300 NURSERY	273, 026	0	-		0	43.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	1, 203, 889	145, 817	106, 022	2 174, 505	0	44.00
50.00	05000 OPERATING ROOM	1, 926, 068	224, 725	163, 396	170, 820	0	50.00
50.01	03330 ENDOSCOPY 05100 RECOVERY ROOM	494, 631	30, 734				50.01
51.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	465, 823 481, 911	95, 829 85, 272			0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	1, 473	0	C	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	3, 123, 756	245, 066			0	54.00 54.01
54.01 56.00		0	0 0			0	54.01
57.00	05700 CT SCAN	0	0	C	0	0	57.00
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0 1, 329, 169	0	10.940	0	0	58.00 59.00
60.00	06000 LABORATORY	3, 520, 364	27, 299 209, 752				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	519, 383	11, 493	8, 357	0	0	62.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	825, 182 626, 886	85, 227 110, 742				65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	357, 638	42, 391				67.00
68.00	06800 SPEECH PATHOLOGY	84, 619	16, 326	11, 870	12, 716	0	68.00
69.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	114, 806	15, 538 0				69.00
71.00 72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3, 917, 455 1, 952, 808	0			0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 619, 995	36, 726	26, 703	3 0	0	73.00
74.00 76.00	07400 RENAL DIALYSIS	359, 244	29, 886			0	74.00
76.00	03950 OTHER ANCI LLARY SERVICE COST CENTER 03951 SLEEP LAB	0	0			0	76.00 76.01
76.02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	422, 554	48, 442			0	76.02
76.03	03952 WOUND CARE	951, 046	127, 707	92, 855	5 127, 648	0	76.03
90.00	OUTPATI ENT SERVICE COST CENTERS	189, 098	31, 611	22, 984	26, 403	0	90.00
91.00	09100 EMERGENCY	2, 568, 715					91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	88, 901, 973	5, 831, 286	4, 239, 875	5, 222, 441	0	118.00
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	29, 772	15, 047				190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	365	0				191.00 192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	-	0	194.00
194.01	07951 MARKETI NG	846, 512	0	C	27, 056	0	194.01

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 06/01/2015	Worksheet B	
				To 05/31/2016		pared:
					10/31/2016 8:	<u>18 am</u>
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	OTHER	
	for Cost				ADMI NI STRATI VE	
	Allocation			DEPARTMENT	AND GENERAL	
	(from Wkst A					
	<u>col.7)</u>	1.00	2.00	4,00	5. 01	
194. 02 07952 SENI OR CI RCLE	0	1.00	2.00	4.00		104 02
	0			0 0		194.02
194. 03 07953 SELECT SPECIALTY	0	352, 849	256, 55	3 0		194.03
194.0407954 FREE MEALS	0	0		0 0		194.04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0 0		201.00
202.00  TOTAL (sum lines 118-201)	89, 778, 622	6, 199, 182	4, 507, 36	5, 249, 872	0	202.00

COST A	Financial Systems ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 06/01/2015	Worksheet B Part I	
				Т	0 05/31/2016	Date/Time Pre 10/31/2016 8:	
	Cost Center Description	DATA PROCESSI NG	PURCHASI NG AND RECEI VI NG	CENTRAL SCHEDULI NG	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal	
	OFNERAL CERVICE COST CENTERS	5.02	5.03	5.04	5.05	5A. 05	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5.01 5.02	00560 OTHER ADMINISTRATIVE AND GENERAL 00550 DATA PROCESSING	2, 288, 730					5.0 5.0
5.03	00591 PURCHASI NG AND RECEI VI NG	0	1, 537, 849				5.0
5.04	00540 CENTRAL SCHEDULING	0	6, 860	1, 608, 075			5.0
5.05 5.06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMINI STRATI VE AND GENERAL	0	177 2, 977	0	2, 263, 930 0	13, 129, 660	5.0 5.0
7.00	00700 OPERATION OF PLANT	0	1, 190	0	0	5, 529, 635	
8.00	00800 LAUNDRY & LINEN SERVICE	0	602	0	0	500, 496	1
9.00	00900 HOUSEKEEPING	0	18, 922	0	0	2, 643, 544	
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	0	19, 122 0	0	0	1, 757, 767 681, 939	
13.00	01300 NURSING ADMINISTRATION	0	2, 545	0	0	2, 558, 437	
13.01	01850 PASTORAL CARE	0	113	0	0	144, 626	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0 26, 354	0	0	0 2, 102, 453	14.0 15.0
16.00	01600 MEDICAL RECORDS & LI BRARY	0	1, 062	0	0	663, 070	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.0
22.00	02200 I & SERVI CES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	2, 174, 023	22.0
30.00	03000 ADULTS & PEDIATRICS	209, 483	63, 969	147, 192	207, 217	9, 407, 876	30. 0
31.00	03100 INTENSIVE CARE UNIT	7,606	6, 392	5, 344	7, 523	817, 145	
31.01 33.00	02060 NEONATAL INTENSIVE CARE UNIT	13,065	8, 418	9, 180	12, 924 39, 865	1,067,965	
40.00	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	40, 301 77, 188	18, 964 7, 781	28, 317 54, 236	76, 353	1, 619, 170 2, 255, 248	
43.00	04300 NURSERY	3, 521	0	2, 474	3, 483	320, 741	
44.00	04400 SKI LLED NURSI NG FACI LI TY	14, 774	8, 355	10, 381	14, 614	1, 678, 357	44.0
50.00	ANCI LLARY SERVICE COST CENTERS	180, 840	108, 759	127, 066	178, 884	3, 080, 558	50. 0
50.01	03330 ENDOSCOPY	23, 096	20, 220	16, 228	22, 846	675, 394	
51.00	05100 RECOVERY ROOM	26, 307	9	18, 485	26, 023	772, 816	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	6, 215 25, 196	12, 287 45	4, 367 17, 704	6, 148 24, 924	725, 691 69, 342	
54.00	05400 RADI OLOGY-DI AGNOSTI C	339, 679	5, 600	238, 588	335, 963	4, 766, 821	
54.01	03630 ULTRA SOUND	0	0	0	0	0	54.0
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	0	0	0	0	56.0 57.0
58.00	05800 MRI	0	0	0	0	0	58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	96, 530	56, 347	67, 826	95, 485	1, 818, 912	
	06000 LABORATORY	270, 254	68, 828	189, 892	267, 330	5, 015, 653	
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	16, 444 74, 119	4, 920 16, 090	11, 554 52, 079	16, 266 73, 318	588, 417 1, 298, 689	
66.00	06600 PHYSI CAL THERAPY	23, 380	1, 861	16, 428	23, 127	974, 978	
67.00	06700 OCCUPATIONAL THERAPY	15, 191	193	10, 674	15, 027	525, 222	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	3, 556 15, 348	77 1, 002	2, 498 10, 784	3, 517 15, 182	135, 179 200, 566	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	111, 760		78, 528	110, 551	4, 852, 330	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	114, 328	319, 936	80, 332	113, 092	2, 580, 496	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	318, 364 9, 123	0 980	223, 696 6, 410	314, 920 9, 024	4, 540, 404 436, 397	
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0,410	9,024	430, 377	
76. 01	03951 SLEEP LAB	0	0	0	0	0	76.0
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	14, 699		10, 328		610, 211	
76. 03	03952 WOUND_CARE OUTPATI ENT_SERVICE_COST_CENTERS	34, 215	18, 561	24, 041	33, 845	1, 409, 918	76.0
90.00	09000 CLI NI C	509	2, 617	357	503	274, 082	
91.00	09100 EMERGENCY	203, 639	63, 541	143, 086	201, 436	3, 827, 579	
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART SPECIAL PURPOSE COST CENTERS	1				0	92.0
118.00	SUBTOTALS (SUM OF LINES 1-117)	2, 288, 730	1, 530, 504	1, 608, 075	2, 263, 930	88, 231, 807	]118. 0
100 07	NONREI MBURSABLE COST CENTERS					10 155	100 -
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 024	0	0	63, 159 0	190. 0 191. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.0
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 0
	07951 MARKETI NG 207952 SENI OR CI RCLE	0	321	0	0	873, 889	194. 0 194. 0
	07952 SENTOR CIRCLE 07953 SELECT SPECIALTY	0	0	0	0	0 609, 402	
194.04	07954 FREE MEALS	0	Ő	0	0	0	194. 0
	Cross Foot Adjustments	1				0	200.0

Health Financial Sy	vstems	ST JOSEPH MED	I CAL_CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - (	GENERAL SERVICE COSTS		Provi der		Period:	Worksheet B	
					From 06/01/2015		
					To 05/31/2016	Date/Time Pre 10/31/2016 8:	
Cost C	enter Description	DATA	PURCHASI NG AND	CENTRAL	CASHI ERI NG/ACC	Subtotal	
		PROCESSI NG	RECEI VI NG	SCHEDULI NG	OUNTS		
					RECEI VABLE		
		5.02	5.03	5.04	5.05	5A. 05	
201.00 Negati	ve Cost Centers	0	0	(	0 0	0	201.00
202.00 TOTAL	(sum lines 118-201)	2, 288, 730	1, 537, 849	1, 608, 07	5 2, 263, 930	89, 778, 622	202.00

COST A	Financial Systems ALLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 06/01/2015 o 05/31/2016	Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	OTHER ADMI NI STRATI VE	OPERATI ON OF PLANT	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	10/31/2016 8: DI ETARY	
		AND GENERAL 5.06	7.00	8.00	9.00	10.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 0
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5.01	00560 OTHER ADMINISTRATIVE AND GENERAL						5.0
5.02	00550 DATA PROCESSI NG						5.0
5.03 5.04	00591 PURCHASI NG AND RECEI VI NG 00540 CENTRAL SCHEDULI NG						5.0 5.0
5.04 5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.0
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	13, 129, 660					5.0
7.00	00700 OPERATION OF PLANT	947, 204					7.0
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	85, 733 452, 829			4, 292, 236		8.0 9.0
10.00	01000 DI ETARY	301, 098			308, 239	2, 740, 676	
11.00	01100 CAFETERI A	116, 813			0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	438, 250			35, 515	0	
13.01 14.00	01850 PASTORAL CARE 01400 CENTRAL SERVI CES & SUPPLY	24, 774	49, 716	0	41, 021	0	13.0 14.0
15.00	01500 PHARMACY	360, 142	0	879	Ő	0	15.0
16.00	01600 MEDI CAL RECORDS & LI BRARY	113, 581	223, 849		184, 701	0	16.0
21.00 22.00	02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	372, 401	0	0	0	0	
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	372,401	0	vi 0	0	0	22.0
30. 00	03000 ADULTS & PEDIATRI CS	1, 611, 533	795, 430	275, 532	656, 320	1, 208, 837	30. 0
31.00	03100 I NTENSI VE CARE UNI T	139, 974			216, 417	28, 000	
31.01 33.00	02060 NEONATAL INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT	182, 938 277, 357	58, 520 149, 510		48, 286 123, 363	0 88, 318	31. C
40.00	04000 SUBPROVIDER - IPF	386, 315			93, 740	353, 525	
43.00	04300 NURSERY	54, 942		3, 356	0	0	
44.00	04400 SKI LLED NURSI NG FACI LI TY	287, 496	209, 075	45, 444	172, 511	285, 725	44.0
50.00	ANCI LLARY SERVI CE COST CENTERS	527, 687	322, 214	19, 208	265, 864	0	50.0
50.00	03330 ENDOSCOPY	115, 692	44, 066		205, 804 36, 360	0	50.0
51.00	05100 RECOVERY ROOM	132, 380			113, 371	0	51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	124, 308	122, 264	0	100, 882	0	52.0
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	11, 878 816, 537	0 351, 379	0 39, 925	0 289, 928	0	53.0 54.0
54.00	03630 ULTRA SOUND	010, 337	0	0	207, 720	0	54.0
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	
57.00	05700 CT SCAN	0	0	0	0	0	57.0
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	311, 572	39, 142	15, 698	32, 296	0	
60.00		859, 161	300, 746		248, 150	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	100, 793	16, 480	0	13, 597	0	
65.00		222, 460			100, 829	0	
56.00 57.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	167, 010 89, 968			131, 014 50, 151	0	67.0
58.00	06800 SPEECH PATHOLOGY	23, 156			19, 314	0	
59.00	06900 ELECTROCARDI OLOGY	34, 356		2, 805	18, 382	0	69.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 I MPL. DEV. CHARGED TO PATIENTS	831, 185 442, 029		0	0	0	71.0
73.00	07300 DRUGS CHARGED TO PATIENTS	777, 753		0	43, 449	0	73.0
74.00	07400 RENAL DIALYSIS	74, 753			35, 357	0	
76.00	03950 OTHER ANCI LLARY SERVICE COST CENTER	0	0	0	0	0	
76. 01 76. 02	03951 SLEEP LAB 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	104, 527	0 69, 457	0	0 57 210	0	
76.02	03952 WOUND CARE	241, 513			57, 310 151, 085	0	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	46, 949			37, 398	0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	655, 649	281, 346	119, 252	232, 143	0	91.0 92.0
, <u>2</u> . UU	SPECIAL PURPOSE COST CENTERS			1			1 72.0
118.00	SUBTOTALS (SUM OF LINES 1-117)	12, 864, 696	5, 949, 345	663, 866	3, 856, 993	1, 964, 405	]118. 0
100 07	NONREI MBURSABLE COST CENTERS	40.012	04 575		47.000	-	100.0
	) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN ) 19100 RESEARCH	10, 819	21, 575	0	17, 802		190. 0 191. 0
	19200 PHYSICIANS' PRIVATE OFFICES	63	0	1, 350	0	336, 697	
194.00	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	194.0
	07951 MARKETI NG	149, 694	0	0	0		194.0
	207952 SENI OR CI RCLE 307953 SELECT SPECIALTY	0 104, 388	0 505, 919	0	0 417, 441	0 232, 754	194.0
	107953 SELECT SPECTALLY	104, 388	005,919	0	417,441	232, 754 206, 820	
	Cross Foot Adjustments	1	I	Ĭ	Ű	===, ==0	200. 0

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period:	Worksheet B	
				From 06/01/2015		
				To 05/31/2016		
					10/31/2016 8:	<u>18 am</u>
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
	AND GENERAL					
	5.06	7.00	8.00	9.00	10.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	13, 129, 660	6, 476, 839	665, 21	6 4, 292, 236	2, 740, 676	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ST JOSEPH MEE			Period:	u of Form CMS- Worksheet B	2002-10
					From 06/01/2015 To 05/31/2016	Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PASTORAL CARE	CENTRAL SERVI CES & SUPPLY	10/31/2016 8:   PHARMACY	18 am
		11.00	13.00	13.01	14.00	15.00	
1 00	GENERAL SERVICE COST CENTERS		1	1		[	1 1 00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 01\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-WVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00560 OTHER ADMINISTRATIVE AND GENERAL 00550 DATA PROCESSING 00591 PURCHASING AND RECEIVING 00540 CENTRAL SCHEDULING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01850 PASTORAL CARE	798, 752 44, 889 2, 441	3, 120, 134 0				$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 01 \end{array}$
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	29, 559	-		-	2, 493, 033	14.00 15.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	29, 559 10, 233 0 0	0	(	0 0	0	16.00 21.00
30.00	03000 ADULTS & PEDIATRICS	187, 546					
31.00 31.01	03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T	8, 913 18, 567				0	
33.00	03300 BURN INTENSIVE CARE UNIT	29,089				0	
40.00	04000 SUBPROVI DER - I PF	52, 157	367, 140	30, 897	7 0	0	40.00
43.00	04300 NURSERY	6, 563					1
44.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	30, 643	0	(	0 0	0	44.00
50.00	05000 OPERATING ROOM	32,650	229, 835	19, 342	2 0	0	50.00
50.01	03330 ENDOSCOPY	6, 761					
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	11, 588					51.00 52.00
53.00	05300 ANESTHESI OLOGY	24, 510		0,00	-	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	60, 618	0	0	-	0	
54.01	03630 ULTRA SOUND 05600 RADI OI SOTOPE	C	0	(		0	
56.00 57.00	05700 CT SCAN				-	0	
58.00	05800 MRI	C	0		-	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	20, 266		12, 009	9 0		
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	71, 212		(	0	0	00.00
62.00 65.00	06500 RESPIRATORY THERAPY	20, 592				0	1
66.00	06600 PHYSI CAL THERAPY	15, 909		0	0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	6, 599		(	0 0	0	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 681				0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 0, 0	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0			2, 493, 033	
	03950 OTHER ANCILLARY SERVICE COST CENTER					0	1
76.01	03951 SLEEP LAB	C	0	C	0 0	0	1
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	13, 125		0	0	0	
76.03	03952 WOUND CARE OUTPATIENT SERVICE COST CENTERS	23, 376	0	(	0 0	0	76.03
90.00	09000 CLINIC	5, 424	0	0	0 0	0	90.00
	09100 EMERGENCY	56, 044	394, 569	33, 205	5 0	0	
92.00 118.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	793, 654	3, 120, 134	262, 578	3 0	2, 493, 033	92.00
	NONRE MBURSABLE COST CENTERS	1	1	1		· · ·	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	163	0	(	0		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES		0		0 1		191.00 192.00
192 00							192.00
	07950 OTHER NONREIMBURSABLE COST CENTERS						
194.00 194.01	07951 MARKETI NG	4, 935	0	0	0 0		194. 01
194.00 194.01 194.02	07951 MARKETI NG 07952 SENI OR CI RCLE	4, 935 C		(		0	194. 01 194. 02
194.00 194.01 194.02 194.03	07951 MARKETI NG	4, 935 0 0				0	194. 01

Health Financial Systems	ST JOSEPH MED	DI CAL_CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period:	Worksheet B	
				From 06/01/2015		
			-	To 05/31/2016		
					10/31/2016 8:	<u>18 am</u>
Cost Center Description	CAFETERI A	NURSI NG	PASTORAL CARE	CENTRAL	PHARMACY	
		ADMI NI STRATI ON		SERVICES &		
				SUPPLY		
	11.00	13.00	13.01	14.00	15.00	
201.00 Negative Cost Centers	0	0	) (	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	798, 752	3, 120, 134	262, 57	в	2, 493, 033	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ST JOSEPH MEI			1	Period: From 06/01/2015	u of Form CMS-: Worksheet B Part I	
						To 05/31/2016	Date/Time Pre 10/31/2016 8:	18 am
			INTER	VS & F	RESI DENTS			
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SERVICES-S. Y&FRING APPRV		SERVI CES-OTHE PRGM COSTS APPRV		Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	21.00		22.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	[	T					
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 01\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 21.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00560 OTHER ADMINISTRATI VE AND GENERAL 00550 DATA PROCESSING 00591 PURCHASING AND RECEIVING 00540 CENTRAL SCHEDULING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMINISTRATI VE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01850 PASTORAL CARE 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LI BRARY 02100 I & SERVICES OTHER PORCH	1, 195, 434 C		0	2 546 42			$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 01\\ 13.\ 01\\ 13.\ 01\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	C	0		2, 546, 42	4		22.00
30.00	03000 ADULTS & PEDIATRICS	109, 425		0	376, 17	6 16, 060, 007	-376, 176	30.00
	03100 I NTENSI VE CARE UNI T	3, 973		0		0 1, 554, 017	0	31.00
	02060 NEONATAL INTENSIVE CARE UNIT	6, 825		0		0 1, 526, 632	0	31.01
	03300 BURN INTENSIVE CARE UNIT	21, 051		0		0 2, 560, 477	0	33.00
	04000 SUBPROVI DER – I PF	40, 320		0		0 3, 715, 047	0	40.00
	04300 NURSERY	1,839		0		0 437, 577	0	•
44.00	04400 SKI LLED NURSI NG FACI LI TY	7, 717	1	0		0 2, 716, 968	0	44.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	94, 463	1	0	564, 26	4 5, 156, 085	-564, 264	50.00
	03330 ENDOSCOPY	12,064		0		0 971, 366	0	50.00
	05100 RECOVERY ROOM	13, 742		0		0 1, 296, 853	0	•
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 246		0		0 1, 189, 197	0	52.00
	05300 ANESTHESI OLOGY	13, 161		0		0 94, 381	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	177, 337		0		6, 502, 545	0	54.00
	03630 ULTRA SOUND	0		0		0 0	0	
	05600 RADI OI SOTOPE 05700 CT SCAN	0		0		0 0	0	
	05800 MRI			0			0	58.00
	05900 CARDI AC CATHETERI ZATI ON	50, 423		Ő		2, 443, 013	0	59.00
60.00	06000 LABORATORY	141, 168	3	0		6, 638, 603	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	8, 590		0		0 727, 877	0	62.00
	06500 RESPIRATORY THERAPY	38, 717		0		0 1, 803, 760	0	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	12, 213 7, 935		0		0 1, 459, 907 0 740, 655	0	66.00 67.00
	068/00 SPEECH PATHOLOGY	1, 857		0		0 740, 855	0	68.00
	06900 ELECTROCARDI OLOGY	8,017		o		0 289, 297	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	58, 379		0		0 5, 741, 894	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	59, 720		0		0 3, 082, 245	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	166, 299		0		0 8, 073, 596	0	•
	07400 RENAL DIALYSIS	4, 765		0		0 596, 727	0	74.00
	03950 OTHER ANCILLARY SERVICE COST CENTER 03951 SLEEP LAB		Ś	0			0	76.00 76.01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	7,678	3	0		0 862, 308	0	76.02
	03952 WOUND CARE	17, 872		0	28, 93		-28, 937	
	OUTPATIENT SERVICE COST CENTERS							
		266		0	1, 417, 89		-1, 417, 895	•
	09100 EMERGENCY	106, 372	<u>_</u>	0		0 5, 706, 159	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS		L				0	92.00
118.00		1, 195, 434		0	2, 387, 27	2 86, 062, 235	-2, 387, 272	118.00
51 50	NONREI MBURSABLE COST CENTERS	., ., ., ., ., .		~1	_,, _,		2,00,7272	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C		0		0 113, 518		190. 00
	19100 RESEARCH	C		0		0 0		191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE COST CENTERS			0	159, 15	2 497, 627	-159, 152	192.00 194.00
	07950 OTHER NONRETMBORSABLE COST CENTERS		Ó	0		0 1, 028, 518		194.00
	· · ·		1	~1		.,	Ŭ	

Health Financial Systems	ST JOSEPH MED	DI CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 06/01/2015	Worksheet B Part I	
				To 05/31/2016		pared: 18 am
		I NTERNS &	RESI DENTS		10,01,2010 0.	
Cost Center Description	MEDI CAL	SERVI CES-SALAR	SERVI CES-OTHE	R Subtotal	Intern &	
	RECORDS &	Y & FRINGES	PRGM COSTS		Residents Cost	
	LI BRARY	APPRV	APPRV		& Post	
					Stepdown	
					Adjustments	
	16.00	21.00	22.00	24.00	25.00	
194. 02 07952  SENI OR CI RCLE	C	0		0 0	0	194.02
194. 03 07953 SELECT SPECIALTY	C	0	)	0 1, 869, 904	0	194.03
194.04 07954 FREE MEALS	C	0		0 206, 820	0	194.04
200.00 Cross Foot Adjustments		0		0 0	0	200.00
201.00 Negative Cost Centers	C C	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	1, 195, 434	0	2, 546, 42	89, 778, 622	-2, 546, 424	202.00

JUST ALLUCAT	TION - GENERAL SERVICE COSTS		Provider CCN: 150047	Period: From 06/01/2015	Worksheet B Part I
				To 05/31/2016	Date/Time Prepare 10/31/2016 8:18 a
	Cost Center Description	Total		1	
GENERA	AL SERVICE COST CENTERS	26.00			
	CAP REL COSTS-BLDG & FIXT				1.
1 1	CAP REL COSTS-MVBLE EQUIP				2.
1 1	EMPLOYEE BENEFITS DEPARTMENT				4.
1 1	OTHER ADMINISTRATIVE AND GENERAL				5.
	DATA PROCESSING PURCHASING AND RECEIVING				5.
	CENTRAL SCHEDULING				5.
1 1	CASHI ERI NG/ACCOUNTS RECEI VABLE				5.
1 1	OTHER ADMINISTRATIVE AND GENERAL				5.
1 1	OPERATION OF PLANT				7.
. 00 00800	LAUNDRY & LINEN SERVICE				8.
1 1	HOUSEKEEPING				9.
1 1	DIETARY				10.
1 1					11.
1 1	NURSI NG ADMI NI STRATI ON PASTORAL CARE				13.
1 1	CENTRAL SERVICES & SUPPLY				13.
	PHARMACY				15.
	MEDICAL RECORDS & LIBRARY				16.
	I&R SERVICES-SALARY & FRINGES APPRV				21.
2.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.
	ENT ROUTINE SERVICE COST CENTERS	_			
	ADULTS & PEDIATRICS	15, 683, 831			30.
	INTENSIVE CARE UNIT	1, 554, 017			31.
1 1	NEONATAL INTENSIVE CARE UNIT	1, 526, 632			31.
1 1	BURN INTENSIVE CARE UNIT SUBPROVIDER - IPF	2, 560, 477 3, 715, 047			33. 40.
1 1	NURSERY	437, 577			43.
1 1	SKILLED NURSING FACILITY	2, 716, 968			44.
	LARY SERVICE COST CENTERS				
	OPERATING ROOM	4, 591, 821			50.
1 1	ENDOSCOPY	971, 366			50.
1 1	RECOVERY ROOM	1, 296, 853			51.
1 1	DELIVERY ROOM & LABOR ROOM	1, 189, 197			52. 53.
	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	94, 381 6, 502, 545			53.
	ULTRA SOUND	0, 302, 343			54.
1 1	RADI OI SOTOPE	0			56.
7.00 05700	CT SCAN	0			57.
8.00 05800		0			58.
1 1	CARDIAC CATHETERIZATION	2, 443, 013			59.
	LABORATORY	6, 638, 603			60.
	WHOLE BLOOD & PACKED RED BLOOD CELL RESPI RATORY THERAPY	727, 877 1, 803, 760			62. 65.
	PHYSI CAL THERAPY	1, 459, 907			66.
	OCCUPATIONAL THERAPY	740, 655			67.
	SPEECH PATHOLOGY	204, 595			68.
9.00 06900	ELECTROCARDI OLOGY	289, 297			69.
	MEDICAL SUPPLIES CHARGED TO PATIENT	5, 741, 894			71.
1 1	IMPL. DEV. CHARGED TO PATIENTS	3, 082, 245			72.
	DRUGS CHARGED TO PATIENTS	8,073,596			73.
	RENAL DIALYSIS	596, 727			74.
	OTHER ANCILLARY SERVICE COST CENTER SLEEP LAB	0			76. 76.
	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	862, 308			76.
	WOUND CARE	2, 029, 681			76.
	TIENT SERVICE COST CENTERS				
	CLINIC	433, 934			90.
1.00 09100		5, 706, 159			91.
	OBSERVATION BEDS (NON-DISTINCT PART				92.
	AL PURPOSE COST CENTERS	02 (74 0/2			110
	SUBTOTALS (SUM OF LINES 1-117)	83, 674, 963			118.
	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	113, 518			190.
90.0019000		113, 518			190.
	PHYSICIANS' PRIVATE OFFICES	338, 475			192.
	OTHER NONREI MBURSABLE COST CENTERS	0			194.
94.0107951		1, 028, 518			194.
	SENI OR CI RCLE	0			194.
94. 03 07953	SELECT SPECIALTY	1, 869, 904			194.
	FREE MEALS	206, 820			194.
00.00	Cross Foot Adjustments	0			200.
	Negative Cost Centers	0			201.
	TOTAL (sum lines 118-201)	87, 232, 198			202.

ALLOCA	Financial Systems TION OF CAPITAL RELATED COSTS	ST JOSEPH MED		F	Period: From 06/01/2015 Fo 05/31/2016	u of Form CMS-: Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS		10/31/2016 8:	<u>18 am</u>
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS			1			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	70, 165	51,017	7 121, 182	121, 182	
5. 01	00560 OTHER ADMINI STRATI VE AND GENERAL	0	0			0	5.01
5.02	00550 DATA PROCESSI NG	0	199, 686			2, 790	5.02
5.03 5.04	00591 PURCHASI NG AND RECEI VI NG 00540 CENTRAL SCHEDULI NG	0	172, 863 49, 200			1, 559 4, 474	5.03 5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	47,200			41	5.05
5.06	00590 OTHER ADMINI STRATI VE AND GENERAL	0	134, 487			7, 788	5.06
7.00	00700 OPERATION OF PLANT	0	1, 055, 572			3, 813	7.00
3.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	55, 088 834, 043			0 2, 472	8.00 9.00
10.00	01000 DI ETARY	0	260, 544			2,472	10.00
1.00	01100 CAFETERI A	0	0			0	11.00
3.00	01300 NURSI NG ADMI NI STRATI ON	0	30, 020			6, 679	
3.01 4.00	01850 PASTORAL CARE 01400 CENTRAL SERVICES & SUPPLY	0	34, 674		1 59,885 0 0	225 0	13.01
14.00	01500 PHARMACY	0	0		-	5, 121	14.00
6.00	01600 MEDICAL RECORDS & LIBRARY	0	156, 121		J	642	
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	22.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	554, 765	403, 365	5 958, 130	22, 545	30.00
	03100 I NTENSI VE CARE UNI T	0	182, 929			1, 181	•
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	40, 815	29, 676		2, 582	31.01
33.00	03300 BURN INTENSIVE CARE UNIT	0	104, 274			3, 627	33.00
10.00 13.00	04000 SUBPROVIDER - IPF 04300 NURSERY	0	79, 235 0			5, 572 883	1
4. 00	04400 SKILLED NURSING FACILITY	0	145, 817			4, 029	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	0	224, 725			3, 943	
50.01 51.00	03330 ENDOSCOPY 05100 RECOVERY ROOM	0	30, 734 95, 829			1, 046 1, 631	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	85, 272			1, 558	
53.00	05300 ANESTHESI OLOGY	0	0			0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	245, 066			6, 925	
54.01 56.00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	0			0	54.0 <sup>4</sup> 56.00
	05700 CT SCAN	0	0			0	
58.00	05800 MRI	0	0	0	0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	27, 299			2, 918	
50.00 52.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	209, 752 11, 493			7, 773 0	60.00
52.00	06500 RESPIRATORY THERAPY	0	85, 227			2, 556	
6.00	06600 PHYSI CAL THERAPY	0	110, 742			2, 125	
57.00	06700 OCCUPATI ONAL THERAPY	0	42, 391				
58.00 59.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	16, 326 15, 538			294 383	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	15, 556			363 0	1
12.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	36, 726			0	73.00
74.00 76.00	07400 RENAL DIALYSIS 03950 OTHER ANCILLARY SERVICE COST CENTER	0	29, 886 0			0	74.00
76.00 76.01	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0			0	76.00
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	48, 442	35, 222	-	1, 469	
76. 03	03952 WOUND CARE	0	127, 707			2, 947	76.03
0 00			01 / 11	22.02		/10	00.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0	31, 611 196, 222			610 7, 117	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		170,222		0		92.00
	SPECIAL PURPOSE COST CENTERS						
18.00	· · · · · · · · · · · · · · · · · · ·	0	5, 831, 286	4, 239, 875	5 10, 071, 161	120, 548	118.00
190 00	NONREIMBURSABLE COST CENTERS	0	15, 047	10, 94	1 25, 988	0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15, 047	10, 94	0 25, 988		190.00
92.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.00
94 00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(	0 0		194.00 194.01
	07951 MARKETI NG						

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
				From 06/01/2015 To 05/31/2016		pared:
					10/31/2016 8:	<u>18 am</u>
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4.00	
194. 03 07953 SELECT SPECIALTY	0	352, 849	256, 55	3 609, 402	0	194.03
194.04 07954 FREE MEALS	0	0		0 0	0	194.04
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	6, 199, 182	4, 507, 36	9 10, 706, 551	121, 182	202.00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der		eriod: com 06/01/2015 05/31/2016	Worksheet B Part II Date/Time Pre	nared <sup>.</sup>
	Cost Center Description	OTHER ADMI NI STRATI VE	DATA PROCESSI NG	PURCHASI NG AND RECEI VI NG		10/31/2016 8: CASHI ERI NG/ACC OUNTS	18 am
		AND GENERAL				RECEI VABLE	
	GENERAL SERVICE COST CENTERS	5.01	5.02	5.03	5.04	5.05	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00 5.01
5.01	00560 OTHER ADMINISTRATIVE AND GENERAL	0	347, 666				5.01
5.03	00591 PURCHASI NG AND RECEI VI NG	0	0	300, 109			5.03
5.04	00540 CENTRAL SCHEDULING	0	0	1, 339	90, 786		5.04
5.05 5.06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	35 581	0	76 0	5.05
5.00 7.00	00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	0	0	232	0	0	5.06 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	117	0	0	8.00
9.00	00900 HOUSEKEEPI NG	0	0	3, 693	0	0	9.00
10.00	01000 DI ETARY	0	0	3, 732 0	0	0	10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	0	497	0	0	11.00 13.00
13.01	01850 PASTORAL CARE	0	0	22	0	0	13.01
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	5, 143 207	0	0	15.00 16.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	207	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	Ő	0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	31, 825 1, 155		8, 309 302	0	30.00 31.00
31.00	02060 NEONATAL INTENSIVE CARE UNIT	0	1, 133		518	0	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	6, 123		1, 598	0	33.00
40.00	04000 SUBPROVI DER – I PF	0	11, 727		3, 062	0	40.00
43.00 44.00	04300 NURSERY	0	535		140	0	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	2, 244	1, 630	586	0	44.00
50.00	05000 OPERATING ROOM	0	27, 474	21, 224	7, 173	0	50.00
50.01	03330 ENDOSCOPY	0	3, 509		916	0	50.01
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	3, 997 944		1, 043 247	0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	3, 828		999	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	51, 561		13, 479	76	54.00
54.01	03630 ULTRA SOUND	0	0	0	0	0	54.01
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	0	0	0	0	56.00 57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	14, 665		3, 829	0	59.00
	06000 LABORATORY	0	41, 058		10, 719	0	
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	0	2, 498 11, 260		652 2, 940	0	62.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	3, 552		927	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	2, 308		603	0	67.00
68.00		0	540		141	0	68.00
69.00 71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 332 16, 979		609 4, 433	0	69.00 71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	17, 369		4, 535	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	48, 367		12, 627	0	73.00
	07400 RENAL DIALYSIS	0	1, 386		362	0	74.00
76. 00 76. 01	03950 OTHER ANCILLARY SERVICE COST CENTER 03951 SLEEP LAB	0	0	0	0	0	76.00 76.01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	2, 233	154	583	0	76.02
76.03	03952 WOUND CARE	0	5, 198		1, 357	0	76.03
00.00	OUTPATIENT SERVICE COST CENTERS			<b></b>	20		00.00
	09000 CLINIC 09100 EMERGENCY	0	77 30, 937		20 8, 077	0	90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	Ū	30, 737	12, 400	0,077	0	92.00
	SPECIAL PURPOSE COST CENTERS	Y			I		
118.00		0	347, 666	298, 675	90, 786	76	118.00
190 00	NONREIMBURSABLE COST CENTERS	0	0	1, 371		0	190.00
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	О		192.00
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194.00
	07951 MARKETI NG 07952 SENI OR CI RCLE	0	0	63	0		194. 01 194. 02
	07953 SELECT SPECIALTY	0	0	0	0		194.02
194.04	07954 FREE MEALS	0	0	0	0		194. 04
200.00	Cross Foot Adjustments						200.00

Health Financial Systems	ST JOSEPH MEDI	ICAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		eri od:	Worksheet B	
				rom 06/01/2015		
			T	o 05/31/2016		
					10/31/2016 8:	
Cost Center Description	OTHER	DATA	PURCHASI NG AND	CENTRAL	CASHI ERI NG/ACC	
	ADMI NI STRATI VE	PROCESSI NG	RECEI VI NG	SCHEDULI NG	OUNTS	
	AND GENERAL				RECEI VABLE	
	5.01	5.02	5.03	5.04	5.05	
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00   TOTAL (sum lines 118-201)	0	347, 666	300, 109	90, 786	76	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS		Provi der	1	Period: From 06/01/2015 Fo 05/31/2016	u of Form CMS-: Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL		LAUNDRY & LI NEN SERVICE		10/31/2016 8: DI ETARY	
	GENERAL SERVICE COST CENTERS	5.06	7.00	8.00	9.00	10.00	
1.00 2.00 4.00 5.01 5.02 5.03 5.04	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00560 OTHER ADMINISTRATIVE AND GENERAL 00550 DATA PROCESSING 00591 PURCHASING AND RECEIVING 00540 CENTRAL SCHEDULING						1.00 2.00 4.00 5.01 5.02 5.03 5.04
5.05 5.06 7.00 8.00 9.00 10.00 11.00 13.00 13.01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01850 PASTORAL CARE	240, 640 17, 363 1, 572 8, 301 5, 519 2, 141 8, 033 454	1, 844, 478 22, 494 340, 561 106, 386 0	119, 32! ( ( ( ( (	5 1, 795, 495 128, 940 0 14, 856 17, 160	694, 560 0 0	5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 13. 01
14.00 15.00 16.00 21.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	0 6, 602 2, 082 0 6, 826	0 0 63, 748 0	( 158 ( (	0 0	0 0 0 0	14.00 15.00 16.00 21.00 22.00
30. 00	03000 ADULTS & PEDIATRICS	29, 504	226, 523	49, 42	4 274, 547	306, 351	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 566	74, 694	1, 669	9 90, 530	7, 096	31.00
31.01 33.00	02060 NEONATAL INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT	3, 353 5, 084	16, 665 42, 577			0 22, 382	31.01 33.00
40.00	04000 SUBPROVI DER – I PF	7, 081	32, 354			89, 593	
	04300 NURSERY	1,007				0	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	5, 270	59, 540	8, 152	2 72, 163	72, 410	44.00
	05000 OPERATING ROOM	9,673				0	50.00
50. 01 51. 00	03330 ENDOSCOPY 05100 RECOVERY ROOM	2, 121	12, 549			0	50.01 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 427 2, 279	39, 129 34, 818		3 47, 425 0 42, 200	0	52.00
	05300 ANESTHESI OLOGY	218	0		0 0	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	14, 968	100, 066		2 121, 280 0 0	0	54.00 54.0
56.00	05600 RADI OI SOTOPE	0	0			0	56.00
57.00	05700 CT SCAN	0	0	(	0 0	0	57.0
58.00		0 5 711	0	2.91		0	58.0
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	5, 711 15, 749				0	59.0 60.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 848	4, 693		5, 688	0	62.0
	06500 RESPIRATORY THERAPY	4,078				0	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 061			0 54,805 0 20,979	0	66. 0 67. 0
68. 00	06800 SPEECH PATHOLOGY	424	6, 666		8, 079	0	68.0
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	630 15, 236			3 7,689 0 0	0	69.0 71.0
	07200 I MPL. DEV. CHARGED TO PATIENTS	8, 103				0	72.0
	07300 DRUGS CHARGED TO PATIENTS	14, 257			18, 175	0	73.0
	07400 RENAL DIALYSIS 03950 OTHER ANCILLARY SERVICE COST CENTER	1, 370			7 14, 790 0 0	0	74.0
	03951 SLEEP LAB	0	0			0	76.0
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 916			23, 973	0	76.0
76. 03	03952 WOUND CARE OUTPATIENT SERVICE COST CENTERS	4, 427	52, 146	504	4 63, 201	0	76.0
90.00	09000 CLINIC	861	12, 907	4, 393	3 15, 644	0	90.00
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	12, 019	80, 122	21, 39	1 97, 108	0	91.00 92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	235, 783	1, 694, 258	119, 083	3 1, 613, 427	497, 832	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	198	6, 144		7,447	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0, 144		0 7,447		190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	1	0	242		85, 328	192.00
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0				194.0
174.01	07951 MARKETI NG	2,744					194. 0 <sup>°</sup> 194. 0
	U/952 SENTUR CTRULE						
194. 02 194. 03	07952 SENIOR CIRCLE 07953 SELECT SPECIALTY 07954 FREE MEALS	1, 914	144, 076		174, 621	58, 986 52, 414	194. 0

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
				From 06/01/2015		
			1	Fo 05/31/2016		
					10/31/2016 8:	<u>18 am</u>
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
	AND GENERAL					
	5.06	7.00	8.00	9.00	10.00	
201.00 Negative Cost Centers	0	0	(	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	240, 640	1, 844, 478	119, 325	5 1, 795, 495	694, 560	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	ST JOSEPH MEE			Period: From 06/01/2015	worksheet B Part II	
					To 05/31/2016		
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PASTORAL CARE	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		11.00	13.00	13.01	14.00	15.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		1			-	1.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ \end{array}$	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00560 OTHER ADMINISTRATI VE AND GENERAL 00550 DATA PROCESSI NG 00591 PURCHASI NG AND RECEI VI NG 00540 CENTRAL SCHEDULI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMINISTRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	2, 141					$ \begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00 \end{array} $
13.00	01300 NURSI NG ADMI NI STRATI ON	120					13.00
13. 01 14. 00	01850 PASTORAL CARE 01400 CENTRAL SERVICES & SUPPLY			91, 91			13.01
15.00	01500 PHARMACY	79	0		0 0	17, 103	
16.00 21.00	01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRV	27			-	0	
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV					0	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	500					
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	502				0	
31.01	02060 NEONATAL INTENSIVE CARE UNIT	50	3, 948	3, 849	9 0	0	31.01
33. 00 40. 00	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	78 140				0	
43.00	04300 NURSERY	18				0	
44.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	82	0	(	0	0	44.00
50.00	05000 OPERATING ROOM	88	6, 946	6, 770	0 0	0	50.00
50.01	03330 ENDOSCOPY	18				0	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	31				0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	C		(		0	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	162				0	
56.00	05600 RADI OI SOTOPE	C	0	(	0 0	0	
57.00 58.00	05700 CT SCAN 05800 MRI				-	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	54	4, 312	4, 203	-	0	59.00
		191		(	0	0	00.00
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	55				0	
66.00	06600 PHYSI CAL THERAPY	43		(	0 0	0	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	18				0	
69.00	06900 ELECTROCARDI OLOGY	8	0	(	0 0	0	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		0			0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0		0 0	17, 103	
74.00	07400 RENAL DIALYSIS	C	0	(	0	0	
76. 00 76. 01	03950 OTHER ANCI LLARY SERVICE COST CENTER 03951 SLEEP LAB					0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03952 WOUND CARE	35				0	76.02
76.03	OUTPATIENT SERVICE COST CENTERS	03	0			0	70.03
90.00	09000 CLI NI C	15				0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	150	11, 924	11, 623	3 0	0	91.00 92.00
118.00		2, 128	94, 290	91, 91	1 0	17, 103	118.00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191.00	19100 RESEARCH	C	0			0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00 194.00
	07950 OTHER NONREIMBURSABLE COST CENTERS 07951 MARKETING	13	0				194.00
	07952 SENIOR CIRCLE	C	0		0 0	0	194. 02
	A TATA A						1.0.1 -
194.03	07953 SELECT SPECIALTY 07954 FREE MEALS	C	0				194.03 194.04

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
				From 06/01/2015		
				To 05/31/2016	Date/Time Pre 10/31/2016 8:	
Cost Center Description	CAFETERI A	NURSI NG	PASTORAL CARE	CENTRAL	PHARMACY	
'		ADMI NI STRATI ON	1	SERVICES &		
				SUPPLY		
	11.00	13.00	13.01	14.00	15.00	
201.00 Negative Cost Centers	0	C	)	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	2, 141	94, 290	91, 91	1 0	17, 103	202.00

Heal th Finance ALLOCATION OF	ial Systems F CAPITAL RELATED COSTS	ST JOSEPH MED			CCN: 150047	Peri od:	u of Form CMS-: Worksheet B	2552-10
						From 06/01/2015 To 05/31/2016		
				NTERNS &	RESI DENTS		10/31/2016 8:	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Y &	CES-SALAR FRI NGES APPRV	SERVI CES-OTHE PRGM COSTS APPRV		Intern & Residents Cost & Post Stepdown Adjustments	
CENEDA		16.00	2	21.00	22.00	24.00	25.00	
	L SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT							1 00
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	CAP REL COSTS-MVBLE EQUI P EMPLOYEE BENEFITS DEPARTMENT OTHER ADMI NI STRATI VE AND GENERAL DATA PROCESSI NG PURCHASI NG AND RECEI VI NG CENTRAL SCHEDULI NG CASHI ERI NG/ACCOUNTS RECEI VABLE OTHER ADMI NI STRATI VE AND GENERAL OPERATION OF PLANT LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG ADMI NI STRATI ON PASTORAL CARE CENTRAL SERVI CES & SUPPLY PHARMACY MEDI CAL RECORDS & LI BRARY I &R SERVI CES-SALARY & FRI NGES APPRV	413, 604 0	þ	C				1.00 2.00 4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00 8.00 9.00 10.00 11.00 13.01 14.00 15.00 16.00 21.00
	I & R SERVICES-OTHER PRGM COSTS APPRV ENT ROUTINE SERVICE COST CENTERS	0			6, 82	6		22.00
30. 00         03000 /           31. 00         03100           31. 01         02060 /           33. 00         03300 /	ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT	37, 868 1, 375 2, 362 7, 285				2, 036, 798 501, 518 127, 984 341, 869	0 0 0 0	30.00 31.00 31.01 33.00
	SUBPROVIDER – IPF NURSERY	13, 953 636	1			366, 933 6, 580	0	40.00
	SKILLED NURSING FACILITY	2,671	1			480, 616	0	•
	ARY SERVICE COST CENTERS	22 (00	1			710 501	0	
	OPERATING ROOM ENDOSCOPY	32, 690 4, 175				710, 521 104, 690	0	50.00 50.01
1 1	RECOVERY ROOM	4, 756	1			274, 257	0	51.00
1 1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	1, 123 4, 555				237, 775 9, 609	0	52.00 53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	61, 276				801, 299	0	54.00
	ULTRA SOUND RADI OI SOTOPE					0	0	•
	CT SCAN					0	0	56.00 57.00
58.00 05800 1		0	1			0	0	58.00
	CARDI AC CATHETERI ZATI ON	17, 450	1			138, 759	0	59.00
	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELL	48, 854 2, 973				689, 939 39, 162	0	60.00 62.00
	RESPIRATORY THERAPY	13, 398				261, 649	0	65.00
	PHYSI CAL THERAPY	4, 226	1			305, 581	0	66.00
	OCCUPATIONAL THERAPY	2,746	1			120, 093	0	67.00 68.00
	SPEECH PATHOLOGY ELECTROCARDI OLOGY	643 2, 774				45, 003 48, 302	0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	20, 203				180, 581	0	71.00
	IMPL. DEV. CHARGED TO PATIENTS	20, 667				113, 109	0	72.00
	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	57, 550				246, 504	0	73.00
	OTHER ANCILLARY SERVICE COST CENTER	1, 649 0				84, 034 0	0	74.00
	SLEEP LAB	0				0	0	76.01
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2,657	1			136, 464	0	76.02
	NOUND CARE	6, 185	2		I	360, 212	0	76.03
90.00 09000		92	2			89, 725	0	90.00
91.00 09100	EMERGENCY	36, 812	1			668, 573	0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART						0	92.00
	L PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	413, 604	ł	C		0 9, 528, 139	0	118.00
NONREI	MBURSABLE COST CENTERS				I			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2			41, 157		190.00
191.0019100	RESEARCH PHYSI CLANS' PRI VATE OFFI CES					0 85, 571		191.00 192.00
194.0007950	OTHER NONREIMBURSABLE COST CENTERS	0				0	0	194.00
194.01 07951 1	MARKETI NG	0	P			3, 445	0	194.01

Health Financial Systems	ST JOSEPH MED	DI CAL CENTER		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150047	Peri od:	Worksheet B	
				From 06/01/2015 To 05/31/2016		nared
					10/31/2016 8:	<u>18 am</u>
		INTERNS &	RESI DENTS			
Cost Center Description	MEDI CAL RECORDS &	SERVICES-SALAF Y & FRINGES	PRGM COSTS		Intern & Residents Cost	
	LIBRARY	APPRV	APPRV		& Post	
	Erbioact				Stepdown	
					Adjustments	
	16.00	21.00	22.00	24.00	25.00	
194. 02 07952 SENI OR CI RCLE	C			0		194. 02
194. 03 07953  SELECT SPECI ALTY	C			988, 999	0	194.03
194.0407954 FREE MEALS	C			52, 414		194.04
200.00 Cross Foot Adjustments		0	6,82	6, 826		200. 00
201.00 Negative Cost Centers	C	) (	D	0 0		201.00
202.00  TOTAL (sum lines 118-201)	413, 604	4) (	6,82	10, 706, 551	0	202.00

Heal th	Financial Systems	ST JUSEPH MEDI	CAL CENTER			I CMS-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 150047	Period: Workshee From 06/01/2015 Part II To 05/31/2016 Date/Tim	et B Prepared:
	Cost Center Description	Total				016 8: 18 am
	CENERAL CERVICE COST CENTERS	26.00			· · · · · · · · · · · · · · · · · · ·	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL					5. 01
5. 02	00550 DATA PROCESSI NG					5. 02
. 03	00591 PURCHASING AND RECEIVING					5.03
. 04	00540 CENTRAL SCHEDULING					5.04
. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 0
. 06	00590 OTHER ADMINISTRATIVE AND GENERAL					5.0
'. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.0
. 00 . 00	00900 HOUSEKEEPING					9.0
0.00	01000 DI ETARY					10.0
1.00	01100 CAFETERIA					11.0
3.00	01300 NURSI NG ADMI NI STRATI ON					13.0
3. 01	01850 PASTORAL CARE					13.0
4.00	01400 CENTRAL SERVICES & SUPPLY					14.0
5.00	01500 PHARMACY					15.00
6.00	01600 MEDICAL RECORDS & LIBRARY					16.00
1.00	02100 I & R SERVICES-SALARY & FRINGES APPRV 02200 I & R SERVICES-OTHER PRGM COSTS APPRV					21.0
2.00	INPATIENT ROUTINE SERVICE COST CENTERS					22.0
30.00	03000 ADULTS & PEDI ATRI CS	2,036,798				30. 0
31.00	03100 I NTENSI VE CARE UNI T	501, 518				31.0
1. 01	02060 NEONATAL INTENSIVE CARE UNIT	127, 984				31.0
3.00	03300 BURN INTENSIVE CARE UNIT	341, 869				33.0
10.00	04000 SUBPROVI DER – I PF	366, 933				40.00
3.00	04300 NURSERY	6, 580				43.00
14.00	04400 SKI LLED NURSI NG FACI LI TY	480, 616				44.00
50.00	ANCI LLARY SERVICE COST CENTERS	710, 521				50.00
50. 00 50. 01	03330 ENDOSCOPY	104, 690				50.0
51.00	05100 RECOVERY ROOM	274, 257				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	237, 775				52.00
53.00	05300 ANESTHESI OLOGY	9, 609				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	801, 299				54.00
54.01	03630 ULTRA SOUND	0				54.0
6.00	05600 RADI OI SOTOPE	0				56.00
57.00 58.00	05700 CT SCAN 05800 MRI	0				57.00 58.00
59.00 59.00	05900 CARDI AC CATHETERI ZATI ON	138, 759				59.0
50.00	06000 LABORATORY	689, 939				60.0
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	39, 162				62.0
5.00	06500 RESPI RATORY THERAPY	261, 649				65.00
56.00	06600 PHYSI CAL THERAPY	305, 581				66.00
57.00	06700 OCCUPATI ONAL THERAPY	120, 093				67.00
8.00	06800 SPEECH PATHOLOGY	45,003				68.00
9.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	48, 302 180, 581				69.00 71.0
71.00 72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	113, 109				72.00
3.00	07300 DRUGS CHARGED TO PATIENTS	246, 504				73.0
4.00	07400 RENAL DI ALYSI S	84,034				74.0
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0				76.00
6. 01	03951 SLEEP LAB	0				76. 0 <sup>-</sup>
6. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	136, 464				76. 02
6. 03	03952 WOUND CARE	360, 212				76.03
0 00	OUTPATIENT SERVICE COST CENTERS	89, 725				90.00
90.00 91.00	09100 EMERGENCY	668, 573				90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	000, 373				92.00
2.00	SPECIAL PURPOSE COST CENTERS					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
18.00		9, 528, 139				118.00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	41, 157				190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0				191.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	85, 571				192.00 194.00
	07950 OTHER NONRETMBURSABLE COST CENTERS	3, 445				194. 00 194. 0
	07951 MARKETING 07952 SENI OR CI RCLE	3, 445				194.0
	07953 SELECT SPECIALTY	988, 999				194.02
94 03						
	07954 FREE MEALS	52.414				194.04
194.04		52, 414 6, 826				200. 00
	Cross Foot Adjustments					

ST JOSEPH MEDICAL CENTER

In Lieu of Form CMS-2552-10

Health Financial Systems

	Financial Systems LLOCATION - STATISTICAL BASIS	ST JOSEPH MED			Period:	u of Form CMS-2 Worksheet B-1	
					rom 06/01/2015 o 05/31/2016	Date/Time Pre 10/31/2016 8:	
		CAPI TAL REL	ATED COSTS			10/01/2010 0.	
	Cost Center Description	BLDG & FIXT (SQUARE FOO TAGE)	MVBLE EQUIP (SQUARE FOO TAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	DATA PROCESSI NG (GROSS CHAR GES)	
		1.00	2.00	4.00	5. 01	5.02	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	416, 929		1			1.00
2.00 4.00 5.01 5.02 5.03 5.04 5.05	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00560 OTHER ADMI NI STRATI VE AND GENERAL 00550 DATA PROCESSI NG 00591 PURCHASI NG AND RECEI VI NG 00540 CENTRAL SCHEDULI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	4, 719 0 13, 430 11, 626 3, 309	416, 929 4, 719 0 13, 430 11, 626 3, 309	31, 876, 658 0 733, 927 409, 940		550, 207, 230 0 0 0	2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05
5.06 7.00 8.00 9.00 10.00 11.00 13.00	00590 OTHER ADMINISTRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATI ON	9, 045 70, 993 3, 705 56, 094 17, 523 0 2, 019	9, 045 70, 993 3, 705 56, 094 17, 523 0 2, 019	2, 048, 419 1, 002, 782 650, 155 0		0 0 0 0 0 0 0 0 0 0	5.06
13. 01 14. 00 15. 00 16. 00	01300 NORSTNG ADMINISTRATION 01850 PASTORAL CARE 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	2,019 2,332 0 10,500 0	2,019 2,332 0 10,500 0	59, 160 0 1, 346, 806 168, 968	0         0           0         0           3         0           0         0	0 0 0 0 0 0	13. 01 14. 00 15. 00 16. 00 21. 00
30.00	03000 ADULTS & PEDIATRICS	37, 311	37, 311	5, 934, 101	0	50, 356, 603	30.00
31.00	03100 I NTENSI VE CARE UNI T	12, 303	12, 303			1, 828, 258	
31. 01 33. 00	02060 NEONATAL INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT	2, 745 7, 013	2, 745 7, 013			3, 140, 697 9, 687, 756	
40.00	04000 SUBPROVI DER – I PF	5, 329	5, 329			18, 554, 919	
43.00	04300 NURSERY	0,021	0	232, 171		846, 396	43.00
44.00	04400 SKILLED NURSING FACILITY	9, 807	9, 807	1, 059, 579	0	3, 551, 360	44.00
F0 00		15 114	15 114	1 027 202	2 0	42 471 142	
50. 00 50. 01	05000 OPERATI NG ROOM 03330 ENDOSCOPY	15, 114 2, 067	15, 114 2, 067		-	43, 471, 142 5, 551, 891	50.00 50.01
51.00	05100 RECOVERY ROOM	6, 445	6, 445			6, 323, 894	
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 735	5, 735			1, 493, 951	
53.00	05300 ANESTHESI OLOGY	0	0	C		6, 056, 813	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 482	16, 482			81, 685, 617	54.00
	03630 ULTRA SOUND	0	0			0	
	05600 RADI OI SOTOPE 05700 CT SCAN	0	0	0	0	0	56.00 57.00
57.00	05800 MRI	0	0			0	57.00
	05900 CARDI AC CATHETERI ZATI ON	1,836	1, 836	767, 534	0	23, 204, 248	
60.00	06000 LABORATORY	14, 107	14, 107		ч о	64, 964, 792	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	773	773		, i	3, 952, 861	62.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	5, 732 7, 448	5, 732 7, 448			17, 817, 136 5, 620, 185	
67.00	06700 OCCUPATI ONAL THERAPY	2,851	2, 851	323, 547		3, 651, 684	67.00
68.00	06800 SPEECH PATHOLOGY	1, 098	1, 098			854, 761	68.00
	06900 ELECTROCARDI OLOGY	1, 045	1, 045	100, 849	0	3, 689, 417	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	26, 865, 454	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	2, 470	2, 470			27, 482, 802 76, 529, 742	
	07400 RENAL DIALYSIS	2, 470	2, 470			2, 192, 998	
	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	C	0 0	0	76.00
	03951 SLEEP LAB	0	0	C	0	0	76.01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03952 WOUND CARE	3, 258 8, 589	3, 258 8, 589			3, 533, 303 8, 224, 694	
	OUTPATIENT SERVICE COST CENTERS			1			
	09000 CLI NI C	2, 126	2, 126			122, 245	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 197	13, 197	1, 871, 781	0	48, 951, 611	91.00 92.00
	SPECIAL PURPOSE COST CENTERS	1					
118.00		392, 186	392, 186	31, 710, 102	2 0	550, 207, 230	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,012	1, 012	2, 277	/ 0	0	190.00
	19100 RESEARCH	0	0	2,2//	0		191.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0	192.00
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	(	0		194.00
10/1 (11	07951 MARKETI NG	0	0	164, 279	0	0	194.01

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 06/01/2015 To 05/31/2016	Date/Time Pre 10/31/2016 8:	pared: 18 am
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FOO TAGE)	MVBLE EQUIP (SQUARE FOO TAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	(GROSS CHAR GES)	
	1.00	2.00	4.00	5. 01	5.02	
194. 02 07952 SENI OR CI RCLE	0	0		0 0	0	194. 02
194. 03 07953 SELECT SPECIALTY	23, 731	23, 731		0 0	0	194. 03
194.0407954 FREE MEALS	0	0		0 0	0	194.04
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	6, 199, 182	4, 507, 369	5, 249, 87	2 0	2, 288, 730	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	14. 868675	10. 810879	0. 16469	0. 000000	0.004160	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			121, 18	2 0	347, 666	204. 00
205.00 Unit cost multiplier (Wkst. B, Part			0. 00380	0. 000000	0. 000632	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	ST JOSEPH MED			eriod:	u of Form CMS-: Worksheet B-1	2552-10
				FI	rom 06/01/2015 05/31/2016	Date/Time Pre 10/31/2016 8:	
	Cost Center Description	PURCHASI NG AND RECEI VI NG	SCHEDULI NG	CASHI ERI NG/ACC OUNTS		OTHER ADMI NI STRATI VE	
		(COSTED REQ S)	(GROSS CHAR GES)	RECEI VABLE (GROSS CHAR		AND GENERAL (ACCUM. COST)	
		5.03	5.04	GES) 5.05	5A. 06	5.06	
	GENERAL SERVICE COST CENTERS	3.03	3.04	3.03	57.00	3.00	
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 01
5.02 5.03	00550 DATA PROCESSING 00591 PURCHASING AND RECEIVING	9, 386, 602					5.02 5.03
5.03 5.04	00540 CENTRAL SCHEDULING	9, 380, 802	550, 207, 230				5.03
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 080	0	550, 207, 230			5.05
5.06 7.00	00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	18, 170 7, 264	0	0	-13, 129, 660	76, 648, 962 5, 529, 635	5.06 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 672	0	0	0	500, 496	8.00
9.00	00900 HOUSEKEEPI NG	115, 494	0	0	0	2, 643, 544	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	116, 713	0	0	0	1, 757, 767 681, 939	10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	15, 533	0	0	0	2, 558, 437	13.00
13.01	01850 PASTORAL CARE	691	0	0	0	144, 626	13.01
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	0	0	0 2, 102, 453	14.00
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	160, 860	0	0	0	2, 102, 453 663, 070	15.00 16.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	2, 174, 023	22.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	390, 450	50, 356, 603	50, 356, 603	0	9, 407, 876	30.00
31.00	03100 I NTENSI VE CARE UNI T	39, 015	1, 828, 258		0	817, 145	
31.01	02060 NEONATAL INTENSIVE CARE UNIT	51, 380	3, 140, 697	3, 140, 697	0	1, 067, 965	
33.00 40.00	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	115, 753 47, 495	9, 687, 756 18, 554, 919		0	1, 619, 170 2, 255, 248	
43.00	04300 NURSERY	0	846, 396	846, 396	0	320, 741	
44.00	04400 SKILLED NURSING FACILITY	50, 996	3, 551, 360	3, 551, 360	0	1, 678, 357	44.00
50, 00	ANCI LLARY SERVI CE COST CENTERS	663, 835	43, 471, 142	43, 471, 142	0	3, 080, 558	50.00
50. 01	03330 ENDOSCOPY	123, 419	5, 551, 891	5, 551, 891	0	675, 394	50. 01
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	53 74, 998	6, 323, 894 1, 493, 951	6, 323, 894 1, 493, 951	0	772, 816 725, 691	51.00 52.00
53.00	05300 ANESTHESI OLOGY	273	6, 056, 813		0	69, 342	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	34, 182	81, 685, 617	81, 685, 617	0	4, 766, 821	54.00
54. 01 56. 00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	0	0	0	0	54.01 56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
	05800 MRI	0	0	0	0	0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	343, 928 420, 110	23, 204, 248 64, 964, 792	23, 204, 248 64, 964, 792	0	1, 818, 912 5, 015, 653	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	30, 029	3, 952, 861	3, 952, 861	0	588, 417	62.00
65.00	06500 RESPI RATORY THERAPY	98, 212	17, 817, 136	17, 817, 136	0	1, 298, 689	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	11, 362 1, 175	5, 620, 185 3, 651, 684	5, 620, 185 3, 651, 684	0	974, 978 525, 222	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	470	854, 761	854, 761	0	135, 179	
69.00	06900 ELECTROCARDI OLOGY	6, 114	3, 689, 417	3, 689, 417	0	200, 566	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 869, 961 1, 952, 808	26, 865, 454 27, 482, 802	26, 865, 454 27, 482, 802	0	4, 852, 330 2, 580, 496	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 752, 000	76, 529, 742	76, 529, 742	0	4, 540, 404	
74.00	07400 RENAL DI ALYSI S	5, 981	2, 192, 998		0	436, 397	74.00
76. 00 76. 01	03950 OTHER ANCILLARY SERVICE COST CENTER 03951 SLEEP LAB	0	0	0	0	0	76.00 76.01
76.02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	4, 832	3, 533, 303		0	610, 211	76.02
76.03	03952 WOUND CARE	113, 294	8, 224, 694		0	1, 409, 918	
90.00	OUTPATIENT SERVICE COST CENTERS	15, 976	122, 245	122, 245	0	274, 082	90.00
	09100 EMERGENCY	387, 837	48, 951, 611		0	3, 827, 579	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	9, 341, 770	550, 207, 230	550, 207, 230	-13, 129, 660	75, 102, 147	118 00
	NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,				, 5, 102, 147	10.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	42, 871	0	0	0	63, 159	
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		191. 00 192. 00
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 MARKETI NG	1, 961	0	0	0	873, 889	194.01
	07952 SENI OR CI RCLE 07953 SELECT SPECI ALTY	0	0	0	0	0 609, 402	194.02 194.03
174.03	JOTTO DECOT DE COLACIT	<u> </u>	0	0	0	007,402	1174.00

Health Fin	ancial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 06/01/2015 To 05/31/2016		pared: 18 am
	Cost Center Description	PURCHASI NG AND	CENTRAL		CReconciliation		
		RECEI VI NG	SCHEDULI NG	OUNTS		ADMI NI STRATI VE	
		(COSTED REQ S)	(GROSS CHAR	RECEI VABLE		AND GENERAL	
			GES)	(GROSS CHAR		(ACCUM. COST)	
				GES)			
		5.03	5.04	5.05	5A. 06	5.06	
194.04 079	54 FREE MEALS	0	C		0 0	0	194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 537, 849	1, 608, 075	2, 263, 93	0	13, 129, 660	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 163834	0. 002923	0. 00411	5	0. 171296	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	300, 109	90, 786	7	6	240, 640	204.00
205.00	Unit cost multiplier (Wkst. B, Part    )	0. 031972	0. 000165	0. 00000	0	0. 003140	205. 00

COST A	Financial Systems ALLOCATION - STATISTICAL BASIS		DI CAL CENTER Provi der		Period:	Worksheet B-1	2552-1
					rom 06/01/2015 o 05/31/2016	Date/Time Pre 10/31/2016 8:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT (SQUARE FOO	LI NEN SERVI CE (POUNDS OF	(SQUARE FOO TAGE)	(MEALS SERVED)	(FTE'S)	
		TAGE) 7.00	LAUNDRY) 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		1	1			1 1.0
1.00 2.00	00200 CAP REL COSTS-BEDG & FIXT						2.0
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5.01	00560 OTHER ADMINISTRATIVE AND GENERAL						5.0
5.02 5.03	00550 DATA PROCESSING 00591 PURCHASING AND RECEIVING						5.0 5.0
5.04	00540 CENTRAL SCHEDULING						5.0
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. C
5.06	00590 OTHER ADMINI STRATI VE AND GENERAL	202.007					5.0
7.00 3.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	303, 807 3, 705					7. C
9.00	00900 HOUSEKEEPI NG	56, 094		1	3		9.0
0.00	01000 DI ETARY	17, 523		17, 523	161, 894		10.0
1.00		0	-		-	44, 182	
3.00 3.01	01300 NURSI NG ADMI NI STRATI ON 01850 PASTORAL CARE	2,019				2, 483 135	
4.00	01400 CENTRAL SERVICES & SUPPLY	2, 332				0	14.0
15.00	01500 PHARMACY	0	1, 109	0	0 0	1, 635	15.0
6.00	01600 MEDI CAL RECORDS & LI BRARY	10, 500				566	
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV					0	21. C
22.00	INPATIENT ROUTINE SERVICE COST CENTERS			η		0	22.0
30.00	03000 ADULTS & PEDIATRICS	37, 311	347, 750	37, 311	71, 407	10, 374	30. 0
31.00	03100 I NTENSI VE CARE UNI T	12, 303				493	
31.01	02060 NEONATAL INTENSIVE CARE UNIT	2,745				1,027	31.0
3.00 0.00	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	7,013				1, 609 2, 885	
3.00	04300 NURSERY	0,027				363	
4.00	04400 SKILLED NURSING FACILITY	9, 807	57, 355	9, 807	16, 878	1, 695	44.0
0 00	ANCI LLARY SERVICE COST CENTERS	15 114	24.242	15 11/	l 0	1 00(	
50.00 50.01	03330 ENDOSCOPY	15, 114				1, 806 374	50.0 50.0
51.00	05100 RECOVERY ROOM	6, 445				641	51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 735				1, 345	
53.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	16 402	-	14 402	-	0	53.0
54.00 54.01	03630 ULTRA SOUND	16, 482				3, 353 0	54.0 54.0
56.00	05600 RADI OI SOTOPE	0			-	0	56.0
57.00	05700 CT SCAN	0	0 0	c c	0 0	0	57.0
8.00		0	-			0	
59.00 50.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 836 14, 107			-	1, 121 3, 939	
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	773				0, 707	
5.00	06500 RESPI RATORY THERAPY	5, 732				1, 139	
6.00	06600 PHYSI CAL THERAPY	7,448				880	
7.00 8.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	2,851				365 93	
9.00	06900 ELECTROCARDI OLOGY	1,045				160	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		, c		0	71.
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	-	0		0	
3.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	2,470		2, 470 2, 010		0	
4.00 6.00	03950 OTHER ANCILLARY SERVICE COST CENTER	2,010		2,010		0	
6. 01	03951 SLEEP LAB	0	0	C C	-	0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 258		3, 258		726	
6. 03	03952 WOUND CARE	8, 589	3, 545	8, 589	0 0	1, 293	76.0
0. 00	OUTPATI ENT SERVICE COST CENTERS	2, 126	30, 910	2, 126	0	300	90.0
	09100 EMERGENCY	13, 197				3, 100	
2.00							92.0
10 00	SPECIAL PURPOSE COST CENTERS	270.044	007.0//	210.245	114 000	42,000	110 0
18.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	279,064	837, 866	219, 265	116, 039	43, 900	1118. ( 
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,012	. C	1, 012	2 0	9	190. 0
91. OC	19100 RESEARCH	0	0	C	0 0	0	191. (
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	1, 704		19, 889		192.0
	07950 OTHER NONREIMBURSABLE COST CENTERS 07951 MARKETING						194. ( 194. (
	207951 MARKETING 207952 SENIOR CIRCLE						194.0
	07953 SELECT SPECIALTY	23, 731		23, 731	13, 749		194. 0
~ ~ ~ ~	07954 FREE MEALS	0			12, 217	0	194.

Health Fir	ancial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
					From 06/01/2015 To 05/31/2016		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FOO	(MEALS SERVED)	(FTE'S)	
		(SQUARE FOO	(POUNDS OF	TAGE)			
		TAGE)	LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	6, 476, 839	665, 216	4, 292, 23	6 2, 740, 676	798, 752	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	21. 318926	0. 792329	17.59055	4 16. 928830	18. 078675	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1, 844, 478	119, 325	1, 795, 49	5 694, 560	2, 141	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	6. 071216	0. 142126	7. 35834	5 4. 290215	0. 048459	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	ST JOSEPH MED		CCN: 150047	Peri od:	u of Form CMS- Worksheet B-1	
					From 06/01/2015 To 05/31/2016	Date/Time Pre 10/31/2016 8:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG	PASTORAL CARE (DI RECT NRSI NG HRS)		PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHAR	
		HRS)		REQUIS.)		GES)	
		13.00	13.01	14.00	15.00	16.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		[	1			1.00
2.00 4.00 5.01	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00560 OTHER ADMINISTRATIVE AND GENERAL						2.00 4.00 5.01
5. 02 5. 03 5. 04	00550 DATA PROCESSI NG 00591 PURCHASI NG AND RECEI VI NG 00540 CENTRAL SCHEDULI NG						5. 02 5. 03 5. 04
5.05 5.06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI NI STRATI VE AND GENERAL						5.05 5.06
7.00 8.00 9.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						7.00 8.00 9.00
10.00	01000 DI ETARY						10.00
		500.052					11.00
	01300 NURSING ADMINISTRATION 01850 PASTORAL CARE	509, 952 0					13.00 13.01
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0		14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0		0 3, 619, 995 0 0	550, 207, 230	15.00 16.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	215, 777	215, 777	·	0 0	50, 356, 603	30.00
	03100 I NTENSI VE CARE UNI T	10, 252			0 0	1, 828, 258	
	02060 NEONATAL INTENSIVE CARE UNIT	21, 353			0 0	3, 140, 697	•
	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	33, 459 60, 005			0 0	9, 687, 756 18, 554, 919	•
43.00	04300 NURSERY	7, 558			0 0	846, 396	
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0		0 0	3, 551, 360	44.00
50, 00	ANCI LLARY SERVI CE COST CENTERS	37, 564	37, 564		0 0	43, 471, 142	50.00
	03330 ENDOSCOPY	7,778			0 0	5, 551, 891	50.01
	05100 RECOVERY ROOM	15,056			0 0	6, 323, 894	
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	13, 340	13, 340		0 0 0 0	1, 493, 951 6, 056, 813	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	81, 685, 617	54.00
	03630 ULTRA SOUND	0	0		0 0	0	54.01
	05600 RADI OI SOTOPE 05700 CT SCAN				0 0	0	56.00 57.00
	05800 MRI	0	-		0 0	0	
	05900 CARDI AC CATHETERI ZATI ON	23, 322	23, 322		0 0	23, 204, 248	
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	64, 964, 792 3, 952, 861	•
	06500 RESPIRATORY THERAPY	0	0		0 0	17, 817, 136	•
	06600 PHYSI CAL THERAPY	0	0		0 0	5, 620, 185	•
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY				0 0	3, 651, 684 854, 761	1
	06900 ELECTROCARDI OLOGY	0	0		0 0	3, 689, 417	•
	07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0		0 0	26, 865, 454	•
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS				0 3, 619, 995	27, 482, 802 76, 529, 742	•
	07400 RENAL DI ALYSI S	0	0		0 0	2, 192, 998	
	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0	0	76.00
	03951 SLEEP LAB 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0				0 3, 533, 303	76. 01 76. 02
	03952 WOUND CARE	0	0		0 0	8, 224, 694	•
	OUTPATIENT SERVICE COST CENTERS	1					
	09000 CLINIC 09100 EMERGENCY	0 64, 488	-		0 0 0 0	122, 245 48, 951, 611	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	04,400	04,400		0 0	40, 951, 011	92.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	509, 952	509, 952	2	0 3, 619, 995	550, 207, 230	118.00
100.00	NONREI MBURSABLE COST CENTERS			1			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH				0 0 0 0		190. 00 191. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.00
	07951 MARKETING 07952 SENIOR CIRCLE						194. 01 194. 02
	07953 SELECT SPECIALTY	0	0		0 0		194.02

Health Fin	ancial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Period: From 06/01/2015	Worksheet B-1	
					To 05/31/2016	Date/Time Pre 10/31/2016 8:	pared: 18 am
	Cost Center Description	NURSI NG	PASTORAL CARE	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	(DIRECT NRSING	SERVICES &	(COSTED	RECORDS &	
			HRS)	SUPPLY	REQUIS.)	LI BRARY	
		(DI RECT NRSI NG		(COSTED		(GROSS CHAR	
		HRS)		REQUIS.)		GES)	
		13.00	13.01	14.00	15.00	16.00	
194.04079	54 FREE MEALS	0	0		0 0	0	194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	3, 120, 134	262, 578		0 2, 493, 033	1, 195, 434	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 118486		0.00000			
204.00	Cost to be allocated (per Wkst. B, Part II)	94, 290	91, 911		0 17, 103	413, 604	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 184900	0. 180235	0.00000	0 0. 004725	0.000752	205.00

2 00 00000 CAP REL COST S-WBLE EQUIP 0	OST ALLOCATION - STATISTICAL BASIS		I CAL CENTER Provi der	CCN: 150047	Peri od:	u of Form CMS-2 Worksheet B-1	552-
Cost Center Description         SEP 055 - SLASS         Intrems & Proving         Sep 055 - SLASS         Sep 05 - SLASSS         Sep 05 - SLASSS         Sep 05 - SLASSS						Date/Time Prep	
PARK         PHALLOSIS         APPRV           21:00         20:00         20:00           00         CONTRINS, CONT		INTERNS &	RESI DENTS			10/31/2016 8:1	<u>8 am</u>
PARK         PHALLOSIS         APPRV           21:00         20:00         20:00           00         CONTRINS, CONT	Cost Contor Description	SEDVICES-SALAD					
CENERAL_SERVICE CONTINUES         21:00         22:00           00         000000000000000000000000000000000000	cost center bescription						
CENERAL SERVICE COST CENTERS         21.00         22.00           00         0000 CAP REL COST CENTERS         0							
BINAL STRATE         COST CINTIES           00         DOTOQ CAP REL COSTS -MORE EQUIPATION         1           10         DOSOD CAP RADIN ISTRATE VAID CENERAL         1           10         DOSOD CAP RADIN ISTRATE ON VER AND CENERAL         1           11         DOSOD CAPERATING MON ISTRATE ON         1           12         DOSOD CAPERATING MON ISTRATE ON         1           13         DOSOD CAPERATING MON ISTRATE ON         1           14         DOSOD CAPERATING MON ISTRATE ON         1           15         DOSOD CAPERATING MONE CARE AND ISTRATE ON         1           14         DOSOD CAPERATING MONE CARE AND ISTRATE ON         1           15         DOSOD CAPERATING MONE CARE AND ISTRATE ON         1           16         DOSOD CAPERATING MONE CARE AND ISTRATE ON         1           17         DOSOD CAPERATI				-			
100         0.000         CPU REL COSTS-WREE EDULY         1           100         0.000         CPU ROWER HERE IT SUB KARDING         1           100         0.000         CPU RE ADDIN STRATIVE AND GENERAL         1           100         0.000         CPU RE ADDIN STRATIVE AND GENERAL         1           100         0.000         CPU RE ADDIN STRATIVE AND GENERAL         1           100         0.000         CPU RE ADDIN STRATIVE AND GENERAL         1           100         0.000         CPU RE ADDIN STRATIVE AND GENERAL         1           100         0.000         CPU RE ADDIN STRATIVE AND GENERAL         1           11         100         CPU RE ADDIN STRATIVE AND GENERAL         1           11         100         CPU RE ADDIN STRATIVE AND GENERAL         1           11         100         CPU RE ADDIN STRATIVE AND GENERAL         1           11         100         CPU RE ADDIN STRATIVE AND GENERAL         1           11         CPU RE ADDIN STRATIVE AND GENERAL         1         1           11         CPU RE ADDIN STRATIVE AND GENERAL         1         1           11         CPU RE ADDIN STRATIVE ADDIN STRATIVE AND GENERAL         1         1           11         CPU RE ADDIN STRATIVE ADDIN STRAT	GENERAL SERVICE COST CENTERS	21.00					
0.000         SPACE DEPARTMENT         1           0.000         DOBES OF THE PROCESS NO.         1           0.000         SPACE OF THE PROCESS NO.         1           0.0000         SPACE OF THE PROCESS NO.         1           0.00000         SPACE OF THE PROCESS NO.         1           0.00000000000000000000000000000000000							1.0
01         00500 OTHER AUM INSTRATIVE AND GENERAL         0           02         00550 DTHER AUGUESS AND RECEIVIND         1           03         00590 PTHER AND RECEIVIND         1           04         00590 OTHER AUM INSTRATIVE AND GENERAL         1           05         00590 OTHER AUM INSTRATIVE AND GENERAL         1           00         0000 OTHER AUM INSTRATION         1           10         0100 OTHER AUM INSTRATION         1           11         0100 OTHER AUM INSTRATION         1           00         01000 OTHER AUM INSTRATION         1           11         01000 OTHER AUM INSTRATION         1           00							2.C 4.C
0.02         0.050         DATA         PROCESSIN NO.         1           0.03         00591         PROVENSINO AND RECEIVING         1           0.04         OLADA (CHRIAN IS OND RECEIVING         1           0.05         OLADA (CHRIAN IS STRUCES ADDREY         1           0.05         OLADA (CHRIAN IS STRUCE CADE IS CONSTS ADREY         1           0.05         OLADA (CHRIAN IS STRUCE CADE INT T         0         1           0.05         OLADA (CHRIAN IS STRUCE CADE INT T         0         0           0.05         OLADA (CHRIAN IS STRUCE CADE INT T         0<							5. C
0.0         0.0030         CASING CHINAL SCREPTURE ACCENTRAL         1           0.00300         0.00300         CASING CASING OF PLANT         1           0.00300         CASING							5. C
0.00         0.000         0.00000 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>5. C</td>							5. C
0.00         0000         DITER         ADM IN STRATT VE         ADM CENERAL         1           0.00         0000         ADMORY & LINEN SERVICE         4           0.00         COMON DUPERTY         A         1           0.00         COMON DUPERTY         A         A           0.00         COMON DUPERTY         A         B         B           0.00         COMON DUPERTY         A         B         B         B           0.00         COMON DUPERTY         A         B         B         B         B         B         B         B         B         B         B         B         B         B         B         B         B         B         B         B         <							5. C 5. C
0.00         00200         0FERATION OF PLANT         1           0.00         003000         LINDRY & LINPR SERVICE         6           0.00         00000         LINDRY & LINPR SERVICE         6           0.00         00000         LINDRY & LINPR SERVICE         6           0.00         00000         LINDRY & LINPR SERVICES         6           0.00         00000         LINDRY & LINPR SERVICES         1           0.00         00000         LINDRY & LINPR SERVICES         1           0.00         01000         HERRITERY REVICES         8         8           0.00         01000         HERRITERY REVICES         8         8         8000         22           0.00         01000         HERRITERY REVICES         1         300							5.0
0.00         0.0000         NUSSEKEEPI NG         0           0.00         0.0000         NUSSEKEEPI NG         11           0.00         0.0000         NUSSEKEEPI NG         11         0           0.00         0.0000         NULTS & PEDI ATRICS         1.3000         1.300         33           0.00         NUSSEKEEPI NG         1.3000         1.300         33         33           0.00         NUSSEKEEPI NG         1.900         0         44           0.00         NUSSEKEEPI NG         1.900         44         44           0.00         0.00         0         0         0         0         44           0.00         NUSSUN ARANI INFRATORIN         1.900         0 </td <td>00 00700 OPERATION OF PLANT</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>7.0</td>	00 00700 OPERATION OF PLANT						7.0
0.00         0.000         DETARY         1           0.00         0.000         DETARY         1           0.00         0.000         DETARY         1           0.00         DETARY         1         1           0.00         DETARY         SERVICES & SUPPLY         1           0.00         DETARY         SERVICES - SERVICES         1           0.00         DETARY         SERVICES - SERVICES         1           0.00         DETARY         SERVICES - SERVICES         1           0.00         DETARY         SERVICES - SERVICES - SERVICE         2           0.00         DETARY         SERVICES - SERVICES - SERVICE         2           0.00         DETARY         DETARY         BEDA         3           1.00         DETARY         DETARY         D         0           1.00         DETARY         D         D         0         3           1.00         DETARY         D         D         0         3           1.00         DETARY         D         D         D         0           1.00         DETARY         D         D         D         D           1.00         DETARY							8.0
1.00         01100         CAFETERIA         1           0.00         01300         MUSSIN ADMINI STRATION         1           3.01         01850         PASTORAL CARE         1           3.00         01800         PASTORAL CARE         1           3.00         01800         PASTORAL CARE         1           3.00         01800         PASTORAL CARE         1           3.00         01600         PARAMACY         1           3.00         01600         PARAMACY         8         8000           3.00         01600         PASTORAL CARE         SUPPORTAL         5           3.00         01600         PASTORAL CARE         SUPPORTAL         5           3.00         01600         PARAMACY         8         8.000         3           3.01         0200         PASTORAL CARE UNIT         0         0         3         3           3.00         04000         PARAMACY         0         0         0         4           4.00         04000         PARAMACY         0         0         0         4           4.00         04000         PARAMACY         0         0         0         5							9. C 10. C
3.01       0.11800       PASTORAL_CARE       11         3.00       0.01400       CRINELA_SERVICES - SLIPPAY       11         5.00       0.1500       PIARMACY       12         5.00       0.1500       PIARMACY       8,800       22         0.00       0.0200       IAR SERVICES-SLARY & FIN NES APPRV       8,800       22         0.00       0.000       0.0100       IAR SERVICES-OST CENTERS       2         0.00       0.000       0.0000       0.000       33         1.00       0.0100       NITENSIVE CARE UNIT       0       0       33         1.00       0.0000       0.0000       0       44         0.00       0.0000       0.0000       0       44         0.00       0.0000       0       0       44         0.00       0.0000       0       0       55         0.00       0.0000       0       0       55         0.00       0.0000       0       0       55         0.00       0.00000       0       0       55         0.00       0.0000000000000000000       0       0       55         0.00       0.000000000000000000000       0							11.0
4 -00 01400 CENTRAL SERVICES & SUPPLY 5 -00 01500 PHEARACY 6 -00 01500 PHEARACY 10 02100 18 SERVICES-ALLERARY & EN NOES APPRY 8 , 800 12 20 0220 18 SERVICES-ALARY & EN NOES APPRY 8 , 800 12 20 0220 18 SERVICES-ALARY & EN NOES APPRY 10 03100 NURS SERVICES - SUPPLY 10 03100 NURS ENVICE OST CENTERS 10 03100 NURS INVICE OST CENTERS 10 03100 NURS INVICE OST CENTERS 10 04000 NURSERY 10 04000 NURSERY 10 04000 NURSERY 10 05000 CREATING ROMO 10 05100 CREATING ROMO 10 00 0500 C							13. C
5.00         1500         PHARMACY         1           1.00         01500         PHARMACY         1           1.00         02100         IAR SERVICS-SALARY & FRINCES APPRV         8,800         2           0.00         03000         PMATTERT REVICES-COST CENTERS         -         -           0.00         03000         PMATTERT REVICES-COST CENTERS         -         -           0.00         03000         PMATTERT REVICE CASE UNIT         0         0         3           1.00         03000         PMATTENSIVE CARE UNIT         0         0         3         3           1.00         03000         PMATTENSIVE CARE UNIT         0         0         3         3           1.00         03000         PMATTENSIVE CARE UNIT         0         0         4         4           1.00         03000         PMATTENSIVE CARE UNIT         0         0         6         4           1.00         05000         PERATENSIVE CARE UNIT         0         0         6         5           1.00         05100         RECOVERY ROM         1,950         1,950         5         5           1.00         05100         RECOVERY ROM         0         0							13.0
0.00         01co0 MEDICAL RECORDS & LIBRARY         8.00         72           0.00         02co0 LAS SERVICES-ALMEY & FININES APPRV         8.000         72           0.00         03000 ADULTS & PERVICE COST CHER FROM COSTS APPRV         8.000         72           0.00         03000 ADULTS & PERVICE COST CHER FROM COSTS APPRV         8.000         73           0.00         03000 ADULTS & PEDIATRICS         1.300         1.300         33           1.01         02co6 NEONTAL INTENSIVE CARE UNIT         0         0         0         33           0.00         03000 ADURS AVER CARE UNIT         0         0         33         33           0.00         04000 SUBPROVIDER - IPF         0         0         44           0.00         03000 ADURSENY         0         0         44           0.01         03000 CHERATING ROOM         1,950         1,950         55           0.00         03000 CHERATING ROOM         0         0         55         55           0.00         03000 AND SOCOPY         0         0         55         55           0.00         03000 AND SOCOPY ROOM         0         0         55         55           0.00         05000 KNOI ADUR ADOU A DOU ADUD ADUD ADUD ADUD ADUD ADU							14. 0 15. 0
2.00         D2200[14R STERVICES-OTHER PROW COSTS APPRV         8,800         22           1MWAT IFM TRUTINE SERVICE COST CENTERS							16.0
INPATI ENT ROUTINE SERVICE COST CENTERS           1.00         003000 AURITS & PEDIATRICS         1.300         3           1.00         20100 INTENSIVE CARE UNIT         0         0         3           1.00         20300 BURNI INTENSIVE CARE UNIT         0         0         3           3.00         3300 BURNI INTENSIVE CARE UNIT         0         0         3           3.00         3300 BURNI INTENSIVE CARE UNIT         0         0         4           4.00         04300 NURSERY         0         0         4           4.00         04400 SULED         0         0         4           4.00         04400 SULED         0         0         4           6.00         05000 DEVRATI NE ROOM         1, 950         1, 950         1           0.01         0330 ERADISCOPY         0         0         0         0           2.00         05200 DELIVERY ROOM & LABOR ROOM         0         0         5         5           3.00         05000 ARDI CLOCY-DI ACNOSTI C         0         0         0         5           3.00         05000 KRI         0         0         0         5         5           3.00         05000 KRI         CADIVER SEVENDIDI							21. (
0.00 3000 ADULTS & PEDIATRICS 1.300 1.300 33 1.01 02060 NEONATAL INTENSIVE CARE UNIT 0 0 0 3.00 03000 BURN INTENSIVE CARE UNIT 0 0 0 3.00 03000 BURN INTENSIVE CARE UNIT 0 0 0 4.00 04400 SUBPROVIDER - 1PF 0 0 4.00 04400 SUBPROVIDER - 1PF 0 0 4.00 04400 SULLED NURSING FACILITY 0 0 0 4.00 04400 SULLED NURSING FACILITY 0 0 0 4.00 04500 DEFRATING ROAM 1.950 1.950 0.00 0 5.00 05000 DEFRATING ROAM 0 0 0 5.00 05000 DEFRATING ROAM 0 0 0 5.00 05000 ADUSCENT ROAM 0 0 0.00 05000 ADUSCENT ADUSCENT 0 0 0.00 05000 ADUSCENT 0 0 0.00 05		/	8, 800	0			22. (
1.00         03100         INTENSIVE CARE UNIT         0         0         33           1.00         02000         NOMATAL INTENSIVE CARE UNIT         0         0         33           3.00         03200         BURN INTENSIVE CARE UNIT         0         0         34           3.00         03200         BURN INTENSIVE CARE UNIT         0         0         34           3.00         03200         BURN INTENSIVE CARE UNIT         0         0         34           3.00         03200         BURN INTENSIVE CARE UNIT         0         0         34           3.00         03200         BURN INTENSIVE CARE UNIT         0         0         34           4.00         04400         Stoto         0         0         34           4.00         04400         NURSERY         0         0         44           4.00         PARTINE ROOM         1.950         1.950         1.950           0.01         03300         BURN INTENSIVE CARE UNIT         0         0         0           0.01         03300         BURN INSTREMENDICORY         0         0         0         0           0.01         05300         RADINISOTFAL         CANTENSINE FACILINENSINE FACI		1, 300	1.300				30. 0
3.00         0.300         DURN INTENSIVE CARE UNIT         0         0         330           3.00         0.00         0.00         0         43           3.00         0.4300         NURSERY         0         0         44           4.00         0.4400         NURSERY         0         0         44           4.00         0.4400         NURSERY         0         0         44           0.00         0.00         0.00         0         44           0.00         0.000000         1.950         1.950         44           0.00         0.0000000         0         0         55           0.01         0.3300         ENDOSCOPY         0         0         55           0.00         0.5300         ILTA SOUND         0         0         55           1.00         0.5400         IADI DLOCY - DI AGNOSTI C         0         0         55           1.00         0.5400         IADI DLOCY - DI AGNOSTI C         0         0         55           1.00         0.5500         IADI DLOCY - DI AGNOSTI C         0         0         55           1.00         0.5000         IADI DLOCY - DI AGNOSTI C         0 <td< td=""><td></td><td></td><td></td><td>1</td><td></td><td></td><td>31. (</td></td<>				1			31. (
0.00         04000         SUBPROVIDER - 1 IPF         0         0         440           0.00         44000         SKI LLED NURSING FACILITY         0         0         44           0.01         04300         SKI LLED NURSING FACILITY         0         0         44           0.01         05300         OPERATING FROM         1,950         5         5           0.00         05000         OPERATING FROM         0         0         5           0.00         05000         DELIVERY ROM         0         0         5           0.00         05000         DELIVERY ROM & LABOR ROOM         0         0         5           0.00         05000         DELIVERY ROM & LABOR ROOM         0         0         5           0.00         05400         RADIOLOGY-DI AGNOSTIC         0         0         5           0.00         05400         RADIOLOGY-DI AGNOSTIC         0         0         5           0.00         05400         RADIOLOGY-DI AGNOSTIC         0         0         0         5           0.00         05400         RADIOLOGY-DI AGNOSTIC         0         0         0         5           0.00         05400         RADIOLOGY-DI AGNOSTOP		0					31. (
3.00         04300         NURSERY         0         0         44           NOCILLARY SERVICE COST CENTERS         44         44         46         46           NOCILLARY SERVICE COST CENTERS         0         0         65         55           0.00         05000 (PERATIN (R COM)         1,950         1,950         55           1.00         05100 RECOVERY ROM         0         0         55           3.00         04300 (PERATIN (R COM)         0         0         55           3.00         05300 ARESTHESI 0LOCY         0         0         55           3.00         05300 MRI         0         0         0         55           3.00         05300 MRI         0         0         0         55           3.00         05300 MRI		0	-				33. 0 40. 0
4.00         04400         SKILLED NURSING FACILITY         0         0         4400           ANCILLARY SERVICE COST CENTERS							40.0
0.00         05000         0PERATI NG ROOM         1,950         1,950         55           0.00         03300         NMSSTAFEN         0         0         55           0.00         05100         RECOVERY ROOM         0         0         0         55           2.00         05200         DELIVERY ROM & LABOR ROOM         0         0         0         55           2.00         05400         RASTHESI LOGY         0         0         0         55           4.00         05400         RADILOGY-DI AGNOSTI C         0         0         0         55           4.00         05600         RADI ISOTOPE         0         0         0         55           5.00         05600         CARDI AC CATHETERI ZATI ON         0         0         0         55           0.00         05600         CARDI AC CATHETERI ZATI ON         0         0         0         66           0.00         06500         CARDI AC CATHETERI ZATI ON         0         0         0         66           0.00         06500         READI AL THERAPY         0         0         66         66         66         66         66         66         66         66		0					44.0
0.01         03300         ENDOSCOPY         0         0         55           1.00         05100         DECLVERY ROOM         0         0         55           2.00         05200         DELIVERY ROOM         0         0         55           3.00         05300         ANESTHESI OLGGY         0         0         0         55           3.00         05300         ANESTHESI OLGGY         0         0         0         55           4.01         33330         ULTRA SOUND         0         0         0         56           6.00         05600         RADIOLOCY-DIAGNOSTIC         0         0         0         56           7.00         05700         CT SCAN         0         0         0         55           0.00         05000         CARDIAC CATHETERI ZATI ON         0         0         0         66           0.00         05000         CARDIAC CATHETERI ZATI ON         0         0         66         66         0         66000         66         66         66         66         66         66         66         66         66         66         66         66         66         66         66         66		1.050	4.050				50.0
1.00         05100         RECOVERY ROOM         5           2.00         05200         DELIVERY ROOM & LABOR ROOM         0         5           3.00         05300         ANESTHESI OLOGY         0         0         55           3.00         05300         ANESTHESI OLOGY         0         0         55           3.00         05400         RADI OLOGY-DI AGNOSTI C         0         0         55           4.00         05600         RADI OLOGY-DI AGNOSTI C         0         0         56           4.00         05600         RADI OLOGY-DI AGNOSTI C         0         0         56           6.00         05600         RADI OLOGY-DI AGNOSTI C         0         0         56           7.00         05700         CARDI AC CATHETERI ZATI ON         0         0         56           7.00         05700         CARDI AC CATHETERI ZATI ON         0         0         66           7.00         06700         LABORATORY         0         0         66         66           7.00         06700         CLAPATI THERAPY         0         0         66         66         66         66         66         66         66         66         66         66<				1			50. 0 50. 0
3.00         05300         ANESTHESI OLOGY         0         0         54           4.00         05400         RADI OLOGY-DI AGNOSTI C         0         0         54           4.01         03630         ULTRA SOUND         0         0         55           6.00         05600         RADI OLOGY-DI AGNOSTI C         0         0         55           6.00         05600         RADI OLOGY-DI AGNOSTI C         0         0         55           7.00         05700         CARDI AC. CATHETERI ZATI ON         0         0         55           7.00         05700         CARDI AC. CATHETERI ZATI ON         0         0         0         56           0.00         06000         CARDI AC. CATHETERI ZATI ON         0         0         0         66           0.00         06200         WHOLE BLOOD & PACKED RED BLODD CELL         0         0         0         0         66           0.00         06200         RESPIRATORY THERAPY         0         0         0         66         66         60         66         66         60         66         66         66         66         66         66         66         66         66         66         66         <		0					51.0
4 00 05400 RADIOLGGY-DIAGNOSTIC 000000000000000000000000000000000000		0					52.0
4.01       03630       ULTRA SOUND       0       0       56         6.00       03630       ULTRA SOUND       0       0       56         6.00       05600       RADI 01 SOTOPE       0       0       56         7.00       05700       CT SCAN       0       0       57         8.00       05800       MRI       0       0       0       55         9.00       05900       CARDI AC CATHETERI ZATI 0N       0       0       0       66         0.00       06000       LABORATORY       0       0       0       66       66       67       67       66       67       <		0	-				53.0
6.00         05600         RADIOLISOTOPE         0         0         57           7.00         05700         CT SCAN         0         0         57           8.00         05800         MRI         0         0         57           8.00         05800         MRI         0         0         57           8.00         05800         KRI         0         0         57           8.00         05800         CARDIAC CATHETERIZATION         0         0         56           0.00         06200         LABORATORY         0         0         66           0.00         06200         HUSICAL THERAPY         0         0         66           0.00         06000         SPECEH PATHOLOGY         0         0         66           0.00         06000         SPECEH PATHOLOGY         0         0         67           0.00         06000 SPECEH PATHOLOGY         0         0         67         77           0.00         06000 SPECEH PATHOLOGY         0         0         0         77           0.00         04000 CALSUPPLIES CHARGED TO PATIENTS         0         0         77           0.01000 UMEL DEV. CHARGED TO PATIENTS		0					54. ( 54. (
8.00 05800 MRI 0 0 5500 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 00 05600 RADI OI SOTOPE	0	C				56. (
9.00 6590 CARDIAC CATHETRI ZATION 0 0 0 6500 CARDIAC CATHETRI ZATION 670 6500 CARDIAC CATHETRI ZATION 670 6500 CARDIAC CATHETRI ZATION 670 700 00 0 6500 CARDATORY 0 0 0 6500 CARDIAC CATHETRI ZATION 711 CARDIAL CARD		0	C				57.0
0.00         06000         LABORATORY         0         0         6600         6600         MKDLE         BLOOD & PACKED RED BLOOD CELL         0         0         6600         6600         RESPI RATORY THERAPY         0         0         0         6600         6600         RESPI RATORY THERAPY         0         0         0         6600         0         6600         0         6600         0         6600         0         6600         0         6600         0         0         0         0         6600         6600         0         6600         0         6600         0         6600         0         0         0         0         0         6600         0         6600         0         0         0         0         0         6600         0         0         0         0         0         0         6600         0		0					58. ( 59. (
5.00         06500         RESPI RATORY THERAPY         0         0         65           6.00         06600         PHYSI CAL THERAPY         0         0         66           7.00         06700         OCCUPATI ONAL THERAPY         0         0         66           8.00         06800         SPEECH PATHOLOGY         0         0         66           9.00         06900         ELECTROCARDI OLOGY         0         0         66           1.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENT         0         0         0           2.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0         0         72           3.00         07300         RUGS CHARGED TO PATI ENTS         0         0         72           4.00         07400         RHAR INTI C/PSYCHOLOGI CAL SERVI CE COST CENTER         0         0         76           6.01         03950         OTHER ANCI LLARY SERVI CE COST CENTER         0         0         76           6.02         03550         PSYCH ANTI C/PSYCHOLOGI CAL SERVI CES         0         0         76           6.03         03952         WOUND CARE         100         100         76           0         0 <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>60. (</td>		0	0				60. (
6.00         06600         PHYSI CAL THERAPY         0         0         660           0.0700         0CCUPATI ONAL THERAPY         0         0         660           0.00         06000         SPEECH PATHOLOGY         0         0         660           0.00         06000         SPEECH PATHOLOGY         0         0         660           0.00         0000         SPEECH PATHOLOGY         0         0         660           0.00         0000         SPEECH PATHOLOGY         0         0         660           0.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0         0         77           0.00         07300         DRUGS CHARGED TO PATI ENTS         0         0         77           0.00         07300         DRUGS CHARGED TO PATI ENTS         0         0         77           0.00         7300         DRUGS CHARGED TO PATI ENTS         0         0         77           0.00         7300         DRUG REANCI LLARY SERVICE COST CENTER         0         0         77           0.01         3951         SLEEP LAB         0         0         0         76           0.02         33550         PSYCHI ATRI C/PSYCHOLOGI CAL SERVIC		0	0				62. (
7.00       06700       OCCUPATIONAL THERAPY       0       0       65         8.00       06800       SPEECH PATHOLOGY       0       0       66         9.00       06900       ELECTROCARDIOLOGY       0       0       67         1.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       77         2.00       O7200       IMPL. DEV. CHARGED TO PATIENTS       0       0       77         3.00       O7300       RUGS CHARGED TO PATIENTS       0       0       77         4.00       O7400       RENAL DI ALYSI S       0       0       77         6.01       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       76         6.01       03951       SLEEP LAB       0       0       76         6.02       03550       PSYCHI ATRIC/PSYCHOLOGI CAL SERVICES       0       0       76         0.00       09000       CLI NI C       4,900       4,900       77       76         0.00       09000       GI NI C       SUBTOTALS (SUM OF LINES 1-117)       8,250       8,250       76         0.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       97 <td< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td>65.0</td></td<>		0	0				65.0
8.00       06800       SPEECH PATHOLOGY       0       0       660         9.00       06900       ELECTROCARDIOLOGY       0       0       66         1.00       O7100       MEDI CAL SUPPLIES CHARGED T0 PATIENT       0       0       77         2.00       07200       IMPL. DEV. CHARGED T0 PATIENTS       0       0       77         3.00       07400       RENAL DIALYSIS       0       0       77         4.00       07400       RENAL DIALYSIS       0       0       77         6.01       03950       OTHER ANCILLARY SERVICE COST CENTER       0       0       77         6.01       03951       SLEEP LAB       0       0       77         6.02       03952       WOUND CARE       100       100       76         6.02       03952       WOUND CARE       0       0       76         0.00       09000       CLINIC       4,900       4,900       76         0.00       09000       CLINIC       4,900       4,900       97         0.00       09000       CLINIC       4,900       4,900       97         0.00       09000       GLINIC       8,250       8,250       97		0					66. ( 67. (
1.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0         2.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0         3.00       07300       DRUGS CHARGED TO PATIENTS       0       0         3.00       07400       RENAL DI ALYSIS       0       0         4.00       07400       RENAL DI ALYSIS       0       0         6.01       03950       OTHER ANCILLARY SERVICE COST CENTER       0       0         6.01       03951       SLEEP LAB       0       0       76         6.02       03550       PSYCHIATRIC/PSYCHOLOGI CAL SERVICES       0       0       76         6.03       03952       WOUND CARE       100       100       76         0.00       09000       CLINIC       4,900       4,900       97         1.00       09100       EMERGENCY       0       0       97         2.00       09200       OBERVATION BEDS (NON-DI STINCT PART       92       92       92       92       92       92       92       92       92       93       92       93       93       93       93       93       93       93       93       93       93       93		0	0				68.0
2.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0         3.00       07300       DRUGS CHARGED TO PATIENTS       0       0         4.00       07400       RENAL DI ALYSI S       0       0         6.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0         6.01       03951       SLEEP LAB       0       0         6.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       0         6.03       03952       WOUND CARE       100       100       76         7.00       09000       CLI NI C       4,900       4,900       76         0.00       09000       CLI NI C       4,900       4,900       76         1.00       09100       EMERGENCY       0       0       97         2.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       92       92       92       92       92       92       92       92       93       92       94       90       94       90       92       92       93       92       94       92       94       92       93       93       94       94       94       94       94       94		0	C				69. (
3.00       07300       DRUGS CHARGED TO PATIENTS       0       0       73         4.00       07400       RENAL DI ALYSI S       0       0       74         6.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       76         6.01       03951       SLEEP LAB       0       0       76         6.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       0       76         6.03       03952       WOUND CARE       100       100       76         0.00       09000       CLI NI C       4,900       4,900       76         0.00       09000       BERERGENCY       0       0       76         0.00       09000       BERERGENCY       0       0       92         2.00       09200       BERERGENCY       0       0       118         90.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       8,250       8,250       1		0	0				71.0
4.00       07400       RENAL DI ALYSI S       0       0       74         6.00       03950       OTHER ANCI LLARY SERVI CE COST CENTER       0       0       76         6.01       03951       SLEEP LAB       0       0       76         6.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       76         6.03       03952       WOUND CARE       100       100       76         0.00       09000       CLI NI C       4,900       4,900       76         0.00       09000       BERGENCY       0       0       90         0.00       09000       GIFT, FLOWER, CONTRES       118       90       91       91       91       91       91       92       92       92       92       92       92       92       92       92       92       92       92       92 <t< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td>72. ( 73. (</td></t<>		0					72. ( 73. (
6. 01         03951         SLEEP LAB         0         0         76           6. 02         03550         PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES         0         0         76           0. 03952         WOUND CARE         100         100         100         76           0. 03952         WOUND CARE         100         100         76           0. 03952         WOUND CARE         100         100         76           0. 03952         WOUND CARE         100         100         76           0. 00         OPGOC         CLI NIC         4, 900         4, 900         76           0. 00         OPGOC         CLI NIC         4, 900         4, 900         90         90           1. 00         OPGOC         CLI NIC         4, 900         0         90         90         90           2. 00         OPSERVATI ON BEDS (NON-DI STI NCT PART         90         0         90 <td>I. 00 07400 RENAL DIALYSIS</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>74.(</td>	I. 00 07400 RENAL DIALYSIS	0	0				74.(
6.02         03550         PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES         0         0         76           0.03952         WOUND CARE         100         100         100         76           0.03952         WOUND CARE         100         100         76           0.04         09000         CLINIC         4,900         4,900         90           0.00         09100         EMERGENCY         0         0         91           2.00         09200         DSERVATI ON BEDS (NON-DI STI NCT PART         92         92         920         952         92		8 0	C				76.
6.03         03952         WOUND CARE         100         100         100         76           OUTPATIENT SERVICE COST CENTERS         0         4,900         4,900         97		0	-				76. ( 76. (
OUTPATI ENT SERVICE COST CENTERS         4,900         4,900         4,900         900           0.00         09000         CLINIC         4,900         4,900         9000         9000 </td <td></td> <td>100</td> <td></td> <td>1</td> <td></td> <td></td> <td>76.0</td>		100		1			76.0
1.00         09100         EMERGENCY         0         0         9100         SPECIAL PURPOSE COST CENTERS         9200           18.00         SUBTOTALS (SUM OF LINES 1-117)         8,250         8,250         1180         1180           NONREI MBURSABLE COST CENTERS         500         0         0         1900         19100         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         1900         19100         RESEARCH         0         0         1900         1900         19100         RESEARCH         0         1900         19200         PHYSI CI ANS' PRI VATE OFFICES         550         550         1920         19200         PHYSI CI ANS' PRI VATE OFFICES         550         550         1920         19200         19201         19203	OUTPATIENT SERVICE COST CENTERS						
2. 00         09200         OBSERVATION BEDS (NON-DISTINCT PART         92           SPECIAL PURPOSE COST CENTERS         5         5         118         118           NONREI MBURSABLE COST CENTERS         5         8, 250         118         118           NONREI MBURSABLE COST CENTERS         5         0         0         118         119         119         119         119         119         119         119         119         119         119         119         119         119         119         119         119         119         119		4, 900		1			90. (
SPECIAL PURPOSE COST CENTERS           18.00         SUBTOTALS (SUM OF LINES 1-117)         8,250         8,250         118           NONREI MBURSABLE COST CENTERS         0         0         118           90.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         1900           91.00         19100         RESEARCH         0         0         1910           92.00         PHYSI CI ANS' PRI VATE OFFICES         550         550         1920           94.00         07950         0THER NONREI MBURSABLE COST CENTERS         0         0         1940           94.01         07951         MARKETI NG         0         0         1940		- 0	C				91. ( 92. (
18.00         SUBTOTALS (SUM OF LINES 1-117)         8,250         8,250         116           NONREI MBURSABLE COST CENTERS         90.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         1900         19100         RESEARCH         0         0         197         192         0         19200         PHYSI CI ANS' PRI VATE OFFICES         550         550         192         192         192         0         0         192         192         0         192         0         192         0         192         19							7∠.(
90.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         1900           91.00         19100         RESEARCH         0         0         1917           92.00         19200         PHYSI CLANS'         PRI VATE OFFICES         550         550         192           94.00         07950         OTHER NONREI MBURSABLE COST CENTERS         0         0         194           94.01         07951         MARKETI NG         0         0         194		8, 250	8, 250			1	118. (
91.00       19100       RESEARCH       0       0       19100         92.00       19200       PHYSI CLANS' PRI VATE OFFICES       550       550       19200         94.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       19400         94.01       07951       MARKETI NG       0       0       19400	NONREI MBURSABLE COST CENTERS			1			
92.00         19200         PHYSI CLANS'         PRI VATE         OFFICES         550         550         192           94.00         07950         OTHER         NONREI MBURSABLE         COST         CENTERS         0         0         194           94.01         07951         MARKETI NG         0         0         194		0		1			190.0
94. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194 94. 01 07951 MARKETI NG 0 0 194		550					191. C 192. C
				1			194. 0
94.02 07952 SENI OR CI RCLE 0 0 0 194		0	-	1			194. 0 194. 0

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150047	Peri od:	Worksheet B-1
				From 06/01/2015 To 05/31/2016	Date/Time Prepared:
				10 05/31/2010	10/31/2016 8:18 am
	INTERNS &	RESI DENTS			
Cost Center Description	SERVI CES-SALAR				
	Y & FRINGES	PRGM COSTS			
	APPRV	APPRV			
	(ROTATI ONS)	(ROTATI ONS)			
	21.00	22.00	]		
194. 03 07953 SELECT SPECIALTY	0	0	)		194.03
194.04 07954 FREE MEALS	0	0			194.04
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B,	0	2, 546, 424			202.00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	289. 366364			203.00
204.00 Cost to be allocated (per Wkst. B,	0	6, 826	,		204.00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 775682	1		205.00
11)					

COMPUTATI ON	ncial Systems N OF RATIO OF COSTS TO CHARGES	ST JOSEPH MED		CCN: 150047	Peri od:	Worksheet C	2552-1
					From 06/01/2015 To 05/31/2016	Part I Date/Time Pre	narod
					10 05/51/2010	10/31/2016 8:	18 am
			Titl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col. 26)					
		1.00	2.00	3.00	4.00	5.00	-
I NPA	TIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	5.00	4.00	3.00	
	0 ADULTS & PEDI ATRI CS	15, 683, 831		15, 683, 83	1 0	15, 683, 831	30. 00
	O I NTENSI VE CARE UNI T	1, 554, 017		1, 554, 01		1, 554, 017	
31.01 0206	O NEONATAL INTENSIVE CARE UNIT	1, 526, 632		1, 526, 63	2 0	1, 526, 632	31.0
33. 00 0330	O BURN INTENSIVE CARE UNIT	2, 560, 477		2, 560, 47	7 0	2, 560, 477	33.0
	O SUBPROVIDER – I PF	3, 715, 047		3, 715, 04		3, 715, 047	
	0 NURSERY	437, 577		437, 57		437, 577	
	0 SKILLED NURSING FACILITY	2, 716, 968		2, 716, 96	8 0	2, 716, 968	44.0
	LLARY SERVICE COST CENTERS	1 501 001	1				1 - 0 - 0
	O OPERATING ROOM O ENDOSCOPY	4, 591, 821		4, 591, 82		4, 591, 821	
	O RECOVERY ROOM	971, 366 1, 296, 853		971, 36 1, 296, 85		971, 366 1, 296, 853	
	O DELIVERY ROOM & LABOR ROOM	1, 290, 853		1, 290, 83		1, 290, 853	
	0 ANESTHESI OLOGY	94, 381		94, 38		94, 381	
	0 RADI OLOGY-DI AGNOSTI C	6, 502, 545		6, 502, 54		6, 502, 545	
	O ULTRA SOUND	0			0 0	0,000,000	
56.00 0560	0 RADI OI SOTOPE	0			0 0	0	56.0
57.00 0570	O CT SCAN	0			0 0	0	57.0
8.00 0580		0			0 0	0	
	O CARDI AC CATHETERI ZATI ON	2, 443, 013		2, 443, 01		2, 443, 013	
	0 LABORATORY	6, 638, 603		6, 638, 60		6, 638, 603	
	O WHOLE BLOOD & PACKED RED BLOOD CELL	727, 877		727, 87		727, 877	
	O RESPIRATORY THERAPY	1,803,760				1, 803, 760	
	O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY	1, 459, 907		.,		1, 459, 907	
	O SPEECH PATHOLOGY	740, 655 204, 595		740, 65 204, 59		740, 655 204, 595	
	0 ELECTROCARDI OLOGY	289, 297		204, 59		204, 393 289, 297	
	O MEDICAL SUPPLIES CHARGED TO PATIENT	5, 741, 894		5, 741, 89		5, 741, 894	
	O I MPL. DEV. CHARGED TO PATIENTS	3, 082, 245		3, 082, 24		3, 082, 245	
	O DRUGS CHARGED TO PATIENTS	8,073,596		8, 073, 59		8, 073, 596	
	O RENAL DI ALYSI S	596, 727		596, 72		596, 727	
6.00 0395	O OTHER ANCILLARY SERVICE COST CENTER	0			0 0	0	
6.01 0395	1 SLEEP LAB	0			0 0	0	76.0
	0 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	862, 308		862, 30		862, 308	
	2 WOUND CARE	2, 029, 681		2, 029, 68	1 0	2, 029, 681	76.0
	ATLENT SERVICE COST CENTERS	400.001	1	400.00		100.001	
		433, 934		433, 93		433, 934	
	O EMERGENCY	5, 706, 159		5, 706, 15		5, 706, 159	
200.00	O OBSERVATION BEDS (NON-DISTINCT PART Subtotal (see instructions)	2, 129, 492 85, 804, 455		2, 129, 49 85, 804, 45		2, 129, 492 85, 804, 455	
200.00	Less Observation Beds	2, 129, 492		2, 129, 49		2, 129, 492	
		2, 127, 472	4		<u>-</u>	Z, IZ /, 47Z	

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016	Worksheet C Part I Date/Time Pre	pared
				10 00/01/2010	10/31/2016 8:	
			e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	lotal (col.   + col. 7)	6 Cost or Other Ratio	TEFRA	
			+ COL 7)	Ratio	Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	<u> </u>
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
0. 00 03000 ADULTS & PEDIATRICS	45, 668, 725		45, 668, 72	25		1 30. o
1. 00 03100 I NTENSI VE CARE UNI T	1, 828, 258		1, 828, 25			31.0
1. 01 02060 NEONATAL INTENSIVE CARE UNIT	3, 140, 697		3, 140, 69			31.0
3. 00 03300 BURN INTENSIVE CARE UNIT	9, 687, 756		9, 687, 75			33.0
0. 00 04000 SUBPROVIDER - IPF	18, 554, 919		18, 554, 91			40.0
3. 00 04300 NURSERY	846, 396		846, 39			43.0
4.00 04400 SKILLED NURSING FACILITY	3, 551, 360		3, 551, 36	50		44.0
ANCILLARY SERVICE COST CENTERS						1
0. 00 05000 OPERATING ROOM	20, 269, 347	23, 201, 795	43, 471, 14	0. 105629	0.000000	50.0
0. 01 03330 ENDOSCOPY	1, 130, 749	4, 421, 142	5, 551, 89	0. 174961	0.000000	50.0
1.00 05100 RECOVERY ROOM	2, 090, 352	4, 233, 542	6, 323, 89	0. 205072	0.000000	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	1, 473, 951	20, 000	1, 493, 95		0.000000	
3. 00 05300 ANESTHESI OLOGY	3, 068, 911	2, 987, 902			0.000000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	21, 379, 101	60, 306, 516			0.000000	
4.01 03630 ULTRA SOUND	0	0		0 0.000000	0.000000	
6. 00 05600 RADI OI SOTOPE	0	0		0 0.000000	0.00000	
7.00 05700 CT SCAN	0	0		0 0.000000	0.00000	
8.00 05800 MRI	0	0		0 0.00000	0.00000	
9.00 05900 CARDI AC CATHETERI ZATI ON	8, 645, 084	14, 559, 164			0.00000	
	32, 225, 133	32, 739, 659			0.00000	
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CEL 5. 00 06500 RESPIRATORY THERAPY		448, 932			0. 000000	
6. 00 06600 PHYSI CAL THERAPY	15, 885, 751	1, 931, 385			0. 000000 0. 000000	
7. 00 06700 OCCUPATIONAL THERAPY	2, 430, 415 3, 159, 176	3, 189, 770 492, 508			0. 000000	
8. 00 06800 SPEECH PATHOLOGY	556, 293	298, 468			0. 000000	
9. 00 06900 ELECTROCARDI OLOGY	1, 621, 307	2,068,110			0. 000000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN		15, 756, 329			0. 000000	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	11, 542, 635	15, 940, 167			0. 000000	
3. 00 07300 DRUGS CHARGED TO PATIENTS	59, 858, 136	16, 671, 606			0. 000000	
4.00 07400 RENAL DIALYSIS	2, 087, 542	105, 456			0. 000000	
6.00 03950 OTHER ANCILLARY SERVICE COST CENTE		00,100		0 0.000000	0. 000000	
6.01 03951 SLEEP LAB	0	0		0 0.000000	0. 000000	
6. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	5 1, 596, 340	1, 936, 963	3, 533, 30		0. 000000	
6. 03 03952 WOUND CARE	1, 851, 371	6, 373, 323			0.000000	
OUTPATIENT SERVICE COST CENTERS						1
0. 00 09000 CLINIC	7, 200	115, 045	122, 24	3. 549708	0. 000000	90. (
1.00 09100 EMERGENCY	9, 381, 919	39, 569, 692	48, 951, 61	0. 116567	0.000000	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PAP	RT 1, 048, 149	3, 639, 729	4, 687, 87	0. 454255	0.000000	92.1
00.00 Subtotal (see instructions)	299, 200, 027	251, 007, 203	550, 207, 23	30		200.
01.00 Less Observation Beds						201. (
02.00 Total (see instructions)	299, 200, 027	251, 007, 203	550, 207, 23	30		202.0

	Financial Systems	ST JOSEPH MEDICAL			u of Form CMS-	2552-1
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150047	Period: From 06/01/2015 To 05/31/2016	Worksheet C Part I Date/Time Pre 10/31/2016 8:	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30. 00
31.00	03100 I NTENSI VE CARE UNI T					31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT					31.0
33.00	03300 BURN INTENSIVE CARE UNIT					33.00
40.00	04000 SUBPROVIDER - IPF					40.00
43.00	04300 NURSERY					43.00
44.00	04400 SKILLED NURSING FACILITY					44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 105629				50.00
50.01	03330 ENDOSCOPY	0. 174961				50.0 <sup>°</sup>
51.00	05100 RECOVERY ROOM	0. 205072				51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 796008				52.0
	05300 ANESTHESI OLOGY	0. 015583				53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 079605				54.0
54.01	03630 ULTRA SOUND	0. 000000				54.0
56.00	05600 RADI OI SOTOPE	0. 000000				56.00
57.00	05700 CT SCAN	0. 000000				57.0
58.00	05800 MRI	0. 000000				58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 105283				59.0
	06000 LABORATORY	0. 102188				60.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 184139				62.0
65.00	06500 RESPI RATORY THERAPY	0. 101237				65.0
66.00	06600 PHYSI CAL THERAPY	0. 259761				66.0
67.00	06700 OCCUPATI ONAL THERAPY	0. 202826				67.0
68.00	06800 SPEECH PATHOLOGY	0. 239359				68.0
69.00	06900 ELECTROCARDI OLOGY	0.078413				69.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 213728				71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 112152				72.0
	07300 DRUGS CHARGED TO PATIENTS	0. 105496				73.0
	07400 RENAL DIALYSIS	0. 272106				74.0
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0. 000000				76.0
	03951 SLEEP LAB	0. 000000				76.0
76.02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 244052				76.0
	03952 WOUND CARE	0. 246779				76.03
(	DUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	3. 549708				90.00
91.00	09100 EMERGENCY	0. 116567				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 454255				92.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

	ial Systems DF RATIO OF COSTS TO CHARGES	ST JOSEPH MED		CCN: 150047	Peri od:	u of Form CMS-: Worksheet C	
					From 06/01/2015	Part I	
					To 05/31/2016	Date/Time Pre	epared:
			т: +	le XIX	Hospi tal	10/31/2016 8: PPS	18 am
					Costs	PP3	
C	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
C	bost center bescription	(from Wkst. B,	Adj.		Di sal I owance	10101 00313	
		Part I, col.			broarronanoo		
		26)					
		1.00	2.00	3.00	4.00	5.00	
I NPATI E	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	15, 683, 831		15, 683, 83	31 0	15, 683, 831	30.00
31.00 03100 I	NTENSI VE CARE UNI T	1, 554, 017		1, 554, 0	17 0	1, 554, 017	31.00
31.01 02060 N	VEONATAL INTENSIVE CARE UNIT	1, 526, 632		1, 526, 63	32 0	1, 526, 632	31.01
33.00 03300 E	BURN INTENSIVE CARE UNIT	2, 560, 477		2, 560, 4	77 0	2, 560, 477	33.00
	SUBPROVIDER – IPF	3, 715, 047		3, 715, 04	47 0	3, 715, 047	40.00
43.00 04300 N		437, 577		437, 5	77 0	437, 577	43.00
	SKILLED NURSING FACILITY	2, 716, 968	6	2, 716, 90	68 0	2, 716, 968	44.00
	ARY SERVICE COST CENTERS	- T	1				
	DPERATING ROOM	4, 591, 821		4, 591, 82		4, 591, 821	
	ENDOSCOPY	971, 366		971, 30		971, 366	
	RECOVERY ROOM	1, 296, 853		1, 296, 8		1, 296, 853	
	DELIVERY ROOM & LABOR ROOM	1, 189, 197		1, 189, 19		1, 189, 197	
	ANESTHESI OLOGY	94, 381		94, 38		94, 381	
	RADI OLOGY-DI AGNOSTI C	6, 502, 545		6, 502, 54		6, 502, 545	
	JLTRA SOUND	0			0 0	0	
	RADI OI SOTOPE	0			0 0	0	
57.00 05700 0		0			0 0	0	
58.00 05800 N		0			0 0	0	
	CARDI AC CATHETERI ZATI ON	2, 443, 013		2, 443, 0		2, 443, 013	
	ABORATORY	6, 638, 603		6, 638, 60		6, 638, 603	
	WHOLE BLOOD & PACKED RED BLOOD CELL	727, 877		727, 8		727, 877	
	RESPI RATORY THERAPY	1, 803, 760				1, 803, 760	
	PHYSI CAL THERAPY	1, 459, 907				1, 459, 907	
	OCCUPATIONAL THERAPY	740, 655				740, 655	
	SPEECH PATHOLOGY	204, 595		204, 59		204, 595	
		289, 297		289, 29		289, 297	
	MEDICAL SUPPLIES CHARGED TO PATIENT	5, 741, 894		5, 741, 89		5, 741, 894	
	MPL. DEV. CHARGED TO PATIENTS	3, 082, 245		3, 082, 24		3, 082, 245	
	DRUGS CHARGED TO PATIENTS	8,073,596		8,073,59		8, 073, 596	
74.00 07400 R	RENAL DIALYSIS	596, 727		596, 72		596, 727	
76.00 03950 0 76.01 03951 S	)THER ANCILLARY SERVICE COST CENTER SLEEP LAB	0			0 0	0	
		862, 308		862, 30	-	862, 308	
	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2, 029, 681		2, 029, 68		2, 029, 681	
	IENT SERVICE COST CENTERS	2,029,081		2,029,00	0	2, 029, 081	1 /0.03
90. 00 09000 C		433, 934		433, 93	34 0	433, 934	90.00
	EMERGENCY	5, 706, 159		5, 706, 1		5, 706, 159	
	DESERVATION BEDS (NON-DISTINCT PART	2, 129, 492		2, 129, 49		2, 129, 492	
	Subtotal (see instructions)	85, 804, 455				85, 804, 455	
	Less Observation Beds	2, 129, 492		2, 129, 49		2, 129, 492	
					1		

COMPUTA	Financial Systems TION OF RATIO OF COSTS TO CHARGES	ST JOSEPH MED		CCN: 150047	Period: From 06/01/2015	u of Form CMS- Worksheet C Part I	
					To 05/31/2016	Date/Time Pre 10/31/2016 8:	
				le XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
1	NPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
	D3000 ADULTS & PEDIATRICS	45, 668, 725		45, 668, 72	25		30.00
	03100 I NTENSI VE CARE UNI T	1, 828, 258		1, 828, 25			31.00
	02060 NEONATAL INTENSIVE CARE UNIT	3, 140, 697		3, 140, 69			31.0
	D3300 BURN INTENSIVE CARE UNIT	9, 687, 756		9, 687, 7	56		33.00
40.00	04000 SUBPROVI DER – I PF	18, 554, 919		18, 554, 9 <sup>.</sup>	19		40.00
43.00	D4300 NURSERY	846, 396		846, 39	96		43.00
	04400 SKILLED NURSING FACILITY	3, 551, 360		3, 551, 30	50		44.00
	ANCILLARY SERVICE COST CENTERS						
	D5000 OPERATING ROOM	20, 269, 347	23, 201, 795			0.000000	
	D3330 ENDOSCOPY	1, 130, 749	4, 421, 142			0.000000	
	D5100 RECOVERY ROOM	2, 090, 352	4, 233, 542			0.00000	
	D5200 DELIVERY ROOM & LABOR ROOM	1, 473, 951	20, 000			0.00000	
	05300 ANESTHESI OLOGY	3, 068, 911	2, 987, 902			0.00000	
	D5400 RADI OLOGY-DI AGNOSTI C	21, 379, 101	60, 306, 516			0.00000	
	D3630 ULTRA SOUND D5600 RADI 0I SOTOPE	0	0		0 0.000000 0 0.000000	0.000000	
	DS700 CT SCAN	0	0		0 0.000000	0. 000000	
	25800 MRI	0	0		0 0.000000	0. 000000	
	05900 CARDI AC CATHETERI ZATI ON	8, 645, 084	14, 559, 164			0. 000000	
	26000 LABORATORY	32, 225, 133	32, 739, 659			0. 000000	
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELL	3, 503, 929	448, 932			0. 000000	
	06500 RESPIRATORY THERAPY	15, 885, 751	1, 931, 385			0. 000000	
	D6600 PHYSI CAL THERAPY	2, 430, 415	3, 189, 770			0. 000000	
	06700 OCCUPATI ONAL THERAPY	3, 159, 176	492, 508			0.000000	
68.00	06800 SPEECH PATHOLOGY	556, 293	298, 468			0.000000	68.0
69.00	D6900 ELECTROCARDI OLOGY	1, 621, 307	2, 068, 110	3, 689, 4	0. 078413	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 109, 125	15, 756, 329	26, 865, 45	0. 213728	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11, 542, 635	15, 940, 167	27, 482, 80	0. 112152	0.000000	72.0
	D7300 DRUGS CHARGED TO PATIENTS	59, 858, 136	16, 671, 606			0.00000	
	07400 RENAL DI ALYSI S	2, 087, 542	105, 456	2, 192, 99		0.000000	
	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0.000000	0.000000	
	03951 SLEEP LAB	0	0		0 0.000000	0.00000	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 596, 340	1, 936, 963			0.000000	
	03952 WOUND CARE	1, 851, 371	6, 373, 323	8, 224, 69	0. 246779	0.00000	76.03
	DUTPATIENT SERVICE COST CENTERS	7 200	115 045	100.0	1 2 5 4 0 7 0 0	0,000000	
	09000 CLINIC 09100 EMERGENCY	7, 200 9, 381, 919	115, 045			0.00000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 381, 919	39, 569, 692 3, 639, 729			0. 000000 0. 000000	
92.00 ( 200.00	Subtotal (see instructions)	299, 200, 027	3, 639, 729 251, 007, 203			0.00000	200.00
200.00	Less Observation Beds	277,200,027	231,007,203	330, 207, 20			200.00
201.00	Total (see instructions)	299, 200, 027	251,007,203	550, 207, 23			202. 0

	Financial Systems	ST JOSEPH MEDICA			u of Form CMS-2552-
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150047	Period: From 06/01/2015 To 05/31/2016	Worksheet C Part I Date/Time Prepared 10/31/2016 8:18 am
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient		· · · · · · · · · · · · · · · · · · ·	
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.0
31.00	03100 I NTENSI VE CARE UNI T				31.0
31.01	02060 NEONATAL INTENSIVE CARE UNIT				31.0
33.00	03300 BURN INTENSIVE CARE UNIT				33. 0
40.00	04000 SUBPROVI DER – I PF				40. 0
43.00	04300 NURSERY				43.0
44.00	04400 SKI LLED NURSI NG FACI LI TY				43.0
44.00	ANCI LLARY SERVICE COST CENTERS				44. (
50.00	05000 OPERATING ROOM	0. 105629			50.0
50.01	03330 ENDOSCOPY	0. 174961			50.0
51.00	05100 RECOVERY ROOM	0. 205072			51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 796008			52.0
53.00	05300 ANESTHESI OLOGY	0. 015583			53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 079605			54.0
54.01	03630 ULTRA SOUND	0. 000000			54.0
56.00	05600 RADI OI SOTOPE	0. 000000			56.0
57.00	05700 CT SCAN	0. 000000			57.0
58.00	05800 MRI	0. 000000			58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 105283			59.0
60.00	06000 LABORATORY	0. 102188			60.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 184139			62.0
65.00	06500 RESPI RATORY THERAPY	0. 101237			65.0
66.00	06600 PHYSI CAL THERAPY	0. 259761			66.0
67.00	06700 OCCUPATI ONAL THERAPY	0. 202826			67.0
68.00	06800 SPEECH PATHOLOGY	0. 239359			68.0
69.00	06900 ELECTROCARDI OLOGY	0. 078413			69.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 213728			71.0
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 112152			72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 105496			73.0
74.00	07400 RENAL DI ALYSI S	0. 272106			74.0
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0. 000000			76.0
76. 01	03951 SLEEP LAB	0. 000000			76.0
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 244052			76.0
76.03	03952 WOUND CARE	0. 246779			76.0
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	3. 549708			90.0
91.00	09100 EMERGENCY	0. 116567			91. (
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 454255			92.0
					200. 0
200.00		- I			
200.00	Less Observation Beds				201.0

lealth Financial Systems	ST JOSEPH MED			In Lie	u of Form CMS-2	2552-
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF		CCN: 150047	Period: From 06/01/2015 To 05/31/2016	10/31/2016 8:	pared 18 am
			le XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
	(Wkst. B, Part				Reducti on	
	I, col. 26)	II col. 26)		-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	- 1		1	-		
50. 00 05000 OPERATING ROOM	4, 591, 821	710, 521			0	50.0
50. 01 03330 ENDOSCOPY	971, 366	104, 690			0	
51.00 05100 RECOVERY ROOM	1, 296, 853	274, 257	1, 022, 59		0	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 189, 197	237, 775			0	52.0
53. 00 05300 ANESTHESI OLOGY	94, 381	9, 609	84, 7	72 0	0	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 502, 545	801, 299	5, 701, 24	46 0	0	54.0
54.01 03630 ULTRA SOUND	0	0		0 0	0	54.0
6. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.0
7.00 05700 CT SCAN	0	0		0 0	0	57.0
8. 00 05800 MRI	0	0		0 0	0	58. (
9. 00 05900 CARDI AC CATHETERI ZATI ON	2, 443, 013	138, 759	2, 304, 2	54 0	0	59.0
0. 00 06000 LABORATORY	6, 638, 603	689, 939	5, 948, 60	54 0	0	60.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	727, 877	39, 162			0	62.0
5. 00 06500 RESPI RATORY THERAPY	1, 803, 760	261, 649			0	65.0
6. 00 06600 PHYSI CAL THERAPY	1, 459, 907	305, 581			0	66.
7. 00 06700 OCCUPATI ONAL THERAPY	740, 655	120, 093			0	67.
8. 00 06800 SPEECH PATHOLOGY	204, 595	45,003			0	68.
9. 00 06900 ELECTROCARDI OLOGY	289, 297	48, 302			0	69.
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 741, 894	180, 581			0	71.
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 082, 245	113, 109			0	72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	8,073,596	246, 504			0	73.
4. 00 07400 RENAL DIALYSIS	596, 727	84, 034			0	74.
6. 00 03950 OTHER ANCILLARY SERVICE COST CENTER	590,727	04, 034		0 0	0	76.
6. 01 03951 SLEEP LAB	0	0		0 0	0	76.
	862, 308	124 444	725, 84	44 0	0	76.
6. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		136, 464			-	
6. 03 03952 WOUND CARE	2, 029, 681	360, 212	1, 669, 40	09 0	0	76. (
0.00 09000 CLINIC	433, 934	89, 725	344, 20	0 0	0	90.0
					-	
1.00 09100 EMERGENCY	5, 706, 159				0	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 129, 492				0	1
Subtotal (sum of lines 50 thru 199)	57, 609, 906					200. (
201.00 Less Observation Beds	2, 129, 492					201.0
202.00 Total (line 200 minus line 201)	55, 480, 414	5, 665, 841	49, 814, 5	73 0	0	202.0

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE I EDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016	Worksheet C Part II Date/Time Pro 10/31/2016 83	eparec :18 an
	-		le XIX	Hospi tal	PPS	_
Cost Center Description	Cost Net of	Total Charges				
	Capital and	(Worksheet C,				
	Operating Cost			6		
	Reducti on	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS			1			
D. 00 05000 OPERATING ROOM	4, 591, 821					50.
D. 01 03330 ENDOSCOPY	971, 366					50.
1.00 05100 RECOVERY ROOM	1, 296, 853	6, 323, 894	0. 2050	72		51.
2.00 05200 DELIVERY ROOM & LABOR ROOM	1, 189, 197	1, 493, 951				52.
3. 00 05300 ANESTHESI OLOGY	94, 381	6, 056, 813	0. 0155	83		53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 502, 545	81, 685, 617	0. 0796	05		54.
4.01 03630 ULTRA SOUND	0	0	0.0000	00		54.
5. 00 05600 RADI 0I SOTOPE	0	0	0.0000	00		56.
7.00 05700 CT SCAN	0	0	0.0000	00		57.
3. 00 05800 MRI	0	l o	0.0000	00		58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	2, 443, 013	23, 204, 248	0. 1052	83		59.
D. 00 06000 LABORATORY	6, 638, 603					60.
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	727, 877					62.
5. 00 06500 RESPIRATORY THERAPY	1, 803, 760					65.
5. 00 06600 PHYSI CAL THERAPY	1, 459, 907					66.
7. 00 06700 OCCUPATI ONAL THERAPY	740, 655					67.
3. 00 06800 SPEECH PATHOLOGY	204, 595					68.
2. 00 06900 ELECTROCARDI OLOGY	289, 297					69
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 741, 894					71.
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 082, 245					72
						73
	8, 073, 596					74
00 07400 RENAL DIALYSIS	596, 727					
0.00 03950 OTHER ANCI LLARY SERVICE COST CENTER	0					76.
5. 01 03951 SLEEP LAB	0	j v	0.0000			76.
5. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	862, 308					76.
5. 03 03952 WOUND CARE	2, 029, 681	8, 224, 694	0. 2467	79		76.
OUTPATIENT SERVICE COST CENTERS				2.2		1
D. 00 09000 CLINIC	433, 934					90.
1. 00 09100 EMERGENCY	5, 706, 159					91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 129, 492			55		92.
00.00 Subtotal (sum of lines 50 thru 199)	57, 609, 906					200.
01.00 Less Observation Beds	2, 129, 492	0				201.
D2.00 Total (line 200 minus line 201)	55, 480, 414	466, 929, 119				202.

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der		Period: From 06/01/2015 To 05/31/2016		pared: 18 am
		Ti tl	e 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	2, 036, 798	0	2, 036, 79	B 23, 929	85.12	30.00
31. 00 INTENSIVE CARE UNIT	501, 518		501, 51			31.00
31.01 NEONATAL INTENSIVE CARE UNIT	127, 984		127, 98			
33.00 BURN INTENSIVE CARE UNIT	341, 869		341, 86	9 1, 511	226.25	33.00
40. 00 SUBPROVIDER – IPF	366, 933	0	366, 93	3 6, 048	60.67	40.00
43.00 NURSERY	6, 580		6, 58	783 783	8.40	43.00
44.00 SKILLED NURSING FACILITY	480, 616		480, 61	6 4, 888	98.33	44.00
200.00 Total (lines 30-199)	3, 862, 298		3, 862, 29	8 38, 546		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS		1	1			-
30. 00 ADULTS & PEDIATRICS	5, 711					30.00
31.00 INTENSIVE CARE UNIT	166		1			31.00
31.01 NEONATAL INTENSIVE CARE UNIT	0	-				31.01
33.00 BURN INTENSIVE CARE UNIT	211	47, 739				33.00
40. 00 SUBPROVIDER - IPF	3, 790		1			40.00
43.00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	2, 026					44.00
200.00 Total (lines 30-199)	11, 904	1, 136, 819	1			200. 00

ealth Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CA	APITAL COSTS	Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016		pared: 18 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	ů l		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
0. 00 05000 OPERATING ROOM	710, 521	43, 471, 142	0. 01634	45 5, 326, 019	87,054	50.00
0. 01 03330 ENDOSCOPY	104, 690	5, 551, 891	0. 01885	57 344, 193	6, 490	50.01
1.00 05100 RECOVERY ROOM	274, 257	6, 323, 894	0. 04336	68 432, 709	18, 766	51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	237, 775	1, 493, 951	0. 15915		-	52.00
3. 00 05300 ANESTHESI OLOGY	9, 609	6, 056, 813	0. 00158	36 715, 723	1, 135	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	801, 299	81, 685, 617	0. 0098	10 7, 243, 172	71, 056	54.00
4. 01 03630 ULTRA SOUND	0	0	0. 00000	0 00	0	54. 0 <sup>2</sup>
6. 00 05600 RADI OI SOTOPE	0	0	0. 00000	0 00	0	56.00
7.00 05700 CT SCAN	0	0	0. 00000	0 00	0	57.00
8. 00 05800 MRI	0	0	0. 00000	0 00	0	58.00
9. 00 05900 CARDI AC CATHETERI ZATI ON	138, 759	23, 204, 248	0. 00598	30 3, 133, 482	18, 738	59.00
0. 00 06000 LABORATORY	689, 939	64, 964, 792	0. 01062	20 8, 237, 636	87, 484	60.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELI	39, 162	3, 952, 861	0.00990	07 1, 074, 599	10, 646	62.00
5. 00 06500 RESPI RATORY THERAPY	261, 649	17, 817, 136	0. 01468	35 4, 609, 477	67, 690	65.00
6. 00 06600 PHYSI CAL THERAPY	305, 581	5, 620, 185	0. 05437	72 450, 082	24, 472	66.00
7.00 06700 OCCUPATIONAL THERAPY	120, 093	3, 651, 684	0. 03288	37 343, 403	11, 293	67.00
8.00 06800 SPEECH PATHOLOGY	45,003	854, 761	0.05265	50 71, 132	3, 745	68.00
9. 00 06900 ELECTROCARDI OLOGY	48, 302	3, 689, 417	0. 01309	92 375, 823	4, 920	69.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Г 180, 581	26, 865, 454	0.00672	22 3, 485, 225	23, 428	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	113, 109	27, 482, 802	0.0041	16 4, 883, 025	20, 099	72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	246, 504	76, 529, 742	0. 00322	14, 225, 908	45, 822	73.00
4. 00 07400 RENAL DIALYSIS	84, 034	2, 192, 998	0. 0383	1, 233, 204	47, 255	74.00
6.00 03950 OTHER ANCI LLARY SERVICE COST CENTER	R 0		0. 00000		0	
6.01 03951 SLEEP LAB	0	c c	0.0000		0	
6. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	136, 464	3, 533, 303			9, 440	•
6. 03 03952 WOUND CARE	360, 212					
OUTPATIENT SERVICE COST CENTERS	,, = . =					1
0. 00 09000 CLINIC	89, 725	122, 245	0. 73397	77 0	0	90.00
1.00 09100 EMERGENCY	668, 573				31, 536	91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR						
	5, 942, 390			59, 506, 293		

Health Financial Systems	ST JOSEPH MEI	DICAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS	TS Provi der		Period: From 06/01/2015 To 05/31/2016		
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSIVE CARE UNIT	0			0 0	0	30.00 31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	31.01
33. 00 03300 BURN INTENSIVE CARE UNIT				0	0	33.00
40. 00 04000 SUBPROVIDER - IPF				0 0	0	40.00
43. 00 04300 NURSERY				0	0	43.00
44.00 04400 SKI LLED NURSI NG FACI LI TY				0	0	44.00
200.00 Total (lines 30-199) Cost Center Description		Per Diem (col.	Inpatient	Inpati ent	0	200. 00
cost center bescription		5 ÷ col. 6)	Program Days			
	Days	5 ÷ COL 6)	Program Days	Program Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6,00	7.00	8.00	9,00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
30. 00 03000 ADULTS & PEDIATRICS	23, 929	0.00	5, 71	1 0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	479					31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	908			0 0		31.01
33. 00 03300 BURN INTENSIVE CARE UNIT	1, 511			1 0		33.00
40. 00 04000 SUBPROVI DER – I PF	6, 048					40.00
43. 00 04300 NURSERY	783			0 0		43.00
44.00 04400 SKILLED NURSING FACILITY	4, 888			6 0		44.00
200.00   Total (lines 30-199)	38, 546		11, 90			200.00

lealth Financial Systems	ST JOSEPH MED				u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	S Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016		pared: 18 am
		Ti tl	e XVIII	Hospi tal	PPS	10 a
Cost Center Description	Non Physician			h All Other	Total Cost	
	Anestheti st	g		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
50. 01 03330 ENDOSCOPY	0	C		0 0	0	50.0
51.00 05100 RECOVERY ROOM	0	C		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
54.01 03630 ULTRA SOUND	0	C		0 0	0	54.0
56. 00 05600 RADI 0I SOTOPE	0	C		0 0	0	56.0
57.00 05700 CT SCAN	0	C		0 0	0	57.0
58. 00 05800 MRI	0	C		0 0	0	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.0
50. 00 06000 LABORATORY	0	C		0 0	0	60.00
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0	62.0
55. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.0
56. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.0
57. 00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.0
58.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	
59. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 0	0	1 / 0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	
3.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	1
6.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	C		0 0	0	1 / 0/ 0
76.01 03951 SLEEP LAB	0	C		0 0	0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C		0 0	0	
76. 03 03952 WOUND CARE	0	C		0 0	0	76.0
OUTPATIENT SERVICE COST CENTERS				_		
90. 00 09000 CLINIC	0	C		0 0	0	
91.00 09100 EMERGENCY	0	C		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0 0	0	1
200.00 Total (lines 50-199)	0	L C		0 0	0	200.00

Health Financial Systems	ST JOSEPH MED			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 06/01/2015 To 05/31/2016	Part IV Date/Time Pre	narod
				10 03/31/2010	10/31/2016 8:	18 am
		Ti tl	e XVIII	Hospi tal	PPS	10 a
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS		1	1	- 1		
50. 00 05000 OPERATI NG ROOM	0				5, 326, 019	•
50. 01 03330 ENDOSCOPY	0				344, 193	
51.00 05100 RECOVERY ROOM	0	6, 323, 894			432, 709	•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 493, 951				52.00
53. 00 05300 ANESTHESI OLOGY	0	6, 056, 813			715, 723	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	81, 685, 617			7, 243, 172	
54. 01 03630 ULTRA SOUND	0	C	0.00000		0	54.01
56. 00 05600 RADI 0I SOTOPE	0	C	0.00000		0	56.00
57. 00 05700 CT SCAN	0	C	0.00000		0	57.00
58. 00 05800 MRI	0	C	0.00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				3, 133, 482	59.00
60. 00 06000 LABORATORY	0	01,701,772			8, 237, 636	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 952, 861			1, 074, 599	
65. 00 06500 RESPI RATORY THERAPY	0				4, 609, 477	65.00
66. 00 06600 PHYSI CAL THERAPY	0	5, 620, 185				
67.00 06700 OCCUPATIONAL THERAPY	0	3, 651, 684				
68.00 06800 SPEECH PATHOLOGY	0	854, 761				
69.00 06900 ELECTROCARDI OLOGY	0	3, 689, 417				
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0					
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0				4, 883, 025	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				14, 225, 908	
74.00 07400 RENAL DIALYSIS	0	2, 192, 998			1, 233, 204	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0			0	76.00
76. 01 03951 SLEEP LAB	0	0	0.00000			
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0					
76. 03 03952 WOUND CARE	0	8, 224, 694	0.00000	0.00000	449, 107	76.03
		100.045	0.00000	0 000000	0	00.00
90. 00 09000 CLINIC	0					
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50-199)				0.00000	59, 506, 293	
	1 0	400, 929, 119	1		59, 500, 293	I∠00. 00

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	eu of Form CMS-255	52-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	SERVI CE OTHER PASS		CCN: 150047	Period: From 06/01/2015 To 05/31/2016	Date/Time Prepar 10/31/2016 8:18	ired: 3 am
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVICE COST CENTERS		5 (40 74)				
50. 00 05000 OPERATING ROOM	0	5, 613, 716		0		50.00
50. 01 03330 ENDOSCOPY	0	1,025,139		0		50.01
51.00 05100 RECOVERY ROOM	0	1, 412, 517		0		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	13, 074		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	595, 363		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	10, 107, 985		0		54. OC
54. 01 03630 ULTRA SOUND	0	0		0		54.01
56. 00 05600 RADI OI SOTOPE	0	0		0		56.00
57. 00 05700 CT SCAN	0	0		0		57.00
58. 00 05800 MRI	0	0		0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	3, 449, 150		0		59.00
50. 00 06000 LABORATORY	0	2, 736, 279		0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	61, 661		0		62.00
65. 00 06500 RESPI RATORY THERAPY	0	419, 729		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	5, 963		0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	4, 133		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	675		0		68.00
59. 00 06900 ELECTROCARDI OLOGY	0	490, 430		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4, 557, 556		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	6, 482, 860		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 803, 328		0		73.00
74.00 07400 RENAL DIALYSIS	0	98, 551		0		74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0		76.00
76.01 03951 SLEEP LAB	0	0		0		76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 238, 916		0		76. 02
76.03 03952 WOUND CARE	0	1, 826, 790		0	76	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	12, 216		0		90.00
91. 00 09100 EMERGENCY	0	4, 555, 207		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	791, 767		0		92.00
200.00 Total (lines 50-199)	0	49, 303, 005		0	200	00.00

Health Financial Systems	ST JOSEPH MED	DI CAL_CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	S AND VACCINE COST	Provi der	CCN: 150047	Period: From 06/01/2015	Worksheet D Part V	
				To 05/31/2016		pared:
					10/31/2016 8:	18 am
			e XVIII	Hospi tal	PPS	
Cost Contor Description	Cost to Charge	PPS Reimbursed	Charges Cost	Cost	Costs PPS Services	
Cost Center Description	Ratio From	Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(300 1131.)	
	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. 105629			0 0		
50. 01 03330 ENDOSCOPY	0. 174961			0 0	179, 359	•
51.00 05100 RECOVERY ROOM	0. 205072			0 0	289, 668	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 796008			0 0	10, 407	
53. 00 05300 ANESTHESI OLOGY	0. 015583			0 0	9, 278	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 079605			0 0	804, 646	
54. 01 03630 ULTRA SOUND	0. 000000			0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0.00000			0 0	0	56.00
57. 00 05700 CT SCAN	0. 000000			0 0	0	57.00
	0. 000000			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0. 105283 0. 102188			0	363, 137 279, 615	59.00 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CEL				0 0	11, 354	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 104139		1	0 0	42, 492	
66. 00 06600 PHYSI CAL THERAPY	0. 101237			0 0	1, 549	•
67. 00 06700 OCCUPATI ONAL THERAPY	0. 202826			0 0	838	
68. 00 06800 SPEECH PATHOLOGY	0. 239359			0 0	162	•
69. 00 06900 ELECTROCARDI OLOGY	0. 078413			0 0	38, 456	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN				0 0	974,077	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 112152			0 0	727,066	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 105496			0 17, 518		
74. 00 07400 RENAL DI ALYSI S	0. 272106			0 0	26, 816	
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTE				0 0	0	76.00
76.01 03951 SLEEP LAB	0.000000			0 0	0	76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 244052			0 0	302, 360	76.02
76.03 03952 WOUND CARE	0. 246779	1, 826, 790		0 0	450, 813	76.03
OUTPATIENT SERVICE COST CENTERS	· · · ·					1
90. 00 09000 CLI NI C	3. 549708	12, 216		0 0	43, 363	90.00
91. 00 09100 EMERGENCY	0. 116567			0 0	530, 987	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T 0. 454255	5 791, 767		0 0	359, 664	92.00
200.00 Subtotal (see instructions)		49, 303, 005	5, 88	36 17, 518	6, 440, 314	200.00
201.00 Less PBP Clinic Lab. Services-Prog	ram			0 0		201.00
Only Charges						
202.00  Net Charges (line 200 +/- line 201	)	49, 303, 005	5, 88	36 17, 518	6, 440, 314	202.00

Health Financial Systems	ST JOSEPH MED	OICAL CENTER		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016	Worksheet D Part V Date/Time Pre 10/31/2016 8:	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cos	sts		· · · · · · · · · · · · · · · · · · ·		
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	1					_
50. 00       05000       OPERATI NG ROOM         50. 01       03300       ENDOSCOPY         51. 00       05100       RECOVERY ROOM         52. 00       05200       DELI VERY ROOM & LABOR ROOM         53. 00       05300       ANESTHESI OLOGY         54. 00       05400       RADI OLOGY - DI AGNOSTI C         54. 01       03630       ULTRA SOUND         56. 00       05600       RADI OLOGY-E         57. 00       05700       CT SCAN         58. 00       05800       MRI         59. 00       05900       CARDI AC CATHETERI ZATI ON         60. 00       D6000       LABORATORY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				50.00 50.01 51.00 52.00 53.00 54.00 54.01 56.00 57.00 58.00 59.00 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
65.00         06500         RESPI RATORY THERAPY           66.00         06600         PHYSI CAL THERAPY           67.00         06700         OCCUPATI ONAL THERAPY           68.00         06800         SPEECH PATHOLOGY	0	000000000000000000000000000000000000000				65.00 66.00 67.00 68.00
69. 0006900ELECTROCARDI OLOGY71. 0007100MEDI CAL SUPPLI ES CHARGED TO PATI ENT72. 0007200IMPL.DEV.73. 0007300DRUGS CHARGED TO PATI ENTS74. 0007400RENAL DI ALYSI S76. 0003950OTHER ANCI LLARY SERVICE COST CENTER74. 0005450EFER LAD		0 0 1, 848 0 0				69.00 71.00 72.00 73.00 74.00 76.00
76. 01         03951         SLEEP         LAB           76. 02         03550         PSYCHI ATRI C/PSYCHOLOGI CAL         SERVI CES           76. 03         03952         WOUND         CARE           OUTPATI ENT         SERVI CE         COST         CENTERS	0					76. 01 76. 02 76. 03
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	000000000000000000000000000000000000000	0				90.00 91.00 92.00
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program Only Charges202.00Net Charges (line 200 +/- line 201)	601 0 601					200. 00 201. 00 202. 00

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		CCN: 150047 t CCN: 15S047	Period: From 06/01/2015 To 05/31/2016	Worksheet D Part II Date/Time Pre	pared:
		· · ·			10/31/2016 8:	18 am
		Ti tl	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Capital	Total Charges (from Wkst. C,			Capital Costs (column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	i. charges	COTUINIT 4)	
	26)	0)	2)			
	1,00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50. 00 05000 OPERATING ROOM	710, 521	43, 471, 142	0. 0163	45 6, 348	104	50.00
50. 01 03330 ENDOSCOPY	104, 690					50.01
51. 00 05100 RECOVERY ROOM	274, 257					
52.00 05200 DELIVERY ROOM & LABOR ROOM	237, 775					52.00
53.00 05300 ANESTHESI OLOGY	9,609				71	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	801, 299					54.00
54. 01 03630 ULTRA SOUND	0		0.0000		0	54.01
56. 00 05600 RADI OI SOTOPE	0		0.0000		0	56.00
57.00 05700 CT SCAN	0	0	0.0000		0	57.00
58. 00 05800 MRI	0	0	0. 0000	00 00	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	138, 759	23, 204, 248	0.0059	80 0	0	59.00
60. 00 06000 LABORATORY	689, 939	64, 964, 792	0. 0106	20 1, 021, 349	10, 847	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	39, 162	3, 952, 861	0.0099	07 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	261, 649	17, 817, 136	0. 0146	85 326, 786	4, 799	65.00
66. 00 06600 PHYSI CAL THERAPY	305, 581	5, 620, 185	0. 0543	72 134, 918	7, 336	66.00
67.00 06700 OCCUPATIONAL THERAPY	120, 093	3, 651, 684	0. 0328	87 149, 882	4, 929	67.00
68.00 06800 SPEECH PATHOLOGY	45,003	854, 761			1, 455	68.00
69. 00 06900 ELECTROCARDI OLOGY	48, 302					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	180, 581					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	113, 109					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	246, 504					73.00
74.00 07400 RENAL DIALYSIS	84,034	2, 192, 998			1, 263	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	-				76.00
76.01 03951 SLEEP LAB	0		0. 0000		0	76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	136, 464					
76. 03 03952 WOUND CARE	360, 212	8, 224, 694	0. 0437	96 6, 471	283	76.03
OUTPATIENT SERVICE COST CENTERS					-	
90. 00 09000 CLINIC	89, 725					90.00
91.00 09100 EMERGENCY	668, 573					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	.,			0	
200.00   Total (lines 50-199)	5, 665, 841	466, 929, 119	'I	5, 100, 481	62, 191	200.00

Health Financial Systems		ST JOSEPH MED	I CAL_CENTER		In Li	eu of Form CMS-	2552-10
	ENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	6 Provider	CCN: 150047	Peri od:	Worksheet D	
THROUGH COSTS			Component	t CCN: 15SO47	From 06/01/2019 To 05/31/2010		narad
			component	L CCN. 155047	10 05/31/2010	10/31/2016 8:	18 am
			Ti tl	e XVIII	Subprovider -	PPS	10 4
					IPF		
Cost Center	Description	Non Physician	Nursing School	Allied Healt		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cos	t through col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE				1			
50.00 05000 OPERATING R	MOC	0	0		-	0 0	
50. 01 03330 ENDOSCOPY		0	0		0	0 0	
51.00 05100 RECOVERY R00		0	0		0	0 0	
52.00 05200 DELIVERY R00		0	0		0	0 0	
53.00 05300 ANESTHESI OL		0	0		0	0 0	
54.00 05400 RADI OLOGY-DI	AGNOSTIC	0	0		0	0 0	01100
54.01 03630 ULTRA SOUND		0	0		0	0 0	54.01
56. 00 05600 RADI 0I SOTOPI		0	0		0	0 0	
57.00 05700 CT SCAN		0	0		0	0 0	01100
58.00 05800 MRI		0	0		0	0 0	00.00
59.00 05900 CARDI AC CATI	HETERI ZATI ON	0	0		0	0 0	
60. 00 06000 LABORATORY		0	0		0	0 0	00100
	& PACKED RED BLOOD CELL	0	0		0	0 0	
65. 00 06500 RESPI RATORY		0	0		0	0 0	
66.00 06600 PHYSI CAL TH		0	0		0	0 0	66.00
67.00 06700 0CCUPATI ONAI		0	0		0	0 0	
68.00 06800 SPEECH PATHO		0	0		0	0 0	
69.00 06900 ELECTROCARD		0	0		0	0 0	
	PLIES CHARGED TO PATIENT	0	0		0	0 0	
	CHARGED TO PATIENTS	0	0		0	0 0	12.00
73.00 07300 DRUGS CHARGI		0	0		0	0 0	
74.00 07400 RENAL DIALYS		0	0		0	0 0	
	LARY SERVICE COST CENTER	0	0		0	0 0	1 1 01 00
76.01 03951 SLEEP LAB		0	0		0	0 0	1
	PSYCHOLOGI CAL SERVI CES	0	0		0	0 0	10102
76.03 03952 WOUND CARE		0	0		0	0 0	76.03
OUTPATIENT SERVIC	E COST CENTERS	-					
90. 00 09000 CLI NI C		0	0		-	0 0	
91.00 09100 EMERGENCY		0	0		0	0 0	
	BEDS (NON-DISTINCT PART	0	0		0	0 0	12.00
200.00 Total (lines	\$ 5()-199)	0	<u>۱</u>	1	0	רו ∩	200.00

Health Financial Systems	ST JOSEPH MED			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der	CCN: 150047	Peri od:	Worksheet D	
THROUGH COSTS				From 06/01/2015	Part IV	
		Component	t CCN: 15SO47	To 05/31/2016		pared:
		T: +1	e XVIII	Subprovider -	10/31/2016 8: PPS	18 200
		11 ti	e xviii	IPF	PPS	
Cost Conton Description	Tatal	Tatal Changes	Datio of Coo		Inpati ent	
Cost Center Description	Total	Total Charges (from Wkst. C,		Ratio of Cost		
	Outpati ent				Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00		7)	10.00	
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0					1
50. 01 03330 ENDOSCOPY	0	5, 551, 891			13, 572	
51.00 05100 RECOVERY ROOM	0	6, 323, 894	0.0000	0. 000000	169, 255	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 493, 951	0.0000	0. 000000	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	6, 056, 813	0.00000	0. 000000	44, 543	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	81, 685, 617	0.0000	0. 000000	501, 555	54.00
54.01 03630 ULTRA SOUND	0	0		0. 000000	0	
56. 00 05600 RADI OI SOTOPE	0				0	1
57. 00 05700 CT SCAN	0		0.00000		0	
58. 00 05800 MRI	0	, s			0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	, s			0	
60. 00 06000 LABORATORY	0				1, 021, 349	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0.00000		1, 021, 349	1
65. 00 06500 RESPIRATORY THERAPY	0				326, 786	
66. 00 06600 PHYSI CAL THERAPY						
	-				134, 918	
67.00 06700 OCCUPATIONAL THERAPY	0	0,001,001			149, 882	1
68.00 06800 SPEECH PATHOLOGY	0	001/701				
69.00 06900 ELECTROCARDI OLOGY	0	0/00//11/			67, 640	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				73, 230	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				300	
73.00 07300 DRUGS CHARGED TO PATIENTS	0				2, 091, 413	
74. 00 07400 RENAL DIALYSIS	0	2, 192, 998			32, 962	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.0000	0. 000000	0	76.00
76.01 03951 SLEEP LAB	0	0	0.0000	0. 000000	0	76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	3, 533, 303	0.00000	0. 000000	182, 843	76.02
76.03 03952 WOUND CARE	0	8, 224, 694	0.0000	0. 000000		76.03
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLINIC	0	122, 245	0.0000	0. 000000	0	90.00
91. 00 09100 EMERGENCY	0					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					1
200.00 Total (lines 50-199)	0				5, 100, 481	
200.00   10tal (11103 30-177)	0	1 700, 727, 117	I	1	1 5, 100, 401	1-00.00

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der	CCN: 150047	Peri od:	Worksheet D
THROUGH COSTS		Component	- CON 155017	From 06/01/2015 To 05/31/2016	Part IV
		Component	CCN: 15SO47	10 05/31/2016	Date/Time Prepared: 10/31/2016 8:18 am
		Titl	e XVIII	Subprovider -	PPS
				IPF	
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Throug		
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS			1		
50. 00 05000 OPERATI NG ROOM	0	0		0	50.00
50. 01 03330 ENDOSCOPY	0	0		0	50.01
51.00 05100 RECOVERY ROOM	0	0		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 771		0	54.00
54.01 03630 ULTRA SOUND	0	0		0	54.01
56. 00 05600 RADI OI SOTOPE	0	0		0	56.00
57.00 05700 CT SCAN	0	0		0	57.00
58. 00 05800 MRI	0	0		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	59.00
60. 00 06000 LABORATORY	0	611		0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	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 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0	76.00
76. 01 03951 SLEEP LAB	0	0		0	76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	76.02
76. 03 03952 WOUND CARE	0	0		0	76.03
OUTPATIENT SERVICE COST CENTERS	0	0	1	<u> </u>	70.03
90. 00 09000 CLINIC	0	0		0	90, 00
91. 00 09100 EMERGENCY	0	2, 192		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 172		0	92.00
200.00 Total (lines 50-199)	0	4, 574		0	200.00
	I O	4, 574	I	Ч Ч	200.00

	ancial Systems	ST JOSEPH MED		0.011 4500.47		u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST		CCN: 150047 CCN: 15S047	Period: From 06/01/2015 To 05/31/2016		nared <sup>.</sup>
			component	L CON. 155047	10 03/31/2010	10/31/2016 8:	18 am
			Ti tl	e XVIII	Subprovider - IPF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		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.)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS		-		-		
	O OPERATING ROOM	0. 105629			0 0	0	
	0 ENDOSCOPY	0. 174961	0		0 0	0	
	O RECOVERY ROOM	0. 205072	0		0 0	0	
	O DELIVERY ROOM & LABOR ROOM	0. 796008	0		0 0	0	
	O ANESTHESI OLOGY	0. 015583			0 0	0	
	0 RADI OLOGY-DI AGNOSTI C	0. 079605			0 0	141	1
	O ULTRA SOUND	0. 000000	0		0 0	0	
	O RADI OI SOTOPE	0. 000000	0		0 0	0	
	O CT SCAN	0. 000000			0 0	0	
		0. 000000 0. 105283	0		0 0	0	
	O CARDI AC CATHETERI ZATI ON	0. 105283	611		0 0	62	
	0 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 102188			0 0	02	1
	O RESPIRATORY THERAPY	0. 101237	0		0 0	0	
	0 PHYSI CAL THERAPY	0. 101237	0		0 0	0	
	0 OCCUPATIONAL THERAPY	0. 202826	0		0 0	0	
	0 SPEECH PATHOLOGY	0. 239359	0		0 0	0	
	0 ELECTROCARDI OLOGY	0. 078413	0		0 0	0	
	0 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 213728	-		0 0	0	
	0 IMPL. DEV. CHARGED TO PATIENTS	0. 112152	0		0 0	0	
	O DRUGS CHARGED TO PATIENTS	0. 105496	0		0 0	0	1
	0 RENAL DIALYSIS	0. 272106	0		0 0	0	
76.00 0395	O OTHER ANCILLARY SERVICE COST CENTER	0. 000000	0		0 0	0	
76.01 0395	1 SLEEP LAB	0.000000	0		0 0	0	76.01
76.02 0355	O PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 244052	0		0 0	0	76.02
	2 WOUND CARE	0. 246779	0		0 0	0	76.03
OUTP	ATIENT SERVICE COST CENTERS						
90.00 0900	O CLINIC	3. 549708	0		0 0	0	90.00
91.00 0910	O EMERGENCY	0. 116567	2, 192		0 0	256	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 454255	0		0 0	0	92.00
200.00	Subtotal (see instructions)		4, 574		0 0	459	200.00
200.00		1		1			1004 00
200.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges Net Charges (line 200 +/- line 201)		4, 574		0 0		201.00

Health Financial Systems	ST JOSEPH MEDIC				u of Form CMS	-2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der	CCN: 150047	Peri od:	Worksheet D	
		Component	CCN: 15SO47	From 06/01/2015 To 05/31/2016	Part V Date/Time Pr	onarod
		component	L CON. 155047	10 03/31/2010	10/31/2016 8	
		Ti tl	e XVIII	Subprovider -	PPS	10 4
				I PF		
	Cost	S				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
		Services Not				
		Subject To				
		ed. & Coins.				
		(see inst.)				
	6.00	7.00				_
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	0	1			
50. 00 05000 OPERATI NG ROOM 50. 01 03330 ENDOSCOPY	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	0				50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				51.0
53. 00 05300 ANESTHESI OLOGY	0	0				53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.0
54. 01 03630 ULTRA SOUND	0	0				54.0
56. 00 05600 RADI OI SOTOPE	0	0				56.0
57. 00 05700 CT SCAN	0	0				57.0
58. 00 05800 MRI	0	0				58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.0
60. 00 06000 LABORATORY	0	0				60.0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	•			62.0
65. 00 06500 RESPI RATORY THERAPY	0	0				65.0
66. 00 06600 PHYSI CAL THERAPY	0	0				66.0
67.00 06700 OCCUPATIONAL THERAPY	0	0				67.0
68.00 06800 SPEECH PATHOLOGY	0	0				68.0
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.0
74.00 07400 RENAL DIALYSIS	0	0				74.0
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0				76.0
76. 01 03951 SLEEP LAB	0	0				76.0
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76.0
76.03 03952 WOUND CARE	0	0				76.0
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	•			90.0
91.00 09100 EMERGENCY	0	0				91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	•			92.0
200.00 Subtotal (see instructions)	0	0				200. 0
201.00 Less PBP Clinic Lab. Services-Program	0					201.0
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	0				202.00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Li	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	VICE OTHER PASS	S Provi der	CCN: 150047	Peri od:	Worksheet D	
THROUGH COSTS				From 06/01/201		
		Component	t CCN: 155356	To 05/31/201		
		Ti +1	e XVIII	Skilled Nursin	10/31/2016 8: a PPS	18 80
		11 (1	e XVIII	Facility	y PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
cost center bescription	Anesthetist	Nul Sing School	Arrieu near t	Medi cal	(sum of col 1	
	Cost				t through col.	
	CUSI				4)	
	1.00	2.00	3.00	4.00	5, 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0	0		0	0 0	50,00
50. 01 03330 ENDOSCOPY	0			0		
	0			0		
	0			0	° ,	000
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0 0	
53. 00 05300 ANESTHESI OLOGY	0	0		0	0 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	0.00
54.01 03630 ULTRA SOUND	0	0		0	0 0	
56. 00 05600 RADI OI SOTOPE	0	0		0	0 0	56.00
57.00 05700 CT SCAN	0	0		0	0 0	07.00
58.00 05800 MRI	0	0	)	0	0 0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0 0	59.00
60. 00 06000 LABORATORY	0	0		0	o  0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	l o	)	0	ol o	62.00
65. 00 06500 RESPI RATORY THERAPY	0	l a		0	ol o	65.00
66. 00 06600 PHYSI CAL THERAPY	0			0	0 0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0			0	0 0	
68.00 06800 SPEECH PATHOLOGY	0			0	ol o	
69. 00 06900 ELECTROCARDI OLOGY	0			0		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0	0 0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			0		1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0		
74. 00 07400 RENAL DIALYSIS	0			0		
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTER	0			0		
	0			0	-	1
	0			0	0 0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0	0 0	10102
76. 03 03952 WOUND CARE	0	0	1	0	0 0	76.03
OUTPATIENT SERVICE COST CENTERS			-			
90. 00 09000 CLINIC	0	0		-	0 0	
91.00 09100 EMERGENCY	0		1	0	0 0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1	0	0 0	
200.00   Total (lines 50-199)	0	0	1	0	0 0	200.00

Health Financial Systems	ST JOSEPH MED	OICAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 06/01/2015	Part IV	
		Componen	t CCN: 155356	To 05/31/2016	Date/Time Pre 10/31/2016 8:	
		Ti +1	e XVIII	Skilled Nursing	PPS	
			e Aviii	Facility	115	
Cost Center Description	Total	Total Charges	Ratio of Cos		Inpati ent	
	Outpatient	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	$(col \cdot 5 \div col$		Charges	
	col. 2, 3 and		7)	$(col. 6 \div col.$	ondi goo	
	4)		.,	7)		
	6.00	7.00	8,00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	43, 471, 142	0.0000	0. 000000	74, 251	50.00
50. 01 03330 ENDOSCOPY	0				0	
51.00 05100 RECOVERY ROOM	0				0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1, 493, 951			0	•
53. 00 05300 ANESTHESI OLOGY	0				0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0				102, 964	
54. 01   03630 ULTRA SOUND	0	01,000,017			0	•
56. 00 05600 RADI OI SOTOPE	0				0	
57. 00 05700 CT SCAN			0.00000		0	•
58. 00 05800 MRI					0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		-			0	•
60. 00 06000 LABORATORY					470, 607	•
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			1		20, 904	•
65. 00 06500 RESPIRATORY THERAPY					699, 571	
66. 00 06600 PHYSI CAL THERAPY					777, 564	
67. 00 06700 OCCUPATIONAL THERAPY					735, 831	
68. 00 06800 SPEECH PATHOLOGY						
						•
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT					10, 015 172, 058	•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT					172, 058	•
73. 00 07200 DRUGS CHARGED TO PATIENTS					-	
	s s	1010211112			2, 413, 237	
	0				0	•
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTER	U U				0	
76. 01 03951 SLEEP LAB	0		0.00000		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0				0	
76. 03 03952 WOUND CARE	0	8, 224, 694	0.0000	0. 000000	153, 561	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0					
91. 00 09100 EMERGENCY	0					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	.,		0. 000000	864	
200.00  Total (lines 50-199)	0	466, 929, 119	1		5, 644, 994	200.00

lealth Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	ST JOSEPH MED ERVICE OTHER PASS		CCN: 150047	Period:	worksheet D
THROUGH COSTS				From 06/01/2015	
		Componen	t CCN: 155356	To 05/31/2016	
			20/111		10/31/2016 8:18 a
		11 TI	e XVIII	Skilled Nursing Facility	PPS
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Throug	h	
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	C		0	50.
50. 01 03330 ENDOSCOPY	0	C	)	0	50.
51.00 05100 RECOVERY ROOM	0	C		0	51.
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0	52.
33. 00 05300 ANESTHESI OLOGY	0	C		0	53.
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0	54.
4. 01 03630 ULTRA SOUND	0	C		0	54.
6. 00 05600 RADI 0I SOTOPE	0	C		0	56.
57. 00 05700 CT SCAN	0	C		0	57.
58. 00 05800 MRI	0	- (		0	58.
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0	59.
50. 00 06000 LABORATORY	0	C		0	60.
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	62.
55. 00 06500 RESPIRATORY THERAPY	0			0	65.
6. 00 06600 PHYSI CAL THERAPY	0			0	66.
57. 00 06700 OCCUPATI ONAL THERAPY	0		,	0	67.
8. 00 06800 SPEECH PATHOLOGY	0			0	68.
9. 00 06900 ELECTROCARDI OLOGY	0			0	69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0	71.
	0			0	71.
	0	C		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	Ĺ		0	73.
4.00 07400 RENAL DIALYSIS	0	C	)	0	74.
6.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	C		0	76.
6.01 03951 SLEEP LAB	0	C		0	76.
6. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C		0	76.
76.03 03952 WOUND CARE	0	C		0	76.
OUTPATIENT SERVICE COST CENTERS	1 1		1	-1	
20. 00 09000 CLINIC	0	C		0	90.
01.00 09100 EMERGENCY	0	C		0	91.
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0	92.
200.00 Total (lines 50-199)	0	C	)	0	200.

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 06/01/2015 To 05/31/2016		pared: 18 am
		Ti t	le 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	2, 036, 798					
31. 00 I NTENSI VE CARE UNI T	501, 518		501, 51			•
31.01 NEONATAL INTENSIVE CARE UNIT	127, 984		127, 98	4 908	140.95	31.01
33.00 BURN INTENSIVE CARE UNIT	341, 869		341, 86	9 1, 511	226.25	33.00
40. 00 SUBPROVIDER – IPF	366, 933		000, /0			
43.00 NURSERY	6, 580		6, 58			
44.00 SKILLED NURSING FACILITY	480, 616		480, 61		98.33	
200.00 Total (lines 30-199)	3, 862, 298		3, 862, 29	8 38, 546		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 332					30.00
31.00 INTENSIVE CARE UNIT	82	85, 855				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	510					31.01
33.00 BURN INTENSIVE CARE UNIT	65	14, 706				33.00
40. 00 SUBPROVIDER - IPF	226					40.00
43.00 NURSERY	279		1			43.00
44.00 SKILLED NURSING FACILITY	0	C				44.00
200.00 Total (lines 30-199)	2,494	301, 881				200. 00

Health Financial Systems	ST JOSEPH MED	I CAL_CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016		pared:
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)		,	
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	710, 521					
50. 01 03330 ENDOSCOPY	104, 690	5, 551, 891				
51.00 05100 RECOVERY ROOM	274, 257					
52.00 05200 DELIVERY ROOM & LABOR ROOM	237, 775					
53. 00 05300 ANESTHESI OLOGY	9, 609					
54.00 05400 RADI OLOGY-DI AGNOSTI C	801, 299	81, 685, 617			11, 473	
54.01 03630 ULTRA SOUND	0	C	0.0000		0	
56. 00 05600 RADI OI SOTOPE	0	C	0.0000		0	56.00
57.00 05700 CT SCAN	0	C	0.0000		0	57.00
58. 00 05800 MRI	0	C	0.0000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	138, 759					
60. 00 06000 LABORATORY	689, 939					
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	39, 162					
65. 00 06500 RESPI RATORY THERAPY	261, 649					
66. 00 06600 PHYSI CAL THERAPY	305, 581					
67.00 06700 OCCUPATI ONAL THERAPY	120, 093					
68.00 06800 SPEECH PATHOLOGY	45,003					
69. 00 06900 ELECTROCARDI OLOGY	48, 302					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	180, 581					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	113, 109					
73.00 07300 DRUGS CHARGED TO PATIENTS	246, 504					
74.00 07400 RENAL DIALYSIS	84,034					
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	-	010000		-	
76. 01 03951 SLEEP LAB	0		0.0000		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	136, 464					
76. 03 03952 WOUND CARE	360, 212	8, 224, 694	0.0437	96 105, 622	4, 626	76.03
OUTPATIENT SERVICE COST CENTERS	00 705	400.015	0 7000		0.05	00.00
90. 00 09000 CLINIC	89, 725					
91.00 09100 EMERGENCY	668, 573					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	276, 549					
200.00   Total (lines 50-199)	5, 942, 390	466, 929, 119	'I	12, 370, 158	195, 707	∠UU. UU

Health Financial Systems	ST JOSEPH MED	OICAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS	TS Provi der		Period: From 06/01/2015 To 05/31/2016		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description		Allied Health Cost	Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSIVE CARE UNIT	C	C		0 0	0	
31.01 02060 NEONATAL INTENSIVE CARE UNIT	C			0	0	
33.00 03300 BURN INTENSIVE CARE UNIT	C	c c		0	0	33.00
40. 00 04000 SUBPROVIDER - IPF	C	c c		0 0	0	40.00
43.00 04300 NURSERY	C	C		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	C	C		0	0	44.00
200.00 Total (lines 30-199)	C	C	)	0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	23, 929					30.00
31. 00 03100 I NTENSI VE CARE UNI T	479			2 0		31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	908					31.01
33. 00 03300 BURN INTENSIVE CARE UNIT	1, 511			5 0		33.00
40. 00 04000 SUBPROVI DER - I PF	6,048					40.00
43. 00 04300 NURSERY	783			9 0		43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	4,888			0 0		44.00
200.00   Total (lines 30-199)	38, 546	I	2, 49	4 0		200. 00

lealth Financial Systems	ST JOSEPH MED				u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	SERVICE OTHER PASS	6 Provider	CCN: 150047	Period: From 06/01/2015	Worksheet D Part IV	
THROUGH CUSTS				To 05/31/2016	Date/Time Pre	pared:
					10/31/2016 8:	18 am
Cast Caston Daganistica	Non Physician		le XIX	Hospi tal	PPS Total Cost	
Cost Center Description	Anesthetist	Nursing school	ATTIEG Heart	h All Other Medical	(sum of col 1	
	Cost			Educati on Cost		
	0001				4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				- 1		
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	
50. 01 03330 ENDOSCOPY	0	0		0 0	0	
51.00 05100 RECOVERY ROOM	0	0		0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
54. 00  05400  RADI OLOGY-DI AGNOSTI C 54. 01  03630  ULTRA_SOUND	0	0		0 0	0	
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	
57. 00 05700 CT SCAN	0	0		0 0	0	
58. 00 05800 MRI	0	0			0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
50. 00 06000 LABORATORY	0	0		0 0	0	
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
55. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.0
56. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.0
57.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.0
58.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.0
59. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	1 / 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	
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0	0	1 / 0 / 0
76. 01 03951 SLEEP LAB	0	0		0 0	0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	
76. 03 03952 WOUND CARE OUTPATI ENT SERVICE COST CENTERS	0	0		0 0	0	76.0
20. 00 09000 CLINIC	0	0		0 0	0	90.0
21. 00 09100 EMERGENCY	0	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	
200.00 Total (lines 50-199)		0		0 0	-	200. 00

Health Financial Systems	ST JOSEPH MED				u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 06/01/2015 To 05/31/2016	Part IV Date/Time Pre	narod
				10 03/31/2010	10/31/2016 8:	18 am
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS	- 1	1	1	- 1		
50. 00 05000 OPERATI NG ROOM	0				1, 426, 705	
50. 01 03330 ENDOSCOPY	0					
51.00 05100 RECOVERY ROOM	0	6, 323, 894				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 493, 951				
53. 00 05300 ANESTHESI OLOGY	0	6, 056, 813			287, 627	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	81, 685, 617			1, 169, 474	54.00
54. 01 03630 ULTRA SOUND	0	C	0.0000		0	54.0
56. 00 05600 RADI 0I SOTOPE	0	C	0.0000		0	56.00
57. 00 05700 CT SCAN	0	C	0.00000		0	57.00
58. 00 05800 MRI	0	C	0.00000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				81, 822	59.00
60. 00 06000 LABORATORY	0	01,701,772			1, 851, 108	
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 952, 861			219, 064	62.00
65. 00 06500 RESPI RATORY THERAPY	0				1, 341, 724	65.00
66. 00 06600 PHYSI CAL THERAPY	0	5, 620, 185			100, 950	
67. 00 06700 OCCUPATI ONAL THERAPY	0	3, 651, 684				
58. 00 06800 SPEECH PATHOLOGY	0	854, 761	0.00000			
59. 00 06900 ELECTROCARDI OLOGY	0	3, 689, 417				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0					
74.00 07400 RENAL DIALYSIS	0	2, 192, 998				
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0			0	76.00
76. 01 03951 SLEEP LAB		2 522 202	0.00000			
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0					
76.03 03952 WOUND CARE	0	8, 224, 694	0.00000	0.00000	105, 622	76.03
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	122, 245	0.00000	0.00000	307	90.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY						
	0					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50-199)				0.00000	36, 025 12, 370, 158	
200.00  10tal (1108 30-199)	1 0	400, 929, 119	I		12, 370, 158	∠00. 00

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	eu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der	CCN: 150047	Period: From 06/01/2015	Worksheet D Part IV
THROUGH COSTS				To 05/31/2016	
					10/31/2016 8:18 am
			le XIX	Hospi tal	PPS
Cost Center Description	Inpatient Program	Outpatient Program	Outpatient Program		
	Pass-Through	Charges	Pass-Throug	h	
	Costs (col. 8	onal ges	Costs (col.		
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCI LLARY SERVICE COST CENTERS			-		
50.00 05000 OPERATING ROOM	0	C		0	50.00
50. 01 03330 ENDOSCOPY	0	C		0	50.01
51.00 05100 RECOVERY ROOM	0	0	0	0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0	)	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0	)	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	U	)	0	54.00
54. 01 03630 ULTRA SOUND 56. 00 05600 RADI OI SOTOPE	0	0		0	54.01
57. 00 05700 CT SCAN	0	0		0	56.00 57.00
58. 00   05800   MRI	0	0		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	59.00
60. 00 06000 LABORATORY	0	0		0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0	65,00
66. 00 06600 PHYSI CAL THERAPY	0	C		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0	73.00
74.00 07400 RENAL DIALYSIS	0	C	)	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.01 03951 SLEEP LAB	0	0	)	0	76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	76.02
76.03 03952 WOUND CARE	0	0	<u>и</u>	0	76.03
0UTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	C		0	90.00
91. 00 09100 EMERGENCY	0	0		0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	92.00
200.00 Total (lines 50-199)	0	C		0	200.00
	-1		1		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACINE COST         Provider COS: 150047         Period: For 06/07/2016 6:19 and 10/312 PERIOD         Worksheet D Part V Eat J/12016 6:19 and 10/312 PERIOD         Worksheet D Part V Eat J/12016 6:19 and 10/312 PERIOD         Worksheet D Eat V Eat J/12016 6:19 and 10/312 PERIOD         Period: Eat to Charges         Worksheet D Eat V Eat J/12016 6:19 and 10/312 PERIOD           Cost Center Description         Cost to ChargePS Roll Hoursed Ratio From Worksheet D, Part I, col. 9         Cost Subject To Bed. & Coins.         Cost Subject To Bed. & Coins.         PES services Subject To Bed. & Coins.         PES services (see inst.)         Services (see Subject To Bed. & Coins.         PES services Subject To Bed. & Coins.         Services (see Subject To Bed. & Coins.         Services (se Subject To Bed. & Coins.         Sevice To Bed. & Coins.         Sevice Subject To Bed. & Coins.         Subject To Bed. & Coins.         Subject To Bed. & Coins. </th <th>Health Financial Systems</th> <th>ST JOSEPH MEE</th> <th>DI CAL_CENTER</th> <th></th> <th>In Lie</th> <th>u of Form CMS-</th> <th>2552-10</th>	Health Financial Systems	ST JOSEPH MEE	DI CAL_CENTER		In Lie	u of Form CMS-	2552-10
Line         To         05/31/2016         Dite/Time Prepared: 10/31/2016         Dite/Time Prepared: 10/31/2016 <td>APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN</td> <td>D VACCINE COST</td> <td>Provi der</td> <td>CCN: 150047</td> <td></td> <td></td> <td></td>	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der	CCN: 150047			
Cost Center Description         Cost ContrargePFS Reinbursed Ratio From Services (see inst.)         Cost Cost Reinbursed (see inst.)         Cost Reinbursed (see inst.)         PPS Services (see inst.)         Cost (see inst.)           MCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           0.000 (peEnATI NG ROOM 0.0000 (peEnATI NG ROOM 0.0000 (peEnATI NG ROOM 0.0000 (peEnATI NG ROOM 0.0000 (peEnATI NG ROOM 0.00000 (peEnATI NG ROOM 0.000000 (peEnATI NG ROOM 0.00000 (peEnATI NG ROOM 0.000000 (peEnATI						Date/Time Pre	
Cost Center Description         Cost Cost Cost Cost Cost Cost Cost Cost			Tit	le XIX	Hospi tal		10 4
Cost Center Description         Cost to ChargePPS Reimbursed Ratio From         Cost From         Cost Services (see inst.)         Cost Subject To Ded. & Coins.         PPS Services (see inst.)           Anci LLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 OPERATING ROOM         0.105629         0         1.02,112         0         50.00           51.00         05000 OPERATING ROOM         0.205072         0         1.02,112         0         50.00           52.00         05200 OPERATING ROOM         0.205072         0         1.781,512         0         54.00           51.00         05300 ANESTHESI OLOGY         0.1174961         0         0         1.781,512         0         54.00           52.00         05200 DELIVERY ROOM         0.205072         0         0         1.781,512         0         54.00           54.01         03300 LUTAR SOUND ALAGOR ROOM         0.796058         0         0         1.781,512         0         54.00           59.00         05700 GS000 CT SCAN         0.000000         0         0         0         55.00         55.00           50.00         05900 GR00 INSTOPE         0.000000         0         0         56.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
Ratio From Part i, col. 9         Services (see inst.)         Reimbursed Subject To Subject To Subjec	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost		
Worksheet C, Part I, col , 9         inst. )         Services Subject To Ded. & Coins. (see inst.)         Services Not Subject To Ded. & Coins. (see inst.)           0.00         05000 (PERATING ROOM 0.10 (330) (PROSCOPY 0.01 (0330) (PROSCOPY 0.01 (PROS		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
Image: bit with the service of the services of the serv		Worksheet C,			Services Not		
Image: bit with the service of the services of the serv		Part I, col. 9		Subject To	Subject To		
Image: Note of the service cost centres         Image: Note of the service cost centres         Image: Note of the service cost centres					. Ded. & Coins.		
Image: Note of the service cost centres         Image: Note of the service cost centres         Image: Note of the service cost centres				(see inst.)	(see inst.)		
50. 00         05000 (DEPATT INC ROOM         0.105629         0         1, 023, 112         0         50. 00           50. 00         05000 (DEPATT INC ROOM         0.105461         0         61, 415         0         50. 01           51. 00         05100 (RECOVERY ROOM         0.205072         0         0         157, 161         0         51. 00           52. 00         05200 (DELI VERY ROOM & LABOR ROOM         0.796008         0         2.036         0         53. 00           53. 00         05300 (ARSE) OLOGY         0.015583         0         0.205, 978         0         53. 00           64. 00         0.6000 (ARD ILOGY -DI AGNOSTI C         0.079605         0         1, 781, 512         0         54. 00           56. 00         05600 (RAI) OSOTOPE         0.000000         0         0         0         56. 00           57. 00         05600 (RAI) OSOTOPE         0.000000         0         0         0         58. 00           58. 00         05600 (RAI) CATHETREI ZATI ON         0.102283         0         70. 390         59. 90           60. 00         06000 RESPI RATORY         0.102188         0         15. 741         0         65. 00           61. 00         06600 RESPI RATORY		1.00	2.00	3.00		5.00	
50. 01         03330         ENDOSCOPY         0. 174961         0         61.415         0         50. 01           51. 00         05100         RECOVERY ROM         0. 205072         0         0         157. 161         0         51. 00           52. 00         D5200         DELIVERY ROM & LABOR ROM         0. 205072         0         0         20.36         0         52.00           53. 00         D5300         RESTHESI 0LOGY         0. 015583         0         205.978         0         53. 00           54. 01         0.3630         ULTAR SOUND         0. 000000         0         1.781.512         0         54. 01           56. 00         65700         CT SAN         0. 000000         0         0         0         57.00           57. 00         05700         CT SAN         0. 000000         0         0         0         57.00           58. 00         05800         RRI         0. 000000         0         0         1.942.615         0         60. 00           65. 00         CASDA & CATHETERI ZATION         0. 102188         0         1.142.615         0         60. 00           65. 00         06500         RESPI RATORY THERAPY         0. 259761	ANCI LLARY SERVI CE COST CENTERS						
51.00         OS100         RECOVERY ROM         0.205072         0         157.1c1         0         51.00           52.00         05200         DELIVERY ROM & LABOR ROM         0.796088         0         0         2.036         0         52.00           53.00         DS300         AVESTHESI OLOGY         0.015583         0         0         205.978         0         53.00           54.00         OS400         RADI OLOGY-DI AGNOSTI C         0.079605         0         1,781,512         54.00           54.00         Stolo         RADI OLOGY-DI AGNOSTI C         0.000000         0         0         54.00           54.00         Stolo         RADI OLOGY-DI AGNOSTI C         0.000000         0         0         54.00           56.00         Stolo         RADI OLSTOPE         0.000000         0         0         0         55.00           50.00         DS500         CARDI AC CATHETERI ZATI ON         0.105283         0         70.390         59.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00	50.00 05000 OPERATING ROOM	0. 105629	0		0 1, 023, 112	0	50.00
52.00         05200         DELIVERY ROM & LABOR ROM         0.796008         0         2.036         0         52.00           53.00         05300         ANESTHESI OLOGY         0.015583         0         0         205.978         0         53.00           54.00         D5400         RADI OLOGY-DI AGNOSTI C         0.079605         0         0         0         0         0         54.00           54.01         03630         UTRA SOUND         0.00000         0         0         0         54.00           56.00         OSOO RADI OLOGY-DI AGNOSTI C         0.000000         0         0         0         54.00           57.00         OSOO RADI OLOGY-DI AGNOSTI C         0.000000         0         0         0         54.00           58.00         05900         CARDI AC CATHETERI ZATI ON         0.105283         0         0         70.390         58.00           60.00         06000         HABCRAD & AC ALTHETERI ZATI ON         0.102188         0         1.142.615         60.00           61.00         06000         HACKED RED BLOOD CELL         0.184139         0         0         15.741         0         62.00           65.00         065000         RESPI RATORY THERAPY	50. 01 03330 ENDOSCOPY	0. 174961	0		0 61, 415	0	50.01
53.00         NESTHESI OLOGY         0.015583         0         205,978         0         53.00           54.00         05400         RADIOLOGY-DIAGNOSTIC         0.079605         0         0         1,781,512         0         54.00           54.01         03630         ULTRA SOUND         0.000000         0         0         0         0         54.01           57.00         GTS CAN         0.000000         0         0         0         0         56.00           58.00         05800         MRI         CATHETRI ZATION         0.000000         0         0         0         57.00           59.00         05900         CARDIA C CATHETERI ZATION         0.102188         0         0         1.142,615         0         60.00           62.00         06200         HOLE BLODD & PACKED RED BLODD CELL         0.184139         0         0         70,773         0         65.00           64.00         06500         RESPI RATORY THERAPY         0.202826         0         0         9,398         67.00           65.00         06500         SPECIPATIONAL THERAPY         0.202826         0         9,398         67.00           71.00         00700         CCUPATI ONAL THERAPY <td>51.00 05100 RECOVERY ROOM</td> <td>0. 205072</td> <td>2 0</td> <td></td> <td>0 157, 161</td> <td>0</td> <td>51.00</td>	51.00 05100 RECOVERY ROOM	0. 205072	2 0		0 157, 161	0	51.00
54. 00       054.00       RADI OLOGY - DI AGNOSTI C       0.079605       0       1,781,512       0       54. 00         54. 01       03630       ULTRA SOUND       0.000000       0       0       0       54. 00         50. 00       05000       RADI OLOGY - DI AGNOSTI C       0.000000       0       0       0       56. 00         57. 00       05700       CT SCAN       0.000000       0       0       0       57. 00         58. 00       05800       MRI       0.000000       0       0       0       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI 0N       0.102188       0       1,142, 615       0       60. 00         60. 00       06000       HESPI RATORY THERAPY       0.101237       0       70, 773       65. 00       65. 00       66. 00       9, 989       67. 00       67. 00       66. 00       9, 989       67. 00       67. 00       68. 00       9, 989       67. 00       68. 00       9, 989       67. 00       68. 00       69. 00       10, 076       68. 00       69. 00       10, 076       68. 00       69. 00       10, 076       68. 00       69. 00       10, 076       68. 00       69. 00       10, 076       68. 00 <t< td=""><td>52.00 05200 DELIVERY ROOM &amp; LABOR ROOM</td><td>0. 796008</td><td>3 O</td><td></td><td>0 2,036</td><td>0</td><td>52.00</td></t<>	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 796008	3 O		0 2,036	0	52.00
54. 01       0330       ULTRA SOUND       0.000000       0       0       0       0       54. 01         57.00       0500       RADIOI SOTOPE       0.000000       0       0       0       0       56. 00         57.00       05700       CT SCAN       0.000000       0       0       0       0       57.00         59.00       0500       CARDIAC CATHETERIZATION       0.105283       0       0       70.390       59.00         60.00       06000       LABORATORY       0.102188       0       1,142,615       0       60.00         62.00       06200       HNLE BLOOD & PACKED RED BLOOD CELL       0.184139       0       070,773       0       65.00       65.00       65.00       0       66.00       66.00       9,398       67.00       66.00       66.00       9,398       67.00       68.00       06000       SPECH PATHOLOGY       0.239359       0       0       10.076       68.00       6800       6800       6800       SPECH PATHOLOGY       0.239359       0       0       100,076       68.00       69.00       139,614       0       71.00       73.00       73.00       73.00       73.00       73.00       74.00       74.00       74.00	53. 00 05300 ANESTHESI OLOGY	0. 015583	0		0 205, 978	0	53.00
56.00       05600       RADI DI SOTOPE       0.000000       0       0       0       0       56.00         57.00       05700       CT SCAN       0.000000       0       0       0       57.00         58.00       05800       MRI       0.000000       0       0       0       58.00         59.00       05900       CARDI AC       CATHETERI ZATI ON       0.105283       0       70.390       59.00         60.00       06000       LABORATORY       0.102188       0       1,142,615       60.00         65.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0.184139       0       70.773       65.00         66.00       06600       PHYSI CAL THERAPY       0.202826       0       0       9.398       67.00         67.00       06700       OCCUPATI ONAL THERAPY       0.202826       0       0       1.076       68.00         68.00       06800       SPEECH PATHOLOGY       0.239359       0       0       1.076       68.00         71.00       07100       MEDL CAL SUPPLIES CHARGED TO PATI ENTS       0.112152       0       86.168       72.00         73.00       07300       IMPL. DEV. CHARGED TO PATI ENTS       0.127166 </td <td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>0.079605</td> <td>i o</td> <td></td> <td>0 1, 781, 512</td> <td>0</td> <td>54.00</td>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.079605	i o		0 1, 781, 512	0	54.00
57.00       05700       CT SCAN       0.000000       0       0       0       57.00         58.00       05800       MRI       0.000000       0       0       0       58.00         60.00       06000       LABORATORY       0.105283       0       0       70.390       59.00         60.00       06000       LABORATORY       0.102188       0       1,142,615       60.00         62.00       06500       RESPI RATORY       1.01237       0       0       70.773       65.00         66.00       06600       PHYSI CAL THERAPY       0.2059761       0       0       36,624       66.00         0.6100       OCCUPATI ONAL THERAPY       0.2259761       0       0       10.076       68.00         0.6200       VEDTI ONAL THERAPY       0.22526       0       0       10.076       68.00         0.900       ELECTROCARDI OLOGY       0.239359       0       0       10.076       68.00         0.900       ELECTROCARDI OLOGY       0.239359       0       0       19.014       71.00         0.7100       INPL.       DEV. CHARGED TO PATI ENT       0.112152       0       86.168       72.00         0.7200 <td< td=""><td>54.01 03630 ULTRA SOUND</td><td>0.000000</td><td>ol o</td><td></td><td>0 0</td><td></td><td>54.01</td></td<>	54.01 03630 ULTRA SOUND	0.000000	ol o		0 0		54.01
58.00       05800       MRI       0.00000       0       0       0       58.00         59.00       05900       CARDI AC CATHETERI ZATI ON       0.105283       0       0       70,390       0       59.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0.184139       0       1.142,415       0       62.00         65.00       06500       RESPI RATORY THERAPY       0.102188       0       70,773       0       62.00         66.00       00       CCUPATI ONAL THERAPY       0.259761       0       0       36,624       0       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.202826       0       0       9,398       0       67.00         68.00       DEECH PATHOLOGY       0.233359       0       0       10,076       0       68.00         71.00       07100       INPL: DEV. CHARGED TO PATI ENT       0.213728       0       189,614       0       71.00         72.00       07300       INPL: DEV. CHARGED TO PATI ENTS       0.105496       0       421,550       73.00       73.00         74.00       03550       OTHER ANCILLARY SERVICE COST CENTER       0.000000       0       0       76.01	56. 00 05600 RADI OI SOTOPE	0.000000	ol o		0 0	0	56.00
59.00       05900       CARDI AC CATHETERI ZATI ON       0.105283       0       70,390       0       59.00         60.00       06000       LABORATORY       0.102188       0       1,142,615       0       60.00         62.00       06020       WHOLE BLOOD & PACKED RED BLOOD CELL       0.184139       0       0       15,741       0       62.00         65.00       06500       RESPI RATORY THERAPY       0.202826       0       0       70,773       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.202826       0       0       9,398       67.00       66.00         67.00       06000       DEECTROCARDI OLOGY       0.239359       0       0       10,076       68.00       68.00         69.00       DEECTROCARDI OLOGY       0.078413       0       59,337       69.00       72.00       7300       189,614       71.00       72.00       73.00       74.00       86.168       72.00       76.01	57.00 05700 CT SCAN	0.000000	ol o		0 0	0	57.00
59.00       05900       CARDI AC CATHETERI ZATI ON       0.105283       0       70,390       0       59.00         60.00       06000       LABORATORY       0.102188       0       1,142,615       0       60.00         62.00       06020       WHOLE BLOOD & PACKED RED BLOOD CELL       0.184139       0       0       15,741       0       62.00         65.00       06500       RESPI RATORY THERAPY       0.202826       0       0       70,773       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.202826       0       0       9,398       67.00       66.00         67.00       06000       DEECTROCARDI OLOGY       0.239359       0       0       10,076       68.00       68.00         69.00       DEECTROCARDI OLOGY       0.078413       0       59,337       69.00       72.00       7300       189,614       71.00       72.00       73.00       74.00       86.168       72.00       76.01	58. 00 05800 MRI	0.000000	ol o		0 0	0	58.00
60.00       06000       LABORATORY       0.102188       0       1,142,615       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0.184139       0       15,741       62.00         65.00       06500       RESPI RATORY THERAPY       0.101237       0       070,773       66.00         66.00       06600       PHYSI CAL THERAPY       0.259761       0       36,624       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.202826       0       9,398       67.00         68.00       06800       SPEECH PATHOLOGY       0.078413       0       059,337       69.00         06700       0CCUPATI ONAL THERAPY       0.213728       0       189,614       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.213728       0       86,168       72.00         73.00       07300       RUGS CHARGED TO PATI ENTS       0.105496       0       0       0       73.00         74.00       07400       RENAL DI ALYSI S       0.272106       0       0       74.00       76.00         76.01       03950       OTHER ANCI LLARY SERVI CE COST CENTER       0.246779       0       0       0       76.00	59. 00 05900 CARDI AC CATHETERI ZATI ON				0 70, 390	0	59.00
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0.184139       0       0       15,741       0       62.00         65.00       06500       RESPI RATORY THERAPY       0.101237       0       0       70,773       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.259761       0       0       36,624       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.202826       0       9,398       0       67.00         68.00       PSECH PATHOLOGY       0.239359       0       0       10,076       68.00         69.00       ELECTROCARDIOLOGY       0.213728       0       189,614       0       71.00         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.112152       0       86,168       0       72.00         73.00       DRUGS CHARGED TO PATI ENTS       0.272106       0       46,168       0       73.00       73.00       0       74.00       74.00       76.00       0       74.00       76.00       0       76.00       0       76.00       0       76.00       0       76.00       0       76.00       0       76.00       0       76.02       0							60,00
65:00       06500       RESPI RATORY THERAPY       0.101237       0       0       70,773       0       65:00         66:00       06600       PHYSI CAL THERAPY       0.259761       0       0       36,624       0       66:00         67:00       0CCUPATI ONAL THERAPY       0.202826       0       0       9,398       0       67:00         68:00       06800       SPEECH PATHOLOGY       0.239359       0       0       10:076       68:00         69:00       06900       ELECTROCARDI OLOGY       0.078413       0       0       59;337       0       69:00         71:00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.213728       0       0       189,614       0       71:00         72:00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.105496       0       0       421,560       0       73:00       73:00       74:00       74:00       74:00       0       0       0       74:00       76:00       74:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       <	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0, 184139					62.00
66.00       06600       PHYSI CAL THERAPY       0.259761       0       0       36,624       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.202826       0       0       9,398       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.239359       0       0       10,076       0       68.00         69.00       06000       ELECTROCARDI OLOGY       0.078413       0       0       59,337       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.213728       0       0       189,614       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.112152       0       0       86,168       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.105496       0       0       0       74.00         74.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0.000000       0       0       0       76.01         76.01       03952       VOHA TRI C/PSYCHOLOGI CAL SERVICES       0.244052       0       0       15,525       0       76.02         76.02       03552       PSYCHI ATI C/PSYCHOLOGI CA		0, 101237					65.00
67.00       06700       OCCUPATI ONAL THERAPY       0.202826       0       0       9,398       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.239359       0       0       10,076       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.078413       0       0       59,337       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.213728       0       0       86,168       0       71.00       72.00       07300       DRUGS CHARGED TO PATI ENTS       0.112152       0       0       86,168       0       72.00       73.00       07400       RENAL DI ALYSI S       0.222106       0       86,168       0       73.00       73.00       07400 RENAL DI ALYSI S       0.222106       0       0       0       74.00       74.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       7							66,00
68.00       06800       SPEECH PATHOLOGY       0.239359       0       0       10,076       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0.078413       0       0       59,337       0       69.00         71.00       MEDICAL SUPPLIES CHARGED TO PATIENT       0.213728       0       0       189,614       0       72.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.112152       0       0       86,168       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.105496       0       0       421,560       0       73.00         74.00       07400       RENAL DIALYSIS       0.272106       0       0       0       74.00         76.01       03950       OTHER ANCILLARY SERVICE COST CENTER       0.000000       0       0       0       76.01         76.02       03550       PSYCHIATRIC/PSYCHOLOGICAL SERVICES       0.246779       0       0       236,100       0       76.02         76.03       03952       WOUND CARE       0.246779       0       0       3,466       90.00       76.03         70.00       09000       CLINIC       3.549708       0       0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>67.00</td></t<>							67.00
69.00       06900       ELECTROCARDI OLOGY       0.078413       0       59,337       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.213728       0       0       189,614       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.112152       0       0       86,168       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.105496       0       0       421,560       0       73.00         74.00       7400       RENAL DI ALYSI S       0.272106       0       0       0       74.00         76.00       03950       OTHER ANCI LLARY SERVI CE COST CENTER       0.000000       0       0       0       76.01         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.244052       0       0       15,525       0       76.02         76.03       03952       WOUND CARE       0.246779       0       3,466       0       90.00         90.00       09000       CLI NI C       3.549708       0       1,983,077       91.00         91.00       PSICOST CENTERS       0.116567       0       124,936       92.00       226.00							68,00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.213728       0       0       189,614       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.112152       0       0       86,168       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.105496       0       0       421,560       0       73.00         74.00       07400       RENAL DI ALYSI S       0.272106       0       0       0       74.00         76.00       03950       OTHER ANCI LLARY SERVI CE COST CENTER       0.000000       0       0       0       76.00         76.01       03951       SLEP LAB       0.000000       0       0       0       76.00         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.244052       0       0       15,525       0       76.02         76.03       03952       WOUND CARE       0.246779       0       236,100       0       76.03         79.00       09000       CLI NI C       3.549708       0       1,983,077       91.00       91.00         90.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.454255       0       1							69.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.112152       0       0       86,168       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.105496       0       0       421,560       0       73.00         74.00       07400       RENAL DI ALYSIS       0.272106       0       0       0       74.00         76.00       03950       OTHER ANCILLARY SERVICE COST CENTER       0.000000       0       0       0       76.00         76.01       03951       SLEEP LAB       0.000000       0       0       0       76.00         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0.244052       0       0       15,525       0       76.02         76.03       03952       WOUND CARE       0.246779       0       0       236,100       0       76.03         79.00       09000       CLI NI C       3.549708       0       0       3,466       0       90.00         91.00       09000       CLI NI C       0       116567       0       1,983,077       91.00       91.00         92.00       OSBERVATI ON BEDS (NON-DI STI NCT PART       0.454255       0       124,936       200.							
73.00       07300       DRUGS CHARGED TO PATIENTS       0.105496       0       421,560       73.00         74.00       07400       RENAL DI ALYSI S       0.272106       0       0       0       74.00         76.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0.000000       0       0       0       76.00         76.01       03951       SLEEP LAB       0.000000       0       0       0       76.00         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.244052       0       0       15,525       76.02         76.03       03952       WOUND CARE       0.246779       0       0       236,100       76.02         71.00       09000       CLI NI C       3.549708       0       3,466       90.00         91.00       09100       EMERGENCY       0.116567       0       1,983,077       91.00         92.00       OSERVATI ON BEDS (NON-DI STI NCT PART       0.454255       0       124,936       92.00         200.00       Subtotal (see instructions)       0       7,706,614       200.00       201.00         201.00       Less PBP Cli nic Lab. Services-Program Only Charges       0       0       0       201.00							72.00
74.00       07400       RENAL DI ALYSI S       0.272106       0       0       0       74.00         76.00       03950       OTHER ANCI LLARY SERVI CE COST CENTER       0.000000       0       0       0       0       76.00         76.01       03951       SLEEP LAB       0.000000       0       0       0       0       76.01         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.244052       0       0       15,525       0       76.02         76.03       03952       WOUND CARE       0.246779       0       0       236,100       0         90.00       09000       CLI NI C       3.549708       0       0       3,466       0       90.00         91.00       P9000       EMERGENCY       0.116567       0       1,983,077       91.00       91.00         92.00       09200       OBSERVATION BEDS (NON-DI STI NCT PART       0.454255       0       0       124,936       92.00       92.00         200.00       Subtotal (see instructions)       0       0       7,706,614       2200.00       200.00         201.00       Less PBP Clinic Lab. Services-Program Only Charges       0       0       0       201.00							73.00
76.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0.000000       0       0       0       76.00         76.01       03951       SLEEP LAB       0.000000       0       0       0       0       76.01         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0.244052       0       0       15,525       0       76.02         76.03       03952       WOUND CARE       0.246779       0       0       236,100       0       76.03         0UTPATI ENT SERVICE COST CENTERS       0.246779       0       0       3,466       0       90.00         09000       CLI NI C       3.549708       0       0       3,466       90.00       91.00         91.00       O9000       CLI NI C       0.116567       0       1,983,077       91.00       92.00         92.00       09200       OBSERVATION BEDS (NON-DI STI NCT PART       0.454255       0       124,936       92.00       92.00         200.00       Subtotal (see instructions)       0       0       7,706,614       200.00       200.00       201.00       0       0       201.00       0       0       0       0       0       0       0       0       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>74.00</td>							74.00
76.01       03951       SLEEP LAB       0.000000       0       0       0       76.01         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.244052       0       0       15,525       0       76.02         76.03       03952       WOUND CARE       0.246779       0       0       236,100       0       76.03         00100       CLI NI C       0.246779       0       0       3,466       0       90.00         90.00       09000       CLI NI C       3.549708       0       0       3,466       90.00       91.00         91.00       PSERVATION BEDS (NON-DI STI NCT PART       0.454255       0       0       124,936       92.00       92.00         200.00       Subtotal (see instructions)       0       0       7,706,614       200.00       200.00       201.00       0       201.00       201.00					0 0	0	76.00
76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.244052       0       0       15,525       0       76.02         76.03       03952       WOUND CARE       0.246779       0       0       236,100       0       76.03         0UTPATI ENT SERVICE COST CENTERS       0.246779       0       0       3,466       0       90.00         90.00       09000       CLINIC       0       3.549708       0       0       3,466       0       90.00         91.00       09100       EMERGENCY       0.116567       0       0       1,983,077       0       91.00         92.00       09200       OBSERVATION BEDS (NON-DI STI NCT PART       0.454255       0       0       124,936       0       92.00         200.00       Subtotal (see instructions)       0       0       7,706,614       200.00       201.00         201.00       Less PBP Clinic Lab. Services-Program Only Charges       0       0       0       201.00       201.00					0 0	0	76.01
76.03         03952         WOUND_CARE         0.246779         0         236,100         76.03           OUTPATIENT_SERVICE_COST_CENTERS         0         3.549708         0         3,466         0         90.00           90.00         09000         CLINIC         3.549708         0         3,466         0         90.00           91.00         09100         EMERGENCY         0.116567         0         1,983,077         0         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0.454255         0         124,936         0         92.00           200.00         Subtotal (see instructions)         0         0         7,706,614         200.00         201.00         201.00         201.00         201.00         201.00         201.00         0         201.00					0 15, 525	0	
OUTPATIENT SERVICE COST CENTERS           90.00         09000         CLINIC         3.549708         0         3,466         0         90.00           91.00         09100         EMERGENCY         0.116567         0         1,983,077         0         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0.454255         0         0         124,936         0         92.00           200.00         Subtotal (see instructions)         0         0         7,706,614         0         200.00           201.00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         201.00         0         201.00         0         201.00         0         201.00         0         0         201.00         0         201.00         0         0         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00							
90.00         09000         CLINIC         3.549708         0         3.466         90.00           91.00         09100         EMERGENCY         0.116567         0         1,983,077         0         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0.454255         0         0         124,936         0         92.00           200.00         Subtotal (see instructions)         0         0         7,706,614         0         200.00           201.00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         0         0         201.00			<u> </u>				
91.00       09100       EMERGENCY       0.116567       0       1,983,077       0       91.00         92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART       0.454255       0       0       124,936       0       92.00         200.00       Subtotal (see instructions)       0       0       7,706,614       0       200.00         201.00       Less PBP Clinic Lab. Services-Program Only Charges       0       0       0       0       0       201.00		3. 549708	3 0		0 3.466	0	90.00
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         0.454255         0         124,936         0         92.00           200.00         Subtotal (see instructions)         0         0         7,706,614         0         200.00           201.00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         0         0         0         201.00							
200.00 201.00Subtotal (see instructions) Less PBP Clinic Lab. Services-Program Only Charges007,706,614 00200.00 201.00							
201.00Less PBP Clinic Lab. Services-Program00201.00Only Charges0000							
Only Charges							
			0		0 7, 706, 614	0	202.00

50.01         03330         ENOSCOPY         0         10,745         50.0           51.00         05100         RECOVERY ROOM         0         32,229         51.0           52.00         D5200         DELIVERY ROOM & LABOR ROOM         0         1,621         52.0           53.00         OS300         ANESTHESI 0LOGY         0         3,210         53.0           54.01         OS400         RADIONADICAD LANDANTIC         0         141.817         54.0           54.01         OS400         RADION SOLOPE         0         0         56.0         56.00         05000         RADION SOLOPE         0         0         56.0         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         66.00<	Health Financial Systems	ST JOSEPH MED	DI CAL CENTER		In Lie	u of Form CMS-	-2552-10
Cost Center Description         Cost Cost Services Subject To Ded. & Cons. Subject To Subject To S	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provi der	CCN: 150047	From 06/01/2015	Part V Date/Time Pre	
Cost Center Description         Cost S Reimbursed Subject To Ded & Coins Subject T			Tit	le XIX	Hospi tal		. 10 am
Cost Center Description         Cost Reimbursed Services         Cost Subject To Subject To Ded. & Coins.         Cost Reimbursed Services           3.VD Part LLARY SERVICE COST CENTERS         0         0.00         7.00         50.00         05000 (DPEATING ROOM 05000 (DPEATING ROOM 05000 (DPEATING ROOM 05100 (DEINDERY ROOM 10.00 (DEINDERY ROOM 1		Co			noopi tui		
Rel imbursed Services         Rel imbursed Subject To bed. & Coins. (see inst.)         Rel imbursed Subject To bed. & Coins. (see inst.)           ANCILLARY SERVICE COST CENTERS         0         7.00           NOI 03330 ENDOSCOPY         0         108,070           50.00         05000 OPERATING ROM         0         108,070           51.00         05100 DECOVERY ROM         0         102,745           52.00         05200 DELIVERY ROM         0         32,229           53.00         05300 ANESTHESIOLOGY         0         3,210           54.00         05300 ANESTHESIOLOGY         0         3,210           54.00         05300 RADIOLOGY-DI AGNOSTIC         0         141,817           56.00         05600 RADIOLOGY-DI AGNOSTIC         0         0           57.00         05700 CT SCAN         0         0           58.00         05800 RADIOLOGY THERAPY         0         7,111           59.00         05900 CARDIA CATHETERIZATION         7,165         66.0           50.00         05600 RESPIRATORY THERAPY         0         7,165         65.0           50.00         05600 RESPIRATORY THERAPY         0         7,165         65.0           50.00         05600 RESPIRATORION CORY         0         2,412<	Cost Center Description		1				
Services							
Ded.* & Coin ns. (see inst.)         Ded.* & Coin ns. (see inst.)           50.00         05000         0FEATI NG ROOM         0         108,070         50.0           50.00         05000         RECAPERT NG ROOM         0         108,770         50.0           50.00         05000         RECOVERY NOM         0         108,770         50.0           50.00         05100         RECOVERY NOM         0         32,229         51.0           51.00         05100         NECOVERY NOM         0         3,210         53.0           53.00         05300         JUSAN OND         0         3,210         54.0           54.00         05400         RADI LOGY -DI AGNOSTIC         0         141,817         54.0           54.00         05600         RADI LOGY -DI AGNOSTIC         0         0         55.0           57.00         05700 CT SCAN         0         0         56.0         56.0           58.00         OSB00 MRI         0         7.411         59.0         56.0           66.00         RESPIRATORY THERAPY         0         7,165         65.0         65.0           66.00         OSCOON CARDIAC CATHETERIZATION         0         7,165         65.0         66		Servi ces	Services Not				
Inst.         (see inst.)         (see inst.)           ANCILLARY SERVICE COST CENTERS         6.00         7.00           S0.00         OBCORD OPERATING ROOM         0         108,070           S0.01         03330         ENDOSCOPY         0         10,745           S0.00         DS100         PECOVERY ROOM         ABOR ROOM         0         12,222           S1.00         DS100         PECOVERY ROOM         ABOR ROOM         0         1,621           S2.00         DS200         DELIVERY ROOM & LABOR ROOM         0         1,621         52.0           S2.00         DS300         RNDI COVERY ROOM         ALBOR ROOM         0         1,621         52.0           S4.00         DS400         RADI COVERY ROOM         ALBOR ROOM         0         141,817         54.0           S4.00         DS400         O         0         0         57.0         58.0         05900         CARDI AC CATHETERI ZATION         0         7.411         59.0         59.0         59.00         59.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         <		Subject To	Subject To				
ACILILARY SERVICE COST CENTERS         6.00         7.00           50.00         05000         OPERATING ROOM         0         108,070         50.0           50.01         03330         ENDOSCOPY         0         100,745         50.0           51.00         DS1000         RECOVERY ROOM         0         32,229         51.0           52.00         DS2000         ALEVERY ROOM & LABOR ROOM         0         3,210         53.0           53.00         DS3000         ANESTHESI OLOGY         0         3,210         54.0         0         56.0           54.00         DS4000         RADIOLOGY-DI ASINSTI C         0         141,817         54.0         56.0           56.00         DS5000         RADIOLOGY-DI ASINSTI C         0         0         0         55.0           58.00         DS8000         NADIOLOGY-DI ASINSTI C         0         0         0         56.0           59.00         DS8000         RADION CARDIA C CATHETERI ZATI ON         0         7.411         59.0         58.0         58.0         58.0         58.0         58.0         58.0         58.0         58.0         58.0         58.0         58.0         58.0         58.0         58.0         58.0		Ded. & Coins.	Ded. & Coins.				
ANCI LLARY SERVICE COST CENTERS         ANCI LLARY SERVICE COST CENTERS         Solution         S		(see inst.)	(see inst.)				
50.00         05000         0FERATING ROOM         0         108.070         50.0           50.01         0330         ENDOSCOPY         0         10.745         50.0           51.00         DS100 RECOVERY ROOM         0         32,229         51.0           52.00         DS200 MESTHESIOLOGY         0         3,210         53.0           53.00         DS300 ANESTHESIOLOGY         0         3,210         54.0           54.00         DS400 RADIOLOGY-DIAGNOSTIC         0         141.817         54.0           54.00         DS400 RADIOLOGY-DIAGNOSTIC         0         141.817         54.0           56.00         DS600 RATESTHESIOLOGY         0         0         0         55.0           57.00         DS700 CT SCAN         0         0         0         56.0           58.00         DS800 RESPI RATORY         0         17.411         59.0           50.00         DS600 RESPI RATORY THERAPY         0         7.165         65.0           65.00         D6500 RESPI RATORY THERAPY         0         7.165         65.0           66.00         D6600 RESPI RATORY THERAPY         0         7.165         65.0           67.00         D6700 OCCUPATI ONAL THERAPY		6.00	7.00				
50.01         03330         ENDOSCOPY         0         10.745         50.0           51.00         05100         RECOVERY ROOM         0         32,229         51.0           52.00         DELIVERY ROOM & LABOR ROOM         0         1.621         52.0           53.00         OS200 RADIOLOCOV-DI AGNOSTI C         0         141.817         54.0           54.01         03630 ULTAR SOUND         0         0         56.0         57.00	ANCILLARY SERVICE COST CENTERS						
51.00       ISTOR       RECOVERY ROOM       0       32,229       51.0         52.00       05200       DELIVERY ROOM & LABOR ROOM       0       1,621       52.0         53.00       05300       ANESTHESI OLOCY       0       3,210       53.0         54.00       05400       RADI OLOCY-DI AGNOSTI C       0       141,817       54.0         54.01       03600 ILRIA SOUND       0       0       0       54.0         55.00       05500 CRADI OLOCY-DI AGNOSTI C       0       0       0       54.0         56.00       05600 RADI OLOCY-DI AGNOSTI C       0       0       0       54.0         56.00       05600 RADI OLOCY-DI AGNOSTI C       0       0       0       54.0         57.00       05700 CT SCAN       0       0       0       58.0       58.00         68.00       06000 LABORATORY       0       116.762       60.0       60.0       60.0       60.0       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.0       66.00       66.00       66.00       66.00       66.0       66.0       66.0       66.0       66.0       66.0	50. 00 05000 OPERATI NG ROOM	C	108, 070				50.00
52 00       05200       DELIVERY ROOM & LABOR ROOM       0       1, 21       52.0         53.00       05300       ANESTHESI OLOGY       0       3, 210       53.0         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       141, 817       54.0         54.00       05600       RADI OLOGY-DI AGNOSTI C       0       0       54.0         56.00       05600       RADI OLOGY-DI AGNOSTI C       0       0       54.0         57.00       05700       CT SCAN       0       0       56.0         58.00       05800       CARDI AC CATHETERI ZATI ON       0       7,411       59.0         60.00       06000       LABORATORY       0       116,762       60.0         61.00       06000       PASICAR THERAPY       0       7,165       65.0         65.00       06500       RESPI RATORY THERAPY       0       1,906       67.0         66.00       06600       PHYSI CAL THERAPY       0       2,412       66.0         67.00       06700       CUPATI ONAL THERAPY       0       2,412       66.0         68.00       06800 SEECH PATHOLOGY       0       4,453       69.0       67.0         71.00       0	50. 01 03330 ENDOSCOPY	C	10, 745				50.01
53.00       05300       ANESTHESI OLOGY       0       3, 210       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       141, 817       54.0         54.01       0330       UTRA SUND       0       0       54.0         57.00       05700       CT SCAN       0       0       56.0         57.00       05700       CT SCAN       0       0       58.0         59.00       05900       CARDI AC CATHETERI ZATI ON       0       7, 411       59.0         60.00       06000       LABORATORY       0       116, 762       60.0         60.00       06000       RESPI RATORY THERAPY       0       7, 165       65.0         61.00       06600       PHYSI CAL THERAPY       0       9, 513       66.0         63.00       06600       PHYSI CAL THERAPY       0       1, 906       7.0         64.00       OSPOD CULPATI ONAL THERAPY       0       4, 653       69.0         69.00       06900       ELECTROCARDI OLOGY       0       2, 412       68.0         69.00       06900       ELECTROCARDI OLOGY       0       4, 453       73.0         71.00       07100       MEDI CAL SUPPLIES CHARGED	51.00 05100 RECOVERY ROOM	C	32, 229				51.00
54.00       05400       RADI OLOGY-DI AGNOSTI C       0       141, 817       54.00         54.01       03303       ULTRA SOUND       0       0       0         57.00       05700       CT SCAN       0       0       0         58.00       05800       MRI       0       0       0         59.00       05900       CARDI AC CATHETERI ZATI ON       0       7,411       59.0         60.00       06000       LABORATORY       0       116,762       60.0       60.0         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       2,899       62.0       62.0         65.00       06500       RESPI RATORY THERAPY       0       7,165       65.0       66.0       66.00       66.00       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       66.0       66.0       69.0       68.0       66.0       69.0       64.0       72.2       68.0       66.0       69.0       69.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0	52.00 05200 DELIVERY ROOM & LABOR ROOM	C	1, 621				52.00
54.01       03630       ULTRA SOUND       0       0       54.0         56.00       05600       RADIOISOTOPE       0       0       55.0         57.00       05700       CT SCAN       0       0       58.0         58.00       05800       MRI       0       0       58.0         60.00       06000       LABORATORY       0       7,411       59.0         62.00       06200       WHOLE BLODD & PACKED RED BLODD CELL       0       2,899       62.0         65.00       06500       RESPI RATORY THERAPY       0       7,165       65.0         66.00       06600       PHYSI CAL THERAPY       0       7,9513       66.0         67.00       06700       0CCUPATIONAL THERAPY       0       1,906       67.0         68.00       06800       SPECH PATHOLOGY       0       2,412       68.0         69.00       06900       ELECTROCARDIOLOGY       0       4,653       69.0         71.00       07100       INPL. DEV. CHARGED TO PATIENT       0       90.664       72.0         73.00       07300       DRUSS CHARGED TO PATIENTS       0       0       74.0         76.01       03950       OTHER ANCILLARY	53.00 05300 ANESTHESI OLOGY	C	3, 210				53.00
56.00       05600       RADI 01 SOTOPE       0       0         57.00       05700       CT SCAN       0       0         58.00       05800       MRI       0       0         59.00       05800       CARDI AC CATHETERI ZATI 0N       0       7,411       59.0         60.00       06000       LABORATORY       0       116,762       60.0         65.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       2,899       62.0         65.00       06500       RESPI RATORY THERAPY       0       7,165       65.0         66.00       06600       PHYSI CAL THERAPY       0       1,906       67.0         67.00       06700       0CCUPATI IONAL THERAPY       0       1,906       67.0         68.00       06600       PEECH PATHOLOGY       0       2,412       68.0         69.00       06900       ELECTROCARDI OLOGY       0       4,653       69.0         71.00       07100       MPL. DEV. CHARGED TO PATI ENTS       0       9,664       72.0         74.00       07400       RENAL DI ALYSI S       0       0       0       74.0         76.01       03551       SEPI CI DAST CENTER       0	54.00 05400 RADI OLOGY-DI AGNOSTI C	C	141, 817				54.00
57.00       05700       CT SCAN       0       0         58.00       05800       MRI       0       0       0         60.00       06000       LABORATORY       0       116, 762       60.0         60.00       06000       LABORATORY       0       7,411       59.0         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       2,899       62.0         65.00       06500       RESPI RATORY THERAPY       0       7,165       65.0         66.00       06600       PHYSI CAL THERAPY       0       1,906       67.0         67.00       0CCUPATI ONAL THERAPY       0       1,906       68.0       68.0         68.00       06600       PLECTROCARDI OLOGY       0       2,412       68.0         69.00       06900       ELECTROCARDI OLOGY       0       4,653       69.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       44,473       73.0         74.00       07400       RENAL DI ALYSI S       0       0       0         76.01       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       76.0         76.03       03952       WOUND CA	54.01 03630 ULTRA SOUND	C	0 0	1			54.01
58.00       05800       MRI       0       0       58.0         59.00       05900       CARDI AC CATHETERI ZATI ON       0       7,411       59.0         60.00       06000       LABORATORY       0       116,762       60.0         62.00       06200       WHOLE       BLOOD & PACKED RED BLOOD CELL       0       2,899       62.0         65.00       06500       RESPI RATORY THERAPY       0       7,165       65.0         66.00       06600       PHYSI CAL THERAPY       0       1,906       67.0         68.00       06800       SPEECH PATHOLOGY       0       2,412       68.0         69.00       06900       LECTROCARDI OLOGY       0       4,653       69.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       9,664       72.0         73.00       DRUSS CHARGED TO PATIENTS       0       0       73.0       73.0       73.0         76.00       03950       OTHER ANCILLARY SERVICE COST CENTER       0       0       74.0       74.0       74.0       74.0       74.0       74.0       74.0       74.0       74.0       74.0       74.0       74.0       74.0       74.0       74.0       74.0	56. 00 05600 RADI 0I SOTOPE	C	0 0				56.00
59.00       05900       CARDIAC CATHETERIZATION       0       7,411       59.0         60.00       06000       LABORATORY       0       116,762       60.0         62.00       06500       RESPIRATORY THERAPY       0       7,165       65.0         66.00       06600       PHYSI CAL THERAPY       0       7,165       65.0         67.00       0CUPATIONAL THERAPY       0       1,906       66.0       66.0         68.00       06800       SPECH PATHOLOGY       0       2,412       68.0         69.00       06900       ELECTROCARDIOLOGY       0       4,653       69.0         71.00       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       40,526       71.0         72.00       07200       INPL. DEV. CHARGED TO PATIENTS       0       9.664       72.0         73.00       07300       DRUAS CHARGED TO PATIENTS       0       0       74.0         74.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       76.0         76.01       03951       SLEEP LAB       0       0       76.0       76.0         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       3.789       76.0       <	57.00 05700 CT SCAN	C	0 0				57.00
60.00       06000       LABORATORY       0       116, 762       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       2, 899       62.00         65.00       06500       RESPI RATORY THERAPY       0       7, 165       65.00         66.00       06600       PHYSI CAL THERAPY       0       9, 513       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       1, 906       67.00         68.00       0SECH PATHOLOGY       0       2, 412       68.00         69.00       06900       ELECTROCARDI OLOGY       0       4, 653       69.01         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       40, 526       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       44, 473       73.00         74.00       07400       RENAL DI ALYSI S       0       0       74.00       76.01       76.02         76.01       03951       SLEEP LAB       0       0       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02	58. 00 05800 MRI	C	0 0				58.00
60.00       06000       LABORATORY       0       116, 762       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       2, 899       62.00         65.00       06500       RESPI RATORY THERAPY       0       7, 165       65.00         66.00       06600       PHYSI CAL THERAPY       0       9, 513       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       1, 906       67.00         68.00       0SECH PATHOLOGY       0       2, 412       68.00         69.00       06900       ELECTROCARDI OLOGY       0       4, 653       69.01         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       40, 526       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       44, 473       73.00         74.00       07400       RENAL DI ALYSI S       0       0       74.00       76.01       76.02         76.01       03951       SLEEP LAB       0       0       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02	59. 00 05900 CARDI AC CATHETERI ZATI ON	C	7,411				59.00
65.00       06500       RESPI RATORY THERAPY       0       7,165       65.00         66.00       06600       PHYSI CAL THERAPY       0       9,513       66.0         67.00       0CCUPATI ONAL THERAPY       0       1,906       67.00       67.00         68.00       0SEECH       PATHOLOGY       0       1,906       67.00       67.00         69.00       06900       ELECTROCARDI OLOGY       0       4,653       69.00       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       40.526       71.00       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       9,664       73.00       73.00         74.00       07400       RENAL DI ALYSI S       0       0       74.00       0       74.00       76.00		C	116, 762				60.00
66.00       06600       PHYSICAL THERAPY       0       9,513       66.00         67.00       06700       0CCUPATIONAL THERAPY       0       1,906       67.00         68.00       06800       SPEECH PATHOLOGY       0       2,412       68.00         69.00       06900       ELECTROCARDIOLOGY       0       4,653       69.00         71.00       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       40,526       71.00         72.00       07300       DRUCS CHARGED TO PATIENTS       0       9,664       72.00         74.00       07400       RENAL DIALYSIS       0       0       74.00         74.00       03950       OTHER ANCILLARY SERVICE COST CENTER       0       0       76.00         76.01       03951       SLEEP LAB       0       0       76.00       76.00         76.02       03550       PSYCHIATRIC/PSYCHOLOGICAL SERVICES       0       3,789       76.00         76.02       03952       WOUND CARE       0       12,303       90.00         90.00       OUTPATIENT SERVICE COST CENTERS       0       3,789       76.00         90.00       OPOOD       CLINIC       0       12,303       90.00         91.00 <td>62.00 06200 WHOLE BLOOD &amp; PACKED RED BLOOD CELL</td> <td>C</td> <td>2, 899</td> <td></td> <td></td> <td></td> <td>62.00</td>	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	2, 899				62.00
67.00       06700       0CCUPATI ONAL THERAPY       0       1,906       67.00         68.00       06800       SPEECH PATHOLOGY       0       2,412       68.0         69.00       06900       ELECTROCARDI OLOGY       0       4,653       69.0         71.00       OT200       IMPL. DEV. CHARGED TO PATI ENT       0       40,526       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       9,664       72.0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       44,473       73.0         74.00       07400       RENAL DI ALXYS S       0       0       74.0         76.01       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       76.0         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       3,789       76.0         0.00       00000       CLI NI C       0       12,303       76.0       70.0         90.00       090000       CLI NI C       0       12,303       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       231, 161       91.0       91.0       91.0       9	65. 00 06500 RESPI RATORY THERAPY	C	7, 165				65.00
68.00       06800       SPEECH PATHOLOGY       0       2,412       68.0         69.00       06900       ELECTROCARDI OLOGY       0       4,653       69.0         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       40,526       71.0         72.00       IMPL. DEV. CHARGED TO PATI ENTS       0       9,664       73.00       73.00         73.00       O7300       RENAL DI ALYSI S       0       0       74.00       74.00         74.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       74.00         76.01       03951       SLEEP LAB       0       0       76.0         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       3,789       76.0         76.03       03952       WOLND CARE       0       58,265       76.0         0100       DPATI ENT SERVICE COST CENTERS       0       231,161       91.00         90.00       09000       CLI NI C       0       231,161       91.0         92.00       09200       DBSERVATI ON BEDS (NON-DI STI NCT PART       0       56,753       92.0         90.00       Subtotal (see instructions)       0       90.7,347       200.0	66. 00 06600 PHYSI CAL THERAPY	C	9, 513				66.00
69.00       06900       ELECTROCARDIOLOGY       0       4,653       69.0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       40,526       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       9,664       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       44,473       73.0         74.00       07400       RENAL DIALYSIS       0       0       74.0       74.00         76.00       03950       OTHER ANCILLARY SERVICE COST CENTER       0       0       76.0       0         76.01       03951       SLEEP LAB       0       0       76.0	67.00 06700 OCCUPATIONAL THERAPY	C	1, 906				67.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       40, 526       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       9, 664       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       44, 473       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       74.00         76.01       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       76.01       03951       SLEP LAB       76.02         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       3, 789       76.02       76.02         76.03       03952       WOUND CARE       0       58, 265       76.02       76.02         90.00       09000       CLI NI C       0       12, 303       90.02       76.02         91.00       09000       BERRGENCY       0       12, 303       90.02 <td>68.00 06800 SPEECH PATHOLOGY</td> <td>C</td> <td>2, 412</td> <td></td> <td></td> <td></td> <td>68.00</td>	68.00 06800 SPEECH PATHOLOGY	C	2, 412				68.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       9,664       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       44,473       73.0         74.00       07400       RENAL DI ALYSIS       0       0       0         76.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       76.0         76.01       03951       SLEEP LAB       0       0       76.0       76.0         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       3,789       76.0         76.03       03952       WOUND CARE       0       58,265       76.0         90.00       09000       CLI NI C       90.0       90.0       76.0         91.00       09000       CLI NI C       0       12,303       90.0         91.00       09000       BERRENCY       0       231,161       91.0         92.00       09200       BESERVATI ON BEDS (NON-DI STI NCT PART       0       56,753       92.0         200.00       Subtotal (see instructions)       0       907,347       200.00       201.0         0       01y Charges       0       0,347       200.00       201.0	69. 00 06900 ELECTROCARDI OLOGY	C	4, 653				69.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0       44,473       73.00         74.00       07400       RENAL DI ALYSIS       0       0       74.00         76.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       76.00         76.01       03951       SLEP LAB       0       0       76.00         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       3,789       76.00         76.03       03952       WOUND CARE       0       58,265       76.00         00       09000       CLI NI C       90.00       90.00       90.00       90.00         91.00       09000       EMERGENCY       0       12,303       90.00         91.00       09020       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       56,753       92.00         200.00       Subtotal (see instructions)       0       90.7347       200.00       201.00       01y Charges       201.00       90.00       201.00       201.00       01y Charges       201.00       01y Charges       201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	40, 526				71.00
74.00       07400       RENAL DI ALYSI S       0       0       74.00         76.00       03950       OTHER ANCI LLARY SERVI CE COST CENTER       0       0       76.00         76.01       03951       SLEEP LAB       0       0       76.00         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       3,789       76.00         76.03       03952       WOUND CARE       0       58,265       76.00         0017PATI ENT SERVICE COST CENTERS       0       12,303       76.00         90.00       09000       CLI NI C       0       12,303       90.00         91.00       09100       EMERGENCY       0       231, 161       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       56, 753       92.00         200.00       Subtotal (see instructions)       0       907, 347       200.00       201.00         0.11 y Charges       0.11 y Charges       0       907, 347       200.00       201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	9, 664				72.00
76.00       03950       OTHER ANCI LLARY SERVICE COST CENTER       0       0       76.00         76.01       03951       SLEEP LAB       0       0       76.00         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       3,789       76.00         76.03       03952       WOUND CARE       0       58,265       76.00         0UTPATI ENT SERVICE COST CENTERS       0       12,303       90.00         90.00       09100       EMERGENCY       0       231,161       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       56,753       92.00         200.00       Subtotal (see instructions)       0       907,347       200.00       201.00         011 y Charges       011 y Charges       0       000000000000000000000000000000000000		C	44, 473				73.00
76.01       03951       SLEEP LAB       0       0       76.02         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       3,789       76.02         76.03       03952       WOUND CARE       0       58,265       76.02         OUTPATI ENT SERVI CE COST CENTERS       0       12,303       90.00       90.00         90.00       09100       EMERGENCY       0       231,161       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       56,753       92.02         200.00       Subtotal (see instructions)       0       907,347       200.00       201.01         0.11 Charges       0       907,347       0       201.01       201.01       201.01	74.00 07400 RENAL DIALYSIS	C	0 0				74.00
76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       3, 789       76.0         76.03       03952       WOUND CARE       0       58, 265       76.0         0UTPATI ENT SERVI CE COST CENTERS       0       12, 303       90.0       90.0         90.00       09100       EMERGENCY       0       231, 161       91.0         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       56, 753       92.0         200.00       Subtotal (see instructions)       0       907, 347       200.00       201.0         0.12, SP PD Clinic Lab. Services-Program       0       0       201.0       0       201.00       0       201.00       0       201.00       0       201.00       0       201.00       0       201.00       0       201.00       0	76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	C	0 0				76.00
76. 03         03952         WOUND_CARE         0         58, 265         76. 03           OUTPATIENT_SERVICE_COST_CENTERS         90. 00         09000         CLINIC         0         12, 303         90. 0         90. 0           91. 00         09100         EMERGENCY         0         231, 161         91. 0         91. 0         92.00         085RVATION BEDS (NON-DISTINCT PART         0         56, 753         92. 0         200. 00         Subtotal (see instructions)         0         907, 347         200. 0         201. 00         Less PBP Clinic Lab. Services-Program         0         201. 0         0         201. 0         0         101 y Charges         201. 0         101 y Charges         101 y		C	0 0				76.01
OUTPATI ENT SERVICE COST CENTERS           90. 00         09000 CLINIC         0         12, 303         90. 0           91. 00         09100 EMERGENCY         0         231, 161         91. 0           92. 00         09200 OBSERVATI ON BEDS (NON-DI STINCT PART         0         56, 753         92. 0           200. 00         Subtotal (see instructions)         0         907, 347         200. 0           201. 00         Less PBP Clinic Lab. Services-Program         0         201. 0         201. 0         0		C					76.02
90.00         09000         CLINIC         0         12,303         90.0           91.00         09100         EMERGENCY         0         231,161         91.0           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         0         56,753         92.0           200.00         Subtotal (see instructions)         0         907,347         200.0         201.00           201.00         Less PBP Clinic Lab. Services-Program         0         201.00         201	76.03 03952 WOUND CARE	C	58, 265				76.03
91.00         09100         EMERGENCY         0         231, 161         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0         56, 753         92.0           200.00         Subtotal (see instructions)         0         907, 347         200.0         201.0           201.00         Less PBP Clinic Lab. Services-Program Only Charges         0         907, 347         201.0							
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         0         56,753         92.0           200.00         Subtotal (see instructions)         0         907,347         200.0           201.00         Less PBP Clinic Lab. Services-Program         0         201.0         201.0		C					90.00
200.00Subtotal (see instructions)0907, 347200.0201.00Less PBP Clinic Lab. Services-Program0201.00nl y Charges00		C					91.00
201.00     Less PBP Clinic Lab. Services-Program     0       001 y Charges     0		C					92.00
Only Charges		( C	907, 347				200.00
		C					201.00
202.00   Net Charges (line 200 +/- line 201)   0 907,347 202.0							
	202.00   Net Charges (line 200 +/- line 201)	C	907, 347				202.00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150047	Period:	Worksheet D	
		Component	CCN: 15S047	From 06/01/2015 To 05/31/2016	Part II Date/Time Pre	narod
		component	CCN. 155047	10 05/51/2010	10/31/2016 8:	18 am
		Ti t	le XIX	Subprovider -	PPS	
	r		1	IPF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,			(column 3 x	
	(from Wkst. B,		(col. 1 ÷ co	I. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	710, 521	42 471 142	0.0163	45 0	0	50.00
50. 01 03330 ENDOSCOPY	104, 690				0	
51.00 05100 RECOVERY ROOM	274, 257				285	•
52.00 O5200 DELIVERY ROOM & LABOR ROOM	237, 775				0	
53.00 05300 ANESTHESI OLOGY	9,609				2	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	801, 299	81, 685, 617			221	54.00
54. 01 03630 ULTRA SOUND	0	0	0.0000		0	
56. 00 05600 RADI OI SOTOPE	0	0	0.0000		0	•
57. 00 05700 CT SCAN	0	0	0.0000		0	
	120 750	-	0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	138, 759				0	•
	689, 939				755	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65.00 06500 RESPIRATORY THERAPY	39, 162				0	
	261, 649 305, 581	17, 817, 136 5, 620, 185				•
					430 370	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	120, 093 45, 003				370	•
69. 00 06900 ELECTROCARDI OLOGY	48, 302				74	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	180, 581				69	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	113, 109				07	
73. 00 07300 DRUGS CHARGED TO PATIENTS	246, 504	76, 529, 742			477	
74. 00 07400 RENAL DIALYSIS	84,034				4//	
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTER	04,034				0	
76. 01   03951   SLEEP LAB	0	-	0.0000		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	136, 464	-			0	•
76. 03   03952  WOUND_CARE	360, 212				0	
OUTPATIENT SERVICE COST CENTERS		0, 224, 094	0.0437	, o <sub>l</sub> 0	0	/0.03
90. 00 09000 CLINIC	89, 725	122, 245	0. 7339	77 0	0	90.00
91. 00 09100 EMERGENCY	668, 573					90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	008, 573				0	•
200.00 Total (lines 50-199)	5, 665, 841			328, 677		200.00
	1 5,005,041	1 100, 727, 117	I	520,077	J 5, 200	200.00

Health Financial S	ystems	ST JOSEPH MED	I CAL CENTER		In Li	eu of Form CMS-	2552-10
APPORTI ONMENT OF I	NPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PAS	S Provider	CCN: 150047	Period:	Worksheet D	
THROUGH COSTS			Component	- CCN- 155047	From 06/01/2015		norod.
			Component	CCN: 15S047	To 05/31/2016	Date/Time Pre 10/31/2016 8:	18 am
			Ti t	le XIX	Subprovider -	PPS	TO ani
					IPF	110	
Cost	Center Description		Nursing School	Allied Healt		Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cos	t through col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	ERVICE COST CENTERS	-	-		- 1		
50.00 05000 0PERA		0	0		-	0 0	
50.01 03330 ENDOS		0	0		0 0	0 0	
51.00 05100 RECOV		0	0		0 0	0 0	
	ERY ROOM & LABOR ROOM	0	0		0 0	0 0	52.00
53.00 05300 ANESTI		0	0		0 0	0 0	53.00
	LOGY-DI AGNOSTI C	0	0		0 0	0 0	01100
54.01 03630 ULTRA		0	0		0 0	0 0	54.01
56.00 05600 RADI 0		0	0		0 (	0 0	
57.00 05700 CT SC	AN	0	C		0 0	0 0	57.00
58.00 05800 MRI		0	C		0 0	0 0	58.00
59.00 05900 CARDI	AC CATHETERIZATION	0	0		0 0	0 0	59.00
60.00 06000 LABOR	ATORY	0	C		0 0	0 0	60.00
62.00 06200 WHOLE	BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0 0	62.00
65.00 06500 RESPI I	RATORY THERAPY	0	C		0 0	0 0	65.00
66.00 06600 PHYSI	CAL THERAPY	0	0		0 0	0 0	66.00
67.00 06700 0CCUP	ATIONAL THERAPY	0	0		0 0	0 0	67.00
68.00 06800 SPEECI	H PATHOLOGY	0	0		0 (	0 0	68.00
69.00 06900 ELECTI	ROCARDI OLOGY	0	0		0 (	0 0	69.00
	AL SUPPLIES CHARGED TO PATIENT	0	0		0 (	0 0	
	DEV. CHARGED TO PATIENTS	0	0		0 (	0 0	72.00
73.00 07300 DRUGS	CHARGED TO PATIENTS	0	0		0 (	0 0	
74.00 07400 RENAL	DI ALYSI S	0	0		0 (	0 0	74.00
	ANCILLARY SERVICE COST CENTER	0	0		0 (	0 0	1 1 01 00
76.01 03951 SLEEP		0	0		0 (	0 0	76.01
	ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 (	0 0	76.02
76.03 03952 WOUND		0	0		0 (	0 0	76.03
	SERVICE COST CENTERS					1	
90.00 09000 CLINI		0	C		0 (	0 0	90.00
91.00 09100 EMERG		0	0		0 0	0 0	
	VATION BEDS (NON-DISTINCT PART	0	0		0 (	0 0	92.00
200.00 Total	(lines 50-199)				0 (		200.00

Health Financial Systems	ST JOSEPH MED			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PAS	S Provi der	CCN: 150047	Peri od:	Worksheet D	
THROUGH COSTS				From 06/01/2015	Part IV	
		Component	t CCN: 15SO47	To 05/31/2016	Date/Time Pre 10/31/2016 8:	pared:
		т: +	le XIX	Subprovider -	PPS	18 811
		111		IPF	PPS	
Cost Center Description	Total	Total Charges	Datio of Cor		Inpati ent	
cost center bescription	Outpatient	(from Wkst. C,			Program	
			(col. 5 ÷ co			
	Cost (sum of				Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00	8.00	7)	10.00	
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS		40.474.440	0.0000			1 50 00
50. 00 05000 OPERATING ROOM	0				0	
50. 01 03330 ENDOSCOPY	0				0	
51.00 O5100 RECOVERY ROOM	0				6, 572	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 170, 701			0	
53. 00 05300 ANESTHESI OLOGY	0	6, 056, 813	0.0000	0. 000000	1, 504	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	81, 685, 617	0.0000	0. 000000	22, 563	54.00
54. 01 03630 ULTRA SOUND	0	0	0.0000	0. 000000	0	54.01
56. 00 05600 RADI OI SOTOPE	0	C	0.0000	0. 000000	0	56.00
57.00 05700 CT SCAN	0	C	0.0000	0. 000000	0	57.00
58. 00 05800 MRI	0	C	0.0000	0. 000000	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	23, 204, 248			0	59.00
60. 00 06000 LABORATORY	0				71, 085	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				0	
65. 00 06500 RESPI RATORY THERAPY	0				21, 292	•
66. 00 06600 PHYSI CAL THERAPY	0				7, 913	
67. 00 06700 OCCUPATI ONAL THERAPY					11, 248	
68. 00 06800 SPEECH PATHOLOGY					687	
69. 00 06900 ELECTROCARDI OLOGY					5, 638	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT					10, 193	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	-				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				148, 179	•
74.00 07400 RENAL DIALYSIS	0	2,172,770			0	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0				0	
76. 01 03951 SLEEP LAB	0	-	0.0000		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0				0	
76. 03 03952 WOUND CARE	0	8, 224, 694	0.0000	0.00000	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	122, 245	0.0000	0. 000000	0	90.00
91.00 09100 EMERGENCY	0			0. 000000	16, 159	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					
200.00 Total (lines 50-199)	0				328, 677	
			I.	1		

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	ST JOSEPH MED		CCN: 150047	Peri od:	ieu of Form CMS-2552 Worksheet D
THROUGH COSTS				From 06/01/20	15 Part IV
		Componen	t CCN: 15SO47	To 05/31/20	16 Date/Time Prepare 10/31/2016 8:18 a
		Ti t	le XIX	Subprovi der	
				IPF	
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Throug		
	Costs (col. 8		Costs (col.		
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS			.1		
50. 00 05000 OPERATING ROOM	0	C		0	50.
50. 01 03330 ENDOSCOPY	0	C		0	50.
51.00 05100 RECOVERY ROOM	0	C		0	51.
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0	52.
53. 00 05300 ANESTHESI OLOGY	0	C		0	53.
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0	54.
54.01 03630 ULTRA SOUND	0	C		0	54.
56. 00 05600 RADI OI SOTOPE	0	C		0	56.
57.00 05700 CT SCAN	0	C		0	57.
58. 00 05800 MRI	0	C		0	58.
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0	59.
50. 00 06000 LABORATORY	0	C		0	60.
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0	62.
55. 00 06500 RESPI RATORY THERAPY	0	C		0	65.
56. 00 06600 PHYSI CAL THERAPY	0	Ċ		0	66.
57. 00 06700 OCCUPATI ONAL THERAPY	0	(		0	67.
58.00 06800 SPEECH PATHOLOGY	0	(		0	68.
9. 00 06900 ELECTROCARDI OLOGY	0	(		0	69.
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(		0	71.
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	(		0	72.
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	(		0	73.
4. 00 07400 RENAL DIALYSIS	0			0	74.
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0			0	74.
76.01 03951 SLEEP LAB	0		()	0	76.
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	Ś	0	76.
76. 03 03952 WOUND CARE	0	(		0	76.
OUTPATIENT SERVICE COST CENTERS	0	Ĺ	1		/0.
20. 00 09000 CLINIC	0	C		0	90.
90. 00 09100 EMERGENCY	0	C		0	90.
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	92.
200.00   Total (lines 50-199)	0	C	4	0	200.

	Financial Systems ST JOSEPH MED	Provi der CCN: 150047	Period: From 06/01/2015 To 05/31/2016	Worksheet D-1 Date/Time Pre 10/31/2016 8:	pare
		Title XVIII	Hospi tal	PPS	_
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1100	
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed d Inpatient days (including private room days, excluding swin	ays, excluding newborn)		23, 929	
00 00	Private room days (including private room days, excluding swin Private room days (excluding swing-bed and observation bed		ivate room davs	23, 929 0	
00	do not complete this line.	days). If you have only pr	Tvate Toolii days,	0	
00	Semi-private room days (excluding swing-bed and observation	bed days)		20, 680	4
00	Total swing-bed SNF type inpatient days (including private	room days) through December	er 31 of the cost	0	5
	reporting period				
00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	room days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private r	room days) through December	31 of the cost	0	7
	reporting period			-	
00	Total swing-bed NF type inpatient days (including private r	oom days) after December 3	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	/			
00	Total inpatient days including private room days applicable newborn days)	το the Program (excluding	swing-bed and	5, 711	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	coom davs)	Ω	10
	through December 31 of the cost reporting period (see instr		oom dagoy	Ū	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
	December 31 of the cost reporting period (if calendar year,				
. 00	Swing-bed NF type inpatient days applicable to titles V or through December 31 of the cost reporting period	XIX only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or	XIX only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar			Ū	
	Medically necessary private room days applicable to the Pro	gram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	15
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to serv	ices through December 31 c	of the cost	0.00	1 17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to serv	ices after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to servi	cos through Docombor 21 of	the cost	0.00	10
. 00	reporting period	ces through becember 31 of	the cost	0.00	17
. 00	Medicaid rate for swing-bed NF services applicable to servi	ces after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructi Swing-bed cost applicable to SNF type services through Dece		ing pariad (line	15, 683, 831	
. 00	5 x line 17)	inder 31 of the cost report	ing period (inte	0	22
. 00	Swing-bed cost applicable to SNF type services after Decemb	er 31 of the cost reportir	ng period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through Decem	ber 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after Decembe	er 31 of the cost reporting	period (line 8	0	25
	x line 20)		, _5.1.64 (1116-0	0	-
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cos	t (line 21 minus line 26)		15, 683, 831	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-	hed and observation had at	ardes)	0	28
	Private room charges (excluding swing-bed charges)	Ded and Observation Ded Cl	iai yesj	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 2	7 ÷ 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		tions)	0.00	
	Average per diem private room charge differential (line 32 Average per diem private room cost differential (line 34 x		. (1 0115)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35			0.00	30
	General inpatient routine service cost net of swing-bed cos	-	fferential (line	15, 683, 831	37
	27 minus line 36)	· · · · ·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	DUICTNENTC			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A			655.43	38
	Adjusted general inpatient routine service cost per diem (s Program general inpatient routine service cost (line 9 x li			655.43 3,743,161	
	Medically necessary private room cost applicable to the Pro			0, , 10, 101	40
	Total Program general inpatient routine service cost (line			3, 743, 161	1 11

	Financial Systems FATION OF INPATIENT OPERATING COST	ST JOSEPH MED		CCN: 150047 F	In Lie Period:	u of Form CMS- Worksheet D-1	
COMPU	ATTON OF INFATIENT OPERATING COST		Provider	F	From 06/01/2015 0 05/31/2016		pared:
			Titl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0 0	0	42.00
40.00	Intensive Care Type Inpatient Hospital Units	4 554 047	470	0.044.00		<b>500 550</b>	1 40 00
43.00 43.01	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	1, 554, 017 1, 526, 632	479 908				1
44.00	CORONARY CARE UNIT	1, 520, 652	900	1,001.31	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	2, 560, 477	1, 511	1, 694. 56	211	357, 552	
46.00	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			7, 081, 972	48.00
49.00	Total Program inpatient costs (sum of lines	11 through 48)(	see instructio	ns)		11, 721, 237	49.00
50.00	PASS THROUGH COST ADJUSTMENTS			What D arm	of Doute L and		50.00
50.00	Pass through costs applicable to Program inpa	attent routine	services (IIOI	IWKSL. D, SUM	of Parts F and	707, 663	50.00
51.00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, su	m of Parts II	629, 558	51.00
	and IV)						
52.00	Total Program excludable cost (sum of lines !				+! - <b>+</b>	1, 337, 221	•
53.00	Total Program inpatient operating cost excluding medical education costs (line 49 minus line 5		erated, non-phy	si ci an anestne	etist, and	10, 384, 016	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	)				-	
54.00	5 5					0	
55.00 56.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
57.00	Difference between adjusted inpatient operati	ng cost and ta	arget amount (L	ine 56 minus l	ine 53)	0	•
58.00	Bonus payment (see instructions)	ng ooot and ta	inger amount (i		1110 00)	0	
59.00	Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, u	pdated and com	pounded by the	0.00	59.00
(0.00	market basket	act conect up	datad by the m	arkat baakat		0.00	60.00
60.00 61.00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				he amount by	0.00	•
01100	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see i	nstructions)				_	
62.00 63.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ont (coo instru	uctions)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.00
64.00		ts through Dece	ember 31 of the	e cost reportir	ng period (See	0	64.00
(5.00	instructions)(title XVIII only)		21 +				1 1 5 00
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	is after Decemb	ber 31 of the c	ost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.00
	CAH (see instructions)						
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	n December 31 d	of the cost rep	orting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repor	tina period	0	68.00
	(line 13 x line 20)				51		
69.00						0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00
71.00	Adjusted general inpatient routine service co						71.00
72.00	Program routine service cost (line 9 x line						72.00
73.00	Medically necessary private room cost applica	0	•				73.00
74.00 75.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient	•	,		urt II column		74.00
75.00	26, line 45)	outine service		or Kaneet D, Ta			/ 5. 00
76.00	Per diem capital-related costs (line 75 ÷ lin						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		rovider record	ls)			78.00
80.00	Total Program routine service costs for compa	• •		· .	ıs line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tation			-		81.00
82.00	Inpatient routine service cost limitation (li						82.00
83.00 84.00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see ins		15)				83.00 84.00
85.00	Utilization review - physician compensation		ons)				85.00
86.00	Total Program inpatient operating costs (sum	of lines 83 th					86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					0.010	07.00
87.00 88.00	5 .		line 2)			3, 249 655-43	87.00 88.00
	Observation bed cost (line 87 x line 88) (see	•				2, 129, 492	•

Health Financial Systems	ST JOSEPH MED	OICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 06/01/2015 To 05/31/2016	Date/Time Pre 10/31/2016 8:	
		Titl	e 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	2,036,798	15, 683, 831	0. 12986	6 2, 129, 492	276, 549	90.00
91.00 Nursing School cost	0	15, 683, 831	0.00000	2, 129, 492	0	91.00
92.00 Allied health cost	0	15, 683, 831	0.00000	2, 129, 492	0	92.00
93.00 All other Medical Education	0	15, 683, 831	0.00000	2, 129, 492	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150047 Component CCN: 15S047	Period: From 06/01/2015 To 05/31/2016	Worksheet D-1 Date/Time Pre 10/31/2016 8:	pare
	Cost Conton Deparintian	Title XVIII	Subprovider - IPF	PPS	
	Cost Center Description			1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed days,	excluding newborn)		6, 048	1 1.
	Inpatient days (including private room days, excluding swing-be			6, 048	2.
00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	(ave)		6, 048	4
	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0, 040	
	reporting period	5.			
00	Total swing-bed SNF type inpatient days (including private room	n 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 room	days) through December	31 of the cost	0	7
00	reporting period	days) through becomber		0	
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (evoluting	swing_bed and	3, 790	9
	newborn days)	the riggi and text adding	Swilly bed and	5, 790	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl		nom davc) after	0	11
	December 31 of the cost reporting period (if calendar year, ent		Juli uays) arter	0	''
	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
	through December 31 of the cost reporting period				
	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13
	Medically necessary private room days applicable to the Program			0	14
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	f the cost	0.00	17
	reporting period	0			
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	s after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19
	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions)	1		3, 715, 047	21
	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	i of the cost reporting	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportion	ng period (line	0	24
	7 x line 19)				0
. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting		0	25
. 00	Total swing-bed cost (see instructions)			0	26
1	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		3, 715, 047	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 minu	us line 33)(see instruc	tions)	0.00	
. 00	Average per diem private room cost differential (line 34 x line			0.00	35
1	Private room cost differential adjustment (line 3 x line 35)	d privato room cost di	fforontial (line	0 2 715 047	
	General inpatient routine service cost net of swing-bed cost ar 27 minus line 36)	iu private room cost dl'	irerential (IINe	3, 715, 047	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			(14.0)	1
	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3			614. 26 2, 328, 045	
	Medically necessary private room cost applicable to the Program			2, 320, 043	
	Total Program general inpatient routine service cost (line 39 +	. ,		2, 328, 045	

alth Financial Systems MPUTATION OF INPATIENT OPERATING COST		AL CENTER Provi der	CCN: 150047	Peri od:	eu of Form CMS- Worksheet D-1	
		Componen	t CCN: 15SO47	From 06/01/2015 To 05/31/2016	Date/Time Pre	epare
		Titl	e XVIII	Subprovider -	10/31/2016 8: PPS	<u>18</u> a
Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
Cost center bescription	Inpatient CostIn	patient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
.00 NURSERY (title V & XIX only)	1.00	2.00	3.00 0.	4.00	5.00	) 42
Intensive Care Type Inpatient Hospital Uni					· · · · · · · · · · · · · · · · · · ·	
. 00 INTENSIVE CARE UNIT	0	C			-	
. 01   NEONATAL INTENSIVE CARE UNIT . 00   CORONARY CARE UNIT	0	Ĺ	0.	00 0	0	43
. 00 BURN I NTENSI VE CARE UNI T	0	C	0.	00 00	0	
. 00 SURGI CAL I NTENSI VE CARE UNI T						46
. 00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	+
.00 Program inpatient ancillary service cost (	(Wkst. D-3, col. 3,	line 200)			613, 819	48
.00 Total Program inpatient costs (sum of line	es 41 through 48)(se	e instructio	ons)		2, 941, 864	49
PASS THROUGH COST ADJUSTMENTS						1 50
.00 Pass through costs applicable to Program i	npatient routine se	rvices (from	1 WKST. D, SU	n of Parts I and	229, 939	2 50
00 Pass through costs applicable to Program i	npatient ancillary	services (fr	om Wkst. D,	sum of Parts II	62, 191	51
and IV)						
.00 Total Program excludable cost (sum of line .00 Total Program inpatient operating cost exc		tod non nh	cician anost	notist and	292, 130 2, 649, 734	
medical education costs (line 49 minus lin		ted, non-phy		letist, and	2,047,734	55
TARGET AMOUNT AND LIMIT COMPUTATION	•					
<ul><li>00 Program discharges</li><li>00 Target amount per discharge</li></ul>					0.00	
.00 Target amount (line 54 x line 55)					0.00	
.00 Difference between adjusted inpatient oper	rating cost and targ	et amount (I	ine 56 minus	line 53)	0	
.00 Bonus payment (see instructions)					0	
.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period en	ding 1996, ι	updated and co	ompounded by the	0.00	) 59
.00 Lesser of lines 53/54 or 55 from prior year	ar cost report, upda	ted by the m	narket basket		0.00	60
.00 If line 53/54 is less than the lower of li				the amount by	0	
which operating costs (line 53) are less t		(lines 54 x	60), or 1% o	f the target		
amount (line 56), otherwise enter zero (se .00 Relief payment (see instructions)	e instructions)				0	62
. 00 Allowable Inpatient cost plus incentive pa	ayment (see instruct	ions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST	• · ·				1	
.00 Medicare swing-bed SNF inpatient routine of instructions)(title XVIII only)	costs through Decemb	er 31 of the	e cost report	ng period (See	0	64
. 00 Medicare swing-bed SNF inpatient routine of	costs after December	31 of the d	cost reportin	g period (See	0	65
instructions)(title XVIII only)						
. 00 Total Medicare swing-bed SNF inpatient rou	utine costs (line 64	plus line 6	5)(title XVI	ll only). For	0	66
CAH (see instructions) .00 Title V or XIX swing-bed NF inpatient rout	tine costs through D	ecember 31 d	of the cost r	eportina period	0	67
(line 12 x line 19)				51		
.00 Title V or XIX swing-bed NF inpatient rout	tine costs after Dec	ember 31 of	the cost rep	orting period	0	68
(line 13 x line 20) 0.00 Total title V or XIX swing-bed NF inpatier	nt routine costs (li	ne 67 + line	<sup>68)</sup>		0	69
PART III - SKILLED NURSING FACILITY, OTHER			,			
00 Skilled nursing facility/other nursing fac	<b>J</b>			)		70
.00 Adjusted general inpatient routine service .00 Program routine service cost (line 9 x lir		e 70 ÷ line	2)			71
. 00 Medically necessary private room cost appl	,	line 14 x li	ne 35)			73
.00 Total Program general inpatient routine se	ervice costs (line 7	2 + line 73)				74
.00 Capital-related cost allocated to inpatier	nt routine service c	osts (from V	lorksheet B, I	Part II, column		75
26, line 45) .00 Per diem capital-related costs (line 75 ÷	line 2)					76
00 Program capital -related costs (line 9 x li						77
00 Inpatient routine service cost (line 74 mi						78
.00 Aggregate charges to beneficiaries for exc			· · ·	aus lino 70)		79
.00  Total Program routine service costs for co .00  Inpatient routine service cost per diem li	•	t i i ini tati Of		ius IIIe /9)		80
.00 Inpatient routine service cost limitation						82
. 00 Reasonable inpatient routine service costs						83
.00 Program inpatient ancillary services (see		)				84
.00 Utilization review - physician compensation .00 Total Program inpatient operating costs (s						85
PART IV - COMPUTATION OF OBSERVATION BED F	PASS THROUGH COST				r 	
. 00 Total observation bed days (see instruction					0	
<ul> <li>Adjusted general inpatient routine cost per</li> <li>Observation bed cost (line 87 x line 88) (</li> </ul>		ine 2)			0.00	) 88 ) 89
					. 0	γL Ο.

Health Financial Systems	ST JOSEPH M	EDI CAL	CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Period: From 06/01/2015	Worksheet D-1	
			Component		To 05/31/2016		pared: 18 am
			Ti tl	e XVIII	Subprovider -	PPS	
Cost Center Description	Cost	Rou	tine Cost	column 1 ÷	Total	Observati on	
		(fro	m 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	366, 93	33	3, 715, 047	0. 09876	9 0	0	90.00
91.00 Nursing School cost		0	3, 715, 047	0. 00000	0 0	0	91.00
92.00 Allied health cost	1	0	3, 715, 047	0.00000	0 0	0	92.00
93.00 All other Medical Education		0	3, 715, 047	0.00000	0 0	0	93.00

	TION OF INPATIENT OPERATING COST	Provider CCN: 150047 Component CCN: 155356	Period: From 06/01/2015 To 05/31/2016 Skilled Nursing	Worksheet D-1 Date/Time Pre 10/31/2016 8: PPS	pared
	Cost Center Description		Facility		
				1.00	
	PART I – ALL PROVIDER COMPONENTS NPATIENT DAYS				-
	Inpatient days (including private room days and swing-bed days	, excluding newborn)		4, 888	1.0
	Inpatient days (including private room days, excluding swing-b			4, 888	
	Private room days (excluding swing-bed and observation bed day do not complete this line.	s). If you have only pr	ivate room days,	0	3.
1	Semi-private room days (excluding swing-bed and observation be	d days)		4, 888	4.
00	Total swing-bed SNF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	0	5.
00	reporting period Total swing-bed SNF type inpatient days (including private roo	m dave) after Decomber	21 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)	iii days) arter beceniber	ST OF THE COST	0	0.
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7.
	reporting period Tatal awing had NE type inpatient days (including private rear	dava) after December 2	1 of the east	0	
	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember 3	I OI THE COST	0	8.
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 026	9.
	newborn days) Gwien had SNE tung innetient dawa angliashla ta title XV/ULL an			0	10
	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct		oom days)	0	10.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	oom days) after	0	11.
	December 31 of the cost reporting period (if calendar year, en			0	10
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	0	12.
	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.
	after December 31 of the cost reporting period (if calendar ye			0	14
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	m (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
÷	SWING BED ADJUSTMENT		• · · · · · · · · · · · · · · · · · · ·		
7.00	Medicare rate for swing-bed SNF services applicable to service reporting period	s through December 31 o	f the cost	0.00	17.
3. 00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18.
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19.
0. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.
	reporting period	、 、		0 74 / 0 / 0	0.1
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line)	2, 716, 968 0	
	5 x line 17)			0	22.
	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23.
	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24.
	7 x line 19)			0	2
	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25.
	x line 20) Total swing-bed cost (see instructions)			0	26.
	General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		2, 716, 968	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	
	Semi -private room charges (excluding swing bed charges)			0	30.
	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) Average per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	0.00 0.00	
5.00	Average per diem private room cost differential (line 34 x lin		- /	0.00	35.
	Private room cost differential adjustment (line 3 x line 35)	nd polyota area 1 "	fforonti-1 (1)	0	
	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	na private room cost di	TTERENTIAL (LINE	2, 716, 968	37.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
[	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
	Adjusted general inpatient routine service cost per diem (see				38.
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra				39. 40.
	Total Program general inpatient routine service cost (line 39				41

MPUTATION OF INPATIENT OPERATING COST		I CAL CENTER Provi der	CCN: 150047	Peri od:	worksheet D-1	
			t CCN: 155356	From 06/01/2015 To 05/31/2016	Date/Time Pre	epare
		Titl	e XVIII	Skilled Nursing	10/31/2016 8: PPS	18 a
			-	Facility		
Cost Center Description	Total Inpatient Cost		col. 2)	÷	Program Cost (col. 3 x col. 4)	
00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
Intensive Care Type Inpatient Hospital Units	<u> </u>		1		l	42.
00 INTENSIVE CARE UNIT						43.
01 NEONATAL INTENSIVE CARE UNIT 00 CORONARY CARE UNIT						43.
00 BURN INTENSIVE CARE UNIT						45
00 SURGI CAL I NTENSI VE CARE UNI T						46
00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
cost center bescription					1.00	
00 Program inpatient ancillary service cost (W						48.
00 Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructio	ons)			49
00 Pass through costs applicable to Program in	patient routine	services (from	n Wkst. D, su	m of Parts I and		50
	·					
00 Pass through costs applicable to Program in and IV)	patient ancillar	y services (fr	om wkst. D,	sum or Parts II		51
00 Total Program excludable cost (sum of lines						52
00 Total Program inpatient operating cost excl		lated, non-phy	/sician anest	hetist, and		53
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
00 Program di scharges						54
00 Target amount per discharge						55
00 Target amount (line 54 x line 55) 00 Difference between adjusted inpatient opera	ting cost and ta	rget amount (l	ine 56 minus	line 53)		56
00 Bonus payment (see instructions)	thig boot and ta	got amount (i				58
00 Lesser of lines 53/54 or 55 from the cost re	eporting period	ending 1996, ι	updated and c	ompounded by the		59
market basket 00 Lesser of lines 53/54 or 55 from prior year	cost report up	dated by the m	narket basket			60
00 If line 53/54 is less than the lower of line				the amount by		61
which operating costs (line 53) are less that		s (lines 54 x	60), or 1% o	f the target		
amount (line 56), otherwise enter zero (see 00 Relief payment (see instructions)	instructions)					62
00 Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)				63
PROGRAM INPATIENT ROUTINE SWING BED COST 00 Medicare swing-bed SNF inpatient routine cost	ata thraugh Daga	mbor 21 of the	and report	ing pariod (Caa	1	
00 Medicare swing-bed SNF inpatient routine com instructions)(title XVIII only)	sts through bece		e cost report	ing period (see		64
00 Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the d	cost reportin	g period (See		65
instructions)(title XVIII only) 00 Total Medicare swing-bed SNF inpatient routi	ine costs (line	64 nlus line 6	5)(title XVI	ll only) For		66
CAH (see instructions)				ri oniy). Tor		
00 Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 d	of the cost r	eporting period		67
(line 12 x line 19) 00 Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost rep	ortina period		68
(line 13 x line 20)				5 1 1		
00 Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						69
00 Skilled nursing facility/other nursing faci				)	2, 716, 968	70
00 Adjusted general inpatient routine service	cost per diem (l				555.84	71
00 Program routine service cost (line 9 x line 00 Medically necessary private room cost appli	,	(line 14 y li	no 35)		1, 126, 132 0	
00 Total Program general inpatient routine serv	5	•			1, 126, 132	
00 Capital-related cost allocated to inpatient				Part II, column	0	
26, line 45) 00 Per diem capital-related costs (line 75 ÷ li	ine 2)				0.00	76
00 Program capital -related costs (line 9 x line					0.00	
00 Inpatient routine service cost (line 74 min					0	
00 Aggregate charges to beneficiaries for exce 00 Total Program routine service costs for com				nus line 70)	0	
00 Inpatient routine service costs for com				103 1110 17)	0.00	
00 Inpatient routine service cost limitation (	line 9 x line 81	•			0	82
00 Reasonable inpatient routine service costs	•	s)			1, 126, 132	
00 Program inpatient ancillary services (see in 00 Utilization review - physician compensation		ns)			823, 708 0	
00 Total Program inpatient operating costs (su					1, 949, 840	
PART IV - COMPUTATION OF OBSERVATION BED PAS						1
00 Total observation bed days (see instructions 00 Adjusted general inpatient routine cost per		line 2)			0.00	
	ee instructions)					89

Health Financial Systems	ST JOSEPH MED	DI CAL	CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Period: From 06/01/2015	Worksheet D-1	
			Component		To 05/31/2016		pared: 18 am
			Ti tl	e XVIII	Skilled Nursing	PPS	
					Facility		
Cost Center Description	Cost	Rout	tine Cost	column 1 ÷	Total	Observati on	
		(fror	m line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00		2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	0	)	0	0.0000	0 00	0	90.00
91.00 Nursing School cost	0		0	0.0000	0 00	0	91.00
92.00 Allied health cost	0		0	0.0000	0 00	0	92.00
93.00 All other Medical Education	0		0	0.0000	0 00	0	93.00

OMPUT	Financial Systems ST JOSEPH MEDICA ATION OF INPATIENT OPERATING COST	Provider CCN: 150047	Period: From 06/01/2015	u of Form CMS-2 Worksheet D-1	
			To 05/31/2016	Date/Time Prep 10/31/2016 8:	
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		23, 929	1 1
00	Inpatient days (including private room days, excluding swing-b	ped and newborn days)		23, 929	2
00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	ivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation be	ed days)		20, 680	4
00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private roo	am dave) after Decombor	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	bii days) al tel becember :	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room	n dave) after December 2	1 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	i days) arter becember 5	i oi the cost	0	
00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 332	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	nom davs)	0	10
. 00	through December 31 of the cost reporting period (see instruct		com days)	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	1
2.00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		e room davs)	0	12
	through December 31 of the cost reporting period		5 .	-	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	1:
. 00	Medically necessary private room days applicable to the Progra			0	14
. 00	Total nursery days (title V or XIX only)	、 5 5	5,	783	
. 00	Nursery days (title V or XIX only)			279	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	117
	reporting period	J. J			
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing posted (line	15, 683, 831	21
. 00	5 x line 17)	er si of the cost report	ing period (inne	0	
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reportio	ng period (line	0	24
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		15, 683, 831	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)	(jing 20)		0	
	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	- IINE 20)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 2) + line 3)			0.00	
	Average per diem private room charge differential (line 32 mir		tions)	0.00	
	Average per diem private room cost differential (line 34 x lir Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00 0	35
	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	15, 683, 831	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
				655.43	38
. 00	Adjusted general inpatient routine service cost per diem (see	THSTIUCTIONS)	1	0001 10	
. 00	Program general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	38)		873, 033 0	

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	51 505EITI MED	PICAL CENTER Provider		Peri od:	u of Form CMS- Worksheet D-1	
				From 06/01/2015 To 05/31/2016	Date/Time Pre 10/31/2016 8:	
			le XIX	Hospi tal	PPS	
Cost Center Description	Total	Total Inpatient Days	Average Per	Program Days	Program Cost (col. 3 x col.	
			col . 2)	Ť	4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital	437, 577	783	558.8	5 279	155, 919	42.00
43. 00 INTENSIVE CARE UNIT	1, 554, 017	479	3, 244. 2	9 82	266, 032	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	1, 526, 632					
44.00 CORONARY CARE UNIT	0.5/0.477					44.00
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT	2, 560, 477	1, 511	1, 694. 5	6 65	110, 146	45.00
47. 00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
		)     == 200)			1.00	40.00
<ul> <li>48.00 Program inpatient ancillary service cos</li> <li>49.00 Total Program inpatient costs (sum of I</li> </ul>			ns)		1, 703, 578 3, 966, 176	
PASS THROUGH COST ADJUSTMENTS					6, 700, 170	
50.00 Pass through costs applicable to Progra	m inpatient routine	services (from	Wkst. D, sum	of Parts I and	288, 170	50.00
) 51.00  Pass through costs applicable to Progra	m innatient ancillar	ry services (fr	om Wkst D s	um of Parts II	195, 707	51.00
and IV)		y services (11	om wikst. D, S		175,707	01.00
52.00 Total Program excludable cost (sum of I					483, 877	
53.00 Total Program inpatient operating cost medical education costs (line 49 minus	5 1	elated, non-phy	sician anesth	etist, and	3, 482, 299	53.00
TARGET AMOUNT AND LIMIT COMPUTATION	TTHE 52)				1	
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	
56.00  Target amount (line 54 x line 55) 57.00  Difference between adjusted inpatient c	nerating cost and ta	arget amount (1	ine 56 minus	line 53)	0	
58.00 Bonus payment (see instructions)					0	
59.00 Lesser of lines 53/54 or 55 from the co	st reporting period	endi ng 1996, u	pdated and co	mpounded by the	0.00	59.0
market basket 60.00 Lesser of lines 53/54 or 55 from prior	voar cost roport ur	wated by the m	arkat backat		0.00	60.0
61.00 [If line 53/54 is less than the lower of				the amount by	0.00	
which operating costs (line 53) are les		ts (lines 54 x	60), or 1% of	the target		
amount (line 56), otherwise enter zero 62.00 Relief payment (see instructions)	(see instructions)				0	62.00
63.00 Allowable Inpatient cost plus incentive	pavment (see instru	uctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COS	T					
64.00 Medicare swing-bed SNF inpatient routin	e costs through Dece	ember 31 of the	cost reporti	ng period (See	0	64.00
instructions)(title XVIII only) 65.00  Medicare swing-bed SNF inpatient routin	e costs after Decemb	per 31 of the c	ost reportina	period (See	0	65.00
instructions)(title XVIII only)						
66.00 Total Medicare swing-bed SNF inpatient	routine costs (line	64 plus line 6	5)(title XVII	l only). For	0	66.00
CAH (see instructions) 67.00  Title V or XIX swing-bed NF inpatient r	outine costs through	n December 31 d	f the cost re	portina period	0	67.00
(line 12 x line 19)					-	
68.00 Title V or XIX swing-bed NF inpatient r	outine costs after D	December 31 of	the cost repo	rting period	0	68.00
(line 13 x line 20) 69.00  Total title V or XIX swing-bed NF inpat	ient routine costs (	line 67 + line	68)		0	69.00
PART III - SKILLED NURSING FACILITY, OT	HER NURSING FACILITY	, AND ICF/IID	ONLY			1
70.00 Skilled nursing facility/other nursing	2					70.00
71.00  Adjusted general inpatient routine serv 72.00  Program routine service cost (line 9 x		ine /0 ÷ line	2)			71.00
73.00 Medically necessary private room cost a		n (line 14 x li	ne 35)			73.00
74.00 Total Program general inpatient routine	•					74.00
75.00 Capital-related cost allocated to inpat	ient routine service	e costs (from W	orksheet B, P	art II, column		75.00
26, line 45) 76.00  Per diem capital-related costs (line 75	÷line 2)					76.00
77.00 Program capital-related costs (line 9 x	line 76)					77.00
78.00 Inpatient routine service cost (line 74			- )			78.00
79.00 Aggregate charges to beneficiaries for 80.00 Total Program routine service costs for			· · · · · · · · · · · · · · · · · · ·	us line 79)		79.0
81.00 Inpatient routine service costs for	•		(o /o mili			81.0
82.00 Inpatient routine service cost limitati	on (line 9 x line 81					82.0
83.00 Reasonable inpatient routine service co	•	is)				83.00
84.00  Program inpatient ancillary services (s 85.00  Utilization review - physician compensa		ons)				84. 00 85. 00
86.00 Total Program inpatient operating costs						86.00
PART IV - COMPUTATION OF OBSERVATION BE	D PASS THROUGH COST					
87.00  Total observation bed days (see instruc					3, 249 655. 43	
88.00 Adjusted general inpatient routine cost	ner diem (line 27 ·	Line 21				

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 06/01/2015 To 05/31/2016	Date/Time Pre 10/31/2016 8:	
		Tit	le 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	2,036,798	15, 683, 831	0. 12986	6 2, 129, 492	276, 549	90.00
91.00 Nursing School cost	0	15, 683, 831	0.00000	0 2, 129, 492	0	91.00
92.00 Allied health cost	0	15, 683, 831	0.00000	0 2, 129, 492	0	92.00
93.00 All other Medical Education	0	15, 683, 831	0. 00000	0 2, 129, 492	0	93.00

MPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 150047 Component CCN: 15S047 Title XIX	Period: From 06/01/2015 To 05/31/2016 Subprovider -	Worksheet D-1 Date/Time Prep 10/31/2016 8: PPS	pare
	Cost Center Description		IPF		
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed days,			6, 048	1.
00	Inpatient days (including private room days, excluding swing-be			6, 048	2.
00	Private room days (excluding swing-bed and observation bed days do not complete this line.	s). If you have only pr	ivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation bed	l days)		6, 048	4
00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5
~~	reporting period	dava) aftar Daaambar	21 of the east	0	
00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) arter December	31 OF THE COST	0	6
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
	reporting period	<i>y y y</i>			
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	226	9
	newborn days)	5 . 5	5		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, ent		com days) arter	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or XLX $$	only (including privat	e room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	a room davc)	0	13
. 00	after December 31 of the cost reporting period (if calendar yea			0	13
. 00	Medically necessary private room days applicable to the Program			0	14
	Total nursery days (title V or XIX only)			783	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			279	16
. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17
	reporting period	Ū.			
. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19
	reporting period	-			
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructions)			3, 715, 047	21
	Swing-bed cost applicable to SNF type services through December		ing period (line	0,713,047	22
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24
	7 x line 19)			-	
. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		3, 715, 047	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	· · · · · · · · · · · · · · · · · · ·			
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	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)	is line 22) (cas instrue	tions)	0.00	
	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		(10115)	0. 00 0. 00	
	Private room cost differential adjustment (line 3 x line 35)	,		0.00	36
. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	3, 715, 047	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see i			614.26	38
	Program general inpatient routine service cost (line 9 x line 3			138, 823	
	Medically necessary private room cost applicable to the Program	• •		120 022	
00	Total Program general inpatient routine service cost (line 39 +	line 40)		138, 823	4

IPUTATION OF INPATIENT OPERATING COST	DI CAL CENT		CCN: 150047	Peri od:	eu of Form CMS- Worksheet D-	
	Com	ponent	CCN: 15SO47	From 06/01/2015 To 05/31/2016	Date/Time Pr	epare
		Ti t	le XIX	Subprovider -	10/31/2016 8 PPS	:18 :
Cost Center Description Total	Tota	1	Average Per	I PF	Program Cost	
Inpatient Cos	tInpatient	Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
00 NURSERY (title V & XIX only)	2.00	) 0	3.00	4.00	5.00	0 42
Intensive Care Type Inpatient Hospital Units	<b>U</b>	0			۰ ۱	
	0	0				2 43
01 NEONATAL INTENSIVE CARE UNIT 00 CORONARY CARE UNIT	0	0	0.	00 0		0 43 44
	0	0	0.	00 0		3 45
00 SURGI CAL I NTENSI VE CARE UNI T						46
00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
cost center bescription					1.00	_
00 Program inpatient ancillary service cost (Wkst. D-3, col.					39, 788	
00 Total Program inpatient costs (sum of lines 41 through 48) PASS THROUGH COST ADJUSTMENTS	(see insti	ructio	ns)		178, 61	1 49
00 Pass through costs applicable to Program inpatient routine	e services	(from	Wkst. D. su	m of Parts I and	13, 71	1 50
00 Pass through costs applicable to Program inpatient ancilla and IV)	ary service	es (fr	om Wkst. D,	sum of Parts II	3, 253	3 51
00 Total Program excludable cost (sum of lines 50 and 51)					16, 964	4 52
00 Total Program inpatient operating cost excluding capital r	related, no	on-phy	sician anest	hetist, and	161, 64	7 53
medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION						
00 Program di scharges					(	54
00 Target amount per discharge					0.00	
00 Target amount (line 54 x line 55)	torget one	unt (1	ing E( minug	Line E2)		56
00 Difference between adjusted inpatient operating cost and t 00 Bonus payment (see instructions)	target anot	unt (i	The so minus	TThe 53)		0 57 0 58
00 Lesser of lines 53/54 or 55 from the cost reporting period	d ending 19	996, u	pdated and c	ompounded by the		
market basket						
00 Lesser of lines 53/54 or 55 from prior year cost report, u 00 If line 53/54 is less than the lower of lines 55, 59 or 60				the amount by	0.00	0 60 0 61
which operating costs (line 53) are less than expected cos						
amount (line 56), otherwise enter zero (see instructions)						
<pre>00 Relief payment (see instructions) 00 Allowable Inpatient cost plus incentive payment (see instr</pre>	ructions)					D 62 D 63
PROGRAM INPATIENT ROUTINE SWING BED COST					· ·	
00 Medicare swing-bed SNF inpatient routine costs through Dec instructions)(title XVIII only)	cember 31 d	of the	cost report	ing period (See	(	) 64
00 Medicare swing-bed SNF inpatient routine costs after Decen	nber 31 of	the c	ost reportin	g period (See		0 65
instructions)(title XVIII only)						
00 Total Medicare swing-bed SNF inpatient routine costs (line CAH (see instructions)	e 64 plus I	ine 6	5)(title XVI	ll only). For	(	D 66
00 Title V or XIX swing-bed NF inpatient routine costs through	gh December	- 31 o	f the cost r	eporting period		0 67
(line 12 x line 19)						
00 Title V or XIX swing-bed NF inpatient routine costs after (line 13 x line 20)	December 3	31 of	the cost rep	orting period		2 68
00 Total title V or XIX swing-bed NF inpatient routine costs	(line 67 -	⊦line	68)			0 69
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILIT				<u> </u>		
00 Skilled nursing facility/other nursing facility/ICF/IID rc 00 Adjusted general inpatient routine service cost per diem (				)		70
00 Program routine service cost (line 9 x line 71)			-)			72
00 Medically necessary private room cost applicable to Progra	•					73
00 Total Program general inpatient routine service costs (lir 00 Capital-related cost allocated to inpatient routine servic		,		Part II column		74
26, line 45)		n on W	O KONEEL D,			'
00 Per diem capital-related costs (line 75 ÷ line 2)						76
00  Program capital-related costs (line 9 x line 76) 00  Inpatient routine service cost (line 74 minus line 77)						77
00 Aggregate charges to beneficiaries for excess costs (from	provi der i	record	s)			79
00 Total Program routine service costs for comparison to the	•		· .	nus line 79)		80
00 Inpatient routine service cost per diem limitation	21)					81
00 Inpatient routine service cost limitation (line 9 x line 8 00 Reasonable inpatient routine service costs (see instruction						82
00 Program inpatient ancillary services (see instructions)						84
00 Utilization review - physician compensation (see instructi						85
00 Total Program inpatient operating costs (sum of lines 83 t PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		)			I	86
00 Total observation bed days (see instructions)					(	2 87
00 Adjusted general inpatient routine cost per diem (line 27					0.00	3 88 C
00 Observation bed cost (line 87 x line 88) (see instructions	5)				(	D  89

Health Financial Systems	ST JOSEPH	MEDI C	AL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Period: From 06/01/2015	Worksheet D-1	
			Component		To 05/31/2016	Date/Time Prep 10/31/2016 8:	pared: 18 am
			Tit	le XIX	Subprovider - IPF	PPS	
Cost Center Description	Cost	R	outine Cost	column 1 ÷	Total	Observati on	
		(f	rom line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00		2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	366,	933	3, 715, 047	0. 09876	9 0	0	90.00
91.00 Nursing School cost		0	3, 715, 047	0.00000	0 0	0	91.00
92.00 Allied health cost		0	3, 715, 047	0.00000	0 0	0	92.00
93.00 All other Medical Education		0	3, 715, 047	0.00000	0 0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	MEDI CAL CENTER	CCN: 150047	Period:	Worksheet D-3	2552-10
THEATENT ANGLEART SERVICE COST ATTORTONIMENT	TTOVIDEI	CCN. 150047	From 06/01/2015	worksheet D-5	,
			To 05/31/2016	Date/Time Pre	
				10/31/2016 8:	18 am
Cont Conton Decomination	liti	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
			chai yes	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			13, 730, 145		30.00
31. 00 03100 I NTENSI VE CARE UNI T			638, 262		31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT			0000, 202		31.01
33. 00 03300 BURN I NTENSI VE CARE UNI T			1, 387, 076		33.00
40. 00 04000 SUBPROVI DER – I PF			0		40.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		1			
50. 00 05000 OPERATI NG ROOM		0. 10562	29 5, 326, 019	562, 582	50.00
50. 01 03330 ENDOSCOPY		0. 17496		60, 220	50.01
51.00 05100 RECOVERY ROOM		0. 2050	432, 709	88, 737	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 79600	0 80	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 01558	33 715, 723	11, 153	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 07960		576, 593	54.00
54. 01 03630 ULTRA SOUND		0.0000		0	54.01
56. 00 05600 RADI 0I SOTOPE		0.0000	0 00	0	56.00
57. 00 05700 CT SCAN		0.0000	0 00	0	57.00
58. 00 05800 MRI		0.0000	0 00	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 10528	33 3, 133, 482	329, 902	59.00
60. 00 06000 LABORATORY		0. 10218	38 8, 237, 636	841, 788	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 18413	39 1, 074, 599	197, 876	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 10123	37 4, 609, 477	466, 650	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 25976	450, 082	116, 914	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 20282	26 343, 403	69, 651	67.00
68.00 06800 SPEECH PATHOLOGY		0. 2393		17, 026	
69. 00 06900 ELECTROCARDI OLOGY		0. 0784		29, 469	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21372		744, 890	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1121		547, 641	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 10549		1, 500, 776	
74.00 07400 RENAL DI ALYSI S		0. 27210		335, 562	
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTER		0.0000		0	
76.01 03951 SLEEP LAB		0.0000		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 2440		59, 649	
76. 03 03952 WOUND CARE		0. 2467	79 449, 107	110, 830	76. 03
		2 5407			00.00
90. 00 09000 CLINIC		3. 54970		0	
91. 00 09100 EMERGENCY		0. 11650			
02 00 10020010DCEDVATION DEDC (NON DISTINCT DADT		I U. 45423	55 319, 018	144, 916	92.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				7 001 070	200 00
92.00  09200  OBSERVATION BEDS (NON-DISTINCT PART 200.00   Total (sum of lines 50-94 and 96-98) 201.00   Less PBP Clinic Laboratory Services-Program only cl	harges (line 41)		59, 506, 293 0	7, 081, 972	200.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150047	Peri od:	Worksheet D-3	;
			From 06/01/2015		
	Component	CCN: 15SO47	To 05/31/2016	Date/Time Pre 10/31/2016 8:	
	Ti tl	e XVIII	Subprovider -	PPS	
Cast Cantar Description		Ratio of Cos	I PF	I nnoti ont	1
Cost Center Description		To Charges	t Inpatient Program	Inpatient Program Costs	
		10 charges	U U	(col. 1 x col.	
			Charges	(2)	
		1.00	2.00	3.00	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
00 03000 ADULTS & PEDI ATRI CS			0		30
00 03100 INTENSIVE CARE UNIT			0		31
01 02060 NEONATAL INTENSIVE CARE UNIT			0		31
00 03300 BURN INTENSIVE CARE UNIT			0		33
00 04000 SUBPROVIDER - IPF			11, 493, 737		40
00 04300 NURSERY			,		43
ANCI LLARY SERVI CE COST CENTERS		1		· · · · · · · · · · · · · · · · · · ·	1
00 05000 OPERATING ROOM		0. 1056	29 6, 348	671	50
01 03330 ENDOSCOPY		0. 1749	61 13, 572	2, 375	50
00 05100 RECOVERY ROOM		0. 2050	72 169, 255	34, 709	51
00 05200 DELIVERY ROOM & LABOR ROOM		0. 7960		0	
00 05300 ANESTHESI OLOGY		0. 0155		694	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 0796	05 501, 555	39, 926	54
01 03630 ULTRA SOUND		0.0000		0	
00 05600 RADI 0I SOTOPE		0.0000		0	56
00 05700 CT SCAN		0.0000		0	57
00 05800 MRI		0.0000		0	
00 05900 CARDI AC CATHETERI ZATI ON		0. 1052		0	59
00 06000 LABORATORY		0. 1021		104, 370	60
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 1841		0	
00 06500 RESPI RATORY THERAPY		0. 1012		33, 083	65
00 06600 PHYSI CAL THERAPY		0. 2597			
00 06700 OCCUPATI ONAL THERAPY		0. 2028		30, 400	
00 06800 SPEECH PATHOLOGY		0. 2393			
00 06900 ELECTROCARDI OLOGY		0. 0784			
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2137			
00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1121		34	
00 07300 DRUGS CHARGED TO PATIENTS		0. 1054		220, 636	
00 07400 RENAL DI ALYSI S		0. 2721		8, 969	
00 03950 OTHER ANCILLARY SERVICE COST CENTER		0.0000		0	
01 03951 SLEEP LAB		0.0000		0	
02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 2440		-	
03 03952 WOUND CARE		0. 2467		1, 597	
OUTPATI ENT SERVICE COST CENTERS			0,111	., 577	1
00 09000 CLI NI C		3. 5497	0 80	0	90
00 09100 EMERGENCY		0. 1165			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4542		0	
D. 00 Total (sum of lines 50-94 and 96-98)			5, 100, 481	613, 819	
1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	,	201
2.00 Net Charges (line 200 minus line 201)	/		5, 100, 481		202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150047	Peri od:	Worksheet D-3	;
			From 06/01/2015		
	Component	CCN: 155356	To 05/31/2016	Date/Time Pre 10/31/2016 8:	
	Ti tl	e XVIII	Skilled Nursing	PPS	
Cost Contor Description		Datio of Coo	Facility	I ppoti opt	
Cost Center Description		Ratio of Cos	t Inpatient Program	Inpatient Program Costs	
		To Charges	U U		
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
. 00 03000 ADULTS & PEDI ATRI CS			0		30
. 00  03100   INTENSI VE CARE UNI T			0		31
. 01 02060 NEONATAL INTENSIVE CARE UNIT			0		31
. 00 03300 BURN I NTENSI VE CARE UNI T			0		33
. 00 04000 SUBPROVI DER – I PF			0		40
00 04300 NURSERY			0		43
ANCI LLARY SERVI CE COST CENTERS					1 ``
. 00 05000 OPERATI NG ROOM		0. 1056	29 74, 251	7, 843	50
. 01 03330 ENDOSCOPY		0. 1749		0	50
. 00 05100 RECOVERY ROOM		0. 2050	72 0	0	51
. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 7960	0 80	0	52
00 05300 ANESTHESI OLOGY		0.0155	83 0	0	53
. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0796		8, 196	54
. 01 03630 ULTRA SOUND		0.0000		0	
00 05600 RADI 0I SOTOPE		0.0000		0	56
. 00 05700 CT SCAN		0.0000		0	
. 00 05800 MRI		0.0000		0	
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1052		0	
00 06000 LABORATORY		0. 1021		48, 090	
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 1841:		3, 849	
. 00 06500 RESPI RATORY THERAPY		0. 1012		70, 822	
. 00 06600 PHYSI CAL THERAPY		0. 2597		201, 981	
00 06700 OCCUPATI ONAL THERAPY		0. 2028		149, 246	
00 06800 SPEECH PATHOLOGY		0. 2393		3, 247	
00 06900 ELECTROCARDI OLOGY		0.0784			
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2137:			
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1121		0	
00 07300 DRUGS CHARGED TO PATIENTS		0. 1054		254, 587	
00 07400 RENAL DI ALYSI S		0. 2721		201,007	
. 00 03950 OTHER ANCI LLARY SERVICE COST CENTER		0.0000		0	
. 01   03951   SLEEP LAB		0.0000		0	
02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 2440		0	1
03 03952 WOUND CARE		0. 2467		37, 896	
OUTPATI ENT SERVICE COST CENTERS		0.2107	100,001	3.,070	1
. 00 09000 CLINIC		3. 5497	0 80	0	90
00 09100 EMERGENCY		0. 1165		0	
. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART		0. 4542		392	92
D. 00 Total (sum of lines 50-94 and 96-98)			5, 644, 994		
1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201
2.00 Net Charges (line 200 minus line 201)			5, 644, 994		202

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	L CENTER	CCN: 150047	Peri od:	u of Form CMS-2 Worksheet D-3	
INPATIENT ANGILLART SERVICE COST APPORTIONMENT	Provider	CCN. 150047	From 06/01/2015	WOLKSHEEL D-3	
			To 05/31/2016	Date/Time Pre	pared:
				10/31/2016 8:	18 am
	Ti t	le XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	2, 492, 278		30.00
31. 00   03100   NTENSI VE CARE UNI T			309, 468		31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT			1, 772, 252		31.00
33. 00 03300 BURN INTENSIVE CARE UNIT			403, 865		33.00
40. 00 04000 SUBPROVIDER - I PF			405,005		40.00
43. 00 04300 NURSERY			299, 535		43.00
ANCI LLARY SERVI CE COST CENTERS		1	277,000		10.00
50. 00 05000 OPERATING ROOM		0. 1056	29 1, 426, 705	150, 701	50.00
50. 01 03330 ENDOSCOPY		0. 1749		7, 860	
51. 00 05100 RECOVERY ROOM		0. 2050		30, 350	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 7960		316, 861	52.00
53. 00 05300 ANESTHESI OLOGY		0.0155		4, 482	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0796		93, 096	
54.01 03630 ULTRA SOUND		0.0000		0	54.01
56. 00 05600 RADI 0I SOTOPE		0.0000	00 0	0	56.00
57.00 05700 CT SCAN		0.0000	00 0	0	57.00
58. 00 05800 MRI		0.0000	00 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1052	83 81, 822	8, 614	59.00
60. 00 06000 LABORATORY		0. 1021	88 1, 851, 108	189, 161	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 1841	39 219, 064	40, 338	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 1012	37 1, 341, 724	135, 832	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 2597	61 100, 950	26, 223	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2028	26 95, 197	19, 308	
68.00 06800 SPEECH PATHOLOGY		0. 2393			
69. 00 06900 ELECTROCARDI OLOGY		0. 0784		2, 997	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2137		131, 154	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1121		30, 593	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1054		377, 900	
74. 00 07400 RENAL DI ALYSI S		0. 2721			
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTER		0.0000		0	
76. 01 03951 SLEEP LAB		0.0000		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.2440		14, 348	
76. 03 03952 WOUND CARE		0. 2467	79 105, 622	26, 065	76.03
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C		3. 5497	08 307	1, 090	90.00
90. 00 109000 CETNIC 91. 00 109100 EMERGENCY		0. 1165		38, 468	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1185		16, 365	
200.00 Total (sum of lines 50-94 and 96-98)		0.4342	12, 370, 158		
		1	12, 570, 150	1,705,570	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150047	Peri od:	Worksheet D-3	5
			From 06/01/2015		
	Component	t CCN: 15SO47	To 05/31/2016	Date/Time Pre 10/31/2016 8:	
	Ti t	le XIX	Subprovider -	PPS	
Cost Center Description		Ratio of Cos	I PF st Inpatient	Inpati ent	1
		To Charges	Program	Program Costs	
		l io ondigoo		$(col \cdot 1 \times col \cdot$	
			ondi geo	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
. 00 03000 ADULTS & PEDI ATRI CS			0		30
. 00 03100 I NTENSI VE CARE UNI T			0		31
. 01 02060 NEONATAL INTENSIVE CARE UNIT			0		31
. 00 03300 BURN INTENSIVE CARE UNIT			0		33
. 00 04000 SUBPROVI DER – I PF			694, 975		40
00 04300 NURSERY			0		43
ANCI LLARY SERVI CE COST CENTERS					4
. 00 05000 OPERATING ROOM		0. 1056		0	
. 01 03330 ENDOSCOPY		0. 1749		0	
00 05100 RECOVERY ROOM		0. 2050		1, 348	
. OO 05200 DELIVERY ROOM & LABOR ROOM		0. 7960		0	
00 05300 ANESTHESI OLOGY		0. 0155	83 1, 504	23	53
00 05400 RADI OLOGY-DI AGNOSTI C		0. 0796	22, 563	1, 796	54
01 03630 ULTRA SOUND		0.0000		0	54
00 05600 RADI OI SOTOPE		0.0000	0 00	0	50
. 00  05700  CT SCAN		0.0000	0 00	0	57
. 00 05800 MRI		0.0000		0	
00 05900 CARDI AC CATHETERI ZATI ON		0. 1052	83 0	0	59
00 06000 LABORATORY		0. 1021	88 71, 085	7, 264	60
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 1841	39 0	0	62
00 06500 RESPI RATORY THERAPY		0. 1012	37 21, 292	2, 156	65
. 00 06600 PHYSI CAL THERAPY		0. 2597	61 7, 913	2, 055	66
00 06700 OCCUPATI ONAL THERAPY		0. 2028	26 11, 248	2, 281	6
00 06800 SPEECH PATHOLOGY		0. 2393	59 687	164	68
00 06900 ELECTROCARDI OLOGY		0. 0784	13 5, 638	442	69
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21372	28 10, 193	2, 179	71
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1121		0	
00 07300 DRUGS CHARGED TO PATIENTS		0. 1054		15, 632	
. 00 07400 RENAL DI ALYSI S		0. 2721		0	
00 03950 OTHER ANCILLARY SERVICE COST CENTER		0.0000	0 00	0	76
. 01 03951 SLEEP LAB		0.0000	0 00	0	76
02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 2440	52 0	0	76
03 03952 WOUND CARE		0. 2467	79 0	0	76
OUTPATIENT SERVICE COST CENTERS		1			
00 09000 CLI NI C		3. 54970			
. 00 09100 EMERGENCY		0. 1165			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4542		2, 564	
D.00 Total (sum of lines 50-94 and 96-98)			328, 677	39, 788	
1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201
2.00 Net Charges (line 200 minus line 201)		1	328, 677		202

ALCUL	Financial Systems ST JOSEPH MEDICAL ATLON OF RELMBURSEMENT SETTLEMENT	Provider CCN: 150047	Peri od: From 06/01/2015 To 05/31/2016	u of Form CMS-: Worksheet E Part A Date/Time Pre	pared	
		Title XVIII	Hospi tal	10/31/2016 8: PPS	18 am	
				1.00		
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00		
00 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin	ng prior to October 1 (	see	0 3, 244, 882		
02	instructions) DRG amounts other than outlier payments for discharges occurrin instructions)	ng on or after October	1 (see	6, 224, 179	1.0	
03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	r discharges occurring	prior to October	0	1.0	
04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	r discharges occurring	on or after	0		
00 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			681, 899 0	2.0	
02 00	Outlier payment for discharges for Model 4 BPCI (see instruction Managed Care Simulated Payments			0 5, 203, 977	3. 0	
00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	ting period (see instru	ictions)	102.12	4.0	
00	FTE count for all opathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	recent cost reporting	period ending on	8.95	5.	
00	FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)	he criteria for an add-	on to the cap	0.00	6.	
00 01	MMA Section 422 reduction amount to the IME cap as specified un ACA Section 5503 reduction amount to the IME cap as specified u	under 42 CFR §412.105(f		1.89 0.00		
00	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,					
01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.					
02						
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)			7.11	9.	
). 00 I. 00	FTE count for allopathic and osteopathic programs in the currer FTE count for residents in dental and podiatric programs.	nt year from your recor	ds	5.13 0.00		
2.00	Current year allowable FTE (see instructions)			5.13		
3.00	Total allowable FTE count for the prior year.			5.14	13.	
1.00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	r ended on or after Sep	otember 30, 1997,	5.70		
5.00 5.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			5.32 0.00		
7.00	Adjustment for residents displaced by program or hospital closu	ure		0.00		
3.00	Adjusted rolling average FTE count			5.32		
9.00	Current year resident to bed ratio (line 18 divided by line 4).			0.052096	19.	
0. 00	Prior year resident to bed ratio (see instructions)			0. 045040		
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.045040		
2.00	IME payment adjustment (see instructions)			230, 127		
2. 01 8. 00	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE resider		Sec 412 105	4.00		
. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			-1. 98		
5.00	If the amount on line 24 is greater than -O-, then enter the lo instructions)	ower of line 23 or line	e 24 (see	0.00		
. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000		
. 00	IME payments adjustment factor. (see instructions)			0.000000		
3. 00 3. 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0		
. 00	Total IME payment ( sum of lines 22 and 28)			230, 127		
9. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	)		126, 472		
0. 00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (see instruc	ctions)	9.42		
I. 00	Percentage of Medicaid patient days (see instructions)			39.83		
2.00	Sum of lines 30 and 31			49.25		
3.00	Allowable disproportionate share percentage (see instructions)			30.04	33.	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150047	Peri od:	Worksheet E	
			From 06/01/2015 To 05/31/2016	Date/Time Pre	pare
		Title XVIII	Hospi tal	10/31/2016 8: PPS	18 8
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				1
5.00	Total uncompensated care amount (see instructions)		7, 647, 644, 885		
5. 01 5. 02	Factor 3 (see instructions)	r zoro on this line)	0.000218530	0.000220237	
5. 02	Hospital uncompensated care payment (If line 34 is zero, enter (see instructions)	er zero on this inne)	1, 671, 243	1, 410, 872	35
5. 03	Pro rata share of the hospital uncompensated care payment amou	nt (see instructions)	558, 608	940, 582	35
5.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		1, 499, 190	, 10, 002	36
	Additional payment for high percentage of ESRD beneficiary disc				1
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding d		0		40
	652, 682, 683, 684 and 685 (see instructions)				
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	3, 684 an 685. (see	0		41
1 01	instructions)				
1.01	Total ESRD Medicare covered and paid discharges excluding MS-D an 685. (see instructions)	RGS 652, 682, 683, 684	0		41
2.00	Divide line 41 by line 40 (if less than 10%, you do not qualif	v for adjustment)	0.00		42
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682		0.00		43
0.00	instructions)		Ŭ		
4.00	Ratio of average length of stay to one week (line 43 divided by	y line 41 divided by 7	0. 000000		44
	days)				
5.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45
5.00	Total additional payment (line 45 times line 44 times line 41.)	01)	0		46
7.00	Subtotal (see instructions)		12, 591, 404		47
3. 00	Hospital specific payments (to be completed by SCH and MDH, smaller (one instructions)	all rural hospitals	0		48
	only. (see instructions)			Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instructions)			12, 717, 876	49
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and	Pt. II, as applicable)		994, 695	50
1.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	
2.00	Direct graduate medical education payment (from Wkst. E-4, line	e 49 see instructions).		170, 500	
3.00	Nursing and Allied Health Managed Care payment			0	
4.00 5.00	Special add-on payments for new technologies	N		13, 350	
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru			0	
7.00	Routine service other pass through costs (from Wkst. D, Pt. II		nrough 35)	0	
3.00	Ancillary service other pass through costs from Wkst. D, Pt. 1		li ougii ooji	0	
9.00	Total (sum of amounts on lines 49 through 58)			13, 896, 421	
0. 00	Primary payer payments			4, 747	60
I. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		13, 891, 674	
2.00	Deductibles billed to program beneficiaries			900, 536	
8. 00	Coinsurance billed to program beneficiaries			36, 750	
1.00	Allowable bad debts (see instructions)			199, 824	
5.00	Adjusted reimbursable bad debts (see instructions)			129, 886	
5.00	Allowable bad debts for dual eligible beneficiaries (see instru-	uctions)		104,457	
7.00 3.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a	pplicable to MS DDCs (a	o instructions)	13, 084, 274 0	
9.00 9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	
). 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		-,	0	
). 50	RURAL DEMONSTRATION PROJECT			0	
). 88	SCH or MDH volume decrease adjustment			0	
D. 89	Pioneer ACO demonstration payment adjustment amount (see instru	uctions)		0	
0. 90	HSP bonus payment HVBP adjustment amount (see instructions)	-		0	
	HSP bonus payment HRR adjustment amount (see instructions)			0	
J. 91	Bundled Model 1 discount amount (see instructions)			0	
0. 92					
0. 91 0. 92 0. 93	HVBP payment adjustment amount (see instructions)			-52, 500	
). 92				-28, 633	

Health Financial Systems	ST JOSEPH MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016	Worksheet E Part A Date/Time Pre 10/31/2016 8:	
		Ti tl	e XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1.00	
70.96 Low volume adjustment for federal fi the corresponding federal year for t		column O		0	0	70. 96
70.97 Low volume adjustment for federal fi the corresponding federal year for t				0	0	70. 97
70.98 Low Volume Payment-3					0	70. 98
70.99 HAC adjustment amount (see instructi	ons)				88, 557	70.99
71.00 Amount due provider (line 67 minus l		& 70)			12, 914, 584	71.00
71.01 Sequestration adjustment (see instru	ctions)				258, 292	71.01
72.00 Interim payments	,				12, 430, 439	72.00
73.00 Tentative settlement (for contractor	use only)				0	73.00
74.00 Balance due provider (Program) (line		and 73)			225, 853	74.00
75.00 Protested amounts (nonallowable cost	report items) in accordanc	e with			2, 659, 962	75.00
CMS Pub. 15-2, chapter 1, §115.2						
TO BE COMPLETED BY CONTRACTOR (lines			1			
90.00 Operating outlier amount from Wkst.		uctions)			0	
91.00 Capital outlier from Wkst. L, Pt. I,					0	91.00
92.00 Operating outlier reconciliation adj					0	92.00
93.00 Capital outlier reconciliation adjus					0	93.00
94.00 The rate used to calculate the time		tions)			0.00	
95.00 Time value of money for operating ex					0	95.00
96.00 Time value of money for capital rela	ted expenses (see instructi	ons)			0	96.00
				Prior to 10/1		
				1.00	2.00	
HSP Bonus Payment Amount						
100.00 HSP bonus amount (see instructions)				0	0	100.00
HVBP Adjustment for HSP Bonus Paymen						
101.00 HVBP adjustment factor (see instruct				0.000000000	0.000000000	
102.00 HVBP adjustment amount for HSP bonus				0	0	102.00
HRR Adjustment for HSP Bonus Payment						
103.00 HRR adjustment factor (see instructi				0.0000	0.0000	
104.00 HRR adjustment amount for HSP bonus	payment (see instructions)			0	0	104.00

	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ST JOSEPH MED		CCN: 150047 F	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
	AL ACCOLLED CONDITION (INC) REDUCTION CALCULA		110vruer	F	From 06/01/2015 To 05/31/2016	Part A Exhibi	pared:
			Titl	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		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 discharges occurring prior to October 1	1.01	3, 244, 882	3, 244, 882	2	3, 244, 882	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6, 224, 179		6, 224, 179	6, 224, 179	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	(	)	0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	681, 899	294, 389	387, 510	681, 899	2. 00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	(	0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0	(	0 0	0	3.00
4.00	Managed care simulated payments	3.00	5, 203, 977	1, 300, 994	3, 902, 983	5, 203, 977	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 045040	0.045040	0. 045040		5.00
6.00	(see instructions) IME payment adjustment (see instructions)	22.00	230, 127	78, 860	151, 267	230, 127	6.00
6.01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22.00	126, 472				6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of t	he MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0. 000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	(	0 0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	)	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	230, 127	78, 860			9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	126, 472	31, 618	94, 854	126, 472	9. 01
10.00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0.3004	0.3004	0.3004		10.00
10.00	(see instructions)	33.00	0. 3004	0. 3002	+ 0.3004		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	711, 127	243, 691	467, 436	711, 127	11.00
11.01	Uncompensated care payments	36.00	1, 499, 190	558, 608	940, 582	1, 499, 190	11.01
12.00	Additional payment for high percentage of ESF Total ESRD additional payment (see	RD beneficiary 46.00	di scharges 0	(	0 0	0	12.00
10.00	instructions)	47.00	10 501 404	4 400 400	0 170 074	10 501 404	12.00
	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	12, 591, 404 0	4, 420, 430 (	8, 170, 974 0 0		
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	12, 717, 876	4, 452, 048	8, 265, 828	12, 717, 876	15.00
16.00	Payment for inpatient program capital	50.00	994, 695	350, 757	643, 938	994, 695	16.00
17.00	Special add-on payments for new technologies	54.00	13, 350				
17.01	Net organ aquisition cost	55.00	0	(	0 0	0	17.01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	(	0 0	0	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	(	0 0		18.00
19.00	SUBTOTAL			4, 810, 976	8, 914, 945	13, 725, 921	19.00

Heal th	Financial Systems	ST JOSEPH MED	OICAL CENTER		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016		epared:
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
		0	Wkst. L) 1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	752, 771	258, 23			20.00
20.00	Model 4 BPCI Capital DRG other than outlier	1.01	02,771	200, 20	0 0	0	1
21.00	Capital DRG outlier payments	2.00	145, 419	59, 42	21 85, 998		
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
22.00	Indirect medical education percentage (see	5.00	0. 0234	0. 02	0. 0234	-	22.00
	instructions)						
23.00	Indirect medical education adjustment (see instructions)	6.00	17, 615	6, 04	43 11, 572	17, 615	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 1048	0. 104	48 0. 1048		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	78, 890	27, 0	53 51, 827	78, 890	25.00
26.00	Total prospective capital payments (see instructions)	12.00	994, 695	350, 7	57 643, 938	994, 695	26.00
	, · · · • • • • • • • • • • • • • • • •	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		0	A) 1.00	2.00	3.00	4,00	
27.00		0	1.00	2.00	3.00	4.00	27.00
27.00	Low volume adjustment prior to October 1	70, 96	0		0	0	
28.00	Low volume adjustment on or after October 1	70.98	0		0	0	
30.00	HVBP payment adjustment (see instructions)	70.93	-52, 500	-15, 0	32 - 37, 468		
30.00	HVBP payment adjustment for HSP bonus	70.93	-52, 500	-15, 0.	0 -37,400	-52, 500	
30.01	payment (see instructions)	70. 90			0		30.01
31.00	HRR adjustment (see instructions)	70.94	-28, 633	-6, 8	-21, 802	-28, 633	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	1
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 88, 557	88, 557	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT SETTLEMENT Provider CCN: 150047 Period: From 06/0	1/2015	u of Form CMS-2 Worksheet E Part B Date (Time Dree	
	To 05/3 Title XVIII Hospit	1/2016	Date/Time Pre 10/31/2016 8: PPS	
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
. 00	Medical and other services (see instructions)		2, 449	
. 00 . 00	Medical and other services reimbursed under OPPS (see instructions) PPS payments		6, 440, 314 6, 010, 794	
. 00	Outlier payment (see instructions)		52, 048	
. 00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	
. 00 . 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6		0 0.00	
. 00	Transitional corridor payment (see instructions)		0.00	1
. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	
0.00	Organ acquisitions		0	10.00
1. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES		2, 449	11.00
	Reasonable charges			
	Ancillary service charges		23, 404	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0 23, 404	13.00 14.00
+. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges		23, 404	14.00
5. 00	Aggregate amount actually collected from patients liable for payment for services on a charge ba	asis	0	15.00
5. 00	Amounts that would have been realized from patients liable for payment for services on a charged	basi s	0	16.00
7.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)		0. 000000	17 00
	Total customary charges (see instructions)		23, 404	
9.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	e	20, 955	
0.00	instructions)	_	0	
0. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	e	0	20.00
1.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		2, 449	21.0
	Interns and residents (see instructions)		0	
	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 8 and 9)		0 6, 062, 842	23.00
+. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0,002,042	24.00
	Deductibles and coinsurance (for CAH, see instructions)		0	
	5		1, 076, 497	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (sinstructions)	see	4, 988, 794	27.00
8. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)		66, 335	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	
			5, 055, 129 605	1
	Primary payer payments Subtotal (line 30 minus line 31)		5,054,524	•
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	1		
	Composite rate ESRD (from Wkst. I-5, line 11)		-	33.00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		278, 262 180, 870	
	Allowable bad debts for dual eligible beneficiaries (see instructions)		253, 069	
	Subtotal (see instructions)		5, 235, 394	
	MSP-LCC reconciliation amount from PS&R		-13	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)		0	
9.90 9.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
9. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	
	Subtotal (see instructions)		5, 235, 407	
	Sequestration adjustment (see instructions) Interim payments		104, 708 5, 163, 393	
	Tentative settlement (for contractors use only)		0, 103, 393	
3. 00	Balance due provider/program (see instructions)		-32, 694	43.00
4.00			0	44.00
	\$115.2 TO BE COMPLETED BY CONTRACTOR			
0. 00	Original outlier amount (see instructions)		0	90.00
1. 00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
	The rate used to calculate the Time Value of Money			92.00
3.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)		0	93.00 94.00

	Component CCN: 15S047 To 05/ Title XVIII Subprov			pared: <u>18 am</u>
		•	1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		459	•
3.00	PPS payments		571	3.00
4.00 5.00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instructions)		0.000	
6.00	Line 2 times line 5		0.000	
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	•
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	
10.00	Organ acqui si ti ons		0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges			ł
12.00	Anci I I ary service charges		0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	•
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges		0	14.00
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge	basi s	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charg	ebasi s	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)		0. 000000	17.00
			0	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (s	ee	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (s	ee	0	20.00
	instructions)			
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) Interns and residents (see instructions)		0	
	Cost of physicians' services in a teaching hospital (see instructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		571	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		136	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23]	(see	435	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	
30.00	Subtotal (sum of lines 27 through 29)		435	•
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)		0 435	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		100	02.00
	Composite rate ESRD (from Wkst. I-5, line 11)			33.00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	•
			0	
	Subtotal (see instructions)		435	•
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	•
39.00 39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	•
	RECOVERY OF ACCELERATED DEPRECIATION		0	•
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)		435	•
41.00			426	
42.00			0	
43.00 44.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1		0	•
	§115. 2		0	
00.05	TO BE COMPLETED BY CONTRACTOR			00.00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)		0	•
	The rate used to calculate the Time Value of Money			92.00
00 05	Time Value of Money (see instructions)			93.00 94.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150047	Period: From 06/01/2015 To 05/31/2016		
			e XVIII	Hospi tal	PPS	
		Inpati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		12, 430, 4	39 0	5, 134, 193 0	1.00 2.00 3.00
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	1		0 40 (07 (77 ))		- ·
3.01 3.02	ADJUSTMENTS TO PROVIDER			0 12/07/2015 0	29, 200 0	3.0 <sup>°</sup> 3.02
3.02				0	0	3.0
3.04				0	0	3.0
3.05				0	0	3. 0
	Provider to Program	1				
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.5 3.5
3.51				0	0	3.5
3.53				0	Ő	3.5
3.54				0	0	3.5
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	29, 200	3.9
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		12, 430, 4	39	5, 163, 393	4.0
	TO BE COMPLETED BY CONTRACTOR					
. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. C
- 01	Program to Provider			0		
5. 01 5. 02	TENTATI VE TO PROVI DER			0	0	5.0 5.0
5.03				0	0	5.0
	Provider to Program		-			
5.50	TENTATI VE TO PROGRAM			0	0	5.5
5. 51 5. 52				0	0	5.5 5.5
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
-	5. 50-5. 98)					,
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. C
o. 01	SETTLEMENT TO PROVIDER		225, 8	53	0	6. C
0.02	SETTLEMENT TO PROGRAM		10 (5/ 0	0	32, 694	6. C
. 00	Total Medicare program liability (see instructions)		12, 656, 2	92 Contractor	5, 130, 699 NPR Date	7.0
				Number	(Mo/Day/Yr)	

ANALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150047 CCN: 15S047	Period: From 06/01/2015 To 05/31/2016		
		Ti tl	e XVIII	Subprovider - IPF	PPS	
		Inpatien	t Part A		тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00		1.00	2.00	3.00	4.00	4 00
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 035, 4	0	426 0	1.00 2.00
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
02 03 04				0 0 0	0 0 0	3. 02 3. 03 3. 04 3. 05
05	Provider to Program			0	0	3.05
50	ADJUSTMENTS TO PROGRAM			0	0	3.50
51 52 53 54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0 0 0 0 0	0 0 0 0	3.52 3.52 3.52 3.54 3.54
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		3, 035, 4	93	426	4.00
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
. 01	TENTATI VE TO PROVI DER			0	0	5.01
. 02 . 03				0	0 0	5.02 5.03
	Provider to Program					
. 50 . 51 . 52 . 99	TENTATIVE TO PROGRAM Subtotal (sum of lines 5.01-5.49 minus sum of lines			0 0 0	0 0 0	5.50 5.51 5.52 5.99
00	5.50-5.98) Determined net settlement amount (balance due) based on			0	0	6. 00
01	the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		9, 0	0	0 0	6.01 6.02
. 00	Total Medicare program liability (see instructions)		3, 044, 5	72 Contractor Number	426 NPR Date (Mo/Day/Yr)	7.00
			)	1.00	2.00	

ALYS	GIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150047 CCN: 155356	Period: From 06/01/201 To 05/31/2010	6 Date/Time Pre	parec
		Titl	e XVIII	Skilled Nursing	g <u>10/31/2016 8:</u> PPS	18 an
		Innation	it Part A	Facility	rt B	1
		•				
		mm/dd/yyyy 1.00	Amount 2.00		Amount 4.00	
00	Total interim payments paid to provider	1.00	2.00		4.00	1.0
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		004, 5	0	0	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04 05				0	0	3
5	Provider to Program			0	0	3
0	ADJUSTMENTS TO PROGRAM			0	0	3
1				0	0	3
52				0	0	
53				0	0	3
54	Subtatal (sum of lines 2.01.2.40 minus sum of lines			0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		664, 3	84	0	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1	TENTATI VE TO PROVI DER			0	0	
)2				0	0	5
)3	Provider to Program			0	0	5
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			85	0	6
02	SETTLEMENT TO PROGRAM			0	0	-
00	Total Medicare program liability (see instructions)		664, 4	Contractor	0 NPR Date	7
				Number	(Mo/Day/Yr)	
		(	0	1.00	2.00	

Heal th	Financial Systems ST JOSEPH	H MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150047	Peri od:	Worksheet E-1	
			From 06/01/2015 To 05/31/2016		nared
			10 03/31/2010	10/31/2016 8:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPO				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCU				
1.00	Total hospital discharges as defined in AARA §4102 from		e 14	4, 824	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of line			6, 088	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3, 516	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of line			23, 578	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line			550, 207, 230	
6.00	Total hospital charity care charges from Wkst. S-10, co			981, 091	6.00
7.00	CAH only - The reasonable cost incurred for the purchas	se of certified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructi	ions)		0	8.00
9.00	Sequestration adjustment amount (see instructions)			0	9.00
10.00	Calculation of the HIT incentive payment after sequest	ration (see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instruction	ns)		0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30	0 and line 31) (see instruction	ns)	0	32.00

	Financial Systems ST JOSEPH MEDIC. ATLON OF RELMBURSEMENT SETTLEMENT	AL CENTER Provider CCN: 150047	Period:	u of Form CMS-2 Worksheet E-3	
			From 06/01/2015	Part II	
		Component CCN: 15SO47	To 05/31/2016	Date/Time Pre 10/31/2016 8:	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART II – MEDICARE PART A SERVICES – IPF PPS				
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and med	lical education payments)		3, 349, 771	1
00	Net IPF PPS Outlier Payments			1, 629	
00	Net IPF PPS ECT Payments	ant report filed on or b	afara Navambar	6, 639	
00	Unweighted intern and resident FTE count in the most recent c 15, 2004. (see instructions)	ost report filed on or b	erore November	0.00	4
01	Cap increases for the unweighted intern and resident FTE coun	t for residents that were	e displaced by	0.00	4
01	program or hospital closure, that would not be counted withou			0.00	'
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	6
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	7
00	teaching program" (see instuctions) Intern and resident count for IPF PPS medical education adjus	tmont (coo instructions)		0.00	6
00	Average Daily Census (see instructions)	stillerit (see ristructions)		0. 00 16. 524590	
. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of $5150 - 1$ }		0. 000000	
00	Teaching Adjustment (line 1 multiplied by line 10).	the power of 10100 1j.		0.000000	1
00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			3, 358, 039	
. 00	Nursing and Allied Health Managed Care payment (see instructi	on)		0	1:
. 00	Organ acquisition (DO NOT USE THIS LINE)				14
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
. 00	Subtotal (see instructions)			3, 358, 039	
. 00	Primary payer payments			0	1
. 00	Subtotal (line 16 less line 17).			3, 358, 039	
. 00 . 00	Deductibles Subtotal (line 18 minus line 19)			191, 772 3, 166, 267	
. 00	Coinsurance			68, 810	
00	Subtotal (line 20 minus line 21)			3, 097, 457	
00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		14, 229	
	Adjusted reimbursable bad debts (see instructions)			9, 249	
00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		11, 301	2
00	Subtotal (sum of lines 22 and 24)			3, 106, 706	20
00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	2
00	Other pass through costs (see instructions)			0	2
00	Outlier payments reconciliation			0	20
. 00 . 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
. 99	Pioneer ACO demonstration payment adjustment (see instruction Recovery of Accelerated Depreciation	15)		0	
. 00	Total amount payable to the provider (see instructions)			3, 106, 706	
. 01	Sequestration adjustment (see instructions)			62, 134	
00	Interim payments			3, 035, 493	
. 00	Tentative settlement (for contractor use only)			0	33
. 00	Balance due provider/program (line 31 minus lines 31.01, 32 a	ind 33)		9, 079	34
. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	35
<u>.</u>	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Worksheet E-3, Part II, line 2			1, 629	
	Outlier reconciliation adjustment amount (see instructions)			0	51
2.00	The rate used to calculate the Time Value of Money			0.00	52

	Financial Systems	ST JOSEPH MEDICAL			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047	Peri od:	Worksheet E-3	
			Component CCN: 155356	From 06/01/2015 To 05/31/2016	Part VI Date/Time Pre	norod.
			Component CCN. 155556	10 05/31/2010	10/31/2016 8:	
			Title XVIII	Skilled Nursing	PPS	<u></u>
				Facility		
					1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTL SERVICES	EMEMENT - ALL OTHER	HEALTH SERVICES FOR T	ILE XVIII PARI A	PPS SNF	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS	3)				
1.00	Resource Utilization Group Payment (RUGS)	)			775,009	1.00
2.00	Routine service other pass through costs				0	2.00
3.00	Ancillary service other pass through costs				0	3.00
4.00	Subtotal (sum of lines 1 through 3)				775,009	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES			•	· · ·	
5.00	Medical and other services (Do not use this	line as vaccine cos	ts are included in line	e 1 of W/S E,		5.00
	Part B. This line is now shaded.)					
6.00	Deducti bl e				0	6.00
7.00	Coinsurance				97, 066	
	Allowable bad debts (see instructions)				134	8.00
9.00	Reimbursable bad debts for dual eligible ber		tructions)		0	9.00
	Adjusted reimbursable bad debts (see instruc	ctions)			87	10.00
	Utilization review			``	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 ar	nd 7, plus lines 10	and II)(see Instruction	ns)	678, 030	
	Inpatient primary payer payments OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIE	=			0	13.00 14.00
	Pioneer ACO demonstration payment adjustment				0	14.00
	Recovery of Accel erated Depreciation				0	14. 50
15.00	Subtotal (see instructions				678, 030	
15.00	Sequestration adjustment (see instructions)				13, 561	
	Interim payments				664, 384	
	Tentative settlement (for contractor use onl	<b>v</b> )			001,001	17.00
	Balance due provider/program (line 15 minus		d 17)		85	
	Protested amounts (nonallowable cost report			2, chapter 1,	0	19.00
	§115. 2	,				

ALCUL	Financial Systems ST JOSEPH MEDICA ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150047	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 06/01/2015 To 05/31/2016		pared:
			11	10/31/2016 8:	18 am
		Title XIX	Hospi tal	PPS Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
. 00	Inpatient hospital/SNF/NF services		0		1.00
. 00	Medical and other services			907, 347	2.00
. 00	Organ acquisition (certified transplant centers only)		0		3.00
. 00	Subtotal (sum of lines 1, 2 and 3)		0	907, 347	4.0
. 00 . 00	Inpatient primary payer payments		0	0	5.0 6.0
. 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		0	907, 347	7.0
. 00	COMPUTATION OF LESSER OF COST OR CHARGES		<u> </u>	907, 347	/.0
	Reasonable Charges				i i
. 00	Routine service charges		0		8.0
. 00	Ancillary service charges		12, 370, 158	7, 706, 614	9.0
0.00	Organ acquisition charges, net of revenue		0		10.0
1.00	Incentive from target amount computation		0		11.0
2.00	Total reasonable charges (sum of lines 8 through 11)		12, 370, 158	7, 706, 614	12.0
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.0
4.00	basis Amounts that would have been realized from patients liable for	- novmant for convision	n 0	0	14.0
4.00	a charge basis had such payment been made in accordance with 4			0	14.0
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 011 3413. 13(0)	0. 000000	0.000000	15. C
6.00	Total customary charges (see instructions)		12, 370, 158	7, 706, 614	
7.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	12, 370, 158	6, 799, 267	17.0
	line 4) (see instructions)				
8.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lin	e 0	0	18.0
	16) (see instructions)			_	
9.00	Interns and Residents (see instructions)		0	0	19.0
0.00	Cost of physicians' services in a teaching hospital (see instr	-	0	0	
1. 00	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			907, 347	21.0
2.00	Other than outlier payments		0	0	22.0
3.00	Outlier payments		0	0	23.0
4.00	Program capital payments		0	-	24.0
5.00	Capital exception payments (see instructions)		0		25. C
6.00	Routine and Ancillary service other pass through costs		0	0	26.0
7.00	Subtotal (sum of lines 22 through 26)		0	0	
8.00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		0	907, 347	29.0
0 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	20.0
0.00 1.00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0 907, 347	
2.00	Deductibles	1	0	907, 347	
	Coinsurance		0	0	•
4.00	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0	-	35.0
6.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	907, 347	
7.00	ELIMINATE SETTLEMENT		0	-907, 347	37.0
8.00	Subtotal (line 36 ± line 37)		0	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.0
0.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
1.00	Interim payments		0	0	
2.00 3.00	Balance due provider/program (line 40 minus line 41)		0	0	
	Protested amounts (nonallowable cost report items) in accordar	ICE WITH UNN PUB 15-2	0	0	43.0

C C C C C C C C C C C C C C C C C C C	ART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER OMPUTATION OF NET COST OF COVERED SERVICES npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3) npatient primary payer payments Dutpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) OMPUTATION OF LESSER OF COST OR CHARGES Teasonable Charges Routine service charges Ancillary service charges Organ acquisition charges, net of revenue	Component CCN: 15SO47 Title XIX VICES FOR TITLES V OR XI	Subprovi der - IPF 1npati ent 1.00 X SERVI CES 0 0 0 0 0 0	Date/Time Prep 10/31/2016 8: 1 PPS Outpati ent 2.00 0 0 0 0	
C C C C C C C C C C C C C C C C C C C	COMPUTATION OF NET COST OF COVERED SERVICES npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3) npatient primary payer payments Dutpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Teasonable Charges Routine service charges Ancillary service charges		I PF I npati ent 1.00 X SERVICES 0 0 0 0 0 0 0 0 0 0	Outpati ent 2.00 0 0 0	
C C C C C C C C C C C C C C C C C C C	COMPUTATION OF NET COST OF COVERED SERVICES npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3) npatient primary payer payments Dutpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Teasonable Charges Routine service charges Ancillary service charges	VICES FOR TITLES V OR XI	1.00 X SERVICES 0 0 0 0 0 0	2.00	
C C C C C C C C C C C C C C C C C C C	COMPUTATION OF NET COST OF COVERED SERVICES npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3) npatient primary payer payments Dutpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Teasonable Charges Routine service charges Ancillary service charges	VICES FOR TITLES V OR XI	X SERVICES	0 0 0	
C C C C C C C C C C C C C C C C C C C	COMPUTATION OF NET COST OF COVERED SERVICES npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3) npatient primary payer payments Dutpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Teasonable Charges Routine service charges Ancillary service charges			0	
00 I 000 M 000 C 000 S 000 I 000 C 000 S C R R 000 F 000 F 000 F	npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3) npatient primary payer payments Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) OMPUTATION OF LESSER OF COST OR CHARGES Leasonable Charges Routine service charges Ancillary service charges		0000000	0	
00 M 00 C 00 S 00 I 00 C 00 S C C R R 00 F 00 F	Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3) npatient primary payer payments Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) OMPUTATION OF LESSER OF COST OR CHARGES Leasonable Charges Routine service charges Ancillary service charges		0	0	
00 S 00 I 00 C 00 S 00 S 00 F 00 F	Subtotal (sum of lines 1, 2 and 3) npatient primary payer payments Dutpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) OMPUTATION OF LESSER OF COST OR CHARGES leasonable Charges Routine service charges Ancillary service charges		0	0	
00 1 00 0 00 5 00 5 00 R 00 F 00 F	npatient primary payer payments Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges Routine service charges Ancillary service charges		0	0	
00 0 00 S C R 00 F 00 <i>F</i>	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges Routine service charges Ancillary service charges		0		
00 S C R 00 F 00 <i>F</i>	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges Routine service charges Ancillary service charges				
C R 00 F 00 <i>F</i>	COMPUTATION OF LESSER OF COST OR CHARGES Leasonable Charges Routine service charges Ancillary service charges			0	
R 00 F 00 <i>F</i>	easonable Charges Routine service charges Ancillary service charges				
۹ 00 ۹ 00	Routine service charges Ancillary service charges				
00 A	Ancillary service charges		694, 975		
	5 6	0			
. 00 0			328, 677 0	0	
	ncentive from target amount computation		0		
	Fotal reasonable charges (sum of lines 8 through 11)		1, 023, 652	0	
С	USTOMARY CHARGES				
	Amount actually collected from patients liable for payment for	services on a charge	0	0	
	pasi s				
	Amounts that would have been realized from patients liable for		0 ו	0	
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)	0, 000000	0. 000000	
	Ratio of line 13 to line 14 (not to exceed 1.000000) Fotal customary charges (see instructions)		1, 023, 652	0.00000	
	Excess of customary charges over reasonable cost (complete onl	vifline 16 exceeds	1, 023, 652	0	
	ine 4) (see instructions)	y IT THE TO EXCEEds	1, 023, 032	0	
1	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	e 0	0	
1	16) (see instructions)	-			
	nterns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instr		0	0	
	Cost of covered services (enter the lesser of line 4 or line 1		0	0	
	ROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid			
	Other than outlier payments		0	0	
	Dutlier payments Program capital payments		0	0	
	Capital exception payments (see instructions)		0		
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	Ő	
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Fitles V or XIX (sum of lines 21 and 27)		0	0	
С	OMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Jtilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	o	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	557	0	0	
	Subtotal (line $36 \pm 1$ ine $37$ )		0	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		
	Fotal amount payable to the provider (sum of lines 38 and 39)		0	0	
	nterim payments		0	Ő	
	Balance due provider/program (line 40 minus line 41)		0	0	
	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2,	0	0	

	nancial Systems ST JOSEPH MEDICA RADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT		CCN: 150047	Period:	u of Form CMS-2 Worksheet E-4	
	EDUCATION COSTS			From 06/01/2015 To 05/31/2016	Date/Time Pre	pared
		Title	e XVIII	Hospi tal	10/31/2016 8: PPS	iu all
					1.00	
CO	MPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00 Un	nweighted resident FTE count for allopathic and osteopathic j nding on or before December 31, 1996.	programs for	cost reporti	ng periods	7.63	1.0
	nweighted FTE resident cap add-on for new programs per 42 CFI nount of reduction to Direct GME cap under section 422 of MM,		1) (see instr	uctions)	0.00 0.00	2. 3.
	rect GME cap reduction amount under ACA §5503 in accordance astructions for cost reporting periods straddling 7/1/2011)	with 42 CFR	§413.79 (m).	(see	0.00	3.
	djustment (plus or minus) to the FTE cap for allopathic and ( ME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	-0. 80	4.
	CA Section 5503 increase to the Direct GME FTE Cap (see insti traddling 7/1/2011)	ructions for	cost reporti	ng periods	0.00	4.
	CA Section 5506 number of additional direct GME FTE cap slot: eriods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4.
4.	FE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plu 02 plus applicable subscripts				6.83	5.
re	nweighted resident FTE count for allopathic and osteopathic pecords (see instructions)	programs for	the current	year from your	5.13	
.00 En	ter the lesser of line 5 or line 6		Drimory Coro	Othor	5. 13	7.
			Primary Care 1.00	0ther 2.00	<u>Total</u> 3.00	
	eighted FTE count for physicians in an allopathic and osteopa ogram for the current year.	athi c	5.1		5. 13	8.
00 İf	fline 6 is less than 5́enter the amount from line 8, otherwi المانيان المائية المائي		5.1	3 0.00	5.13	9.
0.00 We	eighted dental and podiatric resident FTE count for the currents to the currents of the currents of the count set of the coun	ent year	5. 1	0.00 3 0.00		10. 11.
2. 00 To	otal weighted resident FTE count for the prior cost reporting structions)	g year (see	5.1			12.
3. 00 To	otal weighted resident FTE count for the penultimate cost repear (see instructions)	porting	5.7	0 0.00		13.
	olling average FTE count (sum of lines 11 through 13 divided	by 3).	5.3	2 0.00		14.
	justment for residents in initial years of new programs		0.0			15.
	djustment for residents displaced by program or hospital clos	sure	0.0			16.
	djusted rolling average FTE count er resident amount		5.3 96,168.4			17.
	oproved amount for resident costs		511, 61		511, 616	
00 4d	dditional unweighted allopathic and osteopathic direct GME F	TE rocidont	can clote ree	alved under 12	1.00	20
Se	ec. 413.79(c)(4)		cap stots rec	erved under 42		
	rect GME FTE unweighted resident count over cap (see instruc				0.00	
	lowable additional direct GME FTE Resident Count (see instructed the locally adjustment national average per resident amount		structions)		0.00	
	ultiply line 22 time line 23	Junt (See In	structrons)		95, 636. 89 0	
	otal direct GME amount (sum of lines 19 and 24)				511, 616	
			Inpatient Par A	t Managed care		
			1.00	2.00	3.00	
	MPUTATION OF PROGRAM PATIENT LOAD		0.07	0 4 5 4 0		24
	npatient Days (see instructions) otal Inpatient Days (see instructions)		9, 87 29, 76			26. 27.
	atio of inpatient days to total inpatient days		29, 76 0. 33187			27.
	rogram direct GME amount		169, 79			20.
9 ()() IPr	ogram at toot one uniourt		107, 77			
	eduction for direct GME payments for Medicare Advantage			11, 032		30.

Heal th	Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUT	PATIENT DIRECT	Provider CCN: 150047	Period:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 06/01/2015 To 05/31/2016	Date/Time Pre	nared
				10 03/31/2010	10/31/2016 8:	
			Title XVIII	Hospi tal	PPS	
					1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COM EDUCATION COSTS)	POSITE RATE - TITLE	XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
32.00	Renal dialysis direct medical education cos	ts (from Wkst. B, Pt	. I, sum of col. 20 an	d 23, lines 74	0	32.00
	and 94)					
33.00	Renal dialysis and home dialysis total char			74 and 94)	2, 192, 998	33.00
34.00	Ratio of direct medical education costs to		32 ÷ line 33)		0. 000000	
35.00	Medicare outpatient ESRD charges (see instr				0	35.00
36.00	Medicare outpatient ESRD direct medical edu				0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE	<u>COST - TITLE XVIII O</u>	NLY			
	Part A Reasonable Cost			1		
37.00	Reasonable cost (see instructions)				16, 564, 242	
38.00	Organ acquisition costs (Wkst. D-4, Pt. III				0	38.00
39.00	Cost of physicians' services in a teaching	hospital (see instru	ctions)		0	39.00
40.00	Primary payer payments (see instructions)				4, 747	40.00
41.00	Total Part A reasonable cost (sum of lines	37 through 39 minus	line 40)		16, 559, 495	41.00
10.00	Part B Reasonable Cost				( 110 000	40.00
	Reasonable cost (see instructions)				6, 443, 222	
43.00 44.00	Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus	1:00 (2)			605 6, 442, 617	43.00 44.00
44.00 45.00	Total reasonable cost (sum of lines 41 and				6, 442, 617 23, 002, 112	
45.00	Ratio of Part A reasonable cost to total re		41 · Lino 45)		0. 719912	
40.00	Ratio of Part B reasonable cost to total re				0. 280088	
÷7.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BET				0.200000	ч7.00
48.00	Total program GME payment (line 31)		5		236, 835	48.00
49.00	Part A Medicare GME payment (line 46 x 48)	(title XVIII only) (	see instructions)		170, 500	
50.00	Part B Medicare GME payment (line 47 x 48)		,		66, 335	
22. 50				I	55,000	20.00

	Financial Systems ST JOSEPH MED E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl		CCN: 150047	Period: From 06/01/2015 To 05/31/2016		epare
		General Fund	Specific Purpose Func			
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
0	Cash on hand in banks	-429, 197		0 0	0	1
0	Temporary investments	0		0 0	0	2
0	Notes receivable	0		0 0	0	) 3
0	Accounts receivable	29, 294, 793		0 0	0	4
0	Other receivable	0		0 0	0	) 5
0	Allowances for uncollectible notes and accounts receivable	-5, 502, 678		0 0	0	
0	Inventory	3, 504, 905		0 0	0	
0	Prepaid expenses	585, 073		0 0	0	
0 00	Other current assets Due from other funds	892, 127		0 0	0	
00	Total current assets (sum of lines 1-10)	28, 345, 023		0 0	0	
00	FIXED ASSETS	20, 343, 023	I	0 0	0	4 ''
00	Land	1, 010, 000		0 0	0	12
00	Land improvements	400, 981		0 0	0	
00	Accumulated depreciation	-316, 600		0 0	0	14
00	Bui I di ngs	28, 336, 155		0 0	0	
00	Accumulated depreciation	-13, 990, 401		0 0	0	
00	Leasehold improvements	21, 265, 765		0 0	0	
00	Accumulated depreciation	-5, 627, 624		0 0	0	
	Fixed equipment	477, 890		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Automobiles and trucks Accumulated depreciation	0		0 0	0	
	Major movable equipment	19, 577, 927		0 0	0	
	Accumulated depreciation	-15, 715, 533		0 0	0	
00	Minor equipment depreciable	7, 516, 319		0 0	0	
	Accumulated depreciation	-5, 942, 083		0 0	0	
	HIT designated Assets	0		0 0	0	
00	Accumulated depreciation	0		0 0	0	28
00	Mi nor equipment-nondepreciable	0		0 0	0	29
00	Total fixed assets (sum of lines 12-29)	36, 992, 796		0 0	0	30
	OTHER ASSETS	-	1			1
	Investments	0		0 0	0	
00 00	Deposits on Leases	0		0 0	0	
00	Due from owners/officers Other assets	6, 676, 851		0 0	0	
00	Total other assets (sum of lines 31-34)	6, 676, 851		0 0	0	
00	Total assets (sum of lines 11, 30, and 35)	72, 014, 670		0 0	0	
00	CURRENT LI ABI LI TI ES	12/01/1/070		<u> </u>		
00	Accounts payable	2, 649, 732		0 0	0	37
00	Salaries, wages, and fees payable	2, 979, 273		0 0	0	38
00	Payroll taxes payable	360, 542		0 0	0	
	Notes and loans payable (short term)	22, 222		0 0	0	
	Deferred income	0		0 0	0	
	Accel erated payments	0			0	42
00	Due to other funds	24, 227, 284		0 0	0	
00 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	1, 807, 253 32, 046, 306		0 0	0	
00	LONG TERM LIABILITIES	32, 040, 300		0 0	0	40
00	Mortgage payable	0		0 0	0	1 46
00	Notes payable	35, 185		0 0	0	
00	Unsecured Loans	0		0 0	0	
00	Other long term liabilities	0		0 0	0	
00	Total long term liabilities (sum of lines 46 thru 49)	35, 185		0 0	0	50
00	Total liabilities (sum of lines 45 and 50)	32, 081, 491		0 0	0	<u>)</u> 51
	CAPITAL ACCOUNTS					÷
00	General fund balance	39, 933, 179				52
00	Specific purpose fund			0		53
00	Donor created - endowment fund balance - restricted			0		54
00 00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	
00	Plant fund balance - reserve for plant improvement,				0	
50	replacement, and expansion				0	
		39, 933, 179		0 0	0	59
00	Total fund balances (sum of lines 52 thru 58)					

Heal th	Financial Systems	ST JOSEPH MEDI	CAL CENTER			In Lie	eu of Form CMS-	2552-10
	IENT OF CHANGES IN FUND BALANCES			r CCN: 150047		riod: om 06/01/2015	Worksheet G-	epared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	I
1 00	Fund halanass at baginning of pariod	1.00	2.00	3.00		4.00	5.00	1.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	36, 724, 8 3, 208, 3 39, 933, 1 39, 933, 1	05 32 0		0 0 0 0 0		5.00         6.00         7.00         8.00         9.00         10.00         11.00         12.00         13.00         14.00         15.00         16.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		39, 933, 1	79		0		19.00
		Endowment Fund	PI a	nt Fund			I	
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0			0			1.00 2.00 3.00 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 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0			0 0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150047		iod: 0 06/01/2015	Worksheet G-2 Parts I & II	
			_	To		Date/Time Pre 10/31/2016 8:	
	Cost Center Description		Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
	General Inpatient Routine Services			1			
1.00	Hospi tal		46, 515, 1			46, 515, 121	1.00
2.00	SUBPROVIDER - IPF		18, 554, 9	19		18, 554, 919	2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER						4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY		3, 551, 3	60		3, 551, 360	
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10. 00	Total general inpatient care services (sum of lines 1-9)		68, 621, 4	00		68, 621, 400	10.0
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT		1, 828, 2	58		1, 828, 258	11.00
11. 01	NEONATAL INTENSIVE CARE UNIT		3, 140, 6	97		3, 140, 697	11.0
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT		9, 687, 7	56		9, 687, 756	13.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of I	i nes	14, 656, 7	11		14, 656, 711	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		83, 278, 1	11		83, 278, 111	17.00
18.00	Ancillary services		205, 484, 6	48	207, 682, 737	413, 167, 385	18.00
19.00	Outpatient services		10, 437, 2	68	43, 324, 466	53, 761, 734	19.00
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	o	0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )						25.00
26.00	HOSPICE						26.00
27.00	OTHER (SPECI FY)			0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	299, 200, 0	27	251,007,203	550, 207, 230	
	G-3, line 1)						
	PART II - OPERATING EXPENSES				I		1
29.00	Operating expenses (per Wkst. A, column 3, line 200)				93, 715, 630		29.0
30. 00	ADD (SPECIFY)			0			30.0
31.00				0			31.0
32.00				0			32.0
33.00				0			33.0
34.00				0			34.0
35.00				Ő			35.0
36.00	Total additions (sum of lines 30-35)			Ŭ	0		36.0
37.00	DEDUCT (SPECIFY)			0	0		37.0
38.00				0			38.0
39.00				0			39.0
40.00				0			40.0
40.00				0			40.0
41.00	Total deductions (sum of lines 37-41)			9	0		41.0
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfor			93, 715, 630		42.0
40.00	Tiotal operating expenses (sum of times 27 and 30 millius TIME 42)	( ci ansi el			73, 713, 030		1 43.0

Heal th	Financial Systems	ST JOSEPH MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provi der CCI	N: 150047	Peri od:	Worksheet G-3	
					From 06/01/2015 To 05/31/2016	Date/Time Pre	arod
					10 03/31/2010	10/31/2016 8:	
	1					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part		28)			550, 207, 230	1.00
2.00	Less contractual allowances and discounts or	patients' accounts				453, 474, 188	2.00
3.00	Net patient revenues (line 1 minus line 2)					96, 733, 042	3.00
4.00	Less total operating expenses (from Wkst. G-		)			93, 715, 630	4.00
5.00	Net income from service to patients (line 3	minus line 4)				3, 017, 412	5.00
	OTHER INCOME				1		
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					0	7.00
8.00	Revenues from telephone and other miscellane	ous communication se	ervi ces			0	8.00
9.00	Revenue from television and radio service					0	9.00
10.00						0	10.00
11.00						0	11. 00 12. 00
12.00	Parking lot receipts Revenue from laundry and linen service					-	12.00
	Revenue from meals sold to employees and que	ete				0	13.00
	Revenue from rental of living guarters	515				0	14.00
	Revenue from sale of medical and surgical su	police to other the	a pationte			0	16.00
	Revenue from sale of drugs to other than pat		i patrents			0	17.00
	Revenue from sale of medical records and abs					0	18.00
	Tuition (fees, sale of textbooks, uniforms,					0	19.00
	Revenue from gifts, flowers, coffee shops, a					0	20.00
21.00	5						21.00
22.00						0	22.00
23.00						0	23.00
24.00						190, 893	
	Total other income (sum of lines 6-24)					190, 893	
	Total (line 5 plus line 25)					3, 208, 305	
	OTHER EXPENSES (SPECIFY)					0,200,000	27.00
	Total other expenses (sum of line 27 and sub	scripts)				0	28.00
	Net income (or loss) for the period (line 26					3, 208, 305	
		-			I		

ealth Financial Systems ST JOSEPH CALCULATION OF CAPITAL PAYMENT		Period:	u of Form CMS-2 Worksheet L			
		From 06/01/2015 To 05/31/2016	Parts I-III Date/Time Pre	pare		
			10/31/2016 8:			
	Title XVIII	Hospi tal	PPS			
			1.00			
PART I - FULLY PROSPECTIVE METHOD						
CAPITAL FEDERAL AMOUNT			750 771	1 1.		
00 Capital DRG other than outlier 01 Model 4 BPCI Capital DRG other than outlier	752, 771 0					
00 Capital DRG outlier payments	145, 419					
01 Model 4 BPCI Capital DRG outlier payments	143, 419					
00 Total inpatient days divided by number of days in the o	64.80					
00 Number of interns & residents (see instructions)		5. 32				
00 Indirect medical education percentage (see instructions)						
	Indirect medical education becentage (see instructions)					
1.01) (see instructions)	1.01) (see instructions)					
00 Percentage of SSI recipient patient days to Medicare Pa 30) (see instructions)	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line					
00 Percentage of Medicaid patient days to total days (see	39.83	8				
00 Sum of lines 7 and 8	49.25					
.00 Allowable disproportionate share percentage (see instru	10.48					
. 00 Disproportionate share adjustment (see instructions)			78, 890			
.00 Total prospective capital payments (see instructions)			994, 695			
			1.00			
PART II – PAYMENT UNDER REASONABLE COST			1.00	-		
00 Program inpatient routine capital cost (see instruction	ns)		0	1 1		
00 Program inpatient ancillary capital cost (see instruction			0			
00 Total inpatient program capital cost (line 1 plus line	0					
00 Capital cost payment factor (see instructions)	0					
00 Total inpatient program capital cost (line 3 x line 4)			0			
			1.00			
PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00			
00 Program inpatient capital costs (see instructions)			0	1		
00 Program inpatient capital costs for extraordinary circu	umstances (see instructions)		0	2		
00 Net program inpatient capital costs (line 1 minus line	2)		0	-		
OO Applicable exception percentage (see instructions)			0.00			
00 Capital cost for comparison to payments (line 3 x line			0			
00 Percentage adjustment for extraordinary circumstances			0.00			
00 Adjustment to capital minimum payment level for extraol	rdinary circumstances (line 2 x l	line 6)	0			
00 Capital minimum payment level (line 5 plus line 7)			0	-		
00 Current year capital payments (from Part I, line 12, as			0			
.00 Current year comparison of capital minimum payment leve			0			
	over capital payment (from prio	r year	0	11.		
.00 Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14)		442	0	12.		
Worksheet L, Part III, line 14)	tal payments (line 10 plus line	11) 1		1		
Worksheet L, Part III, line 14) .00 Net comparison of capital minimum payment level to capi		11)	0	13.		
Worksheet L, Part III, line 14) 2.00 Net comparison of capital minimum payment level to capi 3.00 Current year exception payment (if line 12 is positive,	, enter the amount on this line)		0			
Worksheet L, Part III, line 14) 2.00 Net comparison of capital minimum payment level to capi 3.00 Current year exception payment (if line 12 is positive,	, enter the amount on this line) over capital payment for the fol					
Worksheet L, Part III, line 14) 2.00 Net comparison of capital minimum payment level to capi 3.00 Current year exception payment (if line 12 is positive, 4.00 Carryover of accumulated capital minimum payment level	, enter the amount on this line) over capital payment for the fol )			14.		
<ul> <li>Worksheet L, Part III, line 14)</li> <li>.00 Net comparison of capital minimum payment level to capi</li> <li>.00 Current year exception payment (if line 12 is positive,</li> <li>.00 Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line)</li> </ul>	, enter the amount on this line) over capital payment for the fol ) see instructions) ions)		0 0 0	14 15		