Health Financ		ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
This report i payments made	s required by law (42 USC 1395g; since the beginning of the cost	; 42 CFR 413.20(b)). Fai t reporting period being	lure to report can resu deemed overpayments (4)	lt in all interim 2 usc 1395g).	FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLEX COS T SUMMARY	ST REPORT CERTIFICATION	Provider CCN: 15-0047	Period: From 06/01/2016 To 05/31/2017	
PART I - COST	REPORT STATUS				
Provider use only	1.[X] Electronically filed constants.  2.[] Manually submitted constants.  3.[0] If this is an amended at [F] Medicare Utilization.	t report report enter the number	of times the provider r " for low.	Date: 10/30/2 esubmitted this c	
Contractor use only	5. [ 1 ]Cost Report Status 6 (1) As Submitted 7 (2) Settled without Audit 8 (3) Settled with Audit 9 (4) Reopend	. Contractor No.	r this Provider CCN 12.1		

PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST JOSEPH MEDICAL CENTER ( 15-0047 ) for the cost reporting period beginning 06/01/2016 and ending 05/31/2017 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.

Encryption Information ECR: Date: 10/30/2017 Time: 4:19 pm .qKetdnRnY.otsGST:hGqqkjMKC0x0 wZ8WIOBHX1LvAR46eUehlm6NEkhOkS e7M.1hTvx308kA.Y

Date: 10/30/2017 Time: 4:19 pm jwbuSfiqR6vhhLFwhUPovt41eMq400 eytduOewx5VyT7DmnNPxyjN:8Cf8J9 JR.XORNCh908H6Kh

(Signed) or Administrator of Provider(s)

Date

Title XVIII Title V Part A Part B Title XIX HIT 1.00 2.00 3.00 4,00 5.00 PART III - SETTLEMENT SUMMARY Hospital 366,979 -149,677 0 1.00 0 Subprovider - IPF 7,356 0 0 2.00 Subprovider - IRF 0 0 0 0 3.00 Swing bed - SNF Swing bed - NF n 0 0 5.00 0 6.00 SKILLED NURSING FACILITY O 0 7.00 200.00 Total 0 374,335 -149.6770 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.

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18.00 Renal Dialysis   18.00   18.00   19.00												
20.00 Cost Reporting Period (mm/dd/yyyy)  20.00 Type of Control (see instructions) Inpatient PPS information  22.00 Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR \$412.1067 In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section \$412.106(c) (2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section \$412.106(c) (2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.  22.01 Did this hospital receive interim uncompensated care payments for this cost reporting period occurring prior to October 1. Center in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring period occurring on or after October 1. (see instructions) Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring portion of the cost reporting period occurring portion of the cost reporting period or or after October 1. (see instructions) Enter in column 1, "Y" for yes or "N" for no. The portion of the cost reporting period or or after October 1. (see instructions) Enter in column 1, "Y" for yes or "N" for no. The portion of the cost reporting period or or after October 1. (see instructions) Enter in column 1, "Y" for yes or "N" for no. The portion of the cost reporting period or or of the OMB standards for delineating statistical areas adopted by OMS in FY2015? Enter in column 1, "Y" for yes or "N" for no. The portion of the cost reporting period or October 1. Enter in column 2, "Y" for yes or "N" for no. The portion of the cost reporting period or October 1. See instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105? Enter in column 3, "Y" for yes or "N" for no. The portion of the cost reporting period or October 1. See instructions) Does this hospital contain at least 100 but not more than 499 bed												18. 00
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21.00 Type of Control (see instructions)  22.00 Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section \$412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section \$412.106(c)(2) (Pickle amendment hospital) and up. enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section \$412.106(c)(2) (Pickle amendment hospital) receive interia uncompensated care payments for this cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no. For the portion of the cost reporting period occurring on or after October 1. (see instructions)  22.02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in Column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period or or after October 1. See instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with hospital contain at least 100 but not more than 499 beds (as counted in accordance with hospital contain at least 100 but not more than 499 beds (as counted in accordance with hospital contain at least 100 but not more than 499 beds (as counted in accordance with hospital contain at least 100 but not more than 499 beds (as counted in accordance with hospital contain at least 100 but not more than 499 beds (as counted in accordance with hospital contain at least 100 but not more than 499 beds (as counted in accordance with hospital contain at least 100 but not more than 499 beds (as counted in accordance with hospital contain accordance with hospital contain accordance with hospital part of the provider is an								1.00	)	2. 0	0	
Inpati ent PPS Information   22.00   Does this facility qualify and is it currently receiving payments for disproportionate   Y   N   22.00   Share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y"   for yes or "N" for no. Is this facility subject to 42 CFR \$62tin 9412.106? (c) (2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR \$62tin 9412.106? (c) (2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 9412.106(c) (2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 9412.106(c) (2) (Pickle amendment hospital?) In column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)  22.02 Is this a newly merged hospital that requires final uncompensated care payments to be   N   N   22.02   determined at cost reports tell tement? (see instructions) Enter in column 1, "Y" for yes or "N" for the portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see Instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105? Enter in column 3, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see Instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105? Enter in column 3, "Y" for yes or "N" for no. Out-of State Medicaid digital but unpaid days in column 4. (as a point of discharge. In State Medicaid paid days in column 1, in-state Medicaid paid days in column 1, in-st								1	016	05/31/	2017	20.00
share hospital adjustment, in accordance with 42 CFR \$412.1067 In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section \$412.1062 (2) Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.  22.01 Did this hospital receive interial mucompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)  22.02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period or or after October 1.  22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period or or after October 1. See instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on a rafter October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23.00 the prior ocst reporting period? In column 2, enter "Y" for yes or "N" for no.  10.00 Life this provider is an IRPS hospital, enter the instate Medicaid paid days in column 1, in-state Medicaid beinglible unpaid days in column 3, out-of-s		Inpatient PPS Information										
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22.02   Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1. "" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "V" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "V" for yes or "N" for no.    23.00   Which method is used to determine Medicaid days on lines 24 and/or 25 bellow? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.    In-State Medicaid didays in column 1, in-state Medicaid days in column 1, in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid days in column 4, Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid days						_						
determined at čost řeport settlement? (šee instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.  22.03   10 this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412, 105)? Enter in column 3, "Y" for yes or "N" for no.  23.00   No thin method is used to determine Medicaid days on lines 24 and/or 25 below? In column 42 the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  24.00   If this provider is an IPPS hospital, enter the in-state Medicaid digible unpaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid days in column 5, and other Medicaid days in column 6.  25.00   If this provider is an IRF, enter the in-state Medicaid days in column 1, the in-state Medicaid days in column 4, Medicaid days in column 6.  26.00   If this provider is an IRF, enter the in-state Medicaid day in column 1, the in-state Medicaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 4, Medicai	22 02	,	roquires final u	uncomponent	od caro	navmont	ts to bo	N		N		22 02
in column 2, "Y" for ye's or "N" for no, for the portion of the cost reporting period on or after October 1.  22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. Get in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period? In column 2, enter "Y" for yes or "N" for no.  24.00 If this provider is an IPPS hospital, enter the in-state Medicaid eligible unpaid days in column 1, in-state Medicaid days in column 2, out-of-state Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid day in column 1, the in-state Medicaid days in column 1, Medicaid device of the Medicaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 6, Medicaid Medicaid days in column 1, Medicaid Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid Medicaid days i	22.02	determined at cost report settlement	? (see instructio	ons) Enter	in colur	mn 1, "\	Y" for yes			IN		22.02
or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 bellow? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  24.00 If this provider is an IPPS hospital, enter the in-state Medicaid aligible unpaid days in column 1, in-state Medicaid deligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid deligible unpaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid Medicaid eligible unpaid days in column 5, and the			1 9					,				
of the OMB standards for del Theating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.  1. In-State Medicaid by a light by the method of identifying the days in column 1, in-state Medicaid days in column 1, in-state Medicaid days in column 1, in-state Medicaid alighed days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 6.  24.00 If this provider is an IPPS hospital, enter the in-state Medicaid and eligible unpaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid eligible unpaid days in column 5, out-of-state Medicaid eligi		or after October 1.	•				•					
in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412. 105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "V" for yes or "N" for no.  In-State Medicaid by a days in column 2, enter "V" for yes or "N" for no.  In-State Medicaid by a days in column 2, enter "V" for yes or "N" for no.  In-State Medicaid by a days in column 2, enter "V" for yes or "N" for no.  In-State Medicaid by a days in column 3, out-of-state Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 6.  Medicaid paid days in column 1, the in-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid eligible unpaid days in column 5, out-of	22. 03							: N		N		22. 03
cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.  23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method didentifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.    In-State   Medicaid   Medic		in column 1, "Y" for yes or "N" for	no for the portio	on of the c	ost repo	orting p	peri od					
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "\" for yes or "\" for no.    In-State Medicaid paid days in column 1, in-state Medicaid paid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid days in column 5, and other Medicaid days in column 1, the in-state Medicaid deligible unpaid days in column 1, the in-state Medicaid deligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 1, the in-state Medicaid deligible unpaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 1, the in-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 1, the in-state Medicaid days in column 1, the in-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid deligible unpaid days in column 3, out-of-state Medicaid days in column 4, Medicaid												
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.    In-State   Medicaid   Medicaid   Medicaid   Medicaid   Paid days		hospital contain at least 100 but no	t more than 499 k	beds (as co				1				
method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.    In-State   Medicaid	23. 00				or 25 l	below? I	In column		3	N		23. 00
used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.    In-State   Medicaid												
Medicaid paid days  1.00  24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 4, Medicaid days in column 5, and other Medicaid days in column 1, the in-state Medicaid paid days in column 1, the in-state Medicaid paid days in column 1, the in-state Medicaid paid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid days in column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid						es or "N	N" for no.					
paid days eligible unpaid eligible unpaid days in column 1, in-state Medicaid paid days in column 2, out-of-state Medicaid eligible unpaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 7, the in-state Medicaid eligible unpaid days in column 8, and other Medicaid days in column 1, the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid												
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 6.  25.00 If this provider is an IPPS hospital, enter the in-state Medicaid eligible unpaid days in column 6.  26.00 Under is an IPPS hospital, enter the in-state Medicaid eligible unpaid days in column 6.  26.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid Medicaid eligible unpaid days in column 4, Medicaid Medicaid eligible unpaid days in column 4, Medicaid					eligib	ole Me	dicaid N	ledi cai d				
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid								٠ ا				
in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	04.05	lie iii			2. 00	) ;	3. 00	4. 00				04.05
Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	24. 00	in-state Medicaid paid days in colum	n 1, in-state	1, 736		4/6	69	43	7, 0	ນຊຊ	114	24.00
out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid												
column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state  Medicaid paid days in column 1, the in-state  Medicaid eligible unpaid days in column 2,  out-of-state Medicaid days in column 3, out-of-state  Medicaid eligible unpaid days in column 4, Medicaid												
25.00 If this provider is an IRF, enter the in-state  Medicaid paid days in column 1, the in-state  Medicaid eligible unpaid days in column 2,  out-of-state Medicaid days in column 3, out-of-state  Medicaid eligible unpaid days in column 4, Medicaid												
Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	25. 00	If this provider is an IRF, enter th	e in-state	0		О	О	О		0		25. 00
out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid												
		out-of-state Medicaid days in column	3, out-of-state									
					· 							

Health Financial Systems	ST JOSE	EPH MED	CAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DA	TΑ	Provi der CC		eriod: com 06/01/2016 o 05/31/2017	Worksheet S-2 Part I Date/Time Pre 10/30/2017 4:	pared:
		Y/N	IME	Direct GME	I ME	Direct GME	рії
		1. 00	2. 00	3. 00	4. 00	5.00	(1.0)
61.06 Enter the amount of ACA §5503 awa used for cap relief and/or FTEs t care or general surgery. (see ins	hat are nonprimary		0.00	0.00			61. 06
	,	Pri	ogram Name	Program Code	ogram Code Unweighted IME Unweighte FTE Count Direct GME Count		
			1. 00	2. 00	3. 00	4.00	
61.10 Of the FTEs in line 61.05, specif specialty, if any, and the number for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in col FTE unweighted count.	of FTE residents ctions) Enter in in column 2, the the IME FTE	65			0. 00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specif program specialty, if any, and the residents for each expanded progrinstructions) Enter in column 1, enter in column 2, the program column 2, the lime FTE unweighted count a 4, direct GME FTE unweighted count	e number of FTE am. (see the program name, de, enter in column nd enter in column				0. 00	0.00	61. 20
						1.00	
ACA Provisions Affecting the Heal							
62.00 Enter the number of FTE residents your hospital received HRSA PCRE			d in this cost	reporting peri	od for which	0.00	62. 00
62.01 Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Res	that rotated from a iod of HRSA THC prog	a Teachi gram. (s	see instruction		your hospital	0.00	62. 01
63.00 Has your facility trained residen "Y" for yes or "N" for no in colu	ts in nonprovider se	ettings	during this co		eriod? Enter	N	63. 00
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2.00	3.00	
Section 5504 of the ACA Base Year				This base year	is your cost r	eporti ng	
period that begins on or after Ju 64.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facilit er of unweighted nor ations occurring in number of unweighted r hospital. Enter ir	ty train n-priman all non d non-pon n column	ned residents ry care nprovider rimary care n 3 the ratio	0. 00			64. 00
	Program Name	Pri	ogram Code	Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00		2. 00	Si te 3. 00	4. 00	5.00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.00			65. 00

Health Financial Systems ST JOSEPH MEDICAL CENTER		In Lie	eu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	F	eriod: rom 06/01/2016		
	T	o 05/31/2017	Date/Time P	
		V	XIX	_
95.00 If line 94 is "Y", enter the reduction percentage in the applicable colu 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for		1. 00 0. 00 N	2. 00 0. 00 N	95.00
applicable column.  97.00 [If line 96 is "Y", enter the reduction percentage in the applicable colu		0.00	0.00	96. 00
Rural Providers	IIIII 1.		0.00	
<ul><li>105.00 Does this hospital qualify as a critical access hospital (CAH)?</li><li>106.00 If this facility qualifies as a CAH, has it elected the all-inclusive me for outpatient services? (see instructions)</li></ul>	. 3	N		105. 00 106. 00
107.00  If this facility qualifies as a CAH, is it eligible for cost reimburseme training programs? Enter "Y" for yes or "N" for no in column 1. (see ins yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the reimbursed. If yes complete Wkst. D-2, Pt. II.	structions) If			107. 00
108.00 is this a rural hospital qualifying for an exception to the CRNA fee sch CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	nedul e? See 42	N		108. 00
Physi cal 1.00	Occupati onal 2.00	Speech 3.00	Respiratory 4.00	У
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.	2.00	3.00	4.00	109. 00
			1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstrat the current cost reporting period? Enter "Y" for yes or "N" for no.	ion project (410	OA Demo)for	N	110. 00
		1. 0	00 2.00 3.0	0
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no	in column 1 lf	col umn 1 N		115. 00
is yes, enter the method used (A, B, or E only) in column 2. If column 2 3 either "93" percent for short term hospital or "98" percent for long to psychiatric, rehabilitation and long term hospitals providers) based on	!is "E", enter i erm care (includ	n column des		
Pub.15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for yes or "	N" for no.	N		116. 00
117.00 s this facility legally-required to carry malpractice insurance? Enter no.	,			117. 00
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 claim-made. Enter 2 if the policy is occurrence.	. ,			118. 00
	Premiums	Losses	Insurance	
	1. 00	2. 00	3.00	
118.01 List amounts of malpractice premiums and paid losses:	337, 432	161, 57	3	0 118. 01
		1.00	2.00	
118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing and amounts contained therein.		N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pr §3121 and applicable amendments? (see instructions) Enter in column 1, " "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see ins	Y" for yes or the Outpatient	N	N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable device	,	Y		121. 00
patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? Enter "Y" for	-	N N		122. 00
for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet where these taxes are included.		IN IN		122.00
Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N	l" for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00  f this is a Medicare certified kidney transplant center, enter the cert	ification date			126. 00
in column 1 and termination date, if applicable, in column 2.  127.00 f this is a Medicare certified heart transplant center, enter the certi	fication date			127. 00
in column 1 and termination date, if applicable, in column 2.  128.00  f this is a Medicare certified liver transplant center, enter the certi	fication date			128. 00
in column 1 and termination date, if applicable, in column 2.  129.00   f this is a Medicare certified lung transplant center, enter the certif	ication date in			129. 00
column 1 and termination date, if applicable, in column 2.  130.00 If this is a Medicare certified pancreas transplant center, enter the co	erti fi cati on			130. 00
date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare certified intestinal transplant center, enter the	certi fi cati on			131. 00
date in column 1 and termination date, if applicable, in column 2.  132.00 of this is a Medicare certified islet transplant center, the certified is a medicare certified is a column 1 and termination date.	fication date			132. 00
in column 1 and termination date, if applicable, in column 2.		I	I	I

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	ST JOSEPH MED X IDENTIFICATION DATA	Provi der CC	N: 15-0047			u of Form CMS Worksheet S- Part I Date/Time Pr	2 repared:
						10/30/2017 4	: 18 pm
					1. 00	2. 00	
33.00 If this is a Medicare certified ot	her transplant center, en	ter the certifi	cation dat	е			133. 00
in column 1 and termination date,							
34.00 If this is an organ procurement or		he OPO number i	n column 1				134. 0
and termination date, if applicabl	e, in column 2.						
40.00 Are there any related organization	or home office costs as	defined in CMS	Pub. 15-1.		Υ	679005	140. 0
chapter 10? Enter "Y" for yes or "					•	077000	110.0
are claimed, enter in column 2 the							
1. 00	2. 0				3. 00		
If this facility is part of a chai				e name ar	d address	of the	
home office and enter the home off 41.00 Name: COMMUNITY HEALTH SYSTEMS	Contractor name and c			ctor's N	umber: 1030	11	141. 0
42. 00 Street: 4000 MERIDIAN BLVD	PO Box:	5, 1110.	Contra	Ctor 5 N	umber. 1000	, i	142. 0
43. 00 Ci ty: FRANKLI N	State: TN	I	Zip Co	de:	3706	7	143. 0
						1.00	
44.00 Are provider based physicians' cos	sts included in Worksheet A	A?				Y	144. 00
					1. 00	2.00	
45.00 If costs for renal services are cl	aimed on Wkst A line 74	are the costs	for		Y Y	2.00	145. 00
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no in Llude Medicare utilization	column 1. If c	olumn 1 is		•		143.0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c	gy changed from the previous column 1. (See CMS Pub.			lf	N		146. 0
47 00 11 11 11 11 11 11		"11"				1.00	117.0
47.00 Was there a change in the statisti 48.00 Was there a change in the order of						N N	147. 00 148. 00
49.00 Was there a change to the simplifi				or no		N	149. 0
17. 00 mas there a change to the simpiffi	ed cost irriaring metrica. El	Part A	Part B		Title V	Title XIX	117.0
		1.00	2.00		3. 00	4.00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or "	'N" for no for each compon			3. (See 4			155. 0
55.00 Hospital 56.00 Subprovider - IPF		N N	N N		N N	N N	156. 0
57. 00 Subprovi der – TRF		N N	N		N	N N	157. 0
58. 00 SUBPROVI DER							158. 0
59. 00 SNF		N	N		N	N	159. 0
60.00 HOME HEALTH AGENCY		N	N		N	N	160. 0
61. 00 CMHC			N		N	N	161. 0
						1.00	_
Multicampus						1.00	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.						N	165. 0
	Name	County		Zip Code		FTE/Campus	
66.00  f  line 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5.00	00 166. 0
campus enter the name in column  0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 0	00 166. 0
						4.00	
Health Information Technology (197	[) imponting in the Am	on Dogovers	l Dolesses	non+ ^-2		1.00	
Health Information Technology (HII 67.00 Is this provider a meaningful user				nent Act		N	167. 0
67.00  s this provider a meaningful user 68.00  f this provider is a CAH (line 10	- ,	,		") ente	r the	N	0168. 0
reasonable cost incurred for the F			, 107 15 1	), ente	LIIG		9100.0
68.01 If this provider is a CAH and is r	not a meaningful user, does	s this provider			dshi p		168. 0
exception under §413.70(a)(6)(ii)?	PEnter "Y" for yes or "N"	for no. (see i	nstruction	s)	·		
69.00 If this provider is a meaningful utransition factor. (see instruction		is not a CAH (	line 105 i	s "N"),	enter the	0.0	00169. 0

Health Financial Systems	ST JOSEPH MEDIC	AL CENTER	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	Peri od: From 06/01/2016 To 05/31/2017	Worksheet S-2 Part I Date/Time Pre			
		10/30/2017 4:			
			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)			170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this prov			N	0	171. 00
section 1876 Medicare cost plans r					
"Y" for yes and "N" for no in colu	n				
1876 Medicare days in column 2. (s	see instructions)				

	Financial Systems ST JOSEPH MED AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 15-0047	Period: From 06/01/2016 To 05/31/2017	u of Form CMS- Worksheet S-2 Part II Date/Time Pre 10/30/2017 4:	epared:
		<u> </u>		Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	sponses. Ente	r all dates in t	he	
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in o	column 2. (see	Y/N		V/I	
			1.00	2. 00	3. 00	1
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N N	2.00	3. 00	2.0
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provion officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
			Y/N	Туре	Date	
			1. 00	2. 00	3. 00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	N			4.00
. 00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing school? Column 2:	If you is th	e provider is	N		6.0
. 00	the legal operator of the program?	ii yes, is ti	ie provider is	) IN		0.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved 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 program in the current cost report? If yes, see instruction		al education	Υ		9. 0
0. 00	Was an approved Intern and Resident GME program initiated of		he current	N		10.0
1. 00	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11. 0
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1. 00	
2 00	Bad Debts	a coo i notmust	Long		V	12.0
2. 00 3. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection provided to the provider's bad debt collection provided to the provider's bad debt collection provided to the provider of the provider o			st reporting	Y N	12. C
4. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	tructi ons.	N	14. C
5. 00	Did total beds available change from the prior cost reporti	, , , , , , , , , , , , , , , , , , , ,	yes, see inst		N t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
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	08/29/2017	Y	08/29/2017	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	N		N		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	N		N		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.	N		N		19. 0

пеат ин	Financial Systems ST JOSEPH ME	DICAL CENTER		In Lie	u of Form CMS-	2552-10			
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN:	15-0047	Peri od: From 06/01/2016 To 05/31/2017	Worksheet S-2 Part II Date/Time Pre 10/30/2017 4:	epared:			
		Descri p	ti on	Y/N	Y/N				
		0	0 1.00		3. 00				
	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.00			
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date				
		1.00	2.00	3. 00	4. 00				
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	1. 00	21. 00			
	records? If yes, see instructions.								
					1 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EDT CHILL DDENC HOC	DI TALC)		1. 00				
- H	Capital Related Cost	EPT CHILDRENS HUS	PITALS)			-			
	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22. 00			
	Have changes occurred in the Medicare depreciation expense		s made dur	ing the cost	N	23. 00			
	reporting period? If yes, see instructions.								
24. 00	Were new leases and/or amendments to existing leases enter	ed into during th	is cost re	porting period?	N	24. 00			
	If yes, see instructions								
25. 00	Have there been new capitalized leases entered into during instructions.	the cost reporti	ng period?	If yes, see	N	25. 00			
26. 00	Thistructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporting	neriod2 L	f vas saa	N	26. 00			
20.00	instructions.	The Cost Tepol ting	perrou: r	1 yes, see	IN	20.00			
27. 00	Has the provider's capitalization policy changed during th	e cost reporting	period? If	yes, submit	N	27. 00			
	copy.								
	Interest Expense								
28. 00	Were new loans, mortgage agreements or letters of credit e	ntered into durin	g the cost	reporti ng	N	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	hond funds (Deht	Service P	eserve Fund)	N	29. 00			
29.00	treated as a funded depreciation account? If yes, see inst		Sel VI Ce IX	eserve runu)	IN	29.00			
30. 00	Has existing debt been replaced prior to its scheduled mat		bt? If yes	, see	N	30.00			
	instructions.	•	,						
31. 00	Has debt been recalled before scheduled maturity without i	ssuance of new de	bt? If yes	, see	N	31.00			
-	instructions.					-			
	Purchased Services Have changes or new agreements occurred in patient care se	rvi cos furni shod	through co	ntractual	N	32.00			
	arrangements with suppliers of services? If yes, see instr		tili odgir co	iiti actuai	IN	32.00			
	If line 32 is yes, were the requirements of Sec. 2135.2 ap		to competi	tive bidding? If	N	33.00			
	no, see instructions.								
	Provi der-Based Physi ci ans								
34. 00	Are services furnished at the provider facility under an a	rrangement with p	rovi der-ba	sed physi ci ans?	N	34.00			
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	istina aaroomonts	with the	nrovi dor basod	N	35. 00			
33.00	physicians during the cost reporting period? If yes, see i		with the	pi ovi dei -based	IN	33.00			
	priyer or allo darring the coot i open tring period. It yeer coot	noti doti ono		Y/N	Date				
				1. 00	2. 00				
	Home Office Costs								
	Were home office costs claimed on the cost report?			Y		36. 00			
	If line 36 is yes, has a home office cost statement been p	repared by the ho	me office?	Y		37. 00			
	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different fr	om that of	· Y	12/31/2015	38.00			
30.00	the provider? If yes, enter in column 2 the fiscal year en			, i	12/31/2013	30.00			
39. 00	If line 36 is yes, did the provider render services to oth			, N		39.00			
	see instructions.	,	<b>3</b>						
40. 00	If line 36 is yes, did the provider render services to the	vider render services to the home office? If yes, see N							
	instructions.								
		1.00		2	00	-			
	Cost Report Preparer Contact Information	1.00		2.	00				
	Enter the first name, last name and the title/position	VI CTORI A	ROMANKO		41.00				
	held by the cost report preparer in columns 1, 2, and 3,								
41. 00	respecti vel y.			COMMUNITY HEALTH SYSTEMS					
41. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HEALTH	SYSTEMS			42.00			
41. 00 42. 00	respectively. Enter the employer/company name of the cost report preparer.		SYSTEMS	VI CTORLA BOMAN	MORCHS NET				
41. 00 42. 00 43. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HEALTH (615) 925-4333	SYSTEMS	VI CTORI A_ROMANI	KO@CHS. NET	42.00			

Heal th	Financial Systems ST JOS	EPH MED	OLCAL CENTER		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAI	RE	Provi der CCN: 15-00	F	eriod: rom 06/01/2016 o 05/31/2017		pared:
			3.00				
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/positi held by the cost report preparer in columns 1, 2, ar respectively.		MANGER, REVENUE MANAGE	MENT			41. 00
42. 00	Enter the employer/company name of the cost report preparer.						42. 00
43. 00	Enter the telephone number and email address of the report preparer in columns 1 and 2, respectively.	cost					43. 00

| Peri od: | Worksheet S-3 | From 06/01/2016 | Part | To 05/31/2017 | Date/Time Prepared: Health Financial Systems ST JOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0047

					7	o 05/31/2017	Date/Time Pre 10/30/2017 4:	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		72	26, 280	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	
7.00	Total Adults and Peds. (exclude observation			72	26, 280	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		19				8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	31. 01		8	2, 920	0.00	0	
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT	33. 00		12	4, 380	0.00	0	
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			111	40, 515	0.00		14. 00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		30	10, 950	)	0	16. 00
17. 00	SUBPROVI DER – I RF							17. 00
18. 00	SUBPROVI DER						_	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		21	7, 665		0	19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC						_	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			162			_	27. 00
28. 00	Observation Bed Days						0	
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF			_				31. 00
32. 00	Labor & delivery days (see instructions)			0	(	)		32.00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days		l		I	I	I	33. 00

Peri od: Worksheet S-3 From 06/01/2016 Part I To 05/31/2017 Date/Time Prepared: 10/30/2017 4:18 pm

		_		10/30/2017 4: 18				
		I/P Days	s / O/P Visits	/ Trips	Full Time Equivalents			
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
		6.00	7. 00	8. 00	9. 00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	5, 174	1, 134	20, 714			1. 00	
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)	3, 582	7, 823				2. 00	
3.00	HMO IPF Subprovider	1, 354	0				3.00	
4.00	HMO IRF Subprovider	0	0				4. 00	
5. 00	Hospital Adults & Peds. Swing Bed SNF	o	0	0			5. 00	
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6, 00	
7. 00	Total Adults and Peds. (exclude observation	5, 174	1, 134	20, 714			7. 00	
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	14	1	37			8. 00	
8. 01	NEONATAL INTENSIVE CARE UNIT	0	220	567			8. 01	
9.00	CORONARY CARE UNIT						9. 00	
10.00	BURN INTENSIVE CARE UNIT	187	10	1, 423			10. 00	
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00	
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00	
13.00	NURSERY		224	637			13. 00	
14.00	Total (see instructions)	5, 375	1, 589	23, 378	5. 29	497. 04		
15.00	CAH visits	0	0	0			15. 00	
16. 00	SUBPROVI DER - I PF	3, 278	139	5, 427	0.00	28. 50	16. 00	
17. 00	SUBPROVI DER - I RF						17. 00	
18. 00	SUBPROVI DER						18. 00	
19. 00	SKILLED NURSING FACILITY	1, 776	0	4, 685	0.00	15. 00		
20.00	NURSING FACILITY						20. 00	
21. 00	OTHER LONG TERM CARE						21. 00	
22. 00	HOME HEALTH AGENCY						22. 00	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00	
24. 00	HOSPI CE						24. 00	
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10	
25. 00	CMHC - CMHC						25. 00	
26. 00	RURAL HEALTH CLINIC	_	_	_			26. 00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0				
27. 00	Total (sum of lines 14-26)		_		5. 29	540. 54		
28. 00	Observation Bed Days		0	3, 681			28. 00	
29. 00	Ambul ance Tri ps	0		_			29. 00	
30. 00	Employee discount days (see instruction)			0			30. 00	
31. 00	Employee discount days - IRF			0			31. 00	
32. 00	Labor & delivery days (see instructions)	0	114	120			32. 00	
32. 01	Total ancillary labor & delivery room			0			32. 01	
22.00	outpatient days (see instructions)						22.00	
33.00	LTCH non-covered days	0			I	I	33.00	

					To	05/31/2017	Date/Time Prep 10/30/2017 4:	
		Full Time Equivalents	<u>'</u>		Di sch	arges		
	Component	Nonpai d Workers	Title V	-	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00		13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	983	2, 064	4, 876	1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)				578	0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 8. 01 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY				202	0.044	4.074	8. 00 8. 01 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00	Total (see instructions) CAH visits	0.00		0	983	2, 064	4, 876	14. 00 15. 00
16. 00 17. 00 18. 00	SUBPROVI DER	0.00			235	33	403	16. 00 17. 00 18. 00
19. 00 20. 00 21. 00 22. 00 24. 00 24. 10 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambul ance Trips Employee discount days (see instruction)	0. 00 0. 00 0. 00						19. 00 20. 00 21. 00 22. 00 24. 00 24. 10 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00
31. 00 32. 00 32. 01 33. 00	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days							31. 00 32. 00 32. 01 33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0047

| Peri od: | Worksheet S-3 | From 06/01/2016 | Part II | To 05/31/2017 | Date/Time Prepared: |

					To	05/31/2017	Date/Time Pre 10/30/2017 4:	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from	(col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	Worksheet A-6) 3.00	3) 4.00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA							
1.00	SALARIES Total salaries (see	200. 00	30, 572, 564	0	30, 572, 564	1, 124, 325. 00	27. 19	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3.00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3.00
4. 00	Physician-Part A - Administrative		0	0	0	0.00	0. 00	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	_		0. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6.00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7.00
7. 01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8.00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	936, 019 1, 388, 102		936, 019 1, 537, 773	31, 197. 00 64, 546. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		615, 755	0	615, 755	9, 336. 00	65. 95	11.00
12. 00	Contract labor: Top level management and other management and administrative		102, 880	0	102, 880	760. 00	135. 37	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		78, 788	0	78, 788	521.00	151. 22	13.00
14. 00	Home office and/or related orgainzation salaries and wage-related costs		0	О	0	0.00	0.00	14.00
14. 01 14. 02	Home office salaries Related organization salaries		2, 543, 879	0	2, 543, 879 0	84, 439. 00 0. 00		14. 01 14. 02
15. 00	Home office: Physician Part A - Administrative		0	Ö	Ö	0. 00		
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16.00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		6, 235, 811	0	6, 235, 811			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		368, 779 0	0	368, 779 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21.00
22. 00	B Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	О	О			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			23.00
25. 00	Interns & residents (in an approved program)		0	o	0			25. 00
25. 50 25. 51	Home office wage-related Related orgainzation		0	_	0			25. 50 25. 51
25. 52	wage-related Home office: Physician Part A		0	0	0			25. 52
25. 53	- Administrative - wage-related Home office & Contract		0	0	0			25. 53
	Physicians Part A - Teaching - wage-related							]
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	215, 212	l 0	215, 212	7, 684. 00	28. 01	26. 00
27. 00		5. 00						27. 00

| Peri od: | Worksheet S-3 | From 06/01/2016 | Part II | To 05/31/2017 | Date/Time Prepared:

					11	05/31/201/	10/30/2017 4:	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Li ne Number		on of Salaries			Wage (col. 4 ÷	
		Li ilo ilamboi	nopor tou	(from	(col . 2 ± col .	Salaries in	col . 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0.00	0.00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7. 00	903, 461	0	903, 461	45, 115. 00	20. 03	30.00
31.00	Laundry & Linen Service	8. 00	1, 157	-1, 157	0	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	661, 804	0	661, 804	54, 822. 00	12. 07	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see		914, 640	0	914, 640	53, 053. 00	17. 24	35.00
	instructions)							
36. 00	Cafeteri a	11. 00	0	0	0	0.00	0. 00	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38. 00	Nursing Administration	13. 00	1, 754, 688	76, 558	1, 831, 246	53, 120. 00	34. 47	38.00
39. 00	Central Services and Supply	14. 00	293, 372	-293, 372	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	1, 397, 097	0	1, 397, 097	33, 724. 00	41. 43	40.00
41.00	Medical Records & Medical	16. 00	100, 620	0	100, 620	8, 879. 00	11. 33	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	2, 211. 00	0.00	42.00
43. 00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| Peri od: | Worksheet S-3 | From 06/01/2016 | Part III | To 05/31/2017 | Date/Time Prepared:

					''	0 03/31/201/	10/30/2017 4:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						l
1.00	Net salaries (see		31, 487, 204	0	31, 487, 204	1, 177, 378. 00	26. 74	1. 00
	instructions)							
2.00	Excluded area salaries (see		2, 324, 121	149, 671	2, 473, 792	95, 743. 00	25. 84	2. 00
	instructions)							1
3.00	Subtotal salaries (line 1		29, 163, 083	-149, 671	29, 013, 412	1, 081, 635. 00	26. 82	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		3, 341, 302	0	3, 341, 302	95, 056. 00	35. 15	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		6, 235, 811	0	6, 235, 811	0.00	21. 49	5. 00
	(see inst.)							1
6.00	Total (sum of lines 3 thru 5)		38, 740, 196	-149, 671	38, 590, 525	1, 176, 691. 00	32. 80	6. 00
7.00	Total overhead cost (see		10, 039, 286	-149, 671	9, 889, 615	407, 336. 00	24. 28	7. 00
	instructions)							1

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0047	Period: Worksheet S-3 From 06/01/2016 Part IV

	To 05/31/2017	Date/Time Prep 10/30/2017 4:	pared: 18 pm
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		l
	RETI REMENT COST		l
1.00	401K Employer Contributions	481, 425	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
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, 082, 881	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	28, 152	10. 00
11.00	Life Insurance (If employee is owner or beneficiary)	22, 056	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	451	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	9, 142	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	603, 331	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	1, 748, 748	17. 00
18.00	Medicare Taxes - Employers Portion Only	408, 981	18. 00
19.00	Unemployment Insurance	0	19. 00
	State or Federal Unemployment Taxes	117, 250	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
	Total Wage Related cost (Sum of Lines 1 -23)	6, 502, 417	
250	Part B - Other than Core Related Cost	3, 332, 117	55
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	102, 174	25. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0047	Peri od: Worksheet S-3 From 06/01/2016 Part V To 05/31/2017 Date/Time Prepared:

		0 05/31/201/	10/30/2017 4:	
	Cost Center Description	Contract Labor		то р
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	615, 755	6, 502, 417	1. 00
2.00	Hospi tal	615, 755	6, 502, 417	2. 00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	Renal Di al ysi s	0	0	17.00
18. 00	Other	0	0	18. 00

Health Financial Systems ST JOSEPH M	EDICAL CENTER		In lie	eu of Form CMS-:	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der Co	CN: 15-0047	Peri od:	Worksheet S-7	
			From 06/01/2016		
			To 05/31/2017	Date/Time Pre	
				10/30/2017 4:	18 pm
	Group	SNF Days	Swing Bed SNF		
	1.00	2.00	Days	col . 2 + 3)	
(0.00	1. 00 PE2	2.00	3. 00	4.00	69. 00
69. 00	PE1				
70. 00 71. 00	PD2				
72.00	PD2 PD1		0 0	0	1
73. 00	PC2		0 0	0	
74.00	PC2 PC1		0 0	0	
	PB2		0 0	0	
75. 00 76. 00	PB1		0	2	
77. 00	PA2		0 0	0	
78. 00	PA2 PA1		1 0	1	78.00
199. 00	AAA				199. 00
200. 00 TOTAL	AAA	1, 7	-	l	200. 00
200. 00  101AL		1, /	CBSA at	CBSA on/after	200.00
			Beginning of	October 1 of	
			Cost Reporting		
			Peri od	Reporting	
			1 01 1 04	Period (if	
				appl i cabl e)	
			1. 00	2.00	
SNF SERVICES					
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CE	SA code if a rur	al facility,	23060	23060	201. 00
in effect at the beginning of the cost reporting period.	Enter in column	2, the code			
in effect on or after October 1 of the cost reporting per	iod (if applicab	le).			
		Expenses	Percentage	Associ ated	
				with Direct	
				Patient Care	
				and Related	
		1 00	0.00	Expenses?	
	440.4	1.00	2. 00	3.00	
A notice published in the Federal Register Volume 68, No.					
payments beginning 10/01/2003. Congress expected this inc					
expenses. For lines 202 through 207: Enter in column 1 th column 2 the percentage of total expenses for each category					
line 7, column 3. In column 3, enter "Y" for yes or "N" f					
with direct patient care and related expenses for each ca			.s increases asso	ociated	
202. 00 Staffing	regory. (see rns	[	0 0.00		202. 00
203. 00 Recrui tment			0.00	l .	202.00
204. 00 Retention of employees			0.00		204. 00
205. 00 Trai ni ng			0.00		205. 00
206. 00 OTHER (SPECIFY)			0.00		206. 00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column	3)	3, 625, 3			207. 00
20 30 10 tollide (normander o 2, 1 di c 1, 1110 7, col diiil	~ <i>,</i>	0,020,0		I	1-57.00

	Financial Systems ST JOSEPH MEDICAL CENTER AL UNCOMPENSATED AND INDIGENT CARE DATA Provide	er CCN: 15-0047	Peri od:	u of Form CMS-2 Worksheet S-10	
13P1 1	AL UNCOMPENSATED AND INDIGENT CARE DATA PROVIDE	er CCN: 15-0047	From 06/01/2016	worksneet 5-10	U
			To 05/31/2017	Date/Time Pre	pare
				10/30/2017 4:	18 pi
				1. 00	
	Uncompensated and indigent care cost computation				
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	y line 202 colum	n 8)	0. 151306	1.
	Medicaid (see instructions for each line)				
00	Net revenue from Medicaid			23, 818, 306	
00	Did you receive DSH or supplemental payments from Medicaid?	6 4 11 110		Y	3.
00 00	If line 3 is yes, does line 2 include all DSH or supplemental payments If line 4 is no, then enter DSH or supplemental payments from Medicaid			N 5, 452, 527	4.
00	Medical d charges	u		169, 511, 200	
00	Medicaid charges  Medicaid cost (line 1 times line 6)			25, 648, 062	
00	Difference between net revenue and costs for Medicaid program (line 7	minus sum of li	nes 2 and 5 if	23, 040, 002	1
00	<pre>&lt; zero then enter zero)</pre>		noo z ana o,		"
	Children's Health Insurance Program (CHIP) (see instructions for each	line)			
00	Net revenue from stand-alone CHIP			0	9.
. 00	Stand-alone CHIP charges			0	
. 00	Stand-alone CHIP cost (line 1 times line 10)			0	
. 00	Difference between net revenue and costs for stand-alone CHIP (line 1	1 minus line 9;	if < zero then	0	12
	enter zero) Other state or local government indigent care program (see instruction	ns for each line	)		1
. 00	Net revenue from state or local indigent care program (Not included or			194, 703	13
00	Charges for patients covered under state or local indigent care progra			2, 628, 055	
	10)			, ,	
. 00	State or local indigent care program cost (line 1 times line 14)			397, 640	15
. 00	Difference between net revenue and costs for state or local indigent	care program (li	ne 15 minus line	202, 937	16
	13; if < zero then enter zero)			/	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and sinstructions for each line)	state/rocar rndi	gent care program	is (see	
. 00	Private grants, donations, or endowment income restricted to funding	charity care		0	17.
. 00	Government grants, appropriations or transfers for support of hospita			0	
. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig	ent care program	s (sum of lines	202, 937	19
	[8, 12] and 16)	Uni nsured	Insured	Total (col. 1	
		patients	pati ents	+ col . 2)	
		1.00	2.00	3. 00	
	Uncompensated Care (see instructions for each line)				
. 00	Charity care charges and uninsured discounts for the entire facility	8, 546, 3	5, 670	8, 552, 016	20.
. 00	(see instructions) Cost of patients approved for charity care and uninsured discounts (s	ee 1, 293, 1	13 5, 670	1, 298, 783	21
. 00	instructions)	1, 273, 1	3,070	1, 270, 703	21.
. 00	Payments received from patients for amounts previously written off as		0 696	696	22.
	chari ty care				
. 00	Cost of charity care (line 21 minus line 22)	1, 293, 1	13 4, 974	1, 298, 087	23.
00	Dece the amount in line 20 column 2 include charges for noticet days	havand a Langth	of otov limit	1. 00	24
. 00	Does the amount in line 20 column 2 include charges for patient days imposed on patients covered by Medicaid or other indigent care program		or Stay IImit	N	24.
00	If line 24 is yes, enter the charges for patient days beyond the indig		m's Lenath of	0	25.
. 50	stay limit	Jame Sale progra	5 . G.I.g till Ol		~~.
. 00	Total bad debt expense for the entire hospital complex (see instruction	ons)		11, 898, 128	26
. 00	Medicare reimbursable bad debts for the entire hospital complex (see			119, 127	
. 00	Medicare allowable bad debts for the entire hospital complex (see ins	tructions)		183, 271	27.
				11, 714, 857	28
. 01 . 00	Non-Medicare bad debt expense (line 26 minus line 27.01)				
. 01 3. 00 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (	see instructions	)	1, 836, 672	29
6. 00 9. 00 9. 00	· · · · · · · · · · · · · · · · · · ·	see instructions	)		29 30

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	ST JOSEPH MEDIO	CAL CENTER Provider CO	°N: 15_0047	In Lie Period:	u of Form CMS- Worksheet A	2552-10
KLOLA	STITE OF THE BALANCE C	JI EXI ENSES	l l ovi dei co	F	From 06/01/2016 From 05/31/2017	Date/Time Pre	nared·
	Cook Cooking Doorsinking	C-1:	0+1			10/30/2017 4:	18 pm
	Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS  O0100 CAP REL COSTS-BLDG & FIXT		2, 068, 614	2, 068, 614	1, 067, 630	3, 136, 244	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		3, 671, 073	3, 671, 073	1, 302, 319	4, 973, 392	2. 00
4. 00 5. 01	OO400	215, 212 3, 797, 235	165, 667 21, 846, 542			4, 703, 683 0	1
5. 02	00550 DATA PROCESSING	0	21, 040, 342	25, 045, 77		1, 883, 363	1
5. 03 5. 04	00591 PURCHASING AND RECEIVING 00540 CENTRAL SCHEDULING	0	0	(	1, 049, 246 1, 288, 639	1, 049, 246	1
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		1, 900, 608	1, 288, 639 1, 900, 608	1
5.06	00590 ADMIN & GENERAL	0	0	2 210 (2	14, 301, 538	14, 301, 538	
7. 00 8. 00	OO700   OPERATION OF PLANT   OO800   LAUNDRY & LINEN SERVICE	903, 461 1, 157	2, 416, 176 443, 073			3, 402, 627 392, 788	1
9. 00	00900 HOUSEKEEPI NG	661, 804	315, 273	977, 077	3, 631	980, 708	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	2, 034, 089	2, 034, 089		1, 232, 777 799, 707	1
13.00	01300 NURSING ADMINISTRATION	1, 711, 576	216, 844	1, 928, 420	76, 309	2, 004, 729	13. 00
13. 01 14. 00	01850   PASTORAL CARE   01400   CENTRAL SERVI CES & SUPPLY	43, 112 293, 372	23, 326 6, 604, 655			66, 438 0	13. 01 14. 00
15. 00	01500 PHARMACY	1, 397, 097	4, 055, 676			4, 358, 496	
16. 00 21. 00	01600 MEDICAL RECORDS & LIBRARY 02100 I &R SERVICES-SALARY & FRINGES APPRV	100, 620	498, 544			598, 639 0	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	2, 223, 608 0	2, 223, 608		2, 223, 608	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	( (00 0(1	0.070.074	0.070.70	1 000 010	7 74/ 540	
30. 00 31. 00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	6, 699, 861 39, 200	2, 379, 864 18, 063			7, 746, 512 57, 263	1
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	646, 213	146, 625	792, 838	0	792, 838	31. 01
33. 00 40. 00	03300   BURN INTENSIVE CARE UNIT   04000   SUBPROVIDER - IPF	1, 388, 014	0 171, 985	1, 559, 999	.,	1, 564, 647 1, 559, 999	
43.00	04300 NURSERY	O	0	(	281, 730	281, 730	43. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	936, 019	138, 190	1, 074, 209	9 0	1, 074, 209	44.00
50. 00	05000 OPERATING ROOM	1, 356, 849	1, 189, 451	2, 546, 300		2, 149, 020	
50. 01 51. 00	03330   ENDOSCOPY   05100   RECOVERY   ROOM	310, 922	0 46, 399	`		397, 280 357, 209	
52.00	05200 DELIVERY ROOM & LABOR ROOM	768, 989	396, 517	1, 165, 506	-514, 990	650, 516	52. 00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY - DI AGNOSTI C	0 1, 182, 700	1, 193, 318 1, 015, 785			1, 193, 318 2, 889, 058	
54. 01	03630 ULTRA SOUND	310, 514	128, 227	438, 74	-438, 741	0	54. 01
56. 00 57. 00	05600	80, 195 173, 145	217, 211 25, 059			0	
58.00	05800  MRI	0	2, 961	2, 96	-2, 961	0	58. 00
	O5900   CARDI AC   CATHETERI ZATI ON   O6000   LABORATORY	0 2, 052, 423	0 2, 053, 051	4, 105, 474	.,,	1, 274, 209 3, 543, 380	•
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1, 100, 17	413, 091	413, 091	•
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	587, 211 422, 924	170, 407 138, 315			730, 372 464, 644	•
67. 00	06700 OCCUPATI ONAL THERAPY	338, 838	27, 852			366, 690	1
68.00	06800 SPEECH PATHOLOGY	67, 285	6, 251			•	68. 00
69. 00 71. 00	06900   ELECTROCARDI OLOGY   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1, 145, 941	446, 818 0	1, 592, 759	9 -1, 274, 263 3, 014, 388	318, 496 3, 014, 388	1
72.00		0	0	(	2, 562, 611	2, 562, 611	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0 392, 099	392, 099	818, 111 9 0	818, 111 392, 099	
76. 00	03950 MISC ANCILLARY	0	0	. (	0	0	76. 00
76. 01 76. 02	03951   SLEEP LAB   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	311, 501	0 27, 205	338, 706	0 5 -153	0 338, 553	
76. 03	03952 WOUND CARE	582, 105	142, 083			723, 780	1
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	83, 354	24, 082	107, 436	5 0	107, 436	90.00
91. 00	09100 EMERGENCY	1, 963, 627	1, 232, 055			3, 195, 682	91. 00
92. 00	O9200   OBSERVATION BEDS (NON-DISTINCT PART   SPECIAL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	30, 572, 476	58, 313, 033	88, 885, 509	-537, 602	88, 347, 907	118. 00
190. 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	T ol	19, 338	19, 338	3 0	19, 338	190. 00
191.00	19100 RESEARCH	0	0	(	0	0	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES  07950 NONREIMBURSABLE MISC	88	2, 275 0	2, 363	5  0 		192. 00 194. 00
194. 01	07951 MARKETI NG		0		537, 602	537, 602	194. 01
	207952 SENIOR CIRCLE 307953 SELECT SPECIALTY	0	0	(	) ) )		194. 02 194. 03
	07954 FREE MEALS		0				194. 04
		<u> </u>		<u> </u>		<u> </u>	

Heal th Financial	Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECLASSI FI CATION	N AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		eriod: rom 06/01/2016	Worksheet A	
				Т	o 05/31/2017	Date/Time Pre 10/30/2017 4:	
Cos	t Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
200. 00 TOTA	AL (SUM OF LINES 118-199)	30, 572, 564	58, 334, 646	88, 907, 210	0	88, 907, 210	200.00

Period: Worksheet A From 06/01/2016 To 05/31/2017 Date/Time Prepared: 10/30/2017 4: 18 pm

				10/30/2017 4:	18 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8) 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	3, 172, 177	6, 308, 421		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-1, 364, 656	3, 608, 736		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 473	4, 700, 210		4. 00
5.01	00560 OTHER ADMINISTRATIVE AND GENERAL	0	0		5. 01
5. 02	00550 DATA PROCESSING	0	1, 883, 363		5. 02
5. 03	00591 PURCHASING AND RECEIVING	0	1, 049, 246		5. 03
5.04	00540 CENTRAL SCHEDULI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	24 271	1, 288, 639		5. 04 5. 05
5. 05 5. 06	00590 ADMI N & GENERAL	-34, 371 -942, 855	1, 866, 237 13, 358, 683		5. 06
7. 00	00700 OPERATION OF PLANT	-22, 980	3, 379, 647		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	63, 662	456, 450		8. 00
9.00	00900 HOUSEKEEPI NG	0	980, 708		9. 00
10.00	01000 DI ETARY	0	1, 232, 777		10.00
11. 00	01100 CAFETERI A	-57, 117	742, 590		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-2, 707	2, 002, 022		13. 00
13. 01	01850 PASTORAL CARE	0	66, 438		13. 01
	01400 CENTRAL SERVICES & SUPPLY	0	4 350 404		14.00
15.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	-1, 034	4, 358, 496 597, 605		15. 00 16. 00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	-1,034	0		21.00
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	o o	2, 223, 608		22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	2/220/000		22.00
30.00		-881, 635	6, 864, 877		30.00
31. 00	03100 INTENSIVE CARE UNIT	0	57, 263		31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	792, 838		31. 01
	03300 BURN INTENSIVE CARE UNIT	-391, 325	1, 173, 322		33. 00
40.00	04000 SUBPROVI DER - I PF	0	1, 559, 999		40.00
43.00	04300 NURSERY	-58, 476	223, 254		43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	-2, 625	1, 071, 584		44. 00
50. 00		-605, 012	1, 544, 008		50.00
50. 01	03330 ENDOSCOPY	0	397, 280		50. 01
51.00		0	357, 209		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-274, 967	375, 549		52. 00
53.00	05300 ANESTHESI OLOGY	-1, 192, 470	848		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-1, 068	2, 887, 990		54. 00
54. 01	03630 ULTRA SOUND	0	0		54. 01
56.00	05600 RADI OI SOTOPE	0	0		56.00
57. 00 58. 00	05700   CT   SCAN     05800   MRI	0	0		57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	1, 274, 209		59.00
60. 00		-1, 260	3, 542, 120		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	413, 091		62.00
65.00	06500 RESPI RATORY THERAPY	0	730, 372		65. 00
66.00	06600 PHYSI CAL THERAPY	0	464, 644		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	366, 690		67. 00
	06800 SPEECH PATHOLOGY	0			68. 00
	06900 ELECTROCARDI OLOGY	0	318, 496		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	-295	3, 014, 093 2, 562, 611		71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	818, 111		73.00
	07400 RENAL DIALYSIS	0	392, 099		74.00
	03950 MISC ANCILLARY	o	0		76. 00
76. 01		0	0		76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	338, 553		76. 02
76. 03	03952 WOUND CARE	0	723, 780		76. 03
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLI NI C	-8, 150	99, 286		90.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3, 195, 682		91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS				92.00
118. 00		-2, 610, 637	85, 737, 270		118. 00
	NONREI MBURSABLE COST CENTERS	2,0.0,007	-5, .5, 210		1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 338		190. 00
	19100 RESEARCH	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	2, 363		192. 00
	07950 NONREI MBURSABLE MI SC	0	0		194. 00
	07951 MARKETI NG	0	537, 602		194. 01
	207952 SENIOR CIRCLE	0	0		194. 02
	3 07953 SELECT SPECIALTY 1 07954 FREE MEALS	0	0		194. 03 194. 04
200.00		-2, 610, 637	O <sub>1</sub>		200.00
_00.00	1.2 (22 5. 225 . 10 (77)	2,0.0,007	-5,2,0,070	1	, 5. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0047

						0/30/2017 4: 18 pm
		Increases				
	Cost Center	Li ne #	Salary	0ther		
	2.00 A - EMPLOYEE BENEFITS	3. 00	4. 00	5. 00		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 323, 005		1.00
2.00	LWI LOTEL BENEFITTS BELAKTIVENT	0.00	o	4, 323, 003		2.00
2.00				4, 323, 005		2.00
	B - OXYGEN	<u>'</u>	·			
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	44, 788		1. 00
	PATI ENT		_			
2.00		0.00	0	0		2.00
3.00		0. 00 0. 00	0	0		3.00
4. 00 5. 00		0.00	0	0		4. 00 5. 00
5.00				44, 788		5.00
	C - LEASE AND RENTAL		<u> </u>	44, 700		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 288, 876		1.00
2.00		0.00	O	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0. 00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8.00
9.00		0. 00 0. 00	o	0		9.00
10. 00 11. 00		0.00	O	0		10. 00 11. 00
12. 00		0.00		0		12.00
13. 00		0.00	0	0		13. 00
14. 00		0.00	o	Ö		14. 00
15. 00		0.00	o	Ö		15. 00
16.00		0.00	O	0		16. 00
	0			1, 288, 876		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	92, 562		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	975, 068		2. 00
3. 00	CAP REL COSTS-MVBLE EQUIP			13, 443		3. 00
	E - MARKETING		U	1, 081, 073		
1. 00	MARKETI NG	194. 01	149, 671	387, 931		1.00
1.00	0	— — <del>174.</del> 01	149, 671	387, 931		1.00
	F - CNO		,	551,151		
1.00	NURSING ADMINISTRATION	13.00	76, 558	0		1. 00
	0		76, 558	0		
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 969, 600		1.00
0.00	PATI ENT	70.00		0.5(0.444		0.00
2. 00	I MPL. DEV. CHARGED TO	72. 00	0	2, 562, 611		2. 00
3. 00	PATI ENTS	0.00	0	0		3. 00
3.00				5, 532, 211		3.00
	H - DRUGS AND IV COSTS		<u> </u>	0,002,211		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	818, 111		1. 00
	0			818, 111		
	I - A&G COSTS					
1.00	DATA PROCESSING	5. 02	588, 574	1, 294, 789		1. 00
2.00	PURCHASI NG AND RECEI VI NG	5. 03	358, 391	690, 855		2. 00
3.00	CENTRAL SCHEDULI NG	5. 04	1, 125, 869	162, 770		3.00
4. 00	CASHI ERI NG/ACCOUNTS	5. 05	1, 157	1, 899, 451		4. 00
E 00	RECEI VABLE	E 04	2 017 772	10 210 714		E 00
5.00	ADMI N & GENERAL		2, 017, 772 4, 091, 763	<u>18, 319, 7</u> 16 22, 367, 581		5. 00
	J - RADI OLOGY		4, 071, 703	22, 307, 301		
1.00	RADI OLOGY-DI AGNOSTI C	54.00	563, 854	362, 381		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	Ö	0		3. 00
4.00		0.00	ol	o		4. 00
	0		563, 854	362, 381	 	
	K - DIETARY					
1.00	CAFETERI A	1100	0	79 <u>9, 7</u> 07		1. 00
	0		0	799, 707		
4 00	L - MISC DEPARTMENTS	251	055	=		
1.00	BURN INTENSIVE CARE UNIT	33.00	957, 887	606, 760		1.00
2.00	CARDI AC CATHETERI ZATI ON	59.00	855, 551	418, 658		2.00
3. 00 4. 00	ENDOSCOPY	50. 01	259, 296	137, 984		3.00
	WHOLE BLOOD & PACKED RED	62. 00	0	413, 091		4. 00
4.00	BLOOD CELL			l l		

Heal th Financial Systems

ST JOSEPH MEDICAL CENTER

In Lieu of Form CMS-2552-10

Provider CCN: 15-0047
From 06/01/2016
To 05/31/2017
Date/Time Prepared:

					10 05/31/2017 Date/IIMe Pr 10/30/2017 4	repared: I:18 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	0		2, 072, 734	1, 576, 493		
	M - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7. 00	0	85, 341		1. 00
2.00	HOUSEKEEPI NG	9. 00	0	3, 631		2. 00
3.00		0.00	0_	0		3. 00
	0		0	88, 972		
	N - INTERNS AND RESIDENT COST					
1.00	I&R SERVICES-OTHER PRGM	22. 00	0	2, 223, 608		1. 00
	COSTS APPRV	+	+			
	0		0	2, 223, 608		
	O - OB/GYN COSTS					
1.00	ADULTS & PEDIATRICS	30. 00	135, 900	97, 360		1. 00
2.00	NURSERY	43.00	19 <u>1, 3</u> 23	9 <u>0, 4</u> 07		2. 00
	0		327, 223	187, 767		
500.00	Grand Total: Increases		7, 281, 803	41, 082, 504		500.00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 06/01/2016 To 05/31/2017 Date/Time Prepared: Provider CCN: 15-0047

						0 05/31/201/	10/30/2017 4:18 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00 A - EMPLOYEE BENEFITS	7. 00	8. 00	9. 00	10. 00		
1. 00	ADMIN & GENERAL	5. 06	0	4, 322, 989	0		1. 00
2. 00	NURSING ADMINISTRATION	13. 00	o	16			2. 00
	0		0	4, 323, 005			
	B - OXYGEN				1		
1.00	OPERATION OF PLANT	7.00	0	1, 458	1		1.00
2. 00 3. 00	CENTRAL SERVICES & SUPPLY RESPIRATORY THERAPY	14. 00 65. 00	0	16, 149 27, 093			2. 00
4. 00	ELECTROCARDI OLOGY	69.00	0	27, 093 54	1		4. 00
5. 00	LABORATORY	60.00	Ö	34	I		5. 00
	0		0	44, 788			
	C - LEASE AND RENTAL				1		
1.00	ADMIN & GENERAL	5.06	0	17, 508			1.00
2. 00 3. 00	OPERATION OF PLANT DIETARY	7. 00 10. 00	0	893 1, 605			2. 00
4. 00	NURSING ADMINISTRATION	13. 00	0	233			4. 00
5. 00	CENTRAL SERVICES & SUPPLY	14. 00	Ö	575, 091			5. 00
6.00	PHARMACY	15. 00	0	276, 166	1		6. 00
7.00	ADULTS & PEDIATRICS	30.00	0	1, 826			7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	168, 399			8.00
9. 00 10. 00	LABORATORY PHYSI CAL THERAPY	60. 00 66. 00	0	148, 969 96, 595			9. 00 10. 00
11. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 02	0	96, 595 153			11. 00
11.00	SERVICES	70.02	J	133			11.00
12.00	WOUND CARE	76. 03	0	408	0		12. 00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	201			13. 00
14.00	LAUNDRY & LINEN SERVICE	8.00	0	192			14.00
15. 00 16. 00	RECOVERY ROOM	51.00	0	112 525			15. 00 16. 00
10.00	MEDI CAL RECORDS & LI BRARY	1600					16.00
	D - OTHER CAPITAL COSTS		<u> </u>	1,200,070			
1.00	ADMIN & GENERAL	5. 06	0	1, 081, 073			1.00
2.00		0.00	0	0	13		2. 00
3. 00		0.00	•	0	12		3. 00
	O   E - MARKETING		0	1, 081, 073			
1. 00	ADMIN & GENERAL	5. 06	149, 671	387, 931	0		1. 00
1.00	0		149, 671				1. 66
	F - CNO			·			
1.00	ADMIN & GENERAL	<u>5.</u> 06	7 <u>6, 5</u> 58	0	0		1.00
	O MEDICAL CURRILEC		76, 558	0			
1.00	G - MEDICAL SUPPLIES CENTRAL SERVICES & SUPPLY	14. 00	O	5, 520, 981	0		1. 00
2. 00	RADI OI SOTOPE	56.00	0	11, 077	1		2.00
3. 00	RESPI RATORY THERAPY	65.00	o	153	1		3. 00
	0		0	5, 532, 211			
4 00	H - DRUGS AND IV COSTS	45.00	ما	040 444			1.00
1. 00	PHARMACY	<u>15.</u> 00	0	81 <u>8, 1</u> 11 818, 111			1.00
	I - A&G COSTS		U U	610, 111			
1.00	OTHER ADMINISTRATIVE AND	5. 01	3, 797, 234	21, 846, 543	0		1.00
	GENERAL						
2.00	LAUNDRY & LINEN SERVICE	8. 00	1, 157	28, 604			2. 00
3.00	CENTRAL SERVICES & SUPPLY	14.00	293, 372	492, 434	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0	0		4. 00 5. 00
3.00			4, 091, 763	<u>22,</u> 367, 581			3. 00
	J - RADI OLOGY	<u>'</u>	, , , , , ,	, ,			
1.00	ULTRA SOUND	54. 01	310, 514	128, 227			1.00
2. 00	RADI OI SOTOPE	56.00	80, 195	206, 134			2. 00
3.00	CT SCAN	57.00	173, 145	25, 059			3.00
4. 00	MRI	<u>58.</u> 00		<u>2, 9</u> 6 <u>1</u> 362, 381			4. 00
	K - DIETARY		555, 654	302, 301			
1.00	DI ETARY	10.00	0	799, 707	0		1. 00
	0		0	799, 707			
	L - MISC DEPARTMENTS		05	,			
1.00	ADULTS & PEDIATRICS	30.00	957, 887	606, 760			1.00
2. 00 3. 00	LABORATORY ELECTROCARDI OLOGY	60. 00 69. 00	0 855, 551	413, 091 418, 658			2. 00 3. 00
4. 00	OPERATING ROOM	50.00	259, 296	137, 984			4. 00
	0		2, 072, 734	1, 576, 493			25
		'			. '		•

Heal th Financial Systems

ST JOSEPH MEDICAL CENTER

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-0047

From 06/01/2016
To 05/31/2017

Date/Time Prepared:

					1	o 05/31/2017   Date/lime   10/30/2017	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
	M - UTILITIES RECLASS						
1.00	ADMIN & GENERAL	5. 06	0	220	0		1. 00
2.00	LAUNDRY & LINEN SERVICE	8. 00	0	21, 489	0		2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	6 <u>7, 2</u> 63	<u> </u>		3. 00
	0		0	88, 972			
	N - INTERNS AND RESIDENT COST	ΓS					
1.00	I&R SERVICES-SALARY &	21. 00	0	2, 223, 608	0		1. 00
	FRI_NGES_ APPRV						
	0		0	2, 223, 608	3		
	O - OB/GYN COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	327, 223	187, 767	0		1. 00
2.00		0.00	0		o o		2. 00
	0		327, 223	187, 767			
500.00	Grand Total: Decreases		7, 281, 803	41, 082, 504			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0047

Peri od: Worksheet A-7 From 06/01/2016 Part I To 05/31/2017 Date/Time Prepared:

10/30/2017 4:18 pm Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 9, 348, 028 0 1.00 0 2.00 Land Improvements 1, 764, 690 0 2.00 0 3.00 28, 532, 005 3.00 Buildings and Fixtures 6, 164 6, 164 0 0 4.00 Building Improvements 29, 610, 005 561, 656 561, 656 0 4.00 5.00 Fixed Equipment 17, 657, 206 13, 762 0 13, 762 0 5.00 0 6.00 Movable Equipment 49, 203, 330 1, 113, 348 1, 113, 348 2, 958 6.00 0 7.00 HIT designated Assets 2, 833, 813 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 138, 949, 077 1, 694, 930 1, 694, 930 2, 958 8.00 9.00 Reconciling Items 0 0 9.00 138, 949, 077 2, 958 Total (line 8 minus line 9) 1, 694, 930 10.00 0 1, 694, 930 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 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, 538, 169 0 3.00 0 4.00 Building Improvements 30, 171, 661 4.00 5.00 Fi xed Equipment 17, 670, 968 0 5.00 Movable Equipment 50, 313, 720 0 6.00 6.00 7.00 HIT designated Assets 2, 833, 813 0 7.00 Subtotal (sum of lines 1-7) 8.00 140, 641, 049 0 8.00 9.00 Reconciling Items 9.00 10.00 Total (line 8 minus line 9) 140, 641, 049 0 10.00

Heal th	Financial Systems	ST JOSEPH MEDI	ICAL CENTER		In Lie	eu of Form CMS-:	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CC	CN: 15-0047	Peri od: From 06/01/2016 To 05/31/2017		
			CI	JMMARY OF CAP	ΙΤΛΙ	10/30/2017 4:	18 pm
			30	DIVINIART OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
		9. 00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUMI	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	2, 068, 614	0	)	0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 671, 073	0	)	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	5, 739, 687	0		0 0	0	3. 00
		SUMMARY OF	F CAPI TAL				
	Cost Center Description	Other 7	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUMI	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	2, 068, 614				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 671, 073				2. 00
3.00	Total (sum of lines 1-2)	0	5, 739, 687				3. 00

Heal th	Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	1	Period: From 06/01/2016 To 05/31/2017		pared:
		COMI	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	ТО ріп
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
		1.00	2.00	2) 3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	3.00	4.00	5.00	
1. 00	CAP REL COSTS-BLDG & FLXT	69, 822, 548	1 0	69, 822, 548	0. 496459	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	70, 818, 501		70, 818, 50		Ö	2. 00
3.00	Total (sum of lines 1-2)	140, 641, 049		140, 641, 049		0	3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10.00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CI				0.044.604	0/ 05/	4 00
1.00	CAP REL COSTS BLDG & FIXT	0	0	9	3, 244, 621	-36, 256	1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0	0	,	2, 306, 417 5, 551, 038	1, 288, 876 1, 252, 620	2. 00 3. 00
3.00	Total (Sull of Titles 1-2)	0	<u> </u>	IU JMMARY OF CAPI		1, 252, 620	3.00
			30	JIVIIVIART OF CAPT	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C				- 1		
1.00	CAP REL COSTS-BLDG & FIXT	2, 032, 426				6, 308, 421	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13, 443		0	3, 608, 736	2.00
3. 00	Total (sum of lines 1-2)	2, 032, 426	106, 005	975, 068	3 0	9, 917, 157	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-0047 Peri od: Worksheet A-8 From 06/01/2016 To 05/31/2017 Date/Time Prepared:

Expense Classification on Worksheet A   Foliar   Security   Secu						Γο 05/31/2017	Date/Time Prep 10/30/2017 4:	
Cost Center Description   Resis/Costs (2)   Amount   Cent Center   1 into F   Novil A-7 Bef								то рііі
1.00   Investment income					To/From Which the Amount is	to be Adjusted		
1.00   Investment income								
1.00   Investment income								
1.00   Investment income						1		
Troublement Income - CAP REL		Cost Center Description						
Costs-BLIC A TIXI (chapter 2)	1. 00	Investment income - CAP REL	1.00					1. 00
3. 00   Investment Finceme - other (chapter 2)   0   0   0   0   0   0   0   0   0								
Investment income - other	2. 00			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
1.00   Contract Computer   0   0.00	3. 00			0		0.00	0	3. 00
discounts (chairter 8)								
Refunds and rehates of expenses (chapter 8)   B   -36, 250 CAP REL COSTS-BLDG & FIXT   1.00   10   6.00   1.00	4. 00			0		0.00	0	4. 00
Color	5. 00			0		0.00	0	5. 00
Suppliers (chapter 8)		expenses (chapter 8)						
Telephone services (pay stations excluded) (chapter 21)   Stations excluded) (chapter 22)   Stations excluded) (chapter 23)   Stations excluded) (chapter 24)   Stations exclu	6. 00		В	-36, 256	CAP REL COSTS-BLDG & FIXT	1.00	10	6. 00
Stations excluded) (chapter 21)	7. 00		A	-9, 571	ADMIN & GENERAL	5. 06	0	7. 00
Television and radio service (Chapter 21)   0   0   0   0   0   0   0   0   0		stations excluded) (chapter		•				
(chapter 21) 10.00 Provider-based physician A-8-2 -3,964,000 0.00 0.00 0.00 0.00 0.00 0.00 0.00	0.00	1 /		22 000	ODEDATION OF DIANT	7.00		0.00
Parking   Iof (chapter 21)   A -8-2   -3,964,020   0.00	6.00		A	-22, 900	DERATION OF PLANT	7.00	U	6.00
adjustment	9. 00	Parking Lot (chapter 21)		0		0.00	0	
11.00   Saire of Scrap, waste, etc. (Chapter 23)   12.00   Related organization   A-8-1   2,099,969     0   12.00     12.00     13.00   13.00   14.00   14.00   16.00   16.00   15.0	10. 00		A-8-2	-3, 964, 020			0	10.00
Chapter 23)	11 00		B	-1 068	RADLOLOGY-DLAGNOSTIC	54 00	0	11 00
transactions (chapter 10)	11.00			1,000	INDIGEOUS PINGROSTIO	01.00	Ĭ	11.00
13.00   Laundry and I linen service     0   0   0   13.00	12. 00		A-8-1	2, 099, 969			0	12.00
14.00   Caffeteria - employees and guests   B   -57, 117 CAFTERIA   11.00   0   14.00	13 00			0		0.00		13 00
and others			В	-57, 117	CAFETERI A			
16.00   Sale of medical and surgical supplies to other than patients   0   0.00   0.00   0.00   0.17.00	15. 00			0		0.00	o	15.00
Supplies to other than   Datients	14 00			0		0.00		14 00
patients	16.00			U		0.00	0	10.00
patients		pati ents						
18.00   Sale of medical records and abstracts   16.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   19.0	17. 00			0		0.00	0	17. 00
abstracts	18. 00	1.	В	-1. 034	MEDICAL RECORDS & LIBRARY	16.00	0	18. 00
Books.   Setc.		abstracts		,				
20. 00   Vending machines   B   -1,866 ADMIN & GENERAL   5. 06   0 20. 00	19. 00			0		0.00	0	19. 00
21.00   Income from imposition of interest, finance or penal ty charges (chapter 21)   Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments and overpayments and borrowings to repay Medicare overpayments and overpay	20. 00		В	-1. 866	  ADMIN & GENERAL	5. 06	0	20. 00
Charges (Chapter 21)   Chapter 21)				0	0 021121012		1	
22.00   Interest expense on Medicare overpayments and borrowings to repay medicare overpayments and borrowings to repay Medicare overpayments   A-8-3   ORESPIRATORY THERAPY   65.00   23.00								
Overpayments and borrowings to repay Medicare overpayments   A-8-3   ORESPIRATORY THERAPY   65.00   23.00	22 00			0		0.00	0	22 00
23. 00	22.00			0		0.00	Ŭ	22.00
therapy costs in excess of limitation (chapter 14) 24. 00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT 1.00 9 26. 00 COSTS-BLDG & FIXT 1.00 9 26. 00 COSTS-BLDG & FIXT 1.00 9 27. 00 Depreciation - CAP REL A -957, 938 CAP REL COSTS-MVBLE EQUIP 2.00 9 27. 00 28. 00 Non-physician Anesthetist Physicians' assistant 0 0*** Cost Center Deleted *** 19. 00 28. 00 Physicians' assistant 0 0.00 0 29. 00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 30. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0				_				
I imitation (chapter 14)	23. 00		A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
therapy costs in excess of								
I imitation (chapter 14)   Utilization review -	24. 00		A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25.00   Utilization review - physicians' compensation (chapter 21)   26.00   Depreciation - CAP REL   A   929,497 CAP REL COSTS-BLDG & FIXT   1.00   9   26.00   COSTS-BLDG & FIXT   27.00   Depreciation - CAP REL   A   -957,938 CAP REL COSTS-MVBLE EQUIP   2.00   9   27.00   27.00   28.00   Non-physician Anesthetist   0 *** Cost Center Deleted ***   19.00   28.00   29.00   Physicians' assistant   0   0   0   0   29.00								
physicians' compensation (chapter 21)   26.00   Depreciation - CAP REL   A   929, 497 CAP REL COSTS-BLDG & FIXT   1.00   9   26.00   COSTS-BLDG & FIXT   1.00   9   26.00   27.00   Depreciation - CAP REL   A   -957, 938 CAP REL COSTS-MVBLE EQUIP   2.00   9   27.00   COSTS-MVBLE EQUIP   2.00   9   27.00   COSTS-MVBLE EQUIP   2.00   9   27.00   28.00   Non-physician Anesthetist   0 *** Cost Center Deleted ***   19.00   28.00   29.00   30.00   Adjustment for occupational therapy costs in excess of limitation (chapter 14)   Hospice (non-distinct) (see instructions)   0   A-8-3   OSPEECH PATHOLOGY   COSTS-MVBLE EQUIP   COSTS-MVBLE EQUIP   2.00   9   27.00   28.00   29.00	25. 00			0	*** Cost Center Deleted ***	114.00		25. 00
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT		physicians' compensation						
COSTS-BLDG & FIXT   Depreciation - CAP REL   A   -957, 938 CAP REL COSTS-MVBLE EQUIP   2.00   9 27.00	26 00		_	020 407	CAD DEL COSTS, DIDO & ELVT	1 00		26 00
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP         A         -957, 938 CAP REL COSTS-MVBLE EQUIP         2.00         9         27.00           28. 00 Non-physician Anesthetist         0         0 **** Cost Center Deleted ***         19.00         28.00           29. 00 Physicians' assistant         0         0.00         0.29.00           30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         0 OCCUPATIONAL THERAPY         67.00         30.00           30. 99 Hospice (non-distinct) (see instructions)         0 ADULTS & PEDIATRICS         30.00         30.99           31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14)         A-8-3         0 SPEECH PATHOLOGY         68.00         31.00           32. 00 CAH HIT Adjustment for Depreciation and Interest         0         0.00         0.00         0.32.00           33. 00 INSERVICE EDUCATION REVENUE         B         -145 NURSING ADMINISTRATION         13.00         0.33.00	20.00		A	727, 477	CAF REL COSTS-BEDG & TTAT	1.00	7	20.00
28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 40.00 Adjustment for speech instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 SPEECH PATHOLOGY 68.00 31.00 30.99 instructions) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 INSERVICE EDUCATION REVENUE B -145 NURSING ADMINISTRATION 13.00 0 33.00	27. 00	Depreciation - CAP REL	A	-957, 938	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest 33. 00 INSERVICE EDUCATION REVENUE   O OCCUPATIONAL THERAPY  O OCCUPATIONAL THERAPY  O ADULTS & PEDIATRICS  O ADULTS & PEDIATRICS  O OSPEECH PATHOLOGY  O OSPEECH PATHOLO	29 00			0	*** Cost Contor Doloted ***	10.00		29 00
30.00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adj ustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adj ustment for Depreciation and Interest 33.00 INSERVICE EDUCATION REVENUE  A-8-3  OCCUPATIONAL THERAPY  67.00  30.00				0	Cost Center Dereted			
I imitation (chapter 14)   30. 99   Hospice (non-distinct) (see instructions)   31. 00   Adjustment for speech pathology costs in excess of limitation (chapter 14)   32. 00   CAH HIT Adjustment for Depreciation and Interest   33. 00   INSERVICE EDUCATION REVENUE   B   -145 NURSING ADMINISTRATION   13. 00   0   33. 00		1 3	A-8-3	0	OCCUPATI ONAL THERAPY			
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest 33. 00 INSERVICE EDUCATION REVENUE B -145 NURSING ADMINISTRATION 13. 00 0 33. 00								
instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 INSERVICE EDUCATION REVENUE B -145 NURSING ADMINISTRATION 13.00 0 33.00	30 99			Ω	ADULTS & PEDLATRICS	30.00		30. 99
pathology costs in excess of limitation (chapter 14)  32.00 CAH HIT Adjustment for Depreciation and Interest  33.00 INSERVICE EDUCATION REVENUE B -145 NURSING ADMINISTRATION 13.00 0 33.00	55. 77			0		30.00		55. 77
limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 INSERVICE EDUCATION REVENUE B -145 NURSING ADMINISTRATION 13.00 0 33.00	31. 00		A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest 33.00 INSERVICE EDUCATION REVENUE B -145 NURSING ADMINISTRATION 13.00 0 33.00								
Depreciation and Interest  33.00 INSERVICE EDUCATION REVENUE B -145 NURSING ADMINISTRATION 13.00 0 33.00	32. 00			0		0.00	o	32. 00
		Depreciation and Interest	[	_	L			
35. 01   1   1   1   1   25   1   25   1   25   1   25   25								
		I I INCOO REVENUE	l D	-00	PIONI IN A SEIVENAL	5.00	١	

From 06/01/2016 To 05/31/2017 Date/Time Prepared:

					0 05/31/201/	10/30/2017 4:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					•		
					<b>.</b>		
	Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
	1	1. 00	2. 00	3. 00	4. 00	5. 00	
33. 02		В		ADMIN & GENERAL	5. 06		00.02
33. 03	SALE OF SUPPLIES	В	-295	MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 03
				PATI ENT			
33. 04	MI SC REVENUE	В	-25, 967	ADMIN & GENERAL	5. 06	0	33. 04
33. 06	PATIENT PHONE WAGE COSTS	A	-16, 078	ADMIN & GENERAL	5. 06	0	33. 06
33. 07	PATIENT PHONES BENEFITS	A	-3, 473	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 07
33.08	PATIENT TV DEPRECIATION COSTS	A	-214	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 08
33.09	PATIENT TV DEPRECIATION	A	-5, 211	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 09
33. 10	NONALLOWABLE MARKETING	A	-21, 167	ADMIN & GENERAL	5. 06	0	33. 10
33. 11	PHYSICIAN RECRUITING	A	-128, 580	ADMIN & GENERAL	5. 06	0	33. 11
33. 12	LOBBYING EXPENSE IN DUES	A	-10, 377	ADMIN & GENERAL	5. 06	0	33. 12
33. 13	CHARITABLE CONTRIBUTIONS	A	-126, 114	ADMIN & GENERAL	5. 06	0	33. 13
33. 15	IMPUTED RENT	A	-115, 315	ADMIN & GENERAL	5. 06	0	33. 15
33. 16	NONALLOWABLE LEGAL EXPENSES	A	-134, 982	ADMIN & GENERAL	5. 06	0	33. 16
50.00	TOTAL (sum of lines 1 thru 49)		-2, 610, 637				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0047

Worksheet A-8-1 From 06/01/2016

05/31/2017 Date/Time Prepared: 10/30/2017 4:18 pm Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 4. 00 5.00 1.00 2.00 3.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 1.00 CAP REL COSTS-BLDG & FIXT DIRECT ALLOCATION - CAPITAL-1.00 2,009,530 1.00 1. 00 CAP REL COSTS-BLDG & FIXT PASI CAPITAL COSTS - BLDG & 0 2.00 19, 790 2.00 0 1.00 CAP REL COSTS-BLDG & FIXT 3.00 PASI CAPITAL COSTS - MOVEABL 3, 106 3.00 4.00 5. 05 CASHI ERING/ACCOUNTS RECEIVAB PASI OPERATING COSTS 294, 321 4.00 4.03 5.06 ADMIN & GENERAL SHARED SERVICE CENTER ALLOCA 310, 239 0 4.03 1.00 CAP REL COSTS-BLDG & FIXT NEW CAPITAL - BUILDING & FIX NEW CAPITAL - MOVABLE EQUIPM 0 4 04 16, 640 4 04 1.00 CAP REL COSTS-BLDG & FIXT 0 4.05 229,870 4.05 4.06 5.06 ADMIN & GENERAL NON-CAPITAL HOME OFFICE COST 2, 766, 934 0 4.06 4.07 5.06 ADMIN & GENERAL MALPRACTICE COSTS (SEE EXHIB 499,005 0 4 07 2.00 CAP REL COSTS-MVBLE EQUIP CIG LEASED EQUIPMENT (SEE EX 4.08 30, 058 208, 382 4.08 4.09 8.00 LAUNDRY & LINEN SERVICE HOSPITAL LAUNDRY SERVICES (S 425, 011 4.09 4.10 5.06 ADMIN & GENERAL MANAGEMENT FEES 1, 728, 038 4.10 C 5.06 ADMIN & GENERAL 401K FFFS 8.126 4 11 C 4 11 4.12 5.06 ADMIN & GENERAL AUDIT FEES 51, 541 4.12 5.06 ADMIN & GENERAL CORPORATE OVERHEAD ALLOCATIO 0 1, 233, 314 4.13 4.14 5.06 ADMIN & GENERAL 25, 193 PPSI FFFS C 4.14 0 5. 05 CASHI ERING/ACCOUNTS RECEIVAB PASI COLLECTION FEES 4.15 328, 692 4.15 4.16 5.06 ADMIN & GENERAL CIG USE TAX 0 14, 587 4. 16 5.06 ADMIN & GENERAL PASI LIEN UNIT COLLECTION FE 4.17 24,530 4.17 5.06 ADMIN & GENERAL MALPRACTICE ALLOCATIONS (PER 0 297, 814 4.18 4.18 2. OO CAP REL COSTS-MVBLE EQUIP CIG LEASED EQUIPMENT (PER EX 222, 969 4.19 C 4.19 4.20 8.00 LAUNDRY & LINEN SERVICE HOSPITAL LAUNDRY SERVICES (P 361, 349 4.20 5.00 TOTALS (sum of lines 1-4) 6,604,504 4, 504, 535 5.00 Transfer column 6, line 5 to Worksheet A-8, column 2,

\* 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/				
				•			
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

i ei ilibui	Schieff under title Aviii.				
6.00	В	0.0	OCHS, INC	100. 00	6. 00
7.00	В	0.0	O PASI	100.00	7. 00
8.00	С	33.0	OSHARED LAUNDRY	33.00	8. 00
9. 00		0.0	0	0. 00	9. 00
10.00		0.0	0	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

line 12.

011102	333.3				To 05/31/2017	Date/Time Pre 10/30/2017 4:	epared:
	Net	Wkst. A-7 Ref.				10/30/2017 4.	TO PIII
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED OF	RGANIZATIONS OR (	CLAIMED	
	HOME OFFICE CO						
1.00	2, 009, 530						1.00
2.00	19, 790						2. 00
3.00	3, 106						3. 00
4.00	294, 321						4. 00
4.03	310, 239						4. 03
4.04	16, 640						4. 04
4.05	229, 870						4. 05
4.06	2, 766, 934						4. 06
4.07	499, 005						4. 07
4.08	-178, 324						4. 08
4.09	425, 011						4. 09
4. 10	-1, 728, 038						4. 10
4. 11	-8, 126						4. 11
4. 12	-51, 541						4. 12
4. 13	-1, 233, 314						4. 13
4.14	-25, 193						4. 14
4. 15	-328, 692						4. 15
4. 16	-14, 587						4. 16
4. 17	-24, 530						4. 17
4. 18	-297, 814						4. 18
4. 19	-222, 969						4. 19
4. 20	-361, 349						4. 20
5.00	2, 099, 969						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	ED 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.

Termbursement under titte Aviii.		
6. 00	OWNER	6.00
7.00	DEBT COLLECTION	7.00
8.00	LAUNDRY	8.00
9. 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.

Peri od: Worksheet A-8-2 From 06/01/2016 To 05/31/2017 Date/Time Prepared:

							10/30/2017 4:	18 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00		ADULTS & PEDIATRICS	881, 635	881, 635				1. 00
2.00		NURSI NG ADMI NI STRATI ON	2, 562	2, 562	1			2. 00
3.00		BURN INTENSIVE CARE UNIT	391, 325					3. 00
4.00		OPERATING ROOM	605, 012				0	4. 00
		ANESTHESI OLOGY					_	
5.00			1, 192, 470				0	5. 00
6.00		RADI OLOGY-DI AGNOSTI C	0		1		0	6. 00
7. 00		LABORATORY	1, 260				0	7. 00
8.00		CLINIC	8, 150				0	8. 00
9. 00		ADMIN & GENERAL	545, 538			C	0	9. 00
10. 00		NURSERY	58, 476			C	0	10. 00
11. 00	52. 00	DELIVERY ROOM & LABOR ROOM	274, 967	274, 967	' C	C	0	11. 00
12.00	44. 00	SKILLED NURSING FACILITY	2, 625	2, 625	[ C	C	0	12. 00
200.00			3, 964, 020		0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8.00	9. 00	12. 00	13. 00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	C	0	C	0	1. 00
2.00	13. 00	NURSING ADMINISTRATION	0	C	0	C	0	2. 00
3.00	33. 00	BURN INTENSIVE CARE UNIT	0	C	0	C	0	3. 00
4.00	50.00	OPERATING ROOM	0	C	0	C	0	4. 00
5.00	53. 00	ANESTHESI OLOGY	0	C	0	C	0	5. 00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	0		0	C	0	6. 00
7.00	60.00	LABORATORY	0		0	C	0	7. 00
8.00	90.00	CLINIC	0		0	l c	0	8. 00
9.00	5. 06	ADMIN & GENERAL	0		0	l c	0	9. 00
10.00	43. 00	NURSERY	l o				0	10. 00
11. 00	52, 00	DELIVERY ROOM & LABOR ROOM	l 0				0	11. 00
12. 00		SKILLED NURSING FACILITY	0	0		l c	0	12. 00
200.00			0	i o		l d	Ō	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	_	
		I denti fi er	Component	Limit	Di sal I owance	, ray as timorre		
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0					1. 00
2. 00		NURSI NG ADMI NI STRATI ON	l o		-	ľ		2. 00
3. 00		BURN INTENSIVE CARE UNIT	0	0		391, 325		3. 00
4. 00		OPERATI NG ROOM	0	l ~	1	605, 012		4. 00
5.00		ANESTHESI OLOGY	١	ď		1, 192, 470	1	5. 00
6. 00		RADI OLOGY-DI AGNOSTI C				1, 172, 470	1	6. 00
7. 00		LABORATORY				1, 260		7. 00
8. 00		CLI NI C				8, 150		8. 00
9.00		ADMIN & GENERAL				545, 538		9. 00
10.00		NURSERY				58, 476	1	10.00
11. 00		DELIVERY ROOM & LABOR ROOM	0		<u> </u>	274, 967	1	11.00
12. 00	44. 00	SKILLED NURSING FACILITY	0	0	<u> </u>	2, 625	1	12. 00
200.00			0	[ C	)  C	3, 964, 020	1	200. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0047

				10	05/31/2017	Date/lime Prep   10/30/2017 4:	
			CAPI TAL REI	ATED COSTS		107 007 2017 1.	ТО ріп
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	OTHER ADMI NI STRATI VE	
		Allocation (from Wkst A			DEPARTMENT	AND GENERAL	
		col. 7)	1.00	2. 00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS					2. 2.	
1.00	00100 CAP REL COSTS-BLDG & FIXT	6, 308, 421	6, 308, 421				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	3, 608, 736		3, 608, 736			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 700, 210	1		4, 812, 457		4. 00
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL 00550 DATA PROCESSING	1 002 2/3	0	١	0 93, 305	0	5. 01 5. 02
5. 02 5. 03	00591 PURCHASING AND RECEIVING	1, 883, 363 1, 049, 246	l		93, 305 56, 815		5. 02
5. 04	00540 CENTRAL SCHEDULING	1, 288, 639	l		178, 481		5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 866, 237	0		183		5. 05
5.06	00590 ADMIN & GENERAL	13, 358, 683	136, 857	78, 289	284, 008	0	5.06
7.00	00700 OPERATION OF PLANT	3, 379, 647	1, 074, 173	614, 481	143, 223	0	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	456, 450			0	0	8. 00
9.00	00900 HOUSEKEEPI NG	980, 708	l		104, 914	0	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 232, 777 742, 590	265, 135 0		0	0   0	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	2, 002, 022	30, 549	-	283, 468	0	13. 00
13. 01	01850 PASTORAL CARE	66, 438	l		6, 834	Ö	13. 01
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00	01500 PHARMACY	4, 358, 496	0	0	221, 478	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	597, 605	1	1	15, 951	0	16. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0		0		21. 00
22. 00	02200   1 & R SERVI CES-OTHER PRGM COSTS APPRV   INPATIENT ROUTINE SERVICE COST CENTERS	2, 223, 608	0	0	0	0	22. 00
30. 00	03000 ADULTS & PEDIATRICS	6, 864, 877	564, 541	322, 946	931, 798	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	57, 263			6, 214	l o	31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	792, 838	1		102, 442	0	31. 01
33. 00	03300 BURN INTENSIVE CARE UNIT	1, 173, 322	106, 111	60, 701	151, 851	0	33.00
40.00	04000 SUBPROVI DER - I PF	1, 559, 999	l		220, 038	1	40.00
43.00	04300 NURSERY	223, 254		-	30, 330		43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	1, 071, 584	148, 387	84, 885	148, 384	0	44. 00
50. 00	05000 OPERATING ROOM	1, 544, 008	228, 685	130, 819	173, 992	0	50. 00
50. 01	03330 ENDOSCOPY	397, 280	l		41, 105		50. 01
51.00	05100 RECOVERY ROOM	357, 209	97, 517	55, 785	49, 290	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	375, 549	l	1	70, 032	0	52.00
53.00	05300 ANESTHESI OLOGY	848		0	0	0	53. 00
54. 00 54. 01	05400  RADI OLOGY-DI AGNOSTI C   03630  ULTRA SOUND	2, 887, 990	249, 384	142, 660	276, 876	0	54. 00 54. 01
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	Ö	Ö	Ö	0	Ö	57. 00
58.00	05800 MRI	0	0	0	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 274, 209			135, 628	1	59.00
	06000 LABORATORY	3, 542, 120			325, 364	1	60.00
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY	413, 091	11, 696 86, 729		02 090	0	62. 00
66. 00	06600 PHYSI CAL THERAPY	730, 372 464, 644	l		93, 089 67, 045		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	366, 690	l		53, 715	1	67. 00
68. 00	06800 SPEECH PATHOLOGY	73, 536			10, 666	1	68.00
69. 00	06900 ELECTROCARDI OLOGY	318, 496		9, 045	46, 035	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 014, 093	l		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 562, 611	0	١	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	818, 111 392, 099	37, 373 30, 413		0	0	73. 00 74. 00
76. 00	03950 MISC ANCILLARY	392, 099	0 30,413	17, 346	0		74. 00 76. 00
76. 01	03951 SLEEP LAB	0	Ö	o o	0	o o	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	338, 553			49, 381	0	76. 02
76. 03	03952 WOUND CARE	723, 780	129, 957	74, 342	92, 279	0	76. 03
	OUTPATIENT SERVICE COST CENTERS	22.224		10.400	10.01.		
90. 00 91. 00	09000   CLI NI C   09100   EMERGENCY	99, 286 3, 195, 682	l		13, 214 311, 288	1	90. 00 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 193, 002	199,000	114, 227	311, 200	U	91.00
72.00	SPECIAL PURPOSE COST CENTERS		I			I	12.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	85, 737, 270	5, 934, 043	3, 394, 573	4, 788, 716	0	118. 00
190 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 338	15, 312	8, 759	0	0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17, 330	15, 312	1	0		190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2, 363	0	0	14	0	192. 00
	07950 NONREI MBURSABLE MI SC	0	0	0	0		194. 00
194. 01	I 07951 MARKETI NG	537, 602	0	0	23, 727	0	194. 01

Health Financial Systems	ST JOSEPH MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 06/01/2016 To 05/31/2017			
		CAPI TAL REL	_ATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		OTHER ADMINISTRATIVE AND GENERAL		
	0	1.00	2.00	4. 00	5. 01		
194. 02 07952 SENI OR CI RCLE	0	0		0 0	0	194. 02	
194. 03 07953 SELECT SPECIALTY	0	359, 066	205, 40	14 C	0	194. 03	
194.04 07954 FREE MEALS	0	0		0 0	0	194. 04	
200.00 Cross Foot Adjustments						200. 00	
201.00 Negative Cost Centers		0		0 0	0	201.00	
202.00 TOTAL (sum lines 118-201)	86, 296, 573	6, 308, 421	3, 608, 73	4, 812, 457	0	202. 00	

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 06/01/2016 Part I | To 05/31/2017 Date/Time Prepared: 10/30/2017 4:18 pm

						10/30/2017 4:	
	Cost Center Description		PURCHASING AND		CASHI ERI NG/ACC	Subtotal	
		PROCESSI NG	RECEI VI NG	SCHEDULI NG	OUNTS		
		E 02	E 02	E 04	RECEI VABLE	EA OE	
	GENERAL SERVICE COST CENTERS	5. 02	5. 03	5. 04	5. 05	5A. 05	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 01
5.02	00550 DATA PROCESSING	2, 296, 117					5. 02
5.03	00591 PURCHASING AND RECEIVING	0					5. 03
5.04	00540 CENTRAL SCHEDULING	0	5, 479	1, 551, 307			5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	72	0	1, 866, 492		5. 05
5.06	00590 ADMIN & GENERAL	0	1, 648	0	0	13, 859, 485	5. 06
7.00	00700 OPERATION OF PLANT	0	663	0	0	5, 212, 187	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	11, 330	0	0	555, 908	8. 00
9.00	00900 HOUSEKEEPI NG	0	17, 750	0	0	2, 437, 636	9. 00
10. 00	01000 DI ETARY	0	20, 089	0		1, 669, 672	1
11. 00	01100  CAFETERI A	0		0		742, 590	1
13. 00	01300 NURSING ADMINISTRATION	0	.,	0	_	2, 335, 383	1
13. 01	01850 PASTORAL CARE	0	196	0	0	128, 938	
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00	01500 PHARMACY	0	24, 127	0	0	4, 604, 101	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	0		0	0	863, 828	1
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0		0	0	0	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	2, 223, 608	22. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	235, 260	58, 689	158, 930	191, 261	9, 328, 302	30.00
31. 00	03100 INTENSIVE CARE UNIT	4, 540		3, 067		9, 326, 302 367, 418	1
31. 00	02060 NEONATAL INTENSIVE CARE UNIT	8, 520		5, 756		987, 591	
33. 00	03300 BURN INTENSIVE CARE UNIT	41, 983		28, 362		1, 614, 163	1
40. 00	04000 SUBPROVIDER - IPF	76, 386		51, 603		2, 103, 446	1
43. 00	04300 NURSERY	3, 180		2, 148		261, 497	1
44. 00	04400 SKILLED NURSING FACILITY	15, 643		10, 568		1, 498, 156	1
44.00	ANCI LLARY SERVI CE COST CENTERS	15,045	3, 701	10, 300	12, 710	1, 470, 130	1 44. 00
50. 00	05000 OPERATI NG ROOM	175, 152	96, 614	118, 324	142, 395	2, 609, 989	50.00
50. 01	03330 ENDOSCOPY	18, 934				550, 248	1
51. 00	05100 RECOVERY ROOM	19, 629		13, 260		608, 661	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 343		4, 960		609, 867	
53.00	05300 ANESTHESI OLOGY	26, 258		17, 739		66, 283	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	335, 114		226, 386		4, 402, 782	1
54. 01	03630 ULTRA SOUND	0		0		0	1
56.00	05600 RADI OI SOTOPE	0	0	0	o	0	
57.00	05700 CT SCAN	0	0	0	o	0	57. 00
58.00	05800 MRI	0	0	0	o	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	108, 278	39, 856	73, 148	88, 028	1, 762, 819	59. 00
60.00	06000 LABORATORY	278, 911	77, 134	188, 418	226, 748	4, 974, 247	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	14, 726	27, 200	9, 948	11, 972	495, 324	62. 00
65.00	06500 RESPI RATORY THERAPY	65, 814	12, 036	44, 461	53, 505	1, 135, 619	65. 00
66. 00	06600 PHYSI CAL THERAPY	17, 212		11, 628		752, 395	
67. 00	06700 OCCUPATI ONAL THERAPY	16, 699		· ·			1
68. 00	06800 SPEECH PATHOLOGY	2, 898				117, 604	
69. 00	06900 ELECTROCARDI OLOGY	17, 153		11, 587		432, 764	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	161, 580		109, 155		3, 860, 207	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	67, 179		45, 383		3, 112, 950	
73.00	07300 DRUGS CHARGED TO PATIENTS	340, 362		230, 097		1, 723, 829	1
74.00	07400 RENAL DIALYSIS	5, 030		3, 398	4, 090	453, 215	1
76.00	03950 MI SC ANCI LLARY	0	0		U	0	1
76. 01 76. 02	03951   SLEEP LAB   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	12 220	244	8, 943	10.7/2	400.741	1
76. 02	03952 WOUND CARE	13, 239				498, 741	1
70.03	OUTPATIENT SERVICE COST CENTERS	20, 306	13, 814	13, 717	16, 508	1, 084, 703	76. 03
90. 00	09000 CLINIC	561	1, 397	379	456	165, 863	90.00
91. 00	09100 EMERGENCY	198, 227				4, 379, 267	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	170, 227	03,077	133, 712	101, 134	4, 377, 207	1
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118. 00		2, 296, 117	1, 378, 800	1, 551, 307	1, 866, 492	85, 121, 189	118 00
	NONREI MBURSABLE COST CENTERS		., 5, 5, 5, 500	.,,,,	., 555, .,2	22, 12., 107	1
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 661	0	O	46. 070	190. 00
	19100 RESEARCH	0		Ö			191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0		0	_		192. 00
	07950 NONREI MBURSABLE MI SC	0	0	O	o		194. 00
	07951 MARKETI NG	0	744	0	ol	562, 073	
	07952 SENI OR CIRCLE	0	0	0	ol	0	194. 02
194. 03	07953 SELECT SPECIALTY	0	0	0	o	564, 470	194. 03
	07954 FREE MEALS	0	0	0	0	0	194. 04
200.00	Cross Foot Adjustments					0	200. 00

Heal th Financial	Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION	- GENERAL SERVICE COSTS		Provider CC		From 06/01/2016	Worksheet B Part I Date/Time Pre 10/30/2017 4:	
Cost	Center Description	DATA	PURCHASI NG AND	CENTRAL	CASHI ERI NG/ACC	Subtotal	

						10/30/2017 4:	18 pm
	Cost Center 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	Negative Cost Centers	C	0	(	0	C	201. 00
202.00	TOTAL (sum lines 118-201)	2, 296, 117	1, 382, 599	1, 551, 307	1, 866, 492	86, 296, 573	202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 06/01/2016 Part I | To 05/31/2017 Date/Time Prepared: 10/30/2017 4:18 pm

	Cost Conton Decement on	ADMIN 0	ODERATION OF	LAUNDDY 0	HOUSEKEEDI NO	10/30/2017 4:	
	Cost Center Description	ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	OFNEDAL CEDIUS OF COCT OFNEDO	5. 06	7. 00	8. 00	9. 00	10. 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
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00591 PURCHASING AND RECEIVING						5. 03
5.04	00540 CENTRAL SCHEDULING						5. 04
5. 05 5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 ADMI N & GENERAL	13, 859, 485					5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	997, 253	6, 209, 440				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	106, 362	75, 726				8. 00
9.00	00900 HOUSEKEEPI NG	466, 395	1, 146, 492		4, 050, 523		9. 00
10.00	01000 DI ETARY	319, 460	358, 148	0	290, 881	2, 638, 161	10. 00
11. 00	01100 CAFETERI A	142, 080	0	0	0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	446, 831	41, 266	1	33, 515	0	13.00
13. 01	01850 PASTORAL CARE 01400 CENTRAL SERVICES & SUPPLY	24, 670 0	47, 663	0	38, 711	0	13. 01 14. 00
14. 00 15. 00	01500 PHARMACY	880, 907	0	51	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	165, 277	214, 607	0	174, 300	0	16. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	Ö	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	425, 445	0	0	О	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30.00	03000 ADULTS & PEDI ATRI CS	1, 784, 819	762, 591	317, 650	619, 357	1, 171, 998	30. 00
31.00	03100   NTENSI VE CARE UNI T	70, 298	251, 458			2, 087	31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	188, 957	56, 104	958	45, 567	0 050	31. 01
33. 00 40. 00	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	308, 839 402, 454	143, 337 108, 918	40, 573 37, 752	116, 416 88, 461	80, 050 305, 299	33. 00 40. 00
43. 00	04300 NURSERY	50, 032	100, 910	2, 540		303, 249	43. 00
44. 00	04400 SKILLED NURSING FACILITY	286, 644	200, 443		162, 796	263, 551	44. 00
	ANCILLARY SERVICE COST CENTERS				, ,		
50.00	05000 OPERATING ROOM	499, 372	308, 911	22, 824	250, 892	0	50. 00
50. 01	03330 ENDOSCOPY	105, 280	42, 247	38, 259		0	50. 01
51.00	05100 RECOVERY ROOM	116, 456	131, 728			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	116, 686	117, 216	0	95, 201	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	12, 682 842, 389	336, 872	38, 592	273, 601	0	53. 00 54. 00
54. 00	03630 ULTRA SOUND	042, 309	330, 672 0	30, 392 0	273, 601	0	54. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58.00	05800 MRI	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	337, 282	37, 526		30, 478	0	59. 00
60.00	06000 LABORATORY	951, 728	288, 330		234, 176	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	94, 771	15, 799		12, 832	0	62.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	217, 279 143, 956	117, 155 152, 228	95 0	95, 151 123, 637	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	101, 387	58, 271	0	47, 326	0	67.00
68. 00	06800 SPEECH PATHOLOGY	22, 501	22, 442			0	68. 00
69.00	1 1	82, 801	21, 359		17, 347	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	738, 577	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	595, 604	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	329, 822	50, 484	0	41, 002	0	73. 00
74.00	07400 RENAL DIALYSIS	86, 714	41, 082	1, 858	33, 366	0	74.00
76. 00 76. 01	03950 MISC ANCILLARY 03951 SLEEP LAB	0	0	0	0	0	76. 00 76. 01
76. 01	1	95, 425	66, 589	0	54, 083	0	76. 01
76. 03	03952 WOUND CARE	207, 537	175, 549	773	142, 577	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	31, 735	43, 453	21, 702	35, 292	0	90. 00
91. 00	09100 EMERGENCY	837, 890	269, 730	112, 773	219, 070	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
110 0	SPECIAL PURPOSE COST CENTERS	12 (24 507	F 702 724	727.00/	2 (20 700	1 022 005	110 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	13, 634, 597	5, 703, 724	737, 996	3, 639, 790	1, 822, 985	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 815	20, 684	0	16, 799	n	190. 00
	19100 RESEARCH	0,015	20, 304	0	10, 799		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	530	Ö	o	o	499, 814	
194.00	07950 NONREIMBURSABLE MISC	0	0	0	О		194. 00
	1 07951 MARKETI NG	107, 542	0	0	0		194. 01
	2 07952 SENI OR CI RCLE	0	0	0	0		194. 02
	3 07953 SELECT SPECIALTY	108, 001	485, 032	0	393, 934	109, 052	
200. 00	407954 FREE MEALS Cross Foot Adjustments	ا	0	ا	ا	206, 310	200. 00
200.00		0	n	0	n	n	200.00
	1	<u>,                                    </u>		<u> </u>	<u> </u>	0	

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co	1	Period: From 06/01/2016 Fo 05/31/2017	Worksheet B Part I Date/Time Pre 10/30/2017 4:	
Cost Center Description	ADMIN &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	GENERAL	PLANT	LINEN SERVICE			
	5. 06	7. 00	8. 00	9. 00	10.00	
202.00 TOTAL (sum lines 118-201)	13, 859, 485	6, 209, 440	737, 996	4, 050, 523	2, 638, 161	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 06/01/2016 Part I
To 05/31/2017 Date/Time Prepared: 10/30/2017 4:18 pm

				05/31/201/	10/30/2017 4:	
Cost Center Description	CAFETERI A	NURSI NG	PASTORAL CARE	CENTRAL	PHARMACY	
		ADMI NI STRATI ON		SERVICES &		
	11. 00	13. 00	13. 01	SUPPLY 14. 00	15. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	13.01	14.00	15.00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02 00550 DATA PROCESSING						5. 02
5. 03 00591 PURCHASING AND RECEIVING						5. 03
5. 04 00540 CENTRAL SCHEDULING						5. 04
5. 05   00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06   00590 ADMIN & GENERAL						5. 06
7.00 00700 OPERATION OF PLANT						7. 00
8.00   00800   LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00  01000  DI ETARY						10. 00
11. 00   01100   CAFETERI A	884, 670					11. 00
13. 00 O1300 NURSING ADMINISTRATION	51, 898	2, 908, 893				13. 00
13. 01   01850   PASTORAL CARE	2, 247	0	242, 229			13. 01
14. 00   01400   CENTRAL SERVI CES & SUPPLY	0	0	0	0		14. 00
15. 00  01500  PHARMACY	34, 366	0	0	0	5, 519, 425	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	9, 053	0	0	0	0	16.00
21. 00   02100   1 &R SERVI CES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	217 207	1 257 244	104, 619	0	0	30.00
30. 00   03000   ADULTS & PEDI ATRI CS	217, 387	1, 256, 344		0	0	
31. 00   03100   INTENSI VE CARE UNI T	170	1, 013	84 9, 354	0	0	31.00
31.01   02060   NEONATAL INTENSIVE CARE UNIT 33.00   03300   BURN INTENSIVE CARE UNIT	19, 441 33, 857	112, 335	9, 354 16, 291	0	0	31. 01 33. 00
40. 00   04000   SUBPROVI DER - I PF	60, 421	195, 637 349, 205		0	0	40.00
43. 00   04300   NURSERY	6, 085	349, 203 35, 171	2, 929	0	0	43.00
44.00 O4400 SKILLED NURSING FACILITY	31, 801	35, 171	2, 727	0	0	44.00
ANCILLARY SERVICE COST CENTERS	31,001	<u> </u>	<u> </u>	<u> </u>	0	1 44.00
50. 00 05000 OPERATI NG ROOM	35, 786	206, 870	17, 226	0	0	50.00
50. 01   03330   ENDOSCOPY	9, 307	61, 507	5, 122	0	0	50. 01
51. 00   05100   RECOVERY   ROOM	10, 643			0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	14, 056	81, 205	6, 762	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	66, 442	o	o	0	0	54.00
54. 01   03630   ULTRA SOUND	0	0	0	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56.00
57. 00  05700 CT SCAN	0	0	0	0	0	57.00
58. 00   05800   MRI	0	0	0	0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	24, 698	142, 694	11, 882	0	0	59. 00
60. 00   06000   LABORATORY	82, 173	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	21, 243	0	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	12, 105	0	0	0	0	66. 00
67.00 06700 OCCUPATIONAL THERAPY	8, 014	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 738	0	0	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	16, 600	0	0	0	0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	5, 519, 425	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
76. 00 03950 MISC ANCILLARY	0	0	0	0	0	76.00
76. 01   03951   SLEEP LAB	14 110	0	0	0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	14, 119		0	0	0	76. 02
76. 03 03952 WOUND CARE	21, 412	U	U U	U	0	76. 03
90. 00 09000 CLINIC	2, 756	0		0	0	90.00
91. 00   09100   EMERGENCY	71, 488		34, 398	0	0	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	71,400	413,000	34, 370	U	U	92.00
SPECIAL PURPOSE COST CENTERS						72.00
118. 00   SUBTOTALS (SUM OF LINES 1-117)	879, 306	2, 908, 893	242, 229	0	5, 519, 425	118 00
NONREI MBURSABLE COST CENTERS	077,300	2, 700, 073	272,227	<u> </u>	3, 317, 423	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	n	0	n	n	190. 00
191. 00 19100 RESEARCH	1	n		0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 145	n		0		192. 00
194. 00 07950 NONREI MBURSABLE MI SC	1, 143	n		0		194. 00
194. 01 07951 MARKETI NG	4, 219	n		0		194. 01
194. 02 07952 SENI OR CI RCLE	7,217	n		n		194. 01
194. 03 07953 SELECT SPECIALTY	0	n	ا	n		194. 03
194. 04 07954 FREE MEALS	1 0	n	ا	n		194. 04
200.00 Cross Foot Adjustments				Ĭ		200. 00
1 1	T.				i	

Health Fin	ancial Systems	ST JOSEPH MED	DI CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - GENERAL SERVICE COSTS		Provi der C		Peri od: From 06/01/2016	Worksheet B Part I	
					To 05/31/2017		
	Cost Center Description	CAFETERI A	NURSI NG	PASTORAL CAR	E CENTRAL	PHARMACY	
			ADMI NI STRATI ON		SERVICES &		
					SUPPLY		
		11.00	13. 00	13. 01	14. 00	15. 00	
201.00	Negative Cost Centers	0	0		0 0	0	201. 00
202. 00	TOTAL (sum lines 118-201)	884, 670	2, 908, 893	242, 22	9 0	5, 519, 425	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0047

					Io	05/31/2017	Date/lime Prep 10/30/2017 4:	
				INTERNS &	RESI DENTS		10,00,201, 11	то р
		Cost Contor Doserintian	MEDICAL	CEDVICES SALAD	SERVI CES-OTHER	Subtotal	Intorn 0	
		Cost Center Description	MEDICAL RECORDS &	Y & FRINGES	PRGM COSTS		Intern & Residents Cost	
			LI BRARY	APPRV	APPRV		& Post	
							Stepdown	
			1/ 00	21.00	22.00	24.00	Adjustments	
	GENER	AL SERVICE COST CENTERS	16. 00	21.00	22. 00	24. 00	25. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	1	OTHER ADMINISTRATIVE AND GENERAL DATA PROCESSING						5. 01 5. 02
5. 03		PURCHASING AND RECEIVING						5. 02
5.04	1	CENTRAL SCHEDULING						5. 04
5.05		CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06 7. 00		ADMIN & GENERAL OPERATION OF PLANT						5. 06 7. 00
8.00		LAUNDRY & LINEN SERVICE						8. 00
9.00	1	HOUSEKEEPI NG						9. 00
10.00	1	DIETARY						10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION						11. 00 13. 00
13. 00		PASTORAL CARE						13. 00
14. 00		CENTRAL SERVICES & SUPPLY						14. 00
15. 00	1	PHARMACY						15. 00
16.00		MEDICAL RECORDS & LIBRARY	1, 427, 065					16. 00
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRV   I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	2, 649, 053			21. 00 22. 00
22.00		IENT ROUTINE SERVICE COST CENTERS			2, 047, 033			22.00
30. 00	03000	ADULTS & PEDIATRICS	146, 226			17, 037, 090	-1, 327, 797	30. 00
31.00		INTENSIVE CARE UNIT	2, 822			899, 579	0	31.00
31. 01 33. 00		NEONATAL INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT	5, 296 26, 095		,	1, 458, 307 2, 575, 258	-32, 704 0	31. 01 33. 00
40. 00	1	SUBPROVIDER - I PF	47, 478			3, 532, 513	0	40. 00
43.00	1	NURSERY	1, 977		0	360, 231	0	43. 00
44. 00		SKILLED NURSING FACILITY	9, 723	0	0	2, 512, 856	0	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	108, 866	0	294, 339	4, 355, 075	-294, 339	50. 00
50. 01	1	ENDOSCOPY	11, 768	1		858, 050	274, 337	50. 00
51.00		RECOVERY ROOM	12, 200		1	1, 062, 620	0	51. 00
52.00		DELIVERY ROOM & LABOR ROOM	4, 564	0		1, 045, 557	0	52. 00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	16, 321 208, 291	0	-	95, 286 6, 168, 969	0	53. 00 54. 00
54. 01	1	ULTRA SOUND	0	Ö		0, 100, 707	0	54. 01
56. 00	1	RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00		CT SCAN	0	0		0	0	57. 00
58. 00 59. 00	05800	CARDI AC CATHETERI ZATI ON	67, 301	0		2, 435, 247	0	58. 00 59. 00
60.00	1	LABORATORY	173, 358			6, 704, 012	0	60.00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	9, 153			627, 879	0	62. 00
65. 00		RESPIRATORY THERAPY	40, 907			1, 627, 449	0	65. 00
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	10, 698 10, 379			1, 195, 019 755, 280	0	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	1, 801	Ö		184, 313	0	68. 00
69. 00		ELECTROCARDI OLOGY	10, 661	0	0	585, 189	0	69. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	100, 430		_	4, 699, 214	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	41, 755 211, 462		0	3, 750, 309 7, 876, 024	0	72. 00 73. 00
74. 00		RENAL DIALYSIS	3, 127		0	619, 362	0	74. 00
76. 00		MISC ANCILLARY	0	0	0	0	0	76. 00
76. 01		SLEEP LAB	0	0	0	0	0	76. 01
76. 02 76. 03	1	PSYCHIATRIC/PSYCHOLOGICAL SERVICES WOUND CARE	8, 228 12, 621	0		737, 185 1, 906, 807	0 -261, 635	76. 02 76. 03
70.03		TIENT SERVICE COST CENTERS	12,021		201, 035	1, 400, 607	-201, 033	70.03
90.00	09000	CLI NI C	349		· ·	876, 747	-575, 597	90. 00
91.00		EMERGENCY	123, 208	0	156, 981	6, 617, 885	-156, 981	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART AL PURPOSE COST CENTERS					0	92. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	1, 427, 065	0	2, 649, 053	83, 159, 312	-2, 649, 053	118. 00
	NONRE	IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		92, 368		190.00
		RESEARCH PHYSICIANS' PRIVATE OFFICES	0	0		0 504, 260		191. 00 192. 00
194.00	07950	NONREI MBURSABLE MI SC	0	ő		0	0	194. 00
194. 01	07951	MARKETI NG	0	0	0	673, 834	<u> </u>	194. 01
						_		

Health Financial Systems	ST JOSEPH MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B		
				From 06/01/2016 To 05/31/2017		narod:	
				10 03/31/2017	10/30/2017 4:		
		INTERNS &	RESI DENTS				
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		0		0	0	194. 02	
194. 03 07953 SELECT SPECIALTY		0		0 1, 660, 489	0	194. 03	
194.04 07954 FREE MEALS		0		0 206, 310	0	194. 04	
200.00 Cross Foot Adjustments		0		0 0	0	200. 00	
201.00 Negative Cost Centers		0		0 0	0	201. 00	
202.00   TOTAL (sum lines 118-201)	1, 427, 065	5 0	2, 649, 05	86, 296, 573	-2, 649, 053	202. 00	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 06/01/2016 | Part I | To 05/31/2017 | Date/Time Prepared: | 10/30/2017 4: 18 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0047

				10/30/2017 4:	18 pm
		Cost Center Description	Total		
			26. 00		
		AL SERVICE COST CENTERS			
1.00	1	CAP REL COSTS-BLDG & FIXT			1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP			2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 01 5. 02	1	OTHER ADMINISTRATIVE AND GENERAL DATA PROCESSING			5. 01 5. 02
5. 02	1	PURCHASING AND RECEIVING			5. 02
5. 04	1	CENTRAL SCHEDULING			5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
5. 06	1	ADMIN & GENERAL			5. 06
7. 00	1	OPERATION OF PLANT			7. 00
8.00	1	LAUNDRY & LINEN SERVICE			8. 00
9.00	00900	HOUSEKEEPI NG			9. 00
10.00	01000	DI ETARY			10.00
11. 00	01100	CAFETERI A			11. 00
13.00	1	NURSING ADMINISTRATION			13. 00
13. 01	1	PASTORAL CARE			13. 01
14. 00	1	CENTRAL SERVICES & SUPPLY			14. 00
15. 00	1	PHARMACY			15. 00
16.00	1	MEDICAL RECORDS & LIBRARY			16. 00
21. 00	1	1 &R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRV I ENT ROUTINE SERVICE COST CENTERS			22. 00
30. 00		ADULTS & PEDIATRICS	15, 709, 293		30.00
31. 00	1	INTENSIVE CARE UNIT	899, 579		31. 00
31. 01		NEONATAL INTENSIVE CARE UNIT	1, 425, 603		31. 01
33. 00	1	BURN INTENSIVE CARE UNIT	2, 575, 258		33. 00
40.00	1	SUBPROVIDER - IPF	3, 532, 513		40.00
43.00	1	NURSERY	360, 231		43.00
44.00	04400	SKILLED NURSING FACILITY	2, 512, 856		44. 00
	ANCI L	LARY SERVICE COST CENTERS			
50.00		OPERATING ROOM	4, 060, 736		50.00
50. 01	1	ENDOSCOPY	858, 050		50. 01
51.00		RECOVERY ROOM	1, 062, 620		51.00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM	1, 045, 557		52.00
54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	95, 286 6, 168, 969		53. 00 54. 00
54. 00	1	ULTRA SOUND	0, 100, 909		54. 00
56. 00	1	RADI OI SOTOPE	0		56. 00
57. 00	1	CT SCAN	o		57. 00
58.00	05800		O		58. 00
59.00	05900	CARDI AC CATHETERI ZATI ON	2, 435, 247		59. 00
60.00	06000	LABORATORY	6, 704, 012		60. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	627, 879		62. 00
65. 00	1	RESPI RATORY THERAPY	1, 627, 449		65. 00
66.00	1	PHYSI CAL THERAPY	1, 195, 019		66. 00
67. 00	1	OCCUPATIONAL THERAPY	755, 280		67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY	184, 313 585, 189		68. 00
		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	4, 699, 214		69. 00 71. 00
71.00		IMPL. DEV. CHARGED TO PATIENTS	3, 750, 309		72.00
73. 00	1	DRUGS CHARGED TO PATIENTS	7, 876, 024		73. 00
74. 00		RENAL DIALYSIS	619, 362		74. 00
76. 00		MISC ANCILLARY	0		76. 00
76. 01	03951	SLEEP LAB	o		76. 01
76. 02	03550	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	737, 185		76. 02
76. 03	-	WOUND CARE	1, 645, 172		76. 03
		TIENT SERVICE COST CENTERS			
90.00		CLINIC	301, 150		90.00
91.00		EMERGENCY	6, 460, 904		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART			92. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	80, 510, 259		118. 00
1 10.00	_	IMBURSABLE COST CENTERS	00, 310, 234		1, 10. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	92, 368		190. 00
		RESEARCH	0		191. 00
		PHYSICIANS' PRIVATE OFFICES	504, 260		192. 00
194.00	07950	NONREI MBURSABLE MI SC	O		194. 00
	1	MARKETI NG	673, 834		194. 01
	1	SENIOR CIRCLE	O		194. 02
		SELECT SPECIALTY	1, 660, 489		194. 03
		FREE MEALS	206, 310		194. 04
200.00	1	Cross Foot Adjustments	0		200. 00
201.00	1	Negative Cost Centers TOTAL (sum lines 118-201)	0 83 647 520		201. 00 202. 00
202.00	'	TOTAL (SUII TITIES TTO-ZUT)	83, 647, 520		1202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

					Io	05/31/2017	Date/lime Pre   10/30/2017 4:	
				CAPI TAL REI	LATED COSTS			
		Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New Capital				BENEFITS DEPARTMENT	
			Related Costs 0	1. 00	2.00	2A	4. 00	
		AL SERVICE COST CENTERS	-	.,				
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP		71 400	40.045	112 247	112 247	2.00
4. 00 5. 01		EMPLOYEE BENEFITS DEPARTMENT OTHER ADMINISTRATIVE AND GENERAL	0	71, 402	40, 845	112, 247	112, 247 0	4. 00 5. 01
5. 02		DATA PROCESSING	O	203, 205	116, 244	319, 449	2, 177	5. 02
5.03		PURCHASING AND RECEIVING	0	175, 909	100, 629	276, 538	1, 325	5. 03
5.04	1	CENTRAL SCHEDULI NG	0	50, 067		78, 708	4, 163	5. 04
5. 05 5. 06		CASHIERING/ACCOUNTS RECEIVABLE ADMIN & GENERAL	0	0 136, 857	-	0 215, 146	6, 625	5. 05 5. 06
7. 00	1	OPERATION OF PLANT	0	1, 074, 173		1, 688, 654	3, 341	7. 00
8. 00		LAUNDRY & LINEN SERVICE	O	56, 059		88, 128	0	8. 00
9.00	1	HOUSEKEEPI NG	0	848, 741		1, 334, 264	2, 447	9. 00
10.00	1	DIETARY	0	265, 135		416, 806	0	10.00
11. 00 13. 00	1	CAFETERIA NURSI NG ADMINI STRATI ON	0	0 30, 549		0 48, 024	0 6, 613	11. 00 13. 00
13. 00		PASTORAL CARE	0	35, 285		55, 470	159	13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		0	0	14. 00
15. 00		PHARMACY	0	0	-	0	5, 166	
16. 00 21. 00		MEDICAL RECORDS & LIBRARY I&R SERVICES-SALARY & FRINGES APPRV	0	158, 872 0		249, 755 0	372 0	16. 00 21. 00
21.00		I &R SERVICES-SALART & FRINGES APPRV	0	0		0	0	22.00
22.00		I ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		<u> </u>	٥,		22.00
30. 00		ADULTS & PEDIATRICS	0	564, 541		887, 487	21, 722	30. 00
31.00	1	INTENSIVE CARE UNIT	0	186, 153		292, 642 65, 293	145	
31. 01 33. 00		NEONATAL INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT	0	41, 534 106, 111		166, 812	2, 390 3, 542	
40. 00		SUBPROVI DER - I PF	o o	80, 631		126, 756	5, 133	
43.00		NURSERY	0	0	0	0	708	43. 00
44. 00		SKILLED NURSING FACILITY	0	148, 387	84, 885	233, 272	3, 461	44. 00
50. 00	05000	LARY SERVICE COST CENTERS OPERATING ROOM	0	228, 685	130, 819	359, 504	4, 059	50. 00
50. 01		ENDOSCOPY	o	31, 275		49, 166	959	50. 01
51.00	05100	RECOVERY ROOM	0	97, 517	55, 785	153, 302	1, 150	
52. 00		DELIVERY ROOM & LABOR ROOM	0	86, 774		136, 413	1, 634	1
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	0 249, 384	١	0 392, 044	0 6, 459	53. 00 54. 00
54. 00		ULTRA SOUND	0	249, 304	142,000	392, 044	0, 439	54. 00
56.00	1	RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	1	CT SCAN	0	0	0	0	0	57. 00
58. 00 59. 00	05800	MRI  CARDI AC  CATHETERI ZATI ON	0	0 27, 780	0 15, 892	0 43, 672	2 144	58. 00 59. 00
60.00	1	LABORATORY	0	213, 449		335, 552	3, 164 7, 590	
		WHOLE BLOOD & PACKED RED BLOOD CELL	Ö	11, 696		18, 387		62. 00
65. 00	1	RESPI RATORY THERAPY	0	86, 729		136, 342		65. 00
66.00		PHYSI CAL THERAPY	0	112, 693		177, 159	1, 564	•
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	43, 138 16, 613		67, 815 26, 117	1, 253 249	
69. 00		ELECTROCARDI OLOGY	Ö	15, 812		24, 857	1, 074	•
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	37, 373 30, 413		58, 752 47, 811	0	73. 00 74. 00
76. 00		MISC ANCILLARY	o o	0		0	0	76.00
76. 01	03951	SLEEP LAB	0	0	- 1	0	0	76. 01
76. 02	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	49, 296		77, 496	1, 152	
76. 03		WOUND CARE TIENT SERVICE COST CENTERS	0	129, 957	74, 342	204, 299	2, 153	76. 03
90. 00		CLINIC	0	32, 168	18, 402	50, 570	308	90. 00
91.00	09100	EMERGENCY	0	199, 680		313, 907	7, 261	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	O	5, 934, 043	3, 394, 573	9, 328, 616	111, 694	118 00
110.00		IMBURSABLE COST CENTERS	, J	5, 754, 043	J, 374, 373	7, 320, 010	111, 074	1.10.00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15, 312	8, 759	24, 071		190. 00
		RESEARCH	0	0		0		191.00
		PHYSICIANS' PRIVATE OFFICES NONREIMBURSABLE MISC	0	0	0	0		192. 00 194. 00
		MARKETI NG	0	0	0	0		194. 00
		SENI OR CI RCLE		0		ō		194. 02
			<u> </u>		<u> </u>			

Heal th Finar	ncial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION	OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
					From 06/01/2016	Part II	
					To 05/31/2017	Date/Time Pre 10/30/2017 4:	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2. 00	2A	4. 00	
194. 03 07953	SELECT SPECIALTY	0	359, 066	205, 40	4 564, 470	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, 308, 421	3, 608, 73	6 9, 917, 157	112, 247	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 06/01/2016 Part II
To 05/31/2017 Date/Time Prepared: 10/30/2017 4:18 pm

					0 05/31/201/	10/30/2017 4:	
	Cost Center Description	OTHER	DATA	PURCHASING AND		CASHI ERI NG/ACC	
		ADMI NI STRATI VE AND GENERAL	PROCESSI NG	RECEI VI NG	SCHEDULI NG	OUNTS RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
1 00	GENERAL SERVI CE COST CENTERS					I	1 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	0					5. 01
5. 02	00550 DATA PROCESSING	0	321, 626	<u>,                                    </u>			5. 02
5.03	00591 PURCHASING AND RECEIVING	0	0	277, 863			5. 03
5.04	00540 CENTRAL SCHEDULI NG	0	0	1, 101	83, 972		5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	14	0	18	5. 05
5.06	00590 ADMIN & GENERAL	0	0	331	0	0	5. 06
7. 00 8. 00	00700 OPERATION OF PLANT	0	0	133	0	0	7. 00 8. 00
9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	0	2, 277 3, 567	0	0	9.00
10. 00	01000 DI ETARY	0	0	4, 037	0	Ö	10.00
11. 00	01100 CAFETERI A	o	0	0	o o	Ö	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	O	376	0	0	13. 00
13. 01	01850 PASTORAL CARE	0	0	39	0	0	13. 01
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00	01500 PHARMACY	0	0	4, 849	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	104	0	0	16.00
21. 00 22. 00	02100   &R SERVICES-SALARY & FRINGES APPRV 02200   &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21. 00 22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	1 0		<u>,                                    </u>		0	22.00
30. 00	03000 ADULTS & PEDIATRICS	0	32, 931	11, 795	8, 614	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	635	1	166	l	31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	1, 193	1, 169	312	0	31. 01
33.00	03300 BURN INTENSIVE CARE UNIT	0	5, 877	3, 558	1, 537	0	33. 00
40.00	04000 SUBPROVI DER - I PF	0	10, 692	1, 319	2, 797	0	40. 00
43. 00	04300 NURSERY	0	445	1	116	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	2, 190	1, 203	573	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	24, 517	19, 416	6, 413	0	50.00
50. 00	03330 ENDOSCOPY		2, 650	1	693	0	50.00
51. 00	05100 RECOVERY ROOM	0	2, 748	1	719	Ö	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 028	1		Ō	52. 00
53.00	05300 ANESTHESI OLOGY	o	3, 676	18	961	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	46, 908	2, 398	12, 271	0	54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	0	0		0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	15, 156	8, 010	3, 965		59.00
60. 00	06000 LABORATORY	0	39, 041	1		Ö	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	2, 061	1		Ō	62.00
65.00	06500 RESPI RATORY THERAPY	O	9, 212	2, 419	2, 410	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	2, 409		630		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	2, 337			0	
	06800 SPEECH PATHOLOGY	0	406	1		l	
69. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 401	1			69.00
71. 00 72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	22, 617 9, 404	1		l	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	47, 867			18	
74. 00	07400 RENAL DI ALYSI S	o	704	1		0	74. 00
76. 00	03950 MISC ANCILLARY	0	O	0	0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	0	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 853				76. 02
76. 03	03952 WOUND CARE	0	2, 842	2, 776	744	0	76. 03
00.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC		7.0	201	21		00 00
90. 00 91. 00	09100 EMERGENCY	0	79 27, 747	1	21 7, 258	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		21, 141	13,003	7, 230	J	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		0	321, 626	277, 100	83, 972	18	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O	535	0	<b>l</b>	190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	79	0		192. 00
	07950 NONREI MBURSABLE MI SC		0	0	0		194. 00
	07951   MARKETI NG 2 07952   SENI OR CI RCLE		0	149	0		194. 01 194. 02
	307953 SELECT SPECIALTY		0				194. 02
	107954 FREE MEALS		0		0		194. 03
200.00							200. 00
	*	<u>'</u>			'	•	

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
				From 06/01/2016 Fo 05/31/2017		narod:
				10 03/31/2017	10/30/2017 4:	
Cost Center Description	OTHER	DATA	PURCHASI NG ANI	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	201. 00
202.00 TOTAL (sum lines 118-201)	0	321, 626	277, 863	83, 972	18	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 06/01/2016 Part II
To 05/31/2017 Date/Time Prepared: 10/30/2017 4:18 pm

					0 05/31/201/	10/30/2017 4:	
	Cost Center Description	ADMIN &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		GENERAL 5.06	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					  -	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					  -	4. 00
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL					  -	5. 01
5. 02 5. 03	00550 DATA PROCESSING 00591 PURCHASING AND RECEIVING					  -	5. 02 5. 03
5. 03	00540 CENTRAL SCHEDULING					  -	5. 03
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					  -	5. 05
5. 06	00590 ADMI N & GENERAL	222, 102					5. 06
7.00	00700 OPERATION OF PLANT	15, 981	1, 708, 109			  -	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 704	20, 831	112, 940			8. 00
9.00	00900 HOUSEKEEPI NG	7, 474	315, 383	0	1, 663, 135		9. 00
10. 00	01000 DI ETARY	5, 119	98, 520	1	119, 435	643, 917	10.00
11. 00	01100 CAFETERI A	2, 277	0	0	0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	7, 160	11, 352	1	13, 761	0	13.00
13. 01	01850 PASTORAL CARE	395 0	13, 111	0	15, 895	0	13. 01
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	14, 116	0	0	0	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 648	59, 035	0	71, 567	0	16.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	2,040	37,033	1		0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	6, 818	Ö	Ö		0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				·		
30.00	03000 ADULTS & PEDI ATRI CS	28, 610	209, 775	48, 612	254, 306	286, 059	30. 00
31.00	03100 INTENSIVE CARE UNIT	1, 127	69, 172	0	83, 856	509	31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	3, 028	15, 433	147	18, 710	0	31. 01
33. 00	03300 BURN INTENSIVE CARE UNIT	4, 949	39, 430			19, 538	33. 00
40. 00	04000 SUBPROVI DER - I PF	6, 449	29, 961	5, 777		74, 517	40. 00
43. 00	04300 NURSERY	802	0	389		0	43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	4, 593	55, 138	9, 143	66, 844	64, 327	44. 00
50. 00	05000 OPERATING ROOM	8, 002	84, 976	3, 493	103, 016	0	50.00
50. 00	03330 ENDOSCOPY	1, 687	11, 621			0	50. 00
51. 00	05100 RECOVERY ROOM	1, 866	36, 236			0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 870	32, 244			0	52. 00
53.00	05300 ANESTHESI OLOGY	203	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 499	92, 668	5, 906	112, 340	0	54.00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56. 00	05600  RADI 01 S0T0PE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	5, 405	10, 323		12, 514	0	59. 00 60. 00
60. 00 62. 00	06000   LABORATORY   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	15, 251 1, 519	79, 314 4, 346		96, 152 5, 269	0	62.00
65. 00	06500 RESPIRATORY THERAPY	3, 482	32, 227			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 307	41, 875			0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 625	16, 029			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	361	6, 173			0	68. 00
	06900 ELECTROCARDI OLOGY	1, 327	5, 875	560	7, 123	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 835	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 544	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 285	13, 887		16, 835	0	73. 00
74.00	07400 RENAL DIALYSIS	1, 390	11, 301	284	13, 700	0	74.00
76. 00	03950 MISC ANCILLARY	0	0	0	0	0	76. 00
76. 01	03951   SLEEP LAB   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1 520	10.210	0	22 204	0	76. 01
76. 02 76. 03	03952 WOUND CARE	1, 529 3, 326	18, 318		22, 206	0	76. 02 76. 03
70.03	OUTPATIENT SERVICE COST CENTERS	ა, ა20	48, 290	1 118	58, 542	U	70.03
90. 00	09000 CLINI C	509	11, 953	3, 321	14, 491	0	90. 00
91. 00	09100 EMERGENCY	13, 427	74, 198			0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			,		·	92.00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>		•			
118.00	SUBTOTALS (SUM OF LINES 1-117)	218, 499	1, 568, 995	112, 940	1, 494, 489	444, 950	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	141	5, 690	0	6, 898		190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	8	0	0	0	121, 994	
	07950 NONREI MBURSABLE MI SC	1 700	0	l ö	0		194. 00
	07951 MARKETING  07952 SENIOR CIRCLE	1, 723	0		0		194. 01 194. 02
	07952  SELECT SPECIALTY	1, 731	133, 424		161, 748	26, 617	
	107955 SELECT SPECIALITY	1, 731	133, 424 N	0		50, 356	
200.00							200. 00
201.00		0	0	0	o		201. 00
		. '			. '		

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co	1	Period: From 06/01/2016 Fo 05/31/2017	Worksheet B Part II Date/Time Pre 10/30/2017 4:	
Cost Center Description	ADMIN &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	GENERAL	PLANT	LINEN SERVICE			
	5. 06	7. 00	8. 00	9. 00	10.00	
202.00 TOTAL (sum lines 118-201)	222, 102	1, 708, 109	112, 940	1, 663, 135	643, 917	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0047

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 06/01/2016 Part II | To 05/31/2017 Date/Time Prepared: 10/30/2017 4:18 pm

	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PASTORAL CARE	CENTRAL SERVI CES & SUPPLY	10/30/2017 4: PHARMACY	
	JOSUS DA LA CONTROL DE LA CONT	11. 00	13. 00	13. 01	14. 00	15. 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
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5.03	00591 PURCHASING AND RECEIVING						5. 03
5.04	00540 CENTRAL SCHEDULING						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 ADMIN & GENERAL						5. 06
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	2 277					10.00
11.00	01100 CAFETERI A	2, 277	07 420				11.00
13. 00 13. 01	01300 NURSI NG ADMI NI STRATI ON 01850 PASTORAL CARE	134	87, 420	85, 075			13. 00 13. 01
14. 00	01400 CENTRAL SERVICES & SUPPLY	0		05,075	0		14. 00
15. 00	01500 PHARMACY	88			0	24, 227	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	23	l .		0	0	16. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	l .		0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	Ö		Ö	Ö	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_	-	-1	-1		
30.00	03000 ADULTS & PEDI ATRI CS	560	37, 758	36, 744	0	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	0			0	0	31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	50		1	0	0	31. 01
33.00	03300 BURN INTENSIVE CARE UNIT	87	5, 879		0	0	33. 00
40.00	04000 SUBPROVI DER - I PF	156	10, 495	10, 213	0	0	40.00
43.00	04300 NURSERY	16	1, 057	1, 029	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	82	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	92	6, 217	6, 050	0	0	50.00
50. 01	03330 ENDOSCOPY	24	1, 848		0	0	50. 01
51. 00	05100 RECOVERY ROOM	27	1, 618		0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	36	2, 440	2, 375	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	171	0	0	0	0	54.00
54. 01	03630 ULTRA SOUND	0		0	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	_	0	0	0	56.00
57. 00	05700 CT SCAN	0	1	0	0	0	57. 00
58. 00 59. 00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON	0	4, 288	_	0	0	58. 00 59. 00
60.00	06000 LABORATORY	64	4, 200	4, 1/3	0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	55			0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	31			0	Ö	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	21			Ö	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	4	0	1	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	43	l o	Ö	Ö	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	o	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	24, 227	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 MISC ANCILLARY	0	0	0	0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	0	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	36		0	0	0	76. 02
76. 03	03952 WOUND CARE	55	0	0	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS	1					
90. 00	09000 CLI NI C	7	0	0	0	0	90. 00
91. 00	09100 EMERGENCY	184	12, 414	12, 081	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
440.00	SPECIAL PURPOSE COST CENTERS	0.040	07.400	05.075	ام	04.007	440.00
118. 00		2, 263	87, 420	85, 075	0	24, 227	118.00
100.00	NONREI MBURSABLE COST CENTERS				ما	^	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		١	0		190.00
	19100   RESEARCH   19200   PHYSI CI ANS' PRI VATE OFFI CES	0		0	0		191. 00 192. 00
	07950 NONREIMBURSABLE MISC	3			0		192. 00 194. 00
	107950 NONRET MBORSABLE MT SC	11			٥		194. 00 194. 01
	207951 MARKETTING 207952 SENI OR CI RCLE				0		194. 01 194. 02
	307953 SELECT SPECIALTY				0		194. 02
	107954 FREE MEALS				n		194. 03
200. 00							200. 00
	1 122 122 132 133	l .	I .	1			

Health Fina	ancial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der C		Peri od: From 06/01/2016	Worksheet B Part II	
					To 05/31/2017		
	Cost Center Description	CAFETERI A	NURSI NG	PASTORAL CARI	E 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	0		0 0	0	201.00
202. 00	TOTAL (sum lines 118-201)	2, 277	87, 420	85, 07	75 0	24, 227	202. 00

| Peri od: | Worksheet B | From 06/01/2016 | Part II | To 05/31/2017 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

				To	05/31/2017	Date/Time Pre 10/30/2017 4:	
			INTERNS &	RESI DENTS		10/30/2017 4.	TO PIII
		MEDICAL	CEDVILOES CALAD	CEDVILOES OFFIED			
	Cost Center Description	MEDI CAL RECORDS &	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	Subtotal	Intern & Residents Cost	
		LI BRARY	APPRV	APPRV		& Post	
						Stepdown	
		16. 00	21.00	22.00	24. 00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	10.00	21.00	22.00	24.00	23.00	
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 00560 OTHER ADMINISTRATIVE AND GENERAL						4. 00 5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00591 PURCHASING AND RECEIVING						5. 03
5. 04 5. 05	00540 CENTRAL SCHEDULING						5. 04 5. 05
5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 ADMI N & GENERAL						5. 06
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
13. 01	01850 PASTORAL CARE						13. 01
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	383, 504					16. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	1			21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0		6, 818			22. 00
30. 00	O3000 ADULTS & PEDIATRICS	39, 310			1, 904, 283	0	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	759			449, 071		31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	1, 424			115, 810	0	31. 01
33.00	03300 BURN INTENSIVE CARE UNIT	7, 015			317, 955	1	33. 00
40. 00 43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	12, 764 531			333, 351 5, 093	1	40. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	2, 614			443, 440	1	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	29, 266			655, 021	1	50.00
50. 01 51. 00	03330 ENDOSCOPY 05100 RECOVERY ROOM	3, 164 3, 280			96, 685 249, 150	1	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 227			220, 555	1	52. 00
53.00	05300 ANESTHESI OLOGY	4, 387			9, 245	1	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	55, 995			740, 659	1	54. 00
54. 01 56. 00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0			C		54. 01 56. 00
57. 00	05700 CT SCAN	0			C	o o	57. 00
58. 00	05800 MRI	0			C	0	58. 00
59.00	O5900   CARDI AC   CATHETERI ZATI ON   O6000   LABORATORY	18, 092			131, 973		59.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	46, 604 2, 461			645, 430 40, 048		60. 00 62. 00
65. 00	06500 RESPI RATORY THERAPY	10, 997			238, 400		65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 876			279, 760		66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	2, 790 484			111, 939 41, 399		67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 866			46, 893		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 999			156, 602	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11, 225			109, 637	1	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	56, 712 841			235, 944 76, 373	1	73. 00 74. 00
76.00	03950 MISC ANCILLARY	0			70, 373 C		76.00
76. 01	03951 SLEEP LAB	0			C	0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 212			125, 361		76. 02
76. 03	03952 WOUND CARE OUTPATIENT SERVICE COST CENTERS	3, 393	l		326, 538	8 0	76. 03
90. 00	09000 CLINIC	94			81, 634	0	90. 00
91. 00	09100 EMERGENCY	33, 122	ł .		621, 889	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
118. 00	SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1-117)	383, 504	0	0	8, 810, 138	3	118. 00
1 10.00	NONREI MBURSABLE COST CENTERS	303, 304			3, 310, 130	, 0	. 10. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			37, 335		190. 00
	19100 RESEARCH	0			122 024	1	191. 00 192. 00
	19200   PHYSICIANS' PRIVATE OFFICES   07950   NONREIMBURSABLE MISC	0			122, 084 C		194. 00
	07951 MARKETI NG	0			2, 436		194. 01
				<u> </u>			

Health Financial Systems	Sī	T JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED CO	STS		Provi der Co		Peri od:	Worksheet B	
					From 06/01/2016 To 05/31/2017		narad.
					To 05/31/2017	Date/Time Pre 10/30/2017 4:	pareu. 18 nm
			INTERNS &	RESI DENTS		1 107 007 2017 11	, <u>, , , , , , , , , , , , , , , , , , </u>
Cost Center Descrip	ti on	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		0			0	0	194. 02
194. 03 07953 SELECT SPECIALTY		0			887, 990	0	194. 03
194.04 07954 FREE MEALS		0			50, 356	0	194. 04
200.00 Cross Foot Adjustmen	nts		0	6, 81	8 6, 818	0	200. 00
201.00 Negative Cost Center	rs	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 11)	3-201)	383, 504	0	6, 81	8 9, 917, 157	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 06/01/2016 Part II | To 05/31/2017 Date/Time Prepared: 10/30/2017 4: 18 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

			10/30/2017 4	: 18 pm
	Cost Center Description	Total		
- 12	CENEDAL CEDALCE COCT CENTEDO	26. 00		
-	GENERAL SERVICE COST CENTERS			1 00
	DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-MVBLE EQUIP			1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
1	00560 OTHER ADMINISTRATIVE AND GENERAL			5. 01
1	00550 DATA PROCESSING	i		5. 02
	00591 PURCHASING AND RECEIVING			5. 03
	00540 CENTRAL SCHEDULING			5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
1	OO590 ADMIN & GENERAL			5. 06
1	00700 OPERATION OF PLANT			7. 00
1	00800 LAUNDRY & LINEN SERVICE			8. 00
	00900 HOUSEKEEPI NG			9. 00
1	01000 DI ETARY			10.00
1	D1100 CAFETERI A D1300 NURSI NG ADMI NI STRATI ON			13.00
1	01850 PASTORAL CARE			13. 00
1	01400 CENTRAL SERVICES & SUPPLY			14. 00
	01500 PHARMACY			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY			16. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
-	NPATIENT ROUTINE SERVICE COST CENTERS			
1	03000 ADULTS & PEDIATRICS	1, 904, 283		30.00
4	03100 INTENSIVE CARE UNIT	449, 071		31. 00
1	02060 NEONATAL INTENSIVE CARE UNIT	115, 810		31. 01
	D3300 BURN INTENSIVE CARE UNIT D4000 SUBPROVIDER - IPF	317, 955		33.00
1	04300 NURSERY	333, 351 5, 093		40. 00 43. 00
4	04400 SKILLED NURSING FACILITY	443, 440		44. 00
<b>=</b>	ANCILLARY SERVICE COST CENTERS	1 443, 440		1 44. 00
	05000 OPERATING ROOM	655, 021		50.00
50. 01	D3330 ENDOSCOPY	96, 685		50. 01
51.00	05100 RECOVERY ROOM	249, 150		51.00
	D5200 DELIVERY ROOM & LABOR ROOM	220, 555		52. 00
1	D5300 ANESTHESI OLOGY	9, 245		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	740, 659		54.00
	03630 ULTRA SOUND	0		54. 01
4	05600 RADI 0I S0T0PE 05700 CT SCAN	0		56. 00 57. 00
1	05800 MRI			58. 00
1	05900 CARDI AC CATHETERI ZATI ON	131, 973		59. 00
1	06000 LABORATORY	645, 430		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	40, 048		62. 00
	06500 RESPIRATORY THERAPY	238, 400		65. 00
	06600 PHYSI CAL THERAPY	279, 760		66. 00
1	06700 OCCUPATI ONAL THERAPY	111, 939		67. 00
	06800 SPEECH PATHOLOGY	41, 399		68. 00
	06900 ELECTROCARDI OLOGY	46, 893		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	156, 602		71.00
	07300 DRUGS CHARGED TO PATIENTS	109, 637 235, 944		72. 00 73. 00
	07400 RENAL DIALYSIS	76, 373		74.00
4	03950 MISC ANCILLARY	0		76. 00
	03951 SLEEP LAB	0		76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	125, 361		76. 02
76. 03	D3952 WOUND CARE	326, 538		76. 03
	DUTPATIENT SERVICE COST CENTERS			
	09000 CLI NI C	81, 634		90.00
	09100 EMERGENCY	621, 889		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
-	SPECIAL PURPOSE COST CENTERS	0.010.120		110 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	8, 810, 138		118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	37, 335		190. 00
	19100 RESEARCH	07,333		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	122, 084		192. 00
	07950 NONREI MBURSABLE MI SC	0		194. 00
	07951 MARKETI NG	2, 436		194. 01
	07952 SENIOR CIRCLE	0		194. 02
	07953 SELECT SPECIALTY	887, 990		194. 03
	07954 FREE MEALS	50, 356		194. 04
200.00	Cross Foot Adjustments	6, 818		200. 00
201.00	Negative Cost Centers	0		201. 00
202.00	TOTAL (sum lines 118-201)	9, 917, 157		202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 ST JOSEPH MEDICAL CENTER Provider CCN: 15-0047 Peri od: From 06/01/2016 To 05/31/2017 Date/Time Prepared: 10/30/2017 4:18 pm CAPITAL RELATED COSTS

		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FLXT (SQUARE FOO TAGE)	MVBLE EQUIP (SQUARE FOO TAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	DATA PROCESSING (GROSS CHAR GES)	
		1. 00	2. 00	4.00	5. 01	5. 02	
	GENERAL SERVICE COST CENTERS	111.000		1			
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT	416, 929					1. 00 2. 00
4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	4, 719	416, 929 4, 719	1			4.00
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL	4, 717	4,717	1	0		5. 01
5. 02	00550 DATA PROCESSING	13, 430	_	1	_	532, 103, 282	5. 02
5.03	00591 PURCHASING AND RECEIVING	11, 626	11, 626	358, 391	0	0	5. 03
5.04	00540 CENTRAL SCHEDULING	3, 309		1		0	5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0 045	0 9, 045	.,		0	5. 05
5. 06 7. 00	00590 ADMIN & GENERAL 00700 OPERATION OF PLANT	9, 045 70, 993			0	0	5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	3, 705	3, 705	1	_	0	8.00
9. 00	00900 HOUSEKEEPI NG	56, 094	56, 094	1	_	0	9. 00
10.00	01000 DI ETARY	17, 523	17, 523	0		0	10. 00
11.00	01100 CAFETERI A	0	0		0	0	11.00
13. 00 13. 01	01300 NURSI NG ADMINI STRATI ON 01850 PASTORAL CARE	2, 019 2, 332				0	13. 00 13. 01
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 332	2, 332 0			0	14. 00
15. 00	01500 PHARMACY	0	Ö			0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	10, 500	10, 500			0	16. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0		0	21. 00
22. 00	02200 I &R SERVI CES-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	37, 311	37, 311	5, 877, 874	0	54, 521, 370	30. 00
31. 00		12, 303	12, 303			1, 052, 059	1
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	2, 745				1, 974, 604	1
33.00	03300 BURN INTENSIVE CARE UNIT	7, 013	7, 013	957, 887	0	9, 729, 520	33. 00
40. 00	04000 SUBPROVI DER - I PF	5, 329				17, 702, 506	1
43. 00	04300 NURSERY	0	0	1,		736, 956	1
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	9, 807	9, 807	936, 019	0	3, 625, 338	44. 00
50. 00	05000 OPERATI NG ROOM	15, 114	15, 114	1, 097, 553	0	40, 591, 523	50. 00
50. 01	03330 ENDOSCOPY	2, 067	2, 067	1		4, 387, 835	1
51. 00	05100 RECOVERY ROOM	6, 445		1		4, 548, 910	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	5, 735	5, 735	1		1, 701, 634	1
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	16, 482	16, 482	0 1, 746, 554	_	6, 085, 290 77, 662, 509	53. 00 54. 00
54. 00	03630 ULTRA SOUND	10, 462	10, 462	1, 740, 554	0	77, 002, 309	54. 00
56. 00	05600 RADI OI SOTOPE	0	0	Ō	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 836				25, 093, 511	ł
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	14, 107 773	14, 107 773			64, 637, 492 3, 412, 810	1
65. 00		5, 732				15, 252, 411	
66. 00		7, 448				3, 988, 867	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 851	2, 851			3, 869, 877	ı
68. 00	06800 SPEECH PATHOLOGY	1, 098				671, 678	
69. 00 71. 00	1 1	1, 045	1, 045 0			3, 975, 105 37, 446, 007	1
72.00		0	Ö			15, 568, 727	
73.00		2, 470	2, 470	0	0	78, 858, 010	
74.00	I I	2,010	2, 010	0	0	1, 165, 791	74. 00
76. 00		0	0		_	0	76. 00
76. 01 76. 02	03951 SLEEP LAB 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 258	0 3, 258	1	0	2 0/0 020	76. 01 76. 02
	03952 WOUND CARE	8, 589				3, 068, 039 4, 705, 814	76. 02
70.00	OUTPATIENT SERVICE COST CENTERS	0,007	0,007	1 0027 100		1,700,011	70.00
90.00	09000 CLI NI C	2, 126					
91. 00	· · · · · · · · · · · · · · · · · · ·	13, 197	13, 197	1, 963, 627	0	45, 939, 004	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
118. 00	SPECIAL PURPOSE COST CENTERS  SUBTOTALS (SUM OF LINES 1-117)	392, 186	392, 186	30, 207, 593	0	532, 103, 282	118 00
	NONREI MBURSABLE COST CENTERS	0,2,100	3,2,100	00,201,070	<u> </u>	332, 133, 202	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 012	1, 012	0	0		190. 00
	19100 RESEARCH	0	0				191. 00
	D 19200 PHYSI CI ANS' PRI VATE OFFI CES D 07950 NONREI MBURSABLE MI SC	0	0				192. 00 194. 00
	0/07950 NONRETMBURSABLE MESC 1/07951 MARKETING	0	0	1	_		194. 00
. , +. 0	. 10 / 70 / I III/III/III	1 0	<u>'</u>	1 + 7, 0/1	1 0	<u> </u>	1. 7 7. 01

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0047	Peri od: From 06/01/2016 To 05/31/2017 Date/Ti me Prepared:			

				'	0 03/31/201/	10/30/2017 4:	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	OTHER	DATA	
		(SQUARE FOO	(SQUARE FOO		ADMI NI STRATI VE		
		TAGE)	TAGE)	DEPARTMENT	AND GENERAL	(GROSS CHAR	
				(GROSS	(ACCUM. COST)	GES)	
				SALARI ES)			
		1.00	2. 00	4. 00	5. 01	5. 02	
194. 02 07952	SENI OR CIRCLE	0	0	0	0	0	194. 02
194. 03 07953	SELECT SPECIALTY	23, 731	23, 731	0	0	0	194. 03
194. 04 07954	FREE MEALS	0	0	0	0	0	194. 04
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	6, 308, 421	3, 608, 736	4, 812, 457	0	2, 296, 117	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	15. 130684	8. 655517	0. 158527	0.000000	0. 004315	203. 00
204.00	Cost to be allocated (per Wkst. B,			112, 247	0	321, 626	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0. 003698	0.000000	0. 000604	205.00
	(11)						
'	•	'	'	•	'	1	•

	ALLOCATION - STATISTICAL BASIS	31 303EIII MEDI	Provi der CO	CN: 15-0047 Pe	eri od:	Worksheet B-1	
				Fr To	com 06/01/2016 05/31/2017	Date/Time Pre	pared:
	Cook Cooker Doorwinding	DUDCHACING AND	CENTRAL			10/30/2017 4:	18 pm
	Cost Center Description	PURCHASI NG AND RECEI VI NG	CENTRAL SCHEDULI NG	CASHI ERI NG/ACC OUNTS	Reconciliation	ADMIN & GENERAL	
		(COSTED REQ S)	(GROSS CHAR	RECEI VABLE		(ACCUM. COST)	
			GES)	(GROSS CHAR		,	
		5. 03	5. 04	GES) 5. 05	5A. 06	5. 06	
	GENERAL SERVICE COST CENTERS	5.03	5. 04	5.05	5A. 00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 01	OO400						4. 00 5. 01
5. 02	00550 DATA PROCESSING						5. 02
5.03	00591 PURCHASING AND RECEIVING	9, 246, 895					5. 03
5. 04	00540 CENTRAL SCHEDULING	36, 645	532, 103, 282				5. 04
5. 05 5. 06	OO580   CASHI ERI NG/ACCOUNTS   RECEI VABLE   OO590   ADMI N & GENERAL	482 11, 022	0	532, 103, 282 0	-13, 859, 485	72, 437, 088	5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	4, 434	0	o o	-13, 657, 465	5, 212, 187	•
8.00	00800 LAUNDRY & LINEN SERVICE	75, 779	0	0	0	555, 908	8. 00
9.00	00900 HOUSEKEEPI NG	118, 716	0	0	0	2, 437, 636	
10. 00 11. 00	01000   DI ETARY   01100   CAFETERI A	134, 358	0	0	0	1, 669, 672 742, 590	•
13. 00	01300 NURSI NG ADMI NI STRATI ON	12, 503	0	Ö	0	2, 335, 383	1
	01850 PASTORAL CARE	1, 308	0	0	0	128, 938	
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
	O1500   PHARMACY   O1600   MEDI CAL RECORDS & LI BRARY	161, 362 3, 455	0	0	0	4, 604, 101 863, 828	1
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0, 433	0	Ö	0	1	21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	2, 223, 608	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	200 545	E4 E04 070	5, 50, 070			
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	392, 515 7	54, 521, 370 1, 052, 059		0		1
31. 00	02060 NEONATAL INTENSIVE CARE UNIT	38, 893	1, 974, 604		0	1	
33.00	1 1	118, 390	9, 729, 520		0	l	1
40.00	04000 SUBPROVI DER - I PF	43, 903	17, 702, 506		0		1
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	40, 040	736, 956 3, 625, 338		0	· ·	
44.00	ANCI LLARY SERVI CE COST CENTERS	40, 040	3, 023, 330	3, 023, 330	0	1, 470, 130	44.00
50.00	05000 OPERATING ROOM	646, 161	40, 591, 523		0		1
50. 01	03330 ENDOSCOPY	104, 194	4, 387, 835		0		•
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	87 64, 213	4, 548, 910 1, 701, 634		0		
53. 00	1 1	606	6, 085, 290		0	l	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	79, 805	77, 662, 509	77, 662, 509	0	.,,	
	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	0	0	0	0	
	05700 CT SCAN	0	0	0	0	0	
58. 00	05800 MRI	O	0	O	0	0	1
	05900 CARDI AC CATHETERI ZATI ON	266, 561	25, 093, 511		0		
	06000 LABORATORY	515, 876 181, 915	64, 637, 492 3, 412, 810	64, 637, 492 3, 412, 810	0		
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY	80, 495	15, 252, 411	15, 252, 411	0		1
66. 00	06600 PHYSI CAL THERAPY	4, 778	3, 988, 867	3, 988, 867	0	752, 395	1
67. 00	1 1	851	3, 869, 877		0	529, 903	1
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	487 4, 622	671, 678 3, 975, 105	·	0	117, 604 432, 764	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 969, 600	37, 446, 007	37, 446, 007	0		1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 562, 611	15, 568, 727	15, 568, 727	0	3, 112, 950	
73.00		0	78, 858, 010		0	1, 723, 829	
74.00	07400 RENAL DIALYSIS 03950 MISC ANCILLARY	5, 262	1, 165, 791	1, 165, 791 0	0	453, 215 0	1
76. 00	03951 SLEEP LAB	0	0	0	0	l	1
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 447	3, 068, 039		0	· ·	1
76. 03	03952 WOUND CARE	92, 389	4, 705, 814	4, 705, 814	0	1, 084, 703	76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	9, 340	130, 085	130, 085	0	165, 863	90.00
91. 00		435, 376	45, 939, 004		0	l '	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
110 00	SPECIAL PURPOSE COST CENTERS	0.221.400	532, 103, 282	E22 102 202	12 050 405	71 261 704	110 00
118.00	SUBTOTALS (SUM OF LINES 1-117)   NONREIMBURSABLE COST CENTERS	9, 221, 488	532, 103, 282	532, 103, 282	-13, 859, 485	71, 261, 704	]118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17, 798	0	0	0	46, 070	190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 634	0	0	0		192. 00 194. 00
	07950 NONREIMBURSABLE MISC 07951 MARKETING	4, 975	0	0	0	l	
194. 02	07952 SENIOR CIRCLE	1,773	0	-	0	0	194. 02
194. 03	07953 SELECT SPECIALTY	0	0	О	0	564, 470	194. 03
	<del></del>						

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
			[	From 06/01/2016		
			-	Γo 05/31/2017	Date/Time Pre	pared:
			_		10/30/2017 4:	18 pm_
Cost Center Description	PURCHASING AND	CENTRAL	CASHI ERI NG/ACO	C Reconciliation	ADMIN &	
	RECEI VI NG	SCHEDULI NG	OUNTS		GENERAL	
	(COSTED DEO S)	(CDOSS CHAD	DECELVADIE		(ACCUM COST)	

						10/30/2017 4:	
	Cost Center Description	PURCHASING AND	CENTRAL	CASHI ERI NG/ACC	Reconciliation	ADMIN &	
		RECEI VI NG	SCHEDULI NG	OUNTS		GENERAL	
		(COSTED REQ S)	(GROSS CHAR	RECEI VABLE		(ACCUM. COST)	
			GES)	(GROSS CHAR			
				GES)			
		5. 03	5. 04	5. 05	5A. 06	5. 06	
194.04	07954 FREE MEALS	0	0	0	0	0	194. 04
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 382, 599	1, 551, 307	1, 866, 492		13, 859, 485	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 149520	0. 002915	0.003508		0. 191331	203. 00
204.00	Cost to be allocated (per Wkst. B,	277, 863	83, 972	18		222, 102	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 030049	0. 000158	0.000000		0.003066	205. 00

COST CALLOCATION   STATISTICAL DAILS   Provided COIL 15 ONZ   Prov			ICIAI SYSTEMS	ST JUSEPH MEL		ON 45 0047 5		U OF FORM CMS-	
Cost Center Description	COST A	LLOCA	ITON - STATISTICAL BASIS		Provider Co			Worksheet B-1	
Cost Contor Description								Date/Time Pre	nared·
Control   Cont						'	0 03/31/2017		
CAMPAIN   SERVICE   COST CENTERS   CAMPAIN   CROWNED OF A PACE			Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIFTARY		lo piii
SPINEAR SERVICE OIST CENTERS			occi conton posci i pri on						
TAMES   SAMPLING COST CENTERS   7.00   8.00   9.00   10.00   11.00							(27120 0211720)	(1.12.0)	
1.00					†	9, 00	10.00	11. 00	
1.00   00100  CAM PEL COSTS-HULE & FINX		GENER	AL SERVICE COST CENTERS						
2.00 000000 [CONTRAL SIGNATURE ADDIT   2.00 00000 [CONTRAL SIGNATIVE AND CEREDAL   6.00 00000 [CONTRAL SIGNATURE ADDIT   6.00 000000 [CONTRAL SIGNATURE ADDIT   6.00 00000 [CONTRAL SIGNATURE ADDIT   6.00 0000000 [CONTRAL SIGNATURE ADDIT   6.00 000000 [CONTRAL SIGNATURE ADDIT   6.00 000000 [CONTRAL SIGNATURE ADDIT   6.00 0000000 [CONTRA	1.00								1.00
4.00   00000   DOUBLE AMEN ISSUED THE MAN STREET IN SUPPRISED TO   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   000000									•
5.01   DOSSIGNATION PROCESSING   5.00									
5.00   ODSO-DICTARS ASSEMBLY   SECRET VARIES   S. 00									
5.00   00099   PURCHASTING ARD RECEIVING   5.00   0.0009									
5.04 OSSINDAL SCRIPTION SCRIPTION SERVICE OF STATE ASSISTANCE OF STATE OF S									
5.05 000880 CASH LENING ACCOUNTS RECEIVABLE 5.06 00099 ABMIN IN SCREENAL 7.00 100000 (PERATI DU IF PLANT 1.00 010000 (PERATI DU IF PLANT 1.00 00000 (PERATI DU		1	•						
0.0090   ADMIN & GENERAL									
7.00   00700									
8.00   0.0000   LAURDRY & LI NEN SERVICE   3.705   845,996     845,996     9.00   0.0000   CAPERER ADD MISSTACTION   17.523   0   17.523   15.545   1.000   1.000   DIETARY   17.523   0   17.523   15.545   1.000   1.000   DIETARY   17.523   0   0   0   0   0   0   0   1.000   DIETARY   17.500   0   0   0   0   0   0   0   0   0				303.807					
9.00   00900  MUSERCEPI NG		1	ł .		l .				
10.00   01000   DETARY		1	i e						
11.00 0 1100 CAFETERIA 0 0 0 0 47,729 11.00 13.01 0 1300 URSINS MAD MISSING ADMINISTRATION 2.019 0 2,019 0 0 2,448 13.00 13.01 0 1300 DIRSING ADMINISTRATION 2.019 0 0 0 10 10 13.01 13.01 0 1300 DIRSING ADMINISTRATION 2.019 0 0 0 0 10 113.01 13.00 0 1300 DIRSING ADMINISTRATION 2.019 0 0 0 0 10 10 13.01 13.00 0 1300 DIRSING ADMINISTRATION 2.019 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	•		l .				
13.00   01300   NURSING ADMINISTRATION   2,019   0   2,448   33.00   13.01   01800   PASTIONAL CARE   2,332   0   0   14.00						1	1	41 729	
13.01   0.1980   PASTORAL CARE   2.332   0   2.332   0   106   13.01		1	•	_	_	· ·			
14.00 01400 [CRITTAL SERVICES & SUPPLY 0 0 58 0 0 0 14.20 0 15.20 15.00 01500 [MEDICAL RECORDS & LIBRARY 10.500 0 58 0 0 0 1.500 0 0 1.22 10.0 010 010 [MEDICAL RECORDS & LIBRARY 5 FRINGS APPRY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
15.00 0 1500 [PHARMACY   0   0   1,621   15.00   0   1,621   15.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   0   0   0   0   0   0   0   0   0									
16.00   0.600   MEDICAL RECORDS & LIBRARY   10.500   0   10.500   0   0   0   0   0   0   0   0   0					58		أما		ı
21.00				10, 500			-1		
		1	•						l
INPATIL ENT ROUTINE SERVICE COST CENTERS   37, 311   364, 111   37, 311   69, 661   10, 284   30, 00   300, 00   300, 00   AURITS & PEDIDATRIC S   37, 311   364, 111   37, 311   69, 661   10, 284   31, 00   310, 00		4		_	_				
30.00   3000   ADULTS & PEDIATRICS   37, 311   364, 111   37, 311   69, 061   10, 254   30. 00   31. 00   310. 00	22.00						۹		22.00
31.00	30 00			37 311	364 111	37 311	69 061	10 254	30 00
31.01   02000 NEOWATAL INTENSIVE CARE UNIT   2,745   1.098   2,745   0   917   31.01									•
33.00   03300   BURN INTENSIVE CARE UNIT   7, 013   46, 507   7, 013   4.717   1, 597   33.00					l .				•
40. 00									1
43.00   04300 NURSERY   9, 807   68, 480   9, 807   15,530   1,500									•
44, 00   04400  SKILLED NURSING FACILITY   9, 807   68, 490   9, 807   15, 530   1,500   44, 00							1		•
MODIL LLARY SERVICE COST CENTERS   50.00   50.00   67.000   07.00   16.68   50.00   50.00   07.000   07.00   17.00		1	ł						
50.00   05000   0FERTING ROOM   15, 114   26, 162   15, 114   0   1, 688   50. 00   1, 689   50. 00   1, 699   50. 00   1, 699   50. 00   1, 699   50. 00   1, 699   50. 00   1, 699   50. 00   1, 699   50. 00   1, 699   50. 00   1, 699   50. 00   1, 699   50. 00   1, 699   50. 00   1, 699   50. 00	00			7,007	007 100	,, ,,	107 000	., 555	
50.01   03330   CNDOSCOPY   2,067   43,855   2,067   0   439   50.01	50.00			15. 114	26, 162	15. 114	0	1, 688	50.00
51.00		1	•				1		1
52.00   05200   DELLYERY ROOM & LABOR ROOM   5,735   0   5,735   0   0   0   0   0   0   0   0   0							1		ł
53.00   OSSOO   ANESTHESI OLOGY   0   0   0   0   53.00									1
54.00   05400   RADI OLOGY-DIAGNOSTIC   16,482   44,236   16,482   0   3,134   54.00				0,700	0				1
54 01   03630   ILTRA SOUND   0   0   0   0   55.00				16 482	44 236				ł
56 00   05000 RADI OI SOTOPE   0   0   0   0   0   55.00				10, 102	11, 200	10, 102	1	•	
57.00   05700   CT SCAN   0   0   0   0   0   0   0   0   0		1	•	0	0	l d			
58. 00   05900   NRI   0   0   0   0   0   0   0   0   58. 00   59. 00   05900   CARDIA C CATHETERI ZATI ON   1, 836   23, 575   1, 836   0   1, 165   59. 00   60. 00   06000   LABORATORY   14, 107   0   14, 107   0   3, 876   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   773   0   773   0   0   62. 00   65. 00   06500   RESPIRATORY THERAPY   5, 732   109   5, 732   0   1, 002   65. 00   66. 00   06500   RESPIRATORY THERAPY   7, 448   0   7, 448   0   571   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   2, 851   0   2, 851   0   378   67. 00   68. 00   06800   SPECEH PATHOLOGY   1, 098   0   1, 098   0   82   68. 00   69. 00   06800   SPECEH PATHOLOGY   1, 098   0   1, 098   0   69. 00   69. 00   06900   ELECTROCARDI OLOGY   1, 045   4, 192   1, 045   0   783   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   2, 470   0   2, 470   0   0   0   0   0   74. 00   07400   REMAL DI ALYSIS   2, 010   2, 130   2, 010   0   0   0   0   0   76. 01   03951   SLEEP LAB   0   0   0   0   0   0   0   0   0   76. 01   03951   SLEEP LAB   0   0   0   0   0   0   0   0   76. 01   03952   WOUND CARE   8, 589   886   8, 599   0   1, 010   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   3, 258   0   0   0   0   0   0   0   76. 01   09100   EMERGENCY   13, 197   129, 267   13, 197   0   3, 372   91. 00   79. 00   09000   CLEIN C   SUMPICAL SUM OF LINES   1, 117   279, 064   845, 936   219, 265   107, 421   41, 476   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   1, 102   0   0   0   0   0   79. 00   09000   DISERVATI ON BEDS (NON-DISTINCT PART   SPECIAL PURPOSE COST CENTERS   1, 102   0   0   0   0   0   79. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   1, 102   0   0   0   0   0   79. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   1, 102   0   0   0   0   0   79. 00   19000   01900   01900   01900   01900   0		1	•	0	0	l d	ol	0	
59.00   05900   CARDIAC CATHETERIZATION   1,836   23,575   1,836   0   1,165   59.00		1	i e	0	0	l d	ol	0	
60.00   06000   LABORATORY   14,107   0   14,107   0   3,876   60.00		1	•	1. 836	23. 575	1. 836	ol		ı
62.00   06200   MªNULE BLOOD & PACKED RED BLOOD CELL   773   0   773   0   0   62.00   65.00   06500   RESPI RATORY THERAPY   5,732   109   5,732   0   1,002   65.00   66.00   06600   PHYSI CAL THERAPY   7,448   0   7,448   0   571   66.00   67.00   06600   PHYSI CAL THERAPY   2,851   0   2,851   0   378   67.00   67.00   06600   PHYSI CAL THERAPY   2,851   0   2,851   0   378   67.00   68.00   06600   SPEECH PATHOLOGY   1,098   0   1,098   0   82   68.00   69.00   06900   ELECTROCARDI OLOGY   1,045   4,192   1,045   0   783   69.00   71.00   07100   MBDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72.00   072.00   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   2,470   0   2,470   0   0   0   0   74.00   07400   RENAL DI ALYSI S   2,010   2,130   2,010   0   0   0   0   76.01   03950   MISC ANACI LLARY   0   0   0   0   0   0   0   76.01   03951   SLEEP LAB   0   0   0   0   0   0   0   76.03   03952   WOUND CARE   8,589   886   8,589   0   1,010   76.03   03952   WOUND CARE   8,589   886   8,589   0   1,010   76.03   03952   WOUND CARE   8,589   886   8,589   0   1,010   76.04   09000   CLI NI C   0   0   0   0   0   0   76.05   09200   DESERVATI ON BEDS (NON-DI STI NCT PART   76.07   09200   DESERVATI ON BEDS (NON-DI STI NCT PART   76.08   09200   09582   WOUND CARE   0   0   0   0   0   76.00   09400   GIFT, FLOWER, COFFEE SHOP & CANTEEN   77.00   0   0   0   0   0   0   0   78.00   09400   09450   GIFT, FLOWER, COFFEE SHOP & CANTEEN   78.00   09400   09450   OFFICE SHOP & CANTEEN   79.00   09000   09450   NORREI MBURSABLE MISC   0   0   0   0   0   791.00   09750   NORREI MBURSABLE MISC   0   0   0   0   794.00   09750   NORREI MBURSABLE MISC   0   0   0   0   794.00   09751   MARKETI NG   0   0   0   0   0   794.00   09752   SENIOR CI RCLE   0   0   0   0   794.00   09753   SELECT SPECI ALTY   23,731   0   23,731   6,426   0   794.00   09755   SENIOR CI RCLE   0   0   0   794.00   09755   SENIOR CI RCLE   0   0   0   0   794.00   09755		4	l .					· ·	ı
65. 00   06500   RESPIRATORY THERAPY   5,732   109   5,732   0   1,002   65. 00   66. 00   06600   PHYSI CAL THERAPY   7,448   0   7,448   0   571   66. 00   6700   0CCUPATI ONAL THERAPY   2,851   0   2,851   0   378   67. 00   6700   0CCUPATI ONAL THERAPY   2,851   0   2,851   0   378   67. 00   68. 00   06900   DELETROCARDI OLOGY   1,098   0   1,098   0   82   68. 00   68. 00   06900   ELECTROCARDI OLOGY   1,045   4,192   1,045   0   0   0   0   0   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73. 00   0   0   0   0   0   0   0   0   72. 00   73. 00   7									
66.00   06600   PHYSI CAL THERAPY   7,448   0   7,448   0   37,448   0   371   66.00   67.00   06700   0CCUPATI ONAL THERAPY   2,851   0   2,851   0   378   67.00   68.00   06800   SPEECH PATHOLOGY   1,098   0   1,098   0   82   68.00   69.00   06900   ELECTROCARDI OLOGY   1,045   4,192   1,045   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   2,470   0   2,470   0   0   0   0   74.00   07400   RENAL DI ALYSI S   2,010   2,130   2,010   0   0   0   76.01   03950   MISC ANCI LLARY   0   0   0   0   0   0   0   76.01   03951   SLEEP LAB   0   0   0   0   0   0   76.02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   3,258   0   3,258   0   666   76.02   76.03   03952   WOUND CARE   8,589   886   8,589   0   1,010   79.00   09000   CLIN IC   2,126   24,876   2,126   0   130   90.00   79.00   09000   EMERGENCY   13,197   129,267   13,197   0   3,372   91.00   79.00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   18.00   NONREI MBURSABLE COST CENTERS    118.00   SUBTOTALS (SUM OF LINES 1-117)   279,064   845,936   219,265   107,421   41,476   118.00   79.00   199.00   19100   RESEARCH   0   0   0   0   0   0   0   791.00   19100   RESEARCH   0   0   0   0   0   791.00   19100   RESEARCH   0   0   0   0   0   791.00   19100   19100   RESEARCH   0   0   0   0   791.00   19100   19100   RESEARCH   1900   19100   19100   19100   791.00   19100   19100   19100   19100   19100   19100   19100   791.00   19100   19100   19100   19100   19100   19100   19100   791.00   19100   19100   19100   19100   19100   19100   19100   19100   19100   791.00   19100									ı
67. 00   06700   OCCUPATIONAL THERAPY   2,851   0   2,851   0   378   67. 00   68. 00   06800   SPECCH PATHOLOGY   1,098   0   1,098   0   68. 00   06900   ELECTROCARDIOLOGY   1,045   4,192   1,045   0   783   69. 00   06900   ELECTROCARDIOLOGY   1,045   4,192   1,045   0   0   0   0   0   0   0   0   0								· ·	ı
68.00   06800   SPECH PATHOLOGY   1,098   0   1,098   0   82   68.00   69.00   69.00   669.00		1	•						1
69. 00   06900   ELECTROCARDIOLOGY   1, 045   4, 192   1, 045   0   783   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   71. 00   72. 00   07200   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00		1	•						1
71. 00									1
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   73. 00   7300   DRUGS CHARGED TO PATIENTS   2,470   0   2,470   0   0   73. 00   73. 00   74. 00   7		1	•			1	1		•
73. 00 07300 DRUGS CHARGED TO PATIENTS				0	0		1		•
74. 00   07400   RENAL DI ALYSI S   2,010   2,130   2,010   0   0   74. 00   76. 00   3950   MI SC ANCI LLARY   0   0   0   0   0   0   76. 00   76. 00   76. 00   0   0   0   0   0   0   0   0   0				2, 470	0	2. 470	ol	0	
76. 00 03950 MI SC ANCI LLARY 0 0 0 0 0 0 0 76. 00 76. 01 03951 SLEEP LAB 0 0 0 0 0 0 0 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 3, 258 0 3, 258 0 666 76. 02 76. 03 03952 WOUND CARE 8, 589 886 8, 589 0 1, 010 76. 03 76. 03 03952 WOUND CARE 8, 589 886 8, 589 0 1, 010 76. 03 76. 03 03952 WOUND CARE 8, 589 886 8, 589 0 1, 010 76. 03 76. 04 00 09000 CLI NI C 2, 126 24, 876 2, 126 0 130 90. 00 791. 00 09100 EMERGENCY 13, 197 0 3, 372 91. 00 792. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECI AL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LI NES 1-117) 279, 064 845, 936 219, 265 107, 421 41, 476 118. 00 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 1, 012 0 1, 012 0 0 1910. 00 191. 00 19100 RESSEARCH 0 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 29, 452 54 192. 00 194. 00 07950 NONREI MBURSABLE MI SC 0 0 0 0 0 0 194. 00 194. 00 07950 NOREI MBURSABLE MI SC 0 0 0 0 0 0 0 199. 194. 01 194. 01 07951 MARKETI NG 0 0 0 0 0 0 0 0 199. 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 0 0 0 0 0 0 0 194. 02 194. 03 07953 SELECT SPECI ALTY 23, 731 0 23, 731 6, 426 0 194. 03					l .			0	
76. 01   03951   SLEEP LAB   0   0   0   0   0   0   0   76. 01     76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   3, 258   0   3, 258   0   666   76. 02     76. 03   03952   WOUND CARE   8, 589   886   8, 589   0   1, 010     76. 03   03952   WOUND CARE   8, 589   886   8, 589   0   1, 010     76. 03   03952   WOUND CARE	76.00	03950	MISC ANCILLARY		0	1	1	0	•
76. 02				0	0	l	o	0	76. 01
76. 03   03952   WOUND CARE   0   1, 010   76. 03				3, 258	0	3, 258	o o	666	76. 02
90. 00		1	ł .						
91. 00   09100   EMERGENCY   13, 197   129, 267   13, 197   0   3, 372   91. 00   92. 00   SPECIAL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LINES 1-117)   279, 064   845, 936   219, 265   107, 421   41, 476   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   1, 012   0   0   191. 00   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0   0   194. 00   194. 01   07951   MARKETI NG   0   0   0   0   0   194. 01   194. 03   07953   SELECT SPECIALTY   23, 731   0   23, 731   6, 426   0   194. 03   194. 03   07953   SELECT SPECIALTY   23, 731   0   23, 731   6, 426   0   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 04   194. 04   194. 04   194. 05		OUTPA	TIENT SERVICE COST CENTERS						
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   92. 00   SPECIAL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LI NES 1-117)   279, 064   845, 936   219, 265   107, 421   41, 476   118. 00   NONREI MBURSABLE COST CENTERS   1, 012   0   1, 012   0   0   190. 00   19100   RESEARCH   0   0   0   0   0   0   191. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0   192. 00   194. 01   07951   MARKETI NG   0   0   0   0   0   199. 00   194. 02   07952   SENI OR CI RCLE   0   0   0   0   0   194. 02   194. 03   07953   SELECT SPECIALTY   23, 731   0   23, 731   6, 426   0   194. 03   07952   0   0   0   0   0   0   0   0   0	90.00	09000	CLINIC	2, 126	24, 876	2, 126	0	130	90.00
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1-117)   279,064   845,936   219,265   107,421   41,476   118.00   NONREI MBURSABLE COST CENTERS     190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   1,012   0   1,012   0   0   190.00   191.00   19100   RESEARCH   0   0   0   0   0   191.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   29,452   54   192.00   194.00   197.00	91.00	09100	EMERGENCY	13, 197	129, 267	13, 197	0	3, 372	91.00
118.00   SUBTOTALS (SUM OF LINES 1-117)   279,064   845,936   219,265   107,421   41,476   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   1,012   0   1,012   0   0   191.00   191.00   191.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   29,452   54   192.00   194.00   194.00   195.00	92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
NONRE   MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   1,012   0   1,012   0   0   1900. 00   1910. 00   1910. 00   1910. 00   1910. 00   19200		SPECI	AL PURPOSE COST CENTERS						
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 1, 012 0 1, 012 0 0 190. 00 191. 00 191. 00 191. 00 191. 00 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 29, 452 54 192. 00 194. 00 07950 NONREI MBURSABLE MI SC 0 0 0 0 0 194. 00 194. 00 194. 01 07951 MARKETI NG 0 0 0 0 199. 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 0 0 0 0 0 194. 02 194. 03 07953 SELECT SPECI ALTY 23, 731 0 23, 731 6, 426 0 194. 03	118.00	)	SUBTOTALS (SUM OF LINES 1-117)	279, 064	845, 936	219, 265	107, 421	41, 476	118. 00
191. 00   19100   RESEARCH		NONRE	IMBURSABLE COST CENTERS						
191. 00   19100   RESEARCH	190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 012	0	1, 012	0	0	190. 00
194. 00   07950   NONREI MBURSABLE MI SC     0     0     0     0     194. 00       194. 01   07951   MARKETI NG     0     0     0     0     199. 194. 01       194. 02   07952   SENI OR CI RCLE     0     0     0     0     0     0     194. 02       194. 03   07953   SELECT SPECI ALTY     23, 731   0     23, 731   6, 426   0     0 194. 03	191.00	19100	RESEARCH	0	0	[ C	o		
194. 01   07951   MARKETI NG     0     0     0     199   194. 01       194. 02   07952   SENI OR CI RCLE     0     0     0     0     0     194. 02       194. 03   07953   SELECT   SPECI ALTY     23, 731   0     23, 731   6, 426   0     194. 03				0	0	[ C	29, 452		
194. 02 07952 SENI OR CIRCLE 0 0 0 0 0 194. 02 194. 03 07953 SELECT SPECIALTY 23, 731 0 23, 731 6, 426 0 194. 03	194.00	07950	NONREI MBURSABLE MI SC	0	0	[ C	0		
194. 03 07953 SELECT SPECIALTY 23, 731 0 23, 731 6, 426 0 194. 03				0	0	[ C	o o		
				0	0	C	o	0	194. 02
194. 04 07954 FREE MEALS   0  0  12, 157  0 194. 04				23, 731	0	23, 731	6, 426		
	194. 04	07954	FREE MEALS	0	0	[ C	12, 157	0	194. 04
				<del></del>					

Health Fir	nancial Systems	ST JOSEPH MEDICAL CENTER			In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS			Provi der CC		Peri od:	Worksheet B-1	
					From 06/01/2016 To 05/31/2017	Date/Time Pre 10/30/2017 4:	
	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, 209, 440	737, 996	4, 050, 523	2, 638, 161	884, 670	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	20. 438765	0. 872402	16. 599960	16. 970468	21. 200364	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	1, 708, 109	112, 940	1, 663, 13!	643, 917	2, 277	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	5. 622349	0. 133509	6. 815904	4. 142117	0. 054566	205. 00

	Financial Systems	ST JUSEPH MED				U OT FORM CMS-	
COST	NLLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 06/01/2016 To 05/31/2017	Worksheet B-1 Date/Time Pre 10/30/2017 4:	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG	HRS)	SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHAR	
		HRS) 13. 00	13. 01	REQUI S. ) 14. 00	15. 00	GES) 16. 00	
	GENERAL SERVICE COST CENTERS	13.00	13.01	14.00	15.00	10.00	
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	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE 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 ADMIN & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA						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
13. 00 13. 01 14. 00 15. 00 16. 00 21. 00	01300  NURSI NG ADMINISTRATION   01850  PASTORAL CARE   01400  CENTRAL SERVICES & SUPPLY   01500  PHARMACY   01600  MEDICAL RECORDS & LIBRARY   02100  I&R SERVICES-SALARY & FRINGES APPRV	493, 838 0 0 0 0 0	493, 838 0 0 0 0		0 0 3, 487, 455 0 0	532, 103, 282 0	1
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	040.007	040.007			F4 F04 070	
30. 00 31. 00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	213, 287 172	213, 287 172		0 0	54, 521, 370 1, 052, 059	1
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	19, 071	19, 071		0 0	1, 974, 604	1
33.00	03300 BURN INTENSIVE CARE UNIT	33, 213	33, 213		0 0	9, 729, 520	1
40. 00 43. 00	04000   SUBPROVI DER -   PF   04300   NURSERY	59, 284 5, 971	59, 284 5, 971		0 0	17, 702, 506 736, 956	1
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0		0 0	3, 625, 338	1
50.00	05000 OPERATING ROOM	35, 120	35, 120		0 0	40, 591, 523	1
50. 01 51. 00	03330   ENDOSCOPY   05100   RECOVERY   ROOM	10, 442 9, 139	10, 442 9, 139		0 0	4, 387, 835 4, 548, 910	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	13, 786	13, 786			1, 701, 634	1
53.00	05300 ANESTHESI OLOGY	0	0		0 0	6, 085, 290	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	77, 662, 509	
54. 01 56. 00	03630   ULTRA SOUND   05600   RADI OI SOTOPE	0	0		0 0	0	
57. 00	05700 CT SCAN	0	ő			0	1
58. 00	05800 MRI	0	О		0 0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	24, 225	24, 225		0 0	25, 093, 511	
60.00	O6000   LABORATORY   O6200   WHOLE   BLOOD & PACKED   RED   BLOOD   CELL	0	0			64, 637, 492 3, 412, 810	
65. 00	06500 RESPIRATORY THERAPY	0	ő			15, 252, 411	
	06600 PHYSI CAL THERAPY	0	О		0 0	3, 988, 867	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 0	3, 869, 877	
69.00		0	0			671, 678 3, 975, 105	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	37, 446, 007	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	15, 568, 727	1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0 3, 487, 455	78, 858, 010 1, 165, 791	
76. 00	03950 MISC ANCILLARY	Ö	o		0 0	0	1
76. 01	03951 SLEEP LAB	0	О		0 0	0	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	3, 068, 039 4, 705, 814	1
76. 03	03952  WOUND CARE   OUTPATIENT SERVICE COST CENTERS	_jU	U		0 0	4, 705, 814	76. 03
90.00	09000 CLI NI C	0	0		0 0	130, 085	90.00
	09100 EMERGENCY	70, 128	70, 128		0 0	45, 939, 004	1
92.00	O9200   OBSERVATION BEDS (NON-DISTINCT PART   SPECIAL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	493, 838	493, 838		0 3, 487, 455	532, 103, 282	118. 00
190 00	NONREIMBURSABLE COST CENTERS   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN		ol		ol ol	0	190. 00
	19100 RESEARCH		ol				191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	O		0 0	0	192. 00
	07950 NONREI MBURSABLE MI SC	0	0		0		194. 00
	07951 MARKETING  07952 SENIOR CIRCLE						194. 01 194. 02
	07953 SELECT SPECIALTY	Ö	o		o o		194. 03
			·		<u> </u>		

Heal th Fir	nancial Systems	ST JOSEPH MED	DICAL CENTER		In Lie	eu of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der CO	CN: 15-0047	Peri od:	Worksheet B-1	
					From 06/01/2016		
					To 05/31/2017	Date/Time Pre	
		_				10/30/2017 4:	18 pm
	Cost Center Description	NURSI NG	PASTORAL CARE	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	(DIRECT NRSING	SERVICES &	(COSTED	RECORDS &	
			HRS)	SUPPLY	REQUIS.)	LI BRARY	
		(DIRECT NRSING		(COSTED		(GROSS CHAR	
		HRS)		REQUI S. )		GES)	
		13.00	13. 01	14.00	15. 00	16.00	
194. 04 079	54 FREE MEALS	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,	2, 908, 893	242, 229		0 5, 519, 425	1, 427, 065	202. 00

5. 890379

0. 177022

87, 420

0. 490503 85, 075

0. 172273

0. 002682 203. 00 383, 504 204. 00

0. 000721 205. 00

1. 582651 24, 227

0.006947

0.000000

0.000000

203.00

204.00

205.00

Part I)

11)

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,
Part II)

Unit cost multiplier (Wkst. B, Part

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

					10/30/2017 4: 1	
			INTERNS &	RESI DENTS		
		Cost Contor Dosgrintion	SEDVICES SALAD	SEDVI CES OTHED		
		Cost Center Description	SERVICES-SALAR Y & FRINGES	PRGM COSTS		
			APPRV	APPRV		
			(ROTATIONS)	(ROTATI ONS)		
			21.00	22. 00		
4 00		AL SERVICE COST CENTERS	1			4 00
1.00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP				1. 00 2. 00
2. 00 4. 00	1	EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 01	1	OTHER ADMINISTRATIVE AND GENERAL				5. 01
5. 02	1	DATA PROCESSING				5. 02
5.03	00591	PURCHASING AND RECEIVING				5. 03
5.04	1	CENTRAL SCHEDULING				5. 04
5. 05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE				5. 05
5. 06 7. 00	1	ADMIN & GENERAL OPERATION OF PLANT				5. 06 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE				8. 00
9. 00	1	HOUSEKEEPI NG				9. 00
10.00	1	DI ETARY				10.00
11. 00	01100	CAFETERI A				11.00
13. 00		NURSI NG ADMI NI STRATI ON				13. 00
13. 01		PASTORAL CARE				13. 01
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY   PHARMACY				14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY				16. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRV	8, 100			21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV		8, 100		22. 00
		I ENT ROUTINE SERVICE COST CENTERS	1			
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	4,060	4, 060 0	1	30. 00 31. 00
31. 00	1	NEONATAL INTENSIVE CARE UNIT	100	100	1	31. 01
33. 00	1	BURN INTENSIVE CARE UNIT	0	0	1	33. 00
40.00		SUBPROVI DER - I PF	0	0	1	40.00
43.00	1	NURSERY	0	0	1	43. 00
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0		44. 00
50.00		OPERATING ROOM	900	900		50.00
50. 01	03330	ENDOSCOPY	0	0		50. 01
51. 00	1	RECOVERY ROOM	0	0	•	51.00
52.00		DELIVERY ROOM & LABOR ROOM     ANESTHESIOLOGY	0	0	1	52.00
53. 00 54. 00		RADI OLOGY RADI OLOGY	0	0	•	53. 00 54. 00
54. 01	1	ULTRA SOUND	0	0	•	54. 01
56.00	05600	RADI OI SOTOPE	0	0		56.00
57. 00		CT SCAN	0	0	•	57. 00
58. 00	05800	•	0	0		58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0	0	i i	59. 00 60. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	l l	62. 00
65.00	1	RESPI RATORY THERAPY	0	0		65.00
66. 00	1	PHYSI CAL THERAPY	0	0	i .	66.00
67. 00	1	OCCUPATIONAL THERAPY	0	0	•	67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0		68. 00 69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö		71.00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00		RENAL DIALYSIS	0	0		74.00
76. 00 76. 01		MISC ANCILLARY SLEEP LAB	0	0		76. 00 76. 01
76. 01	1	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	1	76. 01
76. 03	1	WOUND CARE	800	800	•	76. 03
		TIENT SERVICE COST CENTERS				
90.00	1	CLINIC	1, 760	1, 760	1	90.00
91. 00 92. 00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	480	480		91. 00 92. 00
92.00		AL PURPOSE COST CENTERS				92.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8, 100	8, 100	1	118. 00
	NONRE	MBURSABLE COST CENTERS				
	1	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
		RESEARCH PHYSICIANS' PRIVATE OFFICES	0	0		191. 00 192. 00
		NONREIMBURSABLE MISC		0		192. 00 194. 00
	1	MARKETI NG		0		194. 01
194. 02	07952	SENIOR CIRCLE	0	0	)	194. 02

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0047	Peri od: From 06/01/2016 To 05/31/2017   Worksheet B-1 Date/Ti me Prepared:			

				10	03/31/2017	10/30/2017 4:	
		INTERNS &	RESI DENTS				
Cost Center Description		SERVI CES-SALAR					
		Y & FRINGES	PRGM COSTS				
		APPRV	APPRV				
		(ROTATIONS)	(ROTATIONS)				
		21.00	22. 00				
194. 03 0795	3 SELECT SPECIALTY	0	0				194. 03
194. 04 0795	4 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, 649, 053				202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	327. 043580	)			203. 00
204. 00	Cost to be allocated (per Wkst. B,	0	6, 818				204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 841728				205. 00
	11)						

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0047 Peri od: Worksheet C From 06/01/2016 Part I Date/Time Prepared: 05/31/2017 10/30/2017 4: 18 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 15, 709, 293 15, 709, 293 15, 709, 293 03100 INTENSIVE CARE UNIT 899, 579 899, 579 899, 579 31.00 31.00 0 02060 NEONATAL INTENSIVE CARE UNIT 31.01 1, 425, 603 1, 425, 603 1, 425, 603 31.01 03300 BURN INTENSIVE CARE UNIT 33.00 2, 575, 258 2, 575, 258 2, 575, 258 33.00 04000 SUBPROVI DER - I PF 0 40.00 3, 532, 513 3, 532, 513 3, 532, 513 40.00 43.00 04300 NURSERY 360, 231 360, 231 0 360, 231 43.00 04400 SKILLED NURSING FACILITY 2, 512, 856 2, 512, 856 2, 512, 856 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4,060,736 4, 060, 736 0 4, 060, 736 50.00 50.01 03330 ENDOSCOPY 858, 050 858, 050 0 858, 050 50.01 51.00 05100 RECOVERY ROOM 1,062,620 0 1, 062, 620 1,062,620 51.00 05200 DELIVERY ROOM & LABOR ROOM 1,045,557 1, 045, 557 52.00 1,045,557 52.00 53.00 05300 ANESTHESI OLOGY 95, 286 95, 286 95, 286 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 6, 168, 969 6, 168, 969 0 6, 168, 969 54.00 03630 ULTRA SOUND 54 01 0 O 54 01 0 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 57.00 05700 CT SCAN 0 0 57.00 0 0 0 0 05800 MRI 58.00 58.00 0 0 05900 CARDIAC CATHETERIZATION 2, 435, 247 2, 435, 247 2, 435, 247 59 00 59 00 60.00 06000 LABORATORY 6, 704, 012 6, 704, 012 6, 704, 012 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 627, 879 627, 879 0 0 0 627, 879 62.00 65 00 06500 RESPIRATORY THERAPY 1 627 449 1, 627, 449 1, 627, 449 65 00 06600 PHYSI CAL THERAPY 1, 195, 019 1, 195, 019 66.00 0 1, 195, 019 66.00 67.00 06700 OCCUPATIONAL THERAPY 755, 280 755, 280 755, 280 67.00 68.00 06800 SPEECH PATHOLOGY 184, 313 184, 313 0 0 0 0 0 184, 313 68.00 06900 ELECTROCARDI OLOGY 585, 189 585, 189 69 00 585 189 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 4, 699, 214 4, 699, 214 4, 699, 214 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 750, 309 3, 750, 309 3, 750, 309 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 7, 876, 024 7, 876, 024 7, 876, 024 73.00 07400 RENAL DIALYSIS 619, 362 74 00 619, 362 619, 362 74 00 0 76.00 03950 MISC ANCILLARY 0 76.00 0 C 03951 SLEEP LAB 0 76.01 76.01 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 737, 185 737, 185 0 737, 185 76.02 03952 WOUND CARE 76.03 1, 645, 172 1, 645, 172 0 1, 645, 172 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 301, 150 301, 150 0 301, 150 90.00 6, 460, 904 09100 EMERGENCY 6.460.904 6.460.904 0 91.00 91.00

2, 370, 417

82, 880, 676

2, 370, 417

80, 510, 259

2, 370, 417

82, 880, 676

2, 370, 417

80, 510, 259

2, 370, 417

82, 880, 676 200. 00

2, 370, 417 201. 00 80, 510, 259 202. 00

0

92 00

200.00

201.00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

In Lieu of Form CMS-2552-10

| Period: | Worksheet C |
| From 06/01/2016 | Part |
| To 05/31/2017 | Date/Time Prepared: | 10/30/2017 | 4:18 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0047

						10/30/2017 4:	18 pm
			Title	XVIII	Hospi tal	PPS	
			Charges				
Cost Center Description		I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	48, 584, 427		48, 584, 42	7		30. 00
31.00	03100 INTENSIVE CARE UNIT	1, 052, 059		1, 052, 05			31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	1, 974, 604		1, 974, 60	4		31. 01
33.00	03300 BURN INTENSIVE CARE UNIT	9, 729, 520		9, 729, 52			33. 00
40.00	04000 SUBPROVI DER - I PF	17, 702, 506		17, 702, 50	6		40. 00
43.00	04300 NURSERY	736, 956		736, 95			43. 00
44.00	04400 SKILLED NURSING FACILITY	3, 625, 338		3, 625, 33	8		44. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	19, 435, 485	21, 156, 038				
50. 01	03330 ENDOSCOPY	876, 401	3, 511, 434			0.000000	
51.00	05100 RECOVERY ROOM	1, 444, 761	3, 104, 149				
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 202, 575	499, 059				
53.00	05300 ANESTHESI OLOGY	3, 102, 822	2, 982, 468				
54.00	05400  RADI OLOGY-DI AGNOSTI C	20, 329, 425	57, 333, 084	77, 662, 50	9 0. 079433	0. 000000	54.00
54. 01	03630 ULTRA SOUND	0	0		0. 000000	0.000000	54. 01
56.00	05600  RADI 0I SOTOPE	0	0		0. 000000	0. 000000	56. 00
57.00	05700  CT SCAN	0	0		0. 000000	0. 000000	
58. 00	05800  MRI	0	0		0. 000000	0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	10, 196, 210	14, 897, 301			0. 000000	
60.00	06000 LABORATORY	30, 757, 723	33, 879, 769			0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	3, 097, 163	315, 647			0. 000000	
65. 00	06500 RESPI RATORY THERAPY	13, 249, 906	2, 002, 505			0. 000000	
66.00	06600 PHYSI CAL THERAPY	2, 566, 545	1, 422, 322				
67.00	06700 OCCUPATI ONAL THERAPY	3, 810, 299	59, 578	3, 869, 87			
68. 00	06800 SPEECH PATHOLOGY	515, 664	156, 014			0. 000000	
69.00	06900 ELECTROCARDI OLOGY	1, 727, 201	2, 247, 904		5 0. 147213	0. 000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15, 532, 837	21, 913, 170	37, 446, 00	7 0. 125493	0. 000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 706, 694	6, 862, 033			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	61, 259, 291	17, 598, 719			0. 000000	
74.00	07400 RENAL DIALYSIS	1, 051, 202	114, 589	1, 165, 79			
76.00	03950 MISC ANCILLARY	0	0		0. 000000	0. 000000	
76. 01	03951 SLEEP LAB	0	0		0. 000000		
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	332, 114	2, 735, 925		9 0. 240279	0. 000000	76. 02
76. 03	03952 WOUND CARE	1, 285, 568	3, 420, 246	4, 705, 81	0. 349604	0. 000000	76. 03
OUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	7, 711	122, 374				
	09100 EMERGENCY	8, 870, 489	37, 068, 515			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 096, 282	4, 840, 661			0. 000000	
200.00		293, 859, 778	238, 243, 504	532, 103, 28	2		200. 00
201.00							201. 00
202.00	Total (see instructions)	293, 859, 778	238, 243, 504	532, 103, 28	2		202. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0047	Peri od: Worksheet C From 06/01/2016 Part I To 05/31/2017 Date/Time Prepared:		

					10/30/2017 4:	18 pm
			Title XVIII	Hospi tal	PPS	
Cost C	enter Description	PPS Inpatient				
		Ratio				
		11.00				
I NPATI ENT RO	OUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS	& PEDI ATRI CS					30. 00
31.00 03100 INTENS	IVE CARE UNIT					31. 00
31. 01 02060 NEONAT	AL INTENSIVE CARE UNIT					31. 01
33. 00 03300 BURN I	NTENSIVE CARE UNIT					33. 00
40. 00 04000 SUBPRO	VIDER - IPF					40. 00
43. 00 04300 NURSER						43.00
	D NURSING FACILITY					44. 00
	ERVICE COST CENTERS					1
50. 00 05000 OPERAT		0. 100039				50.00
50. 01 03330 ENDOSC		0. 195552				50. 01
51. 00 05100 RECOVE		0. 233599				51. 00
	RY ROOM & LABOR ROOM	0. 614443				52. 00
53. 00 05300 ANESTH		0. 014443				53. 00
	OGY-DI AGNOSTI C	0. 079433				54. 00
						•
54. 01   03630   ULTRA		0. 000000				54. 01
56. 00   05600 RADI 01		0. 000000				56. 00
57. 00   05700 CT SCA	N	0. 000000				57. 00
58. 00   05800 MRI	0.0471157551.7471.011	0. 000000				58. 00
	C CATHETERI ZATI ON	0. 097047				59. 00
60. 00   06000 LABORA		0. 103717				60.00
1 1	BLOOD & PACKED RED BLOOD CELL	0. 183977				62.00
	ATORY THERAPY	0. 106701				65. 00
66. 00 06600 PHYSI C		0. 299589				66. 00
	TI ONAL THERAPY	0. 195169				67. 00
68. 00   06800   SPEECH		0. 274407				68. 00
69. 00  06900   ELECTR		0. 147213				69. 00
	L SUPPLIES CHARGED TO PATIENT	0. 125493				71. 00
	DEV. CHARGED TO PATIENTS	0. 240887				72. 00
73. 00 07300 DRUGS	CHARGED TO PATIENTS	0. 099876				73. 00
74. 00   07400   RENAL	DIALYSIS	0. 531280				74. 00
76.00 03950 MISC A	NCI LLARY	0. 000000				76. 00
76. 01 03951 SLEEP	LAB	0.000000				76. 01
76. 02 03550 PSYCHI	ATRI C/PSYCHOLOGI CAL SERVI CES	0. 240279				76. 02
76. 03 03952 WOUND	CARE	0. 349604				76. 03
OUTPATIENT S	SERVICE COST CENTERS					
90. 00 09000 CLI NI C		2. 315025				90.00
91. 00 09100 EMERGE	NCY	0. 140641				91. 00
1	ATION BEDS (NON-DISTINCT PART	0. 399266				92.00
1	al (see instructions)					200. 00
1 1	bservation Beds					201. 00
1 1	(see instructions)					202. 00
1.55	(	1				,

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 06/01/2016 To 05/31/2017		pared: 18 pm
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	15, 709, 293		15, 709, 29	3 0	15, 709, 293	30. 00
31.00 03100 INTENSIVE CARE UNIT	899, 579		899, 57	9 0	899, 579	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	1, 425, 603		1, 425, 60	3 0	1, 425, 603	31. 01
33.00 03300 BURN INTENSIVE CARE UNIT	2, 575, 258		2, 575, 25	8 0	2, 575, 258	33. 00
40. 00   04000   SUBPROVI DER - 1 PF	3, 532, 513		3, 532, 51	3 0	3, 532, 513	40.00
43. 00   04300 NURSERY	360, 231		360, 23	1 0	360, 231	43.00
44.00   04400   SKILLED NURSING FACILITY	2, 512, 856		2, 512, 85	6 0	2, 512, 856	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	4, 060, 736		4, 060, 73	6 0	4, 060, 736	50.00
50. 01   03330   ENDOSCOPY	858, 050		858, 05	0	858, 050	50. 01
51.00   05100   RECOVERY ROOM	1, 062, 620		1, 062, 62	0 0	1, 062, 620	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 045, 557		1, 045, 55	7 0	1, 045, 557	52.00
53. 00   05300   ANESTHESI OLOGY	95, 286		95, 28	6 0	95, 286	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	6, 168, 969		6, 168, 96	9 0	6, 168, 969	54.00
54. 01   03630 ULTRA SOUND	0			0 0	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0			0 0	0	56. 00
== 00  0==00 0= 004N		1	1	ه م		

In Lieu of Form CMS-2552-10

| Period: | Worksheet C |
| From 06/01/2016 | Part |
| To 05/31/2017 | Date/Time Prepared: | 10/30/2017 | 4:18 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0047

					.0 00,01,201,	10/30/2017 4:	18 pm
			Ti tl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	I npati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	48, 584, 427		48, 584, 42	7		30. 00
31.00	03100 INTENSIVE CARE UNIT	1, 052, 059		1, 052, 05	9		31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	1, 974, 604		1, 974, 60	4		31. 01
33.00	03300 BURN INTENSIVE CARE UNIT	9, 729, 520		9, 729, 52	0		33. 00
40.00	04000 SUBPROVI DER - I PF	17, 702, 506		17, 702, 50	6		40.00
43.00	04300 NURSERY	736, 956		736, 95	6		43.00
44.00	04400 SKILLED NURSING FACILITY	3, 625, 338		3, 625, 33	8		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	19, 435, 485	21, 156, 038	40, 591, 52	0. 100039	0.000000	50.00
50. 01	03330 ENDOSCOPY	876, 401	3, 511, 434	4, 387, 83	0. 195552	0.000000	50. 01
51.00	05100 RECOVERY ROOM	1, 444, 761	3, 104, 149	4, 548, 91	0. 233599	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 202, 575	499, 059	1, 701, 63	0. 614443	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	3, 102, 822	2, 982, 468	6, 085, 29	0. 015658	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 329, 425	57, 333, 084	77, 662, 50	9 0. 079433	0.000000	54.00
54. 01	03630 ULTRA SOUND	0	0		0. 000000	0.000000	54. 01
56.00	05600 RADI OI SOTOPE	o	0		0. 000000	0.000000	56.00
57.00	05700 CT SCAN	o	0		0. 000000	0.000000	57.00
58.00	05800 MRI	o	0		0. 000000	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	10, 196, 210	14, 897, 301	25, 093, 51	0. 097047	0.000000	59. 00
60.00	06000 LABORATORY	30, 757, 723	33, 879, 769	64, 637, 49	2 0. 103717	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	3, 097, 163	315, 647	3, 412, 81	0. 183977	0.000000	62.00
65.00	06500 RESPI RATORY THERAPY	13, 249, 906	2, 002, 505	15, 252, 41	0. 106701	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 566, 545	1, 422, 322	3, 988, 86	7 0. 299589	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	3, 810, 299	59, 578	3, 869, 87	7 0. 195169	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	515, 664	156, 014	671, 67	8 0. 274407	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 727, 201	2, 247, 904	3, 975, 10	0. 147213	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15, 532, 837	21, 913, 170	37, 446, 00	7 0. 125493	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 706, 694	6, 862, 033			0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	61, 259, 291	17, 598, 719			0.000000	73. 00
74.00	07400 RENAL DI ALYSI S	1, 051, 202	114, 589			0.000000	74. 00
76.00	03950 MISC ANCILLARY	0	0		0. 000000	0.000000	76. 00
76. 01	03951 SLEEP LAB	o	0		0. 000000	0.000000	1
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	332, 114	2, 735, 925	3, 068, 03		0.000000	
76. 03	03952 WOUND CARE	1, 285, 568	3, 420, 246			0.000000	•
	OUTPATIENT SERVICE COST CENTERS	,,					
90.00	09000 CLI NI C	7, 711	122, 374	130, 08	5 2. 315025	0. 000000	90. 00
91. 00	09100 EMERGENCY	8, 870, 489	37, 068, 515			0. 000000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 096, 282	4, 840, 661			0. 000000	•
200.00		293, 859, 778	238, 243, 504				200. 00
201.00							201. 00
202.00		293, 859, 778	238, 243, 504	532, 103, 28	2		202. 00
					1		

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0047	Period: Worksheet C From 06/01/2016 Part I
		To 05/31/2017 Date/Time Prepared

				To 05/31/2017	Date/Time Prep 10/30/2017 4:1	
			Title XIX	Hospi tal	PPS	<u>o p</u>
	Cost Center Description	PPS Inpatient				
		Ratio				
	LABORT FAIT DOUTLAND OFFICE OFFICE	11. 00				
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					00.00
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT					31. 01
33. 00	03300 BURN INTENSIVE CARE UNIT					33. 00
40. 00 43. 00	04000 SUBPROVI DER - I PF					40.00
44. 00	04300 NURSERY					43.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS					44. 00
50. 00	05000 OPERATING ROOM	0. 100039				50. 00
50. 00	03330 ENDOSCOPY	0. 195552				50. 00
50.01	05100 RECOVERY ROOM	0. 233599				50. 01
52. 00		1				
	05200 DELIVERY ROOM & LABOR ROOM	0. 614443				52.00
53.00	05300 ANESTHESI OLOGY	0. 015658				53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0. 079433				54. 00 54. 01
56. 00		0. 000000				
	05600 RADI 0I SOTOPE 05700 CT SCAN	0. 000000				56.00
57. 00		0. 000000				57. 00
58. 00 59. 00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON	0. 000000 0. 097047				58. 00 59. 00
60.00	06000 LABORATORY	0. 103717				60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 103717				62. 00
65. 00	06500 RESPIRATORY THERAPY	0. 106701				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 299589				66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0. 195169				67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 274407				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 147213				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 125493				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 123473				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 099876				73. 00
74. 00	07400 RENAL DIALYSIS	0. 531280				74. 00
76. 00	03950 MISC ANCILLARY	0. 000000				76. 00
76. 00	03951 SLEEP LAB	0. 000000				76. 01
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 240279				76. 01
76. 02	03952 WOUND CARE	0. 349604				76. 02
70.03	OUTPATIENT SERVICE COST CENTERS	0. 34 7004				70.03
90. 00	09000 CLINIC	2. 315025				90. 00
91. 00	09100 EMERGENCY	0. 140641				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 399266				92.00
200.00		0. 377200			l <sub>s</sub>	200. 00
200.00						201. 00
202. 00						202.00
202.00	1.000 (300 (1130)	ı			Į <del>2</del>	.02.00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE C	OST TO CHARGE RATIOS NET OF	Provider CCN: 15-0047		Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 06/01/2016	Part II

KEDOCT	TONS FOR WEDICALD ONE!			To	05/31/2017	Date/Time Prep 10/30/2017 4:	
			Ti tl	e XIX	Hospi tal	PPS	то ріп
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	4, 060, 736	655, 021		0		50.00
	03330 ENDOSCOPY	858, 050	96, 685		0	1	50. 01
	05100 RECOVERY ROOM	1, 062, 620	249, 150	· ·	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 045, 557	220, 555		0	0	52. 00
	05300 ANESTHESI OLOGY	95, 286	9, 245		0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 168, 969	740, 659	5, 428, 310	0	0	54. 00
	03630 ULTRA SOUND	0	0	0	0	0	54. 01
	05600 RADI 0I S0T0PE	0	0	0	0	0	56. 00
	05700 CT SCAN	0	0	0	0	0	57. 00
	05800 MRI	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 435, 247	131, 973		0	0	59. 00
60.00	06000 LABORATORY	6, 704, 012	645, 430		0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	627, 879	40, 048		0	0	62.00
	06500 RESPI RATORY THERAPY	1, 627, 449	238, 400		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 195, 019	279, 760	915, 259	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	755, 280	111, 939		0	0	67. 00
	06800 SPEECH PATHOLOGY	184, 313	41, 399		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	585, 189	46, 893	538, 296	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 699, 214	156, 602	4, 542, 612	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 750, 309	109, 637	3, 640, 672	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	7, 876, 024	235, 944	7, 640, 080	0	0	73. 00
74.00	07400 RENAL DIALYSIS	619, 362	76, 373	542, 989	0	0	74. 00
76.00	03950 MISC ANCILLARY	0	0	0	0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	0	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	737, 185	125, 361	611, 824	0	0	76. 02
76. 03	03952 WOUND CARE	1, 645, 172	326, 538	1, 318, 634	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	301, 150	81, 634	219, 516	0	0	90. 00
	09100 EMERGENCY	6, 460, 904	621, 889	5, 839, 015	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 370, 417	287, 342	2, 083, 075	0	0	
200.00		55, 865, 343	5, 528, 477	50, 336, 866	0	0	200. 00
201.00	Less Observation Beds	2, 370, 417	287, 342	2, 083, 075	0		201. 00
202.00	Total (line 200 minus line 201)	53, 494, 926	5, 241, 135	48, 253, 791	0	0	202. 00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST	T TO CHARGE RATIOS NET OF	Provider CCN: 15-0047	From 06/01/2016	Worksheet C Part II Date/Time Prepared:

			'	0 03/31/201/	10/30/2017 4:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and		Cost to Charge			
	Operating Cost	Part I, column				
	Reduction	8)	/ col . 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	4, 060, 736					50.00
50. 01  03330 ENDOSCOPY	858, 050					50. 01
51.00   05100   RECOVERY ROOM	1, 062, 620	4, 548, 910				51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 045, 557	1, 701, 634	0. 614443			52.00
53. 00   05300   ANESTHESI OLOGY	95, 286	6, 085, 290				53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	6, 168, 969	77, 662, 509	0. 079433			54.00
54.01  03630 ULTRA SOUND	0	0	0.000000			54. 01
56. 00   05600   RADI 01 SOTOPE	0	0	0.000000			56. 00
57. 00  05700   CT   SCAN	0	0	0.000000			57. 00
58. 00   05800   MRI	0	0	0.000000			58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	2, 435, 247	25, 093, 511	0. 097047			59. 00
60. 00   06000   LABORATORY	6, 704, 012	64, 637, 492	0. 103717			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	627, 879	3, 412, 810	0. 183977			62. 00
65. 00 06500 RESPIRATORY THERAPY	1, 627, 449	15, 252, 411	0. 106701			65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 195, 019	3, 988, 867	0. 299589			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	755, 280	3, 869, 877	0. 195169			67. 00
68. 00   06800   SPEECH PATHOLOGY	184, 313	671, 678	0. 274407			68. 00
69. 00   06900   ELECTROCARDI OLOGY	585, 189	3, 975, 105	0. 147213			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 699, 214	37, 446, 007	0. 125493			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 750, 309	15, 568, 727	0. 240887			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 876, 024	78, 858, 010	0. 099876			73. 00
74. 00   07400   RENAL DIALYSIS	619, 362	1, 165, 791	0. 531280			74. 00
76.00 03950 MISC ANCILLARY	0	0	0. 000000			76. 00
76. 01  03951  SLEEP LAB	0	0	0. 000000			76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	737, 185	3, 068, 039	0. 240279			76. 02
76. 03  03952  WOUND CARE	1, 645, 172	4, 705, 814	0. 349604			76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	301, 150	130, 085	2. 315025			90.00
91. 00 09100 EMERGENCY	6, 460, 904	45, 939, 004	0. 140641			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 370, 417	5, 936, 943	0. 399266			92.00
200.00 Subtotal (sum of lines 50 thru 199)	55, 865, 343	448, 697, 872				200.00
201.00 Less Observation Beds	2, 370, 417	0				201.00
202.00 Total (line 200 minus line 201)	53, 494, 926	448, 697, 872				202.00
			1	1		

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Li∈	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider CO		Period: From 06/01/2016 To 05/31/2017		pared: 18 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26) 1. 00	2.00	2) 3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 ADULTS & PEDIATRICS	1, 904, 283	0	1, 904, 28	33 24, 395	78. 06	30.00
31. 00   INTENSIVE CARE UNIT	449, 071	0	449, 07		12, 137, 05	
31. 01 NEONATAL INTENSIVE CARE UNIT	115, 810		115, 81		204. 25	
33. 00 BURN INTENSIVE CARE UNIT	317, 955		317, 95			
40. 00 SUBPROVI DER - I PF	333, 351	0	333, 35	· ·	61. 42	
43. 00 NURSERY	5, 093		5, 09	· ·	8.00	1
44.00 SKILLED NURSING FACILITY	443, 440		443, 44		•	
200.00 Total (lines 30-199)	3, 569, 003		3, 569, 00	37, 171		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
LANDATI ENT. DOUTLANE, OFFICE OF COOT, OFFITEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	E 474	400,000	1			
30. 00 ADULTS & PEDI ATRI CS	5, 174		•			30.00
31.00   INTENSIVE CARE UNIT 31.01   NEONATAL INTENSIVE CARE UNIT	14	169, 919 0	1			31. 00 31. 01
33. 00 BURN INTENSIVE CARE UNIT	187	41, 783				33.00
40. 00 SUBPROVIDER - IPF	3, 278		•			40.00
43. 00   NURSERY	3, 278	201, 333	1			43. 00
44.00 SKILLED NURSING FACILITY	1, 776	168, 098				44. 00
200. 00 Total (lines 30-199)	10, 429					200. 00

Heal th Finan	cial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTI ONMEN	NT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0047	Period: From 06/01/2016 To 05/31/2017		
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B,	Total Charges (from Wkst. C, Part I, col.	to Charges	Program	Capital Costs (column 3 x column 4)	
		Part II, col. 26)	8)	2)			
		1.00	2.00	3.00	4. 00	5. 00	
ANCI LI	LARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	655, 021	40, 591, 523	0. 01613	4, 657, 236	75, 154	50.00
50. 01   03330	ENDOSCOPY	96, 685	4, 387, 835	0. 02203	288, 962	6, 367	50. 01
51.00 05100	RECOVERY ROOM	249, 150	4, 548, 910	0. 05477	<sup>'</sup> 1 283, 750	15, 541	51.00
	DELIVERY ROOM & LABOR ROOM	220, 555		1	19, 408	2, 516	1
53.00 05300	ANESTHESI OLOGY	9, 245	6, 085, 290	0. 00151	9 545, 766	829	53.00
	RADI OLOGY-DI AGNOSTI C	740, 659	77, 662, 509			58, 819	1
	ULTRA SOUND	0	0	0.00000	0 0	0	54. 01
	RADI OI SOTOPE	0	0	0.00000		0	56. 00
	CT SCAN	0	0	0.00000	0 0	0	57. 00
58. 00 05800		0	0	0.00000	00	0	58. 00
	CARDI AC CATHETERI ZATI ON	131, 973	25, 093, 511	0. 00525	2, 817, 567	14, 818	59. 00
	LABORATORY	645, 430	64, 637, 492	0. 00998	7, 192, 961		
	WHOLE BLOOD & PACKED RED BLOOD CELL	40, 048		•	•		

238, 400

279, 760

111, 939

41, 399

46, 893

156, 602

109, 637

235, 944

125, 361

326, 538

81, 634

621, 889

287, 342

5, 528, 477

76, 373

0

15, 252, 411

3, 988, 867

3, 869, 877

3, 975, 105

37, 446, 007

15, 568, 727

78, 858, 010

1, 165, 791

3,068,039

4, 705, 814

45, 939, 004

448, 697, 872

5, 936, 943

130, 085

671, 678

0.015630

0.070135

0.028926

0.061635

0.011797

0.004182

0.007042

0.002992

0.065512

0.000000

0.000000

0.040860

0.069390

0.627544

0.013537

0.048399

3, 826, 692

344, 696

293, 060

57, 594

368, 139

5, 330, 539

2, 267, 655

13, 888, 759

925, 461

16, 828

350, 825

2, 115, 414

52, 855, 209

316, 576

0

59, 811

24 175

8, 477

3, 550

4, 343

22, 292

15, 969

41, 555

60, 629

0

0 76.01

0 90.00

564, 809 200. 00

688

24, 344

28, 636

15, 322

65.00

66 00

67.00

68.00

69.00

71.00

72.00

73.00

74.00

76.00

76.02

76.03

91.00

92.00

06500 RESPIRATORY THERAPY

06700 OCCUPATI ONAL THERAPY

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES

07200 I MPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

Total (lines 50-199)

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

07400 RENAL DIALYSIS

03950 MISC ANCILLARY

03951 SLEEP LAB

03952 WOUND CARE

09000 CLI NI C

91. 00 09100 EMERGENCY

65.00

66 00

67.00

69.00

71 00

72.00

74.00

76.00

76. 01

76.02

76.03

90.00

200.00

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	TS   Provider CO		Peri od:	Worksheet D	
				rom 06/01/2016		
				o 05/31/2017	Date/Time Pre 10/30/2017 4:	
		Title	xVIII	Hospi tal	PPS	то рііі
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
, , , , , , , , , , , , , , , , , , ,		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cost	Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0	(		0	31. 00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0	(		0	31. 01
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	(		0	33.00
40. 00   04000   SUBPROVI DER - 1 PF	0	0		0	0	40.00
43. 00 04300 NURSERY	0	0			0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0			0	44. 00
200.00 Total (lines 30-199)	0	0			0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	24, 395					30.00
31.00 03100 INTENSIVE CARE UNIT	37			0		31. 00
31.01  02060 NEONATAL INTENSIVE CARE UNIT	567			0		31. 01
33.00   03300   BURN INTENSIVE CARE UNIT	1, 423					33. 00
40. 00   04000   SUBPROVI DER - 1 PF	5, 427			0		40. 00
43. 00   04300   NURSERY	637			0		43. 00
44.00   04400   SKILLED NURSING FACILITY	4, 685	0.00	1, 77 <i>6</i>	0		44. 00
200.00 Total (lines 30-199)	37, 171		10, 429	0		200. 00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0047	Peri od:	Worksheet D
THROUGH COSTS			From 06/01/2016	

THROUGH COSTS				o 05/31/2017	Date/Time Pre 10/30/2017 4:	
		Title	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Non Physician Nu	ursing School	Allied Health	All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	0	0	0	50.00
50. 01   03330   ENDOSCOPY	0	0	0	0	0	50. 01
51.00   05100   RECOVERY ROOM	0	0	0	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
54. 01   03630   ULTRA SOUND	0	0	0	0	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	0	0	0	56. 00
57.00  05700   CT SCAN	0	0	0	0	0	57. 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	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62. 00
65. 00  06500   RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00  06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0	0	0	0	74. 00
76.00  03950   MISC ANCILLARY	0	0	0	0	0	76. 00
76. 01  03951   SLEEP LAB	0	0	0	0	0	76. 01
76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	76. 02
76. 03 03952 WOUND CARE	0	0	0	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0	0	0	0	90. 00
91. 00   09100   EMERGENCY	0	0	0	0	0	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92. 00
200.00   Total (lines 50-199)	0	0	0	0	. 0	200. 00

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	S Provider CC		Period: From 06/01/2016 Fo 05/31/2017	Worksheet D Part IV Date/Time Pre 10/30/2017 4:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati 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	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	40, 591, 523	0. 000000	0.000000	4, 657, 236	50.00
50. 01   03330   ENDOSCOPY	0	4, 387, 835	0. 000000	0. 000000	288, 962	50. 01
51.00 05100 RECOVERY ROOM	0	4, 548, 910	0. 000000	0. 000000	283, 750	51.00
52 OO O5200 DELLVERY ROOM & LABOR ROOM	0	1 701 634	0 000000	loooooo l	19 408	52 00

		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of		(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	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	40, 591, 523			4, 657, 236	50. 00
50. 01	03330 ENDOSCOPY	0	4, 387, 835	0.000000	0.000000	288, 962	50. 01
51.00	05100 RECOVERY ROOM	0	4, 548, 910	0.000000	0.000000	283, 750	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 701, 634	0.000000	0. 000000	19, 408	52.00
53.00	05300 ANESTHESI OLOGY	0	6, 085, 290	0.000000	0. 000000	545, 766	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	77, 662, 509	0.000000	0.000000	6, 167, 407	54.00
54. 01	03630 ULTRA SOUND	0	0	0.000000	0.000000	0	54. 01
56. 00	05600 RADI 0I SOTOPE	0	0	0.000000	0.000000	0	56.00
57. 00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58. 00	05800 MRI	0	0	0.000000	0.000000	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	25, 093, 511	0. 000000	0.000000	2, 817, 567	59. 00
60. 00	06000 LABORATORY	0	64, 637, 492	0. 000000	0.000000	7, 192, 961	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 412, 810	0. 000000	0.000000	779, 914	62. 00
65. 00	06500 RESPI RATORY THERAPY	0	15, 252, 411	0.000000	0. 000000	3, 826, 692	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	3, 988, 867	0.000000	0. 000000	344, 696	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	3, 869, 877	0.000000	0. 000000	293, 060	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	671, 678	0.000000	0. 000000	57, 594	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	3, 975, 105	0.000000	0. 000000	368, 139	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	37, 446, 007	0.000000	0. 000000	5, 330, 539	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	15, 568, 727	0.000000	0. 000000	2, 267, 655	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	78, 858, 010	0.000000	0. 000000	13, 888, 759	73. 00
74. 00	07400 RENAL DIALYSIS	0	1, 165, 791	0.000000	0. 000000	925, 461	74. 00
76. 00	03950 MISC ANCILLARY	0	0	0.000000	0. 000000	0	76. 00
76. 01	03951 SLEEP LAB	0	0	0.000000	0. 000000	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	3, 068, 039	0.000000	0. 000000	16, 828	76. 02
76. 03	03952 WOUND CARE	0	4, 705, 814	0.000000	0. 000000	350, 825	76. 03
	OUTPATIENT SERVICE COST CENTERS			<b>'</b>			
90. 00	09000 CLI NI C	0	130, 085	0.000000	0.000000	0	90.00
91. 00	09100 EMERGENCY	0	45, 939, 004	0. 000000	0. 000000	2, 115, 414	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 936, 943			316, 576	
200.00		0				52, 855, 209	
'		•		•	'		•

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0047	Peri od: From 06/01/2016 To 05/31/2017	Worksheet D Part IV Date/Time Prepared:

				10 05/31/201/	10/30/2017 4:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS				_		
50.00   05000   OPERATING ROOM	0	4, 520, 723	(	D		50.00
50. 01   03330   ENDOSCOPY	0	843, 541	(			50. 01
51.00   05100   RECOVERY ROOM	0	1, 306, 459	(			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	12, 442	(			52.00
53. 00 05300 ANESTHESI OLOGY	0	504, 228	(			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	8, 804, 650	(			54.00
54. 01   03630   ULTRA SOUND	O	0				54. 01
56. 00   05600   RADI OI SOTOPE	o	0				56. 00
57. 00  05700 CT SCAN	o	0				57. 00
58. 00   05800   MRI	o	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	3, 465, 140				59. 00
60. 00   06000   LABORATORY	o	2, 329, 310				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	100, 023				62. 00
65. 00 06500 RESPIRATORY THERAPY	o	419, 123				65. 00
66. 00 06600 PHYSI CAL THERAPY	o	13, 926				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	7, 326				67. 00
68. 00 06800 SPEECH PATHOLOGY	o	2, 763				68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	400, 142				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	7, 157, 737				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	2, 332, 851				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	3, 160, 977				73. 00
74. 00 07400 RENAL DIALYSIS	o	105, 598				74.00
76. 00 03950 MISC ANCILLARY	o	0				76. 00
76. 01 03951 SLEEP LAB	o	0				76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	1, 298, 188				76. 02
76. 03   03952   WOUND CARE	o	1, 028, 023				76. 03
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			_		
90. 00 09000 CLI NI C	0	11, 874				90.00
91. 00 09100 EMERGENCY	l ol	3, 981, 516				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	l ol	844, 610				92. 00
200.00 Total (lines 50-199)	O	42, 651, 170				200. 00

Heal th	Financial Systems	ST JOSEPH MED	DICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der C		Period: From 06/01/2016 To 05/31/2017		pared:
			Ti tl e	: XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	<b>'</b>	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	, ,	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	_					
50. 00	05000 OPERATING ROOM	0. 100039			0	452, 249	
50. 01	03330 ENDOSCOPY	0. 195552			0	164, 956	
51. 00	05100 RECOVERY ROOM	0. 233599			0	305, 188	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 614443			0	7, 645	
53.00	05300 ANESTHESI OLOGY	0. 015658			0	7, 895	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 079433			0	699, 380	54.00
54. 01	03630 ULTRA SOUND	0. 000000	0		0	0	54. 01
56. 00	05600 RADI OI SOTOPE	0.000000			0	0	56. 00
57.00	05700  CT SCAN	0.000000			0	0	57. 00
58. 00	05800  MRI	0. 000000	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 097047			0	336, 281	59. 00
60.00	06000 LABORATORY	0. 103717		8, 83	4 0	241, 589	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 183977			0	18, 402	62. 00
65.00	06500 RESPI RATORY THERAPY	0. 106701			0	44, 721	
66. 00	06600 PHYSI CAL THERAPY	0. 299589			0	4, 172	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 195169			0	1, 430	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 274407	2, 763		0	758	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 147213		•	0	58, 906	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 125493			0	898, 246	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 240887			0	561, 953	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 099876			20, 346	315, 706	
74. 00	07400 RENAL DI ALYSI S	0. 531280			0	56, 102	1
76. 00	03950 MISC ANCILLARY	0. 000000			0	0	76. 00
76. 01	03951 SLEEP LAB	0. 000000	l control of the cont		0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 240279			0	311, 927	
76. 03	03952 WOUND CARE	0. 349604	1, 028, 023	(	0	359, 401	76. 03
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	2. 315025			0	27, 489	
91. 00	09100 EMERGENCY	0. 140641			0	559, 964	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 399266			0	337, 224	
200.00			42, 651, 170	8, 83		5, 771, 584	
201.00					0		201. 00
000 =	Only Charges		40 /51 /55				000 00
202.00	Net Charges (line 200 +/- line 201)		42, 651, 170	8, 83	4 20, 346	5, 771, 584	J202. 00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDI CAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0047	Peri od: From 06/01/2016	

				From 06/01/2016 To 05/31/2017	Part V Date/Time Pre 10/30/2017 4:	epared: 18 pm
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost Reimbursed Services Subject To	Cost Reimbursed Services Not Subject To				
	Ded. & Coins. (see inst.)	Ded. & Coins.				
	6.00	(see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	O				50.00
50. 01  03330  ENDOSCOPY	0					50.00
51. 00   05100   RECOVERY ROOM	0					51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0					52. 00
53. 00   05300   ANESTHESI OLOGY	0	l ol				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01   03630   ULTRA SOUND	0	ol				54. 01
56. 00   05600   RADI 0I SOTOPE	0	o				56. 00
57. 00 05700 CT SCAN	0	o				57. 00
58. 00   05800   MRI	0	o				58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	o				59. 00
60. 00   06000   LABORATORY	916	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62. 00
65. 00   06500   RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	2, 032				73.00
74. 00   07400   RENAL DI ALYSI S 76. 00   03950   MI SC ANCI LLARY	0	0				74. 00 76. 00
76. 00   03950   MESC ANCITELARY 76. 01   03951   SLEEP LAB	0	0				76. 00
76. 01   03931  SLEEP LAB  76. 02   03550  PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES						76. 01
76. 03   03952   WOUND CARE	0					76. 02
OUTPATIENT SERVICE COST CENTERS		<u> </u>				70.03
90. 00 09000 CLINIC	1 0	O				90.00
91. 00   09100   EMERGENCY	o o					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
200.00 Subtotal (see instructions)	916	2, 032				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201. 00
202.00   Net Charges (line 200 +/- line 201)	916	2, 032				202. 00

Health Financial Systems	CT LOCEDII MED	NICAL CENTED		المانما	u of Form CMC (	DEE2 10
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	ST JOSEPH MED	Provider C	CN: 15 0047	Period:	u of Form CMS-2 Worksheet D	2552-10
AFFORTIONWENT OF THEATTENT ANGIELARY SERVICE CAPITA	AL 00313		CCN: 15-S047	From 06/01/2016 To 05/31/2017	Part II Date/Time Pre 10/30/2017 4:	pared: 18 pm
-		Title	xVIII	Subprovi der -	PPS	то рііі
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	·	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	/55.004	10 504 500			4.0	
50.00   05000   OPERATING ROOM	655, 021					
50. 01   03330   ENDOSCOPY	96, 685				38	•
51. 00 05100 RECOVERY ROOM	249, 150					1
52.00 05200 DELIVERY ROOM & LABOR ROOM	220, 555				0	52. 00
53. 00   05300   ANESTHESI OLOGY	9, 245				93	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	740, 659	77, 662, 509			4, 136	1
54. 01  03630 ULTRA SOUND	0	0	0.00000		0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0			0	56. 00
57. 00  05700 CT SCAN	0	0	0.00000		0	57. 00
58. 00  05800   MRI	0	0	0.00000		0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	131, 973	25, 093, 511			0	59. 00
60. 00   06000   LABORATORY	645, 430	64, 637, 492	0.00998	1, 094, 818	10, 932	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	40, 048	3, 412, 810	0. 01173	35 0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	238, 400	15, 252, 411	0. 01563	117, 651	1, 839	65. 00
66. 00   06600   PHYSI CAL THERAPY	279, 760	3, 988, 867	0. 07013	206, 751	14, 500	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	111, 939	3, 869, 877	0. 02892	26 276, 488	7, 998	67. 00
68.00 06800 SPEECH PATHOLOGY	41, 399	671, 678	0. 06163	33, 187	2, 045	68. 00
69. 00 06900 ELECTROCARDI OLOGY	46, 893	3, 975, 105	0. 01179	60, 685	716	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	156, 602	37, 446, 007	0. 00418	63, 762	267	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	109, 637	15, 568, 727	0. 00704	12 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	235, 944	78, 858, 010	0.00299	1, 998, 516	5, 980	73. 00
74. 00   07400   RENAL DIALYSIS	76, 373	1, 165, 791	0. 06551	36, 078	2, 364	74. 00
76.00 03950 MISC ANCILLARY	0	0	0. 00000	00	0	76. 00
76. 01   03951   SLEEP LAB	0	0	0. 00000	00	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	125, 361	3, 068, 039			9, 189	
76. 03 03952 WOUND CARE	326, 538				247	76. 03
OUTPATIENT SERVICE COST CENTERS		.,				
90. 00 09000 CLINIC	81, 634	130, 085	0. 62754	14 0	0	90. 00
91. 00 09100 EMERGENCY	621, 889				4, 881	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92. 00
200.00   Total (lines 50-199)	5, 241, 135			5, 221, 674	78, 427	

	5	CT LOCEDIL MEDI	OAL OFNITED			6.5. 040	0550 40
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	ST JOSEPH MEDI		^N: 15_0047	Period:	eu of Form CMS-2 Worksheet D	2552-10
	COSTS	WIGE OTHER TASS		CCN: 15-S047	From 06/01/2016 To 05/31/2017	Part IV	
			Title	: XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Non Physician N	Nursing School	Allied Heal	th All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost		
		1.00	2. 00	3.00	4. 00	4) 5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
50. 01	03330 ENDOSCOPY	0	0	l .	0 0	0	50. 01
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53.00	05300 ANESTHESI OLOGY	0	0		0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	
54. 01	03630 ULTRA SOUND	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	1
58. 00	05800 MRI	0	0		0 0	0	
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	0	0		0 0	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
65. 00	06500 RESPIRATORY THERAPY	0	0				1
66. 00	06600 PHYSI CAL THERAPY	0	0				
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	o o	1
68. 00	06800 SPEECH PATHOLOGY	o	0		0 0	o o	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	0		0 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	1
74. 00	07400 RENAL DI ALYSI S	0	0		0	0	
76. 00	03950 MISC ANCILLARY	0	0		0 0	0	1
76. 01	03951 SLEEP LAB	0	0		0 0	0	1
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	1	
76. 03	03952 WOUND CARE OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	76. 03
00 00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY		0				
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0	•			
200.00	,		0		o o		200. 00
		-1		1	1	'	1 1 2 2 2

Health Financial Systems	ST JOSEPH MED	DICAL CENTER		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 15-0047	Peri od:	Worksheet D	2002 10
THROUGH COSTS				From 06/01/2016	Part IV	
		Component	CCN: 15-S047	To 05/31/2017	Date/Time Pre 10/30/2017 4:	pared:
		Title	xVIII	Subprovi der -	PPS	то ріп
				IPF		
Cost Center Description	Total	Total Charges			Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
	4)	7.00	0.00	7)	10.00	
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
50. 00 05000 OPERATING ROOM	0	40, 591, 523	0.00000	0. 000000	10, 420	50.00
50. 01   03330   ENDOSCOPY					1, 737	50.00
51. 00   05100 RECOVERY ROOM					237, 967	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		1, 701, 634			237, 407	
53. 00   05300   ANESTHESI OLOGY					60, 925	
54. 00   05400   RADI OLOGY - DI AGNOSTI C					433, 642	
54. 01   03630  ULTRA SOUND	0	77,002,307			133, 042	1
56. 00   05600   RADI OI SOTOPE	0	٥			0	
57. 00   05700   CT   SCAN	0	0	1		0	1
58. 00   05800   MRI	Ö	0	•		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		•		0	
60. 00   06000   LABORATORY	0				1, 094, 818	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 412, 810	0. 00000	0. 000000	0	1
65. 00 06500 RESPIRATORY THERAPY	0				117, 651	65.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 988, 867	0.00000	0. 000000	206, 751	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	3, 869, 877	0.00000	0. 000000	276, 488	67.00
68. 00 06800 SPEECH PATHOLOGY	0	671, 678	0.00000	0. 000000	33, 187	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 975, 105	0.00000	0. 000000	60, 685	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	37, 446, 007			63, 762	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0				1, 998, 516	1
74. 00   07400   RENAL DI ALYSI S	0	1, 165, 791			36, 078	
76. 00 03950 MISC ANCILLARY	0	0			0	
76. 01 03951 SLEEP LAB	0				0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	-,,			224, 884	
76. 03 03952 WOUND CARE	0	4, 705, 814	0. 00000	0. 000000	3, 562	76. 03
OUTPATIENT SERVICE COST CENTERS	-	100		al a aas	_	
90. 00   09000   CLI NI C	0					
91. 00   09100   EMERGENCY	0				360, 601	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-, ,		0. 000000	0	92.00
200.00   Total (lines 50-199)	0	448, 697, 872	I	1	5, 221, 674	J∠UU. UU

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provider CCN: 15-0047	Peri od: From 06/01/2016	Worksheet D Part IV
		Component CCN: 15-S047	To 05/31/2017	Date/Time Prepared: 10/30/2017 4:18 pm
		Title XVIII	Subprovi der -	PPS

Cost Center Description			litte	e XVIII	I PF	PPS	
Program   Program   Program   Program   Pass-Through   Casts (col 8 x col 10)   To 10 to	Cost Center Description	Innationt	Outnationt	Outpatient	IFF		
Pass-Through Costs (col   8   x col   10)   12.00   13.00	cost center bescription						
Costs (col. 8							
ANCILLARY SERVICE COST CENTERS			char ges		1		
NICLILARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS			12.00		_		
50. 01   03330   INDOSCOPY   0   0   0   0   0   55. 01	ANCI LLARY SERVI CE COST CENTERS	1 11100					
51. 00   05100   RECOVERY ROOM   CO   CO   CO   CO   CO   CO   CO	50. 00 05000 OPERATING ROOM	0	0	(	O		50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   0	50. 01 03330 ENDOSCOPY	o	0		0		50. 01
53. 00   05300   ANESTHESI OLOGY   0   0   0   0   53. 00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0   2, 363   0   54. 00   55. 00   05600   RADI OLOGY-DI AGNOSTI C   0   0   0   0   55. 00   05600   RADI OLOGY-DI AGNOSTI C   0   0   0   56. 00   05600   RADI OLOGY-DI AGNOSTI C   0   0   0   57. 00   05700   CT SCAN   0   0   0   0   58. 00   05800   MRI   0   0   0   0   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   60. 00   06000   LABORATORY   0   0   0   61. 00   06000   LABORATORY   0   0   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   63. 00   06500   RESPI RATORY THERAPY   0   274   0   64. 00   06600   PHYSI CAL THERAPY   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   526   0   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   67. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   506   0   67. 00   07300   RRINAL DI ALYSI S   0   0   0   67. 00   07400   RENAL DI ALYSI S   0   0   0   67. 00   07500   MISC ANCI LLARY   0   0   0   67. 00   07500   MISC ANCI LLARY   0   0   0   67. 00   07500   MISC ANCI LLARY   0   0   0   67. 00   07500   CLI NI C   0   0   67. 00   09000   CLI NI C   0   0   67. 00   09000   CLI NI C   0   67. 00   09000   CLI NI C   0   0   67. 00   09000   CLI NI C   0   67. 00   09000   CLI NI C   0   67. 00   09000   CLI NI C   0   0   67. 00   09000   CLI	51. 00   05100   RECOVERY ROOM	o	0		o		51. 00
54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         2, 363         0         54. 00           54. 01         03630         ULTRA SOUND         0         0         0         0         55. 00         56. 00         56. 00         56. 00         56. 00         56. 00         56. 00         56. 00         56. 00         56. 00         57. 00         57. 00         57. 00         57. 00         57. 00         57. 00         57. 00         57. 00         58. 00         0         0         0         0         57. 00         58. 00         58. 00         0         0         0         0         0         59. 00         69.00         0         0         0         59. 00         69.00         60.00         60.00         0 </td <td>52.00 05200 DELIVERY ROOM &amp; LABOR ROOM</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>52.00</td>	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
54. 01 03630 ULTRA SOUND 56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 557. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 577. 00 58. 00 05800 MRI 0 0 0 0 0 0 0 0 5800 MRI 0 0 0 0 0 0 0 0 5800 MRI 0 0 0 0 0 0 0 0 0 5800 MRI 0 0 0 0 0 0 0 0 0 0 5800 MRI 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
54. 01 03630   ULTRA SOUND 56. 00   05600   RADI 01 SOTOPE   0 0 0 0 0   0   56. 00 57. 00   05700   CT SCAN   0 0 0 0   0   0   57. 00 58. 00   05800   MRI   0 0 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 5, 964   0   0   0   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0 0 0   0   0   0   65. 00   06500   RESPI RATORY   THERAPY   0   274   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0 0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0 0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   74. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   76. 01   03951   SLEEP LAB   0   0   0   76. 01   03951   SLEEP LAB   0   0   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   76. 03   007900   CLINI C   0   0   79. 00   09000   CLINI C   0   79. 00   09000   CLINI C   0   0   79. 00   09000   CLINI C   0   79. 00   09000   CLINI C   0   0   7	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 363		0		54.00
57. 00   05700   CT SCAN   0   0   0   0   0   57. 00   58. 00   05800   MRI	54. 01 03630 ULTRA SOUND	0	0		O		54. 01
58. 00         05800 MRI         0         0         0         0         59. 00           59. 00         05900 CARDI AC CATHETERI ZATI ON         0         0         0         0         59. 00           60. 00         06000 LABORATORY         0         5,964         0         60. 00           62. 00         06200 WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0         0           65. 00         06500 RESPI RATORY THERAPY         0         274         0         65. 00           66. 00         06500 PHYSI CAL THERAPY         0         0         0         65. 00           67. 00         06700 OCCUPATI ONAL THERAPY         0         0         0         66. 00           68. 00         06800 SPEECH PATHOLOGY         0         0         0         67. 00           68. 00         06900 ELECTROCARDI OLOGY         0         0         0         68. 00           69. 00         06900 ELECTROCARDI OLOGY         0         0         0         69. 00           71. 00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0         0         0         71. 00           72. 00         07200 IMPL. DEV. CHARGED TO PATI ENTS         0         0         0 <t< td=""><td>56. 00 05600 RADI 0I SOTOPE</td><td>0</td><td>0</td><td></td><td>O</td><td></td><td>56.00</td></t<>	56. 00 05600 RADI 0I SOTOPE	0	0		O		56.00
59. 00       05900 CARDIAC CATHETERIZATION       0       0       0       59. 00         60. 00       06000 LABORATORY       0       5, 964       0       60. 00         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       0         65. 00       06500 RESPI RATORY THERAPY       0       0       0       0       65. 00         66. 00       06600 PHYSI CAL THERAPY       0       0       0       0       66. 00         67. 00       06700 0CCUPATI ONAL THERAPY       0       0       0       0       67. 00         68. 00       06800 SPEECH PATHOLOGY       0       0       0       0       67. 00         69. 00       06900 ELECTROCARDI OLOGY       0       0       0       0       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0       0       0       0       69. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       71. 00         72. 00       07200 DIMPL. DEV. CHARGED TO PATI ENTS       0       0       0       72. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0       0       0       73. 00         76. 01 </td <td>57. 00 05700 CT SCAN</td> <td>o</td> <td>0</td> <td></td> <td>O</td> <td></td> <td>57.00</td>	57. 00 05700 CT SCAN	o	0		O		57.00
60. 00   06000   LABORATORY   0   0   5, 964   0   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0   274   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   526   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   506   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   76. 00   03951   SLEEP LAB   0   0   0   76. 01   03951   SLEEP LAB   0   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   70. 00   09000   CLI NI C   0   70. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART ) 0   0   70. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART )	58. 00 05800 MRI	o	0		O		58.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 65. 00 65. 00 65. 00 65.00 RESPI RATORY THERAPY 0 0 274 0 65. 00 66.	59. 00 05900 CARDI AC CATHETERI ZATI ON	O	0	) (	O		59.00
65. 00	60. 00   06000   LABORATORY	o	5, 964	.  (	O		60.00
66. 00   06600   06600   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   0   0   0	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0	) (	O		62.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68.00 69.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 526 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 72.00 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73.00 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 74.00 RENAL DI ALYSI S 0 0 0 0 0 74.00 RENAL DI ALYSI S 0 0 0 0 0 74.00 RENAL DI ALYSI S 0 0 0 0 0 76.01 03951 SLEEP LAB 0 0 0 0 0 76.01 76.01 03951 SLEEP LAB 0 0 0 0 0 76.01 76.01 03952 WOUND CARE 0 0 0 0 0 0 76.02 76.02 03952 WOUND CARE 0 0 0 0 0 0 0 76.02 76.02 03950 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY	o	274	.  (	O		65.00
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   526   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   76. 00   03950   MI SC ANCI LLARY   0   0   0   0   76. 01   03951   SLEEP LAB   0   0   0   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   76. 03   03952   WOUND CARE   0   0   0   76. 04   09000   CLI NI C   0   0   90. 00   09000   CLI RIC   0   0   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   92. 00   09000   DEMERGENCY   0   92. 00   94. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   95. 00   09000	66. 00 06600 PHYSI CAL THERAPY	O	0	) (	O		66.00
69. 00   06900   ELECTROCARDI OLOGY   0   526   0   69. 00   71. 00   71. 00   77. 0	67. 00 06700 OCCUPATI ONAL THERAPY	O	0	)	O		67.00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0	0	)	O		68.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0	69. 00 06900 ELECTROCARDI OLOGY	0	526		O		69.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   506   0   73. 00   74. 00   74. 00   74. 00   74. 00   74. 00   75. 00   0   0   0   0   0   0   0   0   0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	) (	0		71.00
74. 00   07400   RENAL DI ALYSI S   0   0   0   0   74. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 01   76. 02   76. 02   76. 02   76. 03   76. 02   76. 03   76. 02   76. 03   76. 04   76. 02   76. 03   76. 04   76. 05   76. 02   76. 03   76. 04   76. 05   76. 0	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	) (	O		72.00
76. 00 03950 MI SC ANCI LLARY 0 0 0 0 0 76. 00 76. 01 03951 SLEEP LAB 0 0 0 0 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76. 02 76. 03 03952 WOUND CARE 0 0 0 0 0 76. 03 00172 WOUND CARE 0 0 0 0 0 76. 03 00172 WOUND CARE 0 0 0 0 0 0 76. 03 00172 WOUND CARE 0 0 0 0 0 0 90.00 00172 WOUND CARE 0 0 0 0 0 90.00 00172 WOUND CARE 0 0 0 0 0 90.00 00172 WOUND CARE 0 0 0 0 0 90.00 00172 WOUND CARE 0 0 0 0 90.00 00172 WOUND CARE 0 0 0 0 90.00 00172 WOUND CARE 0 0 0 90.00 00172 WOUND CARE 0 0 90.00 00172 WOUND CARE 0 0 90.00 00172 WOUND CARE 0 0 90.00 00173 WOUND CARE 0 0 90.00 00174 WOUND CARE 0 0 90.00 00175 WOUND CARE 0	73.00 07300 DRUGS CHARGED TO PATIENTS	0	506		O		73.00
76. 01 03951 SLEEP LAB 0 0 0 0 76. 01 76. 02 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76. 02 76. 03 03952 WOUND CARE 0 0 0 0 0 0 76. 03 04 05 05 05 05 05 05 05 05 05 05 05 05 05	74.00 07400 RENAL DIALYSIS	0	0	) (	O		74.00
76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   76. 02   76. 03	76.00 03950 MISC ANCILLARY	0	0	) (	O		76.00
76. 03   03952   WOUND CARE   0 0 0 0   0   76. 03	76. 01   03951   SLEEP LAB	0	0	) (	O		76. 01
OUTPATIENT SERVICE COST CENTERS   90.00   90.00   0   0   0   0   0   0   0   0   0	76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	) (	O		76.02
90. 00   09000   CLI NI C   0   0   0   90. 00   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   0   0   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   0   0   0   0   0   0	76. 03   03952   WOUND CARE	0	0	) (	O		76.03
91. 00   09100   EMERGENCY   0   8, 430   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0   0   0   0   0   0   0   0   0	OUTPATIENT SERVICE COST CENTERS						
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0 0 0 92. 00		0	0		0		90.00
		0	8, 430	) (	C		
200. 00   Total (Lines 50-199)   0   18, 063   0   200. 00		1	0		O		
	200.00   Total (lines 50-199)	0	18, 063		O		200. 00

Health Financial Systems ST JOSE	PH MEDICAL CENT	ER .	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE			From 06/01/2016		
		Title XVIII	Subprovi der - I PF	PPS	
		Charges		Costs	

					10/30/2017 4.	10 piii
		Title	XVIII	Subprovi der -	PPS	
				I PF		
			Charges		Costs	
Cost Center Description	Cost to Charge F	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9	Í	Subject To	Subject To		
	·		Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1, 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 100039	0		0 0	0	50.00
50. 01 03330 ENDOSCOPY	0. 195552	0		0 0		50. 01
51. 00   05100   RECOVERY   ROOM	0. 233599	0		0 0	0	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0. 614443	0			0	52.00
1 I	0. 015658	0		0	•	•
· · · · · · · · · · · · · · · · · · ·	1	0 2/2		0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 079433	2, 363		0	188	54.00
54. 01   03630   ULTRA SOUND	0. 000000	0		0	0	54. 01
56. 00   05600   RADI 01 SOTOPE	0. 000000	0		0	0	56. 00
57. 00  05700   CT SCAN	0. 000000	0		0	0	57. 00
58. 00  05800   MRI	0. 000000	0		0	0	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 097047	0		0	0	59. 00
60. 00   06000   LABORATORY	0. 103717	5, 964		0 0	619	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 183977	0		0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 106701	274		0 0	29	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 299589	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 195169	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 274407	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 147213	526		o o	77	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 125493	0		0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 240887	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 099876	506		0 0	1	73.00
				0	51	•
	0. 531280	0		0	0	74.00
76. 00 03950 MI SC ANCI LLARY	0. 000000	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. 240279	0		0	1	76. 02
76. 03 03952 WOUND CARE	0. 349604	0		0 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	2. 315025	0		0 0	0	90.00
91. 00   09100   EMERGENCY	0. 140641	8, 430		0 0	1, 186	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 399266	0		0 0	0	92.00
200.00 Subtotal (see instructions)		18, 063		0 0	2, 150	200. 00
201.00 Less PBP Clinic Lab. Services-Program				ol o	,	201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		18, 063		0 0	2, 150	202. 00
	1	.5,000	1	-1	_, 100	,

Health Financial Systems	ST JOSEPH MED	NICAL CENTED		In Lie	u of Form CMS-2	2552 1 <i>0</i>
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES		Provider Co	CN: 15-0047	Peri od: From 06/01/2016	Worksheet D	2552-11
		Component	CCN: 15-S047		Date/Time Pre 10/30/2017 4:	pared: 18 pm
		Title	· XVIII	Subprovi der - I PF	PPS	
	Co:	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				

				***	
		Co:	sts		
	Cost Center Description	Cost	Cost		
		Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
		Ded. & Coins.			
		(see inst.)	(see inst.)		
		6. 00	7. 00		
	LLARY SERVICE COST CENTERS				
	OO OPERATING ROOM	0	0	)	50.00
	BO ENDOSCOPY	0	0	)	50. 01
	OO RECOVERY ROOM	0	0	)	51. 00
	DO DELIVERY ROOM & LABOR ROOM	0	0	)	52. 00
53.00 0530	OO ANESTHESI OLOGY	0	0	)	53.00
54.00 0540	OO RADI OLOGY-DI AGNOSTI C	0	0		54.00
54. 01   0363	30 ULTRA SOUND	0	0		54. 01
56.00 0560	00 RADI OI SOTOPE	0	0		56. 00
57. 00 0570	OO CT SCAN	0	0		57. 00
58.00 0580	OO MRI	0	0		58. 00
59.00 0590	OO CARDIAC CATHETERIZATION	0	0		59. 00
60.00 0600	00 LABORATORY	0	0		60.00
62.00 0620	00 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62. 00
65.00 0650	00 RESPI RATORY THERAPY	0	0		65. 00
66.00 0660	00 PHYSI CAL THERAPY	0	0		66. 00
67. 00 0670	OCCUPATIONAL THERAPY	0	0		67. 00
68.00 0680	OO SPEECH PATHOLOGY	0	0		68. 00
69.00 0690	OO ELECTROCARDI OLOGY	0	0	)	69. 00
71. 00 0710	NO MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71. 00
72.00 0720	OO IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	0	0		73. 00
74. 00 0740	OO RENAL DIALYSIS	0	0		74. 00
76. 00 0395	50 MISC ANCILLARY	0	0		76. 00
76. 01 0395	S1 SLEEP LAB	0	0		76. 01
76. 02 0355	O PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		76. 02
	2 WOUND CARE	0	0		76. 03
	PATIENT SERVICE COST CENTERS				
	DO CLI NI C	0	0		90.00
	OO EMERGENCY	0	Ö		91. 00
	OO OBSERVATION BEDS (NON-DISTINCT PART	0	0		92. 00
200.00	Subtotal (see instructions)	1	ol o		200.00
201.00	Less PBP Clinic Lab. Services-Program	1			201. 00
	Only Charges				
202. 00	Net Charges (line 200 +/- line 201)	0	0		202. 00
		1	· ·	1 Control of the Cont	

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ST JOSEPH MEDI RVI CE OTHER PASS	Provi der C	CN: 15-0047 CCN: 15-5356	Period: From 06/01/2016 To 05/31/2017		
		Ti tl e	e XVIII	Skilled Nursing Facility		
Cost Center Description	Non Physician N Anesthetist Cost	lursing School			4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	C	ı	O C	0	50.00
50. 01 03330 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 OL SOTOPE 57. 00 05700 CT SCAN 58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 76. 00 03950 MI SC ANCI LLARY 76. 01 03951 SLEEP LAB 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 03 03952 WOUND CARE						50. 01 51. 00 52. 00 53. 00 54. 01 56. 00 57. 00 58. 00 60. 00 62. 00 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 74. 00 76. 01 76. 01 76. 02
90. 00   09000   CLINIC   91. 00   092	0 0 0 0	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	91. 00

Health Financial Systems	ST JOSEPH MED				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	S Provider C	CN: 15-0047	Peri od: From 06/01/2016	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15-5356	To 05/31/2017	Date/Time Pre 10/30/2017 4:	pared: 18 pm
		Ti tl e	e XVIII	Skilled Nursing Facility	PPS	•
Cost Center Description	Total	Total Charges	Ratio of Cos		Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00		7)	10.00	
ANCILLARY CERVICE COCT CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0	40, 591, 523	0.0000	0. 000000	0	50.00
50. 00   03300   07ERATTING   ROOM 50. 01   03330   ENDOSCOPY	0	4, 387, 835	1		0	
51. 00   05100   RECOVERY   ROOM	0	4, 548, 910	1		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 701, 634			ő	
53. 00   05300   ANESTHESI OLOGY	0	6, 085, 290			0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	77, 662, 509		0. 000000	98, 285	54.00
54. 01   03630   ULTRA SOUND	0	C	0.00000	0. 000000	0	54. 01
56. 00   05600   RADI OI SOTOPE	0	C			0	
57. 00   05700   CT   SCAN	0	C	7 0.00000		0	
58. 00   05800   MRI	0	(	, 0,0000		0	
59. 00   05900   CARDI AC   CATHETERI ZATI ON   60. 00   06000   LABORATORY	0	25, 093, 511			0	
60. 00   06000   LABORATORY 62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0	64, 637, 492 3, 412, 810	1		313, 199 9, 359	
65. 00 06500 RESPI RATORY THERAPY	0	15, 252, 411			284, 956	
66. 00 06600 PHYSI CAL THERAPY	0	3, 988, 867	1		848, 106	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	3, 869, 877	1		848, 726	
68. 00 06800 SPEECH PATHOLOGY	0	671, 678	0. 00000	0. 000000	8, 751	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 975, 105			5, 492	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	37, 446, 007			100, 706	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	15, 568, 727			0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	78, 858, 010			2, 215, 833	
74. 00   07400   RENAL DI ALYSI S 76. 00   03950   MI SC ANCI LLARY	0	1, 165, 791			0	
76. 00   03950 MI SC ANCILLARY 76. 01   03951   SLEEP LAB	0		1		0	
76. 01 03931 SLEEP LAB  76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	3, 068, 039	1		0	
76. 03   03952   WOUND CARE	0	4, 705, 814			44, 072	
OUTPATIENT SERVICE COST CENTERS		.,,.55,611	2. 20000		,072	1
90. 00 09000 CLINIC	0	130, 085	0.00000	0. 000000	0	90.00
91. 00 09100 EMERGENCY	0				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 936, 943	1	0. 000000	0	
200.00 Total (lines 50-199)	0	448, 697, 872	2		4, 777, 485	200.00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS		From 06/01/2016	
		Component CCN: 15-5356	10 05/31/201/	10/30/2017 4:18 pm
		Title XVIII	Skilled Nursing	PPS

		Title	e XVIII	Skilled Nursing	PPS	
	1			Facility		
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col.	9		
	x col . 10)	12.00	x col . 12)			
ANCILLARY SERVICE COST CENTERS	11.00	12. 00	13. 00			
50. 00   05000   OPERATING ROOM			\			50.00
50. 00   03000   0PERATTING   ROOM 50. 01   03330   ENDOSCOPY	0	0		0		50.00
51. 00   05100   RECOVERY   ROOM	0	0				51.00
	0	0	()	0		51.00
	0	0	(	0		
53. 00 05300 ANESTHESI OLOGY	0	0	(	0		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	0		54. 00
54. 01   03630   ULTRA   SOUND	0	0	2	0		54. 01
56. 00   05600   RADI OI SOTOPE	0	0	2	0		56.00
57. 00   05700 CT SCAN	0	0	2	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	0	)	0		60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	)	0		62. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	)	0		65. 00
66. 00   06600   PHYSI CAL THERAPY	0	0	)	0		66. 00
67. 00   06700   0CCUPATI 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   MI SC   ANCI LLARY	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	_1			_		
90. 00   09000   CLI NI C	0	0		0		90.00
91. 00   09100   EMERGENCY	0	0		0		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92. 00
200.00   Total (lines 50-199)	0	0	Pl	0		200. 00

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL (	COSTS	Provi der C	CN: 15-0047	Peri od: From 06/01/2016 To 05/31/2017	Worksheet D Part I	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26) 1. 00	2.00	2) 3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 31. 01 NEONATAL INTENSIVE CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 40. 00 SUBPROVIDER - IPF 43. 00 NURSERY	1, 904, 283 449, 071 115, 810 317, 955 333, 351 5, 093	0	449, 0 115, 8 317, 9	71 37 10 567 55 1, 423 51 5, 427	12, 137. 05 204. 25 223. 44	31. 00 31. 01 33. 00 40. 00
44.00 SKILLED NURSING FACILITY	5, 093 443, 440	l e	443. 4		•	
200.00 Total (lines 30-199)	3, 569, 003	l .	3, 569, 00			200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6) 7.00	0, 007, 0	37, 171		200. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 31. 01 NEONATAL INTENSIVE CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 40. 00 SUBPROVIDER - IPF 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 200. 00 Total (lines 30-199)	1, 134 1 220 10 139 224 0 1, 728	12, 137 44, 935 2, 234 8, 537 1, 792				30. 00 31. 00 31. 01 33. 00 40. 00 43. 00 44. 00 200. 00

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0047	Period: From 06/01/2016	Worksheet D	
					Date/Time Pre 10/30/2017 4:	pared: 18 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	

		Ti tl	e XIX	Hospi tal	PPS	. о р
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
· ·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	655, 021	40, 591, 523	0. 016137	739, 272	11, 930	50.00
50. 01   03330   ENDOSCOPY	96, 685	4, 387, 835	0. 022035	13, 328	294	50. 01
51.00   05100   RECOVERY ROOM	249, 150	4, 548, 910	0. 054771	86, 153	4, 719	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	220, 555	1, 701, 634	0. 129614	403, 061	52, 242	52. 00
53. 00   05300   ANESTHESI OLOGY	9, 245	6, 085, 290	0. 001519	159, 524	242	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	740, 659	77, 662, 509	0. 009537	824, 074	7, 859	54. 00
54. 01   03630   ULTRA SOUND	0	0	0.000000	0	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	0.000000	0	0	56. 00
57. 00  05700 CT SCAN	0	0	0.000000	0	0	57. 00
58. 00   05800   MRI	0	0	0.000000	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	131, 973	25, 093, 511	0. 005259	356, 240	1, 873	59. 00
60. 00   06000   LABORATORY	645, 430	64, 637, 492	0. 009985	1, 219, 411	12, 176	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELI	40, 048	3, 412, 810	0. 011735	89, 814	1, 054	62.00
65. 00 06500 RESPIRATORY THERAPY	238, 400	15, 252, 411	0. 015630	403, 890	6, 313	65. 00
66. 00   06600 PHYSI CAL THERAPY	279, 760	3, 988, 867	0. 070135	76, 669	5, 377	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	111, 939	3, 869, 877	0. 028926	72, 948	2, 110	67. 00
68. 00 06800 SPEECH PATHOLOGY	41, 399	671, 678	0. 061635	90, 909	5, 603	68. 00
69. 00 06900 ELECTROCARDI OLOGY	46, 893	3, 975, 105	0. 011797	48, 166	568	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Г 156, 602	37, 446, 007	0. 004182	483, 517	2, 022	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	109, 637	15, 568, 727	0. 007042	138, 133	973	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	235, 944	78, 858, 010	0. 002992	1, 976, 799	5, 915	73.00
74.00 07400 RENAL DIALYSIS	76, 373	1, 165, 791	0. 065512	81, 866	5, 363	74.00
76.00 03950 MISC ANCILLARY	0	0	0.000000	0	0	76. 00
76. 01   03951   SLEEP LAB	0	0	0.000000	0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	125, 361	3, 068, 039	0. 040860	0	0	76. 02
76. 03 03952 WOUND CARE	326, 538	4, 705, 814	0. 069390	30, 005	2, 082	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	81, 634	130, 085	0. 627544	467	293	90.00
91. 00 09100 EMERGENCY	621, 889	45, 939, 004	0. 013537	333, 632	4, 516	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	Γ 287, 342	5, 936, 943	0. 048399	67, 618	3, 273	92.00
200.00 Total (lines 50-199)	5, 528, 477	448, 697, 872		7, 695, 496	136, 797	200. 00

Health Financial Systems	ST JOSEPH MED			In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				rom 06/01/2016		nonod.
			'	o 05/31/2017	Date/Time Pre 10/30/2017 4:	
Title XIX Hospital PPS						
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cost	Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00  03000  ADULTS & PEDIATRICS	0	0	(	0	0	30. 00
31.00   03100   INTENSIVE CARE UNIT	0	0	(	)	0	31.00
31.01  02060 NEONATAL INTENSIVE CARE UNIT	0	0	(	)	0	31. 01
33.00   03300   BURN INTENSIVE CARE UNIT	0	0	(	)	0	33. 00
40. 00   04000   SUBPROVI DER - 1 PF	0	0	(	0	0	40. 00
43. 00   04300   NURSERY	0	0	(	)	0	43.00
44.00  04400 SKILLED NURSING FACILITY	0	0	)		0	
200.00 Total (lines 30-199)	0	0	(	)	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.		Inpati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7.00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS		1	1		1	
30. 00   03000   ADULTS & PEDI ATRI CS	24, 395	l .		C		30. 00
31.00 03100 INTENSIVE CARE UNIT	37		1	C		31. 00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	567		1			31. 01
33.00 03300 BURN INTENSIVE CARE UNIT	1, 423					33. 00
40. 00   04000   SUBPROVI DER - I PF	5, 427					40. 00
43. 00   04300   NURSERY	637			l C		43. 00
44.00 04400 SKILLED NURSING FACILITY	4, 685	l .	1	0		44. 00
200.00   Total (lines 30-199)	37, 171		1, 728	3  C	1	200. 00

Health Financial Systems	ST JOSEPH MEDIC	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0047	Peri od:	Worksheet D
THROUGH COSTS			From 06/01/2016	

THROUGH COSTS			Ť	05/31/2017	Date/Time Pre 10/30/2017 4:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician Nu	ursing School	Allied Health	All Other	Total Cost	
	Anestheti st	_		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	0	0	0	50.00
50. 01   03330   ENDOSCOPY	0	0	0	0	0	50. 01
51.00   05100   RECOVERY ROOM	0	0	0	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
54. 01   03630   ULTRA SOUND	0	0	0	0	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	0	0	0	56. 00
57.00  05700   CT SCAN	0	0	0	0	0	57. 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	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62. 00
65. 00  06500   RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00  06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00  06900  ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74.00   07400   RENAL DI ALYSI S	0	0	0	0	0	74. 00
76.00   03950   MISC ANCILLARY	0	0	0	0	0	76. 00
76. 01   03951   SLEEP LAB	0	0	0	0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	76. 02
76. 03 03952 WOUND CARE	0	0	0	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0	0	0	0	0	90.00
91. 00   09100   EMERGENCY	0	0	0	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	1 /2.00
200.00   Total (lines 50-199)	0	0	0	0	0	200. 00

Health Financial Systems	SI	JOSEPH MED	OI CAL	CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	NCILLARY SERVIC	E OTHER PASS	S F	Provider Co	CN: 15-0047	Peri od:	Worksheet D	
THROUGH COSTS						From 06/01/2016	Part IV	
1111100011 00313						To 05/31/2017	Date/Time Pre	pared:
							10/30/2017 4:	18 pm
				Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Total	Tota	l Charges	Ratio of Cos	t Outpatient	Inpati ent	
·	0	utpati ent	(fro	m Wkst. C,	to Charges	Ratio of Cost	Program	
	Co	st (sum of	Par	t I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col	. 2, 3 and		8)	7)	(col. 6 ÷ col.	ŭ	
		4)		,		7)		
		4 00		7 00	0 00	0.00	10.00	

			e XIX	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpatient	
	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	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	40, 591, 523			739, 272	50.00
50. 01   03330   ENDOSCOPY	0	4, 387, 835	0. 000000		13, 328	50. 01
51.00   05100   RECOVERY ROOM	0	4, 548, 910			86, 153	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	1, 701, 634	0. 000000	0.000000	403, 061	52.00
53. 00   05300   ANESTHESI OLOGY	0	6, 085, 290	0.000000		159, 524	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	77, 662, 509	0.000000	0.000000	824, 074	54.00
54. 01   03630   ULTRA SOUND	0	0	0.000000	0.000000	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	0.000000	0.000000	0	56.00
57.00  05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58. 00   05800   MRI	0	0	0. 000000	0.000000	ol	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	25, 093, 511	0. 000000	0.000000	356, 240	59.00
60. 00   06000   LABORATORY	0	64, 637, 492	0. 000000	0.000000	1, 219, 411	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 412, 810	0. 000000	0.000000	89, 814	62.00
65. 00 06500 RESPIRATORY THERAPY	0	15, 252, 411	0. 000000	0.000000	403, 890	65.00
66. 00   06600   PHYSI CAL THERAPY	0	3, 988, 867	0.000000	0.000000	76, 669	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	3, 869, 877	0. 000000	0.000000	72, 948	67.00
68. 00 06800 SPEECH PATHOLOGY	0	671, 678		0.000000	90, 909	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 975, 105	0. 000000	0.000000	48, 166	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	37, 446, 007	0.000000	0.000000	483, 517	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	15, 568, 727		0.000000	138, 133	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	78, 858, 010	0. 000000	0.000000	1, 976, 799	73.00
74.00 07400 RENAL DIALYSIS	0	1, 165, 791	0. 000000	0.000000	81, 866	
76. 00 03950 MISC ANCILLARY	0	0	0. 000000	0.000000	o	76.00
76. 01  03951  SLEEP LAB	0	0	0. 000000	0.000000	o	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	3, 068, 039	0. 000000	0.000000	o	76. 02
76. 03 03952 WOUND CARE	0	4, 705, 814	0. 000000	0.000000	30, 005	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	130, 085	0.000000	0.000000	467	90.00
91. 00 09100 EMERGENCY	0	45, 939, 004	0. 000000	0. 000000	333, 632	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 936, 943	0. 000000	0. 000000	67, 618	92.00
200.00 Total (lines 50-199)	0	448, 697, 872			7, 695, 496	200. 00
	•		•	'	'	

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER	In Lieu of Form CMS		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0047	Peri od: From 06/01/2016 To 05/31/2017	Worksheet D Part IV Date/Time Prepared:	

				To 05/31/2017	7 Date/lime Pro   10/30/2017 4	
-		Ti tl	e XIX	Hospi tal	PPS	. то рііі
Cost Center Description	Inpatient	Outpati ent	Outpati ent	'		
· ·	Program	Program	Program			
	Pass-Through	Charges	Pass-Through	1		
	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	(	1	0		50.00
50. 01   03330   ENDOSCOPY	0	(		0		50. 01
51.00   05100   RECOVERY ROOM	0	(		0		51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	(		0		52. 00
53. 00   05300   ANESTHESI OLOGY	0	(		0		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	(		0		54. 00
54. 01   03630   ULTRA SOUND	0	(		0		54. 01
56. 00   05600   RADI OI SOTOPE	0	(		0		56. 00
57. 00   05700   CT   SCAN	0	(		0		57. 00
58. 00   05800   MRI	0	(		0		58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	(		0		59. 00
60. 00   06000   LABORATORY	0	(		0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	(		0		62. 00
65. 00 06500 RESPI RATORY THERAPY	0	(		0		65. 00
66. 00   06600   PHYSI CAL THERAPY	0	(		0		66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	(		0		67. 00
68. 00   06800   SPEECH PATHOLOGY	0	(		0		68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	(		0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(		0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(		0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	(		0		73. 00
74.00 07400 RENAL DIALYSIS	0	(		0		74. 00
76.00 03950 MISC ANCILLARY	0	(		0		76. 00
76. 01   03951   SLEEP LAB	0	(		0		76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	(		0		76. 02
76. 03   03952   WOUND CARE	0	(		0		76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	(		0		90. 00
91. 00   09100   EMERGENCY	0	(		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	(		0		92.00
200.00 Total (lines 50-199)	0	(	)	0		200. 00

Heal th	Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		VACCINE COST	Provi der C	F	Period: From 06/01/2016 To 05/31/2017		pared: 18 pm
			Ti tl	e XIX	Hospi tal	PPS	
	·			Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
	ANOLULARY OFRICAS COOT OFFITERS	1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			1	1 054 (40		
50.00	05000 OPERATING ROOM	0. 100039					
50. 01	03330 ENDOSCOPY	0. 195552	<b>I</b>				50. 01
51. 00	05100 RECOVERY ROOM	0. 233599	<b>I</b>	1	222, 137	1	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 614443	1		114, 381	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 015658		1		l	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 079433		1	.,,	l	54. 00
54. 01	03630 ULTRA SOUND	0. 000000	•		-	0	54. 01
56. 00	05600 RADI 0I SOTOPE	0. 000000			-	0	56. 00
57. 00	05700 CT SCAN	0. 000000		1		0	57. 00
58. 00	05800 MRI	0. 000000	•	1	-	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 097047	•			0	59. 00
60.00	06000 LABORATORY	0. 103717					60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 183977	•			0	62. 00
65. 00	06500 RESPI RATORY THERAPY	0. 106701	•	1		0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 299589	•				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 195169	l l		-1		67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 274407	•		.,	l e	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 147213	ł		,	l e	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 125493					71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 240887	•	1		l e	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 099876	•	1		•	73. 00
74. 00	07400 RENAL DI ALYSI S	0. 531280	•	`	-,	l	74. 00
76. 00	03950 MISC ANCILLARY	0. 000000	•	(	-	0	76. 00
76. 01	03951 SLEEP LAB	0. 000000	•	1		0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 240279		1		l	76. 02
76. 03	03952 WOUND CARE	0. 349604	- C	(	93, 571	0	76. 03
	OUTPATIENT SERVICE COST CENTERS			1		_	
	09000 CLI NI C	2. 315025		1	_, _, _,		
91. 00	09100 EMERGENCY	0. 140641			., ,		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 399266	0		,		
200.00			0	(	.,,	0	200. 00
201.00					0		201. 00
000 00	Only Charges				7 (00 010		000 00
202.00	Net Charges (line 200 +/- line 201)	1	0	(	7, 688, 242	l 0	202. 00

				10 05/31/201/	10/30/2017 4: 18 pm
		Ti tl	e XIX	Hospi tal	PPS
	Cos			<del>'</del>	
Cost Center Description	Cost	Cost			
	Rei mbursed	Rei mbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS			1		
50. 00   05000   OPERATI NG ROOM	0	125, 211			50.00
50. 01   03330   ENDOSCOPY	0	13, 401			50. 01
51. 00   05100   RECOVERY ROOM	0	51, 891			51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	70, 281			52. 00
53. 00 05300 ANESTHESI OLOGY	0	4, 356	1		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	125, 785	1		54. 00
54. 01   03630   ULTRA SOUND	0	0	•		54. 01
56. 00   05600   RADI OI SOTOPE	0	0	ł		56. 00
57. 00   05700   CT   SCAN	0	0	•		57. 00
58. 00   05800   MRI	0	0	1		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	21, 894	1		59. 00
60. 00   06000   LABORATORY	0	105, 276			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 640			62. 00
65. 00 06500 RESPI RATORY THERAPY	0	7, 078			65. 00
66. 00   06600   PHYSI CAL THERAPY	0	1, 209			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	394			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	1, 945			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	7, 974	1		69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	24, 401	1		71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	13, 844	1		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	50, 164			73. 00
74. 00   07400   RENAL DI ALYSI S	0	4, 776	1		74.00
76. 00   03950   MI SC   ANCI LLARY	0	0	1		76.00
76. 01 03951 SLEEP LAB	0	0	1		76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	12, 714			76. 02
76. 03   03952   WOUND CARE	0	32, 713			76. 03
90. 00 O9000 CLINIC	0	5, 250			90, 00
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY		5, 250 230, 888			90.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART		230, 888 88, 708			92.00
,			1		200.00
200.00   Subtotal (see instructions) 201.00   Less PBP Clinic Lab. Services-Program		1, 003, 793			200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	"				201.00
202.00   Net Charges (line 200 +/- line 201)	0	1, 003, 793			202. 00
202.00    Net Glarges (True 200 +/ - True 201)	١	1,003,793	I		1202.00

Health Financial Systems	ST JOSEPH MED				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	IL COSTS	Provi der C		Peri od: From 06/01/2016	Worksheet D Part II	
		Component	CCN: 15-S047	To 05/31/2017	Date/Time Pre 10/30/2017 4:	
		Ti tl	e XIX	Subprovi der – I PF	PPS	•
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
,		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	, and the second	,	
	26)	·				
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	655, 021	40, 591, 523	0. 01613	0 0	0	50. 00
50. 01 03330 ENDOSCOPY	96, 685	4, 387, 835	0. 02203	5 0	0	50. 01
51.00   05100   RECOVERY ROOM	249, 150	4, 548, 910	0. 05477	17, 701	970	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	220, 555	1, 701, 634	0. 12961	4 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	9, 245	6, 085, 290	0. 00151	9 4, 532	7	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	740, 659	77, 662, 509	0.00953	11, 704	112	54.00
54.01 03630 ULTRA SOUND	0	0	0. 00000	0 0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	l c	0. 00000	0 0	0	56. 00
57. 00 05700 CT SCAN	0	l c	0. 00000	0 0	0	57. 00
58. 00   05800   MRI	0	0	0. 00000	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	131, 973	25, 093, 511	0.00525	9 0	0	59.00
60. 00 06000 LABORATORY	645, 430				488	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	40, 048	3, 412, 810	0. 01173	5 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	238, 400			1, 096	17	65.00
66. 00 06600 PHYSI CAL THERAPY	279, 760	3, 988, 867	0. 07013	11, 640	816	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	111, 939	3, 869, 877	0. 02892	14, 113	408	67.00
68. 00 06800 SPEECH PATHOLOGY	41, 399					68. 00
69. 00 06900 ELECTROCARDI OLOGY	46, 893	3, 975, 105	0. 01179	3, 132	37	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	156, 602				4	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	109, 637			2 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	235, 944		•		312	73. 00
74. 00 07400 RENAL DIALYSIS	76, 373		1		0	1
76. 00 03950 MISC ANCILLARY	0				0	76, 00
76. 01   03951   SLEEP LAB	0		•		0	76, 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	125, 361	3, 068, 039			685	76. 02
76. 03   03952   WOUND CARE	326, 538		1			1
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	81, 634	130, 085	0. 62754	4 0	0	90.00
91. 00   09100   EMERGENCY	621, 889				184	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		•		0	92. 00
200.00   Total (lines 50-199)	5, 241, 135			248, 507	4, 064	200. 00

APPORT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	ST JOSEPH MED RVICE OTHER PASS	Provider C	CN: 15-0047 CCN: 15-S047	Period: From 06/01/2016 To 05/31/2017		pared:
			Ti tl	e XIX	Subprovi der - I PF	PPS	•
	Cost Center Description	Non Physician Anesthetist Cost	-		All Other Medical Education Cost	4)	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS			1		1	
50.00	05000 OPERATI NG ROOM	0	0		0 0		
50. 01	03330 ENDOSCOPY	0	0		0 0	_	
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   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	
54. 01	03630 ULTRA SOUND		0			0	
56. 00	05600 RADI OI SOTOPE		0		0 0	0	1
57. 00	05700 CT SCAN	0	0		0 0	ő	
58. 00	05800 MRI	l ol	0		0 0	ő	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	1
60.00	06000 LABORATORY	O	0		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0 0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	07400 RENAL DIALYSIS	0	0		0 0	0	
76.00	03950 MI SC ANCI LLARY	0	0			0	
76. 01	03951 SLEEP LAB		0		0 0	o o	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		o o		1
	03952 WOUND CARE	0	0		0 0	Ō	
	OUTPATIENT SERVICE COST CENTERS	-1	-				1
90.00		0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	1
200.00	Total (lines 50-199)	0	0		ol o	0	200. 00

Health Financial Systems	ST JOSEPH MED	DICAL CENTER		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS		S Provider C		Period: From 06/01/2016 To 05/31/2017	Worksheet D Part IV Date/Time Pre 10/30/2017 4:	pared:
		Ti tl	e XIX	Subprovider -	PPS	то рііі
Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4) 6.00			t Outpatient Ratio of Cost	Inpatient Program Charges	
ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
50. 00 05000 OPERATING ROOM	0	40, 591, 523	0.00000	0. 000000	0	50.00
50. 01   03330   ENDOSCOPY	0				0	
51. 00   05100   RECOVERY   ROOM	0				17, 701	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				0	1
53. 00   05300   ANESTHESI OLOGY	0				4, 532	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0				11, 704	
54. 01   03630   ULTRA   SOUND	0	0			0	
56. 00   05600   RADI OI SOTOPE	0	Ō	1		0	56.00
57. 00   05700   CT   SCAN	0	Ō	•		0	
58. 00   05800 MRI	0	0	•		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	25, 093, 511			0	59. 00
60. 00 06000 LABORATORY	0				48, 841	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 412, 810	0.00000	0. 000000	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0			0. 000000	1, 096	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	3, 988, 867	0.00000	0. 000000	11, 640	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0			0. 000000	14, 113	67. 00
68.00 06800 SPEECH PATHOLOGY	0	671, 678	0.00000	0. 000000	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 975, 105	0.00000	0. 000000	3, 132	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				907	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	15, 568, 727			0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0				104, 168	
74. 00   07400   RENAL DI ALYSI S	0	1, 165, 791			0	
76. 00   03950   MI SC   ANCI LLARY	0	0	0. 00000		0	76. 00
76. 01  03951  SLEEP LAB	0	_	0.0000		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0				16, 764	
76. 03 03952 WOUND CARE	0	4, 705, 814	0. 00000	0. 000000	344	76. 03
OUTPATIENT SERVICE COST CENTERS						1
90. 00   09000   CLI NI C	0				0	
91. 00   09100   EMERGENCY	0				13, 565	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-, ,		0. 000000	0	92.00
200.00   Total (lines 50-199)	0	448, 697, 872	I		248, 507	J200. 00

Health Financial Systems ST JOSEPH MEDICAL CENTER				In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AN	ICILLARY SERVICE OTHER PASS	Provi der Co		Peri od: From 06/01/2016	Worksheet D	
THROUGH COSTS		Component (		To 05/31/2017		
		Ti tl	e XIX	Subprovi der -	PPS	
				I PF		
Cost Center Description	Inpatient	Outpati ent	Outpati ent			

			11 (1	e vi v	IPF	PPS	
	Cost Center Description	Inpatient	Outpati ent	Outpati ent	111		
	· · · · · · · · · · · · · · · · · · ·	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	3	Costs (col.	7		
		x col. 10)		x col. 12)			
		11.00	12.00	13. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING 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	0		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	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	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 MISC ANCILLARY	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						
90.00	09000 CLI NI C	0	0		0		90.00
91. 00	09100 EMERGENCY	0	0		0		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92. 00
200.00	Total (lines 50-199)	0	0		0		200. 00

Health Financial Systems	ST JOSEPH MEDICAL	L CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0047	Peri od: From 06/01/2016	Worksheet D-1	
				Date/Time Prepared: 10/30/2017 4:18 pm	
		Title XVIII	Hospi tal	PPS	

		Title XVIII	Hospi tal	10/30/2017 4: PPS	18 pm	
	Cost Center Description	II the Aviii	nospi tai	FF3		
	DADT I ALL DROWNER COMPONENTS			1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		24, 395	1.00	
2.00	Inpatient days (including private room days, excluding swing-			24, 395	2. 00	
3. 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	
4. 00	Semi-private room days (excluding swing-bed and observation be	ed days)		20, 714	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private room	20, 711	5.00			
	reporting period	3 ,				
6. 00	Total swing-bed SNF type inpatient days (including private room	om days) after December	31 of the cost	0	6. 00	
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	o	7. 00	
,, 00	reporting period	days) till dagi. December	0. 0. 1 0001		,,,,,	
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	the Dreamen (evaluating	owing bod and	F 174	9.00	
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	5, 174	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10.00	
	through December 31 of the cost reporting period (see instructions)					
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11. 00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00	
	through December 31 of the cost reporting period	3 (		1		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00	
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00	
15. 00	Total nursery days (title V or XIX only)	din (exer during swring bed	uays)	Ö	15. 00	
16.00	Nursery days (title V or XIX only)			0	16. 00	
47.00	SWING BED ADJUSTMENT		6.11	0.00	1 4 7 00	
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost	0. 00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00	
	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00	
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20.00	
	reporting period					
21. 00	Total general inpatient routine service cost (see instructions		ing popied (line	15, 709, 293		
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ line 17)	er 31 of the cost report	ing period (iine	0	22. 00	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00	
04.00	x line 18)	04 6 11			04.00	
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line   7 x line 19)			0	24. 00	
25. 00				0	25. 00	
0, 00	x line 20)					
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 15, 709, 293	26. 00 27. 00	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(Title 21 millas Title 20)		13, 707, 273	27.00	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00	
29. 00	Pri vate room charges (excluding swing-bed charges)			0	29. 00	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges)   General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	30. 00 31. 00	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0.00		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
34.00	Average per diem private room charge differential (line 32 min	, ,	tions)	0. 00 0. 00		
35. 00 36. 00					35. 00 36. 00	
37. 00					37.00	
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS				
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			643. 96	38. 00	
39. 00	Program general inpatient routine service cost per dreim (see	•		3, 331, 849	39.00	
40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40. 00	
41. 00	OO Total Program general inpatient routine service cost (line 39 + line 40) 3,331,849 41.					

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provider C		Peri od:	Worksheet D-1	
					From 06/01/2016 To 05/31/2017		pared.
						10/30/2017 4:	
	Coot Conton Decemintion	Total	Ti tl e	Average Per	Hospital Program Days	PPS Program Cost	
	Cost Center Description	Inpatient Cost				(col. 3 x col.	
				col . 2)		4)	
	I	1.00	2. 00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42. 00
43. 00	INTENSIVE CARE UNIT	899, 579	37	24, 312. 9	5 14	340, 381	43. 00
43. 01	NEONATAL INTENSIVE CARE UNIT	1, 425, 603	567	1			43. 01
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	2, 575, 258	1, 423	1, 809. 7	4 187	338, 421	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
10.00	10					1.00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			nns)		6, 545, 423 10, 556, 074	•
17.00	PASS THROUGH COST ADJUSTMENTS	Tr till odgir 10) (	Jee matraetre	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10,000,071	17.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	615, 584	50. 00
51. 00	<pre>                                    </pre>	ationt ancillar	y sorvices (fr	om Wkst D s	um of Darte II	564, 809	51. 00
31.00	and IV)	atrent anciria	y services (ii	UIII WKSt. D, S	um or raits ii	304, 809	31.00
52.00	Total Program excludable cost (sum of lines					1, 180, 393	52. 00
53. 00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	etist, and	9, 375, 681	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54. 00
	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	rgot amount (1	ino E4 minus	lino E2)	0	
58. 00	Bonus payment (see instructions)	ring cost and ta	irget allibuitt (t	The 50 millios	111le 53)		58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	pdated and co	mpounded by the	0.00	
40.00	market basket	agat manamt um	.da+ad by +ba m	arkat baakat		0.00	40.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00
	which operating costs (line 53) are less tha						
(2,00	amount (line 56), otherwise enter zero (see	instructions)				0	(2.00
	00 Relief payment (see instructions) 00 Allowable Inpatient cost plus incentive payment (see instructions)						62. 00 63. 00
00.00	PROGRAM I NPATIENT ROUTINE SWING BED COST	(000 1110114				0	00.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the c	ost renorting	neriod (See	0	65. 00
00.00	instructions) (title XVIII only)						00.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66. 00
67 00	CAH (see instructions) 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 0 6						67. 00
07.00	(line 12 x line 19)	e costs till odgil	December of c	71 1110 0031 10	por tring period		07.00
68. 00	0 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period						68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	. 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						07.00
70. 00	Skilled nursing facility/other nursing facil	•					70. 00
71. 00 72. 00							71. 00 72. 00
73. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)	,			74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	lorksheet B, P	art II, column		75. 00
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
							78. 00
79. 00 80. 00						79. 00 80. 00	
81. 00							81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82. 00
83.00							83. 00 84. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ins)				84. 00 85. 00
	Total Program inpatient operating costs (sum						86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			3, 681 643. 96	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se		/			2, 370, 417	
						,	

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 06/01/2016 To 05/31/2017	Date/Time Prep 10/30/2017 4:	oared: 18 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	1, 904, 283	15, 709, 293	0. 12122	2, 370, 417	287, 342	90.00
91.00 Nursing School cost	0	15, 709, 293	0.00000	2, 370, 417	0	91.00
92.00 Allied health cost	0	15, 709, 293	0.00000	2, 370, 417	0	92.00
93.00 All other Medical Education	0	15, 709, 293	0. 00000	2, 370, 417	0	93. 00

Health Financial Systems	ST JOSEPH MEDICA	L CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0047	Peri od: From 06/01/2016	Worksheet D-1
		Component CCN: 15-S047	To 05/31/2017	Date/Time Prepared: 10/30/2017 4:18 pm
		Title XVIII	Subprovi der -	PPS

		II the Aviii	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			5, 427	1. 00
2.00	Inpatient days (including private room days, excluding swing-			5, 427	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	/s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		5, 427	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5.00
4 00	reporting period	om doug) often December 3	)1 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	3, 278	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)	Join days) ares.		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including private	e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	(only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			O	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	lays)	0	14.00
15.00	Total nursery days (title V or XIX only)		-	0	15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	the cost	0. 00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
	reporting period	3			
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		3, 532, 513	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
	7 x line 19)	•			
25. 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
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 532, 513	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	l and abasement on had abo	, race)	0	20.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0	28. 00 29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	ions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin		11 0113)	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	3, 532, 513	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		650. 91	
39.00	Program general inpatient routine service cost (line 9 x line	•		2, 133, 683	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 2, 133, 683	40. 00 41. 00
00	1.2.2		ı	2, 100, 000	00

llool +b	Financial Customs	CT IOCEDII MEDI (	CAL CENTED		المانما	u of Form CMC	2552 10
	Financial Systems ATION OF INPATIENT OPERATING COST	ST JOSEPH MEDIC	Provi der CCN:		Period: From 06/01/2016		
			Component CCN		To 05/31/2017	10/30/2017 4:	
			Title X'		Subprovi der - I PF	PPS	
	Cost Center Description	Total Inpatient Cost Ir		Average Per em (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
40.00	Thurbos Div. (1) 11 - V. o. VIV 1	1.00	2.00	3.00	4. 00	5. 00	40.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	0	0.0		l .	
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0. 0	0	0	43. 01 44. 00
45. 00	BURN INTENSIVE CARE UNIT	0	0	0.0	0 0	0	
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description		'			1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	line 200)			1. 00 685, 186	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	ee instructions			2, 818, 869	
50. 00	Pass through costs applicable to Program inp.	atient routine s	ervices (from Wi	kst. D, sum	of Parts I and	·	
51. 00	Pass through costs applicable to Program inpand IV)	,	services (from	Wkst. D, s	um of Parts II	78, 427	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ding capital rela	ated, non-physic	cian anesth	etist, and	279, 762 2, 539, 107	1
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (line	e 56 minus	line 53)	ő	1
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting pariod a	nding 1004 und	atad and sa	mnounded by the	0.00	
34.00	market basket	portring perrod en	naring 1990, upu	ateu anu coi	iipourided by the		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line which operating costs (line 53) are less than	s 55, 59 or 60 e n expected costs	nter the lesser	of 50% of		0.00	1
62. 00 63. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	•	tions)			0	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST						1
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	Ü		•		0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)					0	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	4 plus line 65)	(title XVII	l only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	· ·				0	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)			•	rting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF/IID ON	LY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	-		t (IIne 37)			70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)		25)			72. 00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv			35)			73.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	•	,	ksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from pro	· · · · · · · · · · · · · · · · · · ·				79. 00
80. 00 81. 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		st limitation (	line 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83.00	Reasonable inpatient routine service costs (		)				83. 00 84. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				85.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thre	•				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				0	89.00

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 06/01/2016 To 05/31/2017	Date/Time Prep 10/30/2017 4:	
		Title	XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	333, 351	3, 532, 513	0. 09436	7 0	0	90. 00
91.00 Nursing School cost	0	3, 532, 513	0. 00000	0	0	91. 00
92.00 Allied health cost	0	3, 532, 513	0.00000	0	0	92. 00
93.00 All other Medical Education	0	3, 532, 513	0. 00000	0 0	0	93. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047	Peri od: From 06/01/2016	Worksheet D-1
	Component CCN: 15-5356		
	Title XVIII	Skilled Nursing	PPS
		Eocility	

		litie XVIII	Facility	PPS	
	Cost Center Description		rucirity		
	DADT I ALL DROW DED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		4, 685	1. 00
2.00	Inpatient days (including private room days, excluding swing-			4, 685	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only p	rivate room days,	0	3.00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		or 21 of the cost	4, 685	4. 00 5. 00
3.00	reporting period	on days) through becemb	er 31 or the cost	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roor	m days) through Decembe	r 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	m days) after December	31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	arter becomber	31 01 116 6031	١	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excludin	g swing-bed and	1, 776	9. 00
	newborn days)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-		room days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	Konly (including priva	te room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	/ anly (including priva	+	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			٥	13.00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	, , ,		0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21	of the cost	0.00	17. 00
17.00	reporting period	es through becember 31	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 o	f the cost	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of	the cost	0.00	20. 00
20.00	reporting period	3 4. (6. 200020. 0. 0.		0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			2, 512, 856	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost repor	ting period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	na period (line 6	0	23. 00
20.00	x line 18)	or or the dest report.	(	١	20.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost report	ing period (line	0	24. 00
25 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	21 of the cost reportin	a pariod (line 9	0	25 00
25. 00	x line 20)	or the cost reportin	g period (iine 8	U	25. 00
26.00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 512, 856	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed c	narges)	0	28. 00 29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		ctions)	0. 00 0. 00	
35. 00 36. 00	Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost d	ifferential (line	2, 512, 856	37. 00
	27 minus line 36)	<u> </u>	·		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see		T		38. 00
39. 00	Program general inpatient routine service cost per drem (see				39. 00
40. 00	Medically necessary private room cost applicable to the Progra				40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)			41.00

	Financial Systems TATION OF INPATIENT OPERATING COST	ST JOSEPH MEDI		CN: 1E 0047	In Lie	eu of Form CMS-2	
COMPUT	ATTON OF INPATTENT OPERATING COST			CN: 15-0047 CCN: 15-5356	From 06/01/2016 To 05/31/2017	Worksheet D-1 Date/Time Prep	
						10/30/2017 4:	
			Ti tl e	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Days	col. 2	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit						42.00
43. 00	INTENSIVE CARE UNIT	5					43.00
43. 01	NEONATAL INTENSIVE CARE UNIT						43. 0°
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (W			_			48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructio	ons)			49.00
50. 00	Pass through costs applicable to Program in	patient routine s	services (from	n Wkst. D, sur	m of Parts I and		50.00
51. 00		nationt andillary	, corvi coc (fr	som Wkst D	sum of Dorte II		51.00
31.00	and IV)	ipatrent ancirrary	Services (II	OIII WKSt. D,	Sum of Parts II		31.00
52. 00	Total Program excludable cost (sum of lines						52. 00
53. 00	Total Program inpatient operating cost excl medical education costs (line 49 minus line		ated, non-phy	sıcıan anesti	netist, and		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge						54. 00 55. 00
56. 00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient opera	ting cost and tar	get amount (I	ine 56 minus	line 53)		57. 0
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	eporting period e	endina 1996 u	undated and co	ompounded by the	,	58. 0 59. 0
	market basket		C .	•	spourided by the		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of lin				the amount by		60.00
01.00	which operating costs (line 53) are less than						01.00
(2.00	amount (line 56), otherwise enter zero (see	instructions)					(2.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay	ment (see instrud	ctions)				62.00
	PROGRAM INPATIENT ROUTINE SWING BED COST	•					
64. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts through Decem	ber 31 of the	e cost reporti	ng period (See		64.00
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decembe	er 31 of the d	ost reporting	g period (See		65. 00
66 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ina costs (lina A	Anlus line A	5)(+i+la YVII	Lonly) For		66. 00
00.00	CAH (see instructions)	The costs (The c	74 prus rine c	55) (title XVI)	i only). Tol		00.00
67. 00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	December 31 d	of the cost re	eporting period		67.00
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 31 of	the cost repo	orting period		68. 00
	(line 13 x line 20)				<b>.</b>		, , , ,
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER						69.00
70.00	Skilled nursing facility/other nursing faci	lity/ICF/IID rout	ine service o	cost (line 37)	)	2, 512, 856	
71. 00 72. 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ne 70 ÷ line	2)		536. 36 952, 575	
73. 00	Medically necessary private room cost appli	,	(line 14 x li	ne 35)		952, 575	1
74.00	Total Program general inpatient routine ser	•			D	952, 575	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	COSTS (Trom V	vorksneet B, I	art II, COLUMN	0	75.00
76. 00	Per diem capital-related costs (line 75 ÷ l						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x lin Inpatient routine service cost (line 74 min					0	
79. 00	Aggregate charges to beneficiaries for exce		ovi der record	ls)		ő	1
80.00	Total Program routine service costs for com	•	st limitation	ı (line 78 min	nus line 79)	0	
81. 00 82. 00	Inpatient routine service cost per diem lim Inpatient routine service cost limitation (					0.00	81. 0 82. 0
83. 00	Reasonable inpatient routine service costs	(see instructions				952, 575	83. 0
84.00	Program inpatient ancillary services (see i Utilization review - physician compensation		ie)			744, 710 0	84. 00 85. 00
gs on	Total Program inpatient operating costs (su					1, 697, 285	
85. 00 86. 00							I
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PA						07.
	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction Adjusted general inpatient routine cost per	is)	line 2)			0.00	87. 0 88. 0

Health Financial Systems	ST JOSEPH MEI	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	CN: 15-0047	Peri od:	Worksheet D-1	
		Component (	CCN: 15-5356	From 06/01/2016 To 05/31/2017		
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				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	0.00000	0 0	0	90. 00
91.00 Nursing School cost	(	0	0.00000	0 0	0	91.00
92.00 Allied health cost		0	0.00000	0 0	0	92. 00
93.00 All other Medical Education		o	0. 00000	0 0	o	93. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0047	Peri od: From 06/01/2016 To 05/31/2017	Date/Time Prepared:
-	Title XIX	Hospi tal	10/30/2017 4: 18 pm PPS

			10 03/31/2017	10/30/2017 4:	
		Title XIX	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1 00	INPATIENT DAYS	s oveluding newbern)		24, 395	1. 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			24, 395	2.00
3. 00	Private room days (excluding swing-bed and observation bed day	<i>y</i> ,	ivate room days	24, 373	3.00
3.00	do not complete this line.	ys). It you have only pr	i vate i oom days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		20, 714	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
	reporting period	3 , 3			
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period	m daya) after December 2	1 of the cost	0	8. 00
0.00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	i oi the cost	U	0.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 134	9. 00
,, 00	newborn days)	o the freguent (exercianing	oming boa and	.,	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, en				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	x only (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	X only (including private	e room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar ye			· ·	10.00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15.00	Total nursery days (title V or XIX only)		-	637	15. 00
16.00	Nursery days (title V or XIX only)			224	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	es arter becember 51 or	the cost	0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	=)		15, 709, 293	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	15, 707, 275	22.00
22.00	5 x line 17)	or or the cost report	ing period (ine	· ·	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	nariod (line 8	0	25. 00
25.00	x line 20)	or the cost reporting	perrou (rriie o	O	25.00
26. 00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		15, 709, 293	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	29.00
	Semi -pri vate room charges (excluding swing-bed charges)	1: 20)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ 11 ne 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 min	aus lino 22)(soo instruc	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line)	, ,	(10113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	15, 709, 293	
	27 minus line 36)	·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		,		
	Adjusted general inpatient routine service cost per diem (see	•		643. 96	
	Program general inpatient routine service cost (line 9 x line	-		730, 251	•
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 730, 251	
<del>4</del> 1.00	Trotal Trogram general impatrent routine service cost (ITHE 39	+ 1111C 40)	I	/30, ∠51	41.00

Heal th	Financial Systems	ST JOSEPH MEDIC	CAL CENTER		In lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	31 333EI II WEDI	Provi der CC	N: 15-0047	Peri od:	Worksheet D-1	
					From 06/01/2016 To 05/31/2017		
			Title	e XIX	Hospi tal	10/30/2017 4: PPS	το μιι
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost Ir	patient Days		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	360, 231	637	565.			42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	899, 579	37	24, 312.		24, 313	1
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT	1, 425, 603	567	2, 514.	29 220	553, 144	43. 01 44. 00
45.00	BURN INTENSIVE CARE UNIT	2, 575, 258	1, 423	1, 809.	74 10	18. 097	45.00
	SURGICAL INTENSIVE CARE UNIT	2,0,0,200	., .20	., 007.		10,077	46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					4.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 1, 122, 582	48. 00
	Total Program inpatient costs (sum of lines			ns)		2, 575, 061	1
	PASS THROUGH COST ADJUSTMENTS	9 / \		,		,	
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from	Wkst. D, su	n of Parts I and	149, 618	50.00
51. 00		ationt ancillary	services (fro	om Wkst D	cum of Darts II	136, 797	51.00
51.00	and IV)	acronic andiriary	SCIVICES (III	om mot. D, :	oun or raits II	130,797	31.00
52.00	Total Program excludable cost (sum of lines	,				286, 415	52. 00
53.00	Total Program inpatient operating cost exclu		ated, non-phys	sician anest	netist, and	2, 288, 646	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	55. 00
56. 00	Target amount (line 54 x line 55)				>	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	get amount (li	ne 56 minus	Tine 53)	0 0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	portina period er	ndi na 1996. ur	odated and co	ompounded by the	0.00	•
	market basket	5 1 2 2 2	3				
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	1
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00
	amount (line 56), otherwise enter zero (see		(TTHES OT X	50), 01 1% 0	the target		
62.00	Relief payment (see instructions)					0	
63. 00		ent (see instruct	tions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the	cost report	na period (See	0	64. 00
	instructions)(title XVIII only)	<del>-</del>			9   (		
65.00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the co	ost reportin	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 6/	1 nlus line 6	5)(title XVI	Lonly) For	0	66. 00
00.00	CAH (see instructions)	the costs (Title o	prus rine oc	b)(title xvi	1 only). Tol	٥	00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through [	December 31 of	f the cost r	eporting period	0	67. 00
(0.00	(line 12 x line 19)	t£t D	21				(0.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter bed	cember 31 or 1	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	·				ı	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of						70. 00 71. 00
71.00	Program routine service cost (line 9 x line		ie 70 ÷ i i ile 2	-)			72.00
73. 00	Medically necessary private room cost applic		(line 14 x lir	ne 35)			73. 00
74.00	Total Program general inpatient routine serv	•			>+ 11 '		74.00
75. 00	Capital-related cost allocated to inpatient   26, line 45)	routine service (	costs (from Wo	orksneet B, I	rarτ II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78.00	Inpatient routine service cost (line 74 minu		ud dom !	-)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi			( 70 IIII I	, , ,		81.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83.00	Reasonable inpatient routine service costs (		)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		3)				84. 00 85. 00
	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
87.00	Total observation bed days (see instructions		inc 2)			3, 681	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		rne 2)			643. 96 2, 370, 417	
37.00	(30) (30)					2,0,0,117	1 57.00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 06/01/2016 To 05/31/2017	Date/Time Prep 10/30/2017 4:	pared: 18 pm_
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	1, 904, 283	15, 709, 293	0. 12122	2, 370, 417	287, 342	90.00
91.00 Nursing School cost	0	15, 709, 293	0.00000	2, 370, 417	0	91.00
92.00 Allied health cost	0	15, 709, 293	0.00000	2, 370, 417	0	92.00
93.00 All other Medical Education	0	15, 709, 293	0. 00000	2, 370, 417	0	93. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0047	Peri od: From 06/01/2016	Worksheet D-1
	Component CCN: 15-S047	To 05/31/2017	Date/Time Prepared: 10/30/2017 4:18 pm
	Title XIX	Subprovider -	PPS

		litie XIX	Supprovider -	PPS	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			5, 427	1. 00
2.00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day			5, 427	2.00
3. 00	do not complete this line.	ys). It you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		5, 427	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	139	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, et Swing-bed NF type inpatient days applicable to titles V or XI)	nter 0 on this line)		0	
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	3 .	,	0	
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Program	ear, enter O on this lin	e)	0	
15. 00	Total nursery days (title V or XIX only)	dir (excruding swriig-bed	uays)	637	
16. 00	Nursery days (title V or XIX only)				16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	s)		3, 532, 513	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ line 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December : x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		3, 532, 513	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nua lina 22) (aaa inatrua	ti ono)	0.00	
34.00	Average per diem private room charge differential (line 32 mil		trons)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ic 31 <i>)</i>		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 532, 513	
	27 minus line 36)	· · · · · · · · · · · · · · · · · · ·	`		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			650. 91	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			90, 476	
40.00	Medically necessary private room cost applicable to the Progra			0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		90, 476	41. 00

Heal th	Financial Systems	ST JOSEPH MEDIC	CAL CENTER	In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0047 Component CCN: 15-S047	Peri od: From 06/01/2016 To 05/31/2017	Worksheet D-1	
			Title XIX	Subprovider -	10/30/2017 4: PPS	18 pm
	Cost Center Description	Total Inpatient Costlr	Total Average Penpatient Days Diem (col. col. 2)	er 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	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	0 0	. 00 0	0	43.00
	NEONATAL INTENSIVE CARE UNIT	o		. 00		
44. 00	CORONARY CARE UNIT					44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0 0	. 00	0	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)					47.00
	Cost Center Description		'			
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)		1. 00 33, 595	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				124, 071	1
50. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from Wkst. D, s	um of Parts I and	8, 537	50.00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	services (from Wkst. D,	sum of Parts II	4, 064	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu- medical education costs (line 49 minus line	ding capital rela	ated, non-physician anes	thetist, and	12, 601 111, 470	
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges				0	54.00
	Target amount per discharge					55. 00
	Target amount (line 54 x line 55)			50)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	get amount (line 56 minu	s line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket		59. 00			
60. 00 61. 00	0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ŕ	tions)		0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the cost repor	ting period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the cost reporti	ng period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi CAH (see instructions)</pre>	ne costs (line 64	4 plus line 65)(title XV	III only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing ((ine 12 x line 19)	e costs through [	December 31 of the cost	reporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	cember 31 of the cost re	porting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF/IID ONLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facil			7)		70.00
71.00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	•	10 70 = 11110 Z)			71.00
73.00	Medically necessary private room cost applic	able to Program	,			73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital -related cost allocated to inpatient	•	•	Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				76. 00
77. 00	Program capital -related costs (line 9 x line					77. 00
78. 00	Inpatient routine service cost (line 74 minu		nyi don nocenda)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.		*.	inus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on		,		81.00
82.00	Inpatient routine service cost limitation (I	* .	1			82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		)			83. 00 84. 00
85. 00	Utilization review - physician compensation		5)			85. 00
86. 00	Total Program inpatient operating costs (sum		ough 85)			86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions				0	87. 00
88. 00	Adjusted general inpatient routine cost per		ine 2)			88.00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)			0	89. 00

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 06/01/2016 To 05/31/2017	Date/Time Prep 10/30/2017 4:	
		Ti tl	e XIX	Subprovi der - I PF	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	333, 351	3, 532, 513	0. 09436	7 0	0	90.00
91.00 Nursing School cost	0	3, 532, 513	0.00000	0	0	91.00
92.00 Allied health cost	0	3, 532, 513	0.00000	0	0	92.00
93.00 All other Medical Education	0	3, 532, 513	0. 00000	0 0	0	93. 00

Health Financial Systems ST JOSEPH MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 06/01/2016		
			To 05/31/2017	Date/Time Pre 10/30/2017 4:	
	Ti tl e	e XVIII	Hospi tal	PPS	то рііі
Cost Center Description		Ratio of Cos		Inpati ent	
'		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		1	
30. 00   03000   ADULTS & PEDI ATRI CS			13, 228, 387		30.00
31. 00   03100   I NTENSI VE CARE UNI T			57, 716		31.00
31. 01   02060   NEONATAL INTENSIVE CARE UNIT			0		31. 01
33. 00   03300 BURN INTENSIVE CARE UNIT			1, 267, 519		33.00
40. 00   04000   SUBPROVI DER - I PF			0		40.00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS					43. 00
50. 00 O5000 OPERATING ROOM		0. 10003	4, 657, 236	465, 905	50.00
50. 01   03330   ENDOSCOPY		0. 19555			50.00
51. 00   05100   RECOVERY   ROOM		0. 23359			51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 61444			
53. 00   05300   ANESTHESI OLOGY		0. 01565			
54. 00   05400 RADI OLOGY-DI AGNOSTI C		0. 07943		489, 896	
54. 01   03630   ULTRA   SOUND		0.00000		0	54. 01
56. 00   05600   RADI OI SOTOPE		0.00000		0	56.00
57. 00   05700   CT   SCAN		0.00000	00	0	57. 00
58. 00   05800   MRI		0.00000	00	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 09704	2, 817, 567	273, 436	59. 00
60. 00   06000   LABORATORY		0. 10371	7, 192, 961	746, 032	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 18397		143, 486	
65. 00 06500 RESPI RATORY THERAPY		0. 10670			65. 00
66. 00   06600   PHYSI CAL THERAPY		0. 29958			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 19516			
68. 00 06800 SPEECH PATHOLOGY		0. 27440			
69. 00   06900   ELECTROCARDI OLOGY		0. 14721			•
71. 00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 12549			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24088			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0.09987			
74. 00   07400   RENAL DI ALYSI S 76. 00   03950   MI SC ANCI LLARY		0. 53128		491, 679 0	74.00
76. 01   03950   MTSC ANCITELARY 76. 01   03951   SLEEP LAB		0.00000		0	76. 00 76. 01
70. UT   US951 SLEEP LAB		0.00000		4 040	76.01

0. 240279

0. 349604

2. 315025

0.140641

0. 399266

16, 828

350, 825

2, 115, 414

52, 855, 209

52, 855, 209

316, 576

76. 02

76. 03

90.00

91.00

92.00

202. 00

4, 043

122, 650

297, 514

126, 398

6, 545, 423 200. 00 201. 00

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES

Net charges (line 200 minus line 201)

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

OUTPATIENT SERVICE COST CENTERS
09000 CLINIC

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

76.02 76. 03

90.00

200.00

201.00 202.00

03952 WOUND CARE

91. 00 09100 EMERGENCY

Health Financial Systems	ST JOSEPH MEDICAL CENTER			eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0047	Peri od:	Worksheet D-3	
	Component	CCN: 15-S047	From 06/01/2016 To 05/31/2017	Date/Time Pre 10/30/2017 4:	pared:
	Ti tl e	· XVIII	Subprovi der - I PF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		T		Г	
0. 00 03000 ADULTS & PEDI ATRI CS			0	l	30.00
1. 00   03100   INTENSIVE CARE UNIT			0		31.00
1. 01   02060   NEONATAL   INTENSIVE CARE UNIT			0		31.0
3. 00   03300   BURN   INTENSI VE CARE UNIT			0		33.00
0. 00   04000   SUBPROVI DER - I PF			10, 530, 186		40.00
3. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS			10.100		
0. 00   05000   OPERATI NG ROOM		0. 10003			1
0. 01   03330   ENDOSCOPY		0. 19555			
1. 00   05100   RECOVERY ROOM		0. 23359		55, 589	•
2. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 61444		0	
3. 00   05300   ANESTHESI OLOGY		0. 01565		954	53.00
4. 00   05400   RADI OLOGY-DI AGNOSTI C 4. 01   03630   ULTRA SOUND		0.07943		34, 445	
6. 00   05600   RADI OI SOTOPE		0.00000		0	
7. 00   05700   CT   SCAN		0. 00000 0. 00000		0	
8. 00   05800   MRI		0.00000		0	•
9. 00   05900   CARDI AC CATHETERI ZATI ON		0. 09704		0	
0. 00   06000 LABORATORY		0. 10371		1	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 18397		113, 331	1
5. 00 06500 RESPIRATORY THERAPY	<del>-</del>	0. 10670		12, 553	
6. 00   06600   PHYSI CAL THERAPY		0. 29958		61, 940	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 19516			
8. 00 06800 SPEECH PATHOLOGY		0. 27440		9, 107	
9. 00   06900   ELECTROCARDI OLOGY		0. 14721		8, 934	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-	0. 12549		8, 002	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24088			1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 09987			
4. 00   07400   RENAL DI ALYSI S		0. 53128			
6. 00   03950 MI SC ANCI LLARY		0. 00000		0	1
76. 01   03951   SLEEP LAB		0. 00000		Ö	1
6. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 24027		· -	
6. 03   03952   WOUND CARE		0. 34960			1
OUTPATIENT SERVICE COST CENTERS			2,302	, = 10	1
0, 00 09000 CLINIC		2 31502	25 0	0	90.00

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5, 221, 674

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0 92.00 685, 186 200. 00

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92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200. 00 Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

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

91. 00 09100 EMERGENCY

	ST JOSEPH MEDICAL CENTER			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
	Component	CCN: 15-5356	From 06/01/2016 To 05/31/2017	Date/Time Pre 10/30/2017 4:	pared: 18 pm
	Ti tl e	XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs (col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			,		
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31. 00
31. 01   02060   NEONATAL   INTENSIVE CARE UNIT			0		31. 01
33. 00   03300   BURN I NTENSI VE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF			0		33.00
40. 00   04000   SUBPROVI DER - I PF 43. 00   04300   NURSERY			0		40. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 10003	39 0	0	50.00
50. 01   03330   ENDOSCOPY		0. 19555			50. 01
51. 00   05100   RECOVERY ROOM		0. 23359	09	0	51.00
52.00   05200   DELI VERY ROOM & LABOR ROOM		0. 61444	13 0	0	52. 00
53. 00   05300   ANESTHESI OLOGY		0. 01565		0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 07943			54.00
54. 01   03630   ULTRA SOUND		0.00000		0	54. 01
56. 00   05600   RADI 0I SOTOPE 57. 00   05700   CT   SCAN		0. 00000 0. 00000		0	56. 00 57. 00
58. 00   05800 MRI		0.00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 09704		0	59.00
60. 00   06000   LABORATORY		0. 10371		32, 484	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 18397			62. 00
65. 00 06500 RESPI RATORY THERAPY		0. 10670	284, 956	30, 405	65. 00
66. 00   06600   PHYSI CAL THERAPY		0. 29958			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 19516	· ·		
68. 00 06800 SPEECH PATHOLOGY		0. 27440		2, 401	
69. 00 06900 ELECTROCARDI OLOGY		0. 14721	· ·	l	
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 12549 0. 24088	· ·	12, 638	71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS		0. 09987		221, 309	
74. 00 07400 RENAL DI ALYSI S		0. 53128		0	74.00
76. 00 03950 MI SC ANCI LLARY		0. 00000		ő	76.00
76. 01   03951   SLEEP LAB		0.00000		0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 24027	79 0	0	76. 02
76. 03   03952   WOUND CARE		0. 34960	14 44.072	15 408	76 03

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4, 777, 485

03952 WOUND CARE
OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

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

76. 03

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ealth Financial Systems	ST JOSEPH MEDICA	AL CENTER		In Lie	u of Form CMS-2	2552-10
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-0047	Peri od: From 06/01/2016 To 05/31/2017	Worksheet D-3 Date/Time Pre 10/30/2017 4:	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description			Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	

	Cost Center Description	Ratio of Cost	I npati ent	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	,			
30. 00	03000 ADULTS & PEDI ATRI CS		1, 783, 385	l .	30. 00
31.00	03100 INTENSIVE CARE UNIT		4, 076		31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT		783, 853		31. 01
33.00	03300 BURN INTENSIVE CARE UNIT		72, 762		33. 00
40. 00	04000 SUBPROVI DER - I PF		0		40. 00
43.00	04300 NURSERY		258, 855		43. 00
	ANCILLARY SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,			
50. 00	05000 OPERATI NG ROOM	0. 100039	739, 272		50. 00
50. 01	03330 ENDOSCOPY	0. 195552	13, 328	2, 606	50. 01
51.00	05100 RECOVERY ROOM	0. 233599	86, 153	20, 125	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 614443	403, 061	247, 658	52. 00
53.00	05300 ANESTHESI OLOGY	0. 015658	159, 524		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 079433	824, 074	65, 459	54. 00
54. 01	03630 ULTRA SOUND	0.000000	0	0	54. 01
56.00	05600  RADI 0I SOTOPE	0.000000	0	0	56. 00
57.00	05700 CT SCAN	0.000000	0	0	57. 00
58. 00	05800   MRI	0.000000	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 097047	356, 240	34, 572	59. 00
60.00	06000 LABORATORY	0. 103717	1, 219, 411	126, 474	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 183977	89, 814	16, 524	62. 00
65. 00	06500 RESPI RATORY THERAPY	0. 106701	403, 890	43, 095	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 299589	76, 669		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 195169	72, 948		67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 274407	90, 909		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 147213	48, 166		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 125493	483, 517		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 240887	138, 133		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 099876	1, 976, 799		73. 00
	07400 RENAL DI ALYSI S	0. 531280	81, 866		74. 00
	03950 MI SC ANCI LLARY	0. 000000	0., 222	0	76. 00
	03951 SLEEP LAB	0. 000000	0	0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 240279	0	0	76. 02
76. 03	03952 WOUND CARE	0. 349604	30, 005	_	76. 03
70.00	OUTPATIENT SERVICE COST CENTERS	0.017001	50, 000	10, 170	70.00
90.00	09000 CLI NI C	2. 315025	467	1, 081	90.00
91. 00	09100 EMERGENCY	0. 140641	333, 632		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 399266	67, 618	l .	
200.00		3. 577200	7, 695, 496		
201.00			,, 5,5, 4,0	1, 122, 302	201. 00
202.00			7, 695, 496		202.00
202.00	1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1	., 5.5, 170	1	1-32.00

Health Financial Systems	ST JOSEPH MEDICAL CENTER		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0047	Peri od:	Worksheet D-3	
	Component	CCN: 15-S047	From 06/01/2016 To 05/31/2017	Date/Time Prep 10/30/2017 4:	
	Ti tl	e XIX	Subprovi der - I PF	PPS	
Cost Center Description		Ratio of Cos	•	I npati ent	
		To Charges	Program	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 & PEDI ATRI CS		T	1 0		30.00
31. 00   03100   NTENSI VE CARE UNI T			0		31.00
31. 01   02060   NEONATAL   INTENSIVE CARE UNIT			0		31. 01
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
40. 00   04000   SUBPROVI DER -   I PF			451, 350		40. 00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS		•			
50. 00 05000 OPERATING ROOM		0. 10003	39 0	0	50. 00
50. 01   03330   ENDOSCOPY		0. 19555	52 0	0	50. 01
51.00   05100   RECOVERY ROOM		0. 23359	17, 701	4, 135	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 61444		0	52. 00
53. 00   05300   ANESTHESI OLOGY		0. 01565			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 07943		930	1
54. 01   03630   ULTRA SOUND		0.00000		0	54. 01
56. 00   05600   RADI OI SOTOPE		0.00000		0	56.00
57. 00   05700   CT   SCAN 58. 00   05800   MRI		0.00000		0	57. 00 58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0.00000		0	59.00
60. 00   06000   LABORATORY		0. 1037		5, 066	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 18397		3,000	62.00
65. 00 06500 RESPIRATORY THERAPY		0. 10670		117	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 29958		1	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 19516	14, 113	2, 754	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 27440	07	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 1472	3, 132	461	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 12549	907	114	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24088		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 09987		l	
74. 00   07400   RENAL DI ALYSI S		0. 53128		0	74. 00
76. 00 03950 MI SC ANCI LLARY		0.00000		0	76. 00
76. 01   03951   SLEEP LAB		0.00000		0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 24027	·		76. 02

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03952 WOUND CARE
OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

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

76. 03

90.00

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09000 CLI NI C

09100 EMERGENCY

			10 03/31/2017	10/30/2017 4:	
		Title XVIII	Hospi tal	PPS	
	DADT A LABORT WAS DITH. OF DAY OF A LABOR.			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (	see	0 2, 548, 992	1. 00 1. 01
1. 02	<pre>instructions) DRG amounts other than outlier payments for discharges occurri instructions)</pre>	5, 042, 420	1. 02		
1.03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	or discharges occurring	prior to October	0	1. 03
1.04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring	on or after	0	1. 04
2.00	Outlier payments for discharges. (see instructions)			375, 415 0	2. 00 2. 01
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructi	one)		0	2. 01
3. 00	Managed Care Simulated Payments	UIS)		4, 743, 672	3.00
4. 00	Bed days available divided by number of days in the cost repo	rting period (see instru	ctions)	100. 92	4. 00
E 00	Indirect Medical Education Adjustment	t recent cost reporting	noriad anding on	8. 95	5. 00
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)				
6. 00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)			0.00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified u			1. 89	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified		)(1)(IV)(B)(2)	0. 00	7. 01
8.00	If the cost report straddles July 1, 2011 then see instruction Adjustment (increase or decrease) to the FTE count for alloparaffiliated programs in accordance with 42 CFR 413.75(b), 413.75	thic and osteopathic pro		0. 05	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slo	ots under section 5503 o	f the ACA. If	0.00	8. 01
8. 02	the cost report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospital	0. 00	8. 02
9. 00	under section 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see				9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the curre	ent year from your recor	ds	5. 29	10.00
11. 00	FTE count for residents in dental and podiatric programs.				11. 00
12. 00	Current year allowable FTE (see instructions)			5. 29	ı
13.00	Total allowable FTE count for the prior year.			5. 13	
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ar ended on or after Sep	tember 30, 1997,	5. 14	
15. 00	Sum of lines 12 through 14 divided by 3.			5. 19	
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18.00	Adjusted rolling average FTE count			5. 19	
19.00	Current year resident to bed ratio (line 18 divided by line 4)	).		0. 051427	ı
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 052096 0. 051427	
22. 00	IME payment adjustment (see instructions)			210, 275	ı
22. 01	IME payment adjustment - Managed Care (see instructions)			131, 395	
22.0.	Indirect Medical Education Adjustment for the Add-on for Secti	on 422 of the MMA		1017070	
23. 00	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$ .		ec. 412.105	4. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			-1.82	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the linstructions)	ower of line 23 or line	24 (see		25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	)		0	28. 01
29.00	Total IME payment ( sum of lines 22 and 28)			210, 275	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01 pisproportionate Share Adjustment	1)		131, 395	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	10. 68	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	,	•	40. 54	
32.00	Sum of lines 30 and 31			51. 22	1
33.00	Allowable disproportionate share percentage (see instructions)	)		31. 47	33. 00
34.00	Disproportionate share adjustment (see instructions)			597, 255	34. 00

	Financial Systems ST JOSEPH ME ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od:	Worksheet E	
			From 06/01/2016 To 05/31/2017		pared 18 pm
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		0		35. (
5. 01 5. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, e	nter zero on this line) (se	0. 000000000 e 1, 410, 872		35. ( 35. (
	instructions)				
5. 03	Pro rata share of the hospital uncompensated care payment Total uncompensated care (sum of columns 1 and 2 on line 3		470, 290 1, 353, 580		35. ( 36. (
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 throu	gh 46)		
0.00	Total Medicare discharges on Worksheet S-3, Part I excludi	ng discharges for MS-DRGs	0		40.
	652, 682, 683, 684 and 685 (see instructions)		Before 1/1	On/After 1/1	
	I		1. 00	1. 01	
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682 instructions)	, 683, 684 an 685. (see	0	0	41.
1. 01	Total ESRD Medicare covered and paid discharges excluding	MS-DRGs 652, 682, 683, 684	0	o	41.
2. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qu	alify for adjustment)	0.00		42.
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,			1	43.
	instructions)				
4. 00	Ratio of average length of stay to one week (line 43 divid days)	led by line 41 divided by 7	0. 000000		44.
5. 00	Average weekly cost for dialysis treatments (see instructi		0.00	0.00	
5.00	Total additional payment (line 45 times line 44 times line	41.01)	10 127 027		46.
7. 00 8. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH	, small rural hospitals	10, 127, 937		47. 48.
	only. (see instructions)	•			
				Amount 1.00	
9. 00	Total payment for inpatient operating costs (see instructi	•		10, 259, 332	
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I Exception payment for inpatient program capital (Wkst. L,			777, 127	50. 51.
2.00	Direct graduate medical education payment (from Wkst. E-4,			0 166, 087	52.
3. 00	Nursing and Allied Health Managed Care payment			166, 087 0	52. 53.
3. 00 4. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			166, 087 0 17, 362	52. 53. 54.
3. 00 4. 00 4. 01	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment	line 49 see instructions).		166, 087 0	52. 53.
3. 00 4. 00 4. 01 5. 00 6. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i	line 49 see instructions).  de 69) ntructions)		166, 087 0 17, 362 0 0 0	52. 53. 54. 54. 55. 56.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt	line 49 see instructions).  de 69) ntructions) . III, column 9, lines 30 t	hrough 35).	166, 087 0 17, 362 0 0 0	52. 53. 54. 54. 55. 56. 57.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 3. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, P	line 49 see instructions).  de 69) ntructions) . III, column 9, lines 30 t	hrough 35).	166, 087 0 17, 362 0 0 0 0	52. 53. 54. 54. 55. 56. 57. 58.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 3. 00 9. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt	line 49 see instructions).  de 69) ntructions) . III, column 9, lines 30 t	hrough 35).	166, 087 0 17, 362 0 0 0	52. 53. 54. 54. 55. 56. 57. 58.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments	line 49 see instructions).  de 69) ntructions) . III, column 9, lines 30 t tt. IV, col. 11 line 200)	hrough 35).	166, 087 0 17, 362 0 0 0 0 0 11, 219, 908	52. 53. 54. 55. 56. 57. 58. 59.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 3. 00 9. 00 0. 00 1. 00 2. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries	line 49 see instructions).  de 69) ntructions) . III, column 9, lines 30 t tt. IV, col. 11 line 200)	hrough 35).	166, 087 0 17, 362 0 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548	52. 53. 54. 55. 56. 57. 58. 59. 60. 61.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	line 49 see instructions).  de 69) ntructions) . III, column 9, lines 30 t tt. IV, col. 11 line 200)	hrough 35).	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	line 49 see instructions).  de 69) ntructions) . III, column 9, lines 30 t tt. IV, col. 11 line 200)	hrough 35).	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050 103, 138	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 3. 00 9.	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	line 49 see instructions).  le 69) ntructions) . III, column 9, lines 30 to the line 200) nus line 60)	hrough 35).	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64.
3. 00 4. 01 5. 00 6. 00 7. 00 3. 00 9. 00 9. 00 1. 00 2. 00 4. 00 5. 00 6. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	line 49 see instructions).  le 69) ntructions) . III, column 9, lines 30 to the line 200) nus line 60)	hrough 35).	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050 103, 138 67, 040	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 3. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f	line 49 see instructions).  de 69) ntructions) column 9, lines 30 to the IV, col. 11 line 200)  nus line 60)  instructions)  for applicable to MS-DRGs (s	ee instructions)	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050 103, 138 67, 040 103, 138 10, 419, 019	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66.
33. 00 4. 01 4. 01 4. 01 5. 00 6. 00 7. 00 9. 00 11. 00 9. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9	line 49 see instructions).  de 69) ntructions) column 9, lines 30 to the IV, col. 11 line 200)  nus line 60)  instructions)  for applicable to MS-DRGs (s	ee instructions)	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050 103, 138 67, 040 103, 138 10, 419, 019 0	52. 53. 54. 55. 56. 57. 58. 60. 61. 62. 63. 64. 65. 66. 67.
33. 00 44. 00 44. 01 55. 00 66. 00 77. 00 88. 00 99. 00 90. 00 11. 00 90. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	line 49 see instructions).  de 69) ntructions) column 9, lines 30 to the IV, col. 11 line 200)  nus line 60)  instructions)  for applicable to MS-DRGs (s	ee instructions)	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050 103, 138 67, 040 103, 138 10, 419, 019 0 0	52. 53. 54. 55. 56. 57. 58. 60. 61. 62. 63. 64. 65. 66. 67. 68.
33. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 00 00 00 00 00 00 00 00 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT	line 49 see instructions).  de 69) ntructions) column 9, lines 30 to the IV, col. 11 line 200)  nus line 60)  instructions)  for applicable to MS-DRGs (s	ee instructions)	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050 103, 138 67, 040 103, 138 10, 419, 019 0	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68.
33. 00 44. 00 44. 01 55. 00 66. 00 77. 00 88. 00 99. 00 90. 00 11. 00 22. 00 33. 00 44. 00 66. 00 67. 00 68. 00 77. 00 89. 00 99. 00 90. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment	line 49 see instructions).  lee 69) ntructions) . III, column 9, lines 30 to the line 200)  nus line 60)  instructions)  for applicable to MS-DRGs (s. 66). (For SCH see instructions)	ee instructions)	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050 103, 138 67, 040 103, 138 10, 419, 019 0 0	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70.
33. 00 44. 00 44. 01 55. 00 60. 00 77. 00 88. 00 99. 00 00. 00 11. 00 55. 00 66. 00 77. 00 88. 00 99. 00 00. 00 55. 00 66. 00 77. 00 88. 00 99. 00 90. 00 90	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see i HSP bonus payment HVBP adjustment amount (see instructions	line 49 see instructions).  le 69) ntructions) lill, column 9, lines 30 th. IV, col. 11 line 200)  nus line 60)  nstructions) for applicable to MS-DRGs (s. 66). (For SCH see instructions)  nstructions)	ee instructions)	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050 103, 138 67, 040 103, 138 10, 419, 019 0 0 0 0	52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 70. 70. 70.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 2. 00 2. 00 2. 00 4. 00 5. 00 6. 00 7. 00 0. 00 00 00 00 00 00 00 00 00 00 00 00 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see i HSP bonus payment HVBP adjustment amount (see instructions)	line 49 see instructions).  le 69) ntructions) lill, column 9, lines 30 th. IV, col. 11 line 200)  nus line 60)  nstructions) for applicable to MS-DRGs (s. 66). (For SCH see instructions)  nstructions)	ee instructions)	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050 103, 138 67, 040 103, 138 10, 419, 019 0 0 0 0	52. 53. 54. 55. 56. 57. 58. 60. 61. 62. 63. 64. 65. 66. 67. 70. 70. 70.
2. 00 3. 00 4. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 90 0.	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see i HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	line 49 see instructions).  le 69) ntructions) lill, column 9, lines 30 th. IV, col. 11 line 200)  nus line 60)  nstructions) for applicable to MS-DRGs (s. 66). (For SCH see instructions)  nstructions)	ee instructions)	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050 103, 138 67, 040 103, 138 10, 419, 019 0 0 0 0 0	52. 53. 54. 55. 56. 57. 58. 60. 61. 62. 63. 64. 65. 66. 70. 70. 70. 70.
3. 00 4. 00 4. 01 5. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 0. 00 00 00 00 00 00 00 00 00 00 00 00 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see i HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	line 49 see instructions).  le 69) ntructions) lill, column 9, lines 30 th. IV, col. 11 line 200)  nus line 60)  nstructions) for applicable to MS-DRGs (s. 66). (For SCH see instructions)  nstructions)	ee instructions)	166, 087 0 17, 362 0 0 0 0 11, 219, 908 3, 331 11, 216, 577 814, 548 50, 050 103, 138 67, 040 103, 138 10, 419, 019 0 0 0 0	52. 53. 54. 55. 56. 57. 60. 61. 62. 63. 64. 65. 66. 67. 70. 70. 70. 70. 70.

Health Financial Systems S CALCULATION OF REIMBURSEMENT SETTLEMENT		SEPH MEDICAL CENTER Provider C	CN: 15-0047	Peri od: From 06/01/2016 To 05/31/2017	u of Form CMS-2 Worksheet E Part A Date/Time Pre	
					10/30/2017 4:	
		Ti tl e	XVIII	Hospi tal	PPS	
			FFY	' (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy)			0	0	70. 96
	the corresponding federal year for the period prior					
70. 97				0	0	70. 97
	the corresponding federal year for the period ending	g on or after 10/1)				
70. 98	1				0	
70. 99					104, 117	
71.00	Amount due provider (line 67 minus lines 68 plus/mir	nus lines 69 & 70)			10, 250, 688	71. 00
71. 01	Sequestration adjustment (see instructions)				205, 014	71. 01
72.00	Interim payments				9, 678, 695	72. 00
73.00	00 Tentative settlement (for contractor use only)			0	73. 00	
74.00	Balance due provider (Program) (line 71 minus lines	ine 71 minus lines 71.01, 72, and 73)			366, 979	74.00
75.00	Protested amounts (nonallowable cost report items) i	n accordance with			1, 551, 547	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2	2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount	(see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (se	ee instructions)			0	93.00
94.00	The rate used to calculate the time value of money	(see instructions)			0.00	94.00
	Time value of money for operating expenses (see inst				0	95.00
96.00	Time value of money for capital related expenses (se	ee instructions)			0	96.00
	•			Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					1
101.00	HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	101. 00
102.00	HVBP adjustment amount for HSP bonus payment (see in	nstructi ons)		O	0	102. 00
	HRR Adjustment for HSP Bonus Payment					]
103.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see ins	-+\		0	0	104.00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	From 06/01/2016	Worksheet E Part B Date/Time Prepared: 10/30/2017 4:18 pm
•			

			To 05/31/2017	Date/Time Pre 10/30/2017 4:	
		Title XVIII	Hospi tal	PPS	
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			2, 948	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	tions)		5, 771, 584	2.00
3.00	PPS payments		4, 669, 736	3. 00	
4.00	Outlier payment (see instructions)		42, 221	4. 00	
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)	V col 12 line 200		0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	v, cor. 13, 11 ne 200		0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			2, 948	11.00
00	COMPUTATION OF LESSER OF COST OR CHARGES			2,7.10	1 00
	Reasonable charges				
12.00	Ancillary service charges			29, 180	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			29, 180	14. 00
15 00	Customary charges				1 1 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pamounts that would have been realized from patients liable for			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(		iii a Cilai yebasi s	U	16.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	-)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			29, 180	18.00
19.00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	26, 232	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20. 00
21 00	instructions)	i notrusti spo		2.040	21 00
21. 00 22. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	e instructions)		2, 948 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see insti	cuctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	uctions)		4, 711, 957	ł
21100	COMPUTATION OF REIMBURSEMENT SETTLEMENT			1, , 1 1, , 5	2 00
25.00				0	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for			843, 002	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	3, 871, 903	27. 00
20 00	instructions)	no EO)		42 740	20 00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		63, 760 0	28. 00 29. 00
30.00	Subtotal (sum of lines 27 through 29)			3, 935, 663	
31. 00	Primary payer payments			19	31.00
32.00	Subtotal (line 30 minus line 31)			3, 935, 644	ł
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			68, 641	ł
35. 00	Adjusted reimbursable bad debts (see instructions)			44, 617	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	ructions)		68, 641	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			3, 980, 261 0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	39. 50
39. 98	Partial or full credits received from manufacturers for replace		tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	ĺ	0	39. 99
40.00	Subtotal (see instructions)			3, 980, 261	40. 00
40. 01	Sequestration adjustment (see instructions)			79, 605	40. 01
41.00	Interim payments			4, 050, 333	41. 00
42. 00	Tentative settlement (for contractors use only)			0	42. 00
43.00	Balance due provider/program (see instructions)	with ONC D.I. 45 C	-14 4	-149, 677	•
44. 00	Protested amounts (nonallowable cost report items) in accordance 115.2	nce with CMS Pub. 15-2,	cnapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	•
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047		Worksheet E
		From 06/01/2016	
	Component CCN: 15-S047	To 05/31/2017	Date/Time Prepared:
			10/30/2017 4:18 pm
	Title XVIII	Subprovi der -	PPS

PART B - MEDICAL AND OTHER HEALTH SERVICES   0   1.00			Title XVIII	Subprovi der - I PF	PPS	
Name						
Medical and other services (see instructions)		DART R. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
Medical and other services reinbursed under OPPS (see instructions)   2,150   2,00   2,00   0   0   0   0   0   0   0   0   0	1 00				0	1 00
1.567   3.00   1.500		· · · · · · · · · · · · · · · · · · ·	tions)			
Infrare the hospit fall specific payment to cost ratio (see instructions)   0.000   5.00   6.00   1.00   0.00   1.00   0.00   7.00   0.00		,	,			
Line 2 times line 5		, , , , , , , , , , , , , , , , , , , ,			-	
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ctions)			
Transit final corridor payment (see instructions)					-	
Ancil Tarry service other pass through costs from Wist. D, Pt. IV, col. 13. Time 200   0, 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.						
Total cost (sum of lines 1 and 10) (see instructions)			IV, col. 13, line 200			
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges (From Wast. D-4, Pt. 111, col. 4, line 69)   13.00   13.00   Reasonable charges (sum of lines 12 and 13)   14.00   Reasonable charges (sum of lines 12 and 13)   15.00   Reasonable charges (sum of lines 12 and 13)   15.00   Reasonable charges (sum of lines 12 and 13)   15.00   Reasonable charges (sum of lines 12 and 13)   15.00   Reasonable charges (sum of lines 14 and 15 for payment for services on a chargebasis   Reasonable charges (see instructions)   16.00   Reasonable charges (see instructions)   16.00   Reasonable charges (see instructions)   10.000000   10.000000   10.000000   10.000000   10.000000   10.0000000   10.0000000   10.0000000   10.0000000   10.0000000   10.0000000   10.0000000   10.0000000   10.00000000   10.00000000   10.0000000   10.00000000   10.00000000   10.00000000   10.0000000   10.00000000   10.00000000   10.00000000   10.0000000000	10.00	Organ acqui si ti ons				
Reasonable charges	11. 00				0	11. 00
12.00   Ancillary service charges   0   12.00   13.00   13.00   10.00   10.00   13.00   14.0						
13.00   organ acquisition charges (from Wikst. D-4, Pt. III, col. 4, line 69)	12 00				0	12 00
Distorary charges			ine 69)			
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00	14.00	Total reasonable charges (sum of lines 12 and 13)	·		0	14. 00
16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis had actual payment been made in accordance with 42 CFR \$413.3 (c)   17.00   17.	4= 00					45.00
had such payment been made in accordance with 42 CRR \$413.13(e)					-	
17.00	10.00			on a chargebasis	U	16.00
18.00   Total customary charges (see Instructions)   0   18.00   18.	17. 00		<i>-</i> ,		0. 000000	17. 00
Instructions					-	
20. 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   0   21. 00	19. 00		ly if line 18 exceeds li	ine 11) (see	0	19. 00
instructions	20 00		lv if line 11 evceeds li	ine 18) (see	0	20 00
21.00   Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)   0   21.00   22.00   23.00   Cost of physicians' services in a teaching hospital (see instructions)   0   23.00   23.00   25.0	20.00		Ty IT Title IT exceeds IT	1116 10) (366	٥١	20.00
23. 00   Cost of physicians' services in a teaching hospital (see instructions)   0   23. 00	21. 00		e instructions)		0	21. 00
24. 00   Compositive payment (sum of lines 3, 4, 8 and 9)   1,567   24. 00   Compositive payment (sum of lines 3, 4, 8 and 9)   25. 00   25. 00   26. 00		1			-	
COMPUTATION OF REINBURSEMENT SETTLEMENT   Deductibles and coinsurance (for CAH, see instructions)   Deductibles and coinsurance (for CAH, see instructions)   333   26.00   25.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   333   26.00   27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   1,234   27.00			ructions)		-	
25.00   Deductibles and coinsurance (for CAH, see instructions)   0   25.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   333   26.00   27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   1.234   27.00   28.00   Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)   0   28.00   29.00   28.00   Death of lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0   28.00   29.00   28.00   ESRD direct medical education payments (from Wkst. E-4, line 50)   0   29.00	24.00				1,567	24.00
26.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   333   26.00	25. 00				0	25. 00
Instructions	26. 00		r CAH, see instructions)	)	333	26. 00
28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   ERRD direct medical education costs (from Wkst. E-4, line 36)   Composite costs (from Wkst. E-4, line 36)   Composite costs (from Wkst. E-4, line 36)   Composite costs (line 30 minus line 31)   Composite costs (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   Composite costs (see instructions)   Compo	27. 00		plus the sum of lines 22	2 and 23] (see	1, 234	27. 00
29. 00       SSRD direct medical education costs (from Wkst. E-4, line 36)       0       29. 00         30. 00       Subtotal (sum of lines 27 through 29)       1, 234       30. 00         31. 00       Primary payer payments       0       31. 00         32. 00       Subtotal (line 30 minus line 31)       1, 234       32. 00         33. 00       Composite rate ESRD (from Wkst. I-5, line 11)       0       33. 00         34. 00       Allowable bad debts (see instructions)       0       34. 00         35. 00       Allowable bad debts (see instructions)       0       36. 00         36. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       36. 00         37. 00       Subtotal (see instructions)       0       36. 00         38. 00       MSP-LCC reconciliation amount from PS&R       0       38. 00         39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39. 00         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 01       Interim payments       1, 234       40. 00         40. 01       Interim payments       1, 2	20 00		ino 50)		0	20 00
30.00   Subtotal (sum of lines 27 through 29)   1,234   30.00   1,234   30.00   1,234   20.00   1,234   20.00   1,234   20.00   20.0			THE 30)		-	
32.00   Subtotal (line 30 minus line 31)   1,234   32.00     ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00     Composite rate ESRD (from Wkst. 1-5, line 11)   0   34.00     34.00   Allowable bad debts (see instructions)   0   34.00     35.00   Adjusted reimbursable bad debts (see instructions)   0   36.00     36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00     37.00   Subtotal (see instructions)   1,234   37.00     38.00   MSP-LCC reconciliation amount from PS&R   0   38.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00     39.50   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.90     39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.90     40.00   Subtotal (see instructions)   1,234   40.00     40.01   Sequestration adjustment (see instructions)   25   40.01     41.00   Interim payments   1,209   41.00     42.00   Tentative settlement (for contractors use only)   42.00     43.00   Balance due provider/program (see instructions)   0   44.00     Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00     Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00     Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00     Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00     Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00     Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00     Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00     Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00     Frotested amounts (nonallowable cost report items) i					-	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I-5, line I1)   0   34.00   Allowable bad debts (see instructions)   0   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   1,234   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   40.00   Subtotal (see instructions)   1,234   40.00   40.01   Sequestration adjustment (see instructions)   25   40.01   41.00   Interim payments   1,209   41.00   42.00   43.00   43.00   84.00   Fortistive settlement (for contractors use only)   43.00   43.00   Adjustment (see instructions)   0   43.00   43.00   Adjustment (see instructions)   0   43.00   43.00   Credital devices (see instructions)   0   43.00   43.00   Adjustment (see instructions)   0   43.00   43.00   Adjustment (see instructions)   0   43.00   Adjustment (see instruction	31. 00				-	
33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   34.00   Allowable bad debts (see instructions)   0   34.00   34.00   34.00   Allowable bad debts (see instructions)   0   35.00   35.00   Allowable bad debts (see instructions)   0   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   39.90   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.90   39.90   39.90   39.90   Accelerated Depreciation   0   39.90   39.	32. 00		250		1, 234	32. 00
34.00	33 00		CES)		0	33 00
35. 00   Adjusted reimbursable bad debts (see instructions)   0   35. 00   36. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36. 00   37. 00   38. 00   38. 00   38. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   38. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00   39. 50   90. 00   9					-	
37. 00   Subtotal (see instructions)   1, 234   37. 00   38. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00   39. 50   39. 99   Pioneer ACO demonstration payment adjustment (see instructions)   0   39. 98   39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   Sequestration adjustment (see instructions)   1, 234   40. 00   40. 01   41. 00   42. 00   41. 00   42. 00   43. 00   43. 00   44. 00   4					-	
38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 1, 234 40.00 40.01 Sequestration adjustment (see instructions) 25 40.01 Interim payments 25 40.01 Interim payments 25 40.01 Interim payments 25 40.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Original outlier amount (see instructions) 0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00 Time Value of Money (see instructions) 0 93.00			ructions)		-	
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Subtotal (see instructions) 39.99 Subtotal (see instructions) 39.99 Subtotal (see instructions) 39.99 Subtotal (see instructions) 39.99 Time Value of Money (see instructions) 39.99 OO O		1				
99.50 Pi oneer ACO demonstrati on payment adjustment (see instructions)  99.70 Partial or full credits received from manufacturers for replaced devices (see instructions)  99.70 Partial or full credits received from manufacturers for replaced devices (see instructions)  99.70 Partial or full credits received from manufacturers for replaced devices (see instructions)  99.70 Partial or full credits received from manufacturers for replaced devices (see instructions)  99.90 Subtotal (see instructions)  90.00 Interim payments  90.00 Protested amounts (for contractors use only)  90.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, or 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, or 44.00 Protested amount (see instructions)  90.00 Original outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  90.00 The rate used to calculate the Time Value of Money  91.00 Time Value of Money (see instructions)  92.00 Time Value of Money (see instructions)  93.99 Sagner and Sagne						
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 98 39. 99 40. 00 Subtotal (see instructions)  40. 01 Interim payments  11. 00 Interim payments  12. 00 Tentative settlement (for contractors use only)  43. 00 Balance due provider/program (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, provided and outlier amount (see instructions)  90. 00 Original outlier amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  10 39. 98 10 39. 98 11 39. 99 11 39. 90 11 39. 99 11 39. 90 11 39. 90 11 39. 99 11 39. 90 11 39			s)			
40.00       Subtotal (see instructions)       1, 234 40.00         40.01       Sequestration adjustment (see instructions)       25 40.01         41.00       Interim payments       1, 209 41.00         42.00       Tentative settlement (for contractors use only)       0 42.00         43.00       Bal ance due provider/program (see instructions)       0 43.00         44.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2       0 44.00         70 BE COMPLETED BY CONTRACTOR       90.00         91.00       Original outlier amount (see instructions)       0 90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0 91.00         92.00       The rate used to calculate the Time Value of Money       0.00         93.00       Time Value of Money (see instructions)       0 93.00		1 3 3 1	•	ctions)		
40.01       Sequestration adjustment (see instructions)       25       40.01         41.00       Interim payments       1, 209       41.00         42.00       Tentative settlement (for contractors use only)       0       42.00         43.00       Balance due provider/program (see instructions)       0       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2       0       44.00         90.00       Original outlier amount (see instructions)       0       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00         93.00       Time Value of Money (see instructions)       0       93.00	39. 99					
41.00 Interim payments  1, 209 41.00  42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  10 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)		1				
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		1 .				
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  0 0utlier reconciliation adjustment amount (see instructions)  70.00 The rate used to calculate the Time Value of Money  71.00 Time Value of Money (see instructions)  72.00 Time Value of Money (see instructions)  73.00 Time Value of Money (see instructions)  74.00 At. 00 At.						
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 0 93.00						
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)	44. 00	, , ,	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00	90 00				0	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
	92. 00	The rate used to calculate the Time Value of Money			0. 00	92. 00
94.00   Total (sum of lines 91 and 93)   0   94.00		,				
·	94.00	Tiotai (Sum of Tines 91 and 93)		l	0	94.00

Health Financial Systems ST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0047

					10/30/2017 4: 1	18 pm
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		9, 678, 69	5	4, 050, 333	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER			0		2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER			0	0 0	3. 01 3. 02
3. 02				0		3. 02
3. 04				0		3. 03
3. 05				0		3. 04
3.03	Provider to Program			0	0	3. 03
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	ADSOSTMENTS TO TROOK IIII			0	0	3. 51
3. 52				0	l ol	3. 52
3. 53				0	l ol	3. 53
3.54				0	o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 678, 69	5	4, 050, 333	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)  Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	1 0	5. 01
5. 01	TENTATI VE TO PROVIDER			0		5. 02
5. 02				0		5. 02
0.00	Provider to Program			<u> </u>	Ŭ	0.00
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		366, 97		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	149, 677	6. 02
7. 00	Total Medicare program liability (see instructions)		10, 045, 67		3, 900, 656	7. 00
				Contractor	NPR Date	
		,	)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		,	1.00	2.00	8. 00
0.00	name of contractor			T	1	0.00

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

		Title	XVIII	Subprovi der – I PF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 605, 257		1, 209	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3. 04 3. 05			0		0 0	3. 04 3. 05
3.05	Provider to Program		U		0	3. 05
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	7.0500 TIMELYTO TO THOUSE WILL		0		l ől	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)		0 (05 057			
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		2, 605, 257		1, 209	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			ı	_	
5. 01	TENTATIVE TO PROVIDER		0		0	5. 01
5. 02 5. 03			0		0 0	5. 02 5. 03
5.03	Provider to Program		U		0	5. 03
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		7, 356		0	6. 01
6. 01	SETTLEMENT TO PROVIDER		7,350 N		0	6. 01
7. 00	Total Medicare program liability (see instructions)		2, 612, 613		1, 209	7. 00
	, , , , , , , , , , , , , , , , , , , ,		, = :=, 310	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

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

		Title	XVIII	Skilled Nursing Facility	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		640, 320		0	1. 00
2.00	Interim payments payable on individual bills, either		(		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.04	Program to Provider		1	\		0.04
3. 01 3. 02	ADJUSTMENTS TO PROVIDER		(		0	3. 01 3. 02
3. 02					0	3. 02
3. 04					0	3. 04
3. 05					0	3. 05
	Provider to Program		•	•		
3.50	ADJUSTMENTS TO PROGRAM		(		0	3. 50
3. 51			(		0	3. 51
3. 52			(		0	3. 52
3. 53 3. 54			(		0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
3. 77	3. 50-3. 98)		`		J	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		640, 320		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
Г 00	TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after					F 00
5.00	desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider		'			
5.01	TENTATI VE TO PROVI DER		(	)	0	5. 01
5.02			(		0	5. 02
5. 03			(	)	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			1	0	5. 50
5. 51	TENTATI VE TO TROOKAWI				0	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
<i>(</i> 01	the cost report. (1)		,		0	/ 01
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		(		0	6. 01 6. 02
7. 00	Total Medicare program liability (see instructions)		640, 320		0	7. 00
,,,,,	,		3.3,020	Contractor	NPR Date	7. 55
				Number	(Mo/Day/Yr)	
0.00		(	)	1. 00	2. 00	0.05
8.00	Name of Contractor					8. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	Peri od: From 06/01/2016	Worksheet E-3 Part II
	Component CCN: 15-S047	To 05/31/2017	Date/Time Prepared: 10/30/2017 4:18 pm
	Title XVIII	Subprovi der -	PPS
		LDE	

PART II - MEDICARE PART A SERVICES - IPF PPS  1.00 Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)  2. 886, 389  2. 00 Net IPF PPS Cutlier Payments  3. 00 Net IPF PPS ECT Payments  4. 00 Unweighted intern and resident FTE count in the most recent cost report filed on or before November  15, 2004. (see instructions)  4. 01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42  CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)  6. 00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)  7. 00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  8. 00 Intern and resident count for IPF PPS medical education adjustment (see instructions)  8. 00 Intern and resident count for IPF PPS medical education adjustment (see instructions)  9. 00 Average Daily Census (see instructions)  10. 00 Teaching Adjustment factor (f(1 + (line 8/line 9)) raised to the power of .5150 -1}.  11. 00 Teaching Adjustment Factor (f(1 + (line 8/line 9)) raised to the power of .5150 -1}.  12. 00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  13. 00 Nursing and Allied Heal th Managed Care payment (see instruction)  14. 00 Organ acquisition (D0 NOT USE THIS LINE)
PART II - MEDICARE PART A SERVICES - IPF PPS  1.00 Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)  2.00 Net IPF PPS Outlier Payments  3.00 Net IPF PPS ECT Payments  4.00 Unweighted intern and resident FTE count in the most recent cost report filed on or before November  15, 2004. (see instructions)  4.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)  5.00 New Teaching program adjustment. (see instructions)  6.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)  7.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions)  10.00 Teaching Adjustment Factor {(1 + (line 8/line 9)) raised to the power of .5150 -1}.  11.00 Teaching Adjustment (line 1 multiplied by line 10).  12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  Nursing and Allied Health Managed Care payment (see instruction)  2,886,389  713  2,886,389  713  2,886,389  713  2,886,389  713  2,886,389  713  2,886,389  713  72,886,389  74,890  75  70.00  7
1.00 Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments) 2.08 Net IPF PPS Outlier Payments 3.00 Net IPF PPS CT Payments 4.00 Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions) 4.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d) (1) (iii) (F) (1) or (2) (see instructions) 5.00 New Teaching program adjustment. (see instructions) 6.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 7.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 9.00 Average Daily Census (see instructions) 11.00 Teaching Adjustment Factor (((1 + (line 8/line 9)) raised to the power of .5150 -1). 12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 13.00 Nursing and Allied Health Managed Care payment (see instruction)  2, 886, 389 713 713 2, 886, 389 713 714, 890 715 715 717 718 719 719 719 719 719 719 710 7110 7110 7
2.00 Net IPF PPS Outlier Payments 3.00 Net IPF PPS ECT Payments 4.00 Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions) 4.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions) 5.00 New Teaching program adjustment. (see instructions) 6.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 7.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 9.00 Average Daily Census (see instructions) 10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}. 9.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 13.00 Nursing and Allied Health Managed Care payment (see instruction) 9.01 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 9.02 Agjustment FPS PPS Payments (sum of lines 1, 2, 3 and 11) 9.03 Agjustment FPS PPS Payments (sum of lines 1, 2, 3 and 11) 9.04 Agjustment FPS PPS Payments (sum of lines 1, 2, 3 and 11) 9.05 Agjustment FPS PPS Payments (sum of lines 1, 2, 3 and 11) 9.06 Agjustment FPS PPS Payments (sum of lines 1, 2, 3 and 11) 9.07 Agjustment FPS PPS Payments (sum of lines 1, 2, 3 and 11) 9.08 Agjustment FPS PPS Payments (sum of lines 1, 2, 3 and 11) 9.09 Agjustment FPS PPS Payments (sum of lines 1, 2, 3 and 11) 9.09 Agjustment FPS PPS Payments (sum of lines 1, 2, 3 and 11)
3.00 Net IPF PPS ECT Payments 4.00 Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions) 4.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) 5.00 New Teaching program adjustment. (see instructions) 6.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 7.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 9.00 Average Daily Census (see instructions) 11.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}. 12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 13.00 Nursing and Allied Health Managed Care payment (see instruction)  14, 890 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0
4.00 Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions) 4.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) 5.00 New Teaching program adjustment. (see instructions) 6.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 7.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 9.00 Average Daily Census (see instructions) 10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}. 11.00 Teaching Adjustment (line 1 multiplied by line 10). 12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 13.00 Nursing and Allied Health Managed Care payment (see instruction)  Unusing and Allied Health Managed Care payment (see instruction)
15, 2004. (see instructions)  4.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d) (1) (iii) (F) (1) or (2) (see instructions)  5.00 New Teaching program adjustment. (see instructions)  6.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)  7.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions)  9.00 Average Daily Census (see instructions)  10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.  11.00 Teaching Adjustment (line 1 multiplied by line 10).  12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  13.00 Nursing and Allied Health Managed Care payment (see instruction)
Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d) (1) (iii) (F) (1) or (2) (see instructions)  5.00 New Teaching program adjustment. (see instructions)  6.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)  7.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions)  9.00 Average Daily Census (see instructions)  10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.  11.00 Teaching Adjustment (line 1 multiplied by line 10).  Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  13.00 Nursing and Allied Health Managed Care payment (see instruction)
6.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)  7.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions)  9.00 Average Daily Census (see instructions)  10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.  11.00 Teaching Adjustment (line 1 multiplied by line 10).  12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  13.00 Nursing and Allied Health Managed Care payment (see instruction)  0.00 Comparison of the new program growth period of a "new to comparison of
teaching program" (see instuctions)  7.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions)  9.00 Average Daily Census (see instructions)  10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.  11.00 Teaching Adjustment (line 1 multiplied by line 10).  12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  13.00 Nursing and Allied Health Managed Care payment (see instruction)  10.00 Teaching Adjustment (line 1 multiplied by line 10).  10.00 Teaching Adjustment (line 1 multiplied by line 10).  11.00 Teaching Adjustment (line 1 multiplied by line 10).  12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  13.00 Nursing and Allied Health Managed Care payment (see instruction)
7.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions)  9.00 Average Daily Census (see instructions)  10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.  11.00 Teaching Adjustment (line 1 multiplied by line 10).  12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  13.00 Nursing and Allied Health Managed Care payment (see instruction)  0.00 Teaching Adjustment (line 1 multiplied by line 10).  2, 901, 992 12
teaching program" (see instuctions)  8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions)  9.00 Average Daily Census (see instructions)  10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.  11.00 Teaching Adjustment (line 1 multiplied by line 10).  12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  13.00 Nursing and Allied Health Managed Care payment (see instruction)  0.00  14.868493  0.00  0.00  14.868493  0.00  15.10  16.10  17.10  18.10  19.10  19.10  10.10  10.10  10.10  10.10  10.10  10.10  11.10  11.10  11.10  12.10  13.10  13.10  14.868493  15.10  15.10  16.10  17.10  17.10  18.10  19.10
9.00 Average Daily Census (see instructions) 10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}. 11.00 Teaching Adjustment (line 1 multiplied by line 10). 12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 13.00 Nursing and Allied Health Managed Care payment (see instruction)  14.868493 Occupancy 0.000000 10 12.901,992 12 13.00 Nursing and Allied Health Managed Care payment (see instruction)
10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.  11.00 Teaching Adjustment (line 1 multiplied by line 10).  12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  13.00 Nursing and Allied Health Managed Care payment (see instruction)  10.000000 10  11.00 2,901,992 12  13.00 13.00 15.000000 10  14.000000 10  15.000000 10  16.0000000 10  17.000000 10  18.0000000 10  19.0000000 10  19.000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.00000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.0000000 10  19.00000000 10  19.00000000 10  19.00000000 10  19.0000000 10  19.000000000000000000000000000000000
11.00Teaching Adjustment (line 1 multiplied by line 10).01712.00Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)2,901,9921213.00Nursing and Allied Health Managed Care payment (see instruction)013
12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 13.00 Nursing and Allied Health Managed Care payment (see instruction) 2,901,992 12
13.00 Nursing and Allied Health Managed Care payment (see instruction) 0 13
14.00 Organ acquisition (DO NOT USE THIS LINE)
15.00   Cost of physicians' services in a teaching hospital (see instructions) 0   15
16.00   Subtotal (see instructions) 2,901,992   16
17.00 Primary payer payments 0 17
18.00   Subtotal (line 16 less line 17). 2,901,992   18
19. 00   Deducti bl es   179, 116   19
20.00   Subtotal (line 18 minus line 19) 2,722,876   20
21. 00   Coi nsurance   64, 414   2'
22.00   Subtotal (line 20 minus line 21) 2,658,462   22
23.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 11,492 23
24.00 Adjusted reimbursable bad debts (see instructions) 7,470 24
25.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 11,492 25
26.00   Subtotal (sum of lines 22 and 24) 2,665,932   26
27.00 Direct graduate medical education payments (from Wkst. E-4, line 49)
28.00 Other pass through costs (see instructions)
29.00 Outlier payments reconciliation
30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)
30.50 Pioneer ACO demonstration payment adjustment (see instructions)
30. 99 Recovery of Accelerated Depreciation 0 30
31.00 Total amount payable to the provider (see instructions) 2,665,932 3
31.01   Sequestration adjustment (see instructions) 53,319   3
32. 00   Interim payments 2, 605, 257   32
33.00   Tentative settlement (for contractor use only) 0   33
34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 7,356 34
35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35
§115. 2
TO BE COMPLETED BY CONTRACTOR
50.00 Original outlier amount from Worksheet E-3, Part II, line 2
51.00 Outlier reconciliation adjustment amount (see instructions)
52.00 The rate used to calculate the Time Value of Money 0.00 52
53.00   Time Value of Money (see instructions)   0  53

Health Financial Systems	ST JOSEPH MEDIC	AL CENTER	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEM	ENT	Provider CCN: 15-0047	Peri od: From 06/01/2016	Worksheet E-3 Part VI	
		Component CCN: 15-5356	To 05/31/2017	Date/Time Prep 10/30/2017 4:1	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
PART VI - CALCULATION OF REIME	BURSEMENT SETTLEMEMENT - ALL OTH	ER HEALTH SERVICES FOR T	ITLE XVIII PART A	PPS SNF	
SERVI CES					
PROSPECTIVE PAYMENT AMOUNT (SE	EE INSTRUCTIONS)				
1.00 Resource Utilization Group Par	yment (RUGS)			723, 125	1.00
2 00 Pouting corving other pass th	rough costs				2 00

			1
		1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A	A PPS SNF	ı
	SERVI CES SERVI CES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	723, 125	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)	723, 125	4. 00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E,		5. 00
	Part B. This line is now shaded.)		1
6.00	Deducti bl e	0	6. 00
7.00	Coi nsurance	69, 737	7. 00
8.00	Allowable bad debts (see instructions)	0	
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9. 00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11. 00	Utilization review	0	11. 00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	653, 388	12. 00
13.00	Inpatient primary payer payments	0	13. 00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14. 00
14. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14. 50
14. 99	Recovery of Accel erated Depreciation	0	14. 99
15.00	Subtotal (see instructions	653, 388	15. 00
15. 01	Sequestration adjustment (see instructions)	13, 068	15. 01
16.00	Interim payments	640, 320	16. 00
17.00	Tentative settlement (for contractor use only)	0	17. 00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18. 00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,	0	19. 00
	§115. 2		1

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od: Worksheet E-3 From 06/01/2016 Part VII To 05/31/2017 Date/Time Prepared:

PART_VIICALCILIATION OF DELINDISCRIPT. ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				To 05/31/2017	Date/Time Prep 10/30/2017 4:	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX	Hospi tal		
PART VII - CALCULATION OF REIMBURSHAFT - ALL OTHER HEALTH SERVICES   CODEPUTION OF NET COST OF COVERED SERVICES   1.00   Inpatient hospital/SMF/NF services   0   1.003,793 2.00   1.003,793 2.00   Medical and other services   0   1.003,793 2.0						
COMPUTATION OF NET COST OF COVERED SERVICES   1,00,000   1,003,793   2,00   1,003,793				1. 00	2. 00	
Inpatient hospital /SMF/MF services		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XI)	SERVI CES		
2.00   Medical and other services   1,003,793   2,00   3.00   0,003,793   2,00   0   1,003,793   2,00   0   1,003,793   3,00   0,000,793   3,00		COMPUTATION OF NET COST OF COVERED SERVICES				
3.00   Organ acquisition (certified transplant centers only)   3.00   1,003,793   4.00   5.00   Inpatient primary payer payments   0   0,003,793   4.00   1,003,793   4.00   4.00   4.00   4.00   4.00   4.00   4.00   4.00	1.00	Inpatient hospital/SNF/NF services		0		1. 00
Subtotal (sum of lines 1, 2 and 3)	2.00	Medical and other services			1, 003, 793	2.00
5.00	3.00	Organ acquisition (certified transplant centers only)		0		3.00
0.00   0.0	4.00	Subtotal (sum of lines 1, 2 and 3)		0	1, 003, 793	4. 00
1,003,793   7,00				0		5. 00
Reasonable Charges					0	
Reasonable Charges   8.00   Routine service charges   7,695,496   7,688,242   9,00	7. 00			0	1, 003, 793	7. 00
8.00   Routine service charges   0   7, 688, 242   9.00   10.00   0rgan acquisition charges, not of revenue   7, 695, 496   7, 688, 242   10.00   10						
9.00   Ancillary service charges   7, 695, 496   7, 688, 242   9, 00				_		
10.00   Organ acquisition charges, net of revenue   0   10.0		g .		0	7 (00 010	
11.00   Incentive from target amount computation   11.00   7,685,496   7,688,242   12.00   13.00   1				7, 695, 496	7, 688, 242	
12.00   Total reasonable charges (sum of lines 8 through 11)   7,695,496   7,688,242   12.00		1 3 1		0		
CUSTOMARY CHARGES				7 (05 40(	7 (00 040	
13.00   Amount actually collected from patients liable for payment for services on a charge   0   0   13.00	12.00			7, 695, 496	7, 688, 242	12.00
basis   14.00   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.00   15.00   10.00	12 00		sorvi cos on a chargo		0	12 00
14.00   Amounts that would have been realized from patients Liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.00   15.00   16.00   Total customary charges (see instructions)   7,695,496   7,688,424   16.00   1	13.00	1	services on a charge	U	U	13.00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e)  15. 00 Ratio of line 13 to line 14 (not to exceed 1.000000)  16. 00 Total customary charges (see instructions)  17. 00 Excess of customary charges (see instructions)  18. 00 Excess of customary charges (see instructions)  18. 01 Excess of reasonable cost over customary charges (complete only if line 16 exceeds line 16 (see instructions)  19. 00 Interns and Residents (see instructions)  19. 00 Interns and Residents (see instructions)  19. 00 Cost of physic lans' services in a teaching hospital (see instructions)  10. 00 Cost of physic lans' services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of physic lans' services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of payments  10. 00 Cost of payments  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 01 Cost of covered services (enter the lesser of line 16)  10. 00 Cost	14 00		navment for services on	0	0	14 00
15. 00	1 1. 00				Ö	11.00
16.00   Total customary charges (see instructions)   7,695,496   7,688,242   16.00	15. 00		5. K 3. F5. F5(5)	0.000000	0.000000	15. 00
17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   7,695,496   6,684,449   17.00     18.00   Initer 4) (see instructions)						
Iline 4  (see instructions)			if line 16 exceeds			17. 00
16) (see instructions)						
19.00   Interns and Residents (see instructions)   0   0   19.00   20.00   2	18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
20. 00   Cost of physicians' services in a teaching hospital (see instructions)   0   1,003,793   21.00						
21.00	19. 00			0	0	19.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					o l	
22.00   Other than outlier payments   0   0   0   22.00	21. 00	,	·		1, 003, 793	21. 00
23. 00 Outlier payments		, , , , , , , , , , , , , , , , , , ,	ompleted for PPS provide			
24.00 Program capital payments 25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 26.00 Subtotal (sum of lines 22 through 26) 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30 0 0 0 32.00 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 ELIMINATE SETTLEMENT 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  24.00 25.00 25.00 26.00 27.00 27.00 28.00 27.00 28.00 29.0		. ,		_	- 1	
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 ELIMINATE SETTLEMENT 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Balance due provi der/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,					0	
26.00       Routine and Ancillary service other pass through costs       0       0       26.00         27.00       Subtotal (sum of lines 22 through 26)       0       0       27.00         28.00       Customary charges (title V or XIX PPS covered services only)       0       0       28.00         29.00       Titles V or XIX (sum of lines 21 and 27)       0       1,003,793       29.00         COMPUTATION OF REIMBURSEMENT SETTLEMENT         30.00       Excess of reasonable cost (from line 18)       0       0       30.00         31.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       0       1,003,793       31.00         32.00       Deductibles       0       0       32.00         33.00       Coinsurance       0       0       33.00         34.00       Allowable bad debts (see instructions)       0       0       34.00         35.00       Utilization review       0       1,003,793       35.00         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       0       1,003,793       36.00         37.00       Subtotal (line 36 ± line 37)       0       -1,003,793       37.00         38.00       Subtotal (line 36 ± line 37)       0       -1,003,79						
27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 0 1, 003, 793  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 0 1, 003, 793 31. 00 22. 00 Deductibles 0 0 0 32. 00 33. 00 Coinsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 0 1, 003, 793 37. 00 37. 00 Extension of lines 31, 34 and 35 minus sum of lines 32 and 33) 0 1, 003, 793 37. 00 38. 00 Subtotal (line 36 ± line 37) 0 -1, 003, 793 37. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 38. 00 39. 00 Total amount payable to the provider (sum of lines 38 and 39) 0 0 40. 00 41. 00 Horeim payments 10 0 41. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00		' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '			0	
28. 00 Customary charges (title V or XIX PPS covered services only)  Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  Deductibles  Coinsurance  30. 00 Itilization review  30. 00 Utilization review  30. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  Coinsurance  30. 00 Itilization review  30. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  To ELIMINATE SETTLEMENT  Subtotal (line 36 ± line 37)  Direct graduate medical education payments (from Wkst. E-4)  Total amount payable to the provider (sum of lines 38 and 39)  To express the very line and the provider (sum of lines 38 and 39)  Interim payments  Along the very line and 20, plus 29 minus line 41)  Description of lines 21 and 27)  Description of lines 31, 30, 30, 30, 30, 30, 30, 30, 30, 30, 30				_	-	
29.00   Titles V or XIX (sum of lines 21 and 27)   29.00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   30.00   Excess of reasonable cost (from line 18)   30.00   31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   0   1,003,793   31.00   32.00   20.				_	0	
COMPUTATION OF REIMBURSEMENT SETTLEMENT   30.00   Excess of reasonable cost (from line 18)   0   0   30.00   31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   0   1,003,793   31.00   32.00   Deductibles   0   0   0   32.00   33.00   Coinsurance   0   0   0   0   34.00   34.00   Allowable bad debts (see instructions)   0   0   0   34.00   35.00   Utilization review   0   35.00   36.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   0   1,003,793   36.00   37.00   ELIMINATE SETTLEMENT   0   -1,003,793   37.00   38.00   Subtotal (line 36 ± line 37)   0   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00   40.00   Total amount payable to the provider (sum of lines 38 and 39)   0   0   0   41.00   42.00   Balance due provider/program (line 40 minus line 41)   0   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43.00					1 002 702	
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Deductibles 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 ELIMINATE SETTLEMENT 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	29.00			U	1,003,773	29.00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32.00 Deductibles  32.00 Coinsurance  34.00 Allowable bad debts (see instructions)  35.00 Utilization review  36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 ELIMINATE SETTLEMENT  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	30 00			0	0	30 00
32.00   Deductibles   0   0   32.00   33.00   33.00   Coinsurance   0   0   0   33.00   34.00   Allowable bad debts (see instructions)   0   0   34.00   35.00   Utilization review   0   35.00   35.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   0   1,003,793   36.00   37.00   ELIMINATE SETTLEMENT   0   -1,003,793   37.00   38.00   Subtotal (line 36 ± line 37)   0   0   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   0   0   39.00   40.00   Total amount payable to the provider (sum of lines 38 and 39)   0   0   40.00   41.00   Interim payments   0   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43.00		l , , , , , , , , , , , , , , , , , , ,		_		
33.00   Coinsurance   0   0   33.00   34.00   34.00   35.00   Utilization review   0   35.00   35.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   0   1,003,793   36.00   37.00   ELIMINATE SETTLEMENT   0   -1,003,793   37.00   38.00   Subtotal (line 36 ± line 37)   0   0   0   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   0   0   39.00   40.00   41.00   Interim payments   0   0   40.00   41.00   Interim payments   0   0   41.00   42.00   Balance due provider/program (line 40 minus line 41)   0   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43.00				_		
34. 00       Allowable bad debts (see instructions)       0       0       34. 00         35. 00       Utilization review       0       35. 00         36. 00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       0       1,003,793       36. 00         37. 00       ELIMINATE SETTLEMENT       0       -1,003,793       37. 00         38. 00       Subtotal (line 36 ± line 37)       0       0       38. 00         39. 00       Direct graduate medical education payments (from Wkst. E-4)       0       39. 00         40. 00       Total amount payable to the provider (sum of lines 38 and 39)       0       0       40. 00         41. 00       Interim payments       0       0       41. 00         42. 00       Bal ance due provider/program (line 40 minus line 41)       0       0       42. 00         43. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,       0       0       43. 00				0	-	
35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 ELIMINATE SETTLEMENT 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 1, 003, 793 36. 00 1, 003, 793 37. 00 38. 00 0 38. 00 0 38. 00 0 49. 00 0 41. 00 0 42. 00 0 43. 00				_	-	
37. 00   ELIMINATE SETTLEMENT		·		0	_	
37. 00       ELIMINATE SETTLEMENT       0       -1,003,793       37.00         38. 00       Subtotal (line 36 ± line 37)       0       0       38.00         39. 00       Direct graduate medical education payments (from Wkst. E-4)       0       39.00         40. 00       Total amount payable to the provider (sum of lines 38 and 39)       0       0       40.00         41. 00       Interim payments       0       0       41.00         42. 00       Balance due provider/program (line 40 minus line 41)       0       0       42.00         43. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,       0       0       43.00	36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	0	1, 003, 793	36. 00
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  39.00 0 40.00 0 41.00 0 42.00 0 43.00	37.00	, and the second	,	0		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  39.00 0 40.00 0 41.00 0 42.00 0 43.00	38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
41.00 Interim payments  0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 0 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00 43.00	40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	41.00			0	0	41. 00
	42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
chapter 1, §115.2	43.00	, , , , , , , , , , , , , , , , , , , ,	e with CMS Pub 15-2,	0	0	43.00
		chapter 1, §115.2				

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047		Worksheet E-3
		From 06/01/2016	Part VII
	Component CCN: 15-S047	To 05/31/2017	Date/Time Prepared:
			10/30/2017 4: 18 pm
	Title XIX	Subprovi der -	PPS

		II ti e xi x	I PF	PPS	
			Inpati ent	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	TOR TITLES VOR XIV	OERVI OEO		
1.00	Inpatient hospital/SNF/NF services		O		1.00
2. 00	Medical and other services			0	
3. 00	Organ acquisition (certified transplant centers only)		o	Ü	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		o	0	4. 00
5. 00	Inpatient primary payer payments		o	ŭ	5. 00
6.00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		o	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		<u> </u>		7.00
	Reasonable Charges				İ
8.00	Routine service charges		451, 350		8.00
9. 00	Ancillary service charges		248, 507	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		o		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		699, 857	0	•
	CUSTOMARY CHARGES		, , , , , ,		
13.00	Amount actually collected from patients liable for payment for serv	ices on a charge	0	0	13.00
	basis	3			
14.00	Amounts that would have been realized from patients liable for paym	ent for services on	o	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFR	§413. 13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		699, 857	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	699, 857	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instruction	ns)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be compl	eted for PPS provide			
	1 3		0	0	
23. 00	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
25. 00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		0	0	25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00 28. 00	Subtotal (sum of lines 22 through 26)		_		
29. 00	, , , , , , , , , , , , , , , , , , , ,		0	0	ł
29.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		l d	0	29.00
30. 00			O	0	30.00
31. 00	Excess of reasonable cost (from line 18)		0	0	31.00
32. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		0	0	
33. 00			0	0	
	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review		0	U	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		l ő	0	
			Ö	O	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)			0	
	Interim payments		Ö	0	
42. 00	Balance due provider/program (line 40 minus line 41)		Ö	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub 15-2	Ö	0	43. 00
	chapter 1, §115. 2			Ŭ	
	• • • • • • • •		. '		

Heal th	Financial Systems ST JOSEPH MEDICA	AL CENTER		In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provi der Co		Period: From 06/01/2016	Worksheet E-4	
				To 05/31/2017	Date/Time Prep 10/30/2017 4:	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	. 0	·		7. 63	1. 00
2. 00 3. 00	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MM		1) (see instru	uctions)	0. 00 0. 00	2. 00 3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)		§413.79 (m).	(see	0.00	3. 01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	-0. 80	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		cost reporti	ng periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	ructions for (	cost reporting	0. 00	4. 02
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus li	ines 4.01 and	6. 83	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current y	year from your	5. 29	6. 00
7. 00	Enter the lesser of line 5 or line 6				5. 29	7. 00
			Primary Care 1.00	0ther 2.00	<u>Total</u> 3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	athi c	5. 2		5. 29	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6.		5. 2	9 0.00	5. 29	9. 00
10. 00	Weighted dental and podiatric resident FTE count for the curr			0.00		10. 00
10. 01 11. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	rrent year	5. 2 <sup>d</sup>	0. 00 9 0. 00		10. 01 11. 00
12. 00	Total weighted resident FTE count for the prior cost reportin instructions)	g year (see	5. 1			12. 00
13. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porti ng	5. 1	0.00		13. 00
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	5. 19			14. 00
15. 00	Adjustment for residents in initial years of new programs	roaromo	0.00			15. 00 15. 01
15. 01 16. 00	Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo		0.00			16. 00
16. 01	Unweighted adjustment for residents displaced by program or h		0.00			16. 01
17. 00	Adjusted rolling average FTE count		5. 1			17. 00
18. 00 19. 00	Per resident amount Approved amount for resident costs		97, 178. 1 <sup>9</sup> 504, 35		504, 355	18. 00 19. 00
171.00	The provided and arrest to the control of the contr		55.755	<u> </u>		
20.00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	can slots rece	eived under 42	1. 00	20. 00
	Sec. 413.79(c)(4)		54p 5. 515 . 55.	5. 75 <b>u</b> d.1u5. 12		
21. 00 22. 00	Direct GME FTE unweighted resident count over cap (see instru Allowable additional direct GME FTE Resident Count (see instr				0. 00 0. 00	21. 00 22. 00
23. 00	Enter the locally adjustment national average per resident am		structions)		96, 641. 08	
24. 00	Multiply line 22 time line 23				0	
25.00	Total direct GME amount (sum of lines 19 and 24)		Inpatient Par	t Managed care	504, 355	25. 00
			. A	ŭ	2.00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2. 00	3. 00	
26. 00	Inpatient Days (see instructions)		8, 65			26. 00
27. 00 28. 00	Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		28, 28 0. 30588			27. 00 28. 00
29. 00	Program direct GME amount		154, 27			29. 00
30.00	Reduction for direct GME payments for Medicare Advantage			12, 435		30. 00
31. 00	Net Program direct GME amount		I		229, 847	31. 00

Hoal th	Financial Systems ST JOSEPH MEDICA	AL CENTED	In Lio	u of Form CMS-2	2552 10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0047	Peri od:	Worksheet E-4	
	L EDUCATION COSTS	Trevider ed. 18 ee 17	From 06/01/2016 To 05/31/2017	Date/Time Pre 10/30/2017 4:	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI EDUCATION COSTS)	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 ar	nd 23, lines 74	0	32. 00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	1, 165, 791	33. 00
34.00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35. 00
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
37. 00	Reasonable cost (see instructions)			15, 050, 643	
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39. 00
40.00	1 3 1 3 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1	11 (0)		·	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)		15, 047, 312	41.00
42.00	Part B Reasonable Cost Reasonable cost (see instructions)			5, 776, 682	12.00
	Primary payer payments (see instructions)			5, 776, 662	1
44. 00	) ) ) ) )			5, 776, 663	
45. 00	Total reasonable cost (sum of lines 41 and 44)			20, 823, 975	1
46. 00	,	e 41 ÷ line 45)		0. 722596	1
	Ratio of Part B reasonable cost to total reasonable cost (line			0. 277404	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA				
48.00	Total program GME payment (line 31)			229, 847	48. 00
49. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		166, 087	49. 00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		63, 760	50.00

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

Provider CCN: 15-0047

| Peri od: | Worksheet G | From 06/01/2016 | To 05/31/2017 | Date/Time Prepared: 10/30/2017 4: 18 pm

oni y)					10/30/2017 4:	
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-422, 258		0	0	
2. 00 3. 00	Temporary investments Notes receivable	0		-	0	
4. 00	Accounts receivable	25, 433, 777	1		0	
5. 00	Other receivable	0		o o	Ö	
6.00	Allowances for uncollectible notes and accounts receivable	-6, 838, 754	. (	0	0	6.00
7.00	Inventory	3, 551, 091		0	0	
8.00	Prepai d expenses	752, 072		0	0	
9.00	Other current assets	1, 207, 207	1	1	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	23, 683, 135		0	0	
11.00	FIXED ASSETS	23,003,133	'	<u>)</u>	0	11.00
12.00	Land	1, 010, 000	) (	0	0	12. 00
13.00	Land improvements	400, 981	1	0	0	
14.00	Accumulated depreciation	-316, 600	1	0		
15. 00	Bui I di ngs	28, 342, 319	1	0	0	
16.00	Accumulated depreciation	-16, 059, 767	1	0	0	
17. 00 18. 00	Leasehold improvements Accumulated depreciation	21, 866, 171 -6, 538, 939		1	0   0	
19. 00	Fi xed equipment	491, 652	1	1	0	
20. 00	Accumulated depreciation	171,002		o o	Ö	
21.00	Automobiles and trucks	0		0	0	
22.00	Accumulated depreciation	0	) (	0	0	22. 00
23.00	Major movable equipment	19, 711, 597		0	0	
24. 00	Accumulated depreciation	-16, 764, 672	1	1	0	
25. 00	Mi nor equi pment depreci abl e	8, 117, 376		1	0	
26. 00 27. 00	Accumulated depreciation HIT designated Assets	-6, 418, 441			0 0	
28. 00	Accumulated depreciation				0	
29. 00	Mi nor equi pment-nondepreci abl e	Ö	1	o o	Ö	
30.00	Total fixed assets (sum of lines 12-29)	33, 841, 677	' (	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	)		-	
32.00	Deposits on leases	0	1	0	0	
33. 00 34. 00	Due from owners/officers Other assets	8, 719, 794	1		0	1
35. 00	Total other assets (sum of lines 31-34)	8, 719, 794	•	1	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	66, 244, 606	1	o o		
	CURRENT LI ABI LI TI ES					
37.00	Accounts payable	2, 975, 103	1	0		
38. 00	Salaries, wages, and fees payable	3, 007, 689	1	0	0	
39.00	Payroll taxes payable (chart tarm)	355, 371	1	0	0 0	
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	22, 222				
42. 00	Accel erated payments					42.00
43. 00	Due to other funds	15, 791, 064		0	0	1
44.00	Other current liabilities	1, 763, 843	(	0	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	23, 915, 292	! (	0	0	45. 00
	LONG TERM LIABILITIES	ı .	.1	J .		
46.00	Mortgage payable	14 015	) (	1	0	
47. 00 48. 00	Notes payable Unsecured Loans	14, 815				1
49. 00	Other long term liabilities				Ö	
50.00	Total long term liabilities (sum of lines 46 thru 49)	14, 815				
51. 00	Total liabilities (sum of lines 45 and 50)	23, 930, 107	' (	0	0	51.00
F2 00	CAPITAL ACCOUNTS	42 244 400				F2 00
52. 00 53. 00	General fund balance Specific purpose fund	42, 314, 499				52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			1		54.00
55. 00	Donor created - endowment fund balance - unrestricted		1			55. 00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,		1		0	58. 00
EQ 00	replacement, and expansion	40.044.400	,	_	_	FO 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	42, 314, 499 66, 244, 606		0	0 0	
00.00	[59]	00, 244, 000	]	1		00.00
	1 /	1	•	1	•	'

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

					To	o 05/31/2017	Date/Time Pro 10/30/2017 4:	pared: 18 pm
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	
		1.00	2.00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		39, 933, 179			0		1. 00 2. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		-5, 459, 292 34, 473, 887			0		3.00
4. 00	ADJUSTMENTS TO RETAINED EARNINGS	7, 840, 612	34, 473, 007		0	-		
5.00		0			0		C	
6.00		0			0		C	
7.00		0			0			
8. 00 9. 00					0			
10. 00	Total additions (sum of line 4-9)		7, 840, 612		O	0	· ·	10.00
11. 00	Subtotal (line 3 plus line 10)		42, 314, 499			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0			0		C	
13. 00 14. 00		0			0			
15. 00					0			
16. 00		o			0			
17. 00		0			0		C	
18.00	Total deductions (sum of lines 12-17)		0			0	ł	18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		42, 314, 499			0		19. 00
	, , , , , , , , , , , , , , , , , , , ,	Endowment Fund	PI ant	Fund				
		( 00	7.00	0.00				
1. 00	Fund balances at beginning of period	6.00	7. 00	8. 00	0			1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)				O			2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	ADJUSTMENTS TO RETAINED EARNINGS		0					4. 00
5. 00 6. 00			0					5. 00 6. 00
7. 00			0					7. 00
8.00			0					8. 00
9. 00		_	0					9. 00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0			10. 00 11. 00
12. 00	Deductions (debit adjustments) (specify)		0		U			12.00
13. 00			0					13. 00
14. 00			0					14. 00
15.00			0					15. 00 16. 00
16. 00 17. 00			0					16.00
18. 00	Total deductions (sum of lines 12-17)	o	0		0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19. 00

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

			То	05/31/2017	Date/Time Prep 10/30/2017 4:	
	Cost Center Description	Inpatient	_	Outpati ent	Total	ТО РІІІ
	oust defiter bescription	1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00		2.00	3. 00	
	General Inpatient Routine Services					
1.00	Hospi tal	49, 321, 3	83		49, 321, 383	1.00
2.00	SUBPROVI DER - I PF	17, 702, 5			17, 702, 506	2. 00
3.00	SUBPROVIDER - I RF	17,702,0			.,,,,,,,,	3. 00
4. 00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY	3, 625, 3	38		3, 625, 338	7. 00
8.00	NURSING FACILITY	.,			.,,	8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	70, 649, 2	27		70, 649, 227	
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	1, 052, 0	59		1, 052, 059	11. 00
11. 01	NEONATAL INTENSIVE CARE UNIT	1, 974, 6	04		1, 974, 604	11. 01
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT	9, 729, 5	20		9, 729, 520	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 lines	12, 756, 1	83		12, 756, 183	16. 00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	83, 405, 4	10		83, 405, 410	17. 00
18.00	Ancillary services	200, 546, 5	31	196, 145, 309	396, 691, 840	18. 00
19.00	Outpati ent servi ces	9, 974, 4	82	42, 031, 550	52, 006, 032	19. 00
20.00	RURAL HEALTH CLINIC		0	O	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22.00	HOME HEALTH AGENCY					22. 00
23.00	AMBULANCE SERVICES					23. 00
24.00	CMHC					24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26. 00	HOSPI CE					26. 00
27. 00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	293, 926, 4	23	238, 176, 859	532, 103, 282	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			88, 907, 210		29. 00
30. 00	ADD (SPECIFY)		0			30. 00
31. 00			0			31. 00
32. 00			0			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00	T + 1 + 1111 (		0			35. 00
36.00	Total additions (sum of lines 30-35)			0		36. 00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38.00			0			38. 00
39. 00			0			39. 00
40.00			0			40.00
41. 00	Total deductions (sum of lines 27 41)		U			41. 00 42. 00
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	r		88, 907, 210		42.00
43.00	to Wkst. G-3, line 4)	'		00, 901, 210		43.00
	110 mKSt. 0 3, 11110 4)	1	1	I	l	ı

Heal t	n Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0047	Peri od:	Worksheet G-3	
			From 06/01/2016		
			To 05/31/2017	Date/Time Prep 10/30/2017 4:	
				10/30/2017 4.	TO pill
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, line 28)		532, 103, 282	1. 00
2.00	Less contractual allowances and discounts on	patients' accounts		448, 795, 162	2. 00
3.00	Net patient revenues (line 1 minus line 2)	•		83, 308, 120	3. 00
4.00	Less total operating expenses (from Wkst. G-	2, Part II, line 43)		88, 907, 210	4. 00
5.00	Net income from service to patients (line 3	minus line 4)		-5, 599, 090	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellane	ous communication services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and gue	sts		0	14.00
15.00	3 1			0	15. 00
16.00				0	16. 00
17. 00				0	17. 00
18.00				0	18. 00
19. 00		•		0	19. 00
20.00	3	nd canteen		0	20. 00
21. 00	3			0	21. 00
22. 00	· · ·			0	22. 00
23.00	The second secon			0	23. 00
24. 00				139, 798	

0 27. 00

-5, 459, 292 29. 00

25. 00 26. 00

28. 00

139, 798 -5, 459, 292

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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

27. 00 OTHER EXPENSES (SPECIFY)

CALCUL	Financial Systems ST JOSEPH MEDI ATION OF CAPITAL PAYMENT	Provider CCN: 15-0047	Peri od:	u of Form CMS-2 Worksheet L	
			From 06/01/2016 To 05/31/2017	Parts I-III Date/Time Pre	pared
		T: +1 a W/III	Hooni tal	10/30/2017 4: PPS	18 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			606, 979	
. 01	Model 4 BPCI Capital DRG other than outlier			0	1. (
2.00	Capital DRG outlier payments			89, 420	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.0
3. 00	Total inpatient days divided by number of days in the cost r	reporting period (see insi	ructions)	62. 63	
. 00	Number of interns & residents (see instructions)			5. 19 2. 37	
5. 00 5. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by th	ho cum of lines 1 and 1 0	L columns 1 and	2. 37 14, 385	
. 00	1.01) (see instructions)	the sum of fittes faile 1.0	i, coruillis i and	14, 303	0.
7. 00	Percentage of SSI recipient patient days to Medicare Part A	natient days (Worksheet F	nart Aline	10. 68	7.
. 00	30) (see instructions)	patrent days (worksheet t	, part A Title	10.00	′.
3. 00	Percentage of Medicaid patient days to total days (see instr	ructions)		40. 54	8.
. 00	Sum of lines 7 and 8	,		51. 22	
0.00	Allowable disproportionate share percentage (see instruction	ns)		10. 93	10.
1. 00	Di sproporti onate share adjustment (see instructions)			66, 343	11.
2. 00	Total prospective capital payments (see instructions)			777, 127	12.
	DART III DAMENT INDER RELOCUENT COOT			1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			0	1 .
1.00 2.00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)			0	1
3. 00	Total inpatient program capital cost (see instructions)			0	
i. 00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	
. 00	Total Tripatrent program capital cost (Trie 3 x Trie 4)			0	J.
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
. 00	Program inpatient capital costs (see instructions)			0	
. 00	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	
. 00	Net program inpatient capital costs (line 1 minus line 2)			0 0. 00	
. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0.00	
. 00	Percentage adjustment for extraordinary circumstances (see i	instructions)		0. 00	
. 00	Adjustment to capital minimum payment level for extraordinar		(line 6)	0.00	
. 00	Capital minimum payment level (line 5 plus line 7)	ry errediiistances (Trie 2 /	( Title 0)	0	
. 00	Current year capital payments (from Part I, line 12, as appl	Li cable)		0	
0. 00	Current year comparison of capital minimum payment level to		less line 9)	0	
1. 00	Carryover of accumulated capital minimum payment level over	1 1 3 1	,	0	
	Worksheet L, Part III, line 14)	1.9			
	Net comparison of capital minimum payment level to capital p	payments (line 10 plus lir	ne 11)	0	12.
12. 00	Current year exception payment (if line 12 is positive, enter	er the amount on this line	e)	0	13.
				0	14.
3. 00	Carryover of accumulated capital minimum payment level over	capital payment for the i			
3. 00 4. 00	(if line 12 is negative, enter the amount on this line)		January Parisa		
12. 00 13. 00 14. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see in		January Paris	0	
3. 00 4. 00 5. 00 6. 00	(if line 12 is negative, enter the amount on this line)		and the second	0	16.