				107	01/2010 1. 14 pm
PART I - COST	REPORT STATUS				
Provi der use onl y	1. [ X ] Electronically filed 2. [ ] Manually submitted of 3. [ O ] If this is an amende 4. [ F ] Medicare Utilization	ost report d report enter the number c		Date: 10/31/2018 esubmitted this cost r	Time: 1:14 p
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended		this Provider CCN 12.	NPR Date: Contractor's Vendor Co [ O ]If line 5, column number of times r	1 is 4: Enter

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST JOSEPH MEDICAL CENTER (15-0047) for the cost reporting period beginning 06/01/2017 and ending 05/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

		Title XVIII					
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	483, 970	3, 838	0	0	1. 00
2.00	Subprovi der - IPF	0	9	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	101	0		0	7. 00
200.00	Total	0	484 080	3 838	0	0	200 00

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

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0047 Peri od: Worksheet S-2 From 06/01/2017 Part I 05/31/2018 Date/Time Prepared: 10/31/2018 1:09 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 700 BROADWAY STREET 1.00 PO Box: 1.00 State: IN 2.00 City: FORT WAYNE Zip Code: 46802 County: ALLEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST JOSEPH MEDICAL 150047 23060 07/01/1996 N Р Р 3.00 1 Subprovi der - IPF ST JOSPEH GENERATIONS Р Р 4.00 15S047 23060 4 06/01/2003 N 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF SKILLED NURSING 155356 23060 04/01/1990 Ρ Ν 9.00 FACILITY ST JOSEPH 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital - Based Health Clinic - FQHC 16.00

17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 05/31/2018 20.00 06/01/2017 21.00 Type of Control (see instructions) 21.00 4 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ 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 Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 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 Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23.00 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	in-State	Uut-or	out-or	wearcara	other	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	pai d days	eligible	Medi cai d	Medi cai d		days	
		unpai d	paid days	eligible			
		days		unpai d			
	1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24.00 If this provider is an IPPS hospital, enter the	1, 712	446	29	69	6, 586	100	24. 00
in-state Medicaid paid days in column 1, in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid paid days in column 3,							
out-of-state Medicaid eligible unpaid days in column							
4, Medicaid HMO paid and eligible but unpaid days in							
column 5, and other Medicaid days in column 6.							
25.00 If this provider is an IRF, enter the in-state	0	0	0	0	0		25. 00
Medicaid paid days in column 1, the in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid days in column 3, out-of-state							
Medicaid eligible unpaid days in column 4, Medicaid							
HMO paid and eligible but unpaid days in column 5.							

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Li	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICAT		Provi der CC		eriod: rom 06/01/2017	Worksheet S-2	
			T			
		I			Date of Geogr	
26.00 Enter your standard geographic classification (	not wage) sta	atus at the bed	inning of the	1. 00	2.00	26. 00
cost reporting period. Enter "1" for urban or " 27.00 Enter your standard geographic classification (	not wage) sta	atus at the end			1	27. 00
reporting period. Enter in column 1, "1" for ur enter the effective date of the geographic recl 35.00 If this is a sole community hospital (SCH), ent	assi fi cati on	in column 2.	•		0	35. 00
effect in the cost reporting period.						00.00
				Begi nni ng: 1. 00	Endi ng: 2. 00	-
36.00 Enter applicable beginning and ending dates of of periods in excess of one and enter subsequen		Subscript line	36 for number			36. 00
37.00 If this is a Medicare dependent hospital (MDH),		umber of period	ls MDH status		О	37. 00
is in effect in the cost reporting period.  37.01 Is this hospital a former MDH that is eligible accordance with FY 2016 OPPS final rule? Enter				N		37. 01
instructions)	,		•			20.00
38.00 If line 37 is 1, enter the beginning and ending greater than 1, subscript this line for the num enter subsequent dates.						38. 00
				Y/N 1. 00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient ho				N N	N N	39. 00
hospitals in accordance with 42 CFR §412.101(b) for yes or "N" for no. Does the facility meet t with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in instructions)	he mileage re	équirements in	accordance			
40.00 Is this hospital subject to the HAC program red "N" for no in column 1, for discharges prior to	October 1. E	Enter "Y" for y		Y	N	40. 00
no in column 2, for discharges on or after Octo	ber 1. (see i	nstructions)		V	XVIII XIX	
Description Downert Cystem (DDC) Conital				1. (		
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital		di sproporti onat	e share in acc	cordance Y	YN	45. 00
with 42 CFR Section §412.320? (see instructions 46.00 Is this facility eligible for additional paymen pursuant to 42 CFR §412.348(f)? If yes, complet	t exception 1				N N	46. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b)					N N	47. 00
48.00 Is the facility electing full federal capital p						48. 00
Teaching Hospitals  56.00 Is this a hospital involved in training residen	ts in approve	ed GME programs	? Enter "Y" f	for ves Y		56. 00
or "N" for no.		. 0				57. 00
57.00 If line 56 is yes, is this the first cost report GME programs trained at this facility? Enter " is "Y" did residents start training in the first cost and the first cost are as "N" for year in solution 2 life solution.	Y" for yes or t month of th	r "N" for no ir nis cost report	n column 1. If ing period? E	column 1 Enter "Y"		37.00
for yes or "N" for no in column 2. If column 2 "N", complete Wkst. D, Parts III & IV and D-2,	Pt. II, if a	opl i cabl e.				
58.00   If line 56 is yes, did this facility elect cost defined in CMS Pub. 15-1, chapter 21, §2148? If			ıns' services a	ıs N		58. 00
59.00 Are costs claimed on line 100 of Worksheet A?	If yes, compl	ete Wkst. D-2,	Pt. I. NAHE 413.85	Worksheet A		59. 00
			Y/N	Li ne #	Qualification Criterion Code	
60.00 Are you claiming nursing and allied health educ	ation (NAUE)	costs for	1. 00 N	2.00	3.00	60.00
any programs that meet the criteria under §413.	85? (see ins	structions)				60. 00
	Y/N	IME	Direct GME	IME	Direct GME	
44.00 00 10 10 10 10 10 10 10 10 10 10 10 1	1.00	2. 00	3. 00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no i column 1. (see instructions)	n N			0.0	0.00	61.00
61.01 Enter the average number of unweighted primary FTEs from the hospital's 3 most recent cost repending and submitted before March 23, 2010. (se	orts					61. 01
instructions) 61.02 Enter the current year total unweighted primary FTE count (excluding OB/GYN, general surgery FT and primary care FTEs added under section 5503	Es,					61. 02
ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used						61. 03
determining compliance with the 75% test. (see instructions)						

		ICAL CENTER			u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provi der C	1	Period: From 06/01/2017 To 05/31/2018	Worksheet S-2 Part I Date/Time Pre 10/31/2018 1:0	pared:
	Y/N	IME	Direct GME	I ME	Direct GME	
	1. 00	2. 00	3. 00	4. 00	5.00	
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being						61. 04 61. 05 61. 06
used for cap relief and/or FTEs that are nonprimary						01.00
care or general surgery. (see instructions)	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61. 20
					1. 00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital				ind for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instruction)  Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	cti ons) a Teachi	ng Health Cen	ter (THC) into			62. 01
Teaching Hospitals that Claim Residents in Nonprovio	ler Setti	i ngs				
63.00 Has your facility trained residents in nonprovider s "Y" for yes or "N" for no in column 1. If yes, compl	ettings ete line	auring this c es 64 through	ost reporting 67. (see instr	period? Enter uctions)	N	63. 00
			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te	Поэрт саг	2))	
Section 5504 of the ACA Base Year FTE Residents in N	lonnrovi	dor Sottings	1. 00	2.00	3.00	
period that begins on or after July 1, 2009 and befo	re June	30, 2010.	s base year		epor tring	
					0. 000000	64. 00
Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2. 00	3. 00	4. 00	5.00	

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0047 Peri od: Worksheet S-2 From 06/01/2017 Part I 05/31/2018 Date/Time Prepared: 10/31/2018 1:09 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTĔs (col. 3 + col FTEs in 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col. Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0. 00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTFs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 0.000000 67.00 67.00 Enter in column 1, the program 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column

	divided by (column 3 + column								
	4)). (see instructions)								
						1. 00	2. 00	3.00	
	Inpatient Psychiatric Facility F	PPS							
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	IPF), or does it conta	ain an IPF subp	rovi der?	Y			70.00
	Enter "Y" for yes or "N" for no	).							
71. 00	If line 70 is yes: Column 1: Did					N	N	0	71. 00
	recent cost report filed on or b	efore November 15, 20	004? Enter "Y" for ye	es or "N" for n	o. (see				
	42 CFR 412.424(d)(1)(iii)(c)) Co								
	program in accordance with 42 CF								
	Column 3: If column 2 is Y, indi	cate which program ye	ear began during this	cost reporting	peri od.				
	(see instructions)								
	Inpatient Rehabilitation Facilit	3							
75. 00	Is this facility an Inpatient Re		y (IRF), or does it co	ontain an IRF		N			75. 00
	subprovider? Enter "Y" for yes								
76.00	If line 75 is yes: Column 1: Did					N	N	0	76. 00
	recent cost reporting period end								
	no. Column 2: Did this facility								
	CFR 412.424 (d)(1)(iii)(D)? Ente								
	indicate which program year bega	n during this cost re	eporting period. (see	instructions)					

5, the ratio of (column 3

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	JN. 15-0047	Period: From 06/01/2017 To 05/31/2018	Worksheet S- Part I Date/Time Pr 10/31/2018 1	epared
				1.00	1
Long Term Care Hospital PPS					
OO Is this a long term care hospital (LTCH)? Enter "Y" for yes a ls this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.  TEFRA Providers			ng period? Enter	N N	80. ( 81. (
Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)  Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. ( 86. (
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	cl assi fi ed	under sectio	n	N	87.
1000(d)(1)(b)(vi): Litter 1 101 yes of N 101 ho.			V	XI X	
			1. 00	2.00	
Title V and XIX Services		-+   \/   <i>-</i>	NI NI	. v	4 00
00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	services? E	nter y for	N	Y	90.
00 Ís this hospital reimbursed for title V and/or XIX through the			N	Y	91.
full or in part? Enter "Y" for yes or "N" for no in the applic OO Are title XIX NF patients occupying title XVIII SNF beds (dual				N	92.
instructions) Enter "Y" for yes or "N" for no in the applicable		ron)? (see		IN IN	92.
OD Does this facility operate an ICF/IID facility for purposes or		d XIX? Enter	N	N	93.
"Y" for yes or "N" for no in the applicable column.  OD Does title V or XIX reduce capital cost? Enter "Y" for yes, an	nd "N" for n	o in the	N	N	94.
applicable column.	IIG N TOT II	o ili the	IN IN	IN IN	94.
00 $ \dot{f} $ line 94 is "Y", enter the reduction percentage in the appli			0. 00	0.00	95.
Does title V or XIX reduce operating cost? Enter "Y" for yes of applicable column.	or "N" for n	o in the	N	N	96.
00 If line 96 is "Y", enter the reduction percentage in the appli	icable colum	n.	0. 00	0.00	97.
OD Does title V or XIX follow Medicare (title XVIII) for the into stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.			Y	Y	98
O1 Does title V or XIX follow Medicare (title XVIII) for the report, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.				Y	98
Does title V or XIX follow Medicare (title XVIII) for the calc bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			Y	Y	98
for title V, and in column 2 for title XIX.  33 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes				N	98
for title V, and in column 2 for title XIX.  O4 Does title V or XIX follow Medicare (title XVIII) for a CAH reoutpatient services cost? Enter "Y" for yes or "N" for no in a			N d	N	98
in column 2 for title XIX.  55 Does title V or XIX follow Medicare (title XVIII) and add bacl  Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col				Y	98
column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) when cost re Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98
Rural Providers					4
.00 Does this hospital qualify as a CAH? .00 If this facility qualifies as a CAH, has it elected the all-i⊓	nclusive met	hod of payme	nt N		105 106
for outpatient services? (see instructions)	rol mburs	t for lon			107
.00  f this facility qualifies as a CAH, is it eligible for cost i training programs? Enter "Y" for yes or "N" for no in column					107
yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2					
reimbursed. If yes complete Wkst. D-2, Pt. II.	DNA foo scho	dul o Soo 4	2 N		108
.00 Is this a rural hospital qualifying for an exception to the CI CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	KINA TEE SCHE	uure: 3ee 4	2   11		100
	Physi cal	Occupati on		Respi ratory	
.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1.00	2.00	3.00	4.00	109
for yes or "N" for no for each therapy.					
				1.00	
.00 Did this hospital participate in the Rural Community Hospital		on project ( "N" for no.		N	110

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provide	R er CCN: 15-0047	Peri od:	Lieu of Form CM Worksheet	
		From 06/01/20 To 05/31/20	017 Part I	Prepare
		1. 00	2.00	
11.00 If this facility qualifies as a CAH, did it participate in the Frontie Health Integration Project (FCHIP) demonstration for this cost reporti "Y" for yes or "N" for no in column 1. If the response to column 1 is integration prong of the FCHIP demo in which this CAH is participating Enter all that apply: "A" for Ambulance services; "B" for additional befor tele-health services.	ng period? Enter Y, enter the g in column 2.	N	2.00	111.
			1.00 2.00 3.	00
Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for r is yes, enter the method used (A, B, or E only) in column 2. If column 3 either "93" percent for short term hospital or "98" percent for long psychiatric, rehabilitation and long term hospitals providers) based of Pub. 15-1, chapter 22, §2208.1.	n 2 is "E", enter g term care (incl on the definition	in column udes	N C	
16.00 s this facility classified as a referral center? Enter "Y" for yes or 17.00 s this facility legally-required to carry malpractice insurance? Enter no.		"N" for	N   N	116. 117.
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence.	1 if the policy	/ is	1	118.
jerum made. Enter 2 11 the porrey 13 occurrence.	Premi ums	Losses	Insurance	)
	1. 00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:	344, 2	221 84,	445	0 118.
		1. 00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost center off Administrative and General? If yes, submit supporting schedule listing and amounts contained therein.  19.00 DO NOT USE THIS LINE  20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1,	ng cost centers provision in ACA	N N	N	118. 119. 120.
"N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no.  11.00 Did this facility incur and report costs for high cost implantable dev	or the Outpatien nstructions)	t Y		121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e the Worksheet A line number where these taxes are included.				122.
Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and	"N" for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the cein column 1 and termination date, if applicable, in column 2.	ertification date	<b>e</b>		126.
(7.00) If this is a Medicare certified heart transplant center, enter the cer in column 1 and termination date, if applicable, in column 2.	rtification date			127.
28.00 If this is a Medicare certified liver transplant center, enter the cer in column 1 and termination date, if applicable, in column 2.				128.
29.00 If this is a Medicare certified lung transplant center, enter the cert column 1 and termination date, if applicable, in column 2.		n		129.
(0.00) If this is a Medicare certified pancreas transplant center, enter the date in column 1 and termination date, if applicable, in column 2.				130.
11.00   f this is a Medicare certified intestinal transplant center, enter the date in column 1 and termination date, if applicable, in column 2.				131.
(2.00) If this is a Medicare certified islet transplant center, enter the cer in column 1 and termination date, if applicable, in column 2. (2.00) If this is a Medicare certified other transplant center, enter the cor				132.
3.00   f this is a Medicare certified other transplant center, enter the cer in column 1 and termination date, if applicable, in column 2.  4.00   f this is an organ procurement organization (OPO), enter the OPO number of the column of the				133.
and termination date, if applicable, in column 2.  All Providers				
40.00 Are there any related organization or home office costs as defined in chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and h		Y	679005	140.

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0047 Peri od: Worksheet S-2 From 06/01/2017 Part I 05/31/2018 Date/Time Prepared: 10/31/2018 1:09 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141.00 Name: COMMUNITY HEALTH SYSTEMS Contractor's Name: WPS, INC. Contractor's Number: 10301 141 00 142.00 Street: 4000 MERIDIAN BLVD PO Box: 142.00 143.00 City: FRANKLIN State: Zip Code: 37067 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 of costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00

reasonable cost incurred for the HIT assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	"), enter the	9. 9	169. 00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	06/01/2017	05/31/2018	170. 00
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	(	171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

167 00

d168. 00

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the

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

Heal th	Financial Systems ST JOSEPH MED	DI CAL CENTER		In Lie	eu of Form CMS-	-2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0047	Peri od:	Worksheet S-2	
				From 06/01/2017 To 05/31/2018	Part II   Date/Time Pre	enared.
					10/31/2018 1:	
				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	N for all NO re	esponses. Ente	rall dates in	the	
	mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS					+
	Provider Organization and Operation					-
1. 00	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	instructions)			
		•	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare F		N			2. 00
	yes, enter in column 2 the date of termination and in colum	mn 3, "V" for				
2 00	voluntary or "I" for involuntary.		Y			2.00
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of		Y			3.00
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)					
			Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports				1	4
4. 00	Column 1: Were the financial statements prepared by a Cert		N			4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" 1					
	or "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	arrabre in				
5. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5. 00
0.00	those on the filed financial statements? If yes, submit red		"			0.00
	, , , , , , , , , , , , , , , , , , , ,		'	Y/N	Legal Oper.	
				1. 00	2.00	
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		6. 00
	the legal operator of the program?					
7.00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7.00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	adring the	N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved	araduate medic	al education	Υ		9.00
7. 00	program in the current cost report? If yes, see instruction		ai caacation	'		7.00
10. 00	Was an approved Intern and Resident GME program initiated of		he current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than I	I & Rin an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	Dad Dabta				1. 00	-
12. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	e eoo instruct	ione		Υ	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection p			et reporting	N N	13.00
13.00	period? If yes, submit copy.	borrey change c	diring this co.	st reporting	IN	13.00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	ves, see ins	tructi ons.	N	14.00
	Bed Complement		<b>J</b>		•	
15. 00	Did total beds available change from the prior cost reporti	ing period? If	yes, see insti	ructi ons.	Υ	15. 00
			t A		rt B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
4 / 00	PS&R Data		00 (00 (0040		00 (00 (0040	4, 00
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	08/30/2018	Y	08/30/2018	16. 00
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
		N		N		18.00
18.00	Report data for additional claims that have been billed					
18. 00						
18. 00	but are not included on the PS&R Report used to file this					1
18. 00	cost report? If yes, see instructions.	N		N		10 00
18. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	cost report? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems ST JOSEPH ME	DICAL CENTER		In Lie	u of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 15-0047	Peri od: From 06/01/2017 To 05/31/2018	Worksheet S-2 Part II	2 epared:
		Descri	Y/N			
	-	(	)	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	Insport data for other. Beserrae the other day astmorts.	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 records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, se				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	als made dur	ing the cost	N	23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost re	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	? If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during th	e cost renortin	a neriod? If	rves submit	N	27. 00
27.00	copy.  Interest Expense				.,	
28. 00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into dur	ing the cost	t reporting	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or		bt Service F	Reserve Fund)	N	29. 00
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If yes	s, see	N	30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If ves	s. see	N	31.00
	instructions. Purchased Services					
32. 00	Have changes or new agreements occurred in patient care se		d through co	ontractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		g to competi	tive bidding? If	N	33. 00
	no, see instructions. Provider-Based Physicians					
34. 00	Are services furnished at the provider facility under an a	rrangement with	provi der-ba	ased physicians?	N	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	risting agroomon	ts with the	provider based	N	35. 00
	physicians during the cost reporting period? If yes, see i		ts with the	·		33.00
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36.00
	If line 36 is yes, has a home office cost statement been p	repared by the	home office?			36.00
	If yes, see instructions.				40 /04 /004 /	
38. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en	nd of the home o	ffi ce.		12/31/2016	38. 00
39. 00	If line 36 is yes, did the provider render services to oth see instructions.	ner chain compon	ents? If yes	s, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	e home office?	If yes, see	N		40. 00
		1	00	2	00	
	Cost Report Preparer Contact Information			2.		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	VI CTORI A		ROMANKO		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HEAL	TH SYSTEMS			42. 00
40.00	preparer.	(/45) 005 4000		VII CTOR! A BOXXXX	MOSCHE MET	42.00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 925-4333		VI CTORI A_ROMAN	KU@UHS. NE I	43.00

Heal th	Financial Systems ST JOSEPH	H MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN: 15-0047	F	Period: From 06/01/2017 Fo 05/31/2018		pared:
		-	3.00		-		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3 respectively.		IANGER, REVENUE MANAGEME	NT			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 cosreport preparer in columns 1 and 2, respectively.	st					43. 00

Health Financial Systems ST JOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 06/01/2017 | Part I | To 05/31/2018 | Date/Time Prepared: Provider CCN: 15-0047

				'	0 05/31/2018	10/31/2018 1:0	
						I/P Days / 0/P	э у ріп
						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	70	27, 930	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		70	27, 930	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00					8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	31. 01	0	4, 760	0.00	0	8. 01
9.00	CORONARY CARE UNIT						9. 00
10. 00	•	33. 00	12	4, 380	0.00	0	10. 00
11. 00	•						11. 00
12. 00	, ,						12. 00
13.00		43. 00				0	13. 00
14.00			82	37, 070	0. 00		14. 00
15.00		40.00		,		0	15. 00
16.00		40. 00	19	6, 935		0	16. 00
17. 00							17. 00
18.00		44.00		7 000			18. 00
19.00		44. 00	20	7, 300		0	19. 00
20.00							20. 00
21. 00							21. 00
22. 00							22. 00 23. 00
23. 00 24. 00	` ,						24. 00
24. 00		30. 00					24. 00
25. 00	` ' '	30.00					25. 00
26. 00							26. 00
26. 25		89. 00				o	26. 25
27. 00		67.00	121			U	27. 00
28. 00	,		121			0	28. 00
29. 00						U	29. 00
30.00	•						30.00
31. 00	1 3						31. 00
32. 00	1 3		0	2, 720			32. 00
32. 01	<i>y y y y</i>			2,720			32. 01
52.01	outpatient days (see instructions)						32.01
33. 00			•				33. 00
33. 01	LTCH site neutral days and discharges						33. 01
			•		•		•

Health Financial Systems ST JOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0047

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 06/01/2017 | Part |
| To 05/31/2018 | Date/Time Prepared: | 10/31/2018 1:09 pm

				•		10/31/2018 1:	09 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	·
	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	3, 946	991	16, 903			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, 711	7, 640				2. 00
3.00	HMO IPF Subprovider	1, 232	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	3, 946	991	16, 903			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	0	0	0			8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	0	19	569			8. 01
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT	405	141	2, 065			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		51	586			13. 00
14.00	Total (see instructions)	4, 351	1, 202	20, 123	1. 02	475. 62	14. 00
15.00	CAH visits	0	0	0			15. 00
16.00	SUBPROVI DER - I PF	3, 409	389	5, 484	0.00	26. 92	16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	2, 215	0	5, 091	0.00	16. 73	1
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	12			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)				1. 02	519. 27	27. 00
28. 00	Observation Bed Days		0	2, 516			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00	Employee discount days (see instruction)			116			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	100				32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)	_					
33. 00	LTCH non-covered days	0					33.00
33. U l	LTCH site neutral days and discharges	0		I	I	I	33. 01

| Period: | Worksheet S-3 | From 06/01/2017 | Part | To 05/31/2018 | Date/Time Prepared: Provider CCN: 15-0047

				To	05/31/2018	Date/Time Prep 10/31/2018 1:0	
		Full Time		Di sch	arges	10,01,2010 11	9 p
		Equi val ents			_		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	799	2, 016	4, 547	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			400			2 00
2. 00 3. 00	HMO and other (see instructions)			492	U O		2.00
	HMO IPF Subprovider				O O		3.00
4. 00 5. 00	HMO IRF Subprovider				٩		4. 00 5. 00
	Hospital Adults & Peds. Swing Bed SNF						6. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT						8. 01
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	799	2, 016	4, 547	14. 00
15. 00	CAH visits	0.00	· ·		2,0.0	1,017	15. 00
16. 00	SUBPROVIDER - I PF	0. 00	0	o	107	390	16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					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)						24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			0 0			33. 00
33. UI	LTCH site neutral days and discharges			١			33. 01

| Peri od: | Worksheet S-3 | From 06/01/2017 | Part II | To 05/31/2018 | Date/Time Prepared: | Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0047

					T	05/31/2018	Date/Time Prep 10/31/2018 1:0	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2. 00	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	31, 872, 295	0	31, 872, 295	1, 080, 077. 00	29. 51	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	1	0. 00 0. 00		4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6. 00
7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) 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 instructions)	44. 00	1, 138, 705 1, 399, 163		1, 138, 705 1, 399, 163	34, 798. 00 56, 000. 00		9. 00 10. 00
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		508, 341	0	508, 341	7, 350. 00	69. 16	11. 00
12. 00	Care Contract Labor: Top Level		0	0		0.00		12. 00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		100, 790	0	100, 790	761. 00	132. 44	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0. 00	14. 00
14. 01 14. 02	Home office salaries Related organization salaries		2, 650, 566	0	2, 650, 566 0	82, 705. 00 0. 00		14. 01 14. 02
15. 00	Home office: Physician Part A		0	0	0	0.00		15. 00
16. 00	- Administrative 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		5, 237, 837	0	5, 237, 837			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		271, 061	0	271, 061			19. 00
20. 00	Non-physician anesthetist Part A		0	0	1			20. 00
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		502, 841	0	502, 841			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	О	0			25. 52
25. 53	wage-related (core) Home office & Contract		0	0	0			25. 53
	Physicians Part A - Teaching - wage-related (core)							
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	204, 915			7, 726. 00	26. 52	26. 00
	Administrative & General	5. 00	3, 726, 455			133, 830. 00	27. 28	27. 00

| Peri od: | Worksheet S-3 | From 06/01/2017 | Part II | To 05/31/2018 | Date/Time Prepared: |

						00,01,2010	10/31/2018 1:	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0.00	0. 00	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	923, 113	0	923, 113	41, 549. 00	22. 22	30. 00
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		31. 00
32.00	Housekeepi ng	9. 00	776, 991	0	776, 991	56, 199. 00	13. 83	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	Di etary under contract (see		972, 977	0	972, 977	59, 728. 00	16. 29	35.00
	instructions)							
36. 00	Cafeteri a	11. 00	0	0	0	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, 830, 004	75, 949	1, 905, 953	50, 321. 00	37. 88	38.00
39. 00	Central Services and Supply	14. 00	299, 789	0	299, 789	0.00	0. 00	39.00
40.00	Pharmacy	15. 00	1, 510, 272	0	1, 510, 272	34, 601. 00	43. 65	40.00
41.00	Medical Records & Medical	16. 00	108, 303	0	108, 303	8, 380. 00	12. 92	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	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 06/01/2017 | Part III | To 05/31/2018 | Date/Time Prepared: |

					''	0 00/01/2010	10/31/2018 1:	
		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	$(col.2 \pm col.$	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		32, 845, 272	0	32, 845, 272	1, 139, 805. 00	28. 82	1. 00
	instructions)							l
2.00	Excluded area salaries (see		2, 537, 868	0	2, 537, 868	90, 798. 00	27. 95	2. 00
	instructions)							l
3.00	Subtotal salaries (line 1		30, 307, 404	0	30, 307, 404	1, 049, 007. 00	28. 89	3. 00
	minus line 2)							l
4.00	Subtotal other wages & related		3, 259, 697	0	3, 259, 697	90, 816. 00	35. 89	4. 00
	costs (see inst.)							l
5.00	Subtotal wage-related costs		5, 740, 678	0	5, 740, 678	0. 00	18. 94	5. 00
	(see inst.)							l
6.00	Total (sum of lines 3 thru 5)		39, 307, 779	0	39, 307, 779	1, 139, 823. 00	34. 49	6. 00
7.00	Total overhead cost (see		10, 352, 819	0	10, 352, 819	392, 334. 00	26. 39	7. 00
	instructions)							I

ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10				
Provider CCN: 15-0047	Peri od: Worksheet S-3				
	From 06/01/2017   Part IV				

	To 05/31/2018	Date/Time Prep 10/31/2018 1:0	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	556, 144	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)	0	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)	2, 152, 459	8. 02
8. 03	Heal th Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	0	9. 00
10. 00	Dental, Hearing and Vision Plan	21, 984	
	Life Insurance (If employee is owner or beneficiary)	22, 046	
	Accident Insurance (If employee is owner or beneficiary)	664	
	Disability Insurance (If employee is owner or beneficiary)	6, 277	
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
	'Workers' Compensation Insurance	391, 124	
	'	0	16. 00
10.00	Non cumulative portion)	١	10.00
	TAXES		
17. 00	FICA-Employers Portion Only	1, 831, 684	17. 00
	Medicare Taxes - Employers Portion Only	428, 378	
	Unemployment Insurance	0	19.00
	State or Federal Unemployment Taxes	98, 140	
20.00	OTHER	707110	1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
21.00	instructions))	١	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)	5, 508, 900	
	Part B - Other than Core Related Cost	2,222,700	1
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
	1 · · · · · · · · · · · · · · · · · · ·	٠	

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	From 06/01/2017 To 05/31/2018	Worksheet S-3 Part V Date/Time Prepared:			

		10 05/31/2018	10/31/2018 1:0	
	Cost Center Description	Contract Labor		J Pill
	222 2300	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	508, 341	5, 508, 900	1. 00
2.00	Hospi tal	508, 341	5, 508, 900	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 Dialysis	0	0	17.00
18. 00	Other	0	0	18. 00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER			In Lie	u of Form CMS-	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der CC	CN: 15-0047	Peri From To	od: 06/01/2017 05/31/2018	Worksheet S-7 Date/Time Pre 10/31/2018 1:	epared:
		Group	SNF Days	Sw	ing Bed SNF Days		
		1. 00	2. 00		3. 00	4. 00	
69. 00		PE2		0	0	0	69.00
70. 00		PE1		0	0	0	70.00
71. 00		PD2		0	0	0	71. 00
72. 00		PD1		0	0	0	72. 00
73. 00		PC2		0	О	Ō	73.00
74.00		PC1		0	0	Ō	74.00
75. 00		PB2		0	o	0	75. 00
76. 00		PB1		3	o	3	76. 00
77. 00		PA2		0	0	0	1
78. 00		PA1		16	0	16	
199. 00		AAA		0	0		199. 00
200. 00 TOTAL			2, 2 <sup>.</sup>	15	0		200.00
			_,		CBSA at	CBSA on/after	
				Вє	eginning of	October 1 of	
					st Reporting	the Cost	
					Peri od	Reporting	
						Period (if	
						appl i cabl e)	
					1. 00	2. 00	
SNF SERVICES							
201.00 Enter in column 1 the SNF CBSA code or 5 cha	racter non-CBSA c	ode if a rur	al facility,	230	060	23060	201. 00
in effect at the beginning of the cost repor	ting period. Ente	r in column :	2, the code				
in effect on or after October 1 of the cost	reporting period	(if applicab	le).				
			Expenses	F	Percentage	Associ ated	
						with Direct	
						Patient Care	
						and Related	
						Expenses?	
			1. 00		2. 00	3. 00	
A notice published in the Federal Register V							
payments beginning 10/01/2003. Congress expenses							
expenses. For lines 202 through 207: Enter i							
column 2 the percentage of total expenses for							
line 7, column 3. In column 3, enter "Y" for				tsin	creases asso	oci ated	
with direct patient care and related expenses	s for each catego	ry. (see ins	tructions)		0.00		
202. 00 Staffing				0	0.00		202. 00
203. 00 Recrui tment				0	0.00		203. 00
204.00 Retention of employees				0	0.00		204. 00
205. 00 Trai ni ng				0	0. 00		205. 00
206. 00 OTHER (SPECIFY)				0	0. 00		206. 00
207.00 Total SNF revenue (Worksheet G-2, Part I, Ii	ne /, column 3)		4, 099, 0	60			207. 00

SPLI	Financial Systems ST JOSEPH MEDICAL CENTE TAL UNCOMPENSATED AND INDIGENT CARE DATA Provide	r CCN: 15-0047	Peri od:	wof Form CMS-2 Worksheet S-1	
5111	AL UNCOME ENSATED AND TIME CENT CARE DATA	1 6611. 13-0047	From 06/01/2017		
			To 05/31/2018	Date/Time Pre 10/31/2018 1:	
				1.00	
	Uncompensated and indigent care cost computation				
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided b	y line 202 colur	mn 8)	0. 160222	1.
	Medicaid (see instructions for each line)				
00	Net revenue from Medicaid			24, 273, 943	2.
00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental pay		cai d?	N 1 007 704	4.
00 00	If line 4 is no, then enter DSH and/or supplemental payments from Med Medicaid charges	card		1, 886, 724 166, 990, 054	5.
00	Medicald cost (line 1 times line 6)		26, 755, 480	1	
00	Difference between net revenue and costs for Medicaid program (line 7	minus sum of Li	ines 2 and 5 if	594, 813	1
00	<pre>&lt; zero then enter zero)</pre>	Thes 2 and 0, 11	071,010	0.	
	Children's Health Insurance Program (CHIP) (see instructions for each	line)		<u>'</u>	1
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	if < zero then	0	12	
	<pre>enter zero) Other state or local government indigent care program (see instructio</pre>	e for each line	2)		1
. 00	Net revenue from state or local indigent care program (Not included o			292, 717	13
. 00	Charges for patients covered under state or local indigent care program		3, 322, 607		
	10)	(1101 11101 4401		0,022,007	
. 00	State or local indigent care program cost (line 1 times line 14)		532, 355	15	
. 00	Difference between net revenue and costs for state or local indigent	ine 15 minus line	239, 638	16	
	13; if < zero then enter zero)				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)	state/Local Indi	gent care program	ns (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 8, 12 and 16)	ent care progran	ms (sum of lines	834, 451	19
		Uni nsured	Insured	Total (col. 1	
		patients		+ col . 2)	
		1.00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)			T	
. 00	Charity care charges and uninsured discounts for the entire facility	10, 657, 9	904 7, 092	10, 664, 996	20.
	Charity care charges and uninsured discounts for the entire facility (see instructions)				
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (s				
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions)		631 7, 092	1, 714, 723	21.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (s		631 7, 092	1, 714, 723	
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care		631 7, 092 0 160	1, 714, 723 160	21.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care	ee 1,707,6	631 7, 092 0 160	1, 714, 723 160 1, 714, 563	21.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)	1, 707, d	631 7, 092 0 160 631 6, 932	1, 714, 723 160 1, 714, 563	21. 22. 23.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days	1,707,0	631 7, 092 0 160 631 6, 932	1, 714, 723 160 1, 714, 563	21.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progralf line 24 is yes, enter the charges for patient days beyond the indi	ee 1,707,6 1,707,6 beyond a Length	631 7, 092 0 160 631 6, 932	1, 714, 723 160 1, 714, 563	21 22 23 24
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit	beyond a Length	631 7, 092 0 160 631 6, 932	1, 714, 723 160 1, 714, 563 1. 00 N	21. 22. 23. 24. 25.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi	beyond a Length n? gent care progra	631 7, 092 0 160 631 6, 932	1, 714, 723 160 1, 714, 563 1. 00 N 0 7, 173, 765	21. 22. 23. 24. 25. 26.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi Medicare reimbursable bad debts for the entire hospital complex (see	beyond a Length n? gent care progra ons) nstructions)	631 7, 092 0 160 631 6, 932	1, 714, 723 160 1, 714, 563 1. 00 N 0 7, 173, 765 413, 625	21. 22. 23. 24. 25. 26. 27.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see instructions)	beyond a Length n? gent care progra ons) nstructions)	631 7, 092 0 160 631 6, 932	1, 714, 723 160 1, 714, 563 1. 00 N 0 7, 173, 765 413, 625 636, 346	21 22 23 24 25 26 27 27
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see ins Non-Medicare bad debt expense (see instructions)	beyond a length n? gent care progra ons) nstructions)	631 7,092 0 160 631 6,932 n of stay limit	1, 714, 723 160 1, 714, 563 1. 00 N 0 7, 173, 765 413, 625 636, 346 6, 537, 419	21. 22. 23. 24. 25. 26. 27. 27. 28.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see instructions)	beyond a length n? gent care progra ons) nstructions)	631 7,092 0 160 631 6,932 n of stay limit	1, 714, 723 160 1, 714, 563 1. 00 N 0 7, 173, 765 413, 625 636, 346	211 222 23 24 25 26 27 27 28 29

	Financial Systems	ST JOSEPH MEDIC	_	ON 45 0047		u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	- EXPENSES	Provider CO		Period: From 06/01/2017	Worksheet A	
					To 05/31/2018		
	Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cati	10/31/2018 1: Recl assi fi ed	09 pm
	Cost Center Description	Sal al Les	other	+ col . 2)	ons (See A-6)	Trial Balance	
					0.10 (000 /1 0)	(col . 3 +-	
						col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		0.010.057	0.010.05	-	0.407.440	
1.00	00100 CAP REL COSTS-BLDG & FLXT		2, 018, 257			3, 136, 110	1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	204, 915	3, 229, 634 91, 040				2. 00 4. 00
5. 01	00590 REVENUE CYCLE	1, 875, 829	3, 511, 344				
5. 02	00560 PURCHASING RECEIVING AND STORES	66, 683	205, 222			271, 905	
5.03	00591 ADMINISTRATIVE AND GENERAL	1, 783, 943	19, 965, 488		1 -4, 462, 510		5. 03
7.00	00700 OPERATION OF PLANT	923, 113	2, 825, 947	3, 749, 06	0 81, 768	3, 830, 828	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	411, 560			411, 560	
9.00	00900 HOUSEKEEPI NG	776, 991	316, 453				
10.00	01000 DI ETARY	0	2, 050, 096	1			
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	1, 786, 099	260, 085		000, 020		1
13. 00	01301 PASTORAL CARE	43, 905	14, 746			58, 651	
14. 00	01400 CENTRAL SERVICES & SUPPLY	299, 789	5, 622, 928				
15.00	01500 PHARMACY	1, 510, 272	3, 653, 993				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	108, 303	518, 076			626, 272	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	2, 346, 296			0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0		0 2, 346, 296	2, 346, 296	22. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	7 070 104	2 401 444	0 540 45	1 225 414	0 225 024	30.00
31. 00	03100   NTENSIVE CARE UNIT	7, 079, 186 0	2, 481, 466		2 -1, 225, 616 0 0	8, 335, 036 0	
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	749, 864	264, 646	1	-	1, 014, 510	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0 1, 490, 123		
40. 00	04000 SUBPROVI DER - I PF	1, 399, 163	959, 705	2, 358, 86		2, 358, 868	1
43.00	04300 NURSERY	0	0		0 362, 149	362, 149	43. 00
44.00	04400 SKILLED NURSING FACILITY	1, 138, 705	185, 896	1, 324, 60	1 0	1, 324, 601	44. 00
	ANCILLARY SERVICE COST CENTERS	4 044 005		0.057.54	-1	0.050.040	
50. 00 51. 00	O5000 OPERATING ROOM   O5100 RECOVERY ROOM	1, 211, 285	1, 146, 232 86, 655				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	335, 487 753, 720	706, 388			422, 063 831, 571	
53. 00	05300 ANESTHESI OLOGY	755, 720	1, 152, 007			1, 152, 007	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 145, 886	1, 069, 969				
54. 01	03630 ULTRA SOUND	375, 293	137, 776			0	54. 01
56.00	05600 RADI OI SOTOPE	90, 929	157, 302	248, 23	1 -248, 231	0	56. 00
57. 00	05700 CT SCAN	211, 419	53, 912	1		0	57. 00
58. 00	05800 MRI	0	0		0 0	1 720 204	00.00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	2, 012, 120	0 1, 798, 346	3, 810, 46	0 1, 720, 284 6 -455, 776	1, 720, 284 3, 354, 690	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2,012,120	1, 790, 340 N	3, 610, 40	0 331, 677	3, 334, 690	1
65. 00	06500 RESPIRATORY THERAPY	587, 439	162, 146	749, 58		749, 585	
66.00	1 1	439, 668	98, 404			481, 725	
67.00	06700 OCCUPATI ONAL THERAPY	336, 347	28, 463			364, 810	67. 00
	06800 SPEECH PATHOLOGY	64, 335	6, 610				68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 199, 046	781, 971	1, 981, 01		260, 733	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 936, 063		
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 575, 093 0 3, 507, 865		
74. 00		0	343, 498	343, 49		343, 498	
76. 00	03950 MI SC ANCI LLARY	Ö	0	0.107.17	o o	0	1
76. 01	03951 SLEEP LAB	0	0		0 0	0	1
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	423, 818	171, 547	595, 36	5 -172	595, 193	76. 02
76. 03		596, 236	152, 157	748, 39	3 -645	747, 748	76. 03
00.00	OUTPATIENT SERVICE COST CENTERS	42, 470	10.024	/1 [1		/1 [12	00.00
	09000   CLI NI C   09100   EMERGENCY	42, 479 2, 300, 028	19, 034 1, 043, 108			· ·	
92.00		2, 300, 028	1, 043, 100	3, 343, 13	0	3, 343, 130	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		31, 872, 295	60, 048, 403	91, 920, 69	8 100	91, 920, 798	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	•	0		190. 00
	19100 RESEARCH	0	0		0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	ol	100	1			192.00
	07950 NONREI MBURSABLE MI SC 07951 MARKETI NG	O O	0	•	0 0 0		194. 00 194. 01
	207951 WARRETTING	0	0				194. 01
	07954 FREE MEALS	ő	0		0 0		194. 04
200.00		31, 872, 295	60, 048, 503	91, 920, 79			
	·	•					

| Period: | Worksheet A | From 06/01/2017 | To 05/31/2018 | Date/Time Prepared: 10/31/2018 1:09 pm

				10/31/2018 1:	
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation	1	
	CENEDAL CEDVICE COST CENTERS	6. 00	7. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	2, 591, 783	5, 727, 893	,   	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	-855, 416	3, 610, 185		2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 180	3, 532, 093	•	4. 00
5. 01	00590 REVENUE CYCLE	-80, 371	5, 280, 272		5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	0	271, 905		5. 02
5.03	00591 ADMINISTRATIVE AND GENERAL	-4, 105, 793	13, 181, 128		5. 03
7.00	00700 OPERATION OF PLANT	-29, 278	3, 801, 550		7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	-61, 402 0	350, 158	l e e e e e e e e e e e e e e e e e e e	8. 00 9. 00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	1, 097, 263 1, 518, 256		10.00
11. 00	01100 CAFETERI A	-10, 593	519, 427	l control of the cont	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	2, 121, 839		13. 00
13. 01	01301 PASTORAL CARE	0	58, 651		13. 01
14.00	01400 CENTRAL SERVICES & SUPPLY	0	841, 481		14. 00
15. 00	01500 PHARMACY	0	1, 380, 230		15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	55	626, 327		16. 00
	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	2 244 204		21.00
22. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	0	2, 346, 296	0	22. 00
30. 00	03000 ADULTS & PEDI ATRI CS	-1, 228, 420	7, 106, 616		30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0		31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	1, 014, 510		31. 01
33. 00	03300 BURN INTENSIVE CARE UNIT	0	1, 490, 123		33. 00
40.00	04000 SUBPROVI DER - I PF	-771, 302	1, 587, 566		40. 00
43.00	04300 NURSERY	-64, 821	297, 328		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	1, 324, 601		44. 00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	-516, 858	1, 836, 510		50.00
51. 00	05100 RECOVERY ROOM	0 0	422, 063	1	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-526, 400	305, 171		52. 00
53.00	05300 ANESTHESI OLOGY	-1, 151, 804	203	3	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-10, 650	3, 002, 145		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, 720, 284		59.00
60. 00	06000 LABORATORY	-850	3, 353, 840		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	331, 677		62. 00
65. 00	06500 RESPI RATORY THERAPY	0	749, 585		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	481, 725		66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	364, 810		67. 00
68. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	70, 945 260, 733		68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	936, 063	i de la companya del companya de la companya de la companya del companya de la co	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 575, 093		72.00
	07300 DRUGS CHARGED TO PATIENTS	0			73.00
	07400 RENAL DIALYSIS	0	343, 498		74. 00
	03950 MISC ANCILLARY	0	0	1	76. 00
76. 01	03951 SLEEP LAB	0	505 103		76. 01
	03550  PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   03952  WOUND CARE	0	595, 193 747, 748		76. 02 76. 03
70.03	OUTPATIENT SERVICE COST CENTERS	0	747,740	<u> </u>	70.03
90. 00		-5, 580	55, 933	3	90.00
91. 00	09100 EMERGENCY	-164, 632	3, 178, 504		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	SPECIAL PURPOSE COST CENTERS			1	
118. 00	, ,	-6, 995, 512	84, 925, 286	)	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	1	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	l .	192. 00
	07950 NONREI MBURSABLE MI SC	0	O	1	194. 00
194. 01	07951 MARKETI NG	0	O		194. 01
	07952 SENI OR CI RCLE	0	O	l .	194. 02
	07954 FREE MEALS	0	04 005 004		194. 04
200.00	TOTAL (SUM OF LINES 118 through 199)	-6, 995, 512	84, 925, 286	p	200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 06/01/2017 To 05/31/2018 Date/Time Prepared: 10/31/2018 1:09 pm Provider CCN: 15-0047

					10/31/2018 1:	09 pm
	Cost Contor	Increases	Salamu	Othor		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - EMPLOYEE BENEFITS	3.00	4.00	5.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 239, 318		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	O	45		2. 00
	0 — — — — —			3, 239, 363		
	B - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 911		1. 00
	PATI ENT	+		- <del></del>		
	O LEACE AND DENTAL		0	1, 911		
1. 00	C - LEASE AND RENTAL CAP REL COSTS-MVBLE EQUIP	2.00	0	1 224 210		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0.00	0	1, 224, 218 0		2. 00
3.00		0.00	0	o		3. 00
4. 00		0.00	0	o		4. 00
5. 00		0.00	0	Ö		5. 00
6.00		0.00	o	0		6. 00
7.00		0.00	O	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10. 00
11. 00		0. 00	0	0		11. 00
12.00		0. 00	0	0		12. 00
13. 00		0.00	0	0		13. 00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16.00
17. 00				<u>0</u> 1, 224, 218		17. 00
	D - OTHER CAPITAL COSTS		U	1, 224, 218		1
1.00	CAP REL COSTS-BLDG & FIXT	1.00	ol	114, 210		1.00
2. 00	CAP REL COSTS-BLDG & FIXT	1.00	Ö	1, 003, 643		2. 00
3.00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	11, 749		3. 00
	0	+		1, 129, 602		
	F - CNO					1
1.00	NURSING ADMINISTRATION	13. 00	75, 949	0		1. 00
	0		75, 949	0		
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	934, 152		1. 00
2 00	PATI ENT	72.00		2 575 002		2.00
2. 00	I MPL. DEV. CHARGED TO PATI ENTS	72. 00	0	3, 575, 093		2. 00
	[PATIENTS — — — —	+		4, 509, 245		
	H - DRUGS AND IV COSTS		<u> </u>	4, 307, 243		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	3, 507, 865		1.00
	0			3, 507, 865		
	J - RADI OLOGY	<u>'</u>	<u> </u>			
1.00	RADI OLOGY-DI AGNOSTI C	54. 00	677, 641	348, 990		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
	0		677, 641	348, 990		
	K - DIETARY					4
1.00	CAFETERI A	<u>11.</u> 00	•	530, 020		1. 00
	U L MLCC DEDARTMENTS		0	530, 020		-
1 00	L - MISC DEPARTMENTS BURN INTENSIVE CARE UNIT	33.00	1, 172, 534	317, 589		1.00
1. 00 2. 00	CARDIAC CATHETERIZATION	59. 00	960, 707	759, 577		2.00
3.00	WHOLE BLOOD & PACKED RED	62. 00	900, 707	331, 677		3. 00
3.00	BLOOD CELL	02.00	٩	331, 077		3.00
	0	+	2, 133, 241	1, 408, 843		1
	M - UTILITIES RECLASS	' ·	,,	,,		
1.00	OPERATION OF PLANT	7. 00	0	84, 031		1. 00
2.00	HOUSEKEEPI NG	9. 00	0	3, 819		2. 00
3.00		0.00	0	0		3. 00
	0		0	87, 850		]
<u> </u>	N - INTERNS AND RESIDENT COST					4
1.00	I &R SERVI CES-OTHER PRGM	22. 00	0	2, 346, 296		1. 00
	COSTS APPRV	+				
	O OR (CVN COSTS		0	2, 346, 296		-
1 00	O - OB/GYN COSTS ADULTS & PEDIATRICS	30.00	95, 953	170, 435		1.00
1. 00 2. 00	NURSERY	43. 00	199, 552	162, 597		2.00
2.00	0		199, 552 295, 505	16 <u>2, 5</u> 97_ 333, 032		2.00
500.00	Grand Total: Increases		3, 182, 336	18, 667, 235		500.00
	,	1	-, -,	-, ,		

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0047 Peri od: Worksheet A-6 From 06/01/2017 To 05/31/2018 Date/Time Prepared:

		Dogragasa				1/2018 1: 09 p
	Cost Center	Decreases Li ne #	Salary	Other	     Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
Α -	EMPLOYEE BENEFITS	7.00	0.00	7.00	10.00	
	NISTRATIVE AND GENERAL	5. 03	0	3, 239, 363	0	1.
00		0.00	o	0	0	2.
0				3, 239, 363		
	OXYGEN					
00 <u>000</u> R	ATION OF PLANT		0	1, 911	0	1.
0			0	1, 911		
	LEASE AND RENTAL	F 00	ما	47.004	4.0	
	NISTRATIVE AND GENERAL	5. 03	0	16, 834	10	1.
00 OPER.	ATION OF PLANT	7. 00 10. 00	0	352		3
	ING ADMINISTRATION	13. 00	0	1, 820 294		3
O PHAR		15. 00	0	274 276, 170		5
-	TS & PEDIATRICS	30. 00	0	1, 881	0	6
•	OLOGY-DI AGNOSTI C	54.00	0	164, 706	0	7
	RATORY	60.00	0	124, 099		8
	I CAL THERAPY	66.00	0	56, 347		9
	HI ATRI C/PSYCHOLOGI CAL	76. 02	Ö	172		10
SERV		70.02				
	D CARE	76. 03	o	456	0	11
	D CARE	76. 03	o	189		12
00 RECO	VERY ROOM	51.00	o	79	0	13
OO MEDI	CAL RECORDS & LIBRARY	16. 00	О	152	0	14
00 PHYS	ICIANS' PRIVATE OFFICES	192.00	o	100	0	15
00 REVE	NUE CYCLE	5. 01	o	4, 427	0	16
OO CENT	RAL_SERVICES_&_SUPPLY	14. 00	0	57 <u>6, 1</u> 40	0	17
0			0	1, 224, 218		
	OTHER CAPITAL COSTS					
	NISTRATIVE AND GENERAL	5. 03	0	1, 129, 602		1
0		0.00	0	0		2
0		0.00	9_	0	12	3
0	ONIO		0	1, 129, 602		
F -		F 02	75 040			
O ADMI	NISTRATI VE AND GENERAL		7 <u>5, 9</u> 49 75, 949	0	9	1
G -	MEDICAL SUPPLIES		75, 747			
	ATING ROOM	50.00	0	4, 149	0	1
	RAL SERVICES & SUPPLY	14.00	0	4, 505, 096		2
0 CLIVI	INAL SERVICES & SOLLET			4, 509, 245		
H -	DRUGS AND IV COSTS		<u> </u>	1,007,210		
	MACY	15. 00	0	3, 507, 865	0	1
0				3, 507, 865		
J -	RADI OLOGY	<u>'</u>				
	A SOUND	54. 01	375, 293	137, 776	0	1
O RADI	OI SOTOPE	56.00	90, 929	157, 302	0	2
0 <u>CT</u> S	CAN	57. 00	211, 419	53, 912	0	3
0			677, 641	348, 990		
	DIETARY					
O DI ET.	ARY	10.00	0	530, 020		1
0			0	530, 020		
	MISC DEPARTMENTS			a.=	T	
	TS & PEDIATRICS	30.00	1, 172, 534	317, 589		1
	RATORY	60.00	0 70 70 70 70 70 70 70 70 70 70 70 70 70	331, 677		2
0 ELEC	TROCARDI OLOGY	69.00	960, 707	759, 577		3
O	UTILITIES RECLASS		2, 133, 241	1, 408, 843		
	NISTRATIVE AND GENERAL	5. 03	ol	762	O	1
	OLOGY-DI AGNOSTI C	54.00	0	64, 985		2
	NUE CYCLE	5. 01	0	22, 103		3
O KLVE	NOT CLOSE					3
N -	INTERNS AND RESIDENT COST	S	٥	07,000		
	SERVICES-SALARY &	21.00	ol	2, 346, 296	0	1
	GES APPRV	21.00	٩	2, 540, 270	١	'
0	<u> </u>	+		2, 346, 296	<del> </del>	1
0 -	OB/GYN COSTS			_, _ , _ , _ , _ , _ , _ , _ , _ , _ ,		
	VERY ROOM & LABOR ROOM	52.00	295, 505	333, 032	0	1
0		0.00	ol	0	0	2
0	- $   +$	+	295, 505	333, 032		
	d Total: Decreases		3, 182, 336	18, 667, 235		500

In Lieu of Form CMS-2552-10

Period: Worksheet A-7

From 06/01/2017 Part I

To 05/31/2018 Parts/Time Proposed

				T	o 05/31/2018	Date/Time Prep 10/31/2018 1:0	
	·			Acqui si ti ons	_		
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	9, 348, 028	0	0	0	0	1. 00
2.00	Land Improvements	1, 764, 690	11, 145	0	11, 145		2. 00
3.00	Buildings and Fixtures	28, 538, 169	7, 852	0	7, 852		3. 00
4.00	Building Improvements	30, 171, 661	296, 405	0	296, 405	2, 534	4. 00
5.00	Fi xed Equipment	17, 670, 968	1, 055, 376	0	1, 055, 376	16, 067	5. 00
6.00	Movable Equipment	50, 313, 721	4, 272, 416	0	4, 272, 416	437, 896	6. 00
7.00	HIT designated Assets	2, 833, 813	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	140, 641, 050	5, 643, 194	0	5, 643, 194	456, 497	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	140, 641, 050	5, 643, 194	0	5, 643, 194	456, 497	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	9, 348, 028	0				1. 00
2.00	Land Improvements	1, 775, 835	0				2. 00
3.00	Buildings and Fixtures	28, 546, 021	0				3. 00
4.00	Building Improvements	30, 465, 532	0				4. 00
5.00	Fixed Equipment	18, 710, 277	0				5. 00
6.00	Movable Equipment	54, 148, 241	0				6. 00
7.00	HIT designated Assets	2, 833, 813	0				7. 00
8.00	Subtotal (sum of lines 1-7)	145, 827, 747	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	145, 827, 747	O				10. 00

Heal th	Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0047	Peri od: From 06/01/2017 To 05/31/2018	Worksheet A-7 Part II	pared:
			SU	JMMARY OF CAP	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 018, 257	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 229, 634	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	5, 247, 891	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 018, 257				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 229, 634				2. 00
	1		- 047 004	I .			

0 0 0

2, 018, 257 3, 229, 634 5, 247, 891

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 06/01/2017 To 05/31/2018	Worksheet A-7 Part III Date/Time Prep 10/31/2018 1:0	
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI					9.00	
1.00	CAP REL COSTS-BLDG & FIXT	70, 135, 416	0	70, 135, 41	6 0. 480947	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	75, 692, 332					2.00
3.00	Total (sum of lines 1-2)	145, 827, 748		145, 827, 74			3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS	1 0	ı	0 3, 327, 584	0	1. 00
2. 00	CAP REL COSTS-BLDG & FIXT	0	ľ		0 2, 374, 218		2. 00
3.00	Total (sum of lines 1-2)	0			0 2, 374, 218		3. 00
3.00	Total (Sull of Titles 1-2)		SI	JMMARY OF CAPI		1, 224, 210	3.00
			50	5 N.I.V. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1712		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLTAL COCTO OF	11.00	12.00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	1, 282, 456	114, 210	1, 003, 64	3 0	5, 727, 893	1. 00
2. 00	CAP REL COSTS-BLDG & FIXT	1, 202, 430	1		0 0	3, 610, 185	2. 00
3.00	Total (sum of lines 1-2)	1, 282, 456			-	9, 338, 078	
3.00	1.010. (00 01.1.1.00 1.2)	1 ., 202, 100	120,707	1 .,000,01	51	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5. 00

In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-8 From 06/01/2017 | Date/Time Prepared: Provider CCN: 15-0047

				To	05/31/2018	Date/Time Prep 10/31/2018 1:0	
				Expense Classification on		10,01,2010 11	97 p
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		0				4 00
4. 00	Trade, quantity, and time discounts (chapter 8)		Ü		0. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6. 00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	А	-7, 576	ADMINISTRATIVE AND GENERAL	5. 03	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service	Α	-29, 278	OPERATION OF PLANT	7. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-6, 087, 356			0	10. 00
11. 00	Sale of scrap, waste, etc.	В	-10, 650	RADI OLOGY-DI AGNOSTI C	54. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	30, 730			0	12. 00
13. 00	transactions (chapter 10)				0. 00	0	13. 00
14. 00	Laundry and linen service Cafeteria-employees and guests	В	-10, 593	CAFETERI A	11. 00	0	14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and	В	55	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vending machines	В	-1, 255	ADMINISTRATIVE AND GENERAL	5. 03	0	
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to		J		0.00	J	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
24 00	(chapter 21)	^	000 311	CAD DEL COSTS BLOC » FLVT	1 00	0	26 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP	А	-684, 750	CAP REL 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	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
33. 00	Depreciation and Interest FITNESS REVENUE	В	-107, 416	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 00
		'			·		

Health Financial Systems		ST JOSEPH MED	OLCAL CENTER	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 06/01/2017 To 05/31/2018	Date/Time Pre 10/31/2018 1:	
			Expense Classification on			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2. 00	3. 00	4. 00	5. 00	
33. 01 MARKETING EXPENSE	A	-644, 990	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 01
33.04 NON RESTRICT DONATION	В	-1, 380	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 04
33.06 PATIENT PHONE WAGE COSTS	A	-18, 105	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 06
33.07 PATIENT PHONES BENEFITS	A	-3, 180	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
33.11 PHYSICIAN RECRUITING	A	-132, 367	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 11
33.12 LOBBYING EXPENSE IN DUES	A	-1, 937	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 12
33. 13 CHARI TABLE CONTRIBUTIONS	A	-91, 193	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 13

-6, 995, 512

-75, 039 ADMINISTRATIVE AND GENERAL

-104, 118 ADMINI STRATI VE AND GENERAL

5.03

5.03

33. 15

33. 16

50.00

33. 16 NONALLOWABLE LEGAL EXPENSES

column 6, line 200.)

50.00 TOTAL (sum of lines 1 thru 49)
(Transfer to Worksheet A,

33. 15 IMPUTED RENT

<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 Provider CCN: 15-0047 Period: From 06/01/2017

7 Period: Worksheet A-8-1 From 06/01/2017 To 05/31/2018 Date/Time Prepared: 10/31/2018 1:09 pm

				To 05/31/2018	Date/Time Pre 10/31/2018 1:	
	Li ne No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column	
	1. 00	2.00	3. 00	4. 00	5 5. 00	
	A. COSTS INCURRED AND ADJUSTM					
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	GANIZATIONS OR	CLATIMED	
1.00		CAP REL COSTS-BLDG & FLXT	DIRECT ALLOCATION - CAPITAL-	1, 262, 032	0	1. 00
2.00		CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	15, 957		2. 00
3.00		CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - MOVEABL	4, 467		3. 00
4.00	5. 01	REVENUE CYCLE	PASI OPERATING COSTS	234, 983		4. 00
4.03	5. 03	ADMINISTRATIVE AND GENERAL	SHARED SERVICE CENTER ALLOCA	1, 302, 823	1, 013, 566	4. 03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	44, 102	0	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - MOVABLE EQUIPM	274, 914	0	4.05
4.06	5. 03	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	2, 549, 226	0	4.06
4.07	5. 03	ADMINISTRATIVE AND GENERAL	MALPRACTICE COSTS (SEE EXHIB	428, 666	530, 141	4. 07
4.08	2. 00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT (SEE EX	114, 929	0	4. 08
4.09	8. 00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES (S	396, 591	0	4. 09
4. 10	5. 03	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	2, 372, 250	4. 10
4. 11	5. 03	ADMINISTRATIVE AND GENERAL	401K FEES	0	6, 128	4. 11
4. 12	5. 03	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	49, 194	4. 12
4. 13		ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	1, 106, 596	4. 13
4. 14		ADMINISTRATIVE AND GENERAL	PPSI FEES	0	26, 931	4. 14
4. 15		REVENUE CYCLE	PASI COLLECTION FEES	0	315, 354	4. 15
4. 16		ADMINISTRATIVE AND GENERAL	CIG USE TAX	0	19, 612	4. 16
4. 17		ADMINISTRATIVE AND GENERAL	PASI LIEN UNIT COLLECTION FE	0	42, 375	4. 17
4. 18		ADMINISTRATIVE AND GENERAL	HIIM ALLOCATION	0	377, 650	4. 18
4. 19		CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT (PER EX		280, 170	4. 19
4. 20		LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES (P	1	457, 993	4. 20
5. 00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6, 628, 690	6, 597, 960	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					
Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership				
1. 00	2.00	3.00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

1 61	ilibar sellerit araer ti tre XVIII.		
6.0	00 B	0. 00 CHS, I NC 100. 00	6. 00
7. C	00 B	0. 00 PASI 100. 00	7. 00
8.0	00 C	33.00 SHARED_LAUNDRY 33.00	8. 00
9.0	00	0.00	9. 00
10.	00	0.00	10.00
100	0.00 G. Other (financial or		100.00
	non-financial) specify:		

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

			To 05/31/2	2018   Date/Time Prepare 10/31/2018 1:09 p	ed: om
	Net	Wkst. A-7 Ref.			
	Adjustments				
	(col. 4 minus				
	col. 5)*				
	6. 00	7. 00			
			IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS	OR CLAIMED	
	HOME OFFICE CO				
1.00	1, 262, 032				. 00
2.00	15, 957				. 00
3.00	4, 467				. 00
4.00	234, 983				. 00
4.03	289, 257				. 03
4.04	44, 102				. 04
4.05	274, 914				. 05
4.06	2, 549, 226	0		4.	. 06
4.07	-101, 475	0		4.	. 07
4.08	114, 929	9			. 08
4.09	396, 591	0		4.	. 09
4. 10	-2, 372, 250	0		4.	. 10
4. 11	-6, 128	0		4.	. 11
4. 12	-49, 194	0		4.	. 12
4. 13	-1, 106, 596	0		4.	. 13
4.14	-26, 931	0		4.	. 14
4. 15	-315, 354				. 15
4. 16	-19, 612	0		4.	. 16
4. 17	-42, 375	0		4.	. 17
4. 18	-377, 650				. 18
4. 19	-280, 170	9		4.	. 19
4. 20	-457, 993	0		4.	. 20
5.00	30, 730			5.	. 00

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

Related Organization(s) and/or Home Office						
Type of Business						
6. 00						
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

i ei iiibui	Termbursement under title XVIII.								
6. 00	OWNER	6.00							
7.00	DEBT COLLECTION	7.00							
8.00	LAUNDRY	8.00							
9. 00		9.00							
10.00		10.00							
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.

| Period: | Worksheet A-8-2 | From 06/01/2017 | To 05/31/2018 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0047

						To 05/31/2018	B Date/Time Pre 10/31/2018 1:	epared: 09 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADULTS & PEDIATRICS	1, 228, 420			-1		
2.00		NURSERY	64, 821	64, 82		0		
3. 00	1	ADMINISTRATIVE AND GENERAL	1, 656, 689				0	
4.00		SUBPROVIDER - IPF	771, 302				0	
5. 00		OPERATING ROOM	516, 858				0	0.00
6. 00		DELIVERY ROOM & LABOR ROOM	526, 400				0	
7.00		ANESTHESI OLOGY	1, 151, 804				0	
8.00		LABORATORY	850				0	
9.00		CLINIC	5, 580				0	9. 00
10.00		EMERGENCY	164, 632				0	10.00
11. 00	33.00	BURN INTENSIVE CARE UNIT	0 007 254				0	11. 00
200.00	WI+ A I : //	C+ C+ (Dh.,	6, 087, 356			Draw datas	0	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit		Cost of Memberships &	Provider Component	Physician Cost of Malpractice	
		rdentifier	LIIIII L	Li mi t	Continuing	Share of col.	Insurance	
					Education	12	Trisul ance	
	1. 00	2.00	8.00	9.00	12. 00	13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	0.00		) (			1. 00
2.00		NURSERY	0					
3. 00		ADMINISTRATIVE AND GENERAL	0				o o	1
4.00		SUBPROVIDER - IPF	0				o o	1
5.00	50. 00	OPERATING ROOM	0			ol c	0	5. 00
6.00	52. 00	DELIVERY ROOM & LABOR ROOM	0			ol c	0	6. 00
7.00	53. 00	ANESTHESI OLOGY	0				0	7. 00
8.00	60. 00	LABORATORY	0		) (	o  c	0	8. 00
9. 00	90. 00	CLINIC	0		) (	o  c	0	9. 00
10.00	91. 00	EMERGENCY	0	(	) (		0	10.00
11. 00	33.00 BURN INTENSIVE CARE UNIT		0		) (	o  c	0	11. 00
200.00			0	(	) (	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	4.00		14	47.00	47.00	10.00	-	
1.00	1. 00	2.00	15. 00	16. 00	17. 00	18.00		1 00
1.00	1	ADULTS & PEDIATRICS	0			-, -,,		1.00
2. 00 3. 00		NURSERY	0					2. 00 3. 00
3. 00 4. 00	5. 03 ADMI NI STRATI VE AND GENERAL		0	1		1, 656, 689	•	
4. 00 5. 00	40. 00 SUBPROVI DER - I PF 50. 00 OPERATI NG ROOM		0			771, 302 516, 858	•	4. 00 5. 00
6.00	50. OUDPERATING ROOM 52. OO DELIVERY ROOM & LABOR ROOM			)		526, 400		6.00
7. 00	1		0		) (	1, 151, 804		7. 00
7. 00 8. 00	53. OO ANESTHESI OLOGY 60. OO LABORATORY			] /		0 1, 151, 804	•	8.00
9. 00	90. 00 CLI NI C			]		5, 580	•	9. 00
10. 00	90. OOICLI NI C 91. OOIEMERGENCY					164, 632		10.00
11. 00	33.00 BURN INTENSIVE CARE UNIT					) 104, 032	1	11. 00
200.00	33.00	Some officer of the order		1	-	6, 087, 356	1	200.00
200.00			1	1	-1	5, 55., 566	1	, _00.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0047 Peri od: Worksheet B From 06/01/2017 Part I 05/31/2018 Date/Time Prepared: 10/31/2018 1:09 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** REVENUE CYCLE for Cost **BENEFLTS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 1 00 5, 727, 893 5, 727, 893 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 3, 610, 185 3, 610, 185 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 532, 093 64, 831 40, 862 3, 637, 786 4.00 00590 REVENUE CYCLE 229, 965 144. 943 5, 870, 666 5 01 5, 280, 272 5 01 215, 486 5.02 00560 PURCHASING RECEIVING AND STORES 271, 905 159, 721 100, 669 7,660 0 5.02 5.03 00591 ADMINISTRATIVE AND GENERAL 13, 181, 128 124, 263 78, 321 196, 206 0 5.03 7.00 00700 OPERATION OF PLANT 3, 801, 550 1, 272, 921 802, 296 106, 043 7.00 0 00800 LAUNDRY & LINEN SERVICE 50, 900 8 00 350, 158 32, 082 0 8 00 9.00 00900 HOUSEKEEPI NG 1,097,263 770, 636 485, 717 89, 257 0 9.00 01000 DI ETARY 10.00 1, 518, 256 240, 736 151, 732 10.00 01100 CAFETERI A 519, 427 11.00 11.00 01300 NURSING ADMINISTRATION 213, 903 13.00 2, 121, 839 56, 162 35, 398 0 13.00 13.01 01301 PASTORAL CARE 58, 651 32, 038 20, 193 5,044 13.01 0 01400 CENTRAL SERVICES & SUPPLY 14.00 841, 481 34, 438 14.00 01500 PHARMACY 1.380.230 173.492 15.00 15.00 0 0 16.00 01600 MEDICAL RECORDS & LIBRARY 626, 327 144, 252 90.919 12, 441 0 16.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 21.00 21.00 22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 2, 346, 296 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 106, 616 512, 589 323, 076 689, 544 572, 870 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 1,014,510 206, 734 130, 301 86, 141 24,077 31.01 03300 BURN INTENSIVE CARE UNIT 1, 490, 123 33.00 96, 347 60,726 134, 695 163, 071 33.00 40.00 04000 SUBPROVI DER - I PF 1, 587, 566 73, 211 46, 144 160, 729 217, 627 40.00 04300 NURSERY 22, 924 43.00 297, 328 8, 241 43.00 130, 809 44.00 04400 SKILLED NURSING FACILITY 1, 324, 601 134, 731 84, 919 47, 631 44.00 ANCILLARY SERVICE COST CENTERS 501, 250 05000 OPERATING ROOM 1, 836, 510 139, 146 50.00 236, 038 148, 770 50.00 51.00 05100 RECOVERY ROOM 422,063 88, 543 55, 807 38, 539 33, 392 51.00 05200 DELIVERY ROOM & LABOR ROOM 18, 922 52.00 305, 171 78, 789 49, 659 52, 637 52.00 53.00 05300 ANESTHESI OLOGY 203 69, 303 53.00 05400 RADI OLOGY-DI AGNOSTI C 3, 002, 145 209, 478 54.00 226, 435 142, 718 853, 898 54.00 03630 ULTRA SOUND 54.01 54.01 0 0 0 05600 RADI OI SOTOPE 0 0 0 56.00 Λ 56.00 57.00 05700 CT SCAN 0 C 0 0 0 57.00 58.00 05800 MRI 58.00 0 05900 CARDIAC CATHETERIZATION 1, 720, 284 265, 468 59 00 25 224 15 898 110 361 59 00 60.00 06000 LABORATORY 3, 353, 840 193, 806 122, 152 231, 142 683, 304 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 331, 677 10, 620 6, 693 33, 845 62.00 06500 RESPIRATORY THERAPY 65.00 749, 585 78, 748 49, 633 67, 482 159, 963 65.00 06600 PHYSI CAL THERAPY 481. 725 47, 182 66 00 102.323 64 492 50 507 66 00 67.00 06700 OCCUPATIONAL THERAPY 364, 810 39, 168 24, 687 38, 638 47, 172 67.00 06800 SPEECH PATHOLOGY 70, 945 15, 085 9,508 7, 390 6, 404 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 260, 733 14, 357 9,049 27, 379 41, 587 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 936, 063 C 0 0 481, 530 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 575, 093 0 0 123, 750 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 507, 865 33, 934 73.00 21, 388 846, 852 73.00 07400 RENAL DIALYSIS 343, 498 17, 405 o 74.00 27, 614 17, 483 74.00 03950 MISC ANCILLARY 76.00 0 C 0 0 76.00 76. 01 03951 SLEEP LAB 76.01 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76 02 595, 193 44, 759 28, 211 48, 686 35, 679 76.02 03952 WOUND CARE 747.748 117, 998 68, 493 58, 379 76.03 74, 372 76.03 OUTPATIENT SERVICE COST CENTERS 29, 208 90.00 09000 CLI NI C 55.933 18, 409 4,880 1,554 90.00 09100 EMERGENCY 91.00 3, 178, 504 181, 304 114, 273 264, 216 510, 232 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 84, 925, 286 5, 713, 990 3, 601, 422 3, 637, 786 5, 870, 666 118. 00 NONREIMBURSABLE COST CENTERS 0 190 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 13, 903 8,763 191. 00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 0 0 0 0 0 194. 00 07950 NONREI MBURSABLE MI SC 0 194, 00 0 0 0 0 194. 01 194. 01 07951 MARKETI NG 194. 02 07952 SENI OR CIRCLE 0 0 0 0 0 194. 02 194. 04 07954 FREE MEALS 0 o 0 194. 04 200.00 Cross Foot Adjustments 200.00 0 201.00 Negative Cost Centers 0 0 201.00

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 06/01/2017 Fo 05/31/2018	Part I Date/Time Pre 10/31/2018 1:	pared: 09 pm	
		CAPI TAL REI	LATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	REVENUE CYCLE		
	0	1. 00	2. 00	4. 00	5. 01		
202.00 TOTAL (sum lines 118 through 201)	84, 925, 286	5, 727, 893	3, 610, 18	3, 637, 786	5, 870, 666	202. 00	

Peri od: Worksheet B
From 06/01/2017 Part I
To 05/31/2018 Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	PURCHASI NG RECEI VI NG AND	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LI NEN SERVI CE	09 pm
		STORES					
	GENERAL SERVICE COST CENTERS	5. 02	5A. 02	5. 03	7. 00	8. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	00590 REVENUE CYCLE 00560 PURCHASING RECEIVING AND STORES	539, 955					5. 01 5. 02
5. 03	00591 ADMINISTRATIVE AND GENERAL	1, 291	13, 581, 209	13, 581, 209			5. 03
7.00	00700 OPERATION OF PLANT	284	5, 983, 094				7. 00
8.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	12, 690	445, 830				
9. 00 10. 00	01000 DI ETARY	7, 585 8, 353	2, 450, 458 1, 919, 077			<b>l</b>	
11. 00	01100 CAFETERI A	0	519, 427		·	l	
13. 00	01300 NURSI NG ADMI NI STRATI ON	611	2, 427, 913			0	13. 00
13. 01 14. 00	01301 PASTORAL CARE 01400 CENTRAL SERVICES & SUPPLY	30	115, 956 875, 919				13. 01 14. 00
15. 00	01500 PHARMACY	9, 312	1, 563, 034			0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	216	874, 155			0	16. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21. 00
22. 00	02200   1 &R SERVI CES-OTHER PRGM COSTS APPRV   INPATI ENT ROUTI NE SERVI CE COST CENTERS	0	2, 346, 296	446, 646	0	0	22. 00
30. 00	03000 ADULTS & PEDIATRICS	21, 461	9, 226, 156	1, 756, 316	941, 823	239, 338	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0		0	1	1
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	2, 317	1, 464, 080				
33. 00 40. 00	03300 BURN INTENSIVE CARE UNIT	8, 461	1, 953, 423				1
43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	2, 958	2, 088, 235 328, 493			l	
44. 00	04400 SKILLED NURSING FACILITY	3, 251	1, 725, 942				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	42, 108	2, 903, 822		· ·	l e	1
51. 00 52. 00	O5100 RECOVERY ROOM   O5200 DELIVERY ROOM & LABOR ROOM	21 3, 641	638, 365 508, 819				1
53. 00	05300 ANESTHESI OLOGY	10	69, 516			1	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 041	4, 443, 715	845, 914	416, 047	31, 411	
54. 01	03630 ULTRA SOUND	0	0	0	0	0	
56. 00 57. 00	05600		0	0	0	0	
58. 00	05800 MRI	l o	0	Ö	0	Ö	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	20, 188	2, 157, 423		46, 345		59. 00
60.00	06000 LABORATORY	40, 013	4, 624, 257			l e	
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY	20, 815 7, 125	403, 650 1, 112, 536			l e	
66. 00	06600 PHYSI CAL THERAPY	470	746, 699				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	70	514, 545	97, 950	71, 966	0	
68. 00	06800 SPEECH PATHOLOGY	80	109, 412			l e	
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	242 54, 707	353, 347 1, 472, 300			2, 379 0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	230, 627	3, 929, 470			1	
	07300 DRUGS CHARGED TO PATIENTS	0	4, 410, 039		62, 349	0	73. 00
	07400 RENAL DIALYSIS	321	406, 321	77, 348	50, 737	0	
76. 00 76. 01	03950 MISC ANCILLARY 03951 SLEEP LAB	0	0	0	0	0	76. 00 76. 01
	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	311	752, 839	143, 312	82, 240	0	1
76. 03	03952 WOUND CARE	6, 272	1, 073, 262			l	1
	OUTPATIENT SERVICE COST CENTERS						
90. 00 91. 00	l l	0 25, 073	109, 984 4, 273, 602				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	25,073	4, 273, 002	013, 331	333, 123	132, 370	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	3 7	539, 955	84, 902, 620	13, 576, 894	7, 096, 503	624, 222	118. 00
190 00	NONREI MBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		22, 666	4, 315	25, 545	Ι ο	190. 00
191.00	19100 RESEARCH		0	0	· ·		191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
194.00	07950 NONREI MBURSABLE MI SC	0	0	0	0		194. 00
	07951 MARKETI NG	0	0	0	0		194. 01
	07952 SENIOR CIRCLE 07954 FREE MEALS		0	0	0		194. 02 194. 04
200.00			0		0		200.00
201.00	Negative Cost Centers		0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	539, 955	84, 925, 286	13, 581, 209	7, 122, 048	624, 222	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 06/01/2017 | Part |
| To 05/31/2018 | Date/Time Prepared: | 10/31/2018 1:09 pm

				'	0 03/31/2016	10/31/2018 1:	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	PASTORAL CARE	
		9.00	10. 00	11. 00	ADMI NI STRATI ON 13. 00	13. 01	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 REVENUE CYCLE						4.00
5. 01 5. 02	00560 PURCHASING RECEIVING AND STORES						5. 01 5. 02
5. 02	00591 ADMINISTRATIVE AND GENERAL						5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	4, 332, 889					9. 00
10.00	01000 DI ETARY	341, 473	3, 068, 194				10.00
11.00	01100 CAFETERI A	70 ((2)	0	618, 306			11.00
13. 00 13. 01	01300 NURSI NG ADMI NI STRATI ON 01301 PASTORAL CARE	79, 663 45, 444	0	35, 439 1, 560		243, 900	13. 00 13. 01
14. 00	01400 CENTRAL SERVICES & SUPPLY	43, 444	0	11, 930		243, 700	14. 00
15. 00	01500 PHARMACY	o	o	25, 451	o	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	204, 615	О	6, 164	0	0	16. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	C	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	707.00/	4 404 000	4.7.040	4 0/4 /0/	00.007	00.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	727, 086	1, 121, 303	147, 949 0		98, 996 0	30. 00 31. 00
31.00	02060 NEONATAL INTENSIVE CARE UNIT	293, 243	0	14, 270		12, 366	31. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	136, 663	138, 112	24, 916		19, 336	33. 00
40. 00	04000 SUBPROVI DER - I PF	103, 847	359, 624	41, 175		23, 074	40. 00
43.00	04300 NURSERY	0	O	3, 701		3, 291	43.00
44. 00	04400 SKILLED NURSING FACILITY	191, 110	333, 846	25, 589	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	204 200	al	0.4.04.0	054 500	40.075	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	334, 809	0	26, 919		19, 975	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	125, 595 111, 759	0	6, 608 8, 504		5, 533 7, 556	52. 00
53. 00	05300 ANESTHESI OLOGY	111,737	Ö	0, 304	70, 300	7, 330	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	321, 187	O	45, 947	0	0	54.00
54. 01	03630 ULTRA SOUND	0	0	C	0	0	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	C	0	0	56.00
57. 00	05700 CT SCAN	0	0	O	0	0	57. 00
58. 00	05800 MRI	0	0	17 (51	201 010	15.043	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	35, 778 274, 905	0	17, 651 54, 099		15, 843 0	59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	15, 064	0	34, 077	0	0	62. 00
65. 00	06500 RESPIRATORY THERAPY	111, 700	Ö	14, 010	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	145, 140	o	8, 856	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	55, 558	0	5, 965		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	21, 397	0	1, 055		0	68. 00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 364	0	8, 688	0	0	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	48, 133	Ö	Ö	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	39, 169	O	C	0	0	74. 00
76. 00	03950 MISC ANCILLARY	0	o	C	0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	C	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	63, 489	0	13, 337		0	76. 02
76. 03	03952 WOUND CARE OUTPATIENT SERVICE COST CENTERS	167, 375	0	14, 408	0	0	76. 03
90. 00	09000 CLINIC	41, 430	O	1, 071	0	0	90. 00
91. 00	09100 EMERGENCY	257, 172	ő	53, 044		37, 930	91. 00
92. 00		207,172	Ĭ	00,011	100, 111	0,7,700	92. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00		4, 313, 168	1, 952, 885	618, 306	3, 108, 388	243, 900	118. 00
400.04	NONREI MBURSABLE COST CENTERS	40.704	ما				100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 721	0	C			190. 00 191. 00
	) 19100 RESEARCH ) 19200 PHYSI CLANS' PRI VATE OFFI CES	0	788, 855	0	-		191.00
	07950 NONREI MBURSABLE MI SC		700, 033	0	0		194. 00
	07951 MARKETI NG		ő	C	Ö		194. 01
	07952 SENI OR CIRCLE	0	o	C	o	0	194. 02
	107954 FREE MEALS		326, 454	C	0	0	194. 04
200.00		_	_	_	_	_	200.00
201.00		4 222 000	0 0 104	(10.30)	2 100 200		201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 332, 889	3, 068, 194	618, 306	3, 108, 388	243, 900	202.00

					INTERNS &	10/31/2018 1: RESI DENTS	09 pm
	Cost Center Description	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	
		SUPPLY		LI BRARY	APPRV	APPRV	
	T	14.00	15. 00	16. 00	21.00	22. 00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1					1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01	00590 REVENUE CYCLE						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00591 ADMINISTRATIVE AND GENERAL						5. 03
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
13. 01 14. 00	01301 PASTORAL CARE 01400 CENTRAL SERVICES & SUPPLY	1, 054, 591					13. 01 14. 00
	01500 PHARMACY	19, 288	1, 905, 315				15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	447	1, 703, 313	1, 516, 833			16. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	O	0	C			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	C		2, 792, 942	22. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	44 455	ما	4.40.000	1	007 400	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	44, 455	0	148, 000		997, 480 0	30. 00 31. 00
31. 00	02060 NEONATAL INTENSIVE CARE UNIT	4, 799	0	6, 220	_	0	31.00
33. 00	03300 BURN INTENSIVE CARE UNIT	17, 526	o	42, 129		Ö	33.00
40.00		6, 127	0	56, 223		0	40. 00
43.00	04300 NURSERY	0	0	2, 129			
44. 00	04400 SKILLED NURSING FACILITY	6, 735	0	12, 305	0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	87, 223	ol	129, 497	0	797, 983	50.00
51. 00	05100 RECOVERY ROOM	44	o	8, 627		'	ı
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 541	0	4, 889		0	52.00
53.00	05300 ANESTHESI OLOGY	22	0	17, 904		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 727	0	220, 763		0	54.00
54. 01 56. 00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	0	0	0	0	54. 01 56. 00
57. 00	05700 CT SCAN		0	0	0	0	57.00
58. 00	05800 MRI	O	o	Ö	0	Ö	
59. 00	05900 CARDI AC CATHETERI ZATI ON	41, 817	0	68, 583	0	0	59. 00
60.00	06000 LABORATORY	82, 883	0	176, 530		0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	43, 117	0	8, 744		0	62.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	14, 759 973	0	41, 326 12, 189		0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	145	0	12, 187		0	67.00
68. 00	06800 SPEECH PATHOLOGY	165	Ö	1, 654		Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	501	0	10, 744		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	113, 320	0	124, 402		0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	477, 740	1 005 315	31, 970		0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	0 664	1, 905, 315	218, 782 4, 517		l o	74.00
	03950 MISC ANCILLARY	0	o	4, 517		0	76.00
76. 01	03951 SLEEP LAB	o	0	C	0	0	1
76. 02		644	0	9, 218		0	76. 02
76. 03	03952 WOUND CARE	12, 992	0	15, 082	0	997, 479	76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	ol	402	0	0	90.00
91. 00	09100 EMERGENCY	51, 937	0	131, 817			ı
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1		,			92.00
	SPECIAL PURPOSE COST CENTERS						
118. 00	9 /	1, 054, 591	1, 905, 315	1, 516, 833	0	2, 792, 942	118. 00
100.00	NONREI MBURSABLE COST CENTERS	0	ام				190. 00
	19000  GIFT, FLOWER, COFFEE SHOP & CANTEEN   19100  RESEARCH		0	C			190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	l o	Ö	C	0		192. 00
194.00	07950 NONREIMBURSABLE MISC	0	0	C	0		194. 00
	07951 MARKETI NG	0	0	C	0		194. 01
	2 07952 SENI OR CI RCLE	0	0	0	0		194. 02 194. 04
200.00	O7954 FREE MEALS   Cross Foot Adjustments	"	٥	Ü			200. 00
201.00		0	О	C	o o		201.00
202.00		1, 054, 591	1, 905, 315	1, 516, 833	0	2, 792, 942	202. 00

ST JOSEPH MEDICAL CENTER

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

				To	05/31/2018	Date/Time Prepared: 10/31/2018 1:09 pm
	Cost Center Description	Subtotal	Intern &	Total		10/31/2010 1:07 piii
			Residents Cost & Post			
			Stepdown			
		24. 00	Adjustments 25.00	26. 00		
	GENERAL SERVICE COST CENTERS	2.1.00	20.00	20.00		
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
	00590 REVENUE CYCLE 00560 PURCHASING RECEIVING AND STORES					5. 01 5. 02
	00591 ADMINISTRATIVE AND GENERAL					5. 02
	00700 OPERATION OF PLANT					7. 00
	O0800   LAUNDRY & LINEN SERVICE   O0900   HOUSEKEEPING					8. 00 9. 00
10.00	01000 DI ETARY					10. 00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION					11. 00 13. 00
	01301 PASTORAL CARE					13. 01
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14.00
	01600 MEDICAL RECORDS & LIBRARY					15. 00 16. 00
	02100 I &R SERVI CES-SALARY & FRINGES APPRV					21.00
22. 00	02200   & SERVICES-OTHER PRGM COSTS APPRV   INPATIENT ROUTINE SERVICE COST CENTERS					22. 00
	03000 ADULTS & PEDIATRICS	16, 710, 508	-997, 480	15, 713, 028		30.00
	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	0 2, 612, 261	0	0 2, 612, 261		31. 00 31. 01
	03300 BURN INTENSIVE CARE UNIT	3, 168, 934	0	3, 168, 934		33. 00
	04000 SUBPROVI DER - I PF	3, 540, 810	0	3, 540, 810		40.00
	04300 NURSERY 04400 SKILLED NURSING FACILITY	444, 279 2, 919, 126	0	444, 279 2, 919, 126		43. 00 44. 00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM   05100 RECOVERY ROOM	5, 587, 534 1, 151, 573	-797, 983 0	4, 789, 551 1, 151, 573		50. 00 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	987, 000	Ö	987, 000		52. 00
	05300  ANESTHESI OLOGY   05400  RADI OLOGY-DI AGNOSTI C	100, 675 6, 343, 711	0	100, 675 6, 343, 711		53. 00 54. 00
	03630 ULTRA SOUND	0, 343, 711	0	0, 343, 711		54. 01
	05600 RADI OI SOTOPE	0	0	0		56. 00
	05700   CT   SCAN     05800   MRI	0	0	0		57. 00 58. 00
	05900 CARDI AC CATHETERI ZATI ON	3, 011, 577	0	3, 011, 577		59. 00
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	6, 449, 053 566, 927	0	6, 449, 053 566, 927		60. 00 62. 00
65. 00	06500 RESPI RATORY THERAPY	1, 650, 806	Ö	1, 650, 806		65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 244, 006 759, 216	0	1, 244, 006 758, 316		66. 00 67. 00
	06800 SPEECH PATHOLOGY	758, 316 182, 227	0	182, 227		68. 00
	06900 ELECTROCARDI OLOGY	489, 665	0	489, 665		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 990, 292 5, 187, 202	0	1, 990, 292 5, 187, 202		71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	7, 484, 122	0	7, 484, 122		73. 00
	07400 RENAL DIALYSIS 03950 MISC ANCILLARY	578, 756 0	0	578, 756 0		74. 00 76. 00
76. 01	03951 SLEEP LAB	O	Ö	0		76. 01
	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 03952 WOUND CARE	1, 065, 079 2, 701, 714	0 -997, 479	1, 065, 079 1, 704, 235		76. 02 76. 03
	OUTPATIENT SERVICE COST CENTERS	2,701,714	-777, 477	1, 704, 233		70.03
	09000 CLI NI C 09100 EMERGENCY	243, 638	0	243, 638		90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 567, 939	0	6, 567, 939		92.00
	SPECIAL PURPOSE COST CENTERS	00 707 700	0.700.040	00 044 700		110.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	83, 737, 730	-2, 792, 942	80, 944, 788		118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	72, 247	0	72, 247		190. 00
	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	0 788, 855	0	0 788, 855		191. 00 192. 00
194.00	07950 NONREI MBURSABLE MI SC	, 55, 555	ő	0		194. 00
	07951 MARKETI NG 07952 SENI OR CI RCLE	0	0	0		194. 01 194. 02
	07954 FREE MEALS	326, 454	0	326, 454		194. 02
200.00	Cross Foot Adjustments	0	0	0		200. 00
201. 00 202. 00		0 84, 925, 286	0 -2, 792, 942	0 82, 132, 344		201. 00 202. 00
	,		., , , ,			1202. 00

| Peri od: | Worksheet B | From 06/01/2017 | Part II | To 05/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

			Т	o 05/31/2018	Date/Time Pre 10/31/2018 1:	
		CAPI TAL REI	LATED COSTS		10/31/2010 1.	э ріп
Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capital Related Costs				DEPARTMENT	
	0	1.00	2.00	2A	4. 00	
GENERAL SERVI CE COST CENTERS	I		T			1 00
1.00   00100   CAP REL COSTS-BLDG & FLXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT	0	64, 831	40, 862	105, 693	105, 693	4. 00
5. 01 00590 REVENUE CYCLE	0	229, 965			6, 262	5. 01
5.02   00560 PURCHASING RECEIVING AND STORES 5.03   00591 ADMINISTRATIVE AND GENERAL	0	159, 721 124, 263	100, 669 78, 321		223 5, 701	5. 02 5. 03
7. 00 00700 OPERATION OF PLANT	0	1, 272, 921	802, 296		3, 761	7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	0	50, 900	32, 082	82, 982	0	8. 00
9. 00   00900   HOUSEKEEPI NG	0	770, 636			2, 594	9.00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A	0	240, 736 0	151, 732		0	10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	56, 162	35, 398	91, 560	6, 216	13. 00
13. 01   01301   PASTORAL CARE	0	32, 038	20, 193	52, 231	147	13. 01
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY	0	0		0	1, 001 5, 041	14. 00 15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	144, 252	1	235, 171	362	16. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	C	0	0	21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22. 00
30.00 O3000 ADULTS & PEDIATRICS	0	512, 589	323, 076	835, 665	20, 021	30. 00
31. 00   03100   NTENSI VE CARE UNI T	0	0	323, 070	033, 003	20, 021	31. 00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	206, 734			2, 503	31. 01
33. 00 03300 BURN INTENSIVE CARE UNIT	0	96, 347			3, 914	33.00
40. 00   04000  SUBPROVI DER - I PF 43. 00   04300  NURSERY	0	73, 211 0	46, 144	119, 355 0	4, 670 666	40. 00 43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	134, 731	84, 919	219, 650	3, 801	44. 00
ANCILLARY SERVICE COST CENTERS	_					
50. 00   05000   0PERATI NG   ROOM   51. 00   05100   RECOVERY   ROOM	0	236, 038 88, 543			4, 043 1, 120	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	78, 789			1, 530	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	226, 435	142, 718	369, 153	6, 087	54.00
54. 01   03630   ULTRA SOUND 56. 00   05600   RADI OI SOTOPE	0	0		0	0	54. 01 56. 00
57. 00   05700 CT SCAN	0	Ö	d	0	0	57. 00
58. 00   05800   MRI	0	0		0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	0	25, 224 193, 806			3, 207 6, 716	59. 00 60. 00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0	10, 620			0, 710	62. 00
65. 00 06500 RESPIRATORY THERAPY	0	78, 748			1, 961	65. 00
66. 00   06600   PHYSI CAL THERAPY	0	102, 323			1, 468	66.00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	39, 168 15, 085			1, 123 215	67. 00 68. 00
69. 00   06900   ELECTROCARDI OLOGY	Ö	14, 357			796	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0 33, 934	21, 388	0 55, 322	0	72. 00 73. 00
74. 00 07400 RENAL DIALYSIS	0	27, 614			0	74.00
76. 00 03950 MISC ANCILLARY	0	0	C	0	0	76. 00
76. 01   03951   SLEEP LAB	0	0	00.011	0	0	76. 01
76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 03   03952   WOUND CARE	0	44, 759 117, 998	·		1, 415 1, 990	76. 02 76. 03
OUTPATIENT SERVICE COST CENTERS		1177770	7 17 072	1727 070	.,,,,	70.00
90. 00 09000 CLI NI C	0	29, 208			142	90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART	0	181, 304	114, 273	295, 577	7, 677	91. 00 92. 00
SPECIAL PURPOSE COST CENTERS				U		92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 713, 990	3, 601, 422	9, 315, 412	105, 693	118. 00
NONREI MBURSABLE COST CENTERS		40.000	0.7/0	00.444		400 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	13, 903 0	8, 763	22, 666 0		190. 00 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		191.00
194. 00 07950 NONREI MBURSABLE MI SC	0	0	C	0		194. 00
194. 01 07951 MARKETI NG	0	0		0		194. 01 194. 02
194. 02 07952  SENI OR CI RCLE 194. 04 07954  FREE MEALS		) 		0		194. 02 194. 04
200.00 Cross Foot Adjustments				O		200. 00
201.00 Negative Cost Centers		0	C	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	0	5, 727, 893	3, 610, 185	9, 338, 078	105, 693	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0047

Peri od: Worksheet B From 06/01/2017 Part II To 05/31/2018 Date/Time Prepared:

10/31/2018 1:09 pm Cost Center Description REVENUE CYCLE PURCHASI NG ADMINISTRATIVE OPERATION OF LAUNDRY & LINEN SERVICE RECEIVING AND AND GENERAL **PLANT STORES** 5. 01 5.03 7. 00 8. 00 5.02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00590 REVENUE CYCLE 381, 170 5.01 00560 PURCHASING RECEIVING AND STORES 260, 613 5.02 5.02 5.03 00591 ADMINISTRATIVE AND GENERAL 0 208, 908 5.03 623 7.00 00700 OPERATION OF PLANT 2. 095. 953 0 17.518 137 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 0 6, 125 1, 305 27, 523 117, 935 8.00 9 00 00900 HOUSEKEEPI NG 0 3,661 7, 175 416, 700 0 9 00 01000 DI ETARY 5, 619 10.00 10.00 4,031 130, 172 0 01100 CAFETERI A 11.00 1, 521 0 11.00 7, 109 30, 368 13.00 01300 NURSING ADMINISTRATION 0 0 0 295 0 13.00 13.01 01301 PASTORAL CARE 15 340 17, 324 13.01 0 01400 CENTRAL SERVICES & SUPPLY 14.00 2,565 14.00 C 0 0 15.00 01500 PHARMACY 4, 494 4,577 0 0 15.00 16, 00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 104 2,560 78.001 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 C 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 6, 870 22.00 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 37, 172 10, 358 27, 024 277, 170 45, 216 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 0 02060 NEONATAL INTENSIVE CARE UNIT 1, 562 31.01 1, 118 4.287 111, 786 213 31.01 33.00 03300 BURN INTENSIVE CARE UNIT 10, 581 4,084 5,720 52,097 7,842 33.00 04000 SUBPROVIDER - IPF 6, 877 40.00 14, 121 1, 428 6, 114 39, 587 40.00 43 00 04300 NURSERY 962 43 00 535 C 414 04400 SKILLED NURSING FACILITY 44.00 3,091 1,569 5,054 72,853 8,973 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 32, 525 20, 324 8, 502 127, 631 8, 739 50.00 05100 RECOVERY ROOM 51.00 2, 167 10 1,869 47, 878 2, 283 51.00 1, 490 1, 757 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 228 42, 603 0 52.00 05300 ANESTHESI OLOGY 53.00 4, 497 204 0 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 55.641 4.364 13.011 122 439 5.934 54 00 03630 ULTRA SOUND 54.01 0 C C 0 0 54.01 05600 RADI OI SOTOPE 0 0 0 0 56.00 56.00 0 57.00 05700 CT SCAN 0 0 0 o 0 57.00 05800 MRI 58 00 0 0 58 00 0 05900 CARDIAC CATHETERIZATION 59.00 17, 226 9, 744 6, 317 13, 639 2, 934 59.00 44, 338 104, 796 06000 LABORATORY 19, 312 13, 540 60.00 60.00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 2, 196 10,047 1, 182 5, 742 0 62.00 06500 RESPIRATORY THERAPY 10.380 3. 258 65.00 3, 439 42, 581 0 65.00 66.00 06600 PHYSI CAL THERAPY 3,062 227 2, 186 55, 328 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 3,061 34 1,507 21, 179 0 67.00 06800 SPEECH PATHOLOGY 68.00 416 320 8.157 68.00 38 0 06900 ELECTROCARDI OLOGY 1,035 69.00 2.698 117 7.763 450 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 31, 246 26, 404 4, 311 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 8,030 111, 315 11, 505 0 72.00 07300 DRUGS CHARGED TO PATIENTS 54, 951 12, 913 73.00 18.349 0 73.00 C 74.00 07400 RENAL DIALYSIS 1, 134 155 1, 190 14, 932 0 74.00 03950 MISC ANCILLARY 76.00 76.00 0 03951 SLEEP LAB 76. 01 0 C 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 2, 204 76.02 2.315 150 24.203 0 76.02 76.03 03952 WOUND CARE 3,788 3,027 3, 143 63,805 0 76.03 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 15, 793 3. 051 90.00 101 322 91.00 09100 EMERGENCY 33, 108 12, 102 12, 513 98, 036 25, 009 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 381, 170 260, 613 208, 842 2, 088, 435 117, 935 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 7. 518 0 190. 00 66 191. 00 19100 RESEARCH 0 0 0 191.00 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 0 194. 00 07950 NONREI MBURSABLE MI SC 0 0 0 0 194.00 194. 01 07951 MARKETI NG 0 0 0 0 194. 01 0 0 194. 02 07952 SENI OR CIRCLE 0 0 0 0 194.02 194.04 07954 FREE MEALS 0 0 0 0 194, 04 C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 117, 935 202. 00 202.00 TOTAL (sum lines 118 through 201) 381, 170 260, 613 208 908 2, 095, 953

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0047

Peri od: Worksheet B From 06/01/2017 Part II To 05/31/2018 Date/Time Prepared:

10/31/2018 1:09 pm Cost Center Description HOUSEKEEPI NG DI ETARY NURSI NG PASTORAL CARE CAFETERI A ADMI NI STRATI ON 9.00 10.00 11.00 13.01 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00590 REVENUE CYCLE 5 01 5 01 5.02 00560 PURCHASING RECEIVING AND STORES 5.02 00591 ADMINISTRATIVE AND GENERAL 5.03 5.03 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 1, 686, 483 9.00 10.00 01000 DI ETARY 132, 911 665, 201 10 00 01100 CAFETERIA 1, 521 11 00 11 00 13.00 01300 NURSING ADMINISTRATION 31,007 87 166, 642 13.00 13.01 01301 PASTORAL CARE 17,688 C 87, 749 13.01 01400 CENTRAL SERVICES & SUPPLY 29 14.00 0 0 14.00 0 01500 PHARMACY 15.00 Ω 63 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 79,642 0 15 0 0 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21 00 0 0 21.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVI CE COST CENTERS 22.00 22.00 0 0 03000 ADULTS & PEDIATRICS 30.00 283, 001 243, 104 366 67,632 35, 616 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 C 02060 NEONATAL INTENSIVE CARE UNIT 8.449 31.01 114.138 35 4.449 31.01 33.00 03300 BURN INTENSIVE CARE UNIT 53, 193 29, 943 61 13, 212 6, 957 33.00 40.00 04000 SUBPROVIDER - IPF 40, 420 77, 969 101 15, 766 8, 301 40.00 04300 NURSERY 43.00 2, 249 1.184 43.00 04400 SKILLED NURSING FACILITY 44.00 74, 386 72, 380 63 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 130, 317 66 13, 649 7, 187 50.00 05100 RECOVERY ROOM 1, 990 51.00 48.885 0 16 3.780 51.00 05200 DELIVERY ROOM & LABOR ROOM 2, 719 52.00 43,500 0 21 5, 163 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 125, 015 0 113 0 54.00 0 54 01 03630 ULTRA SOUND Ω 0 54 01 0 C 0 05600 RADI OI SOTOPE 0 56.00 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 57.00 0 05800 MRI 58.00 0 0 0 0 58.00 0 05900 CARDIAC CATHETERIZATION 5, 700 59.00 13, 926 0 43 10, 825 59.00 06000 LABORATORY 107,001 60.00 133 0 60.00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 5,863 C 0 62.00 65 00 06500 RESPIRATORY THERAPY 43 477 Ω 65 00 34 0 06600 PHYSI CAL THERAPY 0 66.00 56, 493 22 0 66.00 06700 OCCUPATI ONAL THERAPY 21, 625 0 67.00 15 67.00 68.00 06800 SPEECH PATHOLOGY 8,328 0 68.00 3 0 06900 ELECTROCARDI OLOGY 21 69 00 69 00 7.926 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 18, 735 73.00 0 0 73.00 07400 RENAL DIALYSIS 0 Ω 74 00 15, 246 0 74 00 0 76.00 03950 MISC ANCILLARY 0 0 0 0 76.00 03951 SLEEP LAB 0 76.01 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.02 0 33 0 76.02 24.712 03952 WOUND CARE 76.03 65, 147 O 35 0 76.03 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 16, 126 90.00 09100 EMERGENCY 130 25, 917 91.00 100,099 13,646 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 166, 642 1, 678, 807 423, 396 1, 521 87, 749 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 7,676 0 190, 00 C 191. 00 19100 RESEARCH 0 0 0 191.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 171, 028 0 194.00 07950 NONREIMBURSABLE MISC 0 0 0 0 194.00 194. 01 07951 MARKETI NG 0 0 0 194. 01 194. 02 07952 SENI OR CIRCLE 0 0 0 0 194. 02 194.04 07954 FREE MEALS 0 70, 777 0 194, 04 0 0 200.00 Cross Foot Adjustments 200. 00 0 201.00 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) 1, 686, 483 665, 201 1.521 87, 749 202. 00 166, 642

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 06/01/2017 | Part II | To 05/31/2018 | Date/Time Prepared: 10/31/2018 1: 09 pm

					LUTERNO	10/31/2018 1:	09 pm
					INTERNS &	RESI DENTS	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SERVI CES-SALAR	SERVI CES-OTHER	
	cost center bescription	SERVICES &	THANWAOT	RECORDS &	Y & FRINGES	PRGM COSTS	
		SUPPLY		LI BRARY	APPRV	APPRV	
		14.00	15.00	16.00	21.00	22. 00	
	GENERAL SERVICE COST CENTERS	T			T		
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 REVENUE CYCLE						4. 00 5. 01
5. 01	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00591 ADMINISTRATIVE AND GENERAL						5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON 01301 PASTORAL CARE						13.00
13. 01 14. 00	01400 CENTRAL SERVICES & SUPPLY	3, 595					13. 01 14. 00
15. 00	1	3, 343	14, 241				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2	14, 241	395, 857			16. 00
	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	0,0,007	0		21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	C		6, 870	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	152	0	38, 651			30. 00
31. 00	1	0	0	C			31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	16	0	1, 624			31. 01
33.00	03300 BURN INTENSIVE CARE UNIT	60	0	11, 002			33.00
40. 00 43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	21 0	0	14, 683 556			40. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	23	0	3, 214		1	44. 00
11.00	ANCI LLARY SERVI CE COST CENTERS	20		0,211			11.00
50.00	05000 OPERATI NG ROOM	297	0	33, 819			50.00
51.00	05100 RECOVERY ROOM	0	0	2, 253			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	26	0	1, 277			52. 00
53.00	05300 ANESTHESI OLOGY	0	0	4, 676			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	64	0	57, 378			54.00
54. 01	03630 ULTRA SOUND	0	0	C			54. 01
56. 00 57. 00	05600	0	0	0			56. 00 57. 00
58. 00	05800 MRI		0	0			58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	143	0	17, 911			59.00
60.00	06000 LABORATORY	283	0	46, 102			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	147	0	2, 283			62. 00
65.00	06500 RESPI RATORY THERAPY	50	0	10, 793			65. 00
66.00	06600 PHYSI CAL THERAPY	3	0	3, 183			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	3, 183			67. 00
68. 00	06800 SPEECH PATHOLOGY	1	0	432			68.00
69.00	06900 ELECTROCARDI OLOGY	206	0	2, 806			69. 00 71. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	386 1, 628	0	32, 489 8, 349			72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 020	14, 241	57, 137		1	73. 00
	07400 RENAL DIALYSIS	2	0	1, 180			74. 00
	03950 MISC ANCILLARY	O	0	·			76. 00
76. 01	03951 SLEEP LAB	0	0	C			76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2	0	2, 407			76. 02
76. 03	03952 WOUND CARE	44	0	3, 939			76. 03
00.00	OUTPATIENT SERVICE COST CENTERS		ما	105	I		00.00
90.00	09000   CLI NI C   09100   EMERGENCY	0 177	0	105 34, 425			90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	177	U	34, 423			92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		3, 595	14, 241	395, 857	0	0	118. 00
	NONREI MBURSABLE COST CENTERS		· · · · · ·	·	<u>'</u>		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C			190. 00
	19100 RESEARCH	0	0	C			191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			192.00
	07950 NONREI MBURSABLE MI SC	0	0	0			194. 00
	07951   MARKETI NG   07952   SENI OR CI RCLE		0	0			194. 01 194. 02
	107952 SENTOR CTRCLE		0	0			194. 02
200.00				C	0	6. 870	200. 00
201.00		o	O	C	0	0	201. 00
202.00		3, 595	14, 241	395, 857		6, 870	202. 00
	· · · · · · · · · · · · · · · · · · ·	'					

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 06/01/2017 | Part II | To 05/31/2018 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

						o 05/31/2018   Date/lime Pr   10/31/2018 1	
		Cost Center Description	Subtotal	Intern &	Total		
				Residents Cost			
				& Post Stepdown			
				Adjustments			
			24.00	25. 00	26. 00		
1 00		AL SERVICE COST CENTERS				1	1 00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP					1. 00 2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01		REVENUE CYCLE					5. 01
5.02	1	PURCHASING RECEIVING AND STORES					5. 02
5. 03	1	ADMINISTRATIVE AND GENERAL					5. 03
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00		HOUSEKEEPI NG					9. 00
10.00	01000	DI ETARY					10.00
11.00	1	CAFETERI A					11.00
13. 00 13. 01		NURSI NG ADMI NI STRATI ON PASTORAL CARE					13. 00 13. 01
14. 00	1	CENTRAL SERVICES & SUPPLY					14. 00
15. 00		PHARMACY					15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY					16. 00
21. 00	1	I &R SERVI CES-SALARY & FRI NGES APPRV					21. 00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRV					22. 00
30. 00		I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	1, 921, 148	0	1, 921, 148		30.00
31. 00		INTENSIVE CARE UNIT	0	Ö			31. 00
31. 01	02060	NEONATAL INTENSIVE CARE UNIT	587, 215	0	587, 215		31. 01
33.00	1	BURN INTENSIVE CARE UNIT	355, 739	0	355, 739		33. 00
40. 00 43. 00	1	SUBPROVI DER - I PF	349, 413	0			40.00
44.00	1	NURSERY SKILLED NURSING FACILITY	6, 575 465, 057	0	· ·		43. 00 44. 00
00		LARY SERVICE COST CENTERS	1007 007	ŭ,	100,007		1 50
50.00	1	OPERATING ROOM	771, 907	0	· ·		50. 00
51.00		RECOVERY ROOM	256, 601	0			51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	229, 762 9, 382	0	229, 762 9, 382		52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	759, 199	0			54. 00
54. 01	03630	ULTRA SOUND	0	0	· c		54. 01
56. 00		RADI OI SOTOPE	0	0	C		56. 00
57. 00 58. 00	05700	CT SCAN	0	0	-		57. 00 58. 00
59.00	1	CARDI AC CATHETERI ZATI ON	142, 737	0	142, 737		59.00
60.00		LABORATORY	658, 179	0	658, 179		60.00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	44, 773	0	44, 773		62. 00
65. 00	1	RESPI RATORY THERAPY	244, 354	0	244, 354		65. 00
66. 00 67. 00		PHYSI CAL THERAPY  OCCUPATI ONAL THERAPY	288, 787 115, 582	0	288, 787 115, 582		66. 00 67. 00
68. 00		SPEECH PATHOLOGY	42, 503	0			68. 00
		ELECTROCARDI OLOGY	47, 020	0			69. 00
		MEDICAL SUPPLIES CHARGED TO PATIENT	94, 836	0	· ·		71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	140, 827	0	140, 827		72.00
73. 00 74. 00	1	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	231, 648 78, 858	0	231, 648 78, 858		73. 00 74. 00
76. 00		MISC ANCILLARY	0	Ö	0		76. 00
76. 01		SLEEP LAB	0	0	C		76. 01
76. 02		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	130, 411	0			76. 02
76. 03		WOUND CARE TIENT SERVICE COST CENTERS	337, 288	0	337, 288		76. 03
90. 00		CLINIC	83, 260	0	83, 260		90.00
91. 00		EMERGENCY	658, 416	0	· ·		91.00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92. 00
440.00		AL PURPOSE COST CENTERS	0.054.477	ام	0.054.477	I	140.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)   IMBURSABLE COST CENTERS	9, 051, 477	0	9, 051, 477		118. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	37, 926	0	37, 926		190. 00
		RESEARCH	0	0			191. 00
		PHYSICIANS' PRIVATE OFFICES	171, 028	0	171, 028		192. 00
		NONREI MBURSABLE MI SC	0	0	0		194. 00
	1	MARKETING SENIOR CIRCLE	0	0			194. 01 194. 02
		FREE MEALS	70, 777	0	70, 777		194. 04
200.00		Cross Foot Adjustments	6, 870	0	6, 870		200. 00
201.00	1	Negative Cost Centers	0	0	_		201. 00
202. 00	וי	TOTAL (sum lines 118 through 201)	9, 338, 078	O	9, 338, 078	1	202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0047 Peri od: Worksheet B-1 From 06/01/2017 05/31/2018 Date/Time Prepared: 10/31/2018 1:09 pm CAPITAL RELATED COSTS **PURCHASI NG** Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** REVENUE CYCLE (SQUARE FOO (GROSS CHAR RECEIVING AND (SQUARE FOO BENEFITS TAGE) TAGE) DEPARTMENT STORES. GES) (GROSS (COSTED REQUIS.) SALARI ES) 1.00 2.00 5. 01 5.02 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 416 929 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 416, 929 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4,719 4, 719 31, 667, 380 4.00 00590 REVENUE CYCLE 1, 875, 829 5 01 16, 739 16, 739 505, 205, 399 5 01 5.02 00560 PURCHASING RECEIVING AND STORES 11,626 11,626 66, 683 8, 532, 990 5.02 5.03 00591 ADMINISTRATIVE AND GENERAL 9,045 9, 045 1, 707, 994 20, 407 5.03 7.00 00700 OPERATION OF PLANT 92,655 92, 655 923, 113 0 4, 482 7.00 00800 LAUNDRY & LINEN SERVICE 0 200, 541 8 00 3.705 3, 705 8 00 9.00 00900 HOUSEKEEPI NG 56,094 56, 094 776, 991 0 119, 867 9.00 01000 DI ETARY 17, 523 10.00 17, 523 0 131, 998 10.00 01100 CAFETERI A 11.00 11.00 0 4, 088 01300 NURSING ADMINISTRATION 4.088 9, 655 13.00 1,862,048 13.00 0 13.01 01301 PASTORAL CARE 2, 332 2, 332 43, 905 478 13.01 299, 789 01400 CENTRAL SERVICES & SUPPLY 14.00 0 14.00 0 1, 510, 272 01500 PHARMACY 147, 152 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 10.500 10,500 108, 303 3, 407 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 0 22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 37, 311 37, 311 6,002,605 49, 300, 306 339, 152 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 15,048 15, 048 749, 864 2, 072, 063 36, 611 31.01 03300 BURN INTENSIVE CARE UNIT 33.00 7.013 7, 013 1, 172, 534 14, 033, 621 133, 704 33.00 40.00 04000 SUBPROVI DER - I PF 5, 329 5, 329 1, 399, 163 18, 728, 652 46, 745 40.00 04300 NURSERY 199, 552 43.00 709, 186 0 43.00 51, 382 44.00 04400 SKILLED NURSING FACILITY 9,807 9,807 1, 138, 705 4, 099, 060 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 1, 211, 285 43, 136, 860 50.00 17.181 17, 181 665, 432 50.00 05100 RECOVERY ROOM 51.00 6, 445 6, 445 335, 487 2, 873, 703 337 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 628, 441 52.00 5,735 5, 735 458, 215 57, 531 52.00 53.00 05300 ANESTHESI OLOGY 5, 964, 129 165 53.00 05400 RADI OLOGY-DI AGNOSTI C 73, 469, 768 54.00 16, 482 16, 482 1, 823, 527 142, 871 54.00 03630 ULTRA SOUND 54.01 54.01 0 0 05600 RADI OI SOTOPE 0 0 0 56.00 C 0 56.00 57.00 05700 CT SCAN 0 C 0 0 0 57.00 58.00 05800 MRI 58.00 0 319, 027 05900 CARDIAC CATHETERIZATION 1 836 960, 707 22. 845. 742 59 00 1 836 59 00 58, 804, 110 06000 LABORATORY 60.00 14, 107 14, 107 2, 012, 120 632, 324 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 773 773 2, 912, 610 328, 947 62.00 06500 RESPIRATORY THERAPY 65.00 5,732 5, 732 587, 439 13, 766, 218 112, 599 65.00 06600 PHYSI CAL THERAPY 439, 668 4, 060, 382 66 00 7 448 7 448 7 422 66 00 67.00 06700 OCCUPATIONAL THERAPY 2,851 2,851 336, 347 4, 059, 510 1, 103 67.00 06800 SPEECH PATHOLOGY 1,098 1, 098 64, 335 551, 125 68.00 1, 257 68.00 69.00 06900 ELECTROCARDI OLOGY 1.045 1.045 238, 339 3, 578, 875 3.821 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 C 0 41, 439, 798 864, 529 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 10, 649, 725 3, 644, 716 72.00 2, 470 07300 DRUGS CHARGED TO PATIENTS 2,470 72, 878, 844 73.00 0 73.00 07400 RENAL DIALYSIS 0 1, 504, 604 74.00 2.010 2,010 5,068 74.00 03950 MISC ANCILLARY 0 76.00 0 0 0 76.00 76.01 03951 SLEEP LAB 76.01 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76 02 3, 258 3, 258 423, 818 3, 070, 472 4, 912 76.02 03952 WOUND CARE 8, 589 99, 114 76.03 8,589 596, 236 5, 024, 050 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2.126 2, 126 42.479 133.763 0 90.00 09100 EMERGENCY 91.00 13.197 13, 197 2, 300, 028 43, 909, 782 396, 234 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 8, 532, 990 118. 00 118.00 415, 917 415, 917 31, 667, 380 505, 205, 399 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 1.012 1,012 0 191. 00 19100 RESEARCH 0 0 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 0 194. 00 07950 NONREI MBURSABLE MI SC 0 0 0 194, 00 0 0 0 0 194. 01 194. 01 07951 MARKETI NG 0 194. 02 07952 SENI OR CIRCLE 0 0 0 0 194. 02 194. 04 07954 FREE MEALS O 0 194. 04 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

Health Financial Systems		ST JOSEPH MEDICAL CENTER			In Lieu of Form CMS-2552-10		
COST ALI	LOCATION - STATISTICAL BASIS				Period: From 06/01/2017	Worksheet B-1	
					To 05/31/2018		
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	REVENUE CYCLE		
		(SQUARE FOO	(SQUARE FOO	BENEFITS	(GROSS CHAR	RECEIVING AND	
		TAGE)	TAGE)	DEPARTMENT	GES)	STORES	
				(GROSS		(COSTED	
				SALARI ES)		REQUIS.)	
		1.00	2.00	4. 00	5. 01	5. 02	
202.00	Cost to be allocated (per Wkst. B, Part I)	5, 727, 893	3, 610, 185	3, 637, 786	5, 870, 666	539, 955	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	13. 738294	8. 658992	0. 11487!	0. 011620	0. 063279	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			105, 693	381, 170	260, 613	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 003338	0. 000754	0. 030542	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0047 Peri od: Worksheet B-1 From 06/01/2017 To 05/31/2018 Date/Time Prepared:

				To	05/31/2018	Date/Time Pre 10/31/2018 1:	
	Cost Center Description	Reconciliation	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	
			(ACCUM. COST)	PLANT (SQUARE FOO	LINEN SERVICE (POUNDS OF	(SQUARE FOO TAGE)	
			(ACCOM. COST)	TAGE)	LAUNDRY)	IAGE)	
	CENEDAL CEDILLOS COCT CENTEDO	5A. 03	5. 03	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS  OO100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 REVENUE CYCLE 00560 PURCHASING RECEIVING AND STORES						5. 01
5. 02 5. 03	00591 ADMINISTRATIVE AND GENERAL	-13, 581, 209	71, 344, 077				5. 02 5. 03
7. 00	00700 OPERATION OF PLANT	0	5, 983, 094				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	445, 830		784, 437	i e	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	2, 450, 458 1, 919, 077		0		9. 00 10. 00
11. 00	01100 CAFETERI A		519, 427		0	17, 523	11.00
13. 00	01300 NURSING ADMINISTRATION	0	2, 427, 913		0	4, 088	1
13. 01	01301 PASTORAL CARE	0	115, 956		0	2, 332	1
14. 00 15. 00	01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY	0	875, 919 1, 563, 034		0	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	874, 155	_	0	1	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	2, 346, 296	0	0	0	22. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	9, 226, 156	37, 311	300, 767	37, 311	30.00
31. 00	03100   NTENSI VE CARE UNI T	0	0		0	0,,511	31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	1, 464, 080		1, 415		1
33. 00	03300 BURN INTENSIVE CARE UNIT	0	1, 953, 423		52, 159	1	1
40. 00 43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	0	2, 088, 235 328, 493	1	45, 739 2, 753	1	40. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0			59, 682		44. 00
	ANCILLARY SERVICE COST CENTERS	1					
50. 00 51. 00	05000   OPERATI NG ROOM   05100   RECOVERY ROOM	0	_,,		58, 126	l	50. 00 51. 00
51.00	05200 DELIVERY ROOM & LABOR ROOM	0	638, 365 508, 819		15, 183 0	1	1
53. 00	05300 ANESTHESI OLOGY	0	69, 516		0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 443, 715	1	39, 473	1	54.00
54. 01 56. 00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	0	0	0 0	0	0 0	54. 01 56. 00
57. 00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	2, 157, 423		19, 514		1
60. 00 62. 00	06000   LABORATORY   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0	4, 624, 257 403, 650		0	14, 107 773	60. 00 62. 00
65. 00	06500 RESPIRATORY THERAPY	0	1, 112, 536		Ö	5, 732	1
66. 00	06600 PHYSI CAL THERAPY	0	746, 699		0	7, 448	
67. 00	06700 OCCUPATI ONAL THERAPY	0	514, 545		0	2, 851	67.00
68. 00 69. 00	06800  SPEECH PATHOLOGY   06900  ELECTROCARDI OLOGY		109, 412 353, 347		2, 990	1, 098 1, 045	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 472, 300		0		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	3, 929, 470		0		1
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	4, 410, 039 406, 321		0	1	73. 00 74. 00
	03950 MISC ANCILLARY	0	400, 321	1	0	2,010	1
76. 01	03951 SLEEP LAB	0	0		0	0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	752, 839		0		1
76. 03	03952 WOUND CARE   OUTPATIENT SERVICE COST CENTERS	0	1, 073, 262	8, 589	0	8, 589	76. 03
90. 00	09000 CLI NI C	0	109, 984	2, 126	20, 292	2, 126	90.00
	09100 EMERGENCY	0	4, 273, 602	13, 197	166, 344	13, 197	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					1	92.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	-13, 581, 209	71, 321, 411	281, 133	784, 437	221, 334	118 00
	NONREI MBURSABLE COST CENTERS	10/001/207	7.702.7	2017.00	7017107		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22, 666	1, 012	0		190. 00
	19100  RESEARCH   19200  PHYSI CLANS'   PRI VATE   OFFI CES	0	0	0	0		191. 00 192. 00
	07950 NONREI MBURSABLE MI SC			0	0	l e	194. 00
194. 01	07951 MARKETI NG	0	0	O	Ö	0	194. 01
	07952 SENI OR CI RCLE	0	0	0	0		194. 02
194. 04 200. 00	07954 FREE MEALS Cross Foot Adjustments	0	0	0	0		194. 04 200. 00
200.00							200.00
202. 00	Cost to be allocated (per Wkst. B,		13, 581, 209	7, 122, 048	624, 222	1	1
202.00	Part I)		0.100373	25 242540	0.705750	10 407147	202 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	1	0. 190362	25. 242510	0. 795758	19. 487146	1203.00

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
				From 06/01/2017 To 05/31/2018	Date/Time Pre 10/31/2018 1:	
Cost Center Description	Reconciliation	-			HOUSEKEEPI NG	
		AND GENERAL	PLANT	LINEN SERVICE	(SQUARE FOO	
		(ACCUM. COST)	(SQUARE FOO	(POUNDS OF	TAGE)	
			TAGE)	LAUNDRY)		
	5A. 03	5. 03	7. 00	8. 00	9. 00	
204.00 Cost to be allocated (per Wkst. B,		208, 908	2, 095, 95	3 117, 935	1, 686, 483	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part		0. 002928	7. 42863	0. 150343	7. 584949	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						
	'	'		1	•	•

Heal th	Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST A	NLLOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 06/01/2017 o 05/31/2018	Worksheet B-1 Date/Time Pre 10/31/2018 1:	pared:
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (GROSS SALARI ES)	PASTORAL CARE (GROSS SALARI ES)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. )	07 piii
		10.00	11. 00	13.00	13. 01	14. 00	
4 00	GENERAL SERVICE COST CENTERS	1		T	T		1
1.00 2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 21.00 22.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 REVENUE CYCLE 00560 PURCHASING RECEIVING AND STORES 00591 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01301 PASTORAL CARE 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV	164, 371 0 0 0 0 0 0 0	40, 425 2, 317 102 780 1, 664 403 0	14, 789, 440 0 0 0 0 0 0	14, 789, 440 0 0 0 0	8, 045, 562 147, 152 3, 407 0 0	15. 00 16. 00 21. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	60, 071	9, 673	6, 002, 605	6, 002, 605	339, 152	30.00
31. 00 31. 01 33. 00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0 0 7, 399	0 933 1, 629	749, 864 1, 172, 534	749, 864 1, 172, 534	0 36, 611 133, 704	31. 00 31. 01 33. 00
40. 00 43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	19, 266	2, 692 242			46, 745 0	1
44. 00	04400 SKILLED NURSING FACILITY	17, 885	1, 673			51, 382	1
EO 00	ANCI LLARY SERVI CE COST CENTERS		1 740	1 211 205	1 211 205	44E 422	   E0 00
66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 76. 01 76. 02 76. 03	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03950 MI SC ANCI LLARY 03951 SLEEP LAB 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03952 WOUND CARE	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 760 432 556 0 3, 004 0 0 0 1, 154 3, 537 0 916 579 390 69 568 0 0 0 0 872 942	335, 487 458, 215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	335, 487 458, 215 0 0 0 0 0 0 960, 707 0 0 0 0 0 0 0 0 0 0	1, 103 1, 257 3, 821 864, 529 3, 644, 716 0 5, 068 0 0 4, 912 99, 114	51. 00 52. 00 53. 00 54. 01 56. 00 57. 00 58. 00 59. 00 60. 00 62. 00 66. 00 67. 00 68. 00 67. 00 68. 00 71. 00 72. 00 73. 00 74. 00 76. 01 76. 02 76. 03
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	0	3, 468	2, 300, 028	2, 300, 028	396, 234	91. 00 92. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREI MBURSABLE COST CENTERS	104, 621	40, 425	14, 789, 440	14, 789, 440	8, 045, 562	118. 00
191. 00 192. 00 194. 00 194. 02 194. 02 200. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 NONREI MBURSABLE MI SC 07951 MARKETI NG 07952 SENI OR CI RCLE 07954 FREE MEALS Cross Foot Adjustments	0 0 42, 261 0 0 0 17, 489	0 0 0 0 0			0 0 0 0	190. 00 191. 00 192. 00 194. 00 194. 01 194. 02 194. 04 200. 00
201.00		3, 068, 194	618, 306	3, 108, 388	243, 900	1, 054, 591	201. 00

Heal th F	inancial Systems	ST JOSEPH MEDI	CAL CENTER		In Lieu of Form CMS-2552-10		
COST ALI	LOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 06/01/2017 o 05/31/2018	Date/Time Pre 10/31/2018 1:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	PASTORAL CARE	CENTRAL	
		(MEALS SERVED)	(FTE' S)	ADMI NI STRATI ON	V	SERVICES &	
					SALARI ES)	SUPPLY	
				(GROSS		(COSTED	
				SALARI ES)		REQUIS.)	
		10.00	11. 00	13.00	13. 01	14.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	18. 666273	15. 295139	0. 210176	0. 016491	0. 131077	203. 00
204.00	Cost to be allocated (per Wkst. B,	665, 201	1, 521	166, 642	87, 749	3, 595	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	4. 046949	0. 037625	0. 011268	0. 005933	0. 000447	205. 00
206. 00							206. 00
	, ,						
207. 00							207. 00
	Parts III and IV)						
204. 00	Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,	10. 00 18. 666273 665, 201	11. 00 15. 295139 1, 521	(GROSS SALARI ES) 13. 00 0. 210176 166, 642	SALARI ES)  13. 01 0. 016491 87, 749	SUPPLY (COSTED REQUIS.) 14.00 0.131077 3,595	204. 0 205. 0 206. 0

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0047 Peri od: Worksheet B-1 From 06/01/2017 To 05/31/2018 Date/Time Prepared: 10/31/2018 1:09 pm INTERNS & RESIDENTS Cost Center Description **PHARMACY** MEDI CAL SERVI CES-SALAR SERVI CES-OTHER (COSTED RECORDS & Y & FRINGES PRGM COSTS APPRV REQUIS.) LI BRARY **APPRV** (GROSS CHAR (ROTATIONS) (ROTATIONS) GES) 15. 00 21.00 22.00 16. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00590 REVENUE CYCLE 5 01 5 01 5.02 00560 PURCHASING RECEIVING AND STORES 5.02 5.03 00591 ADMINISTRATIVE AND GENERAL 5.03 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 13.01 01301 PASTORAL CARE 13.01 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 3, 215, 737 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 505, 205, 399 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 1,400 21.00 21.00 0 22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 0 1, 400 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 49, 300, 306 500 500 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 0 31.00 0 31.01 02060 NEONATAL INTENSIVE CARE UNIT 2,072,063 0 0 31.01 33.00 03300 BURN INTENSIVE CARE UNIT 14, 033, 621 0 0 33.00 0 40.00 04000 SUBPROVIDER - IPF 18, 728, 652 0 0 40.00 04300 NURSERY 0 0 43.00 709, 186 0 43.00 44.00 04400 SKILLED NURSING FACILITY 4, 099, 060 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 0 43, 136, 860 400 400 51.00 05100 RECOVERY ROOM 00000000000 2, 873, 703 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 1, 628, 441 0 52 00 52.00 0 53.00 05300 ANESTHESI OLOGY 5, 964, 129 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 73, 469, 768 0 0 54.00 03630 ULTRA SOUND 0 54.01 54.01 0 05600 RADI OI SOTOPE 56.00 C 56.00 0 0 57.00 05700 CT SCAN C 57.00 58.00 05800 MRI 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 22, 845, 742 0 59 00 59 00 0 58, 804, 110 60.00 06000 LABORATORY 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 2, 912, 610 62.00 06500 RESPIRATORY THERAPY 0 65.00 0 0 0 13, 766, 218 0 0 65.00 0 06600 PHYSI CAL THERAPY 66 00 4, 060, 382 66 00 67.00 06700 OCCUPATIONAL THERAPY 4, 059, 510 67.00 06800 SPEECH PATHOLOGY 551, 125 0 68.00 0 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 3, 578, 875 0 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 41, 439, 798 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 10, 649, 725 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 72, 878, 844 0 73.00 3, 215, 737 73.00 0 07400 RENAL DIALYSIS 0 74.00 1,504,604 74.00 0 03950 MISC ANCILLARY 0 0 0 76.00 76.00 76. 01 03951 SLEEP LAB 0 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76 02 3,070,472 0 76 02 03952 WOUND CARE 5, 024, 050 500 500 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 133, 763 0 0 90.00 09100 EMERGENCY 91.00 43, 909, 782 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 3, 215, 737 505, 205, 399 1, 400 1, 400 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 0 191. 00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192. 00 0 194. 00 07950 NONREI MBURSABLE MI SC 194.00 0 0 0 0 194. 01 07951 MARKETI NG C 194. 01 194. 02 07952 SENI OR CIRCLE 0 0 0 0 194.02 194. 04 07954 FREE MEALS 194. 04 0 200.00 Cross Foot Adjustments 200.00

201.00

Negative Cost Centers

Heal th F	inancial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 06/01/2017 To 05/31/2018	Date/Time Pre 10/31/2018 1:	
				I NTERNS 8	RESI DENTS		
	Cost Center Description	PHARMACY			SERVI CES-OTHER		
		(COSTED	RECORDS &	Y & FRINGES	PRGM COSTS		
		REQUI S. )	LI BRARY	APPRV	APPRV		
			(GROSS CHAR	(ROTATIONS)	(ROTATIONS)		
			GES)				
		15. 00	16. 00	21.00	22. 00		
202.00	Cost to be allocated (per Wkst. B,	1, 905, 315	1, 516, 833		2, 792, 942		202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 592497	0. 003002	0.00000	1, 994. 958571		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	14, 241	395, 857		6, 870		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 004429	0. 000784	0. 00000	4. 907143		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

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 06/01/2017 Part I

				rom 06/01/2017 o 05/31/2018	Part I Date/Time Pre 10/31/2018 1:	
		Title	XVIII	Hospi tal	PPS	<u> </u>
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
· ·	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	15, 713, 028		15, 713, 028	0	15, 713, 028	30.00
31.00 03100 INTENSIVE CARE UNIT	0			0	0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	2, 612, 261		2, 612, 261	0	2, 612, 261	31. 01
33.00 03300 BURN INTENSIVE CARE UNIT	3, 168, 934		3, 168, 934		3, 168, 934	
40. 00   04000   SUBPROVI DER - 1 PF	3, 540, 810		3, 540, 810		3, 540, 810	
43. 00   04300   NURSERY	444, 279		444, 279		444, 279	
44.00 04400 SKILLED NURSING FACILITY	2, 919, 126		2, 919, 126			
ANCI LLARY SERVI CE COST CENTERS	2,717,120		2/ / / / / / 20		2/ /. // 120	
50. 00 05000 OPERATING ROOM	4, 789, 551		4, 789, 551	0	4, 789, 551	50.00
51. 00   05100   RECOVERY ROOM	1, 151, 573		1, 151, 573			
52.00 05200 DELIVERY ROOM & LABOR ROOM	987, 000	l e	987, 000		.,,	
53. 00   05300  ANESTHESI OLOGY	100, 675		100, 675		1,	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	6, 343, 711		6, 343, 711			
54. 01   03630   ULTRA SOUND	0, 343, 711		0, 343, 711	Ö	0, 343, 711	54. 01
56. 00   05600   RADI OI SOTOPE				0	1	56.00
57. 00 05700 CT SCAN				0	0	57. 00
58. 00   05800   MRI				0	Ö	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 011, 577		3, 011, 577	_	3, 011, 577	
60. 00   06000   LABORATORY	6, 449, 053		6, 449, 053		6, 449, 053	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	566, 927	•	566, 927		566, 927	62.00
65. 00 06500 RESPIRATORY THERAPY	1, 650, 806				1, 650, 806	
						1
66. 00 06600 PHYSI CAL THERAPY	1, 244, 006		.,,		1, 244, 006	
67. 00 06700 OCCUPATI ONAL THERAPY	758, 316		758, 316		758, 316	1
68. 00 06800 SPEECH PATHOLOGY	182, 227		182, 227			
69. 00 06900 ELECTROCARDI OLOGY	489, 665		489, 665		,	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 990, 292		1, 990, 292		.,	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	5, 187, 202		5, 187, 202		-,,	
73. 00 07300 DRUGS CHARGED TO PATIENTS	7, 484, 122		7, 484, 122		.,	
74. 00   07400   RENAL DI ALYSI S	578, 756		578, 756		578, 756	
76. 00 03950 MI SC ANCI LLARY	0		C	0	0	76. 00
76. 01   03951   SLEEP LAB	0			0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 065, 079		1, 065, 079		,	
76. 03 03952 WOUND CARE	1, 704, 235		1, 704, 235	0	1, 704, 235	76. 03
OUTPATIENT SERVICE COST CENTERS		T				
90. 00   09000   CLI NI C	243, 638		243, 638			1
91. 00   09100   EMERGENCY	6, 567, 939		6, 567, 939		-,,	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 035, 847		2, 035, 847		2, 035, 847	
200.00 Subtotal (see instructions)	82, 980, 635		,,		1, ,	
201.00 Less Observation Beds	2, 035, 847		2, 035, 847		2, 035, 847	
202.00   Total (see instructions)	80, 944, 788	0	80, 944, 788	0	80, 944, 788	202. 00

Date/Time Prepared: 05/31/2018 10/31/2018 1:09 pm Title XVIII Hospi tal **PPS** Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 42, 155, 552 42, 155, 552 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 2, 072, 063 02060 NEONATAL INTENSIVE CARE UNIT 2, 072, 063 31.01 31.01 33.00 03300 BURN INTENSIVE CARE UNIT 14, 033, 621 14, 033, 621 33.00 04000 SUBPROVIDER - IPF 40 00 18, 728, 652 18, 728, 652 40.00 43.00 04300 NURSERY 709, 186 709, 186 43.00 44.00 04400 SKILLED NURSING FACILITY 4, 099, 060 4, 099, 060 44 00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 18, 687, 885 24, 448, 975 43, 136, 860 0.111032 0.000000 50.00 51.00 05100 RECOVERY ROOM 1, 257, 816 1, 615, 887 2, 873, 703 0.400728 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 177, 189 451, 252 1, 628, 441 0.606101 0.000000 52.00 3, 007, 225 05300 ANESTHESI OLOGY 2, 956, 904 5, 964, 129 0.016880 0.000000 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 18, 572, 501 54, 897, 267 73, 469, 768 0.086345 0.000000 54.00 54.01 03630 ULTRA SOUND 0.000000 0.000000 0 54.01 56.00 05600 RADI OI SOTOPE 0 Ω 0 0.000000 0.000000 56.00 05700 CT SCAN 0.000000 57 00 0 C 0 0.000000 57 00 58.00 05800 MRI 0.000000 0.000000 58.00 05900 CARDIAC CATHETERIZATION 22, 845, 742 0.131822 0.000000 59.00 9, 693, 456 13, 152, 286 59.00 32, 925, 234 06000 LABORATORY 25, 878, 876 58, 804, 110 0.109670 0.000000 60.00 60.00 2, 912, 610 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 2, 658, 124 254, 486 0. 194646 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 11, 613, 230 2, 152, 988 13, 766, 218 0.119917 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 3, 326, 926 733, 456 4, 060, 382 0.306377 0.000000 66.00 67 00 06700 OCCUPATIONAL THERAPY 3, 957, 385 102, 125 4, 059, 510 0 186800 0 000000 67 00 68.00 06800 SPEECH PATHOLOGY 485, 249 65, 876 551, 125 0.330645 0.000000 68.00 06900 ELECTROCARDI OLOGY 1, 365, 993 2, 212, 882 3, 578, 875 0.136821 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 16, 608, 240 24, 831, 558 41, 439, 798 0.048029 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 367, 700 10, 649, 725 72.00 5, 282, 025 0.487074 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 55, 508, 074 17, 370, 770 72, 878, 844 0. 102693 0.000000 73.00 74.00 07400 RENAL DIALYSIS 1, 434, 239 70, 365 1, 504, 604 0.384657 0.000000 74.00 76 00 03950 MISC ANCILLARY 0 0 0.000000 0.000000 76 00 03951 SLEEP LAB 76.01 Ω 0.000000 0.000000 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 306, 164 2, 764, 308 3, 070, 472 0. 346878 0.000000 76.02 76.02 76.03 03952 WOUND CARE 1,506,504 3, 517, 546 5, 024, 050 0.339215 0.000000 76.03 OUTPATIENT SERVICE COST CENTERS 1.821415 0.000000 90.00 09000 CLI NI C 7, 187 126, 576 133, 763 90.00 09100 EMERGENCY 8, 065, 255 35, 844, 527 43, 909, 782 0.149578 91.00 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1,052,850 6,091,904 7, 144, 754 0. 284943 0.000000 92.00 200.00 231, 919, 518 Subtotal (see instructions) 273, 285, 881 505, 205, 399 200.00 201.00 Less Observation Beds 201.00

273, 285, 881

231, 919, 518

505, 205, 399

202.00

202.00

Total (see instructions)

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

				10/31/2018 1:09 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	·			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT				31. 01
33.00 03300 BURN INTENSIVE CARE UNIT				33. 00
40. 00   04000   SUBPROVI DER -   1 PF				40. 00
43. 00   04300 NURSERY				43. 00
44.00 04400 SKILLED NURSING FACILITY				44.00
ANCI LLARY SERVI CE COST CENTERS	<b>'</b>			
50. 00 05000 OPERATI NG ROOM	0. 111032			50.00
51. 00 05100 RECOVERY ROOM	0. 400728			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 606101			52.00
53. 00   05300   ANESTHESI OLOGY	0. 016880			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 086345			54.00
54. 01   03630   ULTRA SOUND	0. 000000			54. 01
56. 00   05600   RADI OI SOTOPE	0. 000000			56. 00
57. 00   05700 CT SCAN	0. 000000			57.00
58. 00   05800 MRI	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 131822			59.00
60. 00   06000   LABORATORY	0. 131622			60.00
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0. 194646			62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 119917			65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 114417			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 186800			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 330645			68.00
69. 00   06900   ELECTROCARDI OLOGY	0. 330643			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 048029			71. 00
72. 00   07/100   MPL. DEV. CHARGED TO PATIENT	0. 048029			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 467074			73. 00
74. 00   07400   RENAL DI ALYSI S	0. 102693			74.00
76.00   03950   MISC ANCILLARY	0. 000000			74.00
	1			
76. 01   03951   SLEEP LAB	0.000000			76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 346878			76. 02
76. 03   03952   WOUND CARE	0. 339215			76. 03
OUTPATIENT SERVICE COST CENTERS	1 001445			00.00
90. 00   09000   CLI NI C	1. 821415			90.00
91. 00 09100 EMERGENCY	0. 149578			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 284943			92. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				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

To 05/31/2018 | Date/Time Prepared: 10/31/2018 1:09 pm Hospi tal Title XIX PPS Costs Therapy Limit Cost Center Description Total Cost Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 1.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 15, 713, 028 15, 713, 028 15, 713, 028 03100 INTENSIVE CARE UNIT 0 31.00 31.00 0 02060 NEONATAL INTENSIVE CARE UNIT 31.01 2, 612, 261 2, 612, 261 2, 612, 261 31.01 03300 BURN INTENSIVE CARE UNIT 33.00 3, 168, 934 3, 168, 934 3, 168, 934 33.00 04000 SUBPROVI DER - I PF 0 40.00 3, 540, 810 3, 540, 810 3, 540, 810 40.00 43.00 04300 NURSERY 444, 279 444, 279 0 444, 279 43.00 44.00 04400 SKILLED NURSING FACILITY 2, 919, 126 2, 919, 126 2, 919, 126 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 789, 551 4, 789, 551 0 4, 789, 551 50.00 51.00 05100 RECOVERY ROOM 1, 151, 573 1, 151, 573 0 0 0 1, 151, 573 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 987,000 987,000 987,000 52.00 100, 675 05300 ANESTHESI OLOGY 100, 675 53.00 100, 675 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 343, 711 6, 343, 711 6, 343, 711 54.00 03630 ULTRA SOUND 54.01 0 0 0 0 0 0 0 0 0 0 0 0 0 54.01 05600 RADI OI SOTOPE 56 00 0 O 56 00 0 57.00 05700 CT SCAN 0 0 0 57.00 58.00 05800 MRI 0 0 58.00 Ω 05900 CARDIAC CATHETERIZATION 59.00 3, 011, 577 3, 011, 577 3, 011, 577 59.00 6, 449, 053 06000 LABORATORY 6, 449, 053 60 00 60 00 6, 449, 053 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 566, 927 566, 927 566, 927 62.00 06500 RESPIRATORY THERAPY 65.00 1, 650, 806 1, 650, 806 1, 650, 806 65.00 1, 244, 006 66 00 06600 PHYSI CAL THERAPY 1, 244, 006 1, 244, 006 66 00 06700 OCCUPATIONAL THERAPY 67.00 758, 316 758, 316 758, 316 67.00 68.00 06800 SPEECH PATHOLOGY 182, 227 182, 227 182, 227 68.00 69.00 06900 ELECTROCARDI OLOGY 489, 665 489, 665 0 0 0 0 0 489, 665 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 990, 292 1, 990, 292 71 00 1, 990, 292 71 00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 5, 187, 202 5, 187, 202 5, 187, 202 72.00 07300 DRUGS CHARGED TO PATIENTS 7, 484, 122 7, 484, 122 7, 484, 122 73.00 73.00 74.00 07400 RENAL DIALYSIS 578, 756 578, 756 578, 756 74.00 03950 MISC ANCILLARY 76.00 0 76.00 0 0 0 76. 01 03951 SLEEP LAB 0 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1, 065, 079 1, 065, 079 76.02 1, 065, 079 76.02 1, 704, 2<u>35</u> 03952 WOUND CARE 1, 704, 235 1, 704, 235 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 243, 638 243, 638 0 243, 638 90.00 91.00 09100 EMERGENCY 6, 567, 939 6, 567, 939 0 6, 567, 939 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 2,035,847 2.035.847 2, 035, 847 92.00 200.00 Subtotal (see instructions) 82, 980, 635 0 82, 980, 635 0 82, 980, 635 200. 00 201.00 Less Observation Beds 2,035,847 2, 035, 847 2, 035, 847 201. 00 202.00 Total (see instructions) 80, 944, 788 80, 944, 788 80, 944, 788 202. 00

| Peri od: | Worksheet C | From 06/01/2017 | Part | To 05/31/2018 | Date/Time Prepared: |

					0 05/31/2018	10/31/2018 1:	
			Ti tl	e XIX	Hospi tal	PPS	07 piii
			Charges	5 7.17.	illoopi tui		
	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	
	ATIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS	42, 155, 552		42, 155, 552			30. 00
	DO INTENSIVE CARE UNIT	0		0			31. 00
	NEONATAL INTENSIVE CARE UNIT	2, 072, 063		2, 072, 063			31. 01
	00 BURN INTENSIVE CARE UNIT	14, 033, 621		14, 033, 621			33. 00
	00 SUBPROVI DER - I PF	18, 728, 652		18, 728, 652			40. 00
	00 NURSERY	709, 186		709, 186			43. 00
	OO SKILLED NURSING FACILITY	4, 099, 060		4, 099, 060			44. 00
	LLARY SERVICE COST CENTERS				1		
	OO OPERATI NG ROOM	18, 687, 885	24, 448, 975			0. 000000	1
	OO RECOVERY ROOM	1, 257, 816	1, 615, 887			0. 000000	1
	DO DELIVERY ROOM & LABOR ROOM	1, 177, 189	451, 252			0. 000000	1
	OO ANESTHESI OLOGY	2, 956, 904	3, 007, 225			0. 000000	
4	OO RADI OLOGY-DI AGNOSTI C	18, 572, 501	54, 897, 267	1		0. 000000	
	BO ULTRA SOUND	0	0	1	0.00000	0. 000000	
	OO RADI OI SOTOPE	0	0			0. 000000	1
	OO CT SCAN	0	0	·	0.000000	0.000000	1
	OO MRI	0 (02 45(	12 152 207	·	0.000000	0.000000	ł
	OO CARDI AC CATHETERI ZATI ON	9, 693, 456	13, 152, 286			0.000000	1
	DO LABORATORY DO WHOLE BLOOD & PACKED RED BLOOD CELL	25, 878, 876	32, 925, 234			0.000000	1
	DO RESPIRATORY THERAPY	2, 658, 124	254, 486			0.000000	ł
	DO PHYSI CAL THERAPY	11, 613, 230 3, 326, 926	2, 152, 988			0. 000000 0. 000000	1
	00 OCCUPATIONAL THERAPY	3, 957, 385	733, 456 102, 125			0. 000000	1
	OO SPEECH PATHOLOGY	485, 249	65, 876			0. 000000	
	DO ELECTROCARDI OLOGY	1, 365, 993	2, 212, 882			0. 000000	1
	DO MEDICAL SUPPLIES CHARGED TO PATIENT	16, 608, 240	24, 831, 558			0. 000000	1
	00 IMPL. DEV. CHARGED TO PATIENTS	5, 367, 700	5, 282, 025			0. 000000	•
	DO DRUGS CHARGED TO PATIENTS	55, 508, 074	17, 370, 770			0. 000000	1
	DO RENAL DIALYSIS	1, 434, 239	70, 365			0. 000000	1
	50 MISC ANCILLARY	1, 434, 237	70, 303			0. 000000	•
	51 SLEEP LAB		0		0. 000000	0. 000000	
	50 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	306, 164	2, 764, 308	3, 070, 472		0.000000	•
	52 WOUND CARE	1, 506, 504	3, 517, 546			0. 000000	
	PATIENT SERVICE COST CENTERS	1, 300, 304	3, 317, 340	3, 024, 030	0. 337213	0.000000	70.00
	DO CLINIC	7, 187	126, 576	133, 763	1. 821415	0. 000000	90.00
	DO EMERGENCY	8, 065, 255	35, 844, 527			0. 000000	1
	OO OBSERVATION BEDS (NON-DISTINCT PART	1, 052, 850	6, 091, 904			0. 000000	1
200.00	Subtotal (see instructions)	273, 285, 881	231, 919, 518			2. 223000	200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	273, 285, 881	231, 919, 518	505, 205, 399			202. 00
		•		•			-

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lieu	ı of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN:	From 06/01/2017 To 05/31/2018	Worksheet C Part I Date/Time Prepared:

					10/31/2018 1:09 pm
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31. 00	03100   NTENSIVE CARE UNIT				31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT				31. 01
33.00	03300 BURN INTENSIVE CARE UNIT				33.00
40.00	04000 SUBPROVI DER - I PF				40. 00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 111032			50.00
51.00	05100 RECOVERY ROOM	0. 400728			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 606101			52.00
53.00	05300 ANESTHESI OLOGY	0. 016880			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 086345			54.00
54. 01	03630 ULTRA SOUND	0. 000000			54. 01
56.00	05600 RADI OI SOTOPE	0. 000000			56. 00
57.00	05700 CT SCAN	0. 000000			57. 00
58.00	05800 MRI	0. 000000			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 131822			59. 00
60.00	06000 LABORATORY	0. 109670			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 194646			62. 00
65.00	06500 RESPI RATORY THERAPY	0. 119917			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 306377			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 186800			67. 00
68.00	06800 SPEECH PATHOLOGY	0. 330645			68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 136821			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 048029			71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 487074			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 102693			73. 00
74.00	07400 RENAL DIALYSIS	0. 384657			74. 00
76.00	03950 MISC ANCILLARY	0. 000000			76. 00
76. 01	03951 SLEEP LAB	0. 000000			76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 346878			76. 02
76. 03	03952 WOUND CARE	0. 339215			76. 03
	OUTPATIENT SERVICE COST CENTERS				
		1. 821415			90.00
91.00	09100 EMERGENCY	0. 149578			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 284943			92. 00
200.00					200. 00
201.00					201. 00
202.00	Total (see instructions)				202. 00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE CO REDUCTIONS FOR MEDICAID ONLY	ST TO CHARGE RATIOS NET OF	Provider CCN: 15-0047	From 06/01/2017	Worksheet C Part II Date/Time Prepared:

				1	0 05/31/2018	10/31/2018 1:	
			Titl	e XIX	Hospi tal	PPS	07 piii
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
		(Wkst. B, Part			Reduction	Reduction	
		I, col. 26)		Cost (col. 1 -		Amount	
			Í	col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	•					
50.00	05000 OPERATING ROOM	4, 789, 551	771, 907	4, 017, 644	0	0	50.00
51.00	05100 RECOVERY ROOM	1, 151, 573	256, 601	894, 972	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	987, 000	229, 762	757, 238	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	100, 675	9, 382	91, 293	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 343, 711	759, 199	5, 584, 512	0	0	54.00
54.01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57.00	05700 CT SCAN	o	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	3, 011, 577	142, 737	2, 868, 840	0	0	59. 00
60.00	06000 LABORATORY	6, 449, 053	658, 179	5, 790, 874	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	566, 927	44, 773	522, 154	0	0	62. 00
65.00	06500 RESPIRATORY THERAPY	1, 650, 806	244, 354	1, 406, 452	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 244, 006	288, 787	955, 219	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	758, 316	115, 582	642, 734	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	182, 227	42, 503	139, 724	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	489, 665	47, 020	442, 645	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 990, 292	94, 836	1, 895, 456	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 187, 202	140, 827	5, 046, 375	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 484, 122	231, 648	7, 252, 474	0	0	73. 00
74.00	07400 RENAL DIALYSIS	578, 756	78, 858	499, 898	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	1, 065, 079	130, 411	934, 668	0	0	76. 02
76. 03	03952 WOUND CARE	1, 704, 235	337, 288	1, 366, 947	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	243, 638	83, 260	160, 378	0	0	90. 00
91.00	09100 EMERGENCY	6, 567, 939	658, 416	5, 909, 523	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 035, 847	248, 913	1, 786, 934	0	0	92.00
200.00	Subtotal (sum of lines 50 thru 199)	54, 582, 197	5, 615, 243	48, 966, 954	0	0	200. 00
201.00	Less Observation Beds	2, 035, 847	248, 913	1, 786, 934	0	0	201. 00
202.00	Total (line 200 minus line 201)	52, 546, 350	5, 366, 330	47, 180, 020	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 REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 15-0047	Peri od: From 06/01/2017 To 05/31/2018	Worksheet C Part II Date/Time Prepared:

					10 03/31/2010	10/31/2018 1:09 pm
			Ti tI	e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
	·	Capital and	(Worksheet C,	Cost to Charg	je	
		Operating Cost	Part I, column	Ratio (col.	6	
		Reducti on	8)	/ col. 7)		
		6.00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	4, 789, 551	43, 136, 860	0. 11103	32	50.00
51.00	05100 RECOVERY ROOM	1, 151, 573	2, 873, 703		28	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	987, 000	1, 628, 441	0. 60610	)1	52. 00
53.00	05300 ANESTHESI OLOGY	100, 675	5, 964, 129	0. 01688	80	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 343, 711	73, 469, 768	0. 08634	5	54.00
54. 01	03630 ULTRA SOUND	0	0	0.00000		54. 01
56.00	05600 RADI OI SOTOPE	0	0	0.00000	00	56. 00
57.00	05700 CT SCAN	0	0	0.00000	00	57. 00
58. 00	05800 MRI	0	0	0.00000	00	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 011, 577	22, 845, 742	0. 13182	.2	59. 00
60.00	06000 LABORATORY	6, 449, 053	58, 804, 110	0. 10967	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	566, 927	2, 912, 610	0. 19464	6	62. 00
65.00	06500 RESPI RATORY THERAPY	1, 650, 806	13, 766, 218	0. 11991	7	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 244, 006	4, 060, 382	0. 30637	7	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	758, 316	4, 059, 510	0. 18680	00	67. 00
68. 00	06800 SPEECH PATHOLOGY	182, 227	551, 125	0. 33064	5	68. 00
69.00	06900 ELECTROCARDI OLOGY	489, 665	3, 578, 875	0. 13682	<u>!</u> 1	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 990, 292	41, 439, 798	0. 04802	.9	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 187, 202	10, 649, 725	0. 48707	4	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 484, 122	72, 878, 844	0. 10269	93	73. 00
74.00	07400 RENAL DIALYSIS	578, 756	1, 504, 604	0. 38465	57	74. 00
76.00	03950 MISC ANCILLARY	0	0	0.00000	00	76. 00
76. 01	03951 SLEEP LAB	o	0	0.00000	00	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 065, 079	3, 070, 472	0. 34687	'8	76. 02
76. 03	03952 WOUND CARE	1, 704, 235	5, 024, 050	0. 33921	5	76. 03
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	243, 638	133, 763	1. 82141	5	90.00
91.00	09100 EMERGENCY	6, 567, 939	43, 909, 782	0. 14957	'8	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 035, 847	7, 144, 754	0. 28494	3	92. 00
200.00	Subtotal (sum of lines 50 thru 199)	54, 582, 197	423, 407, 265			200. 00
201.00	Less Observation Beds	2, 035, 847	O			201. 00
202.00	Total (line 200 minus line 201)	52, 546, 350	423, 407, 265			202. 00

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 06/01/2017 To 05/31/2018	10/31/2018 1:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capi tal Related Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2, 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 921, 148	0	1, 921, 14	8 19, 419	98. 93	30.00
31.00 INTENSIVE CARE UNIT	0			0	0.00	31.00
31. 01 NEONATAL INTENSIVE CARE UNIT	587, 215		587, 21	5 569	1, 032. 01	31. 01
33.00 BURN INTENSIVE CARE UNIT	355, 739		355, 73	9 2, 065	172. 27	33. 00
40. 00 SUBPROVI DER - I PF	349, 413	0	349, 41		63. 71	
43. 00 NURSERY	6, 575		6, 57		11. 22	
44.00 SKILLED NURSING FACILITY	465, 057		465, 05	· ·	91. 35	
200.00 Total (lines 30 through 199)	3, 685, 147		3, 685, 14	7 33, 214		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col. 6)				
	6, 00	7.00	+			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	3, 946	390, 378	s I			30.00
31. 00 INTENSIVE CARE UNIT	0,710	1	1			31. 00
31. 01 NEONATAL INTENSIVE CARE UNIT	0	Ö				31. 01
33.00 BURN INTENSIVE CARE UNIT	405	69, 769				33. 00
40. 00 SUBPROVI DER - I PF	3, 409		•			40.00
43. 00 NURSERY	0	1	1			43.00
44.00 SKILLED NURSING FACILITY	2, 215	202, 340				44. 00
200.00 Total (lines 30 through 199)	9, 975	879, 674				200.00

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10								
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Peri od: From 06/01/2017 To 05/31/2018	Worksheet D Part II Date/Time Pre 10/31/2018 1:	pared:	
				XVIII	Hospi tal	PPS		
	Cost Center Description	Capi tal	Total Charges			Capital Costs		
			(from Wkst. C,		Program	(column 3 x		
		(from Wkst. B,			. Charges	column 4)		
		Part II, col.	8)	2)				
		26)						
	I	1.00	2. 00	3. 00	4. 00	5. 00		
	ANCILLARY SERVICE COST CENTERS			1				
50. 00	05000 OPERATING ROOM	771, 907						
51. 00	05100 RECOVERY ROOM	256, 601						
52.00	05200 DELIVERY ROOM & LABOR ROOM	229, 762						
53.00	05300 ANESTHESI OLOGY	9, 382		l .				
54.00	05400   RADI OLOGY-DI AGNOSTI C	759, 199	73, 469, 768				54. 00	
54. 01	03630 ULTRA SOUND	0	0	0. 00000		0	54. 01	
56.00	05600 RADI OI SOTOPE	0	0	0. 00000		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	142, 737					59. 00	
60.00	06000 LABORATORY	658, 179				62, 771	60. 00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	44, 773						
65. 00	06500 RESPI RATORY THERAPY	244, 354	13, 766, 218	0. 01775	2, 726, 682	48, 399	65. 00	
66.00	06600 PHYSI CAL THERAPY	288, 787	4, 060, 382			20, 375	66. 00	
67. 00	06700 OCCUPATI ONAL THERAPY	115, 582		l .				
68. 00	06800 SPEECH PATHOLOGY	42, 503	551, 125	0. 07712	20 54, 835	4, 229	68. 00	
69. 00	06900 ELECTROCARDI OLOGY	47, 020	3, 578, 875	0. 01313	38 291, 262	3, 827	69. 00	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	94, 836	41, 439, 798			14, 867		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	140, 827	10, 649, 725	0. 01322	1, 559, 384	20, 621	72. 00	
73.00	07300 DRUGS CHARGED TO PATIENTS	231, 648	72, 878, 844	0. 00317	79 12, 263, 266			
	07400 RENAL DI ALYSI S	78, 858	1, 504, 604			49, 896		
		0	0	0.00000		0	76. 00	
76. 01	03951 SLEEP LAB	0	0	0.00000	00	0	76. 01	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	130, 411					76. 02	
76 02	020E3 WOLIND CAPE	227 200	E 034 050	0 06713	275 524	25 211	76 02	

337, 288

83, 260

658, 416

248, 913

5, 615, 243

5, 024, 050

43, 909, 782 7, 144, 754 423, 407, 265

133, 763

0.067135

0.622444

0. 014995

0.034839

375, 534

1, 625, 114 385, 507 49, 344, 190

76.03

90.00

25, 211

0

24, 369 91. 00 13, 431 92. 00

564, 131 200. 00

76. 03 03952 WOUND CARE

91. 00 09100 EMERGENCY

200.00

OUTPATIENT SERVICE COST CENTERS

90. 00 09000 CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

Health Financial Systems	ST JOSEPH MED	DICAL CENTER		In Li€	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA				Period: From 06/01/2017 To 05/31/2018	Worksheet D Part III	
			XVIII	Hospi tal	PPS	
Cost Center Description				Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 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	0	31. 00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	31. 01
33.00 03300 BURN INTENSIVE CARE UNIT	0	0			0	
40. 00   04000   SUBPROVI DER -   PF	0	0			٥	40.00
43. 00   04300   NURSERY					l o	43. 00
44. 00 04400 SKILLED NURSING FACILITY					Ĭ	44. 00
200.00 Total (lines 30 through 199)					_	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Dationt	Per Diem (col.	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Days	3 ÷ COI. 0)	Program bays	
	instructions)	minus col. 4)				
	4. 00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
	1 0		10.41	0.00	2.04/	30.00
	0	0	19, 41			1
31. 00   03100   INTENSIVE CARE UNIT		0	1	0.00		
31. 01   02060   NEONATAL   INTENSIVE CARE UNIT		0	56			
33.00 03300 BURN INTENSIVE CARE UNIT		0	2, 06			
40. 00   04000   SUBPROVI DER - 1 PF	0	0	5, 48			
43. 00   04300   NURSERY		0	58			
44.00 04400 SKILLED NURSING FACILITY		0				
200.00 Total (lines 30 through 199)		0	33, 21	4	9, 975	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
INDATION DOUBLING CERVICE COCT CENTERS	9. 00					

30.00

31. 00 31. 01

33. 00 40. 00 43. 00 44. 00 200. 00

30. 00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS

Total (lines 30 through 199)

31. 00 | 03100 | INTENSIVE CARE UNIT 31. 01 | 02060 | NEONATAL | INTENSIVE CARE UNIT

33.00 | 03300 | BURN | INTENSIVE CARE UNIT | 43.00 | 04400 | SUBPROVIDER - IPF | 43.00 | 04400 | SKILLED | NURSING FACILITY |

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0047	Peri od: Worksheet D From 06/01/2017 To 05/31/2018 Date/Time Prepared: 10/31/2018 1:00 pm			

					0 05/31/2018	10/31/2018 1:	pared: O9 nm
-			Title	XVIII	Hospi tal	PPS	<u>о, р</u>
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
1	05000 OPERATING ROOM	0	0	(	0	0	00.00
1	05100 RECOVERY ROOM	0	0	(	0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0	(	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54.00
	03630 ULTRA SOUND	0	0	(	0	0	54. 01
	05600 RADI OI SOTOPE	0	0	(	0	0	56. 00
	05700 CT SCAN	0	0	(	0	0	57. 00
	05800 MRI	0	0	(	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0	0	59. 00
60.00	06000 LABORATORY	0	0	(	0	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(	0	0	62. 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 OCCUPATI ONAL THERAPY	0	0	(	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	(	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	(	0	0	74. 00
76. 00	03950 MISC ANCILLARY	0	0	(	0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	(	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	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(	0	0	90.00
91.00	09100 EMERGENCY	0	0	(	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92. 00
200.00	Total (lines 50 through 199)	0	0	(	0	0	200. 00

Health Financial Systems	ST JOSEPH 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 06/01/2017	Part IV

THROUGH COSTS				To 05/31/2018		
		Title	XVIII	Hospi tal	PPS	07 piii
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
, , , , , , , , , , , , , , , , , , ,	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
			4)			
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	(	43, 136, 860		
51.00   05100   RECOVERY ROOM	0	0	(	2, 873, 703		1
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	(	1, 628, 441	0. 000000	
53. 00   05300   ANESTHESI OLOGY	0	0	(	5, 964, 129		
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	73, 469, 768		1
54. 01   03630   ULTRA SOUND	0	0	(	0	0. 000000	1
56. 00   05600   RADI 0I SOTOPE	0	0	(	0	0. 000000	
57. 00  05700 CT SCAN	0	0	(	0	0. 000000	57. 00
58. 00   05800   MRI	0	0	(	0	0. 000000	1
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0	(	22, 845, 742		
60. 00   06000   LABORATORY	0	0	(	58, 804, 110		l
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(	2, 912, 610		l
65. 00 06500 RESPI RATORY THERAPY	0	0	(	13, 766, 218		•
66. 00   06600 PHYSI CAL THERAPY	0	0	(	4, 060, 382		
67. 00   06700 OCCUPATI ONAL THERAPY	0	0	(	4, 059, 510		1
68. 00   06800   SPEECH PATHOLOGY	0	0	(	551, 125		1
69. 00   06900   ELECTROCARDI OLOGY	0	0	(	3, 578, 875		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	41, 439, 798		1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	10, 649, 725		1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	72, 878, 844		
74. 00   07400   RENAL DIALYSIS	0	0	(	1, 504, 604		1
76.00  03950   MISC ANCILLARY	0	0	(	0	0. 000000	76. 00
76. 01  03951  SLEEP LAB	0	0	(	0	0. 000000	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(			1
76. 03 03952 WOUND CARE	0	0	(	5, 024, 050	0.000000	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0	,	133, 763		1
91. 00   09100   EMERGENCY	0	0	(			1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(	7, 144, 754		1
200.00   Total (lines 50 through 199)	0	0	(	423, 407, 265		200. 00

	Financial Systems	ST JOSEPH MEDI	CAL CENTER			eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER'THROUGH COSTS		EVICE OTHER PASS	Provi der CC		Period: From 06/01/2017 To 05/31/2018	Date/Time Pre 10/31/2018 1:	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
	1	9.00	10.00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS					Т	
50.00	05000 OPERATI NG ROOM	0. 000000	5, 488, 283		0 5, 063, 583		
51. 00	05100 RECOVERY ROOM	0. 000000	384, 443		0 1, 148, 634	1	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	14, 378		0 10, 462	1	
53.00	05300 ANESTHESI OLOGY	0. 000000	690, 152		0 648, 714		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	5, 973, 330		0 8, 493, 744	1	54.00
54. 01	03630 ULTRA SOUND	0. 000000	0		0	0	54. 01
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56. 00
57.00	05700  CT SCAN	0. 000000	0		0	0	57.00
58.00	05800  MRI	0. 000000	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	3, 069, 328		0 2, 348, 321	0	59. 00
60.00	06000 LABORATORY	0. 000000	5, 608, 051		0 2, 297, 341		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	836, 086		0 46, 075	0	62.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	2, 726, 682		0 479, 608	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	286, 480		0 24, 504	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	250, 532		0 21, 408	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	54, 835		0 4, 332	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	291, 262		0 430, 820	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6, 495, 021		0 7, 194, 609	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 559, 384		0 1, 465, 310	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	12, 263, 266		0 3, 008, 348	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	952, 018		0 70, 364	1 0	74.00
76.00	03950 MISC ANCILLARY	0. 000000	0		0 0	0	76. 00
76. 01	03951 SLEEP LAB	0. 000000	0		0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	14, 504		0 1, 119, 308	0	76. 02
76. 03	03952 WOUND CARE	0. 000000	375, 534		0 976, 736	0	76. 03

0. 000000

0.000000

0. 000000

1, 625, 114 385, 507 49, 344, 190

0

90.00

0 91.00 0 92.00

0 200. 00

11, 348 3, 579, 272 1, 323, 864 39, 766, 705

0 0 0

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)

Heal th	Financial Systems	ST JOSEPH MED	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
					From 06/01/2017		
				-	Γο 05/31/2018		
						10/31/2018 1:	09 pm
			litle	XVIII	Hospi tal	PPS	
				Charges	1	Costs	
	Cost Center Description		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.)		
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	_					
	05000 OPERATING ROOM	0. 111032	5, 063, 583	(	0	562, 220	50.00
51.00	05100 RECOVERY ROOM	0. 400728	1, 148, 634		0	460, 290	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 606101	10, 462		0	6, 341	52.00
53.00	05300 ANESTHESI OLOGY	0. 016880	648, 714	.] (	0	10, 950	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 086345			0		
	03630 ULTRA SOUND	0. 000000		1		0	1
	05600 RADI OI SOTOPE	0. 000000	1	1		0	56.00
	05700 CT SCAN					ľ	1
	l	0. 000000			0	0	57. 00
58. 00	05800 MRI	0. 000000	1	1	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 131822			0		1
60.00	06000 LABORATORY	0. 109670			0	251, 949	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 194646	46, 075	(	0	8, 968	62. 00
65.00	06500 RESPI RATORY THERAPY	0. 119917	479, 608		0	57, 513	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 306377	24, 504		0	7, 507	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 186800	21, 408		0	3, 999	67.00
	06800 SPEECH PATHOLOGY	0. 330645			0	1, 432	68. 00
	06900 ELECTROCARDI OLOGY	0. 136821		1	0	58, 945	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 048029			0	345, 550	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 487074		1		713, 714	1
	07300 DRUGS CHARGED TO PATIENTS	0. 102693		l .	29, 694	308, 936	1
	ł	1		1	1		1
	07400 RENAL DI ALYSI S	0. 384657			0	27, 066	1
	03950 MISC ANCILLARY	0. 000000		1	0	0	76. 00
	03951 SLEEP LAB	0. 000000	l control of the cont	1	) 0	0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 346878			0		
	03952 WOUND CARE	0. 339215	976, 736	(	0	331, 324	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	1. 821415	11, 348	(	160	20, 669	90.00
91.00	09100 EMERGENCY	0. 149578	3, 579, 272	(	0	535, 380	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 284943	1, 323, 864		0	377, 226	92.00
200.00			39, 766, 705		29, 854		
201.00					0	1	201. 00
_000	Only Charges			]		l	[
202.00	1 1 3		39, 766, 705		29, 854	5, 521, 194	202, 00
_02.00	, Ind. 900 (11110 200 11110 201)	ı	1 0.7.00,700	'	27,001	0,02.,171	,_ ,_ ,

Health Financial Systems	th Financial Systems ST JOSEPH MEDICAL CENTER In Lie				u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provi der CCN: 15-0047	Peri od: From 06/01/2017 To 05/31/2018	Worksheet D Part V Date/Time Prepared:

				To 05/31/2018	Date/Time Pro	epared:
		Ti tl e	e XVIII	Hospi tal	PPS	
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost	1			
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	C				50. 00
51. 00   05100   RECOVERY ROOM	0	C				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	l c				52.00
53. 00   05300   ANESTHESI OLOGY	0	l c				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0					54.00
54. 01 03630 ULTRA SOUND	0	1				54. 01
56. 00   05600   RADI 0I SOTOPE	0	1				56. 00
57. 00   05700 CT SCAN	0	1				57. 00
58. 00   05800 MRI	0	1				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0					59. 00
60. 00   06000   LABORATORY	0	1	1			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1				62. 00
65. 00 06500 RESPIRATORY THERAPY	0	1				65. 00
66. 00   06600   PHYSI CAL THERAPY	0	1				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	1				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1				69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	3, 049	- 1			73. 00
74. 00 07400 RENAL DIALYSIS	0	0,017	1			74. 00
76. 00 03950 MI SC ANCI LLARY	0	1	1			76. 00
76. 01   03951   SLEEP LAB	0	1	1			76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o o	1	1			76. 02
76. 03   03952   WOUND CARE	l o					76. 03
OUTPATIENT SERVICE COST CENTERS			·1			7 7 0 0 0 0
90. 00   09000  CLI NI C	0	291				90.00
91. 00 09100 EMERGENCY	l o		1			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	l o	1				92. 00
200.00 Subtotal (see instructions)	0	3, 340				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	3, 340	ol			202.00
	1	,				

Health Financial Systems	ST JOSEPH MED				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0047	Peri od: From 06/01/2017	Worksheet D	
		Component	CCN: 15-S047	To 05/31/2018		nared·
		Component	0014. 10 0017	10 00/01/2010	10/31/2018 1:	09 pm
		Title	XVIII	Subprovi der -	PPS	
				IPF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1. 00	2.00	2.00	4.00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4. 00	5.00	
50. 00 O5000 OPERATING ROOM	771, 907	43, 136, 860	0. 0178	0.4	0	50.00
51. 00   05100   RECOVERY   ROOM	256, 601		1			
52. 00   05200   DELIVERY ROOM & LABOR ROOM	229, 762				20, 347	1
53. 00   05300   ANESTHESI OLOGY	9, 382					1
54. 00   05400   RADI OLOGY-DI AGNOSTI C	759, 199		1	· ·		1
54. 01   03630   ULTRA SOUND	759, 199	73,409,700	0.0000		4, 703	1
56. 00   05600 RADI OI SOTOPE	0	0	1		0	56. 00
57. 00   05700 CT SCAN	0	0	1		Ö	1
58. 00   05800 MRI	0		0.0000		Ö	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	142, 737	22, 845, 742			0	59. 00
60. 00   06000   LABORATORY	658, 179				_	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	44, 773				0	1
65. 00 06500 RESPIRATORY THERAPY	244, 354		1		2, 990	65. 00
66. 00 06600 PHYSI CAL THERAPY	288, 787	4, 060, 382	0. 0711	23 251, 948	17, 919	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	115, 582	4, 059, 510	0. 0284 <sup>-</sup>	72 309, 650	8, 816	67. 00
68. 00 06800 SPEECH PATHOLOGY	42, 503	551, 125	0. 0771:	20 35, 242	2, 718	68. 00
69. 00 06900 ELECTROCARDI OLOGY	47, 020	3, 578, 875	0. 0131	88 68, 325	898	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	94, 836	41, 439, 798	0. 0022	39 27, 140	62	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	140, 827				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	231, 648				7, 302	1
74. 00   07400   RENAL DI ALYSI S	78, 858				0	
76. 00   03950   MISC ANCILLARY	0	0			0	
76. 01   03951   SLEEP LAB	0	0	0.0000		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	130, 411					1
76. 03   03952   WOUND CARE	337, 288	5, 024, 050	0. 0671	35 752	50	76. 03
OUTPATIENT SERVICE COST CENTERS				1	_	
90. 00   09000   CLI NI C	83, 260				_	
91. 00 09100 EMERGENCY	658, 416		1			1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)	5, 366, 330	,,,,,,,,		5, 779, 771	0 95, 312	92.00
200.00    Total (Tries 50 tillough 199)	0, 300, 330	1 423, 407, 203	TI .	J, 119, 111	90,312	1200.00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0047 Component CCN: 15-S047	Peri od: From 06/01/2017 To 05/31/2018	Worksheet D Part IV Date/Time Prepared: 10/31/2018 1:09 pm
		Title XVIII	Subprovi der -	PPS

		Title	xVIII	Subprovi der -	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	IPF Allied Health	Allied Health	
cost center bescription	Anesthetist	Post-Stepdown	Indi Si ilg Scriooi	Post-Stepdown	Airreu nearth	
	Cost	Adjustments		Adjustments		
	1, 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	11.00		2.00	0	0.00	
50. 00 OPERATING ROOM	0	0	C	0	0	50. 00
51. 00   05100   RECOVERY ROOM	0	O	l c	o	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	l c	o	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	l c	o	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	o	0	54. 00
54. 01   03630   ULTRA SOUND	0	0	C	o	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	C	0	0	56. 00
57.00 05700 CT SCAN	0	0	C	0	0	57.00
58. 00   05800   MRI	0	0	C	0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0	C	0	0	59. 00
60. 00   06000   LABORATORY	0	0	C	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	0	62. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0	C	0	0	74. 00
76. 00   03950   MISC ANCILLARY	0	0	C	0	0	76. 00
76. 01  03951  SLEEP LAB	0	0	C	0	0	76. 01
76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	0	0	76. 02
76. 03 03952 WOUND CARE	0	0	C	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0	C	0	0	70.00
91. 00   09100   EMERGENCY	0	0	0	0	0	, 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		C		0	,
200.00   Total (lines 50 through 199)	0	0	(	0	0	200. 00

	Financial Systems	ST JOSEPH MED		ON 15 0017		u of Form CMS-1	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS		RVICE UTHER PAS	RVICE OTHER PASS   Provider CCN: 15-0047		Peri od: From 06/01/2017	Worksheet D Part IV	
THROUG	n C0313		·	CCN: 15-S047	To 05/31/2018	Date/Time Pre 10/31/2018 1:	pared: 09 pm
			Titl∈	xVIII	Subprovi der -	PPS	
		ALL 011	T	T	I PF	D 11 CO 1	
	Cost Center Description	All Other Medical	Total Cost (sum of col 1	Total Outpatient	(from Wkst. C,	Ratio of Cost to Charges	
		Education Cost	`	Cost (sum of		(col. 5 ÷ col.	
		Luucati on cost	4)	col. 2, 3 and		7)	
			")	4)	a	,,	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		0 43, 136, 860	0. 000000	50. 00
51.00	05100 RECOVERY ROOM	0	C	)	0 2, 873, 703	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C	)	0 1, 628, 441	0. 000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	C	)	0 5, 964, 129	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C	)	0 73, 469, 768	0.000000	
54. 01	03630 ULTRA SOUND	0	C	)	0	0. 000000	
56.00	05600  RADI 0I SOTOPE	0	C	)	0	0. 000000	
57. 00	05700 CT SCAN	0	C	)	0	0. 000000	
58.00	05800 MRI	0	C	1	0	0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C	1	0 22, 845, 742	0. 000000	
60.00	06000 LABORATORY	0	<u> </u>	1	0 58, 804, 110	0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	<u> </u>	1	0 2, 912, 610	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0		1	0 13, 766, 218	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0		1	0 4, 060, 382	0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	0		1	0 4, 059, 510		
68.00	06800 SPEECH PATHOLOGY	0			0 551, 125	0.000000	
69. 00 71. 00	06900   ELECTROCARDI OLOGY   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			0 3, 578, 875 0 41, 439, 798	0. 000000 0. 000000	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 41, 439, 798 0 10, 649, 725		
73.00	07300 DRUGS CHARGED TO PATIENTS	0			0 72, 878, 844	0. 000000 0. 000000	
74.00	07400 RENAL DIALYSIS	0			0 1, 504, 604	0.000000	
76.00	03950 MISC ANCILLARY	0			0 1, 504, 604	0.000000	
76. 00	03951 SLEEP LAB				0 0	0.000000	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				0 3, 070, 472	0.000000	
	03952 WOUND CARE			1	0 5, 024, 050	0.000000	
, 0. 03	OUTPATIENT SERVICE COST CENTERS		1	1	5, 024, 050	0.000000	1 70.03
90 00	09000 CLINIC	0	C		0 133, 763	0. 000000	90.00
91.00	09100 EMERGENCY				0 43, 909, 782	0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0 7, 144, 754	0. 000000	
,	10.200 000ERVATION DEDS (NON DISTINCT TAKE	1	1	1	0 423, 407, 265		200.00

Heal th Finan	cial Systems	ST JOSEPH MEDIO	CENTED		In Lie	eu of Form CMS-2	2EE2 10
	IT OF INPATIENT/OUTPATIENT ANCILLARY SEI		Provi der C	CN: 15-0047	Peri od:	Worksheet D	2332-10
THROUGH COST		WICE OTHER TAGS		CCN: 15-S047	From 06/01/2017 To 05/31/2018	Part IV	pared: 09 pm
			Title	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0. 000000	0	1	0 0	0	
	RECOVERY ROOM	0. 000000	227, 870	1	0 0	-	
	DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	0 0	0	
	ANESTHESI OLOGY	0. 000000	60, 869		0	0	53. 00
	RADI OLOGY-DI AGNOSTI C	0. 000000	461, 158	1	0 2, 580		
	ULTRA SOUND	0. 000000	0	1	0 0	0	54. 01
	RADI OI SOTOPE	0. 000000	0	1	0 0	0	56. 00
	CT_SCAN	0. 000000	0	1	0 0	0	57. 00
58. 00 05800		0. 000000	0	1	0 0	0	58. 00
	CARDI AC CATHETERI ZATI ON	0. 000000	0	1	0 0	0	59. 00
	LABORATORY	0. 000000	1, 261, 190	1	0 0	0	60.00
	WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	1	0 0	0	62. 00
	RESPI RATORY THERAPY	0. 000000	168, 424		0 0	0	
	PHYSI CAL THERAPY	0. 000000	251, 948	1	0 0	0	
4	OCCUPATIONAL THERAPY	0. 000000	309, 650	1	0 0	0	67. 00
	SPEECH PATHOLOGY	0. 000000	35, 242		0 0	0	
•	ELECTROCARDI OLOGY	0.000000	68, 325		0 0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	27, 140		0 0	0	
	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0. 000000 0. 000000	2, 296, 802		0 0	0	72. 00 73. 00
	RENAL DIALYSIS	0. 000000	2, 290, 802		0	0	
	MISC ANCILLARY	0. 000000	0		0	0	
	SLEEP LAB	0. 000000	0		0 0	0	76. 00
	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0. 000000	221, 279	l .	0 0	0	
	WOUND CARE	0. 000000	752	1	0 0	0	
	TIENT SERVICE COST CENTERS	0.000000	752		0 0	0	70.03
	CLINIC	0. 000000	0		0 0	0	90. 00
	EMERGENCY	0. 000000	389, 122	1	0 0	0	
	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	JU7, 122		0 0	0	
200. 00	Total (lines 50 through 199)	0.000000	5, 779, 771		0 2,580		200. 00
_30.00	1.2.2. (	1 1	0, , , , , ,	1	-, -, -,	,	1=30.00

Health Financial Systems ST JOSEPH MEDICAL CENTER In Li					u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der C		Peri od: From 06/01/2017	Worksheet D Part V	
		Component	CCN: 15-S047	To 05/31/2018	Date/Time Pre 10/31/2018 1:	pared: 09 pm_
		Ti tl e	e XVIII	Subprovi der  - I PF	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	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	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	·	<u> </u>	·	·	<u> </u>	

					IPF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	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	ŕ	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 OPERATI NG ROOM	0. 111032	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0. 400728		0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0, 606101	0	0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 016880	0	0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 086345		0	0	223	
54. 01	03630 ULTRA SOUND	0. 000000			0	0	54. 01
56. 00	05600 RADI OI SOTOPE	0. 000000		0	0	0	56.00
57. 00	05700 CT SCAN	0. 000000		0	_	Ö	57. 00
58. 00	05800 MRI	0. 000000		0	_	Ö	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 131822		0	0	0	59.00
60.00	06000 LABORATORY	0. 131622		0	0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 194646	l e	0	_	0	62.00
65. 00	06500 RESPIRATORY THERAPY	0. 119917		0	_	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 306377		0	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 186800		0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 330645	l .	0	_		68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 136821	0	0	_	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 136821	0	0	_	0	71.00
		1	0	ľ	_	· -	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 487074	0	0	_	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 102693	0	0	0	0	73.00
74.00	07400 RENAL DI ALYSI S	0. 384657	0	0	0	0	74.00
76. 00	03950 MISC ANCILLARY	0. 000000		0	0	0	76.00
76. 01	03951 SLEEP LAB	0. 000000		0	_	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 346878		0	_	0	76. 02
76. 03	03952 WOUND CARE	0. 339215	0	0	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS		_	_	T	_	
90. 00	09000 CLI NI C	1. 821415					
91. 00	09100 EMERGENCY	0. 149578		0		0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 284943		0	_	0	
200.00			2, 580	0	0	223	200. 00
201.00				0	0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		2, 580	0	0	223	202. 00

Health Financial Systems	ST JOSEPH MED	DICAL CENTER		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST Provider CCN: 15-0		CN: 15-0047	Peri od: From 06/01/2017	Worksheet D Part V	
	Component	CCN: 15-S047	To 05/31/2018	Date/Time Pre 10/31/2018 1:	pared: 09 pm	
	Title	XVIII	Subprovi der -	PPS		
				IPF		
	Co	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				

		Cos	sts		
	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		
	NCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0	0	)	50.00
	05100 RECOVERY ROOM	0	0		51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 0	05300 ANESTHESI OLOGY	0	0	)	53.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
54. 01 0	3630 ULTRA SOUND	0	0	)	54. 01
56.00 0	05600 RADI OI SOTOPE	0	0	)	56. 00
57.00 0	05700 CT SCAN	0	0	)	57. 00
58. 00 0	05800 MRI	0	0	)	58. 00
59. 00 0	05900 CARDI AC CATHETERI ZATI ON	0	0	)	59. 00
60.00 0	06000 LABORATORY	0	0	)	60.00
62.00 0	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	)	62. 00
65.00 0	06500 RESPI RATORY THERAPY	0	0	)	65.00
66.00 0	06600 PHYSI CAL THERAPY	0	0	)	66. 00
67.00 0	06700 OCCUPATI ONAL THERAPY	0	0	)	67. 00
68.00 0	06800 SPEECH PATHOLOGY	0	0	)	68. 00
69.00 0	06900 ELECTROCARDI OLOGY	0	0	)	69. 00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
	7400 RENAL DIALYSIS	0	0		74. 00
	03950 MISC ANCILLARY	0	0		76. 00
	03951 SLEEP LAB	0	0		76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		76. 02
	03952 WOUND CARE	0	0		76. 03
	UTPATIENT SERVICE COST CENTERS				1
	09000 CLI NI C	0	0		90.00
	99100 EMERGENCY	0	Ō	)	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	Ō	)	92.00
200.00	Subtotal (see instructions)	0	Ō	)	200. 00
201.00	Less PBP Clinic Lab. Services-Program	0			201. 00
	Only Charges	1			
202. 00	Net Charges (line 200 - line 201)	0	0	)	202. 00
- 1		1		•	•

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 06/01/2017	Worksheet D
Inkough COSTS		Component CCN: 15-5356		
		Title XVIII	Skilled Nursing	

			11116	× AVIII	Facility	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	2001 2011 2000 1 pt 1 011	Anesthetist	Post-Stepdown		Post-Stepdown	7 11 od 11odi til	
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS				'		
50.00	05000 OPERATING ROOM	0	0	)	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
54. 01	03630 ULTRA SOUND	0	0		0	0	54. 01
56.00	05600 RADI 0I SOTOPE	0	0		0	0	56. 00
57.00	05700 CT SCAN	0	0		0	0	57.00
58.00	05800 MRI	0	0		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	)	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	)	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0	74. 00
76.00	03950 MISC ANCILLARY	0	0		0	0	76. 00
76. 01	03951 SLEEP LAB	0	0		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	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	)	0	0	90.00
	09100 EMERGENCY	0	0	)	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			o	0	92. 00
200.00	Total (lines 50 through 199)	0	0	)	0	0	200. 00

	nancial Systems	ST JOSEPH MED				eu of Form CMS-	2552-10
	IMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	6 Provider C	CN: 15-0047	Peri od: From 06/01/2017	Worksheet D Part IV	
THROUGH C	.0515		Component		To 05/31/2018		pared: 09 pm
			Ti tl €	XVIII	Skilled Nursing		<u> </u>
	Cost Center Description	All Other	Total Cost	Total	Facility Total Charges	Ratio of Cost	
	Cost Center Description	Medi cal	(sum of col 1		(from Wkst. C,	to Charges	
		Education Cost	`	Cost (sum of		(col . 5 ÷ col .	
		Eddodti on oost	4)	col . 2, 3 and		7)	
				4)		ĺ	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0	0	l .	0 43, 136, 860		1
	100 RECOVERY ROOM	0	0	1	0 2, 873, 703		
	200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 1, 628, 441	0. 000000	
	300 ANESTHESI OLOGY	0	0	1	0 5, 964, 129		1
	400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 73, 469, 768		
	630 ULTRA SOUND	0			0	0.000000	
	600 RADI OI SOTOPE 700 CT SCAN	0			0 0	0. 000000 0. 000000	
	800 MRI	0	0		0 0	0.00000	1
	900 CARDI AC CATHETERI ZATI ON	0	0		0 22, 845, 742	0.00000	
	000 LABORATORY	0			0 58, 804, 110		
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 2, 912, 610		
	500 RESPIRATORY THERAPY	0	Ö	1	0 13, 766, 218	l .	
	600 PHYSI CAL THERAPY	0	Ö	,	0 4, 060, 382	<b>l</b>	
	700 OCCUPATI ONAL THERAPY	0	O	)	0 4, 059, 510		
68. 00 068	800 SPEECH PATHOLOGY	0	0	)	0 551, 125	0.000000	68. 00
69. 00 069	900 ELECTROCARDI OLOGY	0	0	)	0 3, 578, 875	0. 000000	69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 41, 439, 798	0. 000000	
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0 10, 649, 725		
	300 DRUGS CHARGED TO PATIENTS	0	0		0 72, 878, 844		
	400 RENAL DIALYSIS	0	0	1	0 1, 504, 604		
	950 MISC ANCILLARY	0	0	1	0		
	951 SLEEP LAB	0	0	1	0 0	0.000000	
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	1	0 3, 070, 472		
	952 WOUND CARE TPATLENT SERVICE COST CENTERS	0	0	1	0 5, 024, 050	0. 000000	76. 03
	000 CLINIC	0	0	1	0 133, 763	0. 000000	90.00
	100 EMERGENCY				0 43, 909, 782		
	200 OBSERVATION BEDS (NON-DISTINCT PART			1	0 7, 144, 754		
200.00	Total (lines 50 through 199)	0	-	1	0 423, 407, 265		200. 00

llool +b	Financial Customs	ST JOSEPH MEDI(	CAL CENTED		la lie	of Form CMC	2552 10
<b>APPORT</b>	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICES		Provider Co	CN: 15-0047	Period: From 06/01/2017	worksheet D Part IV	2552-10
THROUG	H COSTS		Component	CCN: 15-5356	To 05/31/2018		pared: 09 pm
			Title	XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	0		0	_	50. 00
51.00	05100  RECOVERY ROOM	0. 000000	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 000000	122, 732		0 0	0	54. 00
54. 01	03630 ULTRA SOUND	0. 000000	0		0 0	0	54. 01
56.00	05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56. 00
57.00	05700  CT SCAN	0. 000000	0		0 0	0	57. 00
58.00	05800  MRI	0. 000000	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60.00	06000 LABORATORY	0. 000000	338, 313		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	33, 467		0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	438, 818		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 243, 802		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 216, 958		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	14, 193		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	5, 776		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	174, 751		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 062, 832		0 0	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
76.00	03950 MISC ANCILLARY	0. 000000	0		0 0	0	76. 00
76. 01	03951  SLEEP LAB	0. 000000	0		0 0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	76. 02
76. 03	03952 WOUND CARE	0. 000000	143, 917		0 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90. 00
91.00	09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00	Total (lines 50 through 199)		7, 795, 559		0	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		Period: From 06/01/2017 To 05/31/2018		pared: 09 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 921, 148	0	1, 921, 14	8 19, 419	98. 93	30. 00
31.00   INTENSIVE CARE UNIT	0			0 0	0.00	31.00
31.01 NEONATAL INTENSIVE CARE UNIT	587, 215		587, 21	5 569	1, 032. 01	
33.00 BURN INTENSIVE CARE UNIT	355, 739		355, 73	9 2, 065	172. 27	33. 00
40. 00 SUBPROVI DER - I PF	349, 413	0	349, 41	3 5, 484	63. 71	40.00
43. 00 NURSERY	6, 575		6, 57	5 586	11. 22	43.00
44.00 SKILLED NURSING FACILITY	465, 057		465, 05	7 5, 091	91. 35	44.00
200.00 Total (lines 30 through 199)	3, 685, 147		3, 685, 14	7 33, 214		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	991	98, 040	)			30. 00
31.00   INTENSIVE CARE UNIT	0	0	1			31. 00
31.01 NEONATAL INTENSIVE CARE UNIT	19		•			31. 01
33.00 BURN INTENSIVE CARE UNIT	141	24, 290				33. 00
40. 00   SUBPROVI DER - I PF	389					40. 00
43. 00 NURSERY	51	572	2			43.00
44.00 SKILLED NURSING FACILITY	0	0	1			44. 00
200.00 Total (lines 30 through 199)	1, 591	167, 293	<b> </b>			200. 00

	Financial Systems	ST JOSEPH MED				eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 06/01/2017 To 05/31/2018	Worksheet D Part II Date/Time Pre 10/31/2018 1:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Capital Related Cost	Total Charges (from Wkst. C,		t Inpatient Program	Capital Costs (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	771, 907					
51.00	05100 RECOVERY ROOM	256, 601		1			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	229, 762					
53.00	05300 ANESTHESI OLOGY	9, 382					53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	759, 199	73, 469, 768	1		7, 723	
54. 01	03630 ULTRA SOUND	0	0	0.00000		0	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	0.00000		0	56.00
57. 00	05700 CT SCAN	0	0	0.00000		0	57.00
58.00	05800 MRI	0	00 045 740	0.00000		0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	142, 737					
60.00	06000 LABORATORY	658, 179					
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	44, 773					62.00
65. 00	06500 RESPIRATORY THERAPY	244, 354					
66.00	06600 PHYSI CAL THERAPY	288, 787					66.00
67.00	06700 OCCUPATI ONAL THERAPY	115, 582					
68.00	06800 SPEECH PATHOLOGY	42, 503					
69.00	06900 ELECTROCARDI OLOGY	47, 020					
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	94, 836		1			
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	140, 827 231, 648					
74.00	07400 RENAL DIALYSIS	78, 858		1			
76.00	03950 MI SC ANCI LLARY	/0,838	1, 304, 604	0.05241		7,447	76.00
	03950 MI SC ANCITLARY			0.00000		0	76.00
	03550 DSVCHLATDLC/DSVCHOLOGLCAL SERVICES	130 /11	3 070 472	1		0	

130, 411

337, 288

83, 260

658, 416

248, 913

5, 615, 243

3, 070, 472

5, 024, 050

43, 909, 782 7, 144, 754 423, 407, 265

133, 763

0.042473

0.067135

0.622444

0. 014995

0.034839

6, 042

100 4, 500 91. 00 1, 257 92. 00

147, 775 200. 00

76. 02 0

76.03

90.00

0

160

90, 004

300, 093

36, 090 8, 473, 385

76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

OUTPATIENT SERVICE COST CENTERS

76. 03 03952 WOUND CARE

90. 00 09000 CLI NI C

200.00

91. 00 09100 EMERGENCY

Health Financial Systems	ST JOSEPH MED	DICAL CENTER		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA				Period: From 06/01/2017 To 05/31/2018	Worksheet D Part III	
			e XIX	Hospi tal	PPS	
Cost Center Description				Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	31. 01
33.00 03300 BURN INTENSIVE CARE UNIT	0	0			0	
40. 00   04000   SUBPROVI DER - I PF	0	0			l o	40.00
43. 00   04300   NURSERY	0				l o	43. 00
44. 00 04400 SKILLED NURSING FACILITY					l	44. 00
200.00 Total (lines 30 through 199)					1	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Dationt	Per Diem (col.	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Days	3 ÷ COI. 0)	Program bays	
	instructions)	minus col. 4)				
	4. 00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
	1 0		10.41	0.00	991	30.00
	0	0	19, 41			
31. 00   03100   INTENSIVE CARE UNIT		0		0.00		
31. 01   02060   NEONATAL INTENSIVE CARE UNIT		0	56			
33.00 03300 BURN INTENSIVE CARE UNIT		0	2, 06			
40. 00   04000   SUBPROVI DER - I PF	0	0	5, 48			
43. 00   04300   NURSERY		0	58			
44.00 04400 SKILLED NURSING FACILITY		0				1
200.00 Total (lines 30 through 199)		0	33, 21	4	1, 591	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					

30.00

31. 00 31. 01

33. 00 40. 00 43. 00 44. 00 200. 00

30. 00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS

Total (lines 30 through 199)

31. 00 | 03100 | INTENSIVE CARE UNIT 31. 01 | 02060 | NEONATAL | INTENSIVE CARE UNIT

33.00 | 03300 | BURN INTENSIVE CARE UNIT 40.00 | 04000 | SUBPROVIDER - IPF 43.00 | 04400 | SKILLED | NURSING FACILITY

200.00

Health Financial Systems	ST	JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE	OTHER PASS	Provider CCN: 15-0047	Peri od: From 06/01/2017 To 05/31/2018	Worksheet D Part IV Date/Time Prepared:

				0 05/31/2018	10/31/2018 1:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	0	(	ή	0	50.00
51. 00   05100   RECOVERY ROOM	0	0	(	0	0	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	(	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54. 00
54. 01   03630   ULTRA SOUND	0	0	(	0	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	(	0	0	56. 00
57. 00   05700   CT   SCAN	0	0	(	-	0	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	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0	(	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0	(	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0	(	0	0	74. 00
76. 00   03950   MISC ANCILLARY	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			1	76. 02
76. 03 03952 WOUND CARE	0	0	(	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0	(	0	0	90. 00
91. 00   09100   EMERGENCY	0	·	(	0	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	l	(		0	
200.00   Total (lines 50 through 199)	0	0	(	0	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 06/01/2017	Part IV

THROUGH COSTS				To 05/31/2018		
		Ti tI	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
			4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS		,				
50.00   05000   OPERATING ROOM	0	0		43, 136, 860		
51.00   05100   RECOVERY ROOM	0	0		2, 873, 703		
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	(	1, 628, 441	0. 000000	
53. 00   05300   ANESTHESI OLOGY	0	0	) (	5, 964, 129		1
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	) (	73, 469, 768	0. 000000	
54. 01  03630 ULTRA SOUND	0	0	) (	0	0. 000000	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	) (	0	0. 000000	
57. 00  05700 CT SCAN	0	0	) (	0	0.000000	57.00
58. 00   05800   MRI	0	0	) (	0	0.000000	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0	) (	22, 845, 742	0.000000	59. 00
60. 00   06000   LABORATORY	0	0	) (	58, 804, 110	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	) (	2, 912, 610	0.000000	62. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	) (	13, 766, 218	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		4, 060, 382	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		4, 059, 510	0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0		551, 125	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	)	3, 578, 875	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	41, 439, 798	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		) (	10, 649, 725	0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		) (	72, 878, 844	0.000000	73. 00
74. 00 07400 RENAL DI ALYSI S	0	l o		1, 504, 604		74.00
76.00 03950 MISC ANCILLARY	0	l o		0	0. 000000	76. 00
76. 01 03951 SLEEP LAB	0	l o		0	0. 000000	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			3, 070, 472	0. 000000	
76. 03 03952 WOUND CARE	0	0		5, 024, 050		1
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	С		133, 763	0.000000	90. 00
91. 00 09100 EMERGENCY	0	1		43, 909, 782		1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		l o		7, 144, 754		1
200.00 Total (lines 50 through 199)	0	O		423, 407, 265		200. 00

	Financial Systems	ST JOSEPH MEDI	_	N 45 0047		eu of Form CMS-2	1002 10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	KALCE OTHER PASS	Provider CO		Peri od: From 06/01/2017	Worksheet D Part IV	
THRUUG	H COSTS				To 05/31/2018		pared:
						10/31/2018 1:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col . 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS				_1	_	4
50.00	05000 OPERATI NG ROOM	0. 000000	1, 025, 856		0	0	00.00
51.00	05100 RECOVERY ROOM	0. 000000	74, 820		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	336, 581		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	188, 728		0	0	00.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	747, 401		0	0	1 0 00
54. 01	03630 ULTRA SOUND	0. 000000	0		0	0	
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	0		0	0	57. 00
58. 00	05800 MRI	0. 000000	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	298, 652		0	0	59. 00
60.00	06000 LABORATORY	0. 000000	1, 212, 952		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	134, 738		0	0	02.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	685, 436		0	0	00.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	48, 245		0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	34, 328	1	0	0	07.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	31, 622		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	38, 546		0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	662, 314		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	174, 474		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 210, 262	'	0	0	73. 00
	07400 RENAL DIALYSIS	0. 000000	142, 083	'	0	0	,
76. 00	03950 MISC ANCILLARY	0. 000000	0		0	0	76. 00
76. 01	03951 SLEEP LAB	0. 000000	0		0	0	1 , 0. 0 .
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	76. 02
76. 03	03952 WOUND CARE	0. 000000	90, 004		0 0	1 0	76. 03

0. 000000

0.000000

0. 000000

300, 093 36, 090 8, 473, 385

160

0 0 0

0 0 0

0

90.00

0 91.00 0 92.00

0 200. 00

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

90. 00 09000 CLINIC

200.00

91. 00 09100 EMERGENCY

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0047 Peri od: Worksheet D From 06/01/2017 Part V 05/31/2018 Date/Time Prepared: 10/31/2018 1:09 pm Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1.00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 111032 1, 269, 371 0 50.00 51.00 05100 RECOVERY ROOM 0.400728 0 197, 649 51.00 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0.606101 0 52 00 68 634 0 05300 ANESTHESI OLOGY 0 53.00 0.016880 0 246, 960 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.086345 1, 434, 785 0 54.00 54. 01 03630 ULTRA SOUND 0.000000 0 0 54.01 O 0 05600 RADI OI SOTOPE 0 0 56.00 0.000000 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MRI 0 58.00 0.000000 0 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 42, 216 59.00 0 131822 0 59 00 0 60.00 06000 LABORATORY 0.109670 0 975, 946 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 194646 5, 376 0 62.00 62.00 06500 RESPIRATORY THERAPY 0.119917 42,041 65.00 65.00 0 0 66.00 06600 PHYSI CAL THERAPY 0 0.306377 7.582 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.186800 0 0 5, 284 0 67.00 06800 SPEECH PATHOLOGY 0. 330645 6, 374 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.136821 0 0 57, 848 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0.048029 0 137, 893 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 487074 83, 006 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.102693 0 73.00 73.00 515, 104 0 07400 RENAL DIALYSIS 0 74.00 0.384657 0 0 74.00 0 03950 MISC ANCILLARY 0.000000 0 0 76.00 0 Ω 76.00 76. 01 03951 SLEEP LAB 0.000000 0 0 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.02 0.346878 0 32, 268 0 76.02 0. 339215 76.03 03952 WOUND CARE 0 0 95, 409 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1.821415 0 90.00 2,600 0 91.00 09100 EMERGENCY 0.149578 0 1, 345, 194 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0. 284943 92.00 0 211, 874 Ω 200.00 Subtotal (see instructions) 0 6, 783, 414 0 200. 00 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

0

6, 783, 414

0

0 202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0047	Peri od: From 06/01/2017	

7 ST. ST. ST. ST. ST. ST. ST. ST. ST.	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		o 10 0017	From 06/01/2017 To 05/31/2018	Part V Date/Time Pr 10/31/2018 1	epared: :09 pm
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0					50. 00
51.00   05100   RECOVERY ROOM	0	, =				51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	1.70,				52. 00
53. 00   05300   ANESTHESI OLOGY	0	4, 169				53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	123, 887				54. 00
54.01   03630   ULTRA SOUND	0	0				54. 01
56. 00   05600   RADI 0I SOTOPE	0	0				56. 00
57.00  05700 CT SCAN	0	0				57. 00
58. 00  05800   MRI	0	0				58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	5, 565				59. 00
60. 00  06000 LABORATORY	0	107, 032				60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1, 046	,			62. 00
65. 00  06500 RESPIRATORY THERAPY	0	5, 041				65. 00
66. 00  06600 PHYSI CAL THERAPY	0	_,,				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67. 00
68.00  06800 SPEECH PATHOLOGY	0	2, 108				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	7, 915				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	-,				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	10, 100				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	52, 898				73. 00
74. 00   07400   RENAL DI ALYSI S	0	0				74. 00
76. 00 03950 MISC ANCILLARY	0	_	1			76. 00
76. 01   03951   SLEEP LAB	0	_				76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	,				76. 02
76. 03 03952 WOUND CARE	0	32, 364				76. 03
OUTPATIENT SERVICE COST CENTERS		1				
90. 00   09000   CLI NI C	0		1			90.00
91. 00 09100 EMERGENCY	0					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	0	,				92.00
200.00 Subtotal (see instructions)	0	931, 643				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)	0	931, 643				202. 00
202.00     Net Charges (Title 200 - Title 201)	1	731,043	1			<sub>1</sub> 202.00

Health Financial Systems	ST JOSEPH MED				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-0047	Peri od:	Worksheet D	
		Component	CCN: 15-S047	From 06/01/2017 To 05/31/2018		norod.
		Component	CCN: 15-3047	10 05/31/2018	Date/Time Pre 10/31/2018 1:	pareu: 09 nm
		Ti †I	e XIX	Subprovi der -	PPS	07 piii
				IPF		
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	
ANCILLARY SERVICE COST CENTERS				.1		
50. 00   05000   OPERATI NG ROOM	771, 907					
51. 00   05100   RECOVERY ROOM	256, 601					
52.00 05200 DELIVERY ROOM & LABOR ROOM	229, 762				0	
53. 00 05300 ANESTHESI OLOGY	9, 382					53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	759, 199					
54. 01   03630   ULTRA SOUND	0	0	0.00000		0	
56. 00   05600   RADI 0I SOTOPE	0	0	0.0000		0	
57. 00   05700   CT   SCAN	0	0	0.0000		0	
58. 00   05800   MRI	0		0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	142, 737				0	
60. 00   06000   LABORATORY	658, 179					
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	44, 773				0	
65. 00   06500   RESPI RATORY THERAPY	244, 354					
66. 00   06600   PHYSI CAL THERAPY	288, 787		l .			
67. 00 06700 OCCUPATI ONAL THERAPY	115, 582					
68. 00 06800 SPEECH PATHOLOGY	42, 503					68. 00
69. 00 06900 ELECTROCARDI OLOGY	47, 020					69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	94, 836				l .	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	140, 827				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	231, 648			· ·		
74. 00   07400   RENAL DI ALYSI S 76. 00   03950   MI SC ANCI LLARY	78, 858	1			_	
76. 00   03950   MISC ANCI LLARY 76. 01   03951   SLEEP LAB	0	0	0. 00000 0. 00000		0	
76. 01   03951   SLEEP LAB 76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	130, 411	3, 070, 472			_	
76. 02   03550   PSYCHIATRIC/PSYCHOLOGICAL SERVICES  76. 03   03952   WOUND CARE	337, 288					
OUTPATIENT SERVICE COST CENTERS	337, 200	5,024,030	0.06713	0	0	76.03
90. 00 09000 CLINIC	83, 260	133, 763	0. 62244	4 0	0	90.00
91. 00   09100   EMERGENCY	658, 416				_	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	036, 410				0	1
200.00 Total (lines 50 through 199)	5, 366, 330	.,,		621, 355		200. 00
200.00    10tal (111103 00 till ough 177)	3, 300, 330	1 425, 407, 205	ı	021, 333	1 7,404	1200.00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0047 Component CCN: 15-S047	Peri od: From 06/01/2017 To 05/31/2018	
		Title XIX	Subprovi der -	PPS

		11 (1	e xix	I PF	113	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
oost conten bescription	Anesthetist	Post-Stepdown	lar sing sensor	Post-Stepdown	/ rred riedr tir	
	Cost	Adjustments		Adjustments		
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATI NG ROOM	0	C	(	0	0	50.00
51.00 05100 RECOVERY ROOM	0	l c	) (	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	) (	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	) (	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	) (	0	0	54.00
54.01 03630 ULTRA SOUND	0	0	) (	0	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	) (	0	0	56. 00
57. 00   05700   CT   SCAN	0	0	) (	0	0	57. 00
58. 00   05800   MRI	0	0	) (	0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0	) (	0	0	59. 00
60. 00   06000   LABORATORY	0	0		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	)	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	) (	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	) (	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0	) (	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0	) (	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	) (	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	) (	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	) (	0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0	)	0	0	74. 00
76. 00   03950   MISC ANCILLARY	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	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(	0	0	, , , , , ,
91. 00   09100   EMERGENCY	0	0	(	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00   Total (lines 50 through 199)	0	0	1	)  0	0	200. 00

Health Fir	nancial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTI ON	MENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVI CE OTHER PAS	S Provider C	CN: 15-0047	Peri od:	Worksheet D	
THROUGH C	OSTS		Component	CCN: 15-S047	From 06/01/2017 To 05/31/2018	Part IV Date/Time Pre 10/31/2018 1:	pared: 09 pm
			Ti tl	e XIX	Subprovi der -	PPS	
		_			IPF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1				
		Education Cost		Cost (sum o		(col. 5 ÷ col.	
			4)	col. 2, 3 ar 4)	nd 8)	7)	
		4.00	5.00	6, 00	7. 00	8. 00	
ANC	CILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
	DOO OPERATING ROOM	0	C		0 43, 136, 860	0.000000	50.00
	100 RECOVERY ROOM	0			0 2, 873, 703	0. 000000	
	200 DELIVERY ROOM & LABOR ROOM	0	ĺ		0 1, 628, 441	0. 000000	
	BOO ANESTHESI OLOGY	0	ĺ		0 5, 964, 129	0. 000000	
54.00 054	400 RADI OLOGY-DI AGNOSTI C	0	l c		0 73, 469, 768	0. 000000	54.00
54. 01   036	630 ULTRA SOUND	0	l c		0 0	0. 000000	54. 01
56. 00 056	600 RADI OI SOTOPE	0	C		0 0	0.000000	56.00
57. 00   057	700 CT SCAN	0	C		0 0	0. 000000	57. 00
58. 00   058	BOO MRI	0	C		0 0	0. 000000	58. 00
	900 CARDIAC CATHETERIZATION	0	C	)	0 22, 845, 742	0. 000000	59. 00
	DOO LABORATORY	0	C	)	0 58, 804, 110	0.000000	
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 2, 912, 610	0. 000000	
	RESPI RATORY THERAPY	0	C	)	0 13, 766, 218	0. 000000	
	600 PHYSI CAL THERAPY	0	C		0 4, 060, 382	0. 000000	
	700 OCCUPATI ONAL THERAPY	0	C	)	0 4, 059, 510	0. 000000	
	BOO SPEECH PATHOLOGY	0	0	)	0 551, 125		
	900 ELECTROCARDI OLOGY	0		2	0 3, 578, 875		
	100 MEDICAL SUPPLIES CHARGED TO PATIENT 200 IMPL. DEV. CHARGED TO PATIENTS	0			0 41, 439, 798	0. 000000 0. 000000	
	300 DRUGS CHARGED TO PATIENTS	0			0 10, 649, 725 0 72, 878, 844		
	400 RENAL DIALYSIS				0 1, 504, 604		
	950 MISC ANCILLARY				0 1, 304, 604	0.000000	1
	951 SLEEP LAB					0. 000000	
	550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	Ö			0 3, 070, 472	0. 000000	
	952 WOUND CARE	0		1	0 5, 024, 050	0. 000000	
	FPATIENT SERVICE COST CENTERS				0/ 02 1/ 000	0.00000	1
	DOO CLINIC	0	C		0 133, 763	0. 000000	90.00
	100 EMERGENCY	o o		1	0 43, 909, 782		
	200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0 7, 144, 754		
200.00	Total (lines 50 through 199)	0	l c	ol .	0 423, 407, 265		200.00

	n Financial Systems FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ST JOSEPH MEDIO	Provi der C	^N: 15_0047	Peri od:	u of Form CMS-: Worksheet D	2332-10
	GH COSTS	KVICE OTHER TASS	Trovider C	CN. 13-0047	From 06/01/2017	Part IV	
11111000	311 00313		,	CCN: 15-S047	To 05/31/2018	Date/Time Pre 10/31/2018 1:	pared: 09 pm
			Ti tl	e XIX	Subprovi der -	PPS	
					IPF		
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col . 6 ÷ col .		Costs (col.	8	Costs (col. 9	
		7)	40.00	x col . 10)	10.00	x col . 12)	
	ANCILLIADY CEDVICE COCT CENTEDO	9. 00	10. 00	11.00	12. 00	13.00	
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0.000000				0	
50.00	1	0. 000000	0		0 0	0	
51.00	05100 RECOVERY ROOM	0. 000000	7, 765		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
53.00	05300 ANESTHESI OLOGY	0. 000000	2, 287		0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	39, 597		0	0	
54. 01	03630 ULTRA SOUND	0. 000000	0		0 0	0	
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	
57. 00	05700 CT SCAN	0. 000000	0		0	0	
58. 00	05800 MRI	0. 000000	0		0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	1	0	0	
60.00	06000 LABORATORY	0. 000000	116, 050		0 0	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	23, 560		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0. 000000	21, 722		0 0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	31, 823		0 0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	2, 215	l .	0 0	0	
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	4, 664		0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	2, 565		0 0	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	1	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	322, 628		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0	0	74.00
76. 00	03950 MISC ANCILLARY	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. 000000	8, 323		0	0	76. 02
76. 03	03952 WOUND CARE	0. 000000	0		0 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00		0. 000000	0		0 0	0	
91. 00	09100 EMERGENCY	0. 000000	38, 156		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	
200.00	Total (lines 50 through 199)		621, 355		0 0	0	200.00

Health Financial Systems	ST	T JOSEPH MEDICAL CE	ENTER		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT	OPERATING COST	Pro	ovider CC1	N: 15-0047	From 06/01/2017	Worksheet D-1 Date/Time Pre 10/31/2018 1:	pared:
			Title	XVIII	Hospi tal	PPS	

DRIT 1.1 PROVIDER COMPANY IS    Impatient days (including private room days, and swing-bed days, excluding newborn)   19,419   1.00   1			Title XVIII	Hospi tal	10/31/2018 1: PPS	09 pm
Inpatient days (including private room days and seing-bed days, excluding newborn)   1,419   1,00		Cost Center Description	THE AVIII	nospi tui		
INPATIENT DAYS   10.00   Impatient days (including private room days and swing-bed days, excluding newborm)   19,419   2.00   Impatient days (including private room days, excluding swing-hed and newborm days)   19,419   2.00		PART I - ALL PROVIDER COMPONENTS			1. 00	
Inpatient days (including private room days), excluding safing-bed and newborn days)   19,419   20   3.00   Private room days (secularing safing-bed and observation bed days). If you have only private room days.   16,803   4.00   16,00   3.00   4.00   16,00   3.00   4.00   16,00   3.00   16,00   3.00   16,00   3.00   16,00   3.00   16,00   3.00   16,00   3.00   16,00   3.00   16,00   3.00		I NPATI ENT DAYS				1
7.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days. 16,900 do not complete this line. 17,000 do not complete this line line. 17,000 do not complete this line line line period (if calledary year, enter 0 on this line). 17,000 do not complete this line line line line line line line line					-	1. 00
do not complete this line.  4. 00 Semi-private room days (excluding swing-bed and observation bed days)  Total swing-bed SM type inputient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed (if calendar year, enter 0 on this line)  7. 00 Total swing-bed (if calendar year, enter 0 on this line)  8. 00 Total swing-bed (if calendar year, enter 0 on this line)  9. 00 Total swing-bed (if calendar year, enter 0 on this line)  9. 00 Total swing-bed (if calendar year, enter 0 on this line)  9. 00 Total swing-bed (if calendar year, enter 0 on this line)  9. 00 Total swing-bed (if calendar year, enter 0 on this line)  9. 00 Total inputient days including private room days) after December 31 of the cost on newton days including private room days) after December 31 of the cost on this line)  10. 00 Swing-bed SM type inputient days applicable to this line)  10. 00 Swing-bed SM type inputient days applicable to this line)  10. 00 Swing-bed SM type inputient days applicable to title XVIII only (including private room days) after 0 incomplete on through December 31 of the cost reporting period (see instruction this line)  10. 00 Swing-bed SM type inputient days applicable to title XVIII only (including private room days) after 0 incomplete on through December 31 of the cost reporting period (see instruction this line)  10. 00 Swing-bed SM type inputient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SM type inputient days applicable to title XVIII only (including private room days)  12. 00 Swing-bed New type inputient days applicable to title XVIII only (including private room days)  13. 00 Swing-bed New type inputient days applicable to title XVIII only (including private room days)  14. 00 Swing-bed New type inputient days applicable to title XVIII only (including private room days)  15. 00 Total swing-bed New type inputient days applicable to title XVIII only (including private room days)  16.					-	
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost open control open cost o	3.00		ys). If you have only pr	ivate room days,	U	3.00
reporting period (1º calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost page 11 reporting period (1º calendar year, enter 0 on this line) 8.00 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost page 11 reporting period (1º calendar year, enter 0 on this line) 9.00 Total inpatient days: including private room days) after December 31 of the cost page 10 reporting period (1º calendar year, enter 0 on this line) 9.00 Total inpatient days: including private room days applicable to the Program (excluding swing-bed and neeborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed FNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed FNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed FNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed FNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed FNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF services applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF services applicable to services through December 31 of the cost reporting p	4.00	· ·	ed days)		16, 903	4. 00
10tal swing-Ded SMF type inpatient days (including private room days) after becember 31 of the cost reporting period (if ceil endar year, enter 0 on this line)   7.00	5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost on the swing-bed of the calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  12. 13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  14. 00 Medically necessary private room days applicable to titles V or XXX only (including private room days)  15. 00 Total nursery days (title V or XXX only)  16. 00 Nursery days (title V or XXX only)  17. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  18. 00 Medical days applicable to the Program (excluding swing-bed days)  19. 00 Medical farte for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days)  19. 00 Medical days applicable to services applicable to services after December 31 of the cost reporting period (including private room days)  19. 00 Medical days of the cost swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  20. 00 Medical days of the swing-bed SNF services applicable to services after December 31 of the cost reporting period (line S XIIII period period SNF services applicable to services after December 31 of the cost reporting peri						
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (see instructions)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if calendar year, enter 0 on this line)   New York of the Cost reporting period (if the Cost reporting period	6.00		om days) after December	31 OF the COST	0	6.00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed SMI type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SMI type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bed SMI type inpatient days applicable to titles Vior IXX only (including private room days) after 0 December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed SMI type inpatient days applicable to titles Vior XIX only (including private room days) on 12. 00 Amount of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to titles Vior XIX only (including private room days) on 13. 00 Amount of the cost reporting period (if calendar year, enter 0 on this line)  16. 00 Including the Vipe inpatient days applicable to titles Vior XIX only (including private room days) on 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) on 14. 00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (including the vipe Vipe Vipe Vipe Vipe Vipe Vipe Vipe V	7. 00		m days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 or the cost reporting period (see instructions) through December 31 or the cost reporting period (see instructions) through December 31 or the cost reporting period (see instructions) through December 31 or the cost reporting period (see instructions) through December 31 or the cost reporting period (see instructions) through December 31 or the cost reporting period (swing-bed NF type inpatient days applicable to title VIII only (including private room days) after 20 on the program (swing-bed NF type inpatient days applicable to title VIII only (including private room days) after 20 on after December 31 of the cost reporting period (including private room days) after 20 on the line of the December 31 of the cost reporting period (including year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (sexcluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title V or XIX only) 11.05.00 Total nursery days (title V or XIX only) 11.05.00 Total nursery days (title V or XIX only) 11.05.00 Total nursery days (title V or XIX only) 11.05.00 Total nurs		reporting period				
1.00   Contain   Inpatient days   Including private room days applicable to the Program (excluding swing-bed and newborn days)   0.00	8.00		m days) after December 3	1 of the cost	0	8. 00
newborn days)  newborn days)  newborn days)  newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Every days (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost Only reporting period (including swing-bed SNF services applicable to services after December 31 of the cost Only Room reporting period (including swing-bed SNF services applicable to services after December 31 of the cost Only Room reporting period (including swing-bed SNF services applicable to services after December 31 of the cost Only Room reporting period (including swing-bed SNF services applicable to services after December 31 of the cost Only Room reporting period (including swing-bed SNF services applicable to services after December 31 of the cost Only Room reporting period (including swing-bed Room Room Room Room Room Room Room Roo	0 00		the Program (eveluding	swing had and	2 0/16	0 00
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December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   12.00						
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 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) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Total nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (land) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (land) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (land) 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (land) 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (land) 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of reporting period (land) 19.00 Total general inpatient routine service cost (see instructions) 10.10 Total general inpatient routine service safter December 31 of the cost reporting period (line of x line 18) 10.10 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 19) 19.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20) 19.00 General inpatient routine service cost net of swing-bed cost (land 21 minus line 26) 10.00 General inpatient routine service cost net of swing-bed cost (land 21 minus line 26) 10.00 General inpatient routine service cost net of swing-bed cost (land 21 minus line 26) 10.00 General i	11.00			oom days) after	0	11.00
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after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   15.00   15.00   16.00   17		, 3	3 (	,		
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   15.00   Nursery days (title V or XIX only)   0   15.00   15.00   Nursery days (title V or XIX only)   0   15.00   15.00   Nursery days (title V or XIX only)   0   15.00   Nursery days (title V or XIX only)   0   15.00   Nursery days (title V or XIX only)   0   15.00   Nursery days (title V or XIX only)   0   15.00   Nursery days (title V or XIX only)   0   15.00   Nursery days (title V or XIX only)   0   15.0	13. 00				0	13. 00
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28. 00 29. 00 29. 00 30			(1: 21 -: 1: 2/)			
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 713, 028)  37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  29.00  29.00  30.00  0 30.00  0.00  30.00  30.00  30.00  31.00  32.00  4.000	27.00		(Trie 21 minus Trie 26)		15, 713, 028	27.00
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15,713,028 and 1)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 31.00 32.0	28. 00		d and observation bed ch	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 713, 028)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Average per diem private room cost differential (line 15, 713, 028)  37.00 Average per diem private room cost differential (line 15, 713, 028)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Average per diem private room cost differential (line 15, 713, 028)  37.00 Average per diem private room cost differential (line 15, 713, 028)  38.00 Average per diem private room cost differential (line 15, 713, 028)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Average per diem private room cost differential (line 15, 713, 028)  37.00 Average per diem private room cost differential (line 15, 713, 028)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Average per diem private room cost differential (line 27 line 38)  38.00 Average per diem private room cost differential (line 27 line 38)  38.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  39.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  39.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  39.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  39.00 Average per diem private room cost differential	29. 00	Private room charges (excluding swing-bed charges)				
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 713, 028)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 32.00 33.00 32.00 33.00 34.00 35.00 Private room cost differential (line 34 x line 31) 35.00 See instructions) 36.00 See instructions) 37.00 See instructions 38.00 See instructions 38.00 Average per diem private room cost differential (line 15, 713, 028) 37.00 See instructions 37.00 See instructions 38.00 See instructions 39.00 Average per diem private room cost differential (line 34 x line 35) 38.00 See instructions 39.00 See instruction		, , , , , , , , , , , , , , , , , , , ,				30.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 713, 028 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 .00 34.00  34.00 35.00  35.00 36.00  36.00 37.00  37.00 27 minus line 36)  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Adjusted general inpatient routine service cost (line 9 x line 38)		,	: Tine 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  35.00  36.00  37.00  38.00  37.00  38.00  37.00						
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 15, 713, 028 27.00 27.00 3			nus line 33)(see instruc	tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00  37.00  37.00  37.00  40.00		Average per diem private room cost differential (line 34 x li				
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  809.16 38.00 Program general inpatient routine service cost (line 9 x line 38)  70.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  80.00 40.00			and private reem east -!	fforontial (1)		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  809.16 38.00  90.16 38.00  10.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)  90.00 Adjusted general inpatient routine service cost (line 9 x line 38)	37.00		and private room cost di	rrerentiai (IINe	15, /13, 028	37.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  809.16 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  809.16 3, 192, 945 3, 192, 945 0 40.00						1
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 3, 192, 945 39.00 40.00						
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	,			
		, , , , , , , , , , , , , , , , , , , ,	*			

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 06/01/2017	Worksheet D-1	
					To 05/31/2018		
			Title	xVIII	Hospi tal	10/31/2018 1: 0 PPS	09 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42. 00
43. 00	INTENSIVE CARE UNIT	0	0	0.0	0 0	0	43. 00
43. 01	NEONATAL INTENSIVE CARE UNIT	2, 612, 261	569	4, 590. 9	7 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	3, 168, 934	2, 065	1, 534. 5	9 405	621, 509	44. 00 45. 00
46. 00		0, 100, 701	2,000	1,001.0	, 100	021,007	46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			`		6, 183, 856	1
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructio	ins)		9, 998, 310	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	460, 147	50. 00
51. 00	<pre>                                    </pre>	atient ancillar	v services (fr	om Wkst D s	um of Parts II	564, 131	51. 00
01.00	and IV)	atront anormal	y services (ii	om mor. b, s	um or rarts rr	001, 101	01.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non nhy	rcician anacth	otist and	1, 024, 278 8, 974, 032	1
55.00	medical education costs (line 49 minus line		rateu, non-pny	Si Ci ali allestii	etist, and	0, 974, 032	33.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION						F4 00
	Program discharges Target amount per discharge					0.00	
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 ta	rget amount (I	ine 56 minus	line 53)	0	
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		•
40.00	market basket						
60. 00 61. 00	If line 53/54 is less than the lower of line				the amount by	0.00	•
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see instructions)  .00 Relief payment (see instructions)						
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST 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>	to often Decemb	or 21 of the o	aat manamtina	norted (Coo	0	65. 00
65.00	instructions)(title XVIII only)	its after Decemb	el 31 of the c	ost reporting	perrou (see		65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 d	of the cost re	porting period	0	67. 00
40.00	(line 12 x line 19)	o costs often D	ocombon 21 of	the cost rope	rting pariod	0	49.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after b	ecember 31 or	the cost repo	iting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72. 00 73. 00
74. 00	1 3 3 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	•					74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	lorksheet 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		rovi der record	ls)			79. 00
	Total Program routine service costs for comp		ost limitation	(line 78 min	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (		s)				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					2, 516	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			809. 16	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				2, 035, 847	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 CC		Peri od:	Worksheet D-1	
				From 06/01/2017 To 05/31/2018	Date/Time Prep 10/31/2018 1:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	1, 921, 148	15, 713, 028	0. 12226	5 2, 035, 847	248, 913	90.00
91.00 Nursing School cost	0	15, 713, 028	0.00000	2, 035, 847	0	91.00
92.00 Allied health cost	0	15, 713, 028	0.00000	2, 035, 847	0	92.00
93.00 All other Medical Education	0	15, 713, 028	0. 000000	2, 035, 847	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 06/01/2017	Worksheet D-1
	Component CCN: 15-S047		
	Title XVIII	Subprovi der -	PPS
		LDE	

		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, 484	1. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		voto room dave	5, 484 0	2. 00 3. 00
3.00	do not complete this line.	75). IT you have only pit	vate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		5, 484	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roof)	om days) through December	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 3	R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	m days) area becomber a	The cost	o .	0. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	n days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber 51	or the cost	O	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	3, 409	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	oly (including private ro	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Join days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	comy (merdaing private	( Toolii days)	O	12.00
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	•	, I	0	14. 00
15. 00	Total nursery days (title V or XIX only)	in (excluding swriig-bed c	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT	a through Docombon 21 of	the east	0.00	17 00
17. 00	Medicare rate for swing-bed SNF services applicable to service 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 t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
17.00	reporting period	through becomber of or	the cost	0.00	17.00
20. 00	Medical drate for swing-bed NF services applicable to services	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, 540, 810	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
22.00	5 x line 17)	21 of the east reporting	nominal (line (	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (Tine 6	U	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
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	21 of the cost reporting	poriod (line 9	0	25. 00
25.00	x line 20)	of the cost reporting	perrou (Trile 8	O	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, 540, 810	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)	line 20)		0. 000000	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	- TTNe 28)		0.00000	
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	nus line 33)(see instruct	i ons)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	,	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	•	1	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	3, 540, 810	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			645. 66	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		2, 201, 055	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 2, 201, 055	40.00
41.00	Trotal Trogram general impatrent routine service cost (IIIIe 39	11116 40)	I	2, 201, 000	41.00

~UMDLIT	Financial Systems ATION OF INPATIENT OPERATING COST	ST JOSEPH MEDIC		N: 15 0047	Peri od:	eu of Form CMS- Worksheet D-1	
JUMPUT	ATION OF INPATIENT OPERATING COST		Provider Component	CCN: 15-0047	Period:   From 06/01/2017   To 05/31/2018	Date/Time Pre	epared:
			'	: XVIII	Subprovi der -	10/31/2018 1: PPS	
	Cost Center Description	Total Inpatient Costli	Total npatient Days	,		Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00	NURSERY (title V & XIX only)	0	2.00				42.0
	Intensive Care Type Inpatient Hospital Units						
3. 00	INTENSIVE CARE UNIT	0	0	•		1	1
3. 01 4. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	١	U	0.	00	,	43. 0
5. 00	BURN INTENSIVE CARE UNIT	O	0	0.	00	0	
	SURGICAL INTENSIVE CARE UNIT						46.0
7.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.0
	·					1. 00	
8. 00	Program inpatient ancillary service cost (Wk					819, 092	
9. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	ee instructio	ns)		3, 020, 147	49.0
0.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, su	m of Parts I and	217, 187	50.0
	111)		•				
1. 00	Pass through costs applicable to Program inp and IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	95, 312	51. 0
2. 00	Total Program excludable cost (sum of lines	50 and 51)				312, 499	52.0
3. 00	Total Program inpatient operating cost exclu	ding capital rela	ated, non-phy	sician anest	netist, and	2, 707, 648	
	medical education costs (line 49 minus line	52)					-
4. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					T 0	54. (
5. 00	Target amount per discharge					0.00	
6. 00	Target amount (line 54 x line 55)			. =	50)	0	
7. 00 8. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (I	ine 56 minus	line 53)	0 0	1
9. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndi ng 1996, u	pdated and c	ompounded by the		
	market basket						
0. 00 1. 00						0.00	1
	amount (line 56), otherwise enter zero (see		(65 6.7 %	00), 0 0	. the target		
52.00	Relief payment (see instructions)					0	
53. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.0
4. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	ng period (See	0	64. (
F 00	instructions)(title XVIII only)		04 6 11				. , , ,
5. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 or the c	ost reportin	g period (See	0	65.0
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For	0	66.0
7 00	CAH (see instructions)		D 21 -	£ +L+			
7. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 c	T the cost r	eporting period	0	67. (
8. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period	0	68. 0
	(line 13 x line 20)			(0)			
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 0
0.00	Skilled nursing facility/other nursing facil				)		70.0
1.00	Adjusted general inpatient routine service c		ne 70 ÷ line	2)			71. (
2. 00 3. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	(line 14 v li	ne 35)		-	72.0
4. 00	Total Program general inpatient routine serv		•				74. (
5. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, I	Part II, column		75. 0
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76. (
7. 00	Program capital -related costs (line 9 x line						77. 0
8. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 0
9.00	Aggregate charges to beneficiaries for exces			*.	aus lina 70)		79. (
0. 00 1. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		sı ıımı tatıon	(IIIIe /8 MII	ius IIIle /9)		80. (
32. 00	Inpatient routine service cost limitation (						82.0
33.00	Reasonable inpatient routine service costs (		)				83.0
34. 00 35. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84.0
	Total Program inpatient operating costs (sum						86.0
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	·				
37. 00	Total observation bed days (see instructions					0	87.0
38. 00	Adjusted general inpatient routine cost per						

Health Financial Systems	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (		From 06/01/2017 To 05/31/2018	Date/Time Pre 10/31/2018 1:	
		Title	XVIII	Subprovi der -	PPS	
	1			I PF		
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	
					(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	349, 413	3, 540, 810	0. 09868	2 0	0	90. 00
91.00 Nursing School cost	0	3, 540, 810	0. 00000	0	0	91.00
92.00 Allied health cost	0	3, 540, 810	0. 00000	0	0	92.00
93.00 All other Medical Education	0	3, 540, 810	0. 00000	0 0	0	93. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0047	Period: From 06/01/2017	Worksheet D-1
	Component CCN: 15-5356		
	Title XVIII	Skilled Nursing	PPS
		Facility	

		litle XVIII	Facility	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			5, 091	1. 00
2.00	Inpatient days (including private room days, excluding swing-	<b>3</b> /		5, 091	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		5, 091	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0,071	5. 00
	reporting period	3 , 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 room	m days) through Dosambar	21 of the cost	0	7. 00
7.00	reporting period	ii days) tiii odgii becellibei	31 Of the Cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	2, 215	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
10.00	through December 31 of the cost reporting period (see instructions)		oom days)	G	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, el		, ,		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 XIX	X onlv (includina privat	e room davs)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period	<del>-</del>		2.22	
18. 00	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	a through December 21 of	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 or	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		: (1:	2, 919, 126	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 or 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
	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 :	31 of the cost reporting	period (line 8	0	25. 00
23.00	x line 20)	or the cost reporting	perrou (Trile o	O	23.00
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, 919, 126	27. 00
29 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and observation had ab	argas)	0	28. 00
29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	ai yes)	0	
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)	11 20) (		0.00	33. 00
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li	, ,	tions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	115 31 <i>)</i>		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 919, 126	
	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 diem (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

Heal th	Financial Systems	ST JOSEPH MEDIC			In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Component (	CN: 15-0047 CCN: 15-5356	Period: From 06/01/2017 To 05/31/2018		pared:
			Title	· XVIII	Skilled Nursing Facility	10/31/2018 1: PPS	09 pm
	Cost Center Description	Total Inpatient CostIn	Total patient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (+i +l o V & VIV only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						J 42.00
43.00	INTENSIVE CARE UNIT						43.00
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 01 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	Line 200)			1. 00	48. 00
	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS			ins)			49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine se	ervices (from	Wkst. D, su	m of Parts I and		50. 00
51. 00	Pass through costs applicable to Program inpa and IV)	,	services (fr	rom Wkst. D,	sum of Parts II		51. 00
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclude medical education costs (line 49 minus line!	ding capital rela	ited, non-phy	sician anest	hetist, and		52. 00 53. 00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54. 00
	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)				50)		56.00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and targ	jet amount (I	ine 56 minus	line 53)		57.00
59. 00	Lesser of lines 53/54 or 55 from the cost reparket basket	porting period er	ndi ng 1996, u	pdated and c	ompounded by the		59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see its content of the second	s 55, 59 or 60 er n expected costs	iter the less	er of 50% of	the amount by		60. 00 61. 00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymo	•	i ons)				62. 00 63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Decemb	er 31 of the	cost report	ing period (See		64. 00
65. 00	Medicare swing-bed SNF inpatient routine costinstructions)(title XVIII only)	ts after December	31 of the c	ost reportin	g period (See		65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line 64	plus line 6	5)(title XVI	II only). For		66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through D	ecember 31 o	of the cost r	eporting period		67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)			·	orting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient   PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLY		0.040.45	69.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co				)	2, 919, 126 573. 39	
72. 00	Program routine service cost (line 9 x line	,		_,		1, 270, 059	72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine servi	•				0 1, 270, 059	1 , 0. 00
75. 00	Capital related cost allocated to inpatient     Capital - related cost allocated to inpatient     26, line 45)	•	,		Part II, column	1, 270, 039	1
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 minus					0	
78. 00 79. 00	Aggregate charges to beneficiaries for excess		vi der record	ls)		0	1
80.00	Total Program routine service costs for compa	arison to the cos		· .	nus line 79)	0	80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li					0.00	81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (	* .				1, 270, 059	1
84.00	Program inpatient ancillary services (see ins		`			1, 195, 155	1
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum					0 2, 465, 214	
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	. g 00/				
07 00	Total observation bed days (see instructions)	)				0	87. 00
87. 00 88. 00	Adjusted general inpatient routine cost per of	diam (line 27 · !	ine 2)		I	0.00	88.00

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 06/01/2017 To 05/31/2018	Date/Time Prep 10/31/2018 1:0	
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on		
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	0	0	0.00000	0	0	90.00
91.00 Nursing School cost	0	0	0.00000	0	0	91.00
92.00 Allied health cost	0	0	0.00000	0	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	0	93. 00

Health Financial Systems	ST JOSEPH MEDICAL	CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0047	Peri od: From 06/01/2017	Worksheet D-1	
			To 05/31/2018	Date/Time Pre 10/31/2018 1:	
		Title XIX	Hospi tal	PPS	
Cost Center Description		·			

		Title XIX	Hospi tal	PPS	09 piii
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			19, 419	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			19, 419	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). 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)		16, 903	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
4 00	reporting period	om daya) after Dacambar (	01 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) arter becember .	si di the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after December 3	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	991	9. 00
	newborn days)	0 . 0			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		nom davs) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, er	nter O on this line)		· ·	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	Conly (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 XI)	( only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)	O	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			586	•
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			51	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	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	the cost	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
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)		15, 713, 028	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	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) 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, 713, 028	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	1
30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 =	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 22) ( :+	h!>	0.00	1
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x lir	, ,	(Tons)	0. 00 0. 00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	10 31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	ferential (line	15, 713, 028	1
	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			809. 16	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		801, 878	39. 00
40.00	Medically necessary private room cost applicable to the Progra	,		0	
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 40)		801, 878	41.00

	Financial Systems	ST JOSEPH MEDI				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0047	Period: From 06/01/2017 To 05/31/2018	Worksheet D-1 Date/Time Prep	pared:
						10/31/2018 1:	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	PPS Program Cost	
	Cost Center Description	Inpatient Cost I				(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	444, 279	586	758.	16 51	38, 666	42. 00
	Intensive Care Type Inpatient Hospital Units			_		_	
43.00	INTENSIVE CARE UNIT	0	0			07 220	
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT	2, 612, 261	569	4, 590.	9/ 19	87, 228	44.00
45. 00	BURN INTENSIVE CARE UNIT	3, 168, 934	2, 065	1, 534.	59 141	216, 377	45. 00
46.00	SURGICAL INTENSIVE CARE UNIT		·				46. 00
47. 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 1, 217, 760	48. 00
	Total Program inpatient costs (sum of lines			ns)		2, 361, 909	
	PASS THROUGH COST ADJUSTMENTS	3 , 1		,			
50.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, su	m of Parts I and	142, 510	50.00
51. 00	Dass through costs applicable to Drogram in	ationt ancillary	convices (fr	om Wkst D	cum of Dorte II	147, 775	51.00
J 1. UU	Pass through costs applicable to Program inpland IV)	actenic and I I al y	Services (II	OII WKSt. D,	Jum Di Failò II	147,775	31.00
52.00	Total Program excludable cost (sum of lines					290, 285	52.00
53.00	Total Program inpatient operating cost exclu	9 1	ated, non-phy	sician anest	hetist, and	2, 071, 624	53. 00
	medical education costs (line 49 minus line	52)					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting ported o	nding 1004 u	ndatad and a	omnounded by the	0 0. 00	58. 00 59. 00
39.00	market basket	porting period e	nurng 1996, u	puateu anu c	onipounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61.00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less tha		(lines 54 x	60), or 1% o	f the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				o	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			Ö	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	ing 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 c	nst renortin	a neriod (See	0	65. 00
00.00	instructions)(title XVIII only)	to arter becombe	. 01 01 1110 0	ost reportin	g period (occ		00.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	ll only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	to through	Dogombon 21 o	f the cost w	ananting namind	0	(7.00
67.00	(line 12 x line 19)	e costs till ough	becember 31 0	i the cost i	eporting perrou	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period	0	68. 00
	(line 13 x line 20)					_	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil				)		70. 00
71. 00	Adjusted general inpatient routine service c	•			•		71.00
72. 00	Program routine service cost (line 9 x line						72. 00
	Medically necessary private room cost applic						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
73.00	26, line 45)	routine service	costs (110m w	orksheet b,	rart II, coranni		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						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi der rocard	e)			78. 00 79. 00
80.00	Total Program routine service costs for comp			*.	nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limi				,		81.00
82.00	Inpatient routine service cost limitation (		`				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		s)				84. 00 85. 00
	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<u> </u>				
87.00	Total observation bed days (see instructions	•				2, 516	1
88. 00	Adjusted general inpatient routine cost per	•	iine 2)			809. 16	ı
80 AA	Observation bed cost (line 87 x line 88) (se					2, 035, 847	

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 06/01/2017 To 05/31/2018	Date/Time Pre 10/31/2018 1:0	
		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, 921, 148	15, 713, 028	0. 12226	5 2, 035, 847	248, 913	90.00
91.00 Nursing School cost	0	15, 713, 028	0.00000	2, 035, 847	0	91.00
92.00 Allied health cost	0	15, 713, 028	0.00000	2, 035, 847	0	92.00
93.00 All other Medical Education	0	15, 713, 028	0.00000	2, 035, 847	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 06/01/2017	Worksheet D-1
	Component CCN: 15-S047		
	Title XIX	Subprovi der -	PPS

		II the XIX	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			5, 484	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			5, 484	
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, 484	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
, 00	reporting period		4 6 11		, 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December 3	or the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	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	the Program (excluding	swing-bed and	389	9. 00
7. 00	newborn days)	the regram (exeruaring	Swilling bed dilid	007	7.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		om days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	on days) arter	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI>		room days)	0	12. 00
40.00	through December 31 of the cost reporting period			ا	40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)  after December 31 of the cost reporting period (if calendar ve			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra	· · · · · · · · · · · · · · · · · · ·	,	0	14. 00
15. 00	Total nursery days (title V or XIX only)	, 5	,	586	15. 00
16. 00	Nursery days (title V or XIX only)			51	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 t	he cost	0. 00	18. 00
40.00	reporting period			2.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	tne cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	e cost	0.00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions		ng poriod (line	3, 540, 810	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost reporti	ng perrod (Trie	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)			ا	
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reportin	g period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	. 3	· `		
26. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0	
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Time 21 minus Time 26)		3, 540, 810	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	rges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 = Average private room per diem charge (line 29 ÷ line 3)	- line 28)		0. 000000 0. 00	1
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 mir	nus line 33)(see instruct	i ons)	0. 00	
35.00	Average per diem private room cost differential (line 34 x lir	ne 31)		0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dif	terential (line	3, 540, 810	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			645. 66	
39.00	Program general inpatient routine service cost (line 9 x line	•		251, 162	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 251, 162	
55	1.2.2		ı	201, 102	

	Financial Systems ATION OF INPATIENT OPERATING COST	ST JOSEPH MEDIC	Provider CC	N: 15-0047	Period:	u of Form CMS Worksheet D-1	
OWII O I	ATTON OF THE ATTENT OF ENATING COST		Component C		From 06/01/2017 To 05/31/2018		
			·	e XIX	Subprovi der -	10/31/2018 1:	
			11116	e XIX	I PF	PPS	
	Cost Center Description	Total Inpatient Costlr	Total patient Days[	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00			42.0
	Intensive Care Type Inpatient Hospital Units		-1				
3.00	INTENSIVE CARE UNIT	0	0	0.		0	
3. 01 4. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.	00 0	0	43. (
5. 00	BURN INTENSIVE CARE UNIT	0	o	0.	00 0	0	
6. 00	SURGICAL INTENSIVE CARE UNIT						46. (
7. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. (
	·					1. 00	
8. 00	Program inpatient ancillary service cost (Wk			`		77, 941	
9. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(Se	e instruction	ns)		329, 103	49.0
0. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from	Wkst. D, su	m of Parts I and	24, 783	50.0
1 00				WI 1 D	6.5	7 4/4	
1. 00	Pass through costs applicable to Program inp and IV)	atient ancillary	services (Tro	OM WKST. D, S	sum of Parts II	7, 464	51.0
2. 00	Total Program excludable cost (sum of lines	50 and 51)				32, 247	52. (
3. 00	Total Program inpatient operating cost exclu		ited, non-phys	sician anestl	hetist, and	296, 856	53. (
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
4. 00	Program di scharges					0	54.
	Target amount per discharge					0.00	1
6. 00 7. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and targ	net amount (Li	ne 56 minus	line 53)	0	
8. 00	Bonus payment (see instructions)	ring cost and targ	jet amourt (11	ne oo minas	11116 00)	0	
9. 00	Lesser of lines 53/54 or 55 from the cost re	porting period er	ndi ng 1996, up	odated and co	ompounded by the	0.00	59. (
0. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report unda	ated by the ma	arket hasket		0. 00	60.0
1. 00	If line 53/54 is less than the lower of line				the amount by	0.00	1
	which operating costs (line 53) are less that		(lines 54 x 6	50), or 1% o	f the target		
2. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	rnstructions)				0	62.0
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)			0	
4 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cos	+- +bb Db	21 -6 +1-			^	
4. 00	instructions)(title XVIII only)	its through beceilik	ber 31 of the	cost report	ing period (see	0	64.0
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the co	ost reportin	g period (See	0	65. 0
6. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	na costs (lina 6/	Inlus lina AF	5)(+i+le YVI	II only) For	0	66. 0
0.00	CAH (see instructions)	The Costs (Title o-	prus rine oc	)(title XVI	ii oniy). Toi	0	00.0
7. 00	Title V or XIX swing-bed NF inpatient routin	e costs through [	December 31 of	the cost r	eporting period	0	67.0
8. 00	(line 12 x line 19)  Title V or XIX swing-bed NF inpatient routin	e costs after Dec	rember 31 of t	the cost ren	orting period	0	68. 0
0. 00	(line 13 x line 20)	ic costs arter bec		ine cost rep	or tring period		00.0
9. 00	Total title V or XIX swing-bed NF inpatient					0	69. 0
0. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				)		70.0
1. 00	Adjusted general inpatient routine service of				,		71.0
2. 00	Program routine service cost (line 9 x line			25)			72.0
3. 00 4. 00	Medically necessary private room cost applic Total Program general inpatient routine serv			ne 35)			73.0
5. 00	Capital -related cost allocated to inpatient			orksheet B, I	Part II, column		75.0
	26, line 45)	2)					7, ,
6. 00 7. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 0 77. 0
8. 00	Inpatient routine service cost (line 74 minu						78. 0
9. 00	Aggregate charges to beneficiaries for exces			*	aug list 70)		79. (
0. 00 1. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitation	(iine 78 mii	nus iine 79)		80.0
2. 00	Inpatient routine service cost limitation (I						82. (
3. 00	Reasonable inpatient routine service costs (						83. 0
4. 00 5. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		;)				84. 0 85. 0
6. 00	Total Program inpatient operating costs (sum						86.0
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
7. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ino 2)			0	87. 0 88. 0
8. 00							

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (		From 06/01/2017 To 05/31/2018	Date/Time Prep 10/31/2018 1:0	
		Ti tl	e XIX	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	349, 413	3, 540, 810	0. 09868	2 0	0	90.00
91.00 Nursing School cost	0	3, 540, 810	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 540, 810			0	92.00
93.00   All other Medical Education	0	3, 540, 810	0. 00000	0 0	0	93. 00

Health Financial Systems ST.	JOSEPH MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN:		Period: From 06/01/2017 To 05/31/2018	Worksheet D-3 Date/Time Pre	pared:
	Ti tle XV	/1.1.1	Hospi tal	10/31/2018 1: 0 PPS	J9 pm
Cost Center Description		itio of Cost		Inpatient	
Sost senter beschiperen		To Charges	Program	Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			10, 478, 386		30. 00
31. 00 03100 INTENSIVE CARE UNIT			0		31. 00
31. 01   02060   NEONATAL   INTENSIVE CARE UNIT			0		31. 01
33. 00 O3300 BURN INTENSIVE CARE UNIT			2, 473, 034		33. 00
40. 00   04000   SUBPROVI DER -   PF			0		40.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43. 00
50. 00 05000 OPERATING ROOM		0. 11103.	2 5, 488, 283	609, 375	50. 00
51. 00   05100  RECOVERY ROOM		0. 40072		154, 057	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 60610			52. 00
53. 00   05300   ANESTHESI OLOGY		0. 01688		11, 650	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08634		515, 767	54. 00
54. 01   03630   ULTRA SOUND		0. 00000		0.07.07	54. 01
56. 00   05600   RADI 0I SOTOPE		0. 00000		0	56. 00
57. 00   05700 CT SCAN		0. 00000		0	57. 00
58. 00   05800 MRI		0.00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 13182	2 3, 069, 328	404, 605	59. 00
60. 00   06000   LABORATORY		0. 10967	0 5, 608, 051	615, 035	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 19464	6 836, 086	162, 741	62. 00
65. 00 06500 RESPIRATORY THERAPY		0. 11991	7 2, 726, 682	326, 976	65.00
66. 00   06600 PHYSI CAL THERAPY		0. 30637	7 286, 480	87, 771	66. 00
67. 00 06700 OCCUPATIONAL THERAPY		0. 18680	0 250, 532	46, 799	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 33064	54, 835	18, 131	68. 00
69. 00   06900   ELECTROCARDI OLOGY		0. 13682	1 291, 262	39, 851	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.04802	9 6, 495, 021	311, 949	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 48707		759, 535	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 10269		1, 259, 352	73.00
74.00   07400   RENAL DIALYSIS		0. 38465	· ·		74. 00
76. 00   03950   MISC ANCILLARY		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. 34687		5, 031	76. 02
76. 03 03952 WOUND CARE		0. 33921	5 375, 534	127, 387	76. 03

1. 821415

0. 149578

0. 284943

1, 625, 114

49, 344, 190

49, 344, 190

385, 507

0

6, 183, 856 200. 00

243, 081

109, 848

90. 00 91. 00

92.00

201. 00

202. 00

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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

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

90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY

200.00

201.00

202.00

Health Financial Systems ST JOSE INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	EPH MEDICAL CENTER Provider CCN:	15-0047	Peri od:	wof Form CMS-2 Worksheet D-3	
	Component CCM		From 06/01/2017 To 05/31/2018		
	·			10/31/2018 1:	
	Title X	VIII	Subprovi der – I PF	PPS	
Cost Center Description		atio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
	_	4 00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1. 00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.0
31. 00   03100   NTENSI VE CARE UNI T			0	l	31.0
31. 01   02060   NEONATAL INTENSIVE CARE UNIT			0		31.0
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33.0
40. 00   04000 SUBPROVI DER - I PF			11, 572, 432		40.0
43. 00   04300   NURSERY			,		43.0
ANCILLARY SERVICE COST CENTERS	-				
50.00 O5000 OPERATING ROOM		0. 11103	32 0	0	50. (
51.00   05100   RECOVERY ROOM		0.40072	28 227, 870	91, 314	51. (
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 60610	0	0	52. (
53. 00   05300   ANESTHESI OLOGY		0. 01688	60, 869	1, 027	53.0
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 08634	•	39, 819	54. (
54. 01   03630   ULTRA SOUND		0.00000		0	54. (
56. 00   05600   RADI 0I SOTOPE		0. 00000		0	56. (
57. 00   05700   CT   SCAN		0.00000		0	57. (
58. 00   05800   MRI		0.00000		0	58. (
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 13182		0	59. (
50. 00   06000   LABORATORY		0. 10967			
52. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL		0. 19464		0	62.
55. 00 06500 RESPIRATORY THERAPY		0. 11991		1	1
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   0CCUPATI ONAL THERAPY		0. 30637	•		66.0
57. 00   06700  OCCUPATI ONAL THERAPY 58. 00   06800  SPEECH PATHOLOGY		0. 18680 0. 33064		57, 843 11, 653	1
59. 00   06900   ELECTROCARDI OLOGY		0. 33064		1	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 13062		1	
72.00 07100 MEDICAL SUPPLIES CHARGED TO PATTENT		0. 48707		1, 304	72.
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 46707		235, 865	
74.00   07400   RENAL DIALYSIS		0. 38465		235, 805	74.
76. 00 03950 MISC ANCILLARY		0. 00000		0	76.
76. 01   03951   SLEEP LAB		0. 00000		0	76.
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 34687			
76. 03   03952   WOUND CARE		0. 33921			
OUTPATIENT SERVICE COST CENTERS		3. 33721	702	200	1
90. 00 09000 CLINIC		1. 82141	5 0	0	90. (
91. 00   09100   EMERGENCY		0. 14957	78 389, 122	58, 204	91.
92 OO 09200 OBSERVATION BEDS (NON-DISTINCT PART		0 28494	13 0	l o	92 (

92.00 | 09200 | SERVATION BEDS (NON-DISTINCT PART 200.00 | Total (sum of lines 50 through 94 and 96 through 98) | Less PBP Clinic Laboratory Services-Program only charges (line 61) | Net charges (line 200 minus line 201)

0. 284943

0 92.00 819,092 200.00 201.00 202.00

		OT 100F011 NED 1011 OF 17F0			6.5	
	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	ST JOSEPH MEDICAL CENTER	ON 15 0047		eu of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0047	Peri od: From 06/01/2017	Worksheet D-3	
		Component	CCN: 15-5356	To 05/31/2018		pared: 09 pm
		Ti tl e	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	-	Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	I NPATIENT ROUTINE SERVICE COST CENTERS				ı	
30. 00				0	•	30. 00
31. 00	03100 INTENSIVE CARE UNIT			0		31.00
31. 01				0		31. 01
33. 00	03300 BURN INTENSIVE CARE UNIT			0		33. 00
40. 00	04000 SUBPROVI DER - I PF			0		40. 00
43. 00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS			_	_	
50.00	05000 OPERATING ROOM		0. 11103		1	
51. 00	05100 RECOVERY ROOM		0. 40072		1	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 60610		0	
53.00	05300 ANESTHESI OLOGY		0. 01688		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 08634			1
54. 01	03630 ULTRA SOUND		0.00000		1	
56.00	05600 RADI OI SOTOPE		0.00000		1	
57. 00	05700 CT SCAN		0.00000		0	07.00
58. 00	05800 MRI		0.00000		0	
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 13182		0	
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 10967			1
65. 00	06500 RESPIRATORY THERAPY		0. 19464 0. 11991		6, 514 52, 622	
66. 00	06600 PHYSI CAL THERAPY		0. 11991			
67. 00	06700 OCCUPATI ONAL THERAPY		0. 18680			
68. 00	06800 SPEECH PATHOLOGY		0. 33064			1
69. 00			0. 13682			1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 04802		8, 393	1
71.00			0. 48707		0, 343	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 10269		417, 224	1
74.00			0. 38465		0	1
76. 00			0.00000		0	1
76. 01	03951 SLEEP LAB		0.00000		0	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 34687		1 0	76. 02
76. 03	03952 WOUND CARE		0. 33921		48, 819	
. 0. 00	OUTDATI ENT. CEDVI CE COCT. CENTEDO		J. 33721		.5,617	1 . 5. 55

7, 795, 559

7, 795, 559

0

90.00

201. 00

202. 00

0 91.00

0 92.00

1, 195, 155 200. 00

1. 821415 0. 149578

0. 284943

OUTPATIENT SERVICE COST CENTERS
09000 CLINIC

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)

90.00

200.00

202.00

91. 00 09100 EMERGENCY

Heal th	Financial Systems	ST JOSEPH MEDICAL CENTER		In lie	eu of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Period: From 06/01/2017 To 05/31/2018	Worksheet D-3	
					10/31/2018 1:	09 pm
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3.00	
20 00	03000 ADULTS & PEDIATRICS			1, 941, 446		30.00
	03100   NTENSI VE CARE UNIT			1, 741, 440		31.00
	02060 NEONATAL INTENSIVE CARE UNIT			70, 421		31. 00
	03300 BURN INTENSIVE CARE UNIT			971, 173		33.00
	04000 SUBPROVI DER - I PF			771,170		40.00
	04300 NURSERY			60, 457		43. 00
	ANCILLARY SERVICE COST CENTERS				l	1
50.00	05000 OPERATING ROOM		0. 11103	1, 025, 856	113, 903	50.00
51.00	05100 RECOVERY ROOM		0. 40072	74, 820	29, 982	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 60610	336, 581	204, 002	52. 00
53.00	05300 ANESTHESI OLOGY		0. 01688	188, 728	3, 186	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 08634	747, 401	64, 534	54.00
	03630 ULTRA SOUND		0.00000		0	54. 01
	05600 RADI 0I SOTOPE		0.00000		0	56. 00
	05700 CT SCAN		0.00000		0	57. 00
	05800  MRI		0.00000		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 13182	298, 652	39, 369	59. 00

0.109670

0.194646

0. 119917

0.306377

0.186800

0.330645

0.136821

0.048029

0.487074

0.102693

0.384657

0.000000

0.000000

0. 346878

0. 339215

1. 821415

0. 149578

0. 284943

1, 212, 952

134, 738

685, 436

48, 245

34, 328

31, 622

38, 546

662, 314

174, 474

142, 083

90,004

300, 093

8, 473, 385

8, 473, 385

36, 090

160

0

2, 210, 262

133, 024

26, 226

82, 195

14, 781

6, 412

10, 456

5, 274

31, 810

84, 982

54, 653

30, 531

44, 887

10, 284

291

1, 217, 760 200. 00

0

0 76.01

226, 978

60.00

62.00

65 00

66.00

67.00

68 00

69.00

71.00

72.00

73.00

74.00

76.00

0 76.02

76.03

90.00

91.00

92.00

201.00

202. 00

60.00

62.00

65.00

66.00

67.00

68 00

69.00

72.00

73.00

74.00

76.00

76.01

76.02

76.03

90.00

91.00

200.00

201. 00 202. 00

06000 LABORATORY

06500 RESPIRATORY THERAPY

06700 OCCUPATIONAL THERAPY

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

09100 EMERGENCY

06200 WHOLE BLOOD & PACKED RED BLOOD CELL

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

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)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Period: From 06/01/2017 To 05/31/2018	Worksheet D-3 Date/Time Pre 10/31/2018 1:	pare
	Ti tl	e XIX	Subprovi der - I PF	PPS	·
Cost Center Description		Ratio of Cos To Charges	_	Inpatient Program Costs (col. 1 x col. 2)	
LANDATI ENT. DOUTLING CERVICE COCT CENTERS		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS  30. 00 03000 ADULTS & PEDIATRICS			0	I	30.
31. 00   03100   NTENSIVE CARE UNIT					31.
31. 01   02060   NEONATAL   NTENSIVE CARE UNIT					31.
33. 00   03300   BURN   INTENSIVE CARE UNIT			0		33.
40. 00   04000   SUBPROVI DER -   1 PF			1, 327, 267		40.
43. 00   04300   NURSERY			0		43.
ANCILLARY SERVICE COST CENTERS		•	<u> </u>	•	
0.00   05000   OPERATING ROOM		0. 11103	2 0	0	50.
1.00   05100   RECOVERY ROOM		0. 40072	7, 765	3, 112	51.
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 60610			
53. 00   05300   ANESTHESI OLOGY		0. 01688		39	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 08634		3, 419	
54. 01   03630   ULTRA SOUND		0.00000		0	
66. 00   05600   RADI 01 SOTOPE		0.00000		0	56
77. 00   05700   CT SCAN		0.00000		1	57
68. 00   05800   MRI		0.00000		1	58
69. 00   05900   CARDI AC CATHETERI ZATI ON		0. 13182		1	59 60
0.00   06000   LABORATORY 2.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL		0. 10967 0. 19464			62
15. 00 06500 RESPIRATORY THERAPY		0. 19464		0 2, 825	
66. 00   06600   PHYSI CAL THERAPY		0. 30637		6, 655	1
17. 00 06700 OCCUPATI ONAL THERAPY		0. 18680			
88. 00 06800 SPEECH PATHOLOGY		0. 33064			
9. 00   06900   SEECT FAMILEOUT		0. 13682			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 04802			
22.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 48707		0	72
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 10269		-	
4. 00   07400   RENAL DI ALYSI S		0. 38465		0	
6. 00 03950 MISC ANCILLARY		0.00000		0	76
6. 01 03951 SLEEP LAB		0. 00000	0	0	76
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 34687		2, 887	76
76. 03 03952 WOUND CARE		0. 33921	5 0	0	76
OUTPATIENT SERVICE COST CENTERS					
90. 00   09000   CLI NI C		1. 82141		_	
91. 00   09100   EMERGENCY		0. 14957			
92 OO 09200 OBSERVATION BEDS (NON-DISTINCT PART		0 28494	.3 0	1 0	92

0. 284943

621, 355

202. 00

0 92.00 77, 941 200.00 201.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

200.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	Peri od: From 06/01/2017 To 05/31/2018

				10/31/2018 1:0	09 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see			0 2, 570, 925	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October	I (see	4, 513, 793	1. 02
1. 03	<pre>instructions) DRG for federal specific operating payment for Model 4 BPCI fc 1 (see instructions)</pre>	or discharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			382, 014 0	2. 00 2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
3. 00	Managed Care Simulated Payments			4, 289, 788	3. 00
4.00	Bed days available divided by number of days in the cost repor Indirect Medical Education Adjustment			102. 09	4.00
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)			8. 95	5. 00
6. 00 7. 00	FTE count for allopathic and osteopathic programs which meet t for new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified u		.	0. 00 1. 89	6. 00 7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.			0.00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.71998), and 67 FR 50069 (August 1, 2002).			0. 05	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap sld report straddles July 1, 2011, see instructions.	ots under § 5503 of the A	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slounder $\S$ 5506 of ACA. (see instructions)	ots from a closed teachin	ng hospital	0.00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)			7. 11	9. 00
	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs.	ent year from your record	ds		11. 00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			5. 29	12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	er ended on or after Sep	tember 30, 1997,	5. 13	
15. 00	Sum of lines 12 through 14 divided by 3.			3. 81	15. 00
16. 00	Adjustment for residents in initial years of the program			0. 00	
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4)			3. 81 0. 037320	
20. 00	Prior year resident to bed ratio (see instructions)	•		0. 057320	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 037320	
22. 00	IME payment adjustment (see instructions)			142, 991	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			86, 581	
	Indirect Medical Education Adjustment for the Add-on for § 422				
23. 00	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$ .	ent cap slots under 42 Cl	FR 412. 105	4. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			-6. 09	
25. 00	If the amount on line 24 is greater than -0-, then enter the linstructions)	ower of line 23 or line	24 (see	0.00	
	Resident to bed ratio (divide line 25 by line 4)  IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	
	IME add-on adjustment amount (see instructions)			0.000000	28.00
	TME add-on adjustment amount (see Firstructions)  IME add-on adjustment amount - Managed Care (see instructions)			0	28. 00
29. 00	Total IME payment ( sum of lines 22 and 28)			142, 991	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01 Disproportionate Share Adjustment	)		86, 581	
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	ntient days (see instruc	tions)	13. 76	30. 00
	Percentage of Medicaid patient days (see instructions)		- /	43. 95	
	Sum of lines 30 and 31			57. 71	
	Allowable disproportionate share percentage (see instructions)			36. 83	
34. 00	Disproportionate share adjustment (see instructions)			652, 326	34. 00

	Financial Systems ST JOSEPH MED ATLON OF RELMBURSEMENT SETTLEMENT			u of Form CMS-2	2552-1
JALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	Peri od: From 06/01/2017 To 05/31/2018		
		Title XVIII	Hospi tal	10/31/2018 1: 0 PPS	09 pm
		THE XVIII		On/After 10/1	
			1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		0	0	]   35. 0
35. 00	Factor 3 (see instructions)		0. 00000000		
35. 02	Hospital uncompensated care payment (If line 34 is zero, er	nter zero on this line) (so			1
35. 03	instructions) Pro rata share of the hospital uncompensated care payment a	amount (soo instructions)	443, 464	1, 069, 861	35.0
	Total uncompensated care (sum of columns 1 and 2 on line 35		1, 513, 325		36.0
	Additional payment for high percentage of ESRD beneficiary				
10.00	Total Medicare discharges on Worksheet S-3, Part I excludir 652, 682, 683, 684 and 685 (see instructions)	ng discharges for MS-DRGs	0		40.0
	032, 002, 003, 004 and 003 (See Histractions)		Before 1/1	On/After 1/1	
			1. 00	1. 01	
11.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	, 683, 684 an 685. (see	0	0	41.0
11. 01	Total ESRD Medicare covered and paid discharges excluding Man 685. (see instructions)	MS-DRGs 652, 682, 683, 684	4 0	0	41. (
12.00	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00		42.0
13. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,	682, 683, 684 an 685. (see	9 0		43.0
14. 00	instructions) Ratio of average length of stay to one week (line 43 divide days)	ed by line 41 divided by 7	0. 000000		44. (
5. 00	Average weekly cost for dialysis treatments (see instruction	ons)	0.00	0.00	45. (
6. 00	Total additional payment (line 45 times line 44 times line	41. 01)	0		46.
7. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	9, 775, 374		47. (
+0.00	only. (see instructions)	, silari rurar nospi tars			40.0
				Amount	
19. 00	Total payment for inpatient operating costs (see instruction	ons)		1. 00 9, 861, 955	49.0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		)	731, 404	
1. 00	Exception payment for inpatient program capital (Wkst. L, F			0	
2.00	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment	line 49 see instructions).		124, 150	52. (
4. 00	Special add-on payments for new technologies			5, 459	
4. 01	Islet isolation add-on payment			0	1
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	
6. 00	Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt.	,	through 25)	0	
8. 00	Ancillary service other pass through costs from Wkst. D, Pt.		tili ougii 33).		
9. 00	Total (sum of amounts on lines 49 through 58)	, ,		10, 722, 968	1
0.00	Primary payer payments			3, 775	
1.00	Total amount payable for program beneficiaries (line 59 mir	nus line 60)		10, 719, 193	
2. 00 3. 00	Deductibles billed to program beneficiaries  Coinsurance billed to program beneficiaries			688, 952 44, 655	1
4. 00	Allowable bad debts (see instructions)			270, 294	1
5. 00	Adjusted reimbursable bad debts (see instructions)			175, 691	
6. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		149, 191	1
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	or applicable to MC DDC- (	coo inctruction=\	10, 161, 277	1
8. 00 9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96	11	,	0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	o). (101 0011 000 111511 <b>u</b> 011 01	13)	o o	1
0. 50	Rural Community Hospital Demonstration Project (§410A Demon	nstration) adjustment (see	instructions)	0	70.
0.87	Demonstration payment adjustment amount before sequestration			0	1
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	1
	Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)	•		0	70. 70.
70. 89	, ,	,		Ö	1
	HSP bonus payment HRR adjustment amount (see instructions)				
70. 89 70. 90 70. 91 70. 92	Bundled Model 1 discount amount (see instructions)			0	
70. 89 70. 90 70. 91	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 -15, 657 -13, 603	70.

Health Financial Systems	ST JOSEPH MEDICAL CENTER		In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider Co		Period: From 06/01/2017 To 05/31/2018	Worksheet E Part A Date/Time Pre 10/31/2018 1:	
	Title	: XVIII	Hospi tal	PPS	•
		FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fi			0	0	70. 96
70. 97 Low volume adjustment for federal fithe corresponding federal year for t	scal year (yyyy) (Enter in column 0		0	0	70. 97
70. 98 Low Volume Payment-3	per von en an en en en en			0	70. 98
70.99 HAC adjustment amount (see instructi	ons)			36, 456	
71.00 Amount due provider (line 67 minus l				10, 095, 561	
71.01 Sequestration adjustment (see instru				201, 911	71. 01
71.02 Demonstration payment adjustment amo	unt after sequestration			0	71. 02
72.00 Interim payments	·			9, 409, 680	72. 00
73.00 Tentative settlement (for contractor	use only)			0	73.00
74.00 Balance due provider/program (line 7 73)	1 minus lines 71.01, 71.02, 72, and			483, 970	74. 00
75.00 Protested amounts (nonallowable cost CMS Pub. 15-2, chapter 1, §115.2	report items) in accordance with			1, 709, 088	75. 00
TO BE COMPLETED BY CONTRACTOR (lines	90 through 96)				
90.00 Operating outlier amount from Wkst.	E, Pt. A, line 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 adj				0	92.00
93.00 Capital outlier reconciliation adjus	tment amount (see instructions)			0	93. 00
94.00 The rate used to calculate the time				0.00	
95.00 Time value of money for operating ex				0	95.00
96.00 Time value of money for capital rela	ted expenses (see instructions)			0	96. 00
			Prior to 10/1		
			1. 00	2. 00	
HSP Bonus Payment Amount					
100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Paymen					
101.00 HVBP adjustment factor (see instruct			0.0000000000	0.0000000000	
102.00 HVBP adjustment amount for HSP bonus HRR Adjustment for HSP Bonus Payment	payment (see instructions)		0	0	102. 00
103.00 HRR adjustment factor (see instructi	ons)		0.0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus	payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstrati	on Project (§410A Demonstration) Adju				
200.00 Is this the first year of the curren		he 21st			200. 00
Century Cures Act? Enter "Y" for yes	or "N" for no.				
Cost Reimbursement					
201.00 Medicare inpatient service costs (fr					201. 00
202.00 Medicare discharges (see instruction					202. 00
203 00 Case-mix adjustment factor (see inst	ructions)		1		203 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	Peri od: From 06/01/2017 To 05/31/2018

			10 03/31/2016	10/31/2018 1:	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
4 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0.040	4 00
1. 00 2. 00	Medical and other services (see instructions)	ti ons)		3, 340	1. 00 2. 00
3.00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	ti ons)		5, 521, 194 4, 236, 614	
4. 00	Outlier payment (see instructions)			35, 924	
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
6.00	Line 2 times line 5	•		0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		0	
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			3, 340	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable charges				1
12. 00	Ancillary service charges			29, 854	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		27,034	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	67)		29, 854	
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for patients and actually collected from patients liable for patients.	payment for services on	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for	r payment for services o	n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e	e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions)	l : 6 li == 10	11) (	29, 854	
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	Ty IT Time 18 exceeds IT	ne II) (See	26, 514	19. 00
20. 00	Excess of reasonable cost over customary charges (complete onl	lv if line 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)	Ty TT TTHE TT EXCECUS TT	110 10) (300	ĺ	20.00
21.00	Lesser of cost or charges (see instructions)			3, 340	21. 00
22.00	Interns and residents (see instructions)			0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			4, 272, 538	24.00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				05 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)	r CALL coo i notructions)		771 225	25. 00
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26);		and 221 (soo	771, 325 3, 504, 553	
27.00	instructions)	prus the sum of filles 22	and 25] (See	3, 304, 333	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ine 50)		44, 991	28. 00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	•		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			3, 549, 544	30.00
31.00	Primary payer payments			792	
32. 00	Subtotal (line 30 minus line 31)			3, 548, 752	32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			22 00
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 365, 894	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			237, 831	
36. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		292, 766	
37. 00		. 401. 03)		3, 786, 583	
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			3, 786, 583	1
40. 01 40. 02	Sequestration adjustment (see instructions)			75, 732	1
41. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 3, 707, 013	
41.00	Tentative settlement (for contractors use only)			3, 707, 013	42.00
43. 00	Balance due provider/program (see instructions)			3, 838	
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2.	chapter 1,	0,000	44. 00
	§115. 2		P		
	TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	l
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			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	Period: From 06/01/2017	Worksheet E
	Component CCN: 15-S047		
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - IPF	PPS	
			171		
	T			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)		T	0	1. 00
2.00	Medical and other services (see instructions)  Medical and other services reimbursed under OPPS (see instruc	tions)		223	2. 00
3.00	OPPS payments			161	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	
8.00	Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9. 00
10. 00	Organ acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable charges				
12. 00	Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				
15. 00 16. 00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable fo			0	
16.00	had such payment been made in accordance with 42 CFR §413.13(		on a chargebasis	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)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete on</pre>	ly if line 11 evceeds li	no 18) (soo	0	20. 00
20.00	instructions)	Ty IT Title IT exceeds IT	116 10) (366	٥	20.00
21. 00	Lesser of cost or charges (see instructions)			0	21. 00
22. 00	Interns and residents (see instructions)			0	
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			161	24. 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (fo		•	32	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	2 and 23] (see	129	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, I</pre>	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	The 30)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			129	30. 00
31. 00	Pri mary payer payments			0	31. 00
32. 00	Subtotal (line 30 minus line 31)	CEC)		129	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	UES)		0	33. 00
34. 00	Allowable bad debts (see instructions)			0	
35.00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			129	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		١	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION			120	
40. 00	Subtotal (see instructions)   Sequestration adjustment (see instructions)			129	1
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41.00	Interim payments			126	41. 00
42. 00	Tentative settlement (for contractors use only)			0	
43. 00 44. 00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda	nce with CMS Dub 1F 2	chanter 1	0	
44.00	§115. 2	nce with two rub. 15-2,	Chapter 1,	O <sub>1</sub>	44.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0 00	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)			-	94. 00
			'	'	

Health Financial Systems ST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 06/01/2017 | Part I | To 05/31/2018 | Date/Time Prepared: Provider CCN: 15-0047

Title XVIII   Hospital PPTS   PST 8					0 05/31/2018	10/31/2018 1:0	
March   Marc			Title	XVIII	Hospi tal		57 PIII
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00   3.01   1.10			I npati en	t Part A		rt B	
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00   3.01   1.10							
Total interim payments paid to provider   9,367,580   3,619,113   1.00   2.00							
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the Interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	1 00	Takal tukada asimaka astid ka mastidan	1.00				1 00
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero   3.00   Usis separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   2.00   2.00   2.00   2.00   3.00							
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero the interim rate for the Cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	2.00				,		2.00
Write NoNE" or enter a zero							
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)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   NONE" or enter a zero. (1)   Program to Provider   NONE" or enter a zero. (1)   NONE" or enter a zero. (1)   NONE	3.00						3.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provi der   ADJUSTMENTS TO PROVIDER   02/14/2018							
ADJUSTMENTS TO PROVIDER							
3.02   3.03   3.04   3.05   3.06   3.07   3.07   3.08   3.09   3.09   3.09   3.00	3 01		02/14/2018	42 100	02/14/2018	87 900	3 01
3.03   0		ADDUST MENTS TO TROVIDER	027 147 2010				
3. 04   0   0   0   3. 04   3. 05						- 1	
Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   3.50   3.51   3.52   0   0   0   3.51   3.52   0   0   0   3.53   3.53   3.54   0   0   0   3.53   3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines   42,100   87,900   3.99   3.50-3.98)   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR						0	3. 04
ADJUSTMENTS TO PROGRAM	3.05			C	)	0	3. 05
3.51   3.52   3.53   0   0   0   3.51   3.52   3.53   0   0   0   3.53   3.53   3.54   0   0   0   3.53   3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines   42,100   87,900   3.99   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   9, 409, 680   3, 707,013   4.00							
3.52   3.53   3.54   3.99   3.50   3.52   3.53   3.54   3.99   3.50 - 3.98   3.50 - 3.99   3.50 - 3.50 - 3.50   3.50 - 3.50 - 3.50   3.50 - 3.50 - 3.50   3.50 - 3.50 - 3.50   3.50 - 3.50 - 3.50   3.50 - 3.50 - 3.50   3.50 - 3.50 - 3.50 - 3.50   3.50 - 3.50 - 3.50   3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 - 3.50 -		ADJUSTMENTS TO PROGRAM					
3.53   3.54   0   0   0   3.53   3.54   3.59   3.50-3.99   3.50-3.99   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   9,409,680   3,707,013   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR						1 - 1	
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   42,100   87,900   3.59   3.50-3.98)   42,100   87,900   3.99   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   9,409,680   3,707,013   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   9,409,680   3,707,013   4.00				1		1 - 1	
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)   9, 409, 680   3, 707, 013   4.00		Subtotal (sum of lines 3 01-3 49 minus sum of lines		1		1 - 1	
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	0. 77			12, 100		07,700	0. 77
appropriate   TO BE COMPLETED BY CONTRACTOR	4.00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 409, 680		3, 707, 013	4.00
TO BE COMPLETED BY CONTRACTOR							
5.00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	F 00		I		1		F 00
Write "NONE" or enter a zero. (1)   Program to Provider	5.00						5.00
Program to Provider							
5.02   0		Program to Provider			,	'	
Description	5.01	TENTATI VE TO PROVI DER		C	)	0	5. 01
Provider to Program							
TENTATI VE TO PROGRAM	5. 03				)	0	5. 03
5.51   5.52   5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   5.50-5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROVIDER   483,970   3,838   6.01   6.02   SETTLEMENT TO PROGRAM   0   0   6.02   7.00   Total Medicare program liability (see instructions)   9,893,650   3,710,851   7.00	E E0		I		\		F F0
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.59 minus sum of lines 7.59 minus		TENTATIVE TO PROGRAM					
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00							
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00		Subtotal (sum of lines 5.01-5.49 minus sum of lines				1	
the cost report. (1) SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  483,970 0 3,838 6.01 0 6.02 7.00 Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00		· ·				1	
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)	6.00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  9,893,650  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	,						, -
7.00 Total Medicare program liability (see instructions) 9,893,650 3,710,851 7.00  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00							
Contractor NPR Date   Number (Mo/Day/Yr)   0   1.00   2.00						1	
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Trotal Medicare program frability (see instructions)		7, 893, 650			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00			(	)			
	8. 00	Name of Contractor					8. 00

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

Inpatient Part A			Title	XVIII	Subprovi der - I PF	PPS	
1.00   Total Interim payments paid to provider   1.00   2.00   3.00   4.00   1.00			Inpatien	t Part A	Par	t B	
1.00   Total interim payments paid to provider   2,669,784   126   1.00   0   0   2.00   0   0   0   0   0   0   0   0   0			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1. 00	2. 00	3. 00	4. 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						l .	
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	2.00			0		0	2.00
write "NONE" or enter a zero							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  ADJUSTMENTS TO PROVIDER  O	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	3.00						3.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider							
3.02   3.03   3.04   3.05   3.03   3.04   3.05   3.03   3.04   3.05							
3.03   0	3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 04   0							
3.05   Provider to Program							
Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   3.50							
3.50   ADJUSTMENTS TO PROGRAM   0   0   3.50     3.51   3.52   0   0   0   3.51     3.52   3.53   0   0   0   3.53     3.54   0   0   0   3.53     3.59   3.50-3.98   0   0   0   3.59     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 appropriate)   To BE COMPLETED BY CONTRACTOR	3.05	Dravidan to Dragger		0		0	3.05
3.51   3.52   3.53   3.53   3.54   3.55   3.55   3.55   3.59   3.50-3.98   3	3 50			0		0	3 50
3.52   3.53   3.54   3.99   3.50-3.98		ADJUSTINENTS TO TROOKAIN					
3.53   3.54   0							
3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.05-3.98)   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   2,669,784   126   4.00   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR							
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)   2, 669,784   126   4.00	3.54			0		0	3. 54
126   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   2,669,784   126   4.00	3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR							
appropriate   TO BE COMPLETED BY CONTRACTOR	4. 00			2, 669, 784		126	4. 00
TO BE COMPLETED BY CONTRACTOR							
5.00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	5 00						5 00
Write "NONE" or enter a zero. (1)   Program to Provider	0.00						0.00
TENTATI VE TO PROVI DER							
S. 02							
Description		TENTATI VE TO PROVI DER					
Provider to Program						- 1	
TENTATI VE TO PROGRAM   0	5.03	Dravi dan ta Dragnam		0		0	5. 03
5.51   0	5 50			0		0	5 50
S. 52   Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50 - 5. 99   Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50 - 5. 98)   S. 50 -		TENTATI VE TO TROCKAW		-			
5.50-5.98)  6.00 Determined net settlement amount (balance due) based on the cost report. (1)  6.01 SETTLEMENT TO PROVIDER  6.02 SETTLEMENT TO PROGRAM  7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00							
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 9 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 2,669,793 126 7.00  Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1. 00 2. 00		1 2 2 2 2 2					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  2,669,793  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6.00	` '					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	. 01						
7.00 Total Medicare program liability (see instructions)  2,669,793  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00							
Contractor NPR Date (Mo/Day/Yr)           0         1.00         2.00				-		1 - 1	
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Total medicale program traditity (see instructions)		2,007,793			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00			(	)	1. 00		
	8. 00	Name of Contractor					8. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | From 06/01/2017 | Part I | Date/Time Prepared: | 10/31/2018 1:09 pm | Skilled Nursing | PPS Provider CCN: 15-0047 Component CCN: 15-5356 Title XVIII Skilled Nursing

		litie	XVIII	Killed Nursing Facility	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		785, 548		0	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)					
	Program to Provider	T		T		
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3. 03 3. 04			0			3. 03 3. 04
3. 04						3. 04
3.03	Provider to Program			1	0	3.03
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		Ö	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
4 00	3. 50-3. 98)		705 540			4 00
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		785, 548	i	0	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	1				
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravidar to Dragram		0	1	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0	1	0	5. 50
5. 51	TENTATIVE TO TROOKAWI				0	5. 51
5. 52			Ö		o o	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		101		0	6. 01
6. 02	SETTLEMENT TO PROGRAM  Total Medicara program Liability (see instructions)		795 440		0	6. 02
7. 00	Total Medicare program liability (see instructions)		785, 649	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00
				•	. '	•

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu					2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0047 Period: From 06/01/2017					
			To 05/31/2018	Date/Time Pro 10/31/2018 1:		
	Title XVIII Hospital					
	TO BE COMPLETED BY CONTRACTOR FOR MOMETANIBARD COST DEPORTS			1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		14		1.00	
2. 00					2. 00	
3.00					3. 00	
4.00						
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00	
7.00	7.00   CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I					
	line 168					
8.00					8. 00	
9.00					9. 00 10. 00	
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					
20.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31. 00	
	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	15)		32.00	
52.00	2. 00   Balance due provider (Title o (or Title 10) militus Title 30 and Title 31) (See Titstructions)					

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
	Component CCN: 15-S047	From 06/01/2017 To 05/31/2018	
	'		10/31/2018 1:09 pm
	Title XVIII	Subprovi der -	PPS
		I PF	

	l PF		
		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2, 977, 691	1. 00
2.00	Net IPF PPS Outlier Payments	4, 245	2. 00
3.00	Net IPF PPS ECT Payments	11, 160	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4. 00
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)	0.00	4. 01
5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6. 00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. 00
8. 00	teaching program" (see instructions) Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	
9. 00	Average Daily Census (see instructions)	15. 024658	
10. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	0	11. 00
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2, 993, 096	
13. 00	Nursing and Allied Health Managed Care payment (see instruction)	0	
14. 00	Organ acquisition (DO NOT USE THIS LINE)		14. 00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	
16. 00	Subtotal (see instructions)	2, 993, 096	16.00
17. 00	Primary payer payments	0	17.00
18. 00	Subtotal (line 16 less line 17).	2, 993, 096	18.00
19. 00	Deducti bl es	169, 648	19.00
20.00	Subtotal (line 18 minus line 19)	2, 823, 448	20.00
21.00	Coi nsurance	99, 169	21.00
22.00	Subtotal (line 20 minus line 21)	2, 724, 279	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23. 00
24.00	Adjusted reimbursable bad debts (see instructions)	l ol	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25. 00
26. 00	Subtotal (sum of lines 22 and 24)	2, 724, 279	26. 00
27. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	l ol	27. 00
28. 00	Other pass through costs (see instructions)	0	28. 00
29. 00	Outlier payments reconciliation	0	
30. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	l ol	30. 50
30. 99	Demonstration payment adjustment amount before sequestration		
31. 00	Total amount payable to the provider (see instructions)	2, 724, 279	
31. 01	Sequestration adjustment (see instructions)	54, 486	
31. 02	Demonstration payment adjustment amount after sequestration	0 1, 100	31. 02
32. 00	Interim payments	2, 669, 784	
33. 00	Tentative settlement (for contractor use only)	2,007,704	33. 00
34. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	9	34. 00
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	Ó	35. 00
33.00	\$115. 2	١	33.00
	TO BE COMPLETED BY CONTRACTOR		
50. 00	Original outlier amount from Worksheet E-3, Part II, line 2	1 215	50. 00
51. 00	Outlier reconciliation adjustment amount (see instructions)	4, 243	51. 00
52. 00	The rate used to calculate the Time Value of Money	0.00	
	Time Value of Money (see instructions)	0.00	
55. 00	Time rates of money (see first actions)	١	55.00

	Financial Systems ST JOSEPH MEDIC			u of Form CMS-2	:552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od:	Worksheet E-3	
		C CON 15 525/	From 06/01/2017		
		Component CCN: 15-5356	To 05/31/2018	Date/Time Prep 10/31/2018 1:0	)area:
		Title XVIII	Skilled Nursing		J <del>9</del> PIII
		II the XVIII	Facility	113	
				1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTH	HER HEALTH SERVICES FOR T	ITLE XVIII PART A	PPS SNF	
	SERVI CES				
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			958, 371	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
4.00	Subtotal (sum of lines 1 through 3)			958, 371	

		1.00	1
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A	A PPS SNF	
	SERVI CES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		l
1.00	Resource Utilization Group Payment (RUGS)	958, 371	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)	958, 371	4. 00
	COMPUTATION OF NET COST OF COVERED SERVICES		l
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	156, 791	7. 00
8.00	Allowable bad debts (see instructions)	158	8. 00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9. 00
10.00	Adjusted reimbursable bad debts (see instructions)	103	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)	801, 683	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	Demonstration payment adjustment amount before sequestration	0	14. 99
15.00	Subtotal (see instructions	801, 683	15. 00
15. 01	Sequestration adjustment (see instructions)	16, 034	15. 01
15. 02	Demonstration payment adjustment amount after sequestration	0	15. 02
16.00	Interim payments	785, 548	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, 15.02, 16, and 17)	101	18. 00
19. 00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER		u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	Peri od: From 06/01/2017 To 05/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX			7	To 05/31/2018	Date/Time Pre 10/31/2018 1:	
DART VII - CALCIDATION OF RETURDIPSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX	Hospi tal		
PART VII - CALCULATION OF RETIMBUSCHEMT - ALL OTHER HEALTH SERVICES   COOPUPITION OF NET COST OF COVERED SERVICES   1.00   Inpatient hospital/SMF/MF services   931,643 2.00   3.00   0.00   Medical and other services   931,643 2.00   3.00   0.00				Inpati ent	Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   1.0				1. 00	2. 00	
Inpatient hospital SNE/NR services		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX	SERVI CES		
2.00   Medical and other services   931,643   2.00   3.00   0.00   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		COMPUTATION OF NET COST OF COVERED SERVICES				
3.00   Organ acquisition (certified transplant centers only)	1.00	Inpatient hospital/SNF/NF services		0		1. 00
Subtotal (sum of lines 1, 2 and 3)	2.00				931, 643	1
Inpatient_primary payer payments						1
0				_	931, 643	1
Topic   Subtotal (Line 4 less sum of lines 5 and 6)   931,643   7.00				0		
COMPUTATION OF LESSER OF COST OR CHARGES   8.00						
Reasonable Charges   8, 00   Routine service charges   8, 473, 385   6, 783, 414   9, 00   10, 00   10   10   10   10   10	7. 00			0	931, 643	7. 00
8.00   Routine service charges   8.00   8.00   10.00						
9.00   Ancillary service charges   8,473,385   6,783,414   9.00   10.00   Incentive from target amount computation   0   11.00   Incentive from target amount computation   11.00   Incentive from target amount computation   12.00   Total reasonable charges (sum of lines 8 through 11)   12.00   Amount actually collected from patients liable for payment for services on a charge basis   13.00   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)   0.00000   0.00000   15.00   16.00   Total customary charges (see instructions)   0.00000   0.00000   15.00   16.00   Total customary charges (see instructions)   0.00000   0.00000   15.00   16.00   Total customary charges (see instructions)   0.00000   0.00000   16.00   16.00   Total customary charges (complete only if line 16 exceeds   8,473,385   5,851,771   17.00   16.00	0.00					0.00
10.00   Organ acquisistion charges, net of revenue   10.00		,		0 472 205	4 702 414	
11.00   Incentive from target amount computation					0, 703, 414	1
12.00   Total reasonable charges (sum of lines 8 through 11)   12.00   CUSTOMARY CHARGES   13.00   Amount actually collected from patients liable for payment for services on a charge 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)   14.00   15.00				0		1
CUSTOMARY CHARGES				8 473 385	6 783 414	1
13.00   Amount actually collected from patients	12.00			0, 473, 303	0, 700, 414	12.00
14.00	13. 00		services on a charge	0	0	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 over reasonable cost (complete only if line 16 exceeds 8, 473, 385 6, 783, 414 16. 00  18. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 8, 473, 385 5, 851, 771 17. 00  18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16 (see instructions)  19. 00 Interns and Residents (see instructions)  19. 00 Interns and Residents (see instructions)  10. 00 Cost of physicians' services in a teaching hospital (see instructions)  10. 00 Cost of payments 0 0 931, 643  21. 00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.  22. 00 Other than outlier payments  23. 00 Outlier payments  24. 00 Uther than outlier payments  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)  20. 00 Excess of reasonable cost (from line 18)  20. 00 Computation of ReimBursExement Service instructions)  20. 00 Computation of ReimBursExement Services only on the service of payments on the service of			3			
15.00   Ratio of Fline 13 to line 14 (not to exceed 1.000000)   0.000000   0.000000   15.00	14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14. 00
16.00   Total customary charges (see instructions)   8, 473, 385   6, 783, 414   6.00   17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   8, 473, 385   5, 851, 771   17.00   17.00   17.00   Excess of reasonable cost over customary charges (complete only if line 16 exceeds line   16 (see instructions)   0   0   18.00   18.00   19.00   1			2 CFR §413.13(e)			
17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   8, 473, 385   5, 851, 771   17.00						1
Iine 4) (see instructions)		, ,				1
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   18.00   16) (see instructions)   19.00   17.	17. 00		y if line 16 exceeds	8, 473, 385	5, 851, 771	17. 00
16) (see instructions)	10.00		viflima 4 avasada lima	0	0	10.00
19,00   Interns and Residents (see instructions)   0   0   19,00   20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   0   20.00	16.00		y IT TITLE 4 exceeds TITLE	U	U	16.00
20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   0   0   931,643   21.00	19 00			0	0	19 00
21.00   Cost of covered services (enter the lesser of line 4 or line 16)   PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			ructions)	_	_	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				_	_	
22.00   Other than outlier payments   0   0   22.00				ers.	, , , , , , , , , , , , , , , , , , , ,	
24.00   Program capital payments   Capital exception payments (see instructions)   Capital (sum of lines 22 through 26)   Capital (sum of lines 22 through 26)   Capital (sum of lines 21 and 27)   Capital (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   Capital (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   Capital (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   Capital (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   Capital (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   Capital (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   Capital (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   Capital (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   Capital (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   Capital (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   Capital (sum of lines 34, 36, 00)   Capital (sum of lines 36, 10)   Cap	22.00		·		0	22. 00
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) 30. 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 Bal ance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 0 25. 00 2 0 0 2 2. 00 2 0 0 0 2 28. 00 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00	Outlier payments		0	0	23. 00
26.00       Routine and Ancillary service other pass through costs       0       0       26.00         27.00       Subtotal (sum of lines 22 through 26)       0       0       27.00         28.00       Customary charges (title V or XIX PPS covered services only)       0       931,643         29.00       Titles V or XIX (sum of lines 21 and 27)       0       931,643         COMPUTATION OF REIMBURSEMENT SETTLEMENT       0       0       30.00         30.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       0       931,643       31.00         32.00       Deductibles       0       0       32.00         33.00       Coinsurance       0       0       34.00         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       931,643       36.00         38.00       Subtotal (line 36 ± line 37)       0       -931,643       37.00         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	24. 00	Program capital payments		0		24. 00
27. 00 Subtotal (sum of lines 22 through 26) 0 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 931,643 29. 00 Titles V or XIX (sum of lines 21 and 27) 0 931,643  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) 0 931,643 31. 00 32. 00 Deductibles 0 0 0 32. 00 33. 00 Coinsurance 0 0 0 0 32. 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) 0 931,643 36. 00 37. 00 ELIMINATE SETTLEMENT 0 -931,643 37. 00 38. 00 Subtotal (line 36 ± line 37) 0 -931,643 36. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 0 0 40. 00 41. 00 Horeim payments 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				0		
28. 00 Customary charges (title V or XIX PPS covered services only)  7					_	
29.00   Titles V or XIX (sum of lines 21 and 27)   0   931,643   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   931,643   31.00   32.00   Deductibles   0   0   0   32.00   33.00   Coinsurance   0   0   0   34.00   34.00   Allowable bad debts (see instructions)   0   0   34.00   35.00   Utilization review   0   35.00   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   931,643   36.00   37.00   ELIMINATE SETTLEMENT   0   -931,643   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   Unterim 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				_	_	
30. 00   Excess of reasonable cost (from line 18)	29. 00	,		0	931, 643	29.00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32.00 Deductibles  32.00 Coinsurance  31.00 Allowable bad debts (see instructions)  32.00 Utilization review  33.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  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,	20.00				0	20.00
32.00 Deductibles 32.00 Coinsurance 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 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,		·		_	_	
33. 00       Coinsurance       0       0       33. 00         34. 00       Allowable bad debts (see instructions)       0       0       34. 00         35. 00       Utilization review       0       35. 00         36. 00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       0       931, 643       36. 00         37. 00       ELIMINATE SETTLEMENT       0       -931, 643       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       43. 00				_		
34.00       Allowable bad debts (see instructions)       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       931,643       36.00         37.00       ELIMINATE SETTLEMENT       0       -931,643       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       49.00         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					_	1
35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 0 931,643 36.00 37.00 ELIMINATE SETTLEMENT 0 -931,643 37.00 38.00 Subtotal (line 36 ± line 37) 0 0 38.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 Total amount payable to the provider (sum of lines 38 and 39) 0 0 0 40.00 Interim payments 0 0 41.00 Interim payments 0 0 41.00 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 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,  0 931,643 36.00  931,643 36.00  931,643 36.00  931,643 36.00  931,643 36.00  931,643 37.00  94.00  94.00  95.00  97.00		· · · · · · · · · · · · · · · · · · ·				1
37. 00       ELIMINATE SETTLEMENT       0       -931,643       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			33)	0	931, 643	1
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				0		1
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 40.00  41.00  0 40.00  41.00  0 42.00  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 0 42.00 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) 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 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 43.00	41.00	Interim payments		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		ice with CMS Pub 15-2,	0	0	43. 00
		cnapter   , §115.2				l

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047 Component CCN: 15-S047	From 06/01/2017	Worksheet E-3 Part VII Date/Time Prepared: 10/31/2018 1:09 pm
	Title XIX	Subprovi der -	PPS

		II tie xix	I PF	PPS	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	ES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		02.00		1
1.00	Inpatient hospital/SNF/NF services		0		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)		0	0	
5.00	Inpatient primary payer payments		o		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	
	COMPUTATION OF LESSER OF COST OR CHARGES		-1		
	Reasonabl e Charges				
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		621, 355	0	9. 00
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)		621, 355	0	12. 00
	CUSTOMARY CHARGES				1
13.00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13. 00
	basi s				
14. 00	Amounts that would have been realized from patients liable for page 1.		0	0	14. 00
	a charge basis had such payment been made in accordance with 42 C	FR §413. 13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
16. 00	Total customary charges (see instructions)		621, 355	0	
17. 00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	621, 355	0	17. 00
	line 4) (see instructions)		_	_	
18. 00	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)			0	10.00
19. 00 20. 00	Interns and Residents (see instructions)	i ana)	0	0	
21. 00	Cost of physicians' services in a teaching hospital (see instruct Cost of covered services (enter the lesser of line 4 or line 16)	i ons)	0	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	plated for DDS provide		U	21.00
22. 00		preted for 113 provide	0	0	22. 00
	Outlier payments		0	0	
24. 00			0	· ·	24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00			o	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		O	0	28. 00
29. 00			o	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		-1		
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)		o	0	31. 00
32.00	Deducti bl es		0	0	32. 00
33.00	Coinsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		O	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	)	0	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41. 00	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41)		0	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

DI RECT	Financial Systems ST JOSEPH MEDICA GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	AL CENTER Provider C		Peri od:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS			From 06/01/2017 To 05/31/2018	Date/Time Prep	
		Ti +l c	: XVIII	Hospi tal	10/31/2018 1: 0 PPS	09 pm
		11 11 6	: AVIII	nospi tai	I FF3	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	7. 63	1. 00
. 00	Unweighted FTE resident cap add-on for new programs per 42 CF		1) (see instr	ructions)	0. 00	2. 00
. 00 . 01	Amount of reduction to Direct GME cap under section 422 of MM. Direct GME cap reduction amount under ACA $\S5503$ in accordance		§413.79 (m).	(see	0. 00 0. 00	3. 00 3. 01
. 00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	-0. 80	4. 00
. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	ng periods	0. 00	4. 01
. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0. 00	4. 02
. 00	periods straddling 7/1/2011) 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 l	ines 4.01 and	6. 83	5. 00
. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	1. 02	6. 00
. 00	Enter the lesser of line 5 or line 6				1. 02	7. 00
			Primary Care		Total	
			1.00	2. 00	3. 00	
. 00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.		1.0		1. 02	8. 00
. 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		1.0	0.00	1. 02	9. 00
0. 00	6. Weighted dental and podiatric resident FTE count for the curr	ent vear		0.00		10. 00
0. 01	Unweighted dental and podiatric resident FTE count for the cu	,		0.00		10. 0
1. 00	Total weighted FTE count	,	1.0	0.00		11.00
2. 00	Total weighted resident FTE count for the prior cost reportininstructions)	g year (see	5. 2	0.00		12. 00
3. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions) $$	porti ng	5. 1	0.00		13. 00
4. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	3.8			14.00
5. 00	Adjustment for residents in initial years of new programs		0.0			15.00
5. 01 6. 00	Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo		0.0			15. 0° 16. 00
6. 01	University adjustment for residents displaced by program or high closure		0.0			16. 00
7. 00	Adjusted rolling average FTE count		3. 8	0. 00		17. 00
8. 00	Per resident amount		100, 092. 6	94, 778. 98		18. 00
9. 00	Approved amount for resident costs		381, 35	53 0	381, 353	19. 00
					1. 00	
J. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots rec	eived under 42		20. 00
1. 00	Direct GME FTE unweighted resident count over cap (see instru	ctions)			0. 00	21. 00
2. 00	Allowable additional direct GME FTE Resident Count (see instr				0.00	
3. 00	Enter the locality adjustment national average per resident a	mount (see i	nstructions)		99, 539. 45	23. 0
	Multiply line 22 time line 23				0	24.00
5. 00	Total direct GME amount (sum of lines 19 and 24)		Innationt Day	t Managed care	381, 353	25. 00
			A A	Managed Care		
	COMPUTATION OF PROOPEN SATISFIT LOAD		1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		7 7/	0 2 042		26. 00
5. 00 7. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions)		7, 7 <i>6</i> 25, 13			26. 00 27. 00
7. 00 3. 00	Ratio of inpatient days to total inpatient days		0. 30879			28. 00
9. 00	Program direct GME amount		117, 76		ļ	29. 00
	Reduction for direct GME payments for Medicare Advantage			8, 455		30.00
0. 00	Reduction for direct one payments for medicale Advantage					

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	Provider CCN: 15-0047	Peri od:	Worksheet E-4	
MEDI CA	MEDICAL EDUCATION COSTS From 06/01/2017 To 05/31/2018				
		Title XVIII	Hospi tal	10/31/2018 1: 0 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 an	d 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, 504, 604	33. 00
34.00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0.000000	34.00
	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			15, 246, 887	
37. 00					
38. 00				0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	00 Primary payer payments (see instructions)			3, 775	
41.00					41. 00
40.00	Part B Reasonable Cost Reasonable cost (see instructions)			E E24 7E7	42. 00
42.00	,			5, 524, 757 792	42.00
44. 00				5, 523, 965	
	Total reasonable cost (sum of lines 41 and 44)			20, 767, 077	
	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line 45)		0. 734004	
	Ratio of Part B reasonable cost to total reasonable cost (line			0. 265996	1
00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAI			2. 200770	100
48. 00	Total program GME payment (line 31)			169, 141	48. 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		124, 150	•
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			44, 991	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

oni y)					10/31/2018 1:	09 pm
		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	-480, 630		0	0	1.00
2. 00 3. 00	Temporary investments	0		-	0	2. 00 3. 00
4.00	Notes recei vabl e Accounts recei vabl e	34, 731, 769	1		0	
5.00	Other recei vable	0		o o	0	
6.00	Allowances for uncollectible notes and accounts receivable	-14, 551, 152		O	0	
7.00	Inventory	3, 333, 704		0	0	7. 00
8.00	Prepai d expenses	1, 283, 801	(	0	0	
9.00	Other current assets	986, 296	1	, 	0	9.00
10.00	Due from other funds Total current assets (sum of lines 1-10)	0 25 202 700			0	10.00
11. 00	FIXED ASSETS	25, 303, 788	1	)	0	11.00
12. 00	Land	1, 010, 000		0	0	12. 00
13.00	Land improvements	412, 126		0	0	
14.00	Accumulated depreciation	-316, 600	(	0		14. 00
15. 00	Bui I di ngs	28, 350, 171	(	-	0	15. 00
16.00	Accumulated depreciation	-18, 078, 777	1	-	0	16. 00
17. 00 18. 00	Leasehold improvements	22, 204, 810	1	, 	0	17. 00
19. 00	Accumulated depreciation Fixed equipment	-7, 441, 035 1, 542, 344		, 	0	18. 00 19. 00
20. 00	Accumulated depreciation	1, 342, 344			0	20.00
21. 00	Automobiles and trucks	Ö		o o	0	21. 00
22.00	Accumul ated depreciation	0		0	0	22. 00
23.00	Major movable equipment	22, 967, 715		0	0	23. 00
24.00	Accumulated depreciation	-17, 258, 781	(	,	0	24. 00
25. 00	Mi nor equi pment depreci abl e	8, 426, 816	1	,	0	25. 00
26. 00	Accumulated depreciation	-6, 893, 875		0	0	26.00
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0			0	27. 00 28. 00
29. 00	Mi nor equi pment-nondepreci abl e	1 0		-	0	
30.00	Total fixed assets (sum of lines 12-29)	34, 924, 914	1	Ó		30.00
	OTHER ASSETS			,		
31.00	Investments	0	(	0	-	31. 00
32. 00	Deposits on Leases	0	(	-	0	32. 00
33. 00	Due from owners/officers	0		-	0	33.00
34. 00 35. 00	Other assets	8, 215, 772	1	,	0	34. 00 35. 00
36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	8, 215, 772 68, 444, 474	1	,		36.00
30. 00	CURRENT LIABILITIES	1 00, 444, 474		,,		30.00
37. 00	Accounts payable	2, 597, 130	(	0	0	37. 00
38. 00	Salaries, wages, and fees payable	2, 898, 187		0	0	38. 00
39. 00	Payroll taxes payable	297, 051	1	0	0	39. 00
40.00	Notes and Loans payable (short term)	12, 963	(	0	0	40.00
41.00	Deferred income Accelerated payments	0		) O	0	41.00
42. 00 43. 00	Due to other funds	27, 266, 449	,		0	42. 00 43. 00
44. 00	Other current liabilities	1, 825, 218	1			
45. 00	Total current liabilities (sum of lines 37 thru 44)	34, 896, 998		O		
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	(	,	0	
47. 00	Notes payable	0	(			
48. 00	Unsecured Loans Other Long term Liabilities	0			0	48. 00 49. 00
49. 00 50. 00	Total long term liabilities (sum of lines 46 thru 49)	0				
51.00	Total liabilities (sum of lines 45 and 50)	34, 896, 998		o o		
	CAPITAL ACCOUNTS					
52.00	General fund balance	33, 547, 476				52. 00
53.00	Specific purpose fund					53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00 57. 00	Governing body created - endowment fund balance			0	_	56.00
57.00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57. 00 58. 00
55. 00	replacement, and expansion					33.00
59. 00	Total fund balances (sum of lines 52 thru 58)	33, 547, 476	(	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	68, 444, 474		0	0	60.00
	[59]					l

ST JOSEPH MEDICAL CENTER

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

					To 05/31/2	2018	Date/Time Prep 10/31/2018 1:0	
		General	Fund	Speci al	Purpose Fund		ndowment Fund	
		1.00	2. 00	3. 00	4. 00		5. 00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)  Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17) Fund balance at end of period per balance	000000000000000000000000000000000000000	2, 314, 499 -8, 767, 023 33, 547, 476 0 33, 547, 476		0 0 0 0 0 0 0 0	0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant					
		Endowment Fund	Prant	Fund				
		6.00	7. 00	8. 00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 0 0 0 0		0 0 0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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

Cost Center Description   Inpatient   Outpatient   Total
PART I - PATIENT REVENUES
PART I - PATIENT REVENUES   Ceneral Inpatient Routine Services   1.00   Hospital   42,864,738   42,864,738   1.00   Hospital   50,800   Hospital   18,728,652   18,728,652   2.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00   18,728,652   3.00
Common
1.00   Hospital
2.00   SUBPROVIDER - IPF   18, 728, 652   2.00   3.00   3.00   3.00   SUBPROVIDER - IRF   3.00   4.00   4.00   5
3. 00   SUBPROVIDER - IRF
5.00   Swing bed - SNF   0   0   0   0   0   0   0   0   0
6. 00
6. 00
7. 00 SKILÉED NURSING FACILITY
8. 00   NURSING FACILITY
10.00   Total general inpatient care services (sum of lines 1-9)   65, 692, 450   65, 692, 450   10.00
Intensive Care Type Inpatient Hospital Services
11. 00   INTENSIVE CARE UNIT   0   11. 00   11
11. 01   NEONATAL INTENSIVE CARE UNIT   2,072,063   11. 01   12. 00   CORONARY CARE UNIT   12. 00   14. 033,621   14. 033,621   14. 033,621   14. 033,621   15. 00   14. 00   SURGICAL INTENSIVE CARE UNIT   14. 00   14. 00   14. 00   15. 00   OTHER SPECIAL CARE (SPECIFY)   16. 00   OTHER SPECIFY)   16. 00   OTHER SPECIFY   O
12.00   CORONARY CARE UNIT   12.00   13.00   BURN INTENSIVE CARE UNIT   14,033,621   14,033,621   13.00   14,033,621   14,033,621   13.00   14,003,621   14,033,621   14,033,621   13.00   14,003,621   14,003,621   14,003,621   15.00   15.00   0
13. 00 BURN INTENSIVE CARE UNIT 14. 00 SURGICAL INTENSIVE CARE UNIT 15. 00 OTHER SPECIAL CARE (SPECIFY) 16. 00 Total intensive care type inpatient hospital services (sum of lines 16, 105, 684 11-15) 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 18. 00 Ancillary services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 19. 00 Qutpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18. 00 19. 00 Qutpatient services 19
14. 00 15. 00 17. 00 18. 00 18. 00 19
15. 00   OTHER SPECIAL CARE (SPECIFY)   16. 00   Total intensive care type inpatient hospital services (sum of lines   16, 105, 684   16, 105, 684   16. 00   16. 00   17. 00   Total inpatient routine care services (sum of lines 10 and 16)   81, 798, 134   17. 00   18. 00   Ancillary services   182, 362, 455   189, 856, 511   372, 218, 966   18. 00   18. 00   18. 00   18. 00   0   0   0   0   0   0   0   0   0
16.00 Total intensive care type inpatient hospital services (sum of lines 11-15) 17.00 Total inpatient routine care services (sum of lines 10 and 16) 18.00 Ancillary services 182, 362, 455 19, 00 Outpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18.00 19.00 Outpatient services 182, 362, 455 189, 856, 511 372, 218, 966 18.00 19.00 Outpatient services 19, 100 Outpatient services 19, 100 Outpatient services 1125, 292 120 Outpatient services 120 Outp
17.00   Total inpatient routine care services (sum of lines 10 and 16)   81,798,134   17.00   18.00   Ancillary services   182,362,455   189,856,511   372,218,966   18.00   19.00   Outpatient services   9,125,292   42,063,007   51,188,299   19.00   20.00   RURAL HEALTH CLINIC   0   0   0   0   0   20.00   21.00   EDERALLY QUALIFIED HEALTH CENTER   0   0   0   21.00   22.00   AMBULANCE SERVICES   23.00   CMHC   24.00   25.00   AMBULATORY SURGICAL CENTER (D.P.)   25.00   AMBULATORY SURGICAL CENTER (D.P.)   0   0   0   0   27.00   28.00   Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.   273,285,881   231,919,518   505,205,399   28.00   ROUNDING   7   91,920,798   29.00   30.00   ROUNDING   7   30.00   3
17. 00
18. 00   Ancillary services   182, 362, 455   189, 856, 511   372, 218, 966   18. 00   19. 00   Outpatient services   9, 125, 292   42, 063, 007   51, 188, 299   19. 00   20. 00   RURAL HEALTH CLINIC   0   0   0   0   0   0   20. 00   21. 00   22. 00   23. 00   AUBULANCE SERVICES   24. 00   24. 00   25. 00   26. 00   26. 00   27. 00
19.00 Outpati ent services 9, 125, 292 42, 063, 007 51, 188, 299 19.00 20.00 RURAL HEALTH CLINIC 0 0 0 0 0 20.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 24.00 CMHC 25.00 AMBULATORY SURGICAL CENTER (D.P.) 25.00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 27.00 27.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 273, 285, 881 231, 919, 518 505, 205, 399 28.00 GO ROUNDING 91, 920, 798 29.00 30.00 ROUNDING 91, 920, 798 29.00 30.00
20. 00 RURAL HEALTH CLINIC 0 0 0 0 0 20. 00 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21. 00 22. 00 HOME HEALTH AGENCY 22. 00 23. 00 AMBULANCE SERVICES 23. 00 24. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 25. 00 26. 00 HOSPICE 26. 00 27. 00 OTHER (SPECIFY) 0 0 0 0 0 27. 00 28. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 273, 285, 881 231, 919, 518 505, 205, 399 28. 00 29. 00 ROUNDING 91, 920, 798 29. 00 30. 00 ROUNDING 7 91, 920, 798 29. 00
21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21. 00 22. 00 23. 00 HOME HEALTH AGENCY 22. 00 23. 00 AMBULANCE SERVICES 23. 00 24. 00 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 25. 00 HOSPICE 27. 00 OTHER (SPECIFY) 0 0 0 0 0 27. 00 27. 00 27. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 273, 285, 881 231, 919, 518 505, 205, 399 28. 00 29. 00 ROUNDING 91, 920, 798 29. 00 30. 00 ROUNDING 91, 920, 798 29. 00 30. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20
23. 00 24. 00 25. 00 AMBULANCE SERVICES CMHC 25. 00 AMBULATORY SURGICAL CENTER (D. P.) HOSPICE 0THER (SPECIFY) Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 273, 285, 881 231, 919, 518 505, 205, 399 28. 00 G-3, line 1) PART II - OPERATING EXPENSES  29. 00 ROUNDING 29. 00 ROUNDING 29. 00 30. 00 29. 00 30. 00 29. 00 29. 00 29. 00 29. 00 30. 00
24. 00 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 26. 00 10 O O O O O O O O O O O O O O O O O O O
25. 00 AMBULATORY SURGICAL CENTER (D. P.)  HOSPICE  OTHER (SPECIFY)  Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.  PART II - OPERATING EXPENSES  Operating expenses (per Wkst. A, column 3, line 200)  ROUNDING  AMBULATORY SURGICAL CENTER (D. P.)  0 0 0 0 0 0 27. 00  273, 285, 881 231, 919, 518 505, 205, 399  28. 00  91, 920, 798  29. 00  30. 00
26. 00
27. 00   OTHER (SPECIFY)   O   O   O   O   O   O   O   O   O
28. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 273, 285, 881 231, 919, 518 505, 205, 399 28. 00
G-3, line 1) PART II - OPERATING EXPENSES  29.00 Operating expenses (per Wkst. A, column 3, line 200) 30.00 ROUNDING  91,920,798 29.00 30.00
PART II - OPERATING EXPENSES  29.00 Operating expenses (per Wkst. A, column 3, line 200) 91,920,798 29.00 30.00 ROUNDING 7 30.00
29.00 Operating expenses (per Wkst. A, column 3, line 200) 91,920,798 29.00 30.00 ROUNDING 7
30. 00 ROUNDI NG 7 30. 00
31.00
32.00
33.00
34.00
35.00
36.00 Total additions (sum of lines 30-35) 7 36.00
37. 00   DEDUCT (SPECI FY) 0   37. 00
38.00
39.00
40.00
41.00
42.00 Total deductions (sum of lines 37-41)
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 91,920,805 43.00
to Wkst. G-3, line 4)

Heal th	Financial Systems ST JOSEPH ME	DI CAL CENTER	In Lie	eu of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0047	Peri od:	Worksheet G-3	
			From 06/01/2017		
			To 05/31/2018	Date/Time Prep 10/31/2018 1:0	
	·			10/31/2016 1.	U9 pili
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		505, 205, 399	1. 00
2.00	Less contractual allowances and discounts on patients' acc			422, 161, 457	
3.00	Net patient revenues (line 1 minus line 2)			83, 043, 942	1
4.00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		91, 920, 805	
5. 00	Net income from service to patients (line 3 minus line 4)			-8, 876, 863	
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communicat	ion 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 guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to othe	r than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER (SPECIFY)			109, 840	24. 00
25.00	Total other income (sum of lines 6-24)			109, 840	25. 00
26.00	Total (line 5 plus line 25)			-8, 767, 023	26. 00
27 00	OTHER EXPENSES (SDECLEV)				27 00

0 27.00

-8, 767, 023 | 29. 00

28.00

27. 00 OTHER EXPENSES (SPECIFY)

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

	Financial Systems ST JOSEPH MED			u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0047	Peri od: From 06/01/2017 To 05/31/2018	Worksheet L Parts I-III Date/Time Pre 10/31/2018 1:	
	PPS				
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			568, 974	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			80, 441	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost	reporting period (see inst	tructions)	54. 14	3.00
4. 00 5. 00	Number of interns & residents (see instructions) Indirect medical education percentage (see instructions)			3. 81 2. 01	4. 00 5. 00
6. 00	Indirect medical education adjustment (multiply line 5 by 1	the sum of lines 1 and 1 0	L columns 1 and	11, 436	1
0.00	1.01) (see instructions)	the sam of fiftes f and f. o	i, cordiniis r and	11, 430	0.00
7. 00					7. 00
8.00					8. 00
9.00					9. 00
10.00	3 (				10.00
11.00					11.00
12. 00	Total prospective capital payments (see instructions)			731, 404	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions)	)		0	2. 00
3.00				0	3. 00
4.00	1.1 1.3			0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1 4 00
1.00	Program inpatient capital costs (see instructions)	anaca (aca i notrusti ana)		0	1.00
2. 00 3. 00	Program inpatient capital costs for extraordinary circumstances (see instructions)				2. 00 3. 00
4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)				
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see	instructions)		0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordina	ary circumstances (line 2 )	(line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9. 00	Current year capital payments (from Part I, line 12, as app			0	9. 00
10.00				0	10.00
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11. 00
12. 00	Net comparison of capital minimum payment level to capital	payments (line 10 plus lin	ne 11)	0	12. 00
13. 00				0	13. 00
14. 00	Carryover of accumulated capital minimum payment level over			0	14. 00
	(if line 12 is negative, enter the amount on this line)		- '		
15. 00				0	15. 00
	Current year operating and capital costs (see instructions)	)		0	16. 00 17. 00
17 00	0   Current year exception offset amount (see instructions)   0   17				