Heal th Financi	al Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
This report is	s required by law (42	USC 1395g: 42 CFR 413.20(b)). Fai f the cost reporting period being			FORM APPROVED OMB NO. 0938-0050 EXPI RES 03-31-2022
HOSPITAL AND F AND SETTLEMENT		OMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-00	From 06/01/2019	Worksheet S Parts I-III Date/Time Prepared: 11/2/2020 12:13 pm
PART I - COST	REPORT STATUS				
Provi der use onl y	1. [X] Electronicall 2. [] Manually prep	y prepared cost report pared cost report		Date: 11/2/20	20 Time: 12:13 pm
	3.[0]If this is an 4.[F]Medicare Util	n amended report enter the number ization. Enter "F" for full or "L	of times the provide " for low.	er resubmitted this co	ost report
Contractor use only	5. [1]Cost Report S (1) As Submitted (2) Settled withou (3) Settled with A (4) Reopened (5) Amended	7. Contractor No. It Audit 8. [N] Initial Report fo	or this Provider CCN	10. NPR Date: 11. Contractor's Vendo 12. [0]If line 5, cc number of tim	or Code: 4 olumn 1 is 4: Enter nes reopened = 0-9.
PART II - CERT	LI FI CATI ON				
ADMI NI STRATI VE PROVI DED OR PE	E ACTION, FINE AND/OR ROCURED THROUGH THE PA	OF ANY INFORMATION CONTAINED IN T IMPRISONMENT UNDER FEDERAL LAW. YMENT DIRECTLY OR INDIRECTLY OF A IMPRISONMENT MAY RESULT.	FURTHERMORE, IF SERV	ICES IDENTIFIED IN TH	IS REPORT WERE
CERTI	FICATION BY CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR OF	PROVI DER(S)		
el ect Expens endi ny comple excep heal ti	ronically filed or man ses prepared by ST JOS g 05/31/2020 and to th ete and prepared from t as noted. I further	re read the above certification st mully submitted cost report and t EPH MEDICAL CENTER (15-0047) for the bost of my knowledge and belief the books and records of the prove- certify that I am familiar with that the services identified in the	the Balance Sheet and or the cost reporting , this report and st vider in accordance w the laws and regulat	I Statement of Revenue period beginning O6, atement are true, con with applicable instru- ions regarding the pu	e and /01/2019 and rrect, uctions, rovision of

[]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)

Title

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	149, 235		0	0	1.00
2.00	Subprovider - IPF	0	3, 548	-609		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-12		7	7.00
200.00	Total	0	152, 783	-61, 230	0	7	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-MEDI CARE.

- 1 1	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DAT	TA I	Provi der	CCN: 15	5-0047	Period: From 06/01	/2010	Worksh Part I	eet S-2	2
							To 05/31.	/2020	Date/T	ime Pre	
	1.00	2	00	3. (00			4.00	11/2/2	020 12:	:13 p
	Hospital and Hospital Health Care Co	omplex Address:									
	Street: 700 BROADWAY STREET	PO Box:									1.
)	City: FORT WAYNE	State: I Component Na		p Code: 4	6802 CBSA	Provi der	ty: ALLEN r Date	Payme	ent Sys	tom (P	2.
					umber	Туре	Certified		, 0, or		
								V	XVIII	-	
	Hospital and Hospital-Based Componen	1.00		2.00 3	3.00	4.00	5.00	6.00	7.00	8.00	-
	Hospi tal	ST JOSEPH MEDICAL		0047 2	3060	1	07/01/1996	N	Р	P	3.
		CENTER								_	
	Subprovider - IPF Subprovider - IRF	ST JOSPEH GENERAT	ITONS 15	SO47 2	3060	4	06/01/2003	B N	P	P	4.
	Subprovi der - (Other)										6.
	Swing Beds - SNF										7.
	Swing Beds - NF Hospital-Based SNF	SKILLED NURSING	15	5356 2	3060		04/01/1990) N	P	P	8.
,		FACILITY ST JOSEF		200000	3000		04/01/1990				9.
	Hospital-Based NF										10.
	Hospi tal -Based OLTC Hospi tal -Based HHA										11.
	Separately Certified ASC										13.
00	Hospi tal -Based Hospi ce										14.
	Hospital-Based Health Clinic - RHC										15.
	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16.
	Renal Dialysis										18
0	Other							<u> </u>			19
							From 1.00			00	-
	Cost Reporting Period (mm/dd/yyyy)						06/01/2			/2020	20
00	Type of Control (see instructions)						4				21.
						1.00	2.00	,	3	00	-
	Inpatient PPS Information										
00	Does this facility qualify and is it disproportionate share hospital adju					Y	N				22.
	IN SULUUULLUURIE SDALE DOSDITAL AOLU		anco with	12 CED							
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	Financial Systems ST JOSE AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	EPH MEDICAL	Provider CC	N: 15-0047	Peri od:		Worksh	eet S-2	2552- 2
						01/2019 31/2020	11/2/2	ime Pre 020 12:	
		In-State Medicaid paid days	ln-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medica HMO da	ys Me)ther di cai d days	
			days		unpai d				
. 00	If this provider is an IRF, enter the in-state	1.00 0	2.00 0	3.00	4.00	5.00	0	6.00	25.
	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.								
						Rural S 00		r Geogr 00	
. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		at the beg	jinning of t	he	1			26.
. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status - "2" for r	ural. If ap		st	1			27.
. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status ir	1	0			35.
						nni ng: 00	Endi 2.	i ng: 00	-
. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb			۷.		36
00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ls MDH statu	IS	0			37
01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								37
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38
						/N 00		/N 00	-
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), or the mileage	(iii)? Ent requiremen	er in colum nts in	ime in	N		N	39.
00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r"Y" for y			N	1	N	40
					·	V 1.00	XVIII 2.00	XI X 3.00	-
00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	t for dian	roporti opot	o chara in	accordance		N	N	45
00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	eption for	extraordi na	ary circumst	ances	N	N	N	40
00 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment	•		2		N	N N	N N	47
00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i	mpacted by	CR 11642 (Y		56
00	GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes did this facility clost rest reith	period duri yes or "N th of this (", complet , if appli	ng which re "for noir cost report e Worksheet cable.	n column 1. ing period? E-4. If co	lf column ? Enter "Y olumn 2 is	/""			57
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		es as	N			58
00	Are costs claimed on line 100 of Worksheet A? If yes	s, complete	Wkst. D-2,	Pt. I. NAHE 413.8 Y/N		heet A ne #	Qualifi	hrough ication on Code	
				1.00	2	00		00	-
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C	85? (see umn 1. If	column 1	N	2.	00	3.	00	60.

IOSPI ⁻	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider C		eriod: rom 06/01/2019 o 05/31/2020	Worksheet S-2 Part I Date/Time Pre 11/2/2020 12:	pared
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N			0.00		61.0
1. 02							61.0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1. 04							61.0
	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)						61.0
1. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.(
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	1
	Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE 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		61. 1
						1.00	1
	ACA Provisions Affecting the Health Resources and Ser						
2.00 2.01	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teachi gram. (s	ng Health Cen ee instructio	ter (THC) into			62. (62. (
3. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this c		<u>ictions)</u>	N	63. (
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onnrovid	ler Settings	1.00 This base year	2.00	3.00	
4.00	period that begins on or after July 1, 2009 and befor	re June ty train a-primar all non d non-pr n column	30, 2010. ed residents y care provider imary care 3 the ratio	0. 00	-		64.

	EX IDENTIFICATION DA		Fr	eriod: com 06/01/2019			
			To	05/31/2020	Date/Ti 11/2/20	me Prep 20 12·1	ared
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (c	ol. 3/	0 p.
			FTEs	FTEs in	(col. 3		
			Nonprovi der Si te	Hospi tal	4))	'	
	1.00	2.00	3.00	4.00	5.0	0	
.00 Enter in column 1, if line 63			0.00	0.00	0.	000000	65.
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3							
divided by (column 3 + column							
4)). (see instructions)			Unweighted	Unweighted	Ratio (c	ol. 1/	
			FTEs	FTEs in	(col . 1		
			Nonprovi der	Hospi tal	2))	·	
			Si te 1.00	2.00	2.0		
Section 5504 of the ACA Current	Year FTF Residents i	n Nonnrovider Settir			<u> </u>		
beginning on or after July 1, 20' 00 Enter in column 1 the number of u	10	•				uo	
FTEs that trained in your hospita (column 1 divided by (column 1 +							
	Program Name	structions) Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (c (col. 3 4))	+ col .	
00 Enter in column 1, the program			FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col . 3 4)) 5.0	+ col .	67.
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	Program Name	Program Code	FTĔs Nonprovider Site	FTES in Hospital	(col . 3 4)) 5.0	+ col.	67.
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3	Program Name	Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospi tal 4.00 0.00	(col . 3 4)) 5.0 0 0	+ col . 0 000000	67.
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	Program Name 1.00 PS	Program Code	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00	(col . 3 4)) 5.0 0 0 2 0 2.00	+ col .	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	Program Name 1.00 PS ychiatric Facility (Program Code	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00	(col . 3 4)) 5.0 0 0 2 0 2.00	+ col . 0 000000	
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	Program Name 1.00 1.00 PS ychiatric Facility (the facility have a afore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	FTES in Hospital 4.00 0.00 1.0 rovider? Y he most o. (see ing o.	(col. 3 4)) 5.0 0 0 2.00	+ col . 0 000000	70.
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	Program Name 1.00 1.00 PS ychiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y y PPS nabilitation Facilit	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTËs Nonprovi der Si te 3.00 0.00 intain an IPF subp sing program in t yes or "N" for n s in a new teach yes or "N" for n	FTES in Hospital 4.00 0.00 1.0 rovider? Y he most o. (see ing o.	(col . 3 4)) 5.0 0 0 2.00	+ col . 0 0000000 3.00	67. (70. (71. (75. (

Health Financial Systems ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS	8-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0047	Period: From 06/01/2019	Worksheet S Part I	-2
			To 05/31/2020	Date/Time P	repared:
				11/2/2020 1	
Long Term Care Hospital PPS				1.00	
 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no. 			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)	TEERA? Ente	er "Y" for ves	or "N" for no	N	85.00
86.00 Did this facility establish a new Other subprovider (exclude					86.00
<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospita 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>	al classified	under sectior	I	N	87.00
			V	XI X	
Title V and VIX Services			1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospita	al services? E	Enter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column.				N N	01.00
91.00 Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl			N	Y	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du	ual certificat			N	92.00
instructions) Enter "Y" for yes or "N" for no in the applica 93.00 Does this facility operate an ICF/IID facility for purposes		nd XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in the applicable column.					
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for r	no in the	N	N	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the app			0.00	0.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	s or "N" for r	no in the	N	N	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app			0.00	0.00	97.00
98.00 Does title V or XIX follow Medicare (title XVIII) for the ir stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f			Y	Y	98.00
column 1 for title V, and in column 2 for title XIX.	5				
98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti				Y	98.01
title XIX.					
98.02 Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes c			Y	Y	98.02
for title V, and in column 2 for title XIX.					
98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye				N	98.03
for title V, and in column 2 for title XIX.					
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no ir			N I	N	98.04
in column 2 for title XIX.					0.0.05
98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Y	98.05
column 2 for title XIX.				N N	00.0(
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column			Y	Y	98.06
column 2 for title XIX.					_
Rural Providers 105.00 Does this hospital qualify as a CAH?			N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive met	hod of paymer	it		106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for co					107.00
training programs? Enter "Y" for yes or "N" for no in columr Column 2: If column 1 is Y and line 70 or line 75 is Y, do					
approved medical education program in the CAH's excluded IF	PF and/or IRF				
Enter "Y" for yes or "N" for no in column 2. (see instructi 108.00 Is this a rural hospital qualifying for an exception to the		dulo? Soo 47	N N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					_
	Physi cal 1.00	Occupationa 2.00	Il Speech 3.00	Respiratory 4.00	<u>/</u>
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00	2.00	3.00	4.00	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
		1			
	al Demonstrati	on project (s	4104	1.00 N	110.00
Demonstration) for the current cost reporting period? Enter "	'Y" for yes or	"N" for no.	lf yes,		110.00
complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	-ksheet E-2, I	ines 200 thro	ough 215, as		
				I	1

Health Financial Systems ST JOSEPH MEDICAL CENT			eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi	der CCN: 15-0047	Period: From 06/01/2019		
		To 05/31/2020	Date/Time Pr 11/2/2020 12	repared: 2:13 pm
		1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in the Front Health Integration Project (FCHIP) demonstration for this cost repor "Y" for yes or "N" for no in column 1. If the response to column 1 i integration prong of the FCHIP demo in which this CAH is participati Enter all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	ting period? Enter s Y, enter the ng in column 2.	r N		111.00
	1.00	2.00	3.00	_
112. 00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", en in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information				112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for in column 1. If column 1 is yes, enter the method used (A, B, or E o in column 2. If column 2 is "E", enter in column 3 either "93" perce for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based the definition in CMS Pub. 15-1, chapter 22, \$2208.1.	nl y) nt			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes	or N			116.00
"N" for no. 117.00 s this facility legally-required to carry malpractice insurance? En	ter N			117.00
"Y" for yes or "N" for no. 118.00 is the malpractice insurance a claims-made or occurrence policy? Ent	er 1	1		118.00
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
	1.00	2.00	3.00	_
118.01 List amounts of malpractice premiums and paid losses:	233, (207, 774	1	0 118. 01
		1.00	2.00	
118.02 Are malpractice premiums and paid losses reported in a cost center of Administrative and General? If yes, submit supporting schedule list and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column "N" for no. Is this a rural hospital with < 100 beds that qualifies Hold Harmless provision in ACA §3121 and applicable amendments? (see	ing cost centers s provision in AC/ 1, "Y" for yes or for the Outpatien		Ν	118. 02 119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost implantable d	evices charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", the Worksheet A line number where these taxes are included.				122. 00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for yes an	d "N" for no lf	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter the				126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 f this is a Medicare certified heart transplant center, enter the c				127.00
in column 1 and termination date, if applicable, in column 2. 128.00 f this is a Medicare certified liver transplant center, enter the c				128.00
in column 1 and termination date, if applicable, in column 2. 129.00 f this is a Medicare certified lung transplant center, enter the ce				129.00
column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare certified pancreas transplant center, enter th				130.00
date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter				131.00
date in column 1 and termination date, if applicable, in column 2. 132.00 f this is a Medicare certified islet transplant center, enter the c				132.00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter the OPO nu and termination date, if applicable, in column 2.				133. 00 134. 00
All Providers All Providers 140.00 Are there any related organization or home office costs as defined i chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and		Y S	HB1848	140. 00

	X IDENTIFICATION DATA	EDICAL CENTER Provider C(CN: 15-0047			u of Form CMS- Worksheet S- Part I Date/Time Pro 11/2/2020 12	2 epared:
1.00		2. 00			3.00		
If this facility is part of a chai				name an	d address	of the	
home office and enter the home off				star's N	mbors. 1020	1	141 0
41.00 Name: COMMUNITY HEALTH SYSTEMS 42.00 Street: 4000 MERIDIAN BLVD	Contractor's Name: PO Box:	WPS, TNC.	Contrac	CTOF S NU	umber: 1030)	141.00
43.00 City: FRANKLIN		TN	Zip Cod	do.	3706	7	142.00
43. 00 city. TRANCEIN	jstate.			JC.	3700		145.00
						1.00	-
44.00 Are provider based physicians' cos	sts included in Workshee	t A?				Y	144.00
					1.00	2.00	
45.00 If costs for renal services are cl					Y		145.0
inpatient services only? Enter "Y" no, does the dialysis facility inc							
period? Enter "Y" for yes or "N"	for no in column 2	UN TOT LINS COST	reporting				
46.00 Has the cost allocation methodolog		iously filed cos	t report?		Ν		146.0
Enter "Y" for yes or "N" for no ir				lf			110.0
yes, enter the approval date (mm/c							
						1.00	
47.00Was there a change in the statisti						N	147.0
48.00 Was there a change in the order of						N	148.0
49.00Was there a change to the simplifi	eu cost finding method?	Enter "Y" for ye Part A			itle V	N Title XIX	149.0
		1, 00	Part B 2.00		3.00	4.00	-
Does this facility contain a provi	der that qualifies for			cation o			
or charges? Enter "Y" for yes or '							
55. 00 Hospi tal		N	N N		N	N N	155. 0
56.00 Subprovider - IPF		N	N		Ν	N	156. C
57.00 Subprovi der – IRF		N	N		Ν	N	157.0
58. 00 SUBPROVI DER							158.0
59. 00 SNF		N	N		N	N	159.0
60. 00 HOME HEALTH AGENCY		N	N		N	N	160. 0
61.00 CMHC			N		N	N	161.0
						1.00	-
Multicampus						1.00	-
65.00 s this hospital part of a Multica	ampus hospital that has /	one or more camp	uses in dif	ferent C	BSAs?	N	165. 0
Enter "Y" for yes or "N" for no.							
	Name	County	State 2	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each						0.0	0 166. 0
campus enter the name in column							
0, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in					1		
CBSA in column 4, FTE/Campus in						1.00	
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI				ent Act			
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user	under §1886(n)? Enter	"Y" for yes or '	'N" for no.			1.00 Y	
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	r under §1886(n)? Enter D5 is "Y") and is a mean	"Y" for yes or ' ingful user (line	'N" for no.		- the		
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	r under §1886(n)? Enter D5 is "Y") and is a mean HT assets (see instructi	"Y" for yes or ' ingful user (line ions)	'N" for no. e 167 is "Y	"), entei			168. 0
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r	under §1886(n)? Enter D5 is "Y") and is a mean HT assets (see instruction not a meaningful user, do	"Y" for yes or ' ingful user (line ions) oes this provide	'N" for no. e 167 is "Y r qualify fo	"), enter or a hard			168. C
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 58.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?	under §1886(n)? Enter D5 is "Y") and is a mean HT assets (see instruction not a meaningful user, do P Enter "Y" for yes or "I	"Y" for yes or ' ingful user (lind ions) oes this provide N" for no. (see i	'N" for no. e 167 is "Y r qualify fo nstructions	"), enter or a harc s)	dshi p	Y	168. C
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 58.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?	under §1886(n)? Enter 55 is "Y") and is a mean HT assets (see instructi not a meaningful user, da ? Enter "Y" for yes or " user (line 167 is "Y") an	"Y" for yes or ' ingful user (lind ions) oes this provide N" for no. (see i	'N" for no. e 167 is "Y r qualify fo nstructions	"), enter or a harc s)	dshi p	Y	168. C
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 58.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) ? 59.00 If this provider is a meaningful u	under §1886(n)? Enter 55 is "Y") and is a mean HT assets (see instructi not a meaningful user, da ? Enter "Y" for yes or " user (line 167 is "Y") an	"Y" for yes or ' ingful user (lind ions) oes this provide N" for no. (see i	'N" for no. e 167 is "Y r qualify fo nstructions	"), enten or a harc s) s "N"), e	dshi p	Y	168. 0 168. 0
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii)? 69.00 If this provider is a meaningful u transition factor. (see instruction	r under §1886(n)? Enter D5 is "Y") and is a mean HT assets (see instruct not a meaningful user, de P Enter "Y" for yes or "H user (line 167 is "Y") an ons)	"Y" for yes or ' ingful user (lind ions) oes this provide N" for no. (see i nd is not a CAH	'N" for no. e 167 is "Y n qualify fo nstruction: (line 105 is	"), enten or a harc s) s "N"), e	dship enter the	Y 9.9	168. 0 168. 0
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) ? 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR t	r under §1886(n)? Enter D5 is "Y") and is a mean HT assets (see instruct not a meaningful user, de P Enter "Y" for yes or "H user (line 167 is "Y") an ons)	"Y" for yes or ' ingful user (lind ions) oes this provide N" for no. (see i nd is not a CAH	'N" for no. e 167 is "Y n qualify fo nstruction: (line 105 is	"), enten or a harc s) s "N"), e	dship enter the ginning	Y 9. 9 Endi ng	167. 0 168. 0 168. 0 99169. 0 170. 0
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under \$413.70(a) (6) (ii)? 69.00 If this provider is a meaningful u transition factor. (see instruction	r under §1886(n)? Enter D5 is "Y") and is a mean HT assets (see instruct not a meaningful user, de P Enter "Y" for yes or "H user (line 167 is "Y") an ons)	"Y" for yes or ' ingful user (lind ions) oes this provide N" for no. (see i nd is not a CAH	'N" for no. e 167 is "Y n qualify fo nstruction: (line 105 is	"), enten or a harc s) s "N"), e	dship enter the ginning	Y 9. 9 Endi ng	168. 0 168. 0 99169. 0
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) ? 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR t	r under §1886(n)? Enter D5 is "Y") and is a mean HT assets (see instruct not a meaningful user, de P Enter "Y" for yes or "H user (line 167 is "Y") an ons)	"Y" for yes or ' ingful user (lind ions) oes this provide N" for no. (see i nd is not a CAH	'N" for no. e 167 is "Y n qualify fo nstruction: (line 105 is	"), enten or a harc s) s "N"), e	dship enter the eginning 1.00	Y 9.9 Endi ng 2.00	168. C 168. C 99169. C
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) (5 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR th period respectively (mm/dd/yyyy)	r under §1886(n)? Enter 5 is "Y") and is a meani HIT assets (see instructin not a meaningful user, da ? Enter "Y" for yes or "I user (line 167 is "Y") and paginning date and ending	"Y" for yes or ' ingful user (lind ions) oes this providen N" for no. (see i nd is not a CAH g date for the re	'N" for no. e 167 is "Y r qualify fo nstruction (line 105 is eporting	"), enten or a harc s) s "N"), e	dship enter the eginning 1.00	Y 9.9 Endi ng 2.00 2.00	168. C 168. C 99169. C
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii) 2 (f this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR th period respectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this provi	r under §1886(n)? Enter 15 is "Y") and is a meaning 11 assets (see instruction 12 ameaningful user, do 2 Enter "Y" for yes or "I 13 user (line 167 is "Y") and 14 ons) 15 ons) 16 ons 17 ons 18 ons 19 ons 19 ons 10 ons	"Y" for yes or ' ingful user (lind ions) oes this provide N" for no. (see i nd is not a CAH g date for the ro individuals enrol	'N" for no. e 167 is "Y' r qualify fo nstruction: (line 105 i: eporting led in	"), enter or a harc s) s "N"), e Be	dship enter the eginning 1.00	Y 9.9 Endi ng 2.00 2.00	168. C 168. C 99169. C
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 70.00 Is this provider a meaningful user 88.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 88.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii) 99.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR to period respectively (mm/dd/yyyy)	r under §1886(n)? Enter 15 is "Y") and is a meaning 11 assets (see instruction 12 a meaningful user, do 2 Enter "Y" for yes or "I user (line 167 is "Y") and peginning date and ending 2 peginning date and ending 2 fider have any days for in 2 reported on Wkst. S-3, P	"Y" for yes or ' ingful user (lind ions) oes this provide N" for no. (see i nd is not a CAH g date for the ro individuals enrol t. I, line 2, col	'N" for no. e 167 is "Y' n qualify fo nstructions (line 105 is eporting led in . 6? Enter	"), enter or a hard s) s "N"), (Be	dship enter the eginning 1.00	Y 9.9 Endi ng 2.00 2.00	168. (168. (99169. (

OSPI T	Financial Systems ST JOSEPH MED AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	I CAL CENTER Provi der	CCN: 15-0047	Peri od:	u of Form CM Worksheet S	
				From 06/01/2019 To 05/31/2020		repared
	· · · ·			Y/N	<u>11/2/2020 1</u> Date	2:13 pm
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO	responses. Ent	er all dates in t	he	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N		1.
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare P	magnam2 If	1.00 N	2.00	3.00	2.
00	yes, enter in column 2 the date of termination and in column voluntary or "1" for involuntary.					2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe	iffices, drug ler or its if the board				3.
	relationships? (see instructions)		× /N	Turna	Data	
			Y/N 1.00	Туре 2.00	Date 3.00	
	Financial Data and Reports		1.00	2.00	3.00	
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	: N			4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
				Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lf ves is	the provider i	s N		6.
00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	5		N		7.
00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		0	N		8. 9.
00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	S.		N		10.
I. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an A	pproved	N		11.
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 13.
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived?	lfyes, see in	structions.	Ν	14.
. 00	Did total beds available change from the prior cost reporti	<u>v</u> i	fyes, see ins Part A	Par	Y t B	15.
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	10/19/2020) Y	10/19/2020	16.
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		Ν		18.
9. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		N		19.

Health Financial Systems

ST JOSEPH MEDICAL CENTER

In Lieu of Form CMS-2552-10

Health Financial Systems ST JOSEPH MEE	DI CAL CENTER		In Lie	u of Form CM	S-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 06/01/2019 To 05/31/2020			
				11/2/2020 1		
	Descri	ption	Y/N	Y/N		
	()	1.00	3.00		
20.00 f line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	Y/N	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		Ν		21.00	
				1.00		
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)				
Capital Related Cost						
22.00 Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.00	
23.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made duri	ng the cost	Ν	23.00	
	Were new leases and/or amendments to existing leases entered into during this cost reporting period?					
25.00 Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	lf yes, see	Ν	25.00	
 26. 00 Were assets subject to Sec. 2314 of DEFRA acquired during the instructions. 	ne cost reporti	ng period? If	yes, see	Ν	26.00	
27.00 Has the provider's capitalization policy changed during the	e cost reportin	g period? If	yes, submit	Ν	27.00	
copy. Interest Expense						
28.00 Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	ntered into dur	ing the cost	reporti ng	N	28.00	
29.00 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		bt Service Re	serve Fund)	Ν	29.00	
30.00 Has existing debt been replaced prior to its scheduled matu		debt? If yes,	see	Ν	30.00	
31.00 Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see	N	31.00	
instructions. Purchased Services					_	
32.00 Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through con	tractual	Ν	32.00	
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competit	ive bidding? If	Ν	33.00	
Provi der-Based Physi ci ans						
34.00 Are services furnished at the provider facility under an ar	rrangement with	provi der-bas	ed physi ci ans?	N	34.00	
If yes, see instructions.	0		1 3			
35.00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the p	rovi der-based	Ν	35.00	
			Y/N	Date		
			1.00	2.00		
Home Office Costs						
36.00 Were home office costs claimed on the cost report?37.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Y Y		36.00 37.00	
If yes, see instructions.38.00If line 36 is yes , was the fiscal year end of the home off			Y	12/31/2019	38.00	
the provider? If yes, enter in column 2 the fiscal year end 39.00 If line 36 is yes, did the provider render services to othe	d of the home o	ffi ce.	Ν		39.00	
see instructions. 40.00 If line 36 is yes, did the provider render services to the		-	Ν		40.00	
instructions.						
	1.	00	2.	00		
Cost Report Preparer Contact Information41.00Enter the first name, last name and the title/position	VI CTORI A		ROMANKO		41.00	
held by the cost report preparer in columns 1, 2, and 3, respectively.						
42.00 Enter the employer/company name of the cost report preparer.	COMMUNITY HEAL	TH SYSTEMS			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	KO@CHS. NET	43.00	

Heal th	Financial Systems ST JOSEPH ME	DICAL CENTER	In Lie	In Lieu of Form CMS-2552-10			
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0047	Period: From 06/01/2019	Worksheet S-2 Part II			
			To 05/31/2020		pared: <u>13 pm</u>		
		3.00					
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	MANGER, REVENUE MANAGEMENT			41.00		
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report				42.00		
	preparer.						
43.00	Enter the telephone number and email address of the cost				43.00		
	report preparer in columns 1 and 2, respectively.						

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	ST JOSEPH MEDI	Provider CC	CN: 15-0047	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 06/01/2019 To 05/31/2020	Part I	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	76	27, 8	16 0. 00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		76	27, 8	16 0.00	0 0 0	5.00 6.00 7.00
8. 00 9. 00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT						8. 00 9. 00
10.00 11.00 12.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	33.00	0	4, 32	0.00	0	10.00 11.00 12.00
13.00 14.00 15.00	NURSERY Total (see instructions) CAH visits		76	32, 13	36 0.00	0	13.00 14.00 15.00
16.00 17.00 18.00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER	40. 00	0	5, 7 ⁻	19	0	16.00 17.00 18.00
19.00 20.00 21.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	44.00	0	6, 30	50	0	19.00 20.00 21.00
22.00 23.00 24.00	HOME HEALTH AGENCY AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE						22.00 23.00 24.00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30. 00					24. 10 25. 00 26. 00
26. 25 27. 00 28. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	89.00	76			0	26.25 27.00 28.00
29.00 30.00 31.00 32.00	Ambulance Trips Employee discount days (see instruction) Employee discount days – IRF Labor & delivery days (see instructions)		0		0		29.00 30.00 31.00 32.00
32. 01 33. 00	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days						32. 01 33. 00
33. 01	LTCH site neutral days and discharges						33.0

IOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 06/01/2019 To 05/31/2020		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	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	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	2, 247	2, 052	12, 01	8		1.00
. 00	HMO and other (see instructions)	2, 421	4, 110				2.00
. 00	HMO IPF Subprovider	1, 372	0				3.00
. 00	HMO IRF Subprovider	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 247	2, 052	12, 01	8		7.00
. 00	INTENSIVE CARE UNIT						8.00
. 00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT	620	149	97	6		10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY						13.00
4.00	Total (see instructions)	2, 867	2, 201	12, 99	4 0.42	358.03	
5.00	CAH visits	0	0		0		15.00
6.00	SUBPROVIDER - IPF	1, 972	130	3, 85	9 0.00	19.60	
7.00	SUBPROVIDER - IRF						17.00
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY	1, 196	63	4, 32	1 0.00	13.55	
0. 00	NURSING FACILITY						20.0
1. 00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPICE						24.0
4. 10	HOSPICE (non-distinct part)			1	7		24.1
5.00	CMHC - CMHC						25.0
6. 00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)				0.42	391.18	27.0
8.00	Observation Bed Days		0	1, 25	8		28.0
9.00	Ambul ance Trips	0					29.0
0.00	Employee discount days (see instruction)			6	5		30.0
1. 00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	О	0		0		32.0
2. 01	Total ancillary labor & delivery room				0		32.0
	outpatient days (see instructions)						
3.00	LTCH non-covered days	О					33.00
3 01	LTCH site neutral days and discharges	0					33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0047	Period: From 06/01/2019 To 05/31/2020		pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII		Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider		0		49 1, 357 36 0 0 0	3, 305	1.00 2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8.00 9.00 10.00 11.00 12.00
14.00 15.00	Total (see instructions) CAH visits	0.00	0	54	49 1, 357	3, 305	
16. 00 17. 00 18. 00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER	0.00	0	10	63 28	321	16.00 17.00 18.00
19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0. 00					19.00 20.00 21.00 22.00 23.00 24.00 24.00 24.10 25.00
25.00 26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00					23. 00 26. 21 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 00
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		33. 00 33. 0 [.]

	Financial Systems AL WAGE INDEX INFORMATION		<u>ST JOSEPH MEI</u>	Provi der C		eriod: rom 06/01/2019		pared:
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Sal ari es (col . 2 ± col . 3)	Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES			1	1			
. 00	Total salaries (see instructions)	200.00	25, 390, 477	0	25, 390, 477	813, 646. 00	31. 21	1.00
00	Non-physician anesthetist Part		C	0	0	0.00	0.00	2.00
00	A Non-physician anesthetist Part		C	0	0	0.00	0.00	3.00
00	B Physician-Part A -		C	0	0	0.00	0.00	4.00
	Administrative							
01 00	Physicians - Part A - Teaching Physician and Non		C		-	0. 00 0. 00		•
00	Physician-Part B Non-physician-Part B for		<i>.</i>	0	0	0.00	0.00	6.00
00	hospital-based RHC and FQHC		(0.00	0.00	0.00
00	services Interns & residents (in an	21.00	C	0	0	0.00	0.00	7.00
	approved program)	21.00			-			
01	Contracted interns and residents (in an approved programs)		C	0	0	0.00	0.00	7.01
00	Home office and/or related organization personnel		C	0	0	0.00	0.00	8.00
00	SNF	44.00	975, 088	-				
0. 00	Excluded area salaries (see instructions)		1, 110, 146	0	1, 110, 146	40, 767. 00	27. 23	10.00
	OTHER WAGES & RELATED COSTS				1			
. 00	Contract Labor: Direct Patient Care		1, 342, 031	0	1, 342, 031	17, 281. 00	77.66	11.00
2. 00	Contract labor: Top level management and other management and administrative services		43, 269	0	43, 269	437.00	99. 01	12.00
. 00	Contract Labor: Physician-Part		2, 238, 534	0	2, 238, 534	32, 185. 00	69. 55	13.00
. 00	A - Administrative Home office and/or related organization salaries and		C	0	0	0.00	0.00	14.00
I. 01	wage-related costs Home office salaries		2, 993, 214	0	2, 993, 214	93, 062. 00	32 16	14. 0 [.]
. 02	Related organization salaries		2, 773, 211	0	0	0.00	0.00	14.0
. 00	Home office: Physician Part A - Administrative		C	0	0	0.00	0.00	15.0
. 00	Home office and Contract		C	0	0	0.00	0.00	16. 0
o. 01	Physicians Part A - Teaching Home office Physicians Part A		C	0	0	0.00	0. 00	16. 0
. 02	- Teaching Home office contract		C	0	0	0.00	0.00	16. 0
	Physicians Part A - Teaching					0.00		
7.00	WAGE-RELATED COSTS Wage-related costs (core) (see		5, 836, 446	0	5, 836, 446			17.00
8. 00	instructions) Wage-related costs (other)							18.00
	(see instructions)			_				
9.00).00	Excluded areas Non-physician anesthetist Part		543, 448 C		543, 448 0			19.00 20.00
. 00	A Non-physician anesthetist Part		C	0	0			21.00
. 00	B Physician Part A -		C	0	0			22.0
	Administrative							
. 01 . 00	Physician Part A - Teaching Physician Part B		C		0			22.0 23.0
00	Wage-related costs (RHC/FQHC)		C	0	-			24.0
. 00	Interns & residents (in an approved program)		Ĺ	0	0			25.0
50	Home office wage-related (core)		655, 099	0	655, 099			25.5
. 51	Related organization		C	0	о			25.5
. 52	wage-related (core) Home office: Physician Part A - Administrative -		C	0	0			25.5
25. 52			C	0	0			

Heal th	Financial Systems		ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 06/01/2019 To 05/31/2020		pared:
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col		col. 5)	
				A-6)	3)	col. 4		
	· · · ·	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII							
26.00	Employee Benefits Department	4.00			309, 37			26.00
27.00	Administrative & General	5.00			3, 382, 58			27.00
28.00	Administrative & General under		120, 850	0	120, 85	0 268.00	450. 93	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	1, 001, 753	0	1, 001, 75			30.00
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		31.00
32.00	Housekeepi ng	9.00	521, 761	0	521, 76			32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Di etary	10.00	0	0		0 0.00	0.00	34.00
35.00	Dietary under contract (see	10.00	710, 141	0	710, 14			35.00
00100	instructions)		, 10, 111		,,			00.00
36,00	Cafeteria	11.00	0	0		0 0.00	0, 00	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00		37.00
38.00	Nursing Administration	13.00	1, 359, 730	0	1, 359, 73	0 35, 340. 00		38.00
39.00	Central Services and Supply	14.00			237, 50			39.00
40.00	Pharmacy	15.00			1, 353, 57			40.00
41.00	Medical Records & Medical	16.00	166, 562		166, 56			41.00
	Records Library	101.00	1007 002				20100	
42.00	Social Service	17.00	682, 536	0	682, 53	6 18, 744. 00	36. 41	42.00
43.00	Other General Service	18.00				0 0.00		43.00
	•							

Heal th	Health Financial Systems			ST JOSEPH MEDICAL CENTER			In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 06/01/2019	Worksheet S-3 Part III			
						To 05/31/2020	Date/Time Prep 11/2/2020 12:			
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly			
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷			
				(from	(col.2 ± col.	Salaries in	col. 5)			
				Worksheet A-6)	3)	col. 4				
		1.00	2.00	3.00	4.00	5.00	6.00			
	PART III - HOSPITAL WAGE INDEX	SUMMARY								
1.00	Net salaries (see		26, 221, 468	0	26, 221, 46	8 850, 526. 00	30. 83	1.00		
	instructions)									
2.00	Excluded area salaries (see		2, 085, 234	0	2, 085, 23	4 68, 951. 00	30. 24	2.00		
	instructions)									
3.00	Subtotal salaries (line 1		24, 136, 234	0	24, 136, 23	4 781, 575. 00	30.88	3.00		
	minus line 2)									
4.00	Subtotal other wages & related		6, 617, 048	0	6, 617, 04	8 142, 965. 00	46.28	4.00		
	costs (see inst.)									
5.00	Subtotal wage-related costs		6, 491, 545	0	6, 491, 54	5 0.00	26.90	5.00		
	(see inst.)									
6.00	Total (sum of lines 3 thru 5)		37, 244, 827	0	37, 244, 82	7 924, 540. 00	40. 28	6.00		
7.00	Total overhead cost (see		9, 846, 360	0	9, 846, 36	0 334, 834. 00	29. 41	7.00		
	instructions)									

Heal th	Financial Systems	ST JOSEPH MEDIO	CAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provider CCN:	15-0047	Peri od: From 06/01/2019 To 05/31/2020		pared:
						Amount Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					504, 281	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contri					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see					0	3.00
4.00	Qualified Defined Benefit Plan Cost (see in					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)					
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pl					0	6.00
7.00	Employee Managed Care Program Administratio	n Fees				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					0	
8.01	Health Insurance (Self Funded without a Third Party Administrator)				0		
8.02	Health Insurance (Self Funded with a Third Party Administrator)				3, 622, 734		
8.03	Health Insurance (Purchased)					0	
9.00	Prescription Drug Plan					0	
10.00	Dental, Hearing and Vision Plan					11, 557	
11.00	Life Insurance (If employee is owner or ben					18, 948	
12.00	Accident Insurance (If employee is owner or					-2, 829	
13.00	Disability Insurance (If employee is owner						13.00
14.00	Long-Term Care Insurance (If employee is ow	ner or beneficiary	y)				14.00
15.00	'Workers' Compensation Insurance					330, 632	
16.00	Retirement Health Care Cost (Only current y	ear, not the extra	aordi nary accru	al require	ed by FASB 106.	0	16.00
	Non cumulative portion)						
17 00	TAXES					1 404 240	17 00
	FICA-Employers Portion Only					1, 486, 249	
18.00 19.00	Medicare Taxes - Employers Portion Only Unemployment Insurance					347, 590	18.00
19.00 20.00	State or Federal Unemployment Taxes						
20.00	OTHER					54, 658	20.00
21 00	Executive Deferred Compensation (Other Than	Dati romant Cast I	Concerted on Lin	oc 1 throu	igh 1 above (coe	0	21.00
21.00	instructions))	Retifement Cost i	Reported on Thi		igit 4 above. (See	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement					0	
	. 00 Total Wage Related cost (Sum of lines 1 -23) 6, 379, 894						
200	Part B - Other than Core Related Cost	/				3, 3, 7, 0, 1	
25 00	OTHER WAGE RELATED COSTS (SPECIFY)						25.00
20.00						I	20.00

Health Financial Systems ST JC	DSEPH MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0047	Peri od:	Worksheet S-3	
		From 06/01/2019	Part V	
		To 05/31/2020	Date/Time Pre	
Cost Center Description		Contract Labor	11/2/2020 12: Benefit Cost	
cost center bescription		1.00	2.00	
PART V - Contract Labor and Benefit Cost			2100	
Hospital and Hospital-Based Component Identification	on:			
1.00 Total facility's contract labor and benefit cost		1, 342, 031	6, 379, 894	1.00
2.00 Hospi tal		1, 342, 031	6, 379, 894	2.00
3.00 Subprovider - IPF		0	0	3.00
4.00 Subprovider - IRF				4.00
5.00 Subprovider - (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 Hospital-Based SNF		0	0	8.00
9.00 Hospital-Based NF				9.00
10.00 Hospital-Based OLTC				10.00
11.00 Hospital-Based HHA				11.00
12.00 Separately Certified ASC				12.00
13.00 Hospital-Based Hospice				13.00
14.00 Hospital-Based Health Clinic RHC				14.00
15.00 Hospital-Based Health Clinic FQHC				15.00
16.00 Hospital-Based-CMHC				16.00
17.00 Renal Dialysis		0	0	17.00
18.00 Other		0	0	18.00

Heal th	Financial Systems ST JOSEPH MEDICAL	CENTER		In Lie	u of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-0047	Peri od:	Worksheet S-1	0
				From 06/01/2019 To 05/31/2020	Date/Time Pre	
					11/2/2020 12:	13 pm
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	/ided by lir	ne 202 columr	18)	0. 211236	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				16, 475, 602	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			ii d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaio	d		1, 466, 941	5.00
6.00	Medi cai d charges				111, 574, 202	
7.00	Medicaid cost (line 1 times line 6)	(line 7 min	o oum of lir	and F. if	23, 568, 488	
8.00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	tine / minu	us sum of iir	les 2 and 5; IT	5, 625, 945	8.00
	Children's Health Insurance Program (CHIP) (see instructions for	r each line	<i>z</i>)			
9.00	Net revenue from stand-al one CHIP				0	9.00
10.00	Stand-al one CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP ((line 11 mir	nus line 9; i	f < zero then	0	12.00
	enter zero)	•				
	Other state or local government indigent care program (see inst					
13.00	Net revenue from state or local indigent care program (Not incl				0	
14.00	Charges for patients covered under state or local indigent care	e program (N	Not included	in lines 6 or	0	14.00
15 00	10)				0	15 00
15. 00 16. 00	State or local indigent care program cost (line 1 times line 14 Difference between net revenue and costs for state or local inc		program (Lin	o 15 minus lino		
10.00	13; if < zero then enter zero)	ingent care	program (TT		0	10.00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indic	ent care program	ns (see	
	instructions for each line)			1 3		
	Private grants, donations, or endowment income restricted to fu				0	
	Government grants, appropriations or transfers for support of h				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent o	care programs	s (sum of lines	5, 625, 945	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line)		12 2/0 2/	Г 0	12 2/0 2/5	1 20 00
20.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	SILITY	13, 369, 36	5 0	13, 369, 365	20.00
21.00	Cost of patients approved for charity care and uninsured discou	ints (see	2, 824, 09	01 0	2, 824, 091	21.00
21.00	instructions)		2, 024, 0	0	2, 024, 071	21.00
22.00	Payments received from patients for amounts previously written	off as	4, 55	5 0	4, 555	22.00
	chari ty care				.,	
23.00	Cost of charity care (line 21 minus line 22)		2, 819, 53	36 0	2, 819, 536	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patier		ond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent care			la langth of	0	25.00
25.00	If line 24 is yes, enter the charges for patient days beyond the stay limit	ie indigent	care program	is rength of	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see ins	structions)			7, 961, 818	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see the		ructions)		245, 577	
	Medicare allowable bad debts for the entire hospital complex (s				377, 810	
28.00	Non-Medicare bad debt expense (see instructions)		,		7, 584, 008	
29.00						
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				4, 553, 785	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			10, 179, 730	31.00

RECI AS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	ST JOSEPH MEDI	Provider CO	CN: 15-0047	Period:	u of Form CMS-2 Worksheet A	2002-11
NEOLAJ	STATISTICAL AND ADJUSTMENTS OF TREAD ALANCE OF			F	rom 06/01/2019		
				T	Fo 05/31/2020	Date/Time Pre 11/2/2020 12:	pared: 13 pm
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		5, 563, 833	5, 563, 833	3 1, 499, 053	7, 062, 886	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		3, 960, 554	3, 960, 554	4 909, 398	4, 869, 952	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	309, 370	93, 614	402, 984	4, 489, 106	4, 892, 090	4.00
5.01	00590 REVENUE CYCLE	1, 430, 260	4, 675, 438			5, 877, 973	5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	29, 673	136, 825			166, 498	
5.03	00591 ADMINI STRATI VE AND GENERAL	1, 922, 647	19, 954, 128			15, 961, 989	
7.00	00700 OPERATION OF PLANT	1,001,753	2, 702, 756			4, 519, 797	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	246, 873			246, 873	
9.00	00900 HOUSEKEEPING	521, 761	292, 657			813, 647	9.00
10.00	01000 DI ETARY	0	1, 801, 133			1, 130, 764	
11.00	01100 CAFETERIA	1 250 720	0	1 722 020		669,049	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 359, 730 237, 502	373, 200 2, 466, 433			1, 732, 468	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					503, 119	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 353, 575 166, 562	2, 273, 971 331, 980			1, 880, 025 498, 541	
17.00	01700 SOCIAL SERVICE	682, 536	71, 295			753, 516	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	082, 530	98, 791	98, 79		98, 791	
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	90, 791	70,77	<u>п</u> 0	70, 771	22.00
30. 00	03000 ADULTS & PEDI ATRI CS	4, 690, 867	2, 723, 305	7, 414, 172	2 -4, 238	7, 409, 934	30.00
33.00	03300 BURN INTENSIVE CARE UNIT	1, 816, 445	1, 844, 191			3, 658, 736	
40.00	04000 SUBPROVI DER – I PF	1, 110, 146	865, 126			1, 975, 272	
44.00	04400 SKI LLED NURSI NG FACI LI TY	975, 088	159, 212			1, 134, 295	
	ANCI LLARY SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1077212	1,101,000	<u> </u>	111011270	1
50.00	05000 OPERATING ROOM	555, 445	645, 403	1, 200, 848	3 108, 499	1, 309, 347	50. OC
51.00	05100 RECOVERY ROOM	130,066	86, 005			216, 071	
53.00	05300 ANESTHESI OLOGY	0	1, 232, 380	1, 232, 380	0 0	1, 232, 380	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	907, 235	915, 076	1, 822, 31	1 174, 790	1, 997, 101	54.00
54.01	03630 ULTRA SOUND	290, 112	54, 728	344, 840	-344, 840	0	54. 0 ⁻
56.00	05600 RADI OI SOTOPE	87, 322	124, 173	211, 495	5 -211, 495	0	56.00
57.00	05700 CT SCAN	202, 483	59, 682	262, 165	-262, 165	0	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	600, 381	1, 286, 927			1, 447, 589	
60.00	06000 LABORATORY	1, 531, 475	968, 149			2, 383, 400	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	100, 328			98, 768	
65.00	06500 RESPI RATORY THERAPY	596, 434	119, 602			702, 628	
66.00	06600 PHYSI CAL THERAPY	316, 356	29, 958			346, 314	
67.00	06700 OCCUPATI ONAL THERAPY	237, 357	19, 016			256, 373	
68.00	06800 SPEECH PATHOLOGY	14, 430	6, 527			20, 957	
69.00	06900 ELECTROCARDI OLOGY	81, 019	8, 734			89, 753	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(785, 904	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			1, 236, 582	
	07300 DRUGS CHARGED TO PATIENTS	0	-			1, 475, 741 228, 336	
	07400 RENAL DI ALYSI S	0	228, 336	228, 336			
76.00 76.01	03950 MISC ANCILLARY 03951 SLEEP LAB	0	0			0	
76.01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			0	
	03952 WOUND CARE	571, 316	295, 306	866, 622	2 -2, 102	864, 520	
, 0. 05	OUTPATIENT SERVICE COST CENTERS	571, 510	275, 500	000, 022	-1 -2,102	004, 320	, 0. 03
90.00	09000 CLINIC	76, 106	6, 077	82, 183	3 0	82, 183	90.00
	09100 EMERGENCY	1, 585, 025	1, 395, 938				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	., 300, 020	., 575, 750		2,700	2, , , , , , , , , , , , , , , , , , ,	92.00
	SPECIAL PURPOSE COST CENTERS	I					1
118.00		25, 390, 477	58, 217, 660	83, 608, 137	7 0	83, 608, 137	118.00
	NONREI MBURSABLE COST CENTERS	1	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190. 00
190.00		-	-	1	1		1
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 758	1, 758	3 0	1, 758	192.00
192.00	07950 MEALS ON WHEELS	0 0	1, 758 0	1, 758	3 O D O		194.00

ilth Financial Systems CLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	<u>ST JOSEPH MEE</u> F EXPENSES	Provider CCN:		n Lieu of Form CMS-2552 Worksheet A
			From 06/01	/2019
			To 05/31	/2020 Date/Time Prepare 11/2/2020 12:13 p
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7.00		
GENERAL SERVICE COST CENTERS 00 00100 CAP REL COSTS-BLDG & FIXT	-1, 515, 600	5, 547, 286		1.
00 00100 CAP_REL_COSTS-BLDG_&_FLXT 00 00200 CAP_REL_COSTS-MVBLE_EQUIP	959, 531			2.
00 00400 EMPLOYEE BENEFITS DEPARTMENT	-4, 562			4.
1 00590 REVENUE CYCLE	29, 430			5.
00560 PURCHASING RECEIVING AND STORES	29,430			5.
00591 ADMI NI STRATI VE AND GENERAL	-2, 332, 013			5.
0 00700 OPERATION OF PLANT	-35,005			7.
0 00800 LAUNDRY & LINEN SERVICE	-112, 739			8.
00 00900 HOUSEKEEPI NG	C			9.
00 01000 DI ETARY				10.
00 01100 CAFETERIA				11.
00 01300 NURSI NG ADMI NI STRATI ON	-4, 262			13.
00 01400 CENTRAL SERVICES & SUPPLY	4,202			14.
00 01500 PHARMACY				15.
00 01600 MEDI CAL RECORDS & LI BRARY	-53			16.
00 01700 SOCIAL SERVICE				17.
00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV				22.
INPATIENT ROUTINE SERVICE COST CENTERS		70,771		
00 03000 ADULTS & PEDI ATRI CS	-892, 040	6, 517, 894		30.
00 03300 BURN INTENSIVE CARE UNIT	-1, 427, 430			33.
00 04000 SUBPROVIDER - IPF	-534, 043			40
00 04400 SKI LLED NURSI NG FACI LI TY	C 001,010			44
ANCI LLARY SERVICE COST CENTERS		1,101,270		
00 05000 OPERATING ROOM	-355,000	954, 347		50.
00 05100 RECOVERY ROOM	C			51
00 05300 ANESTHESI OLOGY				53.
00 05400 RADI OLOGY-DI AGNOSTI C		1, 997, 101		54
01 03630 ULTRA SOUND		0		54
00 05600 RADI OI SOTOPE				56.
00 05700 CT SCAN		0		57
00 05900 CARDI AC CATHETERI ZATI ON	-38,076	1, 409, 513		59
00 06000 LABORATORY	00,070			60
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL				62
00 06500 RESPIRATORY THERAPY				65
00 06600 PHYSI CAL THERAPY		346, 314		66
00 06700 OCCUPATI ONAL THERAPY		256, 373		67
00 06800 SPEECH PATHOLOGY		20, 957		68
00 06900 ELECTROCARDI OLOGY		89, 753		69
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				71
00 07200 IMPL. DEV. CHARGED TO PATIENTS				72
00 07300 DRUGS CHARGED TO PATIENTS		.,		73
00 07400 RENAL DIALYSIS				73.
00 03950 MISC ANCI LLARY		220, 330		76
01 03951 SLEEP LAB		0		76
02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0		76
03 03952 WOUND CARE	-12,000	852, 520		76
OUTPATIENT SERVICE COST CENTERS	- 12, 000	0.02, 020		/0
00 09000 CLINIC	0	82, 183		90
00 09100 EMERGENCY	-596, 196			90.
00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-570, 170	2,001,117		92.
	I			92.
SPECIAL PURPOSE COST CENTERS	6 970 050	76 729 070		110
. 00 SUBTOTALS (SUM OF LINES 1 through 117)	-6, 870, 058	76, 738, 079		118
NONREI MBURSABLE COST CENTERS		0		190.
0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		U 1 750		
		.,		192. 194.
H.00 07950 MEALS ON WHEELS D.00 TOTAL (SUM OF LINES 118 through 199)		0		
$1 \cup 0 \cup 1 \cup $	-6, 870, 058	76, 739, 837		200.

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 RECLASSI FI CATI ONS Provider CCN: 15-0047 Peri od: Worksheet A-6 From 06/01/2019 05/31/2020 То Date/Time Prepared: 11/2/2020 12:13 pm Increases Cost Center Sal ary 0ther Line # 2.00 3.00 4.00 5.00 - EMPLOYEE BENEFITS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 4, 489, 359 1.00 2.00 0.00 0 2.00 0 3.00 0.00 0 0 3.00 ō 4, 489, 359 - LEASE AND RENTAL 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 899, 432 1.00 CAP REL COSTS-BLDG & FIXT 0 2.00 1.00 107, 610 2.00 3.00 0.00 0 0 3.00 0 4.00 0.00 0 4.00 5.00 0 00 0 0 5 00 0 6.00 0.00 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 0 8.00 0 9 00 0 00 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 0 13.00 0.00 13.00 0 14.00 0.00 0 0 14.00 ō 1,007,042 D - OTHER CAPITAL COSTS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 166, 496 1.00 2.00 CAP REL COSTS-BLDG & FIXT 1.00 0 1, 224, 947 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 9,966 3.00 3.00 0 1, 401, 409 - REPAIRS & MAINTENANCE 1.00 OPERATION OF PLANT 7.00 0 762, 899 1.00 0 2.00 0.00 2.00 0 3.00 0.00 0 3 00 4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 0 6.00 0.00 0 6.00 0 7.00 0.00 0 7.00 8.00 0.00 0 0 8.00 0 9.00 0.00 0 9.00 0 10.00 0.00 0 10.00 0 11.00 0.00 0 11.00 12.00 0.00 0 0 12.00 0 13.00 0.00 0 13.00 o 0.00 0 14.00 14.00 15.00 0.00 0 0 15.00 0 16.00 0.00 0 16.00 17.00 0.00 0 0 17.00 0 18.00 0.00 0 18.00 19.00 0.00 19.00 0 0 ō 762, 899 - MEDICAL SUPPLIES 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 785, 904 1.00 PATI ENT IMPL. DEV. CHARGED TO 2.00 72.00 0 1,236,582 2.00 PATI ENTS <u>50. 00</u> 13<u>2, 2</u>85 3.00 OPERATING ROOM С 3.00 0 2, 154, 771 H - DRUGS AND IV COSTS 73.00 1.00 DRUGS CHARGED TO PATIENTS 1, 475, 741 00 1.00 1, 475, 741 J - RADI OLOGY RADI OLOGY-DI AGNOSTI C 579, 917 1.00 54.00 158, 270 1.00 2.00 0.00 C 0 2.00 3.00 0.00 3.00 0 579, 917 lo 158, 270 K – DIETARY CAFETERI A 1 00 11.00 669.049 1 00 0 Ō 669, 049 M - UTILITIES RECLASS

1.00 OPERATION OF PLANT 7.00 0 52,854 1.00 2 00 0 00 0 2.00 0 3.00 0.00 0 3.00 0 52,854 ō 500.00 Grand Total: Increases 579, 917 12, 171, 394 500.00

Health Fin	anci al	Systems
RECLASSI FI	CATION	S

ST JOSEPH MEDICAL CENTER

020	Date/Time	Prepared:
	11/0/0000	10 10

	Financial Systems SIFICATIONS		ST JOSEPH MEDI		CCN: 15-0047	Peri od:	u of Form C Worksheet	
						From 06/01/2019 To 05/31/2020	Date/Time	
		Decreases					11/2/2020	
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Rei	f.		
	6.00	7.00	8.00	9.00	10.00			
	A - EMPLOYEE BENEFITS	5.00		4 400 444				
1.00 2.00	ADMINISTRATIVE AND GENERAL	5. 03 5. 01	0	4, 489, 116 23		0		1.00
2.00 3.00	SOCIAL SERVICE	17.00	0	220		0		3.00
51.00	0		<u>_</u>	4, 489, 359				0.00
	C - LEASE AND RENTAL					1		
1.00	ADMI NI STRATI VE AND GENERAL	5.03	0	14, 067		10		1.00
2.00	OPERATION OF PLANT	7.00	0	465		10		2.00
3.00 4.00	DI ETARY NURSI NG ADMI NI STRATI ON	10.00 13.00	0	1, 320 338		0		3.00
5.00	PHARMACY	15.00	0	271, 780		0		5.00
5.00	ADULTS & PEDIATRICS	30.00	0	173		0		6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	342, 476		0		7.00
B. 00	LABORATORY	60.00	0	90, 107		0		8.00
9.00	MEDI CAL RECORDS & LI BRARY	16.00	0	1		0		9.00
10.00	WOUND CARE	76.03	0	115		0		10.00
11.00 12.00	REVENUE CYCLE CENTRAL SERVICES & SUPPLY	5. 01 14. 00	0	929 283, 458		0		11.00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	263, 436 253		0		12.00
14.00	WHOLE BLOOD & PACKED RED	62.00	0	1, 560		0		14.00
	BLOOD CELL		-	.,				
	0		0	1,007,042		1		
	D - OTHER CAPITAL COSTS				Γ			
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	1, 401, 409		12		1.00
2.00		0.00 0.00	0	0		13 12		2.00
3.00	<u> </u>		— — — 0	1,401,409		12		3.00
	E - REPAIRS & MAINTENANCE		0	1,401,407				
1.00	CARDI AC CATHETERI ZATI ON	59.00	0	90, 501		0		1.00
2.00	REVENUE CYCLE	5.01	0	211, 459		0		2.00
3.00	ADMI NI STRATI VE AND GENERAL	5.03	0	5, 337		0		3.00
4.00	HOUSEKEEPING	9.00	0	771		0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	124		0		5.00
5.00 7.00	CENTRAL SERVICES & SUPPLY ADULTS & PEDIATRICS	14.00 30.00	0	113, 896 4, 065		0		6.00 7.00
3.00	SKILLED NURSING FACILITY	44.00	0	4,005		0		8.00
9.00	OPERATING ROOM	50.00	0	23, 786		0		9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	188, 238		0		10.00
11.00	ULTRA SOUND	54.01	0	22, 741		0		11.00
12.00	RADI OI SOTOPE	56.00	0	23, 472		0		12.00
13.00	CT SCAN	57.00	0	34, 100		0		13.00
14.00 15.00	LABORATORY RESPI RATORY THERAPY	60.00 65.00	0	26, 117 11, 317		0		14.00 15.00
16.00	SOCI AL SERVI CE	17.00	o	95		0		16.00
17.00	BURN INTENSIVE CARE UNIT	33.00	0	1, 900		0		17.00
18.00	WOUND CARE	76.03	0	1, 987		0		18.00
19.00	EMERGENCY	<u>91.</u> 00	0	2, 988		0		19.00
			0	762, 899				
1 00	G - MEDI CAL SUPPLI ES CENTRAL SERVI CES & SUPPLY	14.00	0	1, 803, 462		0		1.00
1.00 2.00	RESPIRATORY THERAPY	65.00	0	1, 803, 462 2, 091		0		2.00
3.00	CARDI AC CATHETERI ZATI ON	59.00	0	349, 218		0		3.00
	0		— — — <u>o</u>	2, 154, 771	<u> </u>	-		0.00
	H - DRUGS AND IV COSTS							
1.00	PHARMACY	15.00	0	<u>1, 475, 7</u> 41		0		1.00
			0	1, 475, 741				
1 00	J - RADI OLOGY ULTRA SOUND	54.01	290, 112	31, 987		0		1.00
1.00 2.00	RADI OI SOTOPE	56.00	87, 322	100, 701		0		1.00
3.00	CT SCAN	57.00	202, 483	25, 582		0		3.00
			579, 917	158, 270		-		
	K – DIETARY							
1.00	DI ETARY		0	<u> </u>		0		1.00
	0 1		0	669, 049				
	M - UTILITIES RECLASS	!	_1					
1.00	ADMI NI STRATI VE AND GENERAL	5.03 54.00	0	4,857		0		1.00
2.00 3.00	RADI OLOGY-DI AGNOSTI C REVENUE CYCLE	54.00 5.01	0	32, 683 15, 314		0		2.00
5.00			— — — 0	<u>15, 314</u> 52, 854		4		3.00
	17		U	52,034	1			

Health Financial Systems	ST JOSEPH MED	ICAL CENTER			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0047		iod: m 06/01/2019 05/31/2020		pared:
			Acqui si ti on	s			
	Begi nni ng	Purchases	Donati on		Total	Disposals and	
	Bal ances					Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00 Land	9, 348, 028	0		0	0	0	1.00
2.00 Land Improvements	1, 775, 835	0		0	0	0	2.00
3.00 Buildings and Fixtures	28, 559, 649	24, 595		0	24, 595	0	3.00
4.00 Building Improvements	31, 494, 835	482, 827		0	482, 827	35, 113	4.00
5.00 Fixed Equipment	18, 720, 883	0		0	0	147, 991	5.00
6.00 Movable Equipment	53, 562, 600	17, 455, 710		0	17, 455, 710	1, 602, 727	6.00
7.00 HIT designated Assets	2, 833, 813	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	146, 295, 643	17, 963, 132		0	17, 963, 132	1, 785, 831	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	146, 295, 643	17, 963, 132		0	17, 963, 132	1, 785, 831	10.00
	Endi ng Bal ance						
		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, 584, 244	0					3.00
4.00 Building Improvements	31, 942, 549	0					4.00
5.00 Fixed Equipment	18, 572, 892	0					5.00
6.00 Movable Equipment	69, 415, 583	0					6.00
7.00 HIT designated Assets	2, 833, 813	0					7.00
8.00 Subtotal (sum of lines 1-7)	162, 472, 944	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	162, 472, 944	0					10.00

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lieu of Form CMS-2552-10		
RECONO	RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0047	Period: From 06/01/2019	Worksheet A-7 Part II	
					To 05/31/2020		pared:
						11/2/2020 12:	13 pm
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			4
1.00	CAP REL COSTS-BLDG & FIXT	5, 563, 833			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 960, 554	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	9, 524, 387	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	0 /				
		14.00	15.00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WORH	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	5, 563, 833				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 960, 554				2.00
3.00	Total (sum of lines 1-2)	0	9, 524, 387				3.00

Health Financial Systems	ST JOSEPH MED	OICAL CENTER		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 06/01/2019 To 05/31/2020		pared: 13 pm
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	71, 650, 656 90, 822, 288 162, 472, 944	0	90, 822, 28 162, 472, 94	8 0. 558999	0 0 0 F_CAPITAL	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1				
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		0 2, 980, 512 0 4, 936, 721 0 7, 917, 233	882, 796	1.00 2.00 3.00
	0	0	JMMARY OF CAPI		770, 400	3.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1// 10/	1 004 04	7	5 5 47 00 (1 00
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	1, 067, 721 0			7 0 0 0	5, 547, 286 5, 829, 483	1.00 2.00
3.00 Total (sum of lines 1-2)	1, 067, 721				5, 829, 483 11, 376, 769	3.00

	Financial Systems MENTS TO EXPENSES		ST JOSEPH MED	DI CAL CENTER Provider CCN: 15-0047	In Lie Period:	u of Form CMS-2 Worksheet A-8	
ADJUJI	MENTS TO EXIENSES				From 06/01/2019 To 05/31/2020	Date/Time Pre	pared:
				Expense Classification of	on Worksheet A	11/2/2020 12:	13 pm
				To/From Which the Amount i			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne #	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		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 (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)		0				
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4, 685	ADMI NI STRATI VE AND GENERAL	5. 03	0	7.00
8.00	Television and radio service	А	-35,005	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	-4, 635, 638			0	10.00
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	170, 301			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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 supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and	В	-53	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
	abstracts	5	0				19.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	В		ADMI NI STRATI VE AND GENERAL	5.03		
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
04.00	limitation (chapter 14)				((
24.00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	* 114.00		25.00
20.00	physicians' compensation		Ū.				20.00
26.00	(chapter 21) Depreciation - CAP REL	А	-2, 687, 545	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL	А	880, 667	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		Ω	*** Cost Center Deleted ***	* 19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
33.00	Depreciation and Interest PARKING GARAGE & MISC INCOME	В	-110, 368	ADMI NI STRATI VE AND GENERAL	5.03	0	33.00

Health Financial Systems		ST JOSEPH MED	DI CAL CENTER	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0047	Period:	Worksheet A-8	
				rom 06/01/2019		
				Fo 05/31/2020		
			Expense Classification on	Workshoot A	11/2/2020 12:	13 pm
			To/From Which the Amount is			
				to be Aujusteu		
Cost Center Description Basis	/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 MARKETING & RECRUITING EXPENSE	A	-198, 820	ADMI NI STRATI VE AND GENERAL	5.03	0	33.01
33. 02 PENALTI ES	А	-3, 750	ADMINISTRATIVE AND GENERAL	5.03	0	33.02
33.03 FITNESS REVENUE	В	-70	ADMINISTRATIVE AND GENERAL	5.03	0	33.03
33.04 SENIOR CIRCLE	А	-2, 311	ADMINISTRATIVE AND GENERAL	5.03	0	33.04
33.06 PATIENT PHONE WAGE COSTS	А	-18, 155	ADMINISTRATIVE AND GENERAL	5.03	0	33.06
33.07 PATIENT PHONES BENEFITS	А	-4, 562	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08 PATIENT PHONE DEPRECIATION	А	-232	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
COST						
33.09 PATIENT TV DEPRECIATION	A	-2, 290	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.12 LOBBYING EXPENSE IN DUES	A	-934	ADMINISTRATIVE AND GENERAL	5.03	0	33. 12
33. 13 CHARI TABLE CONTRI BUTI ONS	A	-88, 057	ADMINISTRATIVE AND GENERAL	5.03	0	33.13
33.15 IMPUTED RENT	A	-17, 160	CAP REL COSTS-MVBLE EQUIP	2.00	10	33. 15
33.16 NONALLOWABLE LEGAL EXPENSES	A	-110, 855	ADMINISTRATIVE AND GENERAL	5.03	0	33.16
50.00 TOTAL (sum of lines 1 thru 49)		-6, 870, 058				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	ST JOSEPH ME	DI CAL CENTER	In Lie	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Period: From 06/01/2019	Worksheet A-8	-1
OFFICE	COSTS			To 05/31/2020		pared:
					11/2/2020 12:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:			1 0/7 704		
1.00			CAPI TAL-RELATED INTEREST	1,067,721	0	1.00
2.00		CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	14, 964		2.00
3.00		CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL		0	3.00
4.00		REVENUE CYCLE	PASI OPERATING COSTS	420, 761	0	4.00
4.01		ADMINISTRATIVE AND GENERAL	SHARED SERVICE CENTER ALLOCA		1, 131, 763	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	89, 260	0	4.02
4.03		CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	96, 166	0	4.03
4.04	5. 03	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	2, 719, 118	0	4.04
4.05	5. 03	ADMINISTRATIVE AND GENERAL	MALPRACTICE COSTS	440, 785	695, 745	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	272, 886	272, 362	4.06
4.07	5.03	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	2, 549, 103	4.07
4.08	5.03	ADMINISTRATIVE AND GENERAL	401K FEES	0	6,057	4.08
4.09	5.03	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	47,017	4.09
4.10	5.03	ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	995, 254	4.10
4.11	5.03	ADMINISTRATIVE AND GENERAL	HIIM ALLOCATION	0	247,014	4.11
4.12	5.01	REVENUE CYCLE	PASI COLLECTION FEES	0	391, 331	4.12
4.13	5.03	ADMINISTRATIVE AND GENERAL	PASI LIEN UNIT COLLECTION FE	0	5, 744	4.13
4.14		LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE	148, 755		4.14
5.00	TOTALS (sum of lines 1-4).			6, 773, 185		5.00
	Transfer column 6, line 5 to				.,,,	
	Worksheet A-8, column 2,					
	line 12.					
* The	amounts on lines 1-4 (and sub	scripts as appropriate) are t	transferred in detail to Work	sheet A column	6 lines as	

* 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.

	not been posted to worksheet A, cordinas i and/or 2, the amount arrowable should be mareated in cordinary or this part.								
				Related Organization(s) and/	or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	1.00	2.00	3.00	4.00	5.00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

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

1 CT IIID GT			
6.00	В	0.00 CHS, INC 100.00	6.00
7.00	В	0.00 PASI 100.00	7.00
8.00	С	33.00 SHARED LAUNDRY 33.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

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

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

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

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

organization.

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0047	From 06/01/2019	Worksheet A-8-1 Date/Time Prepared:

					11/2/2020 12:	13 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO					
1.00	1, 067, 721					1.00
2.00	14, 964	1 1				2.00
3.00	1,856					3.00
4.00	420, 761	0				4.00
4.01	369, 150	0				4.01
4.02	89, 260	9				4.02
4.03	96, 166	9				4.03
4.04	2, 719, 118	0				4.04
4.05	-254, 960	0				4.05
4.06	524	10				4.06
4.07	-2, 549, 103	0				4.07
4.08	-6, 057	0				4.08
4.09	-47,017	0				4.09
4.10	-995, 254	0				4.10
4.11	-247,014	0				4.11
4.12	-391, 331	0				4.12
4.13	-5, 744	0				4.13
4.14	-112, 739	0				4.14
5.00	170, 301					5.00
* The	amounts on lin	$\alpha \leq 1_{-1}$ (and sub	scrints as annronriate) are tran	sforred in detail to Wor	ksheet A column 6 lines as	

* 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.

nus not	been posted to norresheet n,		
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
-	D INTERRELATIONCULD TO RELAT	TED ADAMU ZATION (C) AND (AD HOME AFEL AF	

 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 ci ilibui			
6.00	OWNER		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY		8.00
9.00			9.00
10.00		1	0.00
10. 00 100. 00		10	00.00

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

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

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

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

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

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

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

Heal th	Financial Syste	ems	ST JOSEPH ME	DICAL CENTER		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider C		Period: From 06/01/2019 To 05/31/2020	Date/Time Pre	pared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component		11/2/2020 12: Physician/Prov ider Component Hours	<u>13 pm</u>
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	892, 040	892, 040	C	0	0	1.00
2.00	33.00	BURN INTENSIVE CARE UNIT	1, 427, 430	1, 427, 430	C	0	0	2.00
3.00	5. 03	ADMINISTRATIVE AND GENERAL	776, 591	776, 591	C	0	0	3.00
4.00	50.00	OPERATING ROOM	355, 000	355, 000	C	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	4, 262	4, 262	C	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	534,043	534, 043	C	0	0	6.00
7.00	59.00	CARDI AC CATHETERI ZATI ON	38,076		C	0	0	7.00
8.00		WOUND CARE	12,000	12,000	C	0	0	8.00
9.00		EMERGENCY	596, 196		C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			4, 635, 638		(0	200.00
200100	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200100
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
			2	Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	33.00	BURN INTENSIVE CARE UNIT	0	0	C	0	0	2.00
3.00	5. 03	ADMINISTRATIVE AND GENERAL	0	0	C	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	C	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	0	0	C	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	C	0	0	6.00
7.00		CARDI AC CATHETERI ZATI ON	0	0	C	0	0	7.00
8.00		WOUND CARE	0	0	C	0	0	8.00
9.00		EMERGENCY	0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			0	0	C	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component Share of col. 14	Limit	Di sal I owance	5		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0	0	(892, 040		1.00
2.00		BURN INTENSIVE CARE UNIT	0	0	C			2.00
3.00		ADMI NI STRATI VE AND GENERAL	0	0	0			3.00
4.00		OPERATING ROOM	0	0	C			4.00
5.00		NURSING ADMINISTRATION	0	0	0			5.00
6.00		SUBPROVIDER - IPF	0	0	0			6.00
7.00		CARDI AC CATHETERI ZATI ON	0	0	(7.00
8.00		WOUND CARE	0	0	(8.00
9.00		EMERGENCY	0	0	(9.00
10.00	0.00	4	0	0	(10.00
200.00			0					200.00
200.00	I	1	1 0	0		1,000,000		200.00

	Financial Systems	ST JOSEPH MED				u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CO		eriod: rom 06/01/2019	Worksheet B Part I	
				T		Date/Time Pre	
				ATED COSTS		11/2/2020 12:	13 pm
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	REVENUE CYCLE	
		for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		<u>col. 7)</u> 0	1.00	2.00	4.00	5. 01	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.01	
1.00	00100 CAP REL COSTS-BLDG & FIXT	5, 547, 286	5, 547, 286				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	5, 829, 483		5, 829, 483			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 887, 528		65, 981	5, 016, 296		4.00
5.01	00590 REVENUE CYCLE	5, 907, 403	222, 714	234, 044	286, 056		5.01
5.02	00560 PURCHASING RECEIVING AND STORES	166, 498		162, 554	5, 935		5.02
5.03	00591 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	13, 629, 976	120, 345	126, 467	384, 535		5.03
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	4, 484, 792 134, 134	1, 537, 431 49, 295	1, 615, 641 51, 803	200, 354 0	0	7.00 8.00
9.00	00900 HOUSEKEEPING	813, 647	746, 337	784, 304	104, 354	0	9.00
10.00	01000 DI ETARY	1, 130, 764	233, 145	245,006	0		10.00
11.00	01100 CAFETERI A	669, 049	0	0	0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 728, 206	85, 419	89, 764	271, 950	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	503, 119	0	0	47, 501	0	14.00
15.00	01500 PHARMACY	1, 880, 025	0	0	270, 719		15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	498, 488	139, 704	146, 811 0	33, 313 136, 509		16.00 17.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	753, 516 98, 791	0		130, 509		22.00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	70, 771	0	0	0	0	22.00
30.00	03000 ADULTS & PEDIATRICS	6, 517, 894	539, 775	567, 234	938, 185	614, 333	30.00
33.00	03300 BURN INTENSIVE CARE UNIT	2, 231, 306	93, 309	98, 055	363, 294	229, 417	33.00
40.00	04000 SUBPROVIDER - IPF	1, 441, 229					40.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	1, 134, 295	114, 171	119, 979	195, 021	70, 135	44.00
F0 00	ANCI LLARY SERVICE COST CENTERS	054 247	220 505	240.224	111_001	449.039	
50.00 51.00	05100 RECOVERY ROOM	954, 347 216, 071	228, 595 85, 751	240, 224 90, 114	111, 091 26, 014	448, 038 33, 190	50.00 51.00
53.00	05300 ANESTHESI OLOGY	1, 232, 380	03,731	0	20, 014	46, 907	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 997, 101	219, 295	230, 451	297, 435		54.00
54.01	03630 ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 409, 513 2, 383, 400	24, 428 187, 695	25, 671 197, 243	120, 078 306, 300		59.00 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 383, 400 98, 768	10, 285	197, 243	300, 300	15, 707	62.00
65.00	06500 RESPI RATORY THERAPY	702, 628		80, 145	119, 289		65.00
66.00	06600 PHYSI CAL THERAPY	346, 314	99, 096		63, 272	51, 753	
67.00	06700 OCCUPATI ONAL THERAPY	256, 373	37, 933	39, 863	47, 472	49, 471	67.00
68.00	06800 SPEECH PATHOLOGY	20, 957			2, 886		
69.00	06900 ELECTROCARDI OLOGY	89, 753			16, 204		
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	785, 904	0	0	0	91, 604	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	1, 236, 582 1, 475, 741	32, 864	34, 535	0	585, 403 881, 853	
74.00	07400 RENAL DIALYSIS	228, 336	26, 743		0	13, 530	
76.00	03950 MI SC ANCI LLARY	0	0	0	0	0	76.00
76.01	03951 SLEEP LAB	0	0	0	0	0	76.01
76.02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	76.02
76.03	03952 WOUND CARE	852, 520	114, 278	120, 091	114, 265	39, 243	76.03
~~~~~	OUTPATIENT SERVICE COST CENTERS	00.400	00.007	00.70/	45 004	0.00/	00.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	82, 183		29, 726	15, 221 317, 010		90.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 381, 779	175, 588	184, 520	317,010	789, 257	91.00 92.00
72.00	SPECIAL PURPOSE COST CENTERS						/2.00
118.00		76, 738, 079	5, 533, 821	5, 815, 333	5, 016, 296	6, 650, 217	118.00
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 465	14, 150	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 758	0	0	0		192.00
	07950 MEALS ON WHEELS	0	0	0	0		194.00
200.00			_	~	_		200. 00 201. 00
201.00		76, 739, 837	0 5, 547, 286	0 5, 829, 483	0 5, 016, 296		201.00
		10,137,037	J, J47, 200	J, UZ7, 403	5, 010, 290	0,000,217	1202. UU

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	ST JOSEPH MEDI	Provider C	CN: 15-0047 F	Period:	u of Form CMS-2 Worksheet B	2002-10
				F T	rom 06/01/2019 o 05/31/2020	Part I Date/Time Pre 11/2/2020 12:	
	Cost Center Description	PURCHASI NG RECEI VI NG AND STORES	Subtotal	ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.02	5A. 02	5.03	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 REVENUE CYCLE						5.01
5.02	00560 PURCHASING RECEIVING AND STORES	489, 672					5.02
5.03	00591 ADMINI STRATI VE AND GENERAL	8,062	14, 269, 385				5.03
7.00	00700 OPERATION OF PLANT	1, 230	7, 839, 448				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	11,036	246, 268			440, 147	
9.00	00900 HOUSEKEEPING	6, 136	2, 454, 778			0	
10.00	01000 DI ETARY	72, 605	1, 681, 520			0	
11.00		0	669, 049			0	
13.00	01300 NURSI NG ADMI NI STRATI ON	468	2, 175, 807			0	
14.00	01400 CENTRAL SERVICES & SUPPLY	12, 192	562, 812			0	
15.00	01500 PHARMACY	1,774	2, 152, 518			0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	64	818, 380			0	
17.00	01700 SOCIAL SERVICE	11	890, 036			0	
22.00	02200 I & SERVICES-OTHER PRGM COSTS APPRV	0	98, 791	22, 566	0	0	22.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	44.554	0 400 075	0.100.000	1 504 004	100.004	0.00
30.00	03000 ADULTS & PEDIATRICS	16, 554	9, 193, 975			103, 284	1
33.00	03300 BURN INTENSIVE CARE UNIT	14, 483	3, 029, 864			50, 319	
40.00	04000 SUBPROVIDER - IPF	3, 026	2,051,795			44, 360	
44.00	04400 SKI LLED NURSI NG FACI LI TY	4, 976	1, 638, 577	374, 280	318, 753	36, 024	44.00
50.00	ANCI LLARY SERVICE COST CENTERS	29, 758	2,012,053	459, 589	638, 212	18, 447	50.00
51.00	05100 RECOVERY ROOM	27,730	451, 140			7, 849	
53.00	05300 ANESTHESI OLOGY	5	1, 279, 292			0,047	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 185	3, 837, 491			33, 588	
54.01	03630 ULTRA SOUND	0,100	0,007,171	0,0,002		00,000	1
56.00	05600 RADI OI SOTOPE	0	0			0	1
57.00	05700 CT SCAN	0	0		-	0	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	15, 958	1, 859, 255	424, 687	68, 201	22, 256	
60.00	06000 LABORATORY	43,035	3, 943, 090			0	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	8, 916	144, 484			0	
65.00	06500 RESPIRATORY THERAPY	5,672	1, 173, 322			0	
66.00	06600 PHYSI CAL THERAPY	286	664, 859			0	
67.00	06700 OCCUPATI ONAL THERAPY	9	431, 121			0	67.00
68.00	06800 SPEECH PATHOLOGY	0	56, 490	12, 903	40, 787	0	68.00
69.00	06900 ELECTROCARDI OLOGY	231	191, 691	43, 786	38, 818	1, 601	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	61, 578	939, 086	214, 504	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	121, 198	1, 943, 183	443, 858	3 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2, 424, 993			0	73.00
74.00	07400 RENAL DI ALYSI S	243	296, 956	67, 830	74, 664	0	74.00
76.00	03950 MI SC ANCI LLARY	0	0			0	76.00
76.01	03951 SLEEP LAB	0	0	C	0 0	0	
76.02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	0 0	0	76.02
76.03	03952 WOUND CARE	12, 455	1, 252, 852	286, 174	319, 050	0	76.03
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·			1		
90.00	09000 CLI NI C	14	158, 437			19, 282	
91.00	09100 EMERGENCY	29, 512	3, 877, 666	885, 729	490, 220	103, 137	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
110 00	SPECIAL PURPOSE COST CENTERS	400 (70	7/ 710 4/4	14 0/0 /75		440 147	1110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	489, 672	76, 710, 464	14, 262, 675	9, 592, 527	440, 147	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27 615	6, 308	3 37, 592	0	190.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES		27, 615 1, 758				190.00
		0	1,700	402	- 0		
192.00			0	r n		∩	1194 00
192.00 194.00	07950 MEALS ON WHEELS	0	0	C	0 0	0	194.00
192.00	07950 MEALS ON WHEELS Cross Foot Adjustments	0	0	C C			194.00 200.00 201.00

Heal th	Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-:	2552-10
COST AI	LLOCATI ON - GENERAL SERVI CE COSTS		Provider CC	-	Period: From 06/01/2019 Fo 05/31/2020	Worksheet B Part I Date/Time Pre 11/2/2020 12:	
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						1 1 00
2.00 4.00 5.01 5.02 5.03	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						1.00 2.00 4.00 5.01 5.02 5.03
8.00 9.00 10.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	5, 099, 180 447, 999 0	3, 164, 524 0	821, 87:	2		7.00 8.00 9.00 10.00 11.00
13. 00 14. 00 15. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	164, 136 0 0	0 0 0	46, 89 17, 52 38, 61	7 3, 122, 313 3 0 5 52, 567	708, 896 3, 327	15.00
17.00 22.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	268, 447 0 0	0 0	9, 60 24, 87		121 21 0	17.00
	03000 ADULTS & PEDI ATRI CS	1, 037, 200	1, 117, 786	213, 36	3 1, 113, 925	31, 049	30.00
	03300 BURN INTENSIVE CARE UNIT	179, 297	193, 032	63, 81		27, 166	•
	04000 SUBPROVIDER - IPF 04400 SKILLED NURSING FACILITY	113, 540 219, 385	337, 045 377, 400	54, 10 37, 40		5, 677 9, 333	
	ANCI LLARY SERVICE COST CENTERS	219, 300	377,400	57,40.	2 271, 303	9, 333	44.00
	05000 OPERATI NG ROOM	439, 255	0	19, 21	2 92, 812	55, 816	50.00
	05100 RECOVERY ROOM	164, 775	0	3, 69	30, 719	0	
	05300 ANESTHESI OLOGY	0	0		0	10	
	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	421, 384	0	60, 69		15, 353 0	
	05600 RADI OI SOTOPE	0	0	(		0	
	05700 CT SCAN	0	0	(	0 0	0	
	05900 CARDI AC CATHETERI ZATI ON	46, 940	0	21, 94		29, 932	•
1		360, 664	0	73, 97		80, 718	•
1	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	19, 763 146, 546	0	23, 90		16, 724 10, 639	•
	06600 PHYSI CAL THERAPY	190, 418	0	11, 42		536	•
67.00	06700 OCCUPATI ONAL THERAPY	72, 890	0	7, 26	0 0	17	67.00
	06800 SPEECH PATHOLOGY	28, 072	0	46		0	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	26, 717	0	2, 89		433 115, 499	•
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			227, 327	
	07300 DRUGS CHARGED TO PATIENTS	63, 149	0	(	0 0	0	
	07400 RENAL DI ALYSI S	51, 388	0	(	0 0		74.00
	03950 MISC ANCILLARY	0	0		0 0	0	
	03951 SLEEP LAB 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			0	
	03952 WOUND CARE	219, 589	0	24, 07	121, 816	23, 362	1
	OUTPATIENT SERVICE COST CENTERS			,			
	09000 CLI NI C	54, 354	0	2, 65		27	
	09100 EMERGENCY	337, 399	0	63, 45	9 439, 770	55, 354	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	5, 073, 307	2, 025, 263	821, 87	2 3, 122, 313	708, 896	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	25, 873	0		0 0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	767, 156		0		192.00
194.00 200.00	07950 MEALS ON WHEELS Cross Foot Adjustments	0	372, 105	(	ן א	0	194. 00 200. 00
200.00	Negative Cost Centers	0	0	(	0 0	0	200.00
202.00	TOTAL (sum lines 118 through 201)	5, 099, 180	3, 164, 524	821, 87	3, 122, 313	708, 896	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ST JOSEPH MEDI	CAL CENTER Provider C	CN: 15 0047	In Lie Period:	u of Form CMS- Worksheet B	2552-10
	LLUCATION - GENERAL SERVICE CUSIS		Provider C		From 06/01/2019 To 05/31/2020	Part I Date/Time Pre 11/2/2020 12:	epared: 13 pm
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVIC	I NTERNS & RESI DENTS E SERVI CES-OTHER PRGM COSTS APPRV	Subtotal	
		15.00	16.00	17.00	22.00	24.00	
1 00	GENERAL SERVICE COST CENTERS			1			1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 REVENUE CYCLE						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES						5.02
5.03	00591 ADMINISTRATIVE AND GENERAL						5.03
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
	01100 CAFETERIA						10.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY	2, 738, 702					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 673, 524	Ļ			16.00
	01700 SOCIAL SERVICE	0	C				17.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	C		0 121, 357		22.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	154 405	732,09	101 257	17, 425, 714	30.00
	03300 BURN INTENSIVE CARE UNIT	0	154, 605 57, 736			5, 094, 094	
	04000 SUBPROVI DER – I PF	0	66, 521			3, 798, 363	1
	04400 SKILLED NURSING FACILITY	0	17,650			3, 563, 387	
	ANCI LLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	112, 755		0 0	3, 848, 151	
	05100 RECOVERY ROOM	0	8, 353		0 0	1, 008, 991	
	05300 ANESTHESI OLOGY	0	11, 805		0 0	1, 583, 320	
	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0	272, 968 C		0 0 0 0	6, 130, 280 0	1
	05600 RADI OI SOTOPE	0	C	1	0 0	0	1
	05700 CT SCAN	0	C	1	0 0	0	1
	05900 CARDI AC CATHETERI ZATI ON	0	66, 340		0 0	2, 611, 456	1
60.00	06000 LABORATORY	0	207, 727		0 0	6, 090, 871	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 953		0 0	246, 641	1
	06500 RESPI RATORY THERAPY	0	47,646		0 0	1, 882, 988	1
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	13, 024		0 0	1, 308, 797	
	06800 SPEECH PATHOLOGY	0	12, 450 676		0 0	728, 118 139, 397	
	06900 ELECTROCARDI OLOGY	0	14, 342		0 0	320, 286	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	23, 053		0 0	1, 292, 142	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	147, 325		0 0	2, 761, 693	
	07300 DRUGS CHARGED TO PATIENTS	2, 738, 702	221, 930		0 0	6, 094, 438	
	07400 RENAL DIALYSIS	0	3, 405		0 0	494, 698	
	03950 MISC ANCI LLARY	0	C		0 0	0	
	03951 SLEEP LAB	0	C		0 0	0	
	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 03952 WOUND CARE	0	9, 876		0 0	0 2, 256, 789	
70.03	OUTPATIENT SERVICE COST CENTERS	0	7,070	/	0 0	2,230,707	70.03
90.00	09000 CLINIC	0	757	/	0 0	369, 053	90.00
	09100 EMERGENCY	0	198, 627	,	0 0	6, 451, 361	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
72.00	SPECIAL PURPOSE COST CENTERS						
			1, 673, 524	1, 289, 84	4 121, 357	75, 501, 028	118.00
118.00		2, 738, 702					
118.00	NONREIMBURSABLE COST CENTERS					07 200	190 00
118. 00 190. 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 0		190.00
118.00 190.00 192.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES				0 0 0 0 0 0	769, 316	192.00
118.00 190.00 192.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFI CES 07950 MEALS ON WHEELS	0	C			769, 316 372, 105	192.00
118.00 190.00 192.00 194.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 MEALS ON WHEELS Cross Foot Adjustments Negative Cost Centers	0	C		0 0 0 0 0 0	769, 316 372, 105 0	192.00 194.00 200.00 201.00

Heal th Financ COST ALLOCATI	ial Systems ON - GENERAL SERVICE COSTS	ST JOSEPH MEDI	CAL CENTER Provider CCN	l: 15-0047	In Li Period: From 06/01/2019 To 05/31/2020	) Date/Time Pre	pared:
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		1.	11/2/2020 12:	<u>13 pm</u>
		25.00	26.00				
1.00         00100 (           2.00         00200 (           4.00         00400 (           5.01         00590 (	L SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT REVENUE CYCLE PURCHASING RECEIVING AND STORES						1.00 2.00 4.00 5.01 5.02
5.03 00591 / 7.00 00700 ( 8.00 00800   9.00 00900	ADMI NI STRATI VE AND GENERAL OPERATI ON OF PLANT LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG DI ETARY						5. 03 7. 00 8. 00 9. 00 10. 00
11. 00 01100 ( 13. 00 01300 ( 14. 00 01400 ( 15. 00 01500 (	CAFETERIA NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY PHARMACY WEDI CAL RECORDS & LI BRARY						11. 00 13. 00 14. 00 15. 00 16. 00
17.00 01700 9 22.00 02200	SOCIAL SERVICE I&R SERVICES-OTHER PRGM COSTS APPRV ENT ROUTINE SERVICE COST CENTERS						17.00 22.00
33.00 03300 I 40.00 04000 S	ADULTS & PEDIATRICS BURN INTENSIVE CARE UNIT SUBPROVIDER - IPF	-121, 357 0 0	17, 304, 357 5, 094, 094 3, 798, 363				30. 00 33. 00 40. 00
	SKILLED NURSING FACILITY ARY SERVICE COST CENTERS	0	3, 563, 387				44.00
50.00 05000 0	OPERATING ROOM	0	3, 848, 151				50.00
	RECOVERY ROOM	0	1,008,991				51.00
	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	1, 583, 320 6, 130, 280				53.00 54.00
54.01 03630 I	ULTRA SOUND	0	0				54.01
	RADI OI SOTOPE	0	0				56.00
	CT SCAN CARDI AC CATHETERI ZATI ON	0	2, 611, 456				57.00 59.00
60.00 06000 I	LABORATORY	0	6, 090, 871				60.00
	NHOLE BLOOD & PACKED RED BLOOD CELL RESPI RATORY THERAPY	0	246, 641 1, 882, 988				62.00 65.00
	PHYSI CAL THERAPY	0	1, 308, 797				66.00
	OCCUPATIONAL THERAPY	0	728, 118				67.00
	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	139, 397 320, 286				68.00 69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 292, 142				71.00
	IMPL. DEV. CHARGED TO PATIENTS	0	2, 761, 693				72.00
	DRUGS CHARGED TO PATIENTS	0	6, 094, 438				73.00 74.00
	RENAL DI ALYSI S MI SC ANCI LLARY	0	494, 698 0				74.00 76.00
76.01 03951	SLEEP LAB	0	0				76. 01
	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0				76.02
76. 03 03952 \ OUTPAT	I ENT SERVICE COST CENTERS	0	2, 256, 789				76.03
90.00 09000		0	369, 053				90.00
91.00 09100 1		0	6, 451, 361				91.00
	DBSERVATION BEDS (NON-DISTINCT PART L PURPOSE COST CENTERS	0					92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	-121, 357	75, 379, 671				118.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	97, 388				190. 00
	PHYSI CI ANS' PRI VATE OFFI CES	0	769, 316				192.00
	MEALS ON WHEELS Cross Foot Adjustments	0	372, 105 0				194. 00 200. 00
	Negative Cost Centers	0	0				200.00
	TOTAL (sum lines 118 through 201)	-121, 357	76, 618, 480				202.00

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO		Period: From 06/01/2019 To 05/31/2020	Worksheet B Part II Date/Time Pre 11/2/2020 12:	pared: 13 pm
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	62, 787	65, 98	1 128, 768	128, 768	4.00
5.01	00590 REVENUE CYCLE	0	222, 714			7, 343	•
5.02 5.03	00560 PURCHASING RECEIVING AND STORES 00591 ADMINISTRATIVE AND GENERAL	0	154, 685 120, 345			152 9, 871	5. 02 5. 03
7.00	00700 OPERATION OF PLANT	0	1, 537, 431	1, 615, 64		5, 143	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	49, 295				8.00
9.00	00900 HOUSEKEEPING	0	746, 337			2, 679	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	233, 145		6 478, 151 0 0	0	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	85, 419	89, 76	-	6, 981	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	1, 219	•
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	0 139, 704		0 0 1 286, 515	6, 949 855	•
17.00	01700 SOCIAL SERVICE	0	139,704		0 200, 515	3, 504	17.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	E 20 77E	E(7.00	4 1 107 000	24.004	1 20 00
30. 00 33. 00	03000 ADULTS & PEDIATRICS 03300 BURN INTENSIVE CARE UNIT	0	539, 775 93, 309			24, 084 9, 326	•
	04000 SUBPROVI DER – I PF	0	59, 088			5, 699	•
44.00	04400 SKILLED NURSING FACILITY	0	114, 171	119, 97	9 234, 150	5, 006	44.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0	228, 595	240, 22	4 468, 819	2, 852	50.00
51.00	05100 RECOVERY ROOM	0	85, 751	90, 11		668	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	219, 295	230, 45		7,635	•
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	0	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	24, 428				•
60.00		0	187, 695			7, 863	•
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	0	10, 285 76, 265			0 3, 062	62.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	99, 096			1, 624	1
67.00	06700 OCCUPATI ONAL THERAPY	0	37, 933			1, 219	•
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	14, 609 13, 904			74 416	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	13, 904		0 0		•
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	32, 864			0	73.00
	07400 RENAL DIALYSIS 03950 MISC ANCILLARY	0	26, 743	28, 10	4 54, 847 0 0	0	74.00 76.00
	03951 SLEEP LAB	0	0		0 0	0	76.01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76.02
76.03	03952 WOUND CARE OUTPATIENT SERVICE COST CENTERS	0	114, 278	120, 09	1 234, 369	2, 933	76.03
90.00	09000 CLINIC	0	28, 287	29, 72	6 58, 013	391	90.00
	09100 EMERGENCY	0	175, 588				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	5, 533, 821	5, 815, 33	3 11, 349, 154	128, 768	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 465	14, 15	0 27, 615	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
194.00 200.00	07950 MEALS ON WHEELS Cross Foot Adjustments	0	0		0 0		194. 00 200. 00
200.00			n		0 0		200.00
202.00		0	5, 547, 286	5, 829, 48	3 11, 376, 769		

ALLOC	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0047	Peri od: From 06/01/2019 To 05/31/2020	Worksheet B Part II Date/Time Pre 11/2/2020 12:	epared: 13 pm
	Cost Center Description	REVENUE CYCLE	PURCHASI NG RECEI VI NG AND STORES	ADMI NI STRATI N AND GENERAL	/E OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5.02	5.03	7.00	8.00	
	GENERAL SERVICE COST CENTERS		1				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4/4 101					4.00
5.01 5.02	00590 REVENUE CYCLE	464, 101					5.01
5.02 5.03	00560 PURCHASING RECEIVING AND STORES 00591 ADMINISTRATIVE AND GENERAL	0			10		5.02
7.00	00700 OPERATION OF PLANT	0					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0					
9.00	00900 HOUSEKEEPING	0				134, 900	1
10.00	01000 DI ETARY	0	47,060			0	
11.00	01100 CAFETERIA	0	0			0	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	304			0	
14.00	01400 CENTRAL SERVICES & SUPPLY	0				0	
15.00	01500 PHARMACY	0				0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0				0	
17.00	01700 SOCIAL SERVICE	0				0	17.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	c			0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS		·	•			
30.00	03000 ADULTS & PEDIATRICS	42, 887	10, 730	38, 51	7 499, 489	36, 348	30.00
33.00	03300 BURN INTENSIVE CARE UNIT	16, 016	9, 388	12, 70	86, 345	17, 709	33.00
40.00	04000 SUBPROVI DER – I PF	18, 453	1, 962	8, 60	)3 54, 678	15, 611	40.00
44.00	04400 SKILLED NURSING FACILITY	4, 896	3, 225	6, 87	105, 650	12, 678	44.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	31, 278					
51.00	05100 RECOVERY ROOM	2, 317				2, 762	
53.00	05300 ANESTHESI OLOGY	3, 275		5, 36		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	75, 587				11, 821	
54.01	03630 ULTRA SOUND	0	-		0 0	0	
56.00	05600 RADI OI SOTOPE	0	-		0 0	0	
57.00	05700 CT SCAN	0	-		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	18, 403					
60.00		57,623				0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	1,096				0	
65.00 66.00	06600 PHYSI CAL THERAPY	13, 217 3, 613				0	
67.00	06700 OCCUPATIONAL THERAPY	3, 454				0	1
68.00	06800 SPEECH PATHOLOGY	188					
69.00	06900 ELECTROCARDI OLOGY	3, 978				564	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 395				0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	40, 868				0	
73.00	07300 DRUGS CHARGED TO PATIENTS	61, 563				0	
	07400 RENAL DI ALYSI S	945					
76.00		0			0 0	0	
76.01		0	c c		0 0	0	
76. 02		0	C		0 0	0	
	03952 WOUND CARE	2,740	8, 073	5, 25	53 105, 748	0	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	210	9	66	26, 175	6, 786	90.00
91.00	09100 EMERGENCY	55,099	19, 129	16, 25	59 162, 483	36, 297	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	464, 101	317, 391	261, 78	3, 179, 423	154, 900	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			6 12, 460		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	C		7 0		192.00
	07950 MEALS ON WHEELS	0	0		0 0	0	194.00
200.00							200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
201.00	TOTAL (sum lines 118 through 201)	464, 101	317, 391	261, 90	3, 191, 883	154, 900	

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 06/01/2019 To 05/31/2020	Worksheet B Part II Date/Time Pre 11/2/2020 12:	pared:
Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS				11		
1.00       00100       CAP REL COSTS-BLDG & FLXT         2.00       00200       CAP REL COSTS-MVBLE EQUIP         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.01       00590       REVENUE CYCLE         5.02       00560       PURCHASI NG RECEIVING AND STORES         5.03       00591       ADMINISTRATIVE AND GENERAL         7.00       00700       OPERATION OF PLANT         8.00       00800       LAUNDRY & LINEN SERVICE         9.00       00900       HOUSEKEEPING         10.00       01000       DIETARY         11.00       01100       CAFETERIA         13.00       01300       NURSI NG ADMINISTRATION         14.00       01400       CENTRAL SERVICES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MEDICAL RECORDS & LIBRARY	2, 238, 223 196, 644 0 72, 045 0 0 117, 831	944, 651 0 0 0 0 0 0	2, 805 160 60 132 33	0 342, 840 0 0 2 5, 772 3 0	11, 542 54 2	15. 00 16. 00
17.00 01700 SOCIAL SERVICE	0	0	85		0	
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	0	0	C	0 0	0	22.00
30. 00         03000         ADULTS & PEDIATRICS           33. 00         03300         BURN INTENSIVE CARE UNIT           40. 00         04000         SUBPROVIDER - IPF           44. 00         04400         SKILLED NURSING FACILITY	455, 266 78, 700 49, 837 96, 296	333, 673 57, 623 100, 612 112, 659	725 218 185 128	52, 796 28, 177	506 442 92 152	33.00 40.00
ANCI LLARY SERVI CE COST CENTERS	100.00/			10 101		50.00
50. 00         05000         OPERATI NG         ROOM           51. 00         05100         RECOVERY         ROOM           53. 00         05300         ANESTHESI OLOGY           54. 00         05400         RADI OLOGY-DI AGNOSTI C           54. 01         03630         ULTRA           56. 00         05600         RADI OL SOTOPE           57. 00         05700         CT	192, 806 72, 326 0 184, 962 0 0 0	0 0 0 0 0 0 0	66 13 207 0 0	3 3, 373 0 0 7 0 0 0 0 0 0 0	909 0 250 0 0 0	51.00 53.00 54.00 54.01 56.00
59. 00       05900       CARDI AC CATHETERI ZATI ON         60. 00       06000       LABORATORY         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL         65. 00       06500       RESPI RATORY THERAPY         66. 00       06600       PHYSI CAL THERAPY         67. 00       06700       OCCUPATI ONAL THERAPY         68. 00       06800       SPEECH PATHOLOGY         69. 00       06900       ELECTROCARDI OLOGY	20, 604 158, 309 8, 675 64, 325 83, 582 31, 994 12, 322 11, 727	0 0 0 0 0 0 0 0 0	75 252 0 82 39 25 2 2 10	2 0 2 0 5 0 2 0 2 0 2 0	487 1, 314 272 173 9 0 0 7	60.00 62.00 65.00 66.00 67.00 68.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT         72.00       07200       I MPL. DEV. CHARGED TO PATI ENTS         73.00       07300       DRUGS CHARGED TO PATI ENTS         74.00       07400       RENAL DI ALYSI S         76.00       03950       MI SC ANCI LLARY         76.01       03951       SLEEP LAB         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES         76.03       03952       WOUND CARE         OUTPATI ENT SERVI CE COST CENTERS       OUTPATI ENT SERVI CE	0 0 27, 718 22, 556 0 0 0 96, 386	0 0 0 0 0 0 0 0	C C C C C C C C C C C C C C C C C C C	0     0       0     0       0     0       0     0       0     0       0     0       0     0       2     13, 376	1, 881 3, 704 0 7 0 0 0 380	72.00 73.00 74.00 76.00 76.01 76.02
90. 00 91. 00 92. 00	23, 858 148, 097	0 0	ç 217		0 901	
118.00 SUBTOTALS (SUM OF LINES 1 through 117	) 2, 226, 866	604, 567	2, 805	342, 840	11, 542	118.00
NONREI MBURSABLE COST CENTERS190.0019000GIFT, FLOWER, COFFEE SHOP & CANTEEN192.0019200PHYSICIANS' PRIVATE OFFICES194.0007950MEALS ON WHEELS200.00Cross Foot Adjustments201.00Negative Cost Centers	11, 357 0 0	0 229, 006 111, 078 0			0 0	190. 00 192. 00 194. 00 200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 238, 223	944, 651	2, 805	342, 840	0 11, 542	201.00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		Period: From 06/01/2019	Worksheet B	
					To 05/31/2020	Part II Date/Time Pre 11/2/2020 12:	epared: 13 pm
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI C	I NTERNS & RESI DENTS E SERVI CES-OTHER PRGM COSTS APPRV	Subtotal	
		15.00	16.00	17.00	22.00	24.00	
	GENERAL SERVICE COST CENTERS			1	- <u>1</u> T		_
11.00 13.00	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 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						1.00 2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	23, 083					14.00
	01600 MEDICAL RECORDS & LIBRARY	23,005	537, 986				16.00
	01700 SOCIAL SERVICE	0	C		2		17.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	C		0 414		22.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	0	49, 711			2, 736, 114	
	03300 BURN INTENSIVE CARE UNIT	0	18, 564			552, 401	
	04000 SUBPROVIDER - IPF 04400 SKILLED NURSING FACILITY	0	21, 389 5, 675			431, 250 622, 523	
+4.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	5, 675	0 0, 34		022, 023	44.00
50.00	05000 OPERATING ROOM	0	36, 255	j	0	988, 927	50.00
	05100 RECOVERY ROOM	0	2,686		0	341, 253	
53.00	05300 ANESTHESI OLOGY	О	3, 796		0	12, 438	3 53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	87, 658		0	1, 042, 191	
	03630 ULTRA SOUND	0	C		0	C	
	05600 RADI OI SOTOPE	0	C		0	C	
	05700 CT SCAN 05900 CARDI AC CATHETERI ZATI ON	0	C 21, 331		0	0 170, 552	
	06000 LABORATORY	0	66, 792		0	895, 205	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1, 271		0	48, 309	
	06500 RESPIRATORY THERAPY	0	15, 320		0	331, 759	
	06600 PHYSI CAL THERAPY	0	4, 188		0	390, 962	
	06700 OCCUPATI ONAL THERAPY	0	4, 003		0	155, 407	67.00
	06800 SPEECH PATHOLOGY	0	217		0	56, 520	
	06900 ELECTROCARDI OLOGY	0	4, 611		0	63, 648	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	7,412		0	59, 539 178, 646	
	07200 TMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	23, 083	47, 370 71, 358		0		73.00
	07400 RENAL DIALYSIS	23,005	1, 095		0	105, 599	
	03950 MISC ANCI LLARY	o	1, 0, 0		o l	100, 07, C	1
	03951 SLEEP LAB	0	C		0	C	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C		0	C	76.02
76.03	03952 WOUND CARE	0	3, 175	j	0	472, 515	76.03
	OUTPATIENT SERVICE COST CENTERS			1		110.07/	
	09000 CLINIC 09100 EMERGENCY	0	243		0	118, 376 918, 882	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	63, 866		0	918, 882	91.00
2.00	SPECIAL PURPOSE COST CENTERS			1	1		72.00
118.00		23, 083	537, 986	26, 17	2 0	10, 984, 716	118.00
	NONREI MBURSABLE COST CENTERS		,			.,,,,,,	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	)	0	51, 548	190. 00
		0	C		0	229 013	192.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	U	C C				
192.00 194.00	07950 MEALS ON WHEELS	0	C		0	111, 078	194.00
192.00	07950 MEALS ON WHEELS Cross Foot Adjustments	0	C			111, 078 414	

Cost Center Description         Intern & September 2010         Intern & September 2010         Intern & September 2010           All usteents         All usteents         26.00         26.00         27.00           1.00         Control CAP REL COST ANDLE FOULP         26.00         20.00         20.00           2.00         COST CAPTER EXPRETS         26.00         20.00         20.00         20.00           2.00         COST CAPTER EXPRETS         CENTRAL SERVICE         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00         20.00	Health Financial Systems	ST JOSEPH MEDIC	CAL CENTER	In Lie	eu of Form CMS-2552-10
Residents         Obst Stupdom         Adjust           Joint Council         Joint Councin         Joint Council         J	ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-	From 06/01/2019	Part II
ENERGY SERVICE COST CENTERS           0.0000 CAP REL COSTS-BUBLE SOLP AT T           2.0000 CAP REL COSTS-BUBLE SOLP AT T           2.0000 CAP REL COSTS-BUBLE SOLP AT TS           2.00000 CAP REL COSTS-BUBLE SOLP AT TS           2.000000 CAP REL COSTS A PREY           1.0000 CAPERTIA A           1.0000 CAPERTIA A           1.0000 CAP REL COSTS A PREY           1.0000 CAPERTIA A           1.0000 CAPERTIA A           1.0000 CAPERTIA A           1.0000 CAPERTIA A           1.00000 CAPERTIA A           1.00000 CAPERTIA A           1.00000000 CAPERTIA A           1.000000000000000000000000000000000000	Cost Center Description	Residents Cost & Post Stepdown	Total		
1:00 00100 CAP REL COSTS-BLIDS & FIXT		25.00	26.00		
2 00 00200 CAP HEL COSTS -INVOLE COULP + 4 00 00400 EPUCYUE BERENET IS OPERATINENT 5 00 00500 PUCYUSE MENENENT IS OPERATINENT 5 00 00500 PUCYUSE MENENENT IS OPERATINENT 5 00 00500 PUCYUSE MENENENT (C AND STORES 5 00 00500 PUCYUSE MENENS STORE C AND STORES 5 00 00500 PUCYUSE MENENS STORE C AND STORES 5 00 1000 CHARANY 1 0 00 10100 CAFETERI A 1 0 00 10100 CENTRAL SERVICES A SUPPLY 1 0 00 1000 OURSI MENENDIN STRATION 1 0 00 10100 SOCIAL SERVICES A SUPPLY 1 0 00 1000 OURS MENENDE A LURARY 1 0 00 1000 OURS MENENDE A LURARY 1 0 00 1000 OURS STALES SERVICES A SUPPLY 1 0 00 0000 PUCKATINE SERVICE COST CENTER 1 0 00 1000 OURS MENENDE A LURARY 1 0 00 1000 OURS STALES SERVICES A SUPPLY 1 0 00 00000 PUCKATINE SERVICE COST CENTER 1 0 00 0000 OURS MENENDE A LURARY 1 0 00 0000 OURS MENENDE A LURARY 1 0 00 0000 OURS STALED MENENDE A LURARY 1 0 00 0000 OURSTALED MENENDE A LURARY 1		1 1	1		
4.00       00400 [APUCUPE BELNELT IS DEPARTINENT       4.0         5.01       00550 PURVABLS NG RECEI VINA AND STORES       5.0         5.03       00560 PURVABLS NG RECEI VINA AND STORES       5.0         5.04       00700 QPERATI NO OF PLANT       7.0         5.00       01700 DIELANY       1.0         5.01       007100 QPERATI SERVICE       10.0         5.00       01500 PLANESKIN CES & SUPPLY       11.0         5.00       01500 PLANESKIN CES AND PLY       11.0         5.00       01500 PLANESKIN CARDIN ISTRATION       11.0         7.00       01500 PLANESKIN CARDIN ISTRATION       12.2         7.00       01500 PLANESKIN CARDIN ISTRATION       0         7.00       01500 PLANESKIN CARDIN ISTRATION       0         7.00       01500 PLANESKIN CARDIN ISTRATIO					1.00
9. 01       00500 PREVENUE CYCLE       5.0         5.20       00561 PADRUASKIS RECELVIVING AND STORES       5.0         5.01       00501 PADRUASKIS RECELVIVING AND STORES       5.0         5.03       00501 PADRUASKIS REPEAU VING AND STORES       5.0         8.00       006000 PERATION OF PLANT       8.0         9.00       000000 PERATION OF PLANT       10.0         9.00       01000 PERATION OF PLANT       10.0         9.00       01000 PERATION OF PLANT       10.0         9.00       01400 PERATION OF PLANT       10.0         9.00       01400 PERATION OF PLANT       0         9.00       01400 PERATION OF PLANT       0         9.00       01400 PERATION OF PLANT       0         9.00       01300 PLANT       PLANTRICS       0         9.00       01400 PERATION OF PLANT       0       52,2,101       30.0         9.00       01000 PERATION OF PLANTRICS       0       98,9,27       50.0         9.00       050					2.00
5.02       00560       PURCHASHING RECEIVING AND STORES       5.0         5.03       00570       OPERATING OF PLANT       5.0         7.00       00700       OPERATING OF PLANT       5.0         7.01       00700       OPERATING OF PLANT       5.0         7.01       00700       PROSENEED NG       7.0         7.01       00700       PROSENEED NG       7.0         7.01       00700       PROSENEED NG       7.0         7.01       00700       OPERATING SERVICE       7.0         7.01       00700       OPERATING SERVICE       10.0         7.02       01700       SCALLSERVICE       10.0         7.02       01700       SCALLSERVICE ASERVICE       10.0         7.03       01700       SCALLSERVICE COST CENTERS       22.0         7.04       01700       SCALLSERVICE COST CENTERS       22.0         7.04       01700       SCALLSERVICE COST CENTERS       20.0         7.05       01700       SCALLSERVICE COST CENTERS       20.0         7.06       00000       SCALLSERVICE COST CENTERS       20.0         7.06       00000       SCALLSERVICE COST CENTERS       20.0         7.00       SCALLSERVICE COST CENTERS					4.00
b. 03         00590         AdM IN STRATI VE AND CREMERAL         5.0           7.00         00700         0PENATION OF PLANT         8.00           8.00         00800         LAURRY & LINEN SERVICE         8.00           9.00         00700         DISTREPARY         10.00           11.00         01100         DISTREPARY         11.00           11.00         01100         DISTREPARY         11.00           11.00         01100         DISTREPARY         11.00           11.00         O11000         DISTREPARY         11.00           11.00         O11000         MENTATION         11.00           11.00         O11000         MENTATION         11.00           11.00         O11000         MENTATINE NOUTINE SERVICE COST CATERES         0           00.000         O14000 ADULTS & PEDIATRICS STAPHY         0         43.1.200         40.0           10.00         SOLOD OFENTINE FACILITY         0         43.1.200         40.0           01.000         SUBHILED INDER FACILITY         0         43.1.200         40.0           10.00         SOLOD OFENTINE FACILITY         0         43.1.200         40.0           10.00         SOLOD OFENTINE FACILITY         0					5. 01
7. 00         00700 (PERATION OF PLANT         7. 0           8.00         00800 (LAUNORY & LINEN SERVICE         8.0           9. 00         00700 (LAUNORY & LINEN SERVICE         8.0           9. 01         00100 CAFETERIA         110.0           11. 00         01100 CAFETERIA         110.0           13. 00         01400 CENTRAL SERVICES & SUPPLY         110.0           14. 00         01400 CENTRAL SERVICES & SUPPLY         110.0           15. 00         01500 MISSICA SERVICES         2.726.1           20. 00         02300 BURNITINE SERVICE COST CENTERS         220.0           00.00         03000 BURNITINE SERVICE COST CENTERS         20.0           00.00         03000 BURNITINE CARE (WIIT         0         552, 401         33.0           0.00         03000 BURNITINE CARE (WIIT         0         622, 523         40.0           44.00         04400 SH LISE NOR COST CENTERS         90.0         31.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         <					
8. 00         00800 LAURORY & LINEN SERVICE         8. 0           9.00         00500 HUSEKEEPINGS         90           11.00         01100 CAFFTERIA         110           13. 00         01300 NUESING ADMINISTRATION         110           13. 00         01300 NUESING ADMINISTRATION         110           14.00         01400 CAFFTERIA         110           15. 00         01500 PHARMACY         110           16. 00         01500 PHARMACY         110           17. 00         01700 SOCIAL SERVICES & SUPPLY         110           17. 00         01700 SOCIAL SERVICE COST CONTERNET         0         2, 736, 114         30           30. 01300 SURPI INTENENTINE FACILITY         0         4, 52, 2401         30         33, 30           40. 00 4400 SURPI INTENENTING FACILITY         0         42, 728, 211         30, 30         33, 30           40. 00 4400 SURPINTORE RE FORM         0         43, 725, 2401         30, 44, 44           41. 00 4400 SURPINTORE RE FORMO         0         43, 725, 2401         30, 44, 44           41. 00 4400 SURPINTORE RE FORMO         0         44, 44         44, 40         44, 44, 44, 44, 44, 44, 44, 44, 44, 44,					
9 00 00000 HUSEKEPING 0000 FEARY 0000 HUSEKEPING 0000 FEARY 0000 HUSENG ADM NISTRATION 00000 HETARY 00000000 HETARY 000000000000000000000000000000000000					
10.00         01000         DETRAY         10.0           11.00         01100         CAFETER IA         11.0           13.00         01300         NUESING ADMINISTRATION         13.0           14.00         01400         CHITRAL SERVICES & SUPPLY         13.0           15.00         01500         PHARMACY         13.0           16.00         01600         DERASELSENCIES & SUPPLY         13.0           17.00         01700 SOCIAL SERVICES AS DIFRE PRAVICES         10.0           22.00         02200 DIESA SERVICES - OTHER PRAVICOSTS APPRV         22.0           17.00         01700 SOCIAL SERVICE COST CENTERS         0         2.736.114         30.0           30.00         032000         PENATRIE NE ROUTINE SERVICE         0         43.400         33.0           31.00         032000         PENATRIE NE ROUTINE         0         43.4253         50.0           31.00         05100 FENATINE NE ROW         0         988.927         50.0         50.0           51.00         05100 REDOVERY PROM         0         341.253         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0         50.0 <td></td> <td></td> <td></td> <td></td> <td>9.00</td>					9.00
11.00       01100       CATERRIA       11.0         13.00       01300       CHARLARS SERVICES A SUPPLY       13.0         14.00       01400       CENTROL SERVICES A LIBRARY       13.0         17.00       01700       CENTROL RESING ADMINISTRATION       14.0         16.00       01400       MEDICAL RECORDS & LIBRARY       15.0         17.00       01700       CENTROL RESINCE COST CENTERS       0         00.00       02200 IAR SERVICES-OTHER PROMICOSTS APPRV       22.0       20.0         INPARTENT ROUTH DE SERVICE COST CENTERS       0       2.736, 114       30.0         30.00       03300 ADULTS & PEDIATRICS       0       431, 250       40.0         0.4400       O4400 SULED NIRSING FACILITY       0       622, 253       44.0         AMCILLARY SERVICE COST CENTERS       0       341, 253       50.0       50.0         15.00       05000 PENATING ROUTH ROUTH       0       988, 927       50.0       50.0         16.00       SCON REDOVERANT ROUTH       0       988, 927       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0					10.00
14 00       01400       CENTRAL SERVICES & SUPPLY       14.0         15.00       01500       MEDIO HARMACY       15.0         16.00       01600       HEDICAL, RECORDS & LIBRARY       15.0         17.00       01700       SERVICES-OTHER PROM COSTS APPRV       22.0         18.00       03000 ADULTS & PEDIATRICS       0       2.736, 114       30.0         30.00       03000 ADULTS & PEDIATRICS       0       2.736, 114       33.0         30.00       03000 ADULTS & PEDIATRICS       0       43.250       40.0         44.00       044000 SUBPROVIDER - IPF       0       643.252       44.0         44.00       044000 SUBLEN INTERSING FACILITY       0       622.523       44.0         44.00       04000 SUBPROVIDER - IPF       0       11.042, 191       54.0         55.00       05500 ARSTIRS ING FACILITY       0       622.523       44.0         46.01       04000 SUBPROVIDER - NOM       0       241.253       55.0         56.00       0500 ARSTIRS INGOCY       0       11.042,191       54.0         57.00       05700 CARDIAC CATHETER IZATION       0       0       56.0         57.00       05700 CARDIAC CATHETER IZATION       0       170.55.20       59.0<					11.00
15 00       01500       PHARMACY       15 0         16 00       01700       SOCIAL SERVICE       15 0         17 00       01700       SOCIAL SERVICE       16 0         18 00       0180 SERVICE       22.736,114       30 0         30 00       03000 BURDICAL SERVICE COST CENTERS       30 0       33.0         30 00       03000 SUBPROVIDER - IPF       0       431,250       40 0         ANDICILLARY SERVICE COST CENTERS       0       22.736,114       30 0       33.0         30 00       03000 SUBPROVIDER - IPF       0       431,250       40 0       44 0         ANDICILLARY SERVICE COST CENTERS       0       22.438       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0       53.0 <td>13.00 01300 NURSING ADMINISTRATION</td> <td></td> <td></td> <td></td> <td>13.00</td>	13.00 01300 NURSING ADMINISTRATION				13.00
16 0.0       01600       HEDICAL, RECORDS & LIBRARY       16.0         7.00       01700       00100       SIENU CE       77.0         17.00       01700       00100       SIENU CES-OTHER PROM COSTS APPRV       72.0         10.00       022001 (AR SERVI CE CS-OTHER PROM COSTS APPRV       22.0       73.0         10.00       030000 (ADULTS & PEDIATRICS       0       2.736.114       33.0         30.00       03300 (DURN I NERSIN CE CALLITY       0       6431.250       44.0         44.00       044000 SURPERVIDER - IPF       0       6431.253       51.0         00.00       05000 OPERATI ING ROOM       0       948.927       51.0         51.00       05100 (PECATING ROOM       0       341.253       53.0         52.00       05000 (ARDIACS) (DORY       0       1.042.191       54.0         54.00       05400 (ARDIACS) (DORY       0       0       56.0         57.00       05700 C TSCAN       0       0       57.0         59.00       05900 CARDIAC CATHETER LATION       0       170.552       59.0         60.00       66000 PEST INSCHAPY       0       95.265       66.0         65.00       65.00       65.00       56.00       56.00	14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
17.00       01700 SOCIAL SERVICE       17.0         17.00       0200 IAS SERVICES-OTHER PROMICOSTS APPRV       22.0         10.00       03000 IAS SERVICE COST CENTERS       30.0         33.00       03300 BURN INTENSIVE CARE UNIT       0       552.401       33.0         40.00       04000 SUBPROVIDE COST CENTERS       40.0       40.0       40.0         40.00       04000 SUBPROVIDE COST CENTERS       40.0       40.0       40.0         40.00       04000 SUBPROVIDE COST CENTERS       50.0       0       989.27       50.0         51.00       05100 ORECOVERY ROOM       0       341.253       51.0       51.0         53.00       0800 RADIO RADUCS APTIESI DLOGY       0       12.438       53.0         54.00       0400 RADIO LOS APTIESI DLOGY       0       12.438       53.0         55.00       0500 OREAD LAS SUND       0       0       50.0       50.0         55.00       0500 CARID LOC CATHERER ZATI ON       0       170.552       50.0       50.0         66.00       06000 RADIOR SUNDY THERAPY       0       331.759       56.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0       50.0					15.00
22.00         j22200 j.88 SERVICES_OTHER PROM COSTS APPRV         22.0           10.000         03000 ADULTS & PEDIATRICS         30.0           30.00         03000 ADULTS & PEDIATRICS         32.736,114         30.0           30.00         03000 SUBRN INTERSIVE CARE UNIT         0         552,401         33.0           40.00         04000 SUBPROVIDER - IPF         0         433,250         40.0           41.00         04000 SUBPROVIDER - IPF         0         433,250         40.0           41.00         04000 SUBPROVIDER - IPF         0         433,250         40.0           41.00         04000 SUBPROVIDER - IPF         0         431,253         51.0           51.00         05000 PECOVERY ROOM         0         968,927         51.0           53.00         05300 RECOVERY ROOM         0         12.438         53.0           54.01         03400 RADI CLOSCYDER         0         1.0.42,191         54.0           54.01         03400 RADI CLOSCYDIAK SOURD         0         0         50.0         55.0           59.00         05900 CARDIA CCATHETERIZATION         0         170,552         59.0         50.0           60.00         06000 READTING VIERAPY         0         331,759         66.0					16.00
INPAT ENT NOUTINE SERVICE COST CENTERS         Image: Center State         Image:					17.00
20.00       03000       AULTS & PEDIATRICS       0       2,736,114       30.0         30.00       03000       BURN INTERVIVE CARE UNIT       0       552,401       40.0         40.00       Q40000       SUBPROVIDER - IPF       0       431,250       40.0         40.00       G4000 SHLIED NURSING FACILITY       0       622,523       40.0         ANCILLARY SERVICE COST CENTERS       0       0.4000 PERATINE ROOM       0       341,253       50.0         51.00       05000 PERATINES IOLOGY       0       1.2,438       53.0       53.0       53.0       53.0       55.0       54.0       54.0       54.0       54.0       54.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0       55.0					22.00
33.00       D3300       BURN INTERSIVE CARE UNIT       0       552,401       332.         40.00       Odd000 SUBPROVIDER - IPF       0       431,250       40.0         40.00       Odd000 SUBPROVIDER - IPF       0       622,523       44.0         40.01       Stotool SUBPROVID Ro ROW       0       341,250       50.0         50.00       D50000 (PEDATING ROW       0       341,253       51.0         51.00       D50000 (ARESTHESI LOGY       0       1,42,438       53.0         54.00       D5400 (AND ILOGY-DI AGNOSTI C       0       1,042,191       54.0         55.00       D5500 (CT SCAN       0       0       0       55.0         55.00       D5500 (CT SCAN       0       0       0       55.0         56.00       D5600 (RESPI RATORY       0       0       75.0       55.0         50.00       D5000 (RESPI RATORY       0       330,759       65.0       66.0       66.00       66.00       65.0       66.00       66.00       66.00       66.00       66.00       66.00       65.0       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00<		0	2 736 114		30.00
40.00         04000 SUBEROVIDER - IPF         0         43.1250         40.0           44.00         04400 SKILED NURSING FACILITY         0         622,523         44.0           ANCILLARY SERVICE COST CENTERS         988,927         50.0         50.0         50.00         50.00         51.0         51.00         51.00         51.00         53.00         63.00         74.48         53.0         53.0         53.0         53.00         53.00         64.00         74.438         53.0         54.0         54.00         54.00         54.00         54.00         54.00         55.0         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00 <t< td=""><td></td><td>1</td><td></td><td></td><td>33.00</td></t<>		1			33.00
44.00     04400[SKILLED NURSING FACILITY     0     622,523     44.0       ANCILLARY SERVICE COST CENTERS     0     988,927     50.0     50.0       51.00     05000 (PERATING ROOM     0     341,253     50.0       51.00     05300 ANESTHESI OLOGY     0     1,042,191     54.0       54.00     05300 ANESTHESI OLOGY     0     1,042,191     54.0       55.00     05500 CARDI OLOGY-DI AGNOSTI C     0     0     0       56.00     05600 RADI OLOGY-DI AGNOSTI C     0     0     0       57.00     05700 CT SCAN     0     0     0     55.0       57.00     05700 CT SCAN     0     0     0     55.0       60.00     06000 CASOR TARY     0     170,552     59.0       60.00     06000 RESPI RATORY     0     331,759     66.0       65.00     05600 RESPI RATORY     0     331,759     66.0       66.00     06000 RESPI RATORY     0     35,407     67.0       67.00     0700 OCCUPATI ONAL THERAPY     0     339,759     65.0       68.00     06800 SPECH PATHOLOGY     0     56,520     60.0       69.00     068000 SPECH PATHOLOGY     0     56,520     60.0       71.00     07100 MEDI CAL SUPPLIES CHARGED					40.00
50. 00       05000       0PERATING ROOM       0       988, 927       50.0         51. 00       05100 RECOVER ROOM       0       341, 253       51.0         51. 00       05300 ANESTHESI OLOGY       0       12, 438       53.0         54. 00       05300 ANESTHESI OLOGY       0       1, 042, 191       54.0         54. 01       0330 ULTRA SOUND       0       0       55.0         57. 00       05700 CT SCAN       0       0       0         59. 00       05900 CLABORATORY       0       895, 205       60.0         60. 00       06000 LABORATORY       0       897, 205       60.0         60. 00       06000 LABORATORY       0       331, 759       66.0         61.00       06600 PHYSICAL HERAPY       0       331, 759       66.0         60.00       06600 SPECH PATHOLOGY       0       55.407       67.0         61.00       06600 SPECH PATHOLOGY       0       55.520       68.0         68.00       06800 SPECH PATHOLOGY       0       56.520       68.0         69.00       06900 ELECTROCARDIOLOGY       0       56.520       67.0         71.00       0700 MEDICAL SUPPLIES CHARGED TO PATIENT       0       71.0       <		0			44.00
51:00       05100       RECOVERY ROOM       51:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       53:00       55:00       50:00       55:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       59:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00       50:00					
53.00     05300     ANESTHESI OLOGY     0     12.438     53.2       54.00     05400     RADIOLOGY-DI AGNOSTI C     0     1.042,191     54.0       54.01     03630     NULTRA SOUND     0     0     54.0       55.00     05500     CRADIOLOGY-DI AGNOSTI C     0     0     54.0       56.00     05600     RADIOLOGY-DI AGNOSTI C     0     0     0       57.00     05700 CT SCAN     0     0     0     57.0       69.00     06000     LABORATORY     0     895,205     60.0       60.00     06000     RESPIRATORY THERAPY     0     331,759     66.0       66.00     06600     PHYSICAL THERAPY     0     316,759     67.0       67.00     06700 CCUPATI ONAL THERAPY     0     356,520     66.0       68.00     06600 SPEECH PATHOLOGY     0     56,520     68.0       69.00     06600 SPEECH PATHOLOGY     0     56,539     71.0       71.00     07300 KENAR ALORED TO PATI ENT     0     59,59     71.0       72.00     07300 DRUGS CHARGED TO PATI ENTS     0     105,599     74.0       73.00     07300 RENGR CHARGED TO PATI ENTS     0     105,599     74.0       74.00     07300 RENGR CHARGED TO PATI					50.00
54.00       05400       RADIOLOGY-DI AGROSTIC       0       1.042, 191       54.0         54.01       03630       ULTRA SOUND       0       0       54.0         54.01       03630       ULTRA SOUND       0       0       54.0         55.00       05500       CRD IOSTOPE       0       0       0       57.0         57.00       05700       CAT SCAN       0       0       0       57.0         60.00       06200       LABORATORY       0       895, 205       60.0       60.0         61.00       06500       RESPIRATORY THERAPY       0       331, 759       65.0       66.0         62.00       06500       RESPIRATORY THERAPY       0       390, 962       66.0       66.0         63.00       06500       RESPIRATORY THERAPY       0       155, 407       67.0       67.0       67.0       66.0       67.0       66.00       66.0       66.0       66.0       67.0       66.00       67.0       66.00       67.0       66.0       67.0       66.00       67.0       66.0       67.0       66.0       67.0       66.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0       67.0		1			51.00
54.01       03630       ULTRA SOUND       54.0         56.00       05600       RADI OI SOTOPE       0       0         57.00       05700       CARDI AC CATHETERI ZATI ON       0       170.7552         59.00       05700       CARDI AC CATHETERI ZATI ON       0       170.7552         60.00       6000       LABORATORY       0       895.205       600.0         62.00       06500       LABORATORY       0       331,759       65.0         66.00       06600       PHSI CAT THERAPY       0       331,759       65.0         66.00       06600       PECH THERAPY       0       390,962       66.0         67.00       06700       OCCUPATI ONAL THERAPY       0       356,468       69.0         68.00       66000       SPECH PATHOLOGY       0       56,520       68.0         69.00       06900       ELECTROCARDI OLOGY       0       56,530       71.0         70.00       70100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       178,646       72.0         72.00       70200       INPL. DEV. CHARGED TO PATI ENTS       0       105,599       74.0       76.0         76.00       03950 MILS C ANCI LLARY       0					
56.00       05600       RADI 01 SOTOPE       0       0       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00       57.00 <t< td=""><td></td><td>1</td><td></td><td></td><td></td></t<>		1			
57.00       05700       C SCAN       0       0       57.0         59.00       05900       CARDI AC CATHETERI ZATI ON       0       170, 552       59.0         60.00       06000       LABORATORY       0       895, 205       60.0         62.00       06500       RESPIRATORY THERAPY       0       331, 759       65.0         65.00       06500       PHYSI CAL THERAPY       0       331, 759       66.0         66.00       06600       PHYSI CAL THERAPY       0       331, 759       66.0         66.00       06600       PHYSI CAL THERAPY       0       155, 407       67.0         67.00       06700       0CCUPATI ONAL THERAPY       0       59, 539       67.0         68.00       06800       PEECH PATHOLOCY       0       63, 648       69.0         69.00       06900       FLECTROCABDI DAGY       0       63, 648       72.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       178, 646       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       105, 599       74.0       76.0         76.00       03950       MISC ANCI LLARY       0       0       0 <t< td=""><td></td><td>-</td><td></td><td></td><td>56.00</td></t<>		-			56.00
59:00       05900       CARDIAC CATHETERIZATION       0       170,552       59.0         60:00       06000       LABORATORY       0       895,205       60.0         60:00       06200       HOLE BLOOD & PACKED RED BLOOD CELL       0       48,309       62.0         61:00       06500       RESPIRATORY THERAPY       0       331,759       65.0         66:00       06000       PHYSICAL THERAPY       0       390,962       66.0         67:00       06700       0CUPATI ONAL THERAPY       0       155,407       67.0         68:00       06800       SPECH PATHOLOGY       0       63,648       69.0         69:00       06000       LECTROCARDI OLOGY       0       63,648       69.0         71:00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       178,646       72.0         72:00       07200 INPL:       DEV. CHARGED TO PATIENTS       0       105,599       74.0         74:00       07400       RENAL DI ALYSI S       0       105,599       74.0         76:01       03550 SUES CHARGED TO COST CENTERS       0       0       76.0       76.0         00       09000 ELECTRONCOST CENTERS       0       118,376       90.0		0			57.00
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       48,309       62.0         65.00       06500       RESPI RATORY THERAPY       0       331,759       65.0         66.00       0600       PHYSICAL THERAPY       0       330,962       66.0         67.00       06700       0CCUPATI ONAL THERAPY       0       155,407       67.0         68.00       OBGOD CELECTROCARDI OLOGY       0       63,648       69.0         69.00       OBGOD ELECTROCARDI OLOGY       0       63,648       69.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       59,539       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       178,646       72.0         73.00       07300       RENAL DI ALYSI S       0       105,599       74.0         76.00       03950       MISC ANCI LLARY       0       0       0       76.0         03952       03952       MISC ANCI LLARY       0       0       0       76.0       76.0         03952       09100 CARE       0       118,376       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0		0	170, 552		59.00
65.00       06500       RESPIRATORY THERAPY       0       331,759       65.00         66.00       06600       PHYSICAL THERAPY       0       390,962       66.00         67.00       0C0700       0CUPATIONAL THERAPY       0       155,407       67.00         68.00       06800       SPEECH PATHOLOGY       0       56,520       68.00         69.00       06900       ELECTROCARDIOLOGY       0       63,648       69.0         71.00       MDI CAL SUPPLIES CHARGED TO PATIENT       0       59,539       71.10         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       178,646       72.0         73.00       07300       RDIGS CHARGED TO PATIENTS       0       105,599       74.0         76.00       03950       MI SC ANCI LLARY       0       0       0         76.01       03951       SLEEP LAB       0       0       76.0         0.03950       MI SC ANCI LLARY       0       0       76.0       76.00         0.03951       MI SC ANCI LLARY       0       0       0       76.00         0.03952       WOUND CARE       0       0       0       76.00         0.000       OPO00 CLI NI C	60. 00 06000 LABORATORY	0	895, 205		60.00
66.00       06600       PHYSI CAL THERAPY       0       390, 962       66.0         67.00       06700       0CCUPATI ONAL THERAPY       0       155, 407       67.0         68.00       06800       SPEECH PATHOLOGY       0       56, 520       68.0         69.00       06900       ELECTROCARDI OLOGY       0       63, 648       69.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       59, 539       71.0         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       291, 700       73.0         73.00       07300       RUGS CHARGED TO PATI ENTS       0       291, 700       73.0       74.00         74.00       07400       RENAL DI ALYSI S       0       105, 599       74.0       76.00       3951       76.00       3951       76.00       3951       76.00       3951       76.00       76.00       3951       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00 </td <td></td> <td></td> <td></td> <td></td> <td>62.00</td>					62.00
67.00       06700       OCUPATIONAL THERAPY       0       155, 407       67.0         68.00       06800       SPEECH PATHOLOGY       0       56, 520       68.0         69.00       06900       ELECTROCARD LOGY       0       63, 648       69.0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       59, 539       71.0         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0       178, 646       72.0         73.00       ORUGS CHARGED TO PATIENTS       0       105, 599       74.0       74.00       74.00       74.00       76.01       03950       MISC ANCILLARY       0       0       76.02       039550       PSYCHIATRIC/PSYCHOLOGICAL SERVICES       0       0       76.02       03952       WOUND CARE       0       76.02       0       76.02       0       76.02       0       76.02       0       76.02       0       76.02       0       76.02       0       76.02       0       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02		-			65.00
68.00       06800       SPECH PATHOLOGY       0       56,520       68.00         69.00       06900       ELECTROCARDI OLOGY       0       63,648       69.0         71.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       59,539       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0       178,646       72.00         73.00       07300       RENA DI ALYSI S       0       105,599       74.00       74.00         74.00       O7400       RENAL DI ALYSI S       0       105,599       74.00       74.00         76.00       03950       MISC ANCI LLARY       0       0       0       76.00       03952       WOLND CARE       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00		-			66.00
69.00       06900       ELECTROCARDIOLOGY       0       63,648       69.0         71.00       MEDICAL SUPPLIES CHARGED TO PATIENT       0       59,539       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       178,646       72.0         73.00       07300       RRUGS CHARGED TO PATIENTS       0       291,700       73.0         74.00       07400       RENAL DIALYSIS       0       105,599       74.0         76.00       03950       MISC ANCILLARY       0       0       76.00         76.01       3951       SLEEP LAB       0       0       76.00         76.02       03950       PSYCHIATRIC/PSYCHOLOGICAL SERVICES       0       0       76.00         76.02       03950       PSYCHIATRIC/PSYCHOLOGICAL SERVICES       0       472,515       76.00         76.00       09000       CLINIC       0       118,376       90.00         90.00       090000       CLINIC       0       918,882       91.00         92.00       09200       BBSTOTALS (SUM OF LINES 1 through 117)       0       10,984,716       91.00         92.00       092000       GST ENTRES       91.00       91.00,984,716       118.00 <td< td=""><td></td><td>-</td><td></td><td></td><td></td></td<>		-			
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       59,539       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       178,646       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       291,700       73.0         74.00       07400       RENAL DI ALYSI S       0       105,599       74.0         76.00       03950       MISC ANCI LLARY       0       0       0         76.01       03951       SLEEP LAB       0       0       76.0         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       0       76.0         03952       WOUND CARE       0       118,376       90.0       76.0         90.00       090000       CLI NI C       0       118,376       90.0         91.00       090200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       918,882       92.0         92.00       092000       DSERVATI ON BEDS (NON-DI STI NCT PART       0       10,984,716       118.0         INNEL MBURSABLE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1 through 1177)       0       10,984,716       190.0         190.00       IFT,					69.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       178,646       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       291,700       73.0         74.00       07400       RENAL DIALYSIS       0       105,599       74.0         76.00       03950       MISC ANCILLARY       0       0       76.00         76.01       03951       SLEEP LAB       0       0       76.00         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       76.00         76.03       03952 WOUND CARE       0       472,515       76.00         00000       CLI NI C       0       118,376       90.00         09000       CLI NI C       0       918,882       91.00         92.00       09200       DBSERVATI ON BEDS (NON-DI STI NCT PART       0       91.882         92.00       09200       CI NIC       0       10,984,716       118.00         NOREI MBURSABLE COST CENTERS         118.00       SUBBTOTALS (SUM OF LI NES 1 through 117)       0       10,984,716       190.00         192.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       229,013       192.00		-			71.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0       291,700       73.0         74.00       07400       RENAL DI ALYSIS       0       105,599       74.0         76.00       03950       MI SC ANCI LLARY       0       0       76.00         76.01       03951       SLEEP LAB       0       0       76.01         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       0       76.00         76.03       03952       WOUND CARE       0       472,515       76.00         00       09000       CLI NI C       0       118,376       90.00         09100       EMERGENCY       0       918,882       91.00       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       918,882       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       118.00       118.00         NORREL MBURSABLE COST CENTERS       110,984,716       118.00         NORREL MBURSABLE COST CENTERS       190.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       51,548       190.00         192.00       190000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0<		0			72.00
76.00       03950       MI SC ANCI LLARY       0       0       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00		0	291, 700		73.00
76. 01       03951       SLEEP LAB       0       0       76. 02         76. 02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       76. 02         76. 03       03952       WOUND CARE       0       472, 515       76. 02         00       09000       CLI NI C       0       472, 515       76. 02         90. 00       09000       CLI NI C       0       118, 376       90. 02         91. 00       092000       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       918, 882       91. 02         92. 00       092000       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       10, 984, 716       92. 02         90. 00       19200       OBSERVATI ON BEDS (SUM OF LINES 1 through 117)       0       10, 984, 716       118. 02         118. 00       SUBTOTALS (SUM OF LINES 1 through 117)       0       10, 984, 716       118. 02         118. 00       SUBTOTALS (SUM OF LINES 1 through 117)       0       10, 984, 716       119. 02         119. 00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       229, 013       192. 02         192. 00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       229, 013       192. 02         194. 00		0	105, 599		74.00
76. 02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES       0       0       76. 02       76. 02         76. 03       03952       WOUND CARE       0       472, 515       76. 02         0UTPATI ENT SERVICE COST CENTERS       0       118, 376       90. 02       90. 02         90. 00       09000       CLI NI C       0       118, 376       90. 02         91. 00       09100       EMERGENCY       0       918, 882       91. 02         92. 00       09SERVATI ON BEDS (NON-DI STI NCT PART       0       91. 02       92. 02         SPECIAL PURPOSE COST CENTERS       90. 02       10, 984, 716       118. 02         INONREL MBURSABLE COST CENTERS         118. 00       SUBTOTALS (SUM OF LI NES 1 through 117)       0       10, 984, 716         118. 00       SUBTOTALS (SUM OF LI NES 1 through 117)       0       10, 984, 716         118. 00       190.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0         192. 00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       229, 013       192. 02         194. 00       07950       MEALS ON WHEELS       0       111, 078       194. 02       200. 02         200. 00       Cross Foot Adj ustments       0		0			76.00
76. 03       03952       WOUND CARE       0       472, 515       76. 0         OUTPATI ENT SERVICE COST CENTERS       0       118, 376       90. 0       90. 0         90. 00       09000       CLINIC       0       118, 376       90. 0         91. 00       09100       EMERGENCY       0       918, 882       91. 0         92. 00       09SERVATI ON BEDS (NON-DI STINCT PART       0       92.00       92.00       0SERVATI ON BEDS (NON-DI STINCT PART       92. 0         90. 00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       10, 984, 716       118. 00         SUBTOTALS (SUM OF LINES 1 through 117)       0       10, 984, 716       118. 00         NONREI MBURSABLE COST CENTERS         190. 00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       51, 548       190. 0         192. 00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       229, 013       192. 0         194. 00       07950       MEALS ON WHELS       0       111, 078       194. 0         200. 00       Cross Foot Adj ustments       0       0       414       200. 0         201. 00       Negati ve Cost Centers       0       0       0       201. 0 </td <td></td> <td>-</td> <td></td> <td></td> <td>76.01</td>		-			76.01
OUTPATI ENT SERVICE COST CENTERS         90.00           90.00         09000         CLINIC         0         118,376         90.0           91.00         09100         EMERGENCY         0         918,882         91.0           92.00         09SERVATI ON BEDS (NON-DI STINCT PART         0         918,882         91.0           92.00         OBSERVATI ON BEDS (NON-DI STINCT PART         0         910,984,716         92.0           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         10,984,716         118.0           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         10,984,716         118.0           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         51,548         190.0           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         0         229,013         192.0           194.00         07950         MEALS ON WHELS         0         111,078         194.0         200.00           200.00         Cross Foot Adjustments         0         414         200.00         201.00			8		
90.00       09000       CLINIC       0       118,376       90.0         91.00       09100       EMERGENCY       0       918,882       91.0         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       918,882       91.0         92.00       OSPECIAL PURPOSE COST CENTERS       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       <		0	412, 515		/0.03
91.00       09100       EMERGENCY       0       918,882       91.0         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       92.0         SPECIAL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       10,984,716       118.0         NONREI MBURSABLE COST CENTERS         190.00       1977, FLOWER, COFFEE SHOP & CANTEEN       0       51,548       190.0         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       229,013       192.0         194.00       07950       MEALS ON WHEELS       0       111,078       194.0         200.00       Cross Foot Adj ustments       0       414       200.0         201.00       Negative Cost Centers       0       0       201.0		0	118, 376		90.00
92.00         O9200         OBSERVATION BEDS (NON-DISTINCT PART         0         92.00           SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         10,984,716         118.00           NONREI MBURSABLE COST CENTERS           190.00         19700         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         51,548         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         229,013         192.00           194.00         07950         MEALS ON WHEELS         0         111,078         194.00           200.00         Cross Foot Adj ustments         0         414         200.00           201.00         Negative Cost Centers         0         0         201.00		1			91.00
SUBTOTALS         SUBTOTALS         SUM OF LINES 1 through 117)         0         10,984,716         118.00           NONREI MBURSABLE         COST CENTERS         100.00         10,984,716         110.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00         100.00		1			92.00
NONREI MBURSABLE         COST         CENTERS           190.00         GI FT,         FLOWER,         COFFEE         SHOP & CANTEEN         190.00           192.00         19200         PHYSI CI ANS'         PRI VATE         OFFI CES         0         229,013         192.00           194.00         07950         MEALS         ON WHEELS         0         111,078         194.00           200.00         Cross Foot Adjustments         0         414         200.00         201.00         0         201.00         0         0         201.00         0         0         0         0         0         0         0         201.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td></td> <td><u>.</u></td> <td></td> <td></td> <td></td>		<u>.</u>			
190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       51,548       190.0         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       229,013       192.0         194.00       07950       MEALS ON WHEELS       0       111,078       194.0         200.00       Cross Foot Adjustments       0       414       200.0         201.00       Negative Cost Centers       0       0       0		0	10, 984, 716		118.00
192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       0       229,013       192.00         194.00       07950       MEALS ON WHEELS       0       111,078       194.00         200.00       Cross Foot Adjustments       0       414       200.00         201.00       Negative Cost Centers       0       0       201.00					
194.00         07950         MEALS ON WHEELS         0         111,078         194.00           200.00         Cross Foot Adjustments         0         414         200.00           201.00         Negative Cost Centers         0         0         201.00		0			190.00
200.00         Cross Foot Adjustments         0         414         200.00           201.00         Negative Cost Centers         0         0         201.00		0			
201.00         Negative Cost Centers         0         0         201.00					200.00
		-			200.00
ZUZ. UU   TUTAL (SUIII ETHES FTO LITUUUJI ZUT)   U  ET, 370, 704  IZUZ. U	202.00 TOTAL (sum lines 118 through 201)	0	11, 376, 769		202.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	ST JOSEPH MED	ICAL CENTER Provider CC		eriod:	u of Form CMS-2 Worksheet B-1	
				rom 06/01/2019 o 05/31/2020		
	CAPI TAL REL	ATED COSTS			11/2/2020 12:	
Cost Center Description	BLDG & FI XT (SQUARE FOO TAGE)	MVBLE EQUIP (SQUARE FOO TAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHAR GES)	PURCHASI NG RECEI VI NG AND STORES (COSTED REQUI S.)	
	1.00	2.00	4.00	5. 01	5.02	
GENERAL SERVICE COST CENTERS	416, 929					1.00
2. 00       00200       CAP       REL       COSTS       EQUIP         4. 00       00400       EMPLOYEE       BENEFITS       DEPARTMENT         5. 01       00590       REVENUE       CYCLE         5. 02       00560       PURCHASI NG       RECEI VI NG       AND       STORES         5. 03       00591       ADMI NI STRATI VE       AND       GENERAL         7. 00       00700       OPERATI ON OF       PLANT         8. 00       00800       LAUNDRY & LI NEN SERVICE         9. 00       00900       HOUSEKEEPI NG         10. 00       01000       DI ETARY	4, 719 16, 739 11, 626 9, 045 115, 552 3, 705 56, 094 17, 523	416, 929 4, 719 16, 739 11, 626 9, 045 115, 552 3, 705 56, 094 17, 523 0	25, 081, 107 1, 430, 260 29, 673 1, 922, 647 1, 001, 753 0 521, 761 0 0	356, 850, 088 0 0 0 0 0 0 0 0	5, 418, 429 89, 206 13, 614 122, 120 67, 898 803, 397 0	2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00
13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL SERVI CES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MEDI CAL RECORDS & LI BRARY         17.00       01700       SOCI AL SERVI CE         22.00       02200       LI DESERVICE	6, 420 0 10, 500 0	6, 420 0 10, 500 0	1, 359, 730 237, 502 1, 353, 575 166, 562 682, 536	0 0 0	5, 182 134, 912 19, 630 713 124	14.00 15.00 16.00 17.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	22.00
30. 00 03000 ADULTS & PEDI ATRI CS	40, 569	40, 569	4, 690, 867	32, 964, 842	183, 173	30.00
33.00 03300 BURN INTENSIVE CARE UNIT	7, 013	7, 013	1, 816, 445	12, 310, 408	160, 265	
40. 00 04000 SUBPROVIDER - IPF 44. 00 04400 SKILLED NURSING FACILITY	4, 441	4, 441	1, 110, 146		33, 489	
44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	8, 581	8, 581	975, 088	3, 763, 427	55, 059	44.00
50. 00 05000 OPERATI NG ROOM	17, 181	17, 181	555, 445	24, 041, 550	329, 282	50.00
51.00 05100 RECOVERY ROOM	6, 445	6, 445	130, 066		0	51.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1 407 152	2, 517, 036	58 90, 575	
54. 01 03630 ULTRA SOUND	16, 482 0	16, 482 0	1, 487, 152 0	58, 224, 083 0	90, 575	54.00 54.01
56. 00 05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1,836	1, 836	600, 381	14, 145, 023	176, 582	
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	14, 107 773	14, 107 773	1, 531, 475 0	44, 291, 530 842, 806	476, 195 98, 663	
65. 00 06500 RESPIRATORY THERAPY	5,732	5, 732	596, 434		62, 766	
66. 00 06600 PHYSI CAL THERAPY	7, 448	7, 448	316, 356		3, 162	
67. 00 06700 OCCUPATI ONAL THERAPY	2,851	2, 851	237, 357	2, 654, 583	99	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	1, 098 1, 045	1, 098 1, 045	14, 430 81, 019		0 2, 555	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 045	1, 045	01,019	4, 915, 444		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	31, 412, 498		
73.00 07300 DRUGS CHARGED TO PATIENTS	2,470	2, 470	0	47, 319, 867	0	73.00
74. 00 07400 RENAL DIALYSI S 76. 00 03950 MI SC ANCI LLARY	2,010	2, 010	0	725, 995	2, 685 0	
76. 01 03951 SLEEP LAB	0	0	0	0	0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	76.02
76. 03 03952 WOUND CARE OUTPATI ENT SERVICE COST CENTERS	8, 589	8, 589	571, 316	2, 105, 748	137, 823	76.03
90. 00 09000 CLINIC	2, 126	2, 126	76, 106	161, 302	157	90.00
91.00 09100 EMERGENCY	13, 197	13, 197	1, 585, 025		326, 559	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)	415, 917	415, 917	25, 081, 107	356, 850, 088	5, 418, 429	118.00
NONREI MBURSABLE COST CENTERS						100.5-
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	1,012	1, 012	0	0	0	190. 00 192. 00
194. 00 07950 MEALS ON WHEELS	0	0	0	0		192.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	E E 47 000	E 020 400	E 01/ 00/	/ /EO 047	400 (70	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	5, 547, 286	5, 829, 483	5, 016, 296	6, 650, 217	489, 672	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	13. 305110	13. 981956	0. 200003	0. 018636	0. 090372	203.00
204.00 Cost to be allocated (per Wkst. B,			128, 768		317, 391	
Part II)			0.005124	0 001201		20E 00
205.00 Unit cost multiplier (Wkst. B, Part			0.005134	0.001301	0. 058576	203.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0047			Period: From 06/01/2019	Worksheet B-1		
					Date/Time Pre 11/2/2020 12:		
	CAPI TAL REL	ATED COSTS					
Cost Center Description	BLDG & FIXT (SQUARE FOO TAGE)	MVBLE EQUIP (SQUARE FOO TAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHAR GES)	PURCHASI NG RECEI VI NG AND STORES (COSTED REQUI S.)		
	1.00	2.00	4.00	5. 01	5.02	207.00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

	nancial Systems DCATION - STATISTICAL BASIS	ST JOSEPH MED	ICAL CENTER Provider CO	CN: 15-0047 P	In Lie eriod:	u of Form CMS- Worksheet B-1	
JUSI ALL	South Strate Broto				rom 06/01/2019	Date/Time Pre	
						11/2/2020 12:	
	Cost Center Description	Reconciliation	ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (SQUARE FOO	
			(ACCUM. COST)	(SQUARE FOO	(POUNDS OF	TAGE)	
		54.00		TAGE)	LAUNDRY)		
GE	NERAL SERVICE COST CENTERS	5A. 03	5.03	7.00	8.00	9.00	
	100 CAP REL COSTS-BLDG & FIXT						1.0
	200 CAP REL COSTS-MVBLE EQUIP						2.0
	400 EMPLOYEE BENEFITS DEPARTMENT						4.0
	1590 REVENUE CYCLE 1560 PURCHASING RECEIVING AND STORES						5.0 5.0
	591 ADMINI STRATI VE AND GENERAL	-14, 269, 385	62, 470, 452				5.0
. 00 00	700 OPERATION OF PLANT	0	7, 839, 448	259, 248			7.0
	800 LAUNDRY & LINEN SERVICE	0	246, 268		516, 727		8. C
1	900 HOUSEKEEPI NG 000 DI ETARY	0	2, 454, 778 1, 681, 520		0	199, 449 17, 523	1
	100 CAFETERIA	0	669, 049		0	17, 523	
	300 NURSI NG ADMI NI STRATI ON	0	2, 175, 807	6, 420	0	6, 420	
	400 CENTRAL SERVICES & SUPPLY	0	562, 812	0	0	0	
	500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY	0	2, 152, 518		0	0	
	700 SOCIAL SERVICE	0	818, 380 890, 036	10, 500 0	0	10, 500 0	
	200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	98, 791	0	0	0	
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	0	9, 193, 975		121, 252	40, 569	
	300 BURN INTENSIVE CARE UNIT 000 SUBPROVIDER - IPF	0	3, 029, 864 2, 051, 795		59, 074 52, 078	7, 013 4, 441	
	400 SKILLED NURSING FACILITY	0	1, 638, 577		42, 292	8, 581	
	CI LLARY SERVICE COST CENTERS		170007077		12/2/2	0,001	
	000 OPERATING ROOM	0	2, 012, 053	17, 181	21, 657	17, 181	
	100 RECOVERY ROOM	0	451, 140	6, 445	9, 215	6, 445	1
	300 ANESTHESI OLOGY 400 RADI OLOGY-DI AGNOSTI C	0	1, 279, 292 3, 837, 491	0 16, 482	39, 432	0 16, 482	
	630 ULTRA SOUND	0	0,007,471	0	0,432	0,402	
	600 RADI OI SOTOPE	0	0	0	0	0	56.0
	700 CT SCAN	0	0	0	0	0	
	900 CARDI AC CATHETERI ZATI ON 000 LABORATORY	0	1, 859, 255		26, 128 0	1,836	
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 943, 090 144, 484	14, 107 773	0	14, 107 773	
	500 RESPIRATORY THERAPY	0	1, 173, 322	5, 732	0	5, 732	
	600 PHYSI CAL THERAPY	0	664, 859		0	7,448	
	700 OCCUPATIONAL THERAPY	0	431, 121	2,851	0	2,851	
	800 SPEECH PATHOLOGY 900 ELECTROCARDI OLOGY	0	56, 490 191, 691	1, 098 1, 045	0 1, 880	1, 098 1, 045	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	939, 086	0	0	0	
2.00 07	200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 943, 183		0	0	
	300 DRUGS CHARGED TO PATIENTS	0	2, 424, 993	2, 470	0	2, 470	
	400 RENAL DIALYSIS 950 MISC ANCILLARY	0	296, 956	2, 010	0	2, 010 0	1
	951 SLEEP LAB	0	0	0	0	0	1
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	
	952 WOUND CARE	0	1, 252, 852	8, 589	0	8, 589	76. C
	TPATIENT SERVICE COST CENTERS		450.407	0.10/			
	000 CLINIC 100 EMERGENCY	0	158, 437 3, 877, 666		22, 637 121, 082	2, 126 13, 197	
	200 OBSERVATION BEDS (NON-DISTINCT PART	0	3, 077, 000	13, 197	121, 002	13, 197	91.0
	ECIAL PURPOSE COST CENTERS				I.		1 /2/ 0
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	-14, 269, 385	62, 441, 079	258, 236	516, 727	198, 437	]118. 0
	NREI MBURSABLE COST CENTERS						1000
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 200 PHYSICIANS' PRIVATE OFFICES	0	27, 615 1, 758		0	1, 012	190. C
	950 MEALS ON WHEELS	0	1,758	0	0		194.0
00.00	Cross Foot Adjustments		0		0	0	200. 0
01.00	Negative Cost Centers						201.0
02.00	Cost to be allocated (per Wkst. B,		14, 269, 385	9, 630, 119	440, 147	5, 099, 180	202.0
03.00	Part I) Unit cost multiplier (Wkst. B, Part I)		0. 228418	37. 146358	0. 851798	25. 566335	203 0
03.00	Cost to be allocated (per Wkst. B,		261, 908		154, 900	25, 566335 2, 238, 223	
	Part II)		201,700	2, 171, 500	,	_, 200, 220	
205.00	Unit cost multiplier (Wkst. B, Part		0. 004193	12. 312083	0. 299771	11. 222032	205.0
06 00	II) NAHE adjustment amount to be allocated						204 0
206.00	(per Wkst. B-2)						206. 0
207.00	NAHE unit cost multiplier (Wkst. D,						207.0
	Parts III and IV)						1

OST ALL	nancial Systems OCATION - STATISTICAL BASIS		Provider C		eriod: rom 06/01/2019	Worksheet B-1
				T		Date/Time Prepa 11/2/2020 12:13
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (GROSS SALARI ES)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)
05		10.00	11.00	13.00	14.00	15.00
.00         OC           .00         OC           .00         OC           .01         OC           .02         OC           .03         OC           .00         OC	INERAL SERVICE COST CENTERS         1100       CAP REL COSTS-BLDG & FIXT         1200       CAP REL COSTS-BLDG & FIXT         1200       CAP REL COSTS-MVBLE EQUIP         1400       EMPLOYEE BENEFITS DEPARTMENT         1590       REVENUE CYCLE         1560       PURCHASING RECEIVING AND STORES         1591       ADMINISTRATIVE AND GENERAL         1700       OPERATION OF PLANT         1800       LAUNDRY & LINEN SERVICE         1900       HOUSEKEEPING         1000       CAFETERIA         3000       NURSING ADMINISTRATION         4000       CENTRAL SERVICES & SUPPLY         500       PHARMACY         600       MEDICAL RECORDS & LIBRARY         700       SOCIAL SERVICE         2200       I& SERVICES-OTHER PRGM COSTS APPRV	118, 330 0 0 0 0 0 0 0 0 0 0 0	29, 775 1, 699 635 1, 399 348 901 0	8, 268, 503 0 139, 207 0 454, 477	4, 182, 100 19, 630 713 124 0	1 1 1, 876, 230 0 1 0 1 0 2
	IPATI ENT ROUTI NE SERVI CE COST CENTERS	41 707	7 720	2 040 004	102 172	0.3
3.00 03 0.00 04 4.00 04	3000 ADULTS & PEDIATRICS 3300 BURN INTENSIVE CARE UNIT 3000 SUBPROVIDER - IPF 1400 SKILLED NURSING FACILITY	41, 797 7, 218 12, 603 14, 112	7, 730 2, 312 1, 960 1, 355	1, 273, 323 679, 564	183, 173 160, 265 33, 489 55, 059	0 3 0 3 0 4 0 4
0.00         05           1.00         05           3.00         05           4.00         05           4.00         05           7.00         05           9.00         05           0.00         06           2.00         06           5.00         06           6.00         06           6.00         06           7.00         07           3.00         07           3.00         07           3.00         07           6.01         03           6.02         03           6.02         03           6.02         03           6.03         03	ICI LLARY SERVICE COST CENTERS ODD OPERATING ROOM OPERATING ROOM RECOVERY ROOM ANESTHESI OLOGY ANESTHESI OLOGY ANESTHES		696 134 0 2, 199 0 0 0 795 2, 680 0 866 414 263 17 105 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	81, 350 0 0 0 190, 407 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	329, 282 0 58 90, 575 0 0 176, 582 476, 195 98, 663 62, 766 3, 162 99 0 2, 555 681, 380 1, 341, 106 0 2, 685 0 0 1, 341, 206 0 1, 341, 106 1, 341, 106 1, 341, 106 1, 341, 106 1, 341, 106 1, 341, 106 1, 341, 105 1, 345 1, 345 1, 345 1, 345 1, 345 1, 345 1, 345 1, 345 1,	5 0 5 0 5 0 5 0 5 0 5 0 5 0 6 0 6 0 6 0 6 0 6 0 6 0 6 0 7 1, 876, 230 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 7 0 7 7 0 7 7 0 7 7 0 7 7 0 7 7 0 7 7 7 7 7 7 7 7 7 7 7 7 7
1.00 09 2.00 09	1000 EMERGENCY 2000 OBSERVATION BEDS (NON-DISTINCT PART ECIAL PURPOSE COST CENTERS	0	2, 299		326, 559	09
18.00	SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS	75, 730	29, 775	8, 268, 503	4, 182, 100	1, 876, 230 11
90.0019 92.0019	NAREL MUDRSABLE COST CENTERS 2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2200 PHYSICIANS' PRIVATE OFFICES '950 MEALS ON WHEELS Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 28, 686 13, 914 3, 164, 524	0 0 0 821, 872	0 0 3, 122, 313	0 0 0 708, 896	0 19 0 19 0 19 20 20 2, 738, 702 20
03.00 04.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	26. 743210 944, 651	27. 602754 2, 805	0. 377615	0. 169507 11, 542	1. 459684 20 23, 083 20
05.00	Part II) Unit cost multiplier (Wkst. B, Part	7. 983191	0. 094207	0. 041463	0. 002760	0. 012303 20
06.00	II) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,					20

/001 /1		cial Systems ION – STATISTICAL BASIS	51 503EI II MEE	Provider CC	CN: 15-0047	Period:	u of Form CM Worksheet B	
						From 06/01/2019 To 05/31/2020		
					INTERNS &		11/2/2020 1	12:13 pi
		Cost Center Description	MEDI CAL	SOCI AL SERVI CE	RESI DENTS SERVI CES-OTH	ER		
			RECORDS &		PRGM COSTS			
			LI BRARY	(TOTAL PATIENT	APPRV			
			(GROSS CHAR GES)	DAYS)	(ROTATI ONS)			
			16. 00	17.00	22.00			
		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.
		CAP REL COSTS-BEDG & TTXT						2.
		EMPLOYEE BENEFITS DEPARTMENT						4.
		REVENUE CYCLE						5.
		PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL						5.
		OPERATION OF PLANT						7.
		LAUNDRY & LINEN SERVICE						8.
		HOUSEKEEPI NG DI ETARY						9.
		CAFETERIA						10.
3.00	01300	NURSING ADMINISTRATION						13.
		CENTRAL SERVICES & SUPPLY						14.
		PHARMACY MEDICAL RECORDS & LIBRARY	356, 850, 088					15. 16.
		SOCIAL SERVICE	350, 850, 088 C	1				17.
		I&R SERVICES-OTHER PRGM COSTS APPRV	C	0	10	00		22.
		ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	32, 964, 842	12, 018	1(	00		30.
		BURN INTENSIVE CARE UNIT	12, 310, 408		П	0		33.
0.00	04000	SUBPROVIDER - IPF	14, 183, 573	1		0		40.
		SKILLED NURSING FACILITY	3, 763, 427	4, 321		0		44.
		LARY SERVICE COST CENTERS	24, 041, 550	0		0		50.
		RECOVERY ROOM	1, 780, 968			0		51.
		ANESTHESI OLOGY	2, 517, 036	1		0		53.
		RADI OLOGY-DI AGNOSTI C ULTRA SOUND	58, 224, 083	1		0		54. 54.
		RADI OI SOTOPE	0	0		0		56.
		CT SCAN	C	0		0		57.
		CARDI AC CATHETERI ZATI ON	14, 145, 023			0		59.
		LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELL	44, 291, 530 842, 806			0		60. 62.
		RESPI RATORY THERAPY	10, 158, 998			0		65.
		PHYSI CAL THERAPY	2, 777, 068			0		66.
		OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	2, 654, 583			0		67.
		ELECTROCARDI OLOGY	144, 152 3, 057, 976			0		68. 69.
		MEDICAL SUPPLIES CHARGED TO PATIENT	4, 915, 444	0		0		71.
		IMPL. DEV. CHARGED TO PATIENTS	31, 412, 498			0		72.
		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	47, 319, 867 725, 995			0		73.
		MISC ANCILLARY	723, 793 C	0		ŏ		74.
6. 01	03951	SLEEP LAB	C	0		0		76.
		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES WOUND CARE	2 105 749	0		0		76. 76.
		TIENT SERVICE COST CENTERS	2, 105, 748	<u>u</u> 0				/0.
0.00	09000	CLI NI C	161, 302			0		90.
		EMERGENCY	42, 351, 211	0		0		91.
		OBSERVATION BEDS (NON-DISTINCT PART						92.
18.00		SUBTOTALS (SUM OF LINES 1 through 117)	356, 850, 088	21, 174	1(	00		118.
		MBURSABLE COST CENTERS						-
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	C	-		0		190. 192.
		MEALS ON WHEELS	C	0		ŏ		192.
00.00		Cross Foot Adjustments						200.
01.00		Negative Cost Centers	4 470 55	1 000 0	404	- 7		201.
02.00		Cost to be allocated (per Wkst. B, Part I)	1, 673, 524	1, 289, 844	121, 35	o /		202.
03. 00		Unit cost multiplier (Wkst. B, Part I)	0. 004690	60. 916407	1, 213. 5700	oo		203.
04.00		Cost to be allocated (per Wkst. B,	537, 986			14		204.
		Part II) Unit cost multiplier (Wkst. B, Part	0 001500	1 224044	1 1 1 0 00	0		205
05 001			0. 001508	1. 236044	4.14000			205.
205.00		11)						

Health Financial Systems	ST JOSEPH ME	DICAL CENTER		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 06/01/2019	Worksheet B-1	
				To 05/31/2020	Date/Time Prepared: 11/2/2020 12:13 pm	
			INTERNS &			
			RESI DENTS			
Cost Center Description	MEDI CAL	SOCI AL SERVI CE	SERVI CES-OTHE	ER		
	RECORDS &		PRGM COSTS			
	LI BRARY	(TOTAL PATIENT	APPRV			
	(GROSS CHAR	DAYS)	(ROTATIONS)			
	GES)		. ,			
	16.00	17.00	22.00			
207.00 NAHE unit cost multiplier (Wkst. D,					207.00	
Parts III and IV)						

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-:	2552-10
COMPUT	FATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 06/01/2019 To 05/31/2020	Worksheet C Part I Date/Time Pre 11/2/2020 12:	pared: 13 pm
			Title	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	(from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				-1 -1		
30.00	03000 ADULTS & PEDIATRICS	17, 304, 357		17, 304, 35		17, 304, 357	
33.00	03300 BURN I NTENSI VE CARE UNI T	5,094,094		5, 094, 09		5, 094, 094	
40.00	04000 SUBPROVIDER - IPF	3, 798, 363		3, 798, 36		3, 798, 363	
44.00	04400 SKI LLED NURSI NG FACI LI TY	3, 563, 387		3, 563, 38	7 0	3, 563, 387	44.00
50.00	ANCI LLARY SERVI CE COST CENTERS	2 040 151		2 040 15	1 0	2 040 151	50.00
		3, 848, 151		3, 848, 15		3, 848, 151	
51.00 53.00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	1, 008, 991 1, 583, 320		1, 008, 99 1, 583, 32		1, 008, 991 1, 583, 320	51.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C						
54.00	03630 ULTRA SOUND	6, 130, 280		6, 130, 28	0 0	6, 130, 280 0	54.00
56.00	05600 RADI OI SOTOPE	0			0 0	0	56.00
57.00	05700 CT SCAN	0			0 0	0	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 611, 456		2, 611, 45	6 0	2, 611, 456	
60.00	06000 LABORATORY	6, 090, 871		6, 090, 87		6, 090, 871	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	246, 641		246, 64		246, 641	62.00
65.00	06500 RESPI RATORY THERAPY	1, 882, 988	0			1, 882, 988	
66,00	06600 PHYSI CAL THERAPY	1, 308, 797	0	1, 308, 79		1, 308, 797	
67.00	06700 OCCUPATI ONAL THERAPY	728, 118	0	728, 11		728, 118	
68.00	06800 SPEECH PATHOLOGY	139, 397	0	139, 39		139, 397	
69.00	06900 ELECTROCARDI OLOGY	320, 286	0	320, 28		320, 286	69.00
71.00		1, 292, 142		1, 292, 14		1, 292, 142	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 761, 693		2, 761, 69		2, 761, 693	
73.00		6,094,438		6, 094, 43		6, 094, 438	
74.00	07400 RENAL DIALYSIS	494, 698		494, 69		494, 698	
		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	2, 256, 789		2, 256, 78	9 0	2, 256, 789	76.03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	369, 053		369, 05	3 0	369, 053	90.00
91.00	09100 EMERGENCY	6, 451, 361		6, 451, 36	1 0	6, 451, 361	91.00
		1, 639, 715		1, 639, 71	5	1, 639, 715	92.00
200.00		77, 019, 386	0			77, 019, 386	
201.00		1, 639, 715		1, 639, 71		1, 639, 715	
202.00	)   Total (see instructions)	75, 379, 671	0	75, 379, 67	1 0	75, 379, 671	202.00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-0047	Period: From 06/01/2019 To 05/31/2020	Worksheet C Part I Date/Time Pre 11/2/2020 12:	pared: 13 pm
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	29, 027, 916		29, 027, 91			30.00
33.00 03300 BURN INTENSIVE CARE UNIT	12, 310, 408		12, 310, 40			33.00
40. 00 04000 SUBPROVIDER - IPF	14, 183, 573		14, 183, 57			40.00
44.00 04400 SKILLED NURSING FACILITY	3, 763, 427		3, 763, 42	27		44.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	10, 367, 163	13, 674, 387				•
51.00 05100 RECOVERY ROOM	229, 674	1, 551, 294			0.00000	51.00
53. 00 05300 ANESTHESI OLOGY	1, 167, 823	1, 349, 213	2, 517, 03	36 0. 629041	0.00000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	15, 310, 150	42, 913, 933	58, 224, 08	33 0. 105288	0.000000	54.00
54.01 03630 ULTRA SOUND	0	0		0 0.000000	0.00000	54.01
56. 00 05600 RADI 0I SOTOPE	0	0		0 0.000000	0.00000	56.00
57.00 05700 CT SCAN	0	0		0 0.000000	0.000000	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 738, 611	8, 406, 412	14, 145, 02	0. 184620	0.000000	59.00
60. 00 06000 LABORATORY	17, 994, 411	26, 297, 119	44, 291, 53	0. 137518	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	662, 931	179, 875	842, 80	0. 292643	0. 000000	62.00
65. 00 06500 RESPI RATORY THERAPY	8, 902, 086	1, 256, 912	10, 158, 99	0. 185352	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 721, 508	55, 560	2, 777, 06	68 0. 471287	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 609, 666	44, 917			0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	128, 167	15, 985			0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	931, 148	2, 126, 828			0.000000	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 887, 550	2,027,894			0.000000	•
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	13, 692, 630	17, 719, 868			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	32, 194, 477	15, 125, 390			0.000000	•
74.00 07400 RENAL DIALYSIS	625, 747	100, 248			0. 000000	
76.00 03950 MI SC ANCI LLARY	0	0	,	0 0.000000	0. 000000	
76. 01 03951 SLEEP LAB	0	0		0 0.000000	0. 000000	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0.000000	0.000000	•
76. 03 03952 WOUND CARE	169, 625	1, 936, 123	2, 105, 74		0.000000	
OUTPATIENT SERVICE COST CENTERS	107,023	1, 750, 125	2,103,75	1.071720	0.000000	70.03
90. 00 09000 CLINIC	46, 695	114, 607	161, 30	2. 287963	0. 000000	90.00
91. 00 09100 EMERGENCY	7, 693, 369	34, 657, 842			0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 167, 361	2, 769, 565				•
200.00 Subtotal (see instructions)	184, 526, 116	172, 323, 972			0.000000	200.00
201.00 Less Observation Beds	104, 520, 110	112, 323, 712	330, 030, 00			200.00
202.00 Total (see instructions)	184, 526, 116	172, 323, 972	356, 850, 08	20		201.00
	104, 320, 110	112, 323, 912	300, 000, 08			1202. UU

alth Financial Systems MPUTATION OF RATIO OF COSTS TO CHARGES	ST JOSEPH MEDIC	Provi der CCN: 15-0047	Peri od:	u of Form CMS-2552- Worksheet C
WIND ATTON OF NATIO OF COSTS TO CHARGES			From 06/01/2019	Part I
			To 05/31/2020	Date/Time Prepared
				11/2/2020 12:13 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
. 00 03000 ADULTS & PEDIATRICS				30.
. 00 03300 BURN INTENSIVE CARE UNIT				33.
. 00 04000 SUBPROVIDER - IPF				40. (
. 00 04400 SKI LLED NURSI NG FACI LI TY				44.
ANCI LLARY SERVI CE COST CENTERS				
00 05000 OPERATING ROOM	0. 160063			50.0
00 05100 RECOVERY ROOM	0. 566541			51.
00 05300 ANESTHESI OLOGY	0. 629041			53.0
00 05400 RADI OLOGY-DI AGNOSTI C	0. 105288			54.
01 03630 ULTRA SOUND	0. 000000			54.0
00 05600 RADI OI SOTOPE	0. 000000			56.0
00 05700 CT SCAN	0. 000000			57.0
00 05900 CARDI AC CATHETERI ZATI ON	0. 184620			59.0
00 06000 LABORATORY	0. 137518			60.
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 292643			62.0
. 00 06500 RESPI RATORY THERAPY	0. 185352			65.0
. 00 06600 PHYSI CAL THERAPY	0. 471287			66. 0
. 00 06700 OCCUPATIONAL THERAPY	0. 274287			67.0
. 00 06800 SPEECH PATHOLOGY	0. 967014			68.0
. 00 06900 ELECTROCARDI OLOGY	0. 104738			69.0
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 262874			71.0
.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 087917			72.0
00 07300 DRUGS CHARGED TO PATIENTS	0. 128792			73.0
00 07400 RENAL DIALYSIS	0. 681407			74.0
00 03950 MISC ANCI LLARY	0. 000000			76.0
01 03951 SLEEP LAB	0. 000000			76.0
02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76.0
. 03 03952 WOUND CARE	1. 071728			76.0
OUTPATIENT SERVICE COST CENTERS				
00 09000 CLI NI C	2. 287963			90.0
00 09100 EMERGENCY	0. 152330			91.0
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 416496			92.0
0.00 Subtotal (see instructions)				200.
1.00 Less Observation Beds				201.
12.00 Total (see instructions)				202.

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0047	In Lie Period: From 06/01/2019	Worksheet C Part I	
				To 05/31/2020		pared: 13 pm
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description		Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)	2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	17, 304, 357		17, 304, 3	57 0	17, 304, 357	30.00
33. 00 03300 BURN INTENSIVE CARE UNIT	5, 094, 094		5, 094, 0			
40. 00 04000 SUBPROVIDER - IPF	3, 798, 363		3, 798, 3			
44. 00 04400 SKILLED NURSING FACILITY	3, 563, 387		3, 798, 3		3, 748, 303	
ANCI LLARY SERVICE COST CENTERS	3, 303, 307		3, 505, 5	07 0	3, 503, 507	44.00
50. 00 05000 OPERATING ROOM	3, 848, 151		3, 848, 1	51 0	3, 848, 151	50.00
51. 00 05100 RECOVERY ROOM	1, 008, 991		1, 008, 9		1, 008, 991	
53. 00 05300 ANESTHESI OLOGY	1, 583, 320		1, 583, 3		1, 583, 320	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 130, 280		6, 130, 2		6, 130, 280	
54. 01 03630 ULTRA SOUND	0, 130, 200		0, 150, 2	0 0	0, 130, 200	
56. 00 05600 RADI OI SOTOPE	0			0 0	0	
57. 00 05700 CT SCAN	0			0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 611, 456		2, 611, 4	56 0	2, 611, 456	
50. 00 06000 LABORATORY	6, 090, 871		6, 090, 8		6, 090, 871	
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	246, 641		246, 6		246, 641	
55. 00 06500 RESPI RATORY THERAPY	1, 882, 988				1, 882, 988	
56. 00 06600 PHYSI CAL THERAPY	1, 308, 797		1, 308, 7		1, 308, 797	
57.00 06700 OCCUPATI ONAL THERAPY	728, 118		728, 1		728, 118	
58.00 06800 SPEECH PATHOLOGY	139, 397		139, 3		139, 397	
59. 00 06900 ELECTROCARDI OLOGY	320, 286		320, 2		320, 286	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 292, 142		1, 292, 1		1, 292, 142	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 761, 693		2, 761, 6		2, 761, 693	
73.00 07300 DRUGS CHARGED TO PATIENTS	6,094,438		6, 094, 4	38 0	6, 094, 438	73.0
74. 00 07400 RENAL DIALYSIS	494, 698		494, 6	98 0	494, 698	74.0
76. 00 03950 MISC ANCI LLARY	0			0 0	0	76.0
76. 01 03951 SLEEP LAB	0			0 0	0	76.0
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0 0	0	76.0
76.03 03952 WOUND CARE	2, 256, 789		2, 256, 7	89 0	2, 256, 789	76.0
OUTPATIENT SERVICE COST CENTERS						
20. 00 09000 CLINIC	369, 053		369, 0	53 0	369, 053	90.0
91.00 09100 EMERGENCY	6, 451, 361		6, 451, 3		-,,	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 639, 715		1, 639, 7		1, 639, 715	
200.00 Subtotal (see instructions)	77, 019, 386					
201.00 Less Observation Beds	1, 639, 715		1, 639, 7		1, 639, 715	
202.00 Total (see instructions)	75, 379, 671	0	75, 379, 6	71 0	75, 379, 671	202.00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-0047	Period: From 06/01/2019 To 05/31/2020	Worksheet C Part I Date/Time Pre 11/2/2020 12:	
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS	29, 027, 916		29, 027, 91	4		30,00
33. 00 03300 BURN INTENSIVE CARE UNIT	12, 310, 408		29, 027, 9 12, 310, 40			30.00
40. 00 04000 SUBPROVIDER - IPF	12, 310, 408		14, 183, 57			40.00
44. 00 04400 SKILLED NURSING FACILITY	3, 763, 427		3, 763, 42			40.00
ANCI LLARY SERVICE COST CENTERS	3, 703, 427		3, 703, 42			44.00
50. 00 05000 OPERATING ROOM	10, 367, 163	13, 674, 387	24, 041, 55	0. 160063	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	229, 674	1, 551, 294	1, 780, 96		0.000000	51.00
53. 00 05300 ANESTHESI OLOGY	1, 167, 823	1, 349, 213	2, 517, 03		0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	15, 310, 150	42, 913, 933			0.000000	54.00
54. 01   03630   ULTRA_SOUND	13, 310, 130	42, 713, 733	30, 224, 00	0 0. 000000	0.000000	54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0.000000	0.000000	56.00
57. 00 05700 CT SCAN	0	0		0 0.000000	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 738, 611	8, 406, 412	14, 145, 02		0.000000	
60. 00 06000 LABORATORY	17, 994, 411	26, 297, 119	44, 291, 53		0.000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	662, 931	179, 875	842, 80		0.000000	62.00
65. 00 06500 RESPIRATORY THERAPY	8, 902, 086	1, 256, 912	10, 158, 99		0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 721, 508	55, 560	2, 777, 06		0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 609, 666	44, 917	2, 654, 58		0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	128, 167	15, 985	144, 15		0.000000	
69. 00 06900 ELECTROCARDI OLOGY	931, 148	2, 126, 828	3, 057, 97		0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 887, 550	2, 027, 894	4, 915, 44		0.000000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	13, 692, 630	17, 719, 868	31, 412, 49		0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	32, 194, 477	15, 125, 390	47, 319, 86		0.000000	73.00
74. 00 07400 RENAL DIALYSIS	625, 747	100, 248	725, 99		0.000000	
76. 00 03950 MISC ANCI LLARY	023,747	100, 240	120, 11	0 0.000000	0.000000	76.00
76. 01 03951 SLEEP LAB	0	0		0 0.000000	0.000000	76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0.000000	0.000000	
76. 03  03952  WOUND_CARE	169, 625	1, 936, 123	2, 105, 74		0.000000	
OUTPATIENT SERVICE COST CENTERS	107,023	1, 750, 125	2,103,75	1.0/1/20	0.000000	70.03
90. 00 09000 CLINIC	46, 695	114, 607	161, 30	2. 287963	0. 000000	90.00
91. 00 09100 EMERGENCY	7, 693, 369	34, 657, 842	42, 351, 21		0.000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 167, 361	2, 769, 565	3, 936, 92			
200.00 Subtotal (see instructions)	184, 526, 116	172, 323, 972	356, 850, 08		0.000000	200.00
201.00 Less Observation Beds	107, 520, 110	112, 525, 712	555, 555, 66			200.00
202.00 Total (see instructions)	184, 526, 116	172, 323, 972	356, 850, 08	38		201.00
	1 104, 320, 110	112, 323, 712	550, 650, 66			202.00

alth Financial Systems MPUTATION OF RATIO OF COSTS TO CHARGES	ST JOSEPH MEDIC	Provider CCN: 15-0047	Peri od:	u of Form CMS-2552- Worksheet C
INTOTATION OF NATIO OF COSTS TO CHARGES			From 06/01/2019	Part I
			To 05/31/2020	Date/Time Prepared
				11/2/2020 12:13 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
. 00 03000 ADULTS & PEDIATRICS				30.
00 03300 BURN INTENSIVE CARE UNIT				33.
. 00 04000 SUBPROVIDER - IPF				40. (
. 00 04400 SKILLED NURSING FACILITY				44.
ANCI LLARY SERVI CE COST CENTERS				
00 05000 OPERATING ROOM	0. 160063			50.0
00 05100 RECOVERY ROOM	0. 566541			51.
00 05300 ANESTHESI OLOGY	0. 629041			53.0
00 05400 RADI OLOGY-DI AGNOSTI C	0. 105288			54.0
01 03630 ULTRA SOUND	0. 000000			54.0
00 05600 RADI OI SOTOPE	0. 000000			56.0
00 05700 CT SCAN	0. 000000			57.0
00 05900 CARDI AC CATHETERI ZATI ON	0. 184620			59.0
00 06000 LABORATORY	0. 137518			60.0
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 292643			62.0
. 00 06500 RESPI RATORY THERAPY	0. 185352			65.0
. 00 06600 PHYSI CAL THERAPY	0. 471287			66. 0
. 00 06700 OCCUPATIONAL THERAPY	0. 274287			67.0
. 00 06800 SPEECH PATHOLOGY	0. 967014			68.0
. 00 06900 ELECTROCARDI OLOGY	0. 104738			69.0
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 262874			71.0
.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 087917			72.0
00 07300 DRUGS CHARGED TO PATIENTS	0. 128792			73.0
00 07400 RENAL DIALYSIS	0. 681407			74.0
00 03950 MISC ANCI LLARY	0. 000000			76.0
01 03951 SLEEP LAB	0. 000000			76.0
02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76.0
. 03 03952 WOUND CARE	1.071728			76.0
OUTPATIENT SERVICE COST CENTERS				
00 09000 CLI NI C	2. 287963			90.0
00 09100 EMERGENCY	0. 152330			91.0
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 416496			92.0
0.00 Subtotal (see instructions)				200.0
1.00 Less Observation Beds				201.
2.00 Total (see instructions)				202.

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RAREDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 06/01/2019 To 05/31/2020	Date/Time Pre 11/2/2020 12:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
	(Wkst. B, Part				Reducti on	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
	1.00	0.00	col . 2)	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	2 040 151	988, 927	2 050 2	24	0	50.00
	3, 848, 151				-	
	1,008,991					
	1, 583, 320				-	
	6, 130, 280	1, 042, 191	5, 088, 0	39 C	0	
54. 01 03630 ULTRA SOUND	0	0			0	
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	
57.00 05700 CT SCAN	0	470 550			0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 611, 456				0	
60.00 06000 LABORATORY	6, 090, 871				0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	246, 641	48, 309			0	
65. 00 06500 RESPI RATORY THERAPY	1, 882, 988				0	
66.00 06600 PHYSI CAL THERAPY	1, 308, 797				0	
67.00 06700 OCCUPATI ONAL THERAPY	728, 118				0	
68.00 06800 SPEECH PATHOLOGY	139, 397				0	00.00
69. 00 06900 ELECTROCARDI OLOGY	320, 286				0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 292, 142				0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 761, 693				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 094, 438				0	
74.00 07400 RENAL DIALYSIS	494, 698	105, 599	389, 0	99 C	0	
76.00 03950 MISC ANCILLARY	0	0		0 0	0	
76.01 03951 SLEEP LAB	0	0		0 0	0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	
76. 03 03952 WOUND CARE	2, 256, 789	472, 515	1, 784, 2	74 C	0	76.03
OUTPATIENT SERVICE COST CENTERS	1		1		1	-
90. 00 09000 CLI NI C	369, 053				-	
91.00 09100 EMERGENCY	6, 451, 361					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 639, 715				0	
200.00 Subtotal (sum of lines 50 thru 199)	47, 259, 185					200.00
201.00 Less Observation Beds	1, 639, 715					201.00
202.00  Total (line 200 minus line 201)	45, 619, 470	6, 642, 428	38, 977, 0	42 C	0	202.00

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER	In Lie	eu of Form CMS-2552-10	
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider CC		Period: From 06/01/2019 To 05/31/2020	Date/Time Prepared: 11/2/2020 12:13 pm
			e XIX	Hospi tal	PPS
Cost Center Description		Total Charges			
		(Worksheet C,			
	Operating CostP			6	
	Reduction	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS	1 1			. [	
50. 00 05000 OPERATI NG ROOM	3, 848, 151	24, 041, 550			50.00
51.00 05100 RECOVERY ROOM	1, 008, 991	1, 780, 968			51.00
53. 00 05300 ANESTHESI OLOGY	1, 583, 320	2, 517, 036			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 130, 280	58, 224, 083			54.00
54.01 03630 ULTRA SOUND	0	0	01.0000		54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.0000		56.00
57.00 05700 CT SCAN	0	0			57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 611, 456	14, 145, 023			59.00
60. 00 06000 LABORATORY	6, 090, 871	44, 291, 530	0. 1375	18	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	246, 641	842, 806	0. 2926	43	62.00
65. 00 06500 RESPI RATORY THERAPY	1, 882, 988	10, 158, 998	0. 1853	52	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 308, 797	2, 777, 068	0. 4712	87	66.00
67.00 06700 OCCUPATI ONAL THERAPY	728, 118	2, 654, 583	0. 2742	87	67.00
68.00 06800 SPEECH PATHOLOGY	139, 397	144, 152	0. 9670	14	68.00
69. 00 06900 ELECTROCARDI OLOGY	320, 286	3, 057, 976	0. 1047	38	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 292, 142	4, 915, 444	0. 2628	74	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 761, 693	31, 412, 498	0. 0879	17	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 094, 438	47, 319, 867	0. 1287	92	73.00
74.00 07400 RENAL DI ALYSI S	494, 698	725, 995	0. 6814	07	74.00
76. 00 03950 MISC ANCI LLARY	0	0	0.0000	00	76.00
76.01 03951 SLEEP LAB	0	0	0.0000	00	76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.0000		76.02
76.03 03952 WOUND CARE	2, 256, 789	2, 105, 748			76.03
OUTPATIENT SERVICE COST CENTERS	_//	,			
90. 00 09000 CLINIC	369, 053	161, 302	2. 2879	63	90.00
91. 00 09100 EMERGENCY	6, 451, 361	42, 351, 211			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 639, 715	3, 936, 926			92.00
200.00 Subtotal (sum of lines 50 thru 199)	47, 259, 185	297, 564, 764			200.00
201.00 Less Observation Beds	1, 639, 715	0			201.00
202.00 Total (line 200 minus line 201)	45, 619, 470	297, 564, 764			202.00
			I	ļ	12021.00

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS			Period: From 06/01/2019 To 05/31/2020	Date/Time Pre 11/2/2020 12:	
	-		XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col. 26)		(col. 1 - col 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		2:00	0100		0.00	
30. 00 ADULTS & PEDIATRICS	2, 736, 114	C	2, 736, 11	4 13, 276	206.09	30.00
33.00 BURN INTENSIVE CARE UNIT	552, 401		552, 40		565.98	33.00
40. 00 SUBPROVIDER - IPF	431, 250	0	431, 25	0 3, 859	111.75	40.00
44.00 SKILLED NURSING FACILITY	622, 523		622, 52	3 4, 321	144.07	44.00
200.00 Total (lines 30 through 199)	4, 342, 288		4, 342, 28	8 22, 432		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6,00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	1.00	1			
30. 00 ADULTS & PEDI ATRI CS	2, 247					30.00 33.00
40.00 SUBPROVIDER - IPF	1, 972	220, 371				40.00
44.00   SKILLED NURSING FACILITY 200.00   Total (lines 30 through 199)	1, 196		1			44.00
200. OUTOLAT (TTHES SO LITOUGH 199)	0,035	1,200,071	I			J200. 00

Health Financial Systems	ST JOSEPH MED	ST JOSEPH MEDICAL CENTER In Lieu					
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0047	Peri od:	Worksheet D		
				From 06/01/2019 To 05/31/2020	Part II	norod.	
				To 05/31/2020	Date/Time Pre 11/2/2020 12:	13 pm	
		Title	e XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs		
		(from Wkst. C,		Program	(column 3 x		
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)		
	Part II, col.	8)	2)				
	26)	0.00	0.00				
	1.00	2.00	3.00	4.00	5.00		
ANCI LLARY SERVI CE COST CENTERS	000 007		0.0411	1 0/5 100	00.022		
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	988, 927						
53. 00 05300 ANESTHESI OLOGY	341, 253						
54. 00 05300 ANESTHESTOLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 042, 191					53.00	
54. 01 03630 ULTRA SOUND	1, 042, 191	30, 224, 003	0.0000		02,287	54.00	
56. 00 05600 RADI 0I SOTOPE	0		0.00000		0	56.00	
57. 00 05700 CT SCAN	0		0.0000		0	57.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	170, 552	14, 145, 023				59.00	
60. 00 06000 LABORATORY	895, 205						
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	48, 309						
65. 00 06500 RESPIRATORY THERAPY	331, 759						
66. 00 06600 PHYSI CAL THERAPY	390, 962					66.00	
67.00 06700 OCCUPATI ONAL THERAPY	155, 407						
68.00 06800 SPEECH PATHOLOGY	56, 520						
69.00 06900 ELECTROCARDI OLOGY	63, 648						
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	59, 539			13 623, 461	7, 552	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	178, 646						
73.00 07300 DRUGS CHARGED TO PATIENTS	291, 700	47, 319, 867	0.00616	6, 104, 822	37, 630	73.00	
74.00 07400 RENAL DIALYSIS	105, 599	725, 995	0. 1454	54 537, 775	78, 222	74.00	
76.00 03950 MISC ANCILLARY	0	0	0.0000	0 0	0	76.00	
76.01 03951 SLEEP LAB	0	0	0.0000	0 0	0	76.01	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C	0.0000	0 0	0	76. 02	
76.03 03952 WOUND CARE	472, 515	2, 105, 748	0. 22439	3, 514	789	76.03	
OUTPATIENT SERVICE COST CENTERS	1						
90. 00 09000 CLI NI C	118, 376				-		
91. 00 09100 EMERGENCY	918, 882					•	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	259, 267						
200.00   Total (lines 50 through 199)	6, 901, 695	297, 564, 764	·	25, 282, 648	566, 348	200. 00	

Health Financial Systems	ST JOSEPH MEDIC	CAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT	HER PASS THROUGH COSTS	Provider C		Period: From 06/01/2019 To 05/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments	3	Allied Health Post-Stepdowr Adjustments	n Cost	All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000         ADULTS & PEDI ATRI CS           33.00         03300         BURN I NTENSI VE CARE UNI T           40.00         04000         SUBPROVI DER - I PF           44.00         04400         SKI LLED NURSI NG FACI LI TY           200.00         Total (lines 30 through 199)		0 0 0 0			000000000000000000000000000000000000000	33.00
Cost Center Description	Adjustment ( Amount (see 1	Total Costs sum of cols.   through 3, inus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	2001.00
	4.00	5.00	6.00	7.00	8.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000         ADULTS & PEDI ATRI CS           33.00         03300         BURN INTENSI VE CARE UNI T           40.00         04000         SUBPROVI DER - I PF           44.00         04400         SKI LLED NURSI NG FACI LI TY           200.00         Total (I i nes 30 through 199)	0	0 0 0 0 0	13, 27 97 3, 85 4, 32 22, 43	6 0.00 9 0.00 1 0.00	620 1, 972 1, 196	33.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
I NPATI ENT ROUTI NE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS           33.00         03300         BURN INTENSIVE CARE UNIT           40.00         04000         SUBPROVIDER - IPF           44.00         04400         SKILLED NURSING FACILITY           200.00         Total (lines 30 through 199)						30. 00 33. 00 40. 00 44. 00 200. 00

Health Financial Systems	ST JOS	SEPH MEDICA	L CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI THROUGH COSTS	LLARY SERVICE OTI	HER PASS	Provider CC		Period: From 06/01/2019 To 05/31/2020	Worksheet D Part IV Date/Time Pre 11/2/2020 12:	
		_	Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Phy	ysi ci an Nur	sing School	Nursing Schoo	Allied Health	Allied Health	
	Anesth	netist Pos	st-Stepdown	-	Post-Stepdown		
	Co	st Ad	djustments		Adjustments		
	1.	00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM		0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM		0	0		0 0	0	51.00
53.00 05300 ANESTHESI OLOGY		0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0	0		0 0	0	54.00
54.01 03630 ULTRA SOUND		0	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE		0	0		0 0	0	56.00
57.00 05700 CT SCAN		0	0		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0	0		0 0	0	59.00
60. 00 06000 LABORATORY		0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	) CELL	0	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY		0	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY		0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PA	ATI ENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS		0	0		0 0	0	74.00
76.00 03950 MISC ANCI LLARY		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 SER	/I CES	0	0		0 0	0	76.02
76.03 03952 WOUND CARE		0	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·						1
90. 00 09000 CLINIC		0	0		0 0	0	90.00
91.00 09100 EMERGENCY		О	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINC	PART	О			0	0	92.00
200.00 Total (lines 50 through 199)		0	0		0 0	0	200. 00

Health Financial Systems	ST JOSEPH MED			In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0047	Peri od:	Worksheet D	
THROUGH COSTS				From 06/01/2019 To 05/31/2020		nared
				10 00/01/2020	11/2/2020 12:	
			XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 24, 041, 550	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 1, 780, 968		
53.00 05300 ANESTHESI OLOGY	0	0		0 2, 517, 036		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 58, 224, 083		
54.01 03630 ULTRA SOUND	0	0		0 0	0.000000	54.01
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0. 000000	56.00
57.00 05700 CT SCAN	0	0		0 0	0.000000	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 14, 145, 023	0. 000000	59.00
60. 00 06000 LABORATORY	0	0		0 44, 291, 530	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 842, 806	0.000000	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 10, 158, 998	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 777, 068	0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 2, 654, 583		•
68.00 06800 SPEECH PATHOLOGY	0	0		0 144, 152		•
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 3, 057, 976		•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 4, 915, 444		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 31, 412, 498		•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 47, 319, 867		
74. 00 07400 RENAL DI ALYSI S	0	0		0 725, 995		
76. 00 03950 MI SC ANCI LLARY	0	0		0 0	0.000000	•
76.01 03951 SLEEP LAB	0	0		0 0	0.000000	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0 0	0.00000	•
76. 03 03952 WOUND_CARE OUTPATI ENT_SERVI CE_COST_CENTERS	0	0		0 2, 105, 748	0.000000	76.03
90. 00 09000 CLINIC	0	0	1	0 161, 302	0. 000000	90.00
90.00 09100 EMERGENCY	0			0 42, 351, 211		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 42, 331, 211		
200.00 Total (lines 50 through 199)	0			0 297, 564, 764		200.00
	1 0	1 0	I	2/1, 304, 704	I	1200.00

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider CC		Period: From 06/01/2019 To 05/31/2020	Date/Time Pre 11/2/2020 12:	
		Title	XVIII	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	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000	1, 965, 122		0 2, 664, 806	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	154, 093		0 205, 044	0	51.00
53.00 05300 ANESTHESI OLOGY	0. 000000	196, 643		0 223, 018	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 479, 730		0 5, 150, 793	0	54.00
54.01 03630 ULTRA SOUND	0.000000	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0, 000000	1, 479, 413		0 2, 285, 444	0	59.00
60. 00 06000 LABORATORY	0,000000	3, 257, 060		0 1, 372, 263		60,00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	128, 936		0 35,040		62,00
65. 00 06500 RESPI RATORY THERAPY	0,000000	2,097,208		0 163, 163		65,00
66. 00 06600 PHYSI CAL THERAPY	0.000000	186, 993		0 238		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	164, 716		0 209		67.00
68.00 06800 SPEECH PATHOLOGY	0, 000000	26, 713		0 0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	207, 141		0 291, 783		69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0, 000000	623, 461		0 386,066		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0, 000000	3, 205, 640		0 5, 398, 814		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 104, 822		0 3, 224, 085		73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	537, 775		0 52, 081	0	74.00
76. 00 03950 MISC ANCI LLARY	0. 000000	007,770		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. 000000	0		0 0	0	76.02
76. 03  03952  WOUND_CARE	0. 000000	3, 514		0 704, 208	, v	76.02
OUTPATIENT SERVICE COST CENTERS	0.000000	3, 314		704,200	0	70.03
90. 00 09000 CLINIC	0. 000000	0		0 14, 339	0	90.00
91. 00 09100 EMERGENCY	0. 000000	1, 276, 886		0 2, 790, 718		90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 270, 880		0 2, 790, 718		91.00
200.00 Total (lines 50 through 199)	0.000000	25, 282, 648		0 25, 369, 752		200.00
	1 1	23, 202, 040		U 20, 309, 732	1 0	1200.00

Health Financial Systems	ST JOSEPH MED			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0047	Period: From 06/01/2019 To 05/31/2020	Worksheet D Part V Date/Time Pre 11/2/2020 12:	pared: 13 pm
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00		(see inst.)	(see inst.)	5.00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS					101 503	50.00
50. 00 05000 OPERATING ROOM	0. 160063			0 0	426, 537	1
51.00 05100 RECOVERY ROOM	0. 566541	205, 044		0 0	116, 166	1
53. 00 05300 ANESTHESI OLOGY	0. 629041	223, 018		0 0	140, 287	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 105288			0 0	542, 317	
54. 01 03630 ULTRA SOUND	0. 000000			0 0	0	
56. 00 05600 RADI OI SOTOPE	0.00000			0 0	0	
57. 00 05700 CT SCAN	0.000000			0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 184620				421, 939	
60. 00 06000 LABORATORY	0. 137518			0 0	188, 711	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 292643			0 0	10, 254	1
65. 00 06500 RESPI RATORY THERAPY	0. 185352	163, 163		0 0	30, 243	1
66.00 06600 PHYSI CAL THERAPY	0. 471287	238		0 0	112	1
67. 00 06700 OCCUPATI ONAL THERAPY	0. 274287	209		0 0	57	67.00
68. 00 06800 SPEECH PATHOLOGY	0.967014	0 001 700		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 104738			0 0	30, 561	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 262874			0 0	101, 487	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0.087917			0 0	474, 648	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 128792			0 49, 618	415, 236	1
74.00 07400 RENAL DI ALYSI S	0. 681407	52, 081		0 0	35, 488	1
76. 00 03950 MI SC ANCI LLARY	0.00000			0 0	0	
	0.00000			0 0	0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 03 03952 WOUND CARE	0. 000000 1. 071728			0 0	0	
001952 WOUND CARE	1.0/1/28	704, 208		0 0	754, 719	/0.03
90. 00 09000 CLINIC	2. 287963	14, 339		0 0	32, 807	90.00
90. 00 109000 CLINIC 91. 00 109100 EMERGENCY	0. 152330			0 0	425, 110	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 152330			0 0	169, 780	
200.00 Subtotal (see instructions)	0. 410490	25, 369, 752		0		
201.00 Less PBP Clinic Lab. Services-Program		20, 307, 732	32, 10	0 49,010	4, 510, 439	200.00
Only Charges				0		201.00
202.00 Net Charges (line 200 - line 201)		25, 369, 752	32, 18	49, 618	4, 316, 459	202.00

alth Financial Systems ST JOSEPH MEDICAL CENTER					In Lieu of Form CMS-2552-1		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	O VACCINE COST	Provider C		Peri od: From 06/01/2019 To 05/31/2020	Worksheet D Part V Date/Time Pro 11/2/2020 12:	epared: :13 pm	
			e XVIII	Hospi tal	PPS	_	
		sts	1				
Cost Center Description	Cost	Cost					
	Reimbursed	Reimbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
	Ded. & Coins.	Ded. & Coins. (see inst.)					
	(see inst.) 6.00	7.00	-				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	1				
50. 00 05000 OPERATI NG ROOM	0	C				50.00	
51.00 05100 RECOVERY ROOM	0	C				51.00	
53. 00 05300 ANESTHESI OLOGY	0	0				53.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00	
54.01 03630 ULTRA SOUND	0	0				54.0	
56. 00 05600 RADI 0I SOTOPE	0	0				56.0	
57.00 05700 CT SCAN	0	0				57.0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	5,943	0				59.0	
60. 00 06000 LABORATORY	0	0				60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00	
65. 00 06500 RESPI RATORY THERAPY	0	0				65.0	
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.0	
68.00 06800 SPEECH PATHOLOGY	0	C				68.0	
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	•			71.0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1			72.0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	6, 390	1			73.0	
74. 00 07400 RENAL DI ALYSI S	0	0	•			74.0	
76.00 03950 MISC ANCI LLARY	0	0				76.00	
	0	0				76.0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 03 03952 WOUND CARE	0					76.0	
OUTPATIENT SERVICE COST CENTERS	0					/0.0	
90. 00 09000 CLINIC	0	C				90.00	
91. 00 09100 EMERGENCY	0		•			91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C				92.00	
200.00 Subtotal (see instructions)	5,943	6, 390				200.00	
201.00 Less PBP Clinic Lab. Services-Program	0					201.00	
Only Charges							
202.00   Net Charges (line 200 - line 201)	5, 943	6, 390	0			202.00	

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		CCN: 15-SO47	Period: From 06/01/2019 To 05/31/2020		
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Capital	Total Charges (from Wkst. C,			Capital Costs (column 3 x	
	(from Wkst. B.	· · · ·	(col. 1 ÷ co		column 4)	
	Part II, col.	8)	2)	. onarges		
	26)		,			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	988, 927					
51.00 05100 RECOVERY ROOM	341, 253				0	51.00
53. 00 05300 ANESTHESI OLOGY	12, 438					53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 042, 191	58, 224, 083				54.00
54.01 03630 ULTRA SOUND	0	0	0.0000		0	54.01
56. 00 05600 RADI OI SOTOPE	0	0			0	56.00
57.00 05700 CT SCAN	0	0	0.0000		0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	170, 552				0	59.00
60. 00 06000 LABORATORY	895, 205					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	48, 309				0	62.00
65.00 06500 RESPI RATORY THERAPY	331, 759					65.00
66.00 06600 PHYSI CAL THERAPY	390, 962				18, 798	66.00
67.00 06700 OCCUPATI ONAL THERAPY	155, 407					67.00
68.00 06800 SPEECH PATHOLOGY	56, 520					
69.00 06900 ELECTROCARDI OLOGY	63, 648					
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	59, 539					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	178, 646					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	291, 700					
74.00 O7400 RENAL DI ALYSI S	105, 599	725, 995			0	74.00
76. 00 03950 MI SC ANCI LLARY	0	0	0.0000		0	76.00
76. 01 03951 SLEEP LAB	0	0	0.0000		0	76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 03 03952 WOUND CARE	472 515		0.0000		0	76.02
76. 03 03952 WOUND CARE OUTPATIENT SERVICE COST CENTERS	472, 515	2, 105, 748	0.2243	73 205	46	76.03
90. 00 09000 CLINIC	118, 376	161, 302	0. 7338	78 0	0	90.00
91. 00 09100 EMERGENCY	918, 882					90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	910, 002				5,048	
200.00 Total (lines 50 through 199)	6, 642, 428			3, 156, 883	-	
	0, 042, 420	277, 304, 704	I	5, 150, 005	01,701	200.00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C	CN: 15-0047	Peri od:	Worksheet D	
THROUGH COSTS			001 45 0047	From 06/01/2019		
		Component	CCN: 15-SO47	To 05/31/2020	Date/Time Pre 11/2/2020 12:	pared: 13 nm
		Title	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description				ol Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS	-	-	1	-		
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 03630 ULTRA SOUND	0	0		0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 0	0	69.00 71.00
	0			0 0	0	72.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DR0GS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	0			0 0	0	73.00
76. 00   03950 MI SC ANCI LLARY	0			0 0		76.00
76. 01 03950 MI SC ANCI LLART 76. 01 03951 SLEEP LAB	0			0 0		76.00
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0 0		76.02
76. 03  03952  WOUND CARE	0			0 0	0	76.02
OUTPATIENT SERVICE COST CENTERS	0		1	0 0	0	70.03
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	C		0 0	0	200.00
		•				•

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUC	GH COSTS				From 06/01/2019		
			Component	CCN: 15-S047	To 05/31/2020	Date/Time Pre 11/2/2020 12:	pared:
			Title	XVIII	Subprovider -	PPS	13 pill
					IPF	115	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	•	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)	,	(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 24, 041, 550	0.00000	
51.00	05100 RECOVERY ROOM	0	0		0 1, 780, 968	0. 000000	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 2, 517, 036	0.00000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 58, 224, 083	0. 000000	54.00
54.01	03630 ULTRA SOUND	0	0		0 0	0.00000	54.01
56.00	05600 RADI OI SOTOPE	0	0	1	0 0	0.00000	56.00
57.00	05700 CT SCAN	0	0	1	0 0	0.00000	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 14, 145, 023	0. 000000	59.00
60.00	06000 LABORATORY	0	0		0 44, 291, 530	0. 000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 842, 806	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 10, 158, 998	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 2, 777, 068	0, 000000	66,00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 654, 583		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 144, 152		
69.00	06900 ELECTROCARDI OLOGY	0	0		0 3, 057, 976		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 4, 915, 444	0,000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 31, 412, 498	0.000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 47, 319, 867	0. 000000	
	07400 RENAL DI ALYSI S	0	0		0 725, 995		•
	03950 MISC ANCI LLARY	0	0		0 0	0, 000000	•
76.01	03951 SLEEP LAB	0	0		0 0	0. 000000	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0. 000000	
	03952 WOUND CARE	0	0		0 2, 105, 748		•
70.00	OUTPATIENT SERVICE COST CENTERS	0			2,100,710	0.00000	/0.00
90, 00		0	0		0 161, 302	0. 000000	90.00
	09100 EMERGENCY	0	0		42, 351, 211	0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0		0 3, 936, 926		
200.00		0	0		0 297, 564, 764		200.00
200.00			0	1		1	

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C	CN: 15-0047	Peri od:	Worksheet D	
THROUGH COSTS		Company	20N 15 0047	From 06/01/2019		
		Component	CCN: 15-S047	To 05/31/2020	Date/Time Pre 11/2/2020 12:	
		Title	XVIII	Subprovider -	PPS	
				' I PF		
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)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000					
50. 00 05000 OPERATI NG ROOM	0. 000000	43, 842		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0		51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	1, 103		0 306		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	462, 902		0 17, 947	0	54.00
54.01 03630 ULTRA SOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0.000000	934, 258		0 3, 877	0	60.00
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	131, 724		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	133, 527		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	147, 603		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	21, 304		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	47, 961		0 584	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	11, 793		0 9, 052	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	135, 437		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	824, 909		0 180	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0		0 0	0	74.00
76.00 03950 MISC ANCI LLARY	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	0	76.02
76.03 03952 WOUND CARE	0.000000	205		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0.000000	0		0 1, 710	0	90.00
91.00 09100 EMERGENCY	0.000000	260, 315		0 5, 616	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)		3, 156, 883		0 39, 272	0	200. 00

Health Financial Systems	ST JOSEPH MEDI	ICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provider CO	CN: 15-0047 CCN: 15-S047	Period: From 06/01/2019 To 05/31/2020	Worksheet D Part V Date/Time Pre 11/2/2020 12:	pared: 13 pm
		Title	XVIII	Subprovider - IPF	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1					
50.00 05000 OPERATING ROOM	0. 160063	0		0 0	0	1
51.00 05100 RECOVERY ROOM	0. 566541	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 629041	306		0 0	192	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 105288	17, 947		0 0	1, 890	1
54.01 03630 ULTRA SOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 184620	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 137518	3, 877		0 0	533	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 292643	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 185352	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 471287	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 274287	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.967014	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 104738	584		0 0	61	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 262874	9,052		0 0	2, 380	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 087917	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0, 128792	180		0 8, 813	23	1
74.00 07400 RENAL DI ALYSI S	0, 681407	0		0 0	0	1
76. 00 03950 MISC ANCI LLARY	0. 000000	0		0 0	0	
76. 01 03951 SLEEP LAB	0. 000000	0		0 0	0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	
76. 03 03952 WOUND CARE	1. 071728	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	1.071720	0		0 0	0	70.03
90. 00 09000 CLINIC	2. 287963	1, 710		0 0	3, 912	90.00
91. 00 09100 EMERGENCY	0. 152330	5, 616		0 0	855	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 416496	0,010		0 0	000	1
200.00 Subtotal (see instructions)	0.110470	39, 272		0 8, 813		200.00
201.00 Less PBP Clinic Lab. Services-Program		57,272		0 0,013	7, 040	201.00
Only Charges				0		201.00
202.00 Net Charges (line 200 - line 201)		39, 272		0 8, 813	9, 846	202.00

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER	ER In Lieu of Form C			2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0047 CCN: 15-S047	Period: From 06/01/2019 To 05/31/2020	Worksheet D Part V Date/Time Pre 11/2/2020 12:	pared: 13 pm
		Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description		Cost Reimbursed Services Not Subject To Ded. & Coins.	-			
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATI NG ROOM           51.00         05100         RECOVERY ROOM           53.00         05300         ANESTHESI OLOGY           54.00         05400         RADI OLOGY-DI AGNOSTI C           54.01         03630         ULTRA SOUND           56.00         05600         RADI OLOGY-DI AGNOSTI C           57.00         05600         RADI OLOGY-DI AGNOSTI C           57.00         05600         RADI OLOGY-DI AGNOSTI C           57.00         05700         CT SCAN           59.00         05900         CARDI AC CATHETERI ZATI ON           60.00         06000         LABORATORY           62.00         06200         WHOLE         BLOOD & PACKED RED BLOOD CELL           65.00         06500         RESPI RATORY THERAPY         6           67.00         06600         PHYSI CAL THERAPY         6           67.00         06700         OCCUPATI ONAL THERAPY         6           67.00         06600         SPEECH PATHOLOGY         6           68.00         06800         SPEECH PATHOLOGY         6           69.00         06900         ELECTROCARDI OLOGY         7 <t< td=""><td></td><td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td><td></td><td></td><td></td><td>$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 53.\ 00\\ 54.\ 01\\ 56.\ 00\\ 65.\ 00\\ 60.\ 00\\ 62.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 73.\ 00\\ 74.\ 00\\ 74.\ 00\\ 76.\ 01\\ 76.\ 02\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 76.\ 03\\ 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OUTPATIENT SERVICE COST CENTERS           90.00         09000         CLINIC           91.00         09100         EMERGENCY           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART           200.00         Subtotal (see instructions)           201.00         Less PBP Clinic Lab. Services-Program	0 0 0 0	0 0 0 1, 135				90.00 91.00 92.00 200.00 201.00
201.00Itess FBF chrine Lab. Selvices-FlogramOnly Charges202.00Net Charges (line 200 - line 201)	0	1, 135				201.00

IPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS         Provider CON: 15-0047         Period: To 05/31/2020         Period: To 05/31/2020         Period: To 05/31/2020         Period: Description         Period:	Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Li	eu of Form CMS-	2552-10
Introduction Cool of a construction of the constructin on one of the construction of the construction o	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PASS	S Provider C	CN: 15-0047			
Image: construct of the second seco	THROUGH COSTS			000 45 5054			
Cost Center Description         Non Physician Anesthetist         Nursing School Post-Stepdown Adjustments         I i ed Heal th Post-Stepdown Adjustments         PPS           ANCILLARY SERVICE COST CENTERS         1.00         2A         2.00         3A         3.00           50.00         005000 (PERATING ROOM         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			Component	CCN: 15-5356	10 05/31/2020		ared:
Cost Center Description         Non Physician Nursing School Nursing School Nursing School Allied Health Post-Stepdown Adjustments           ANCILLARY SERVICE COST CENTERS         Non Physician Nursing School Nursing Schol Nurschare Nursing School Nursing School Nursing Schol Nursing			Title	XVIII	Skilled Nursing		13 piii
Anesthetist         Post-Stepdown Adjustments         Post-Stepdown Adjustments           ANCILLARY SERVICE COST CENTERS				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Cost         Adjustments         Adjustments         Adjustments           1.00         2A         2.00         3A         3.00           50.00         05000 (PEATI NG ROOM)         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <t< td=""><td>Cost Center Description</td><td>Non Physician</td><td>Nursing School</td><td>Nursing Scho</td><td>ol Allied Health</td><td>Allied Health</td><td></td></t<>	Cost Center Description	Non Physician	Nursing School	Nursing Scho	ol Allied Health	Allied Health	
ANCILLARY SERVICE COST CENTERS         1.00         2A         2.00         3A         3.00           50.00         05000         OPERATING ROM         0         0         0         0         50.00           51.00         05000         OPERATING ROM         0         0         0         0         0         51.00           53.00         05300         ARSTHESI OLOGY         0         0         0         0         53.00           54.00         05400         RADI OLOGY - DI AGNOSTI C         0         0         0         0         54.01           54.01         0330         UTRA SOUND         0         0         0         0         0         54.01           54.01         03400         ILARA SOUND         0         0         0         0         0         54.01           57.00         05700         CT SCAN         0         0         0         0         0         0         57.00           60.00         CARDI AC CATHETERI ZATI ON         0         0         0         0         66.00         660.00         660.00         660.00         660.00         660.00         660.00         660.00         660.00         660.00         660.00<		Anestheti st	Post-Stepdown		Post-Stepdown	ı 🔤	
ANCI LLARY SERVICE COST CENTERS         Image: Control of the co			Adjustments				
50:00         OPERATING ROOM         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O		1.00	2A	2.00	3A	3.00	
51:00       05100       RECOVERY ROOM       0       0       0       0       0       53:00         53:00       05300       ANESTHESI OLOGY       0       0       0       0       53:00       0       53:00       0       0       0       0       0       0       0       53:00       0       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       54:00       56:00       56:00       56:00       56:00       56:00       59:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00       60:00		1		1		1	
53.00       05300       ANESTHESI OLGGY       0       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0       54.01         54.01       03630       ULTRA SOUND       0       0       0       0       0       54.01         56.00       05600       RADI OLOGY-DI AGNOSTI C       0       0       0       0       0       54.01         57.00       05700       CT SCAN       0       0       0       0       55.00         60.00       06000       LABORATORY       0       0       0       0       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       65.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       66.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       0CUCUPATI ONAL THERAPY       0       0       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       72.00         71.00 <td></td> <td>0</td> <td>C</td> <td>)</td> <td>0 0</td> <td>-</td> <td></td>		0	C	)	0 0	-	
54.00       05400       RADIOLOGY-DIAGNOSTIC       0       0       0       0       0       0       0       0       0       0       0       54.00         54.01       03630       ULTRA SOUND       0       0       0       0       0       0       54.00         56.00       05700       CT SCAN       0       0       0       0       0       57.00         59.00       05900       CARDIAC CATHETERIZATION       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td></td> <td>0</td> <td>C</td> <td>)</td> <td>0</td> <td>-</td> <td></td>		0	C	)	0	-	
54.01       03630       ULTRA SOUND       0       0       0       0       54.01         56.00       05600       RADI 01 SOTOPE       0       0       0       0       56.00         57.00       CT SCAN       0       0       0       0       0       57.00         59.00       OS900       CARDI AC CATHETERI ZATI ON       0       0       0       0       59.00         60.00       06000       LABORATORY       0       0       0       0       60.00         62.00       06500       RESPI RATORY THERAPY       0       0       0       0       62.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       66.00         66.00       06500       RESPI RATORY THERAPY       0       0       0       66.00         67.00       06200       VIDUAL THERAPY       0       0       0       66.00         67.00       06200       CCUPATI ONAL THERAPY       0       0       0       66.00         67.00       06800       SPECH PATHOLOGY       0       0       0       0       67.00         68.00       06800       DELCTROCARDI OLOGY		0	C	)	0	-	
56.00         05600         RADI 0I SOTOPE         0         0         0         0         56.00           57.00         05700         CT SCAN         0         0         0         0         57.00           59.00         05000         CARDI AC CATHETERI ZATI 0N         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		0	C	)	0		
57.00       05700       CT SCAN       0       0       0       0       57.00         59.00       05900       CARDIAC CATHETERIZATION       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		0	C	)	0	-	
59.00       OS900       CARDI AC CATHETERI ZATI ON       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		0	C	)	0	۵ ۱	
60.00       LABORATORY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		0	C	)	0	٥ ١	
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       0       0       62.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0       65.00         67.00       06700       0CCUPATI 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       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       0       71.00         72.00       07200       IMUL DEV. CHARGED TO PATI ENTS       0       0       0       73.00       73.00       73.00       73.00       73.00       73.00       73.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00		0	C	)	0	-	
65.00       06500       RESPIRATORY THERAPY       0       0       0       0       0       66.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       0CCUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       0       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       73.00         74.00       RENAL DI ALYSI S       0       0       0       0       74.00         76.01       03950       MISC ANCI LLARY       0       0       0       0       76.01         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       0       0       76.02		0	C	)	0 (	-	
66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0<		0	C	)	0 (		
67.00       06700       OCCUPATIONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0       0       0       0       0       0       69.00         71.00       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       0       72.00         73.00       07300       RENAL DIALYSIS       0       0       0       0       73.00         74.00       03950       MISC ANCILLARY       0       0       0       0       74.00         76.01       03951       SLEEP LAB       0       0       0       0       0       76.01         76.02       03550       PSYCHIATRIC/PSYCHOLOGICAL SERVICES       0       0       0       0       76.02         76.02       03552       WOUND CARE       0       0       0       0       0       0       76.02         76.02       03552       WOUND CARE		0	C	)	0 (		
68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0       0       0       0       0       0       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       0       72.00         73.00       07300       RUGS CHARGED TO PATIENTS       0       0       0       0       73.00         74.00       07400       RENAL DIALYSI S       0       0       0       0       74.00         76.00       03950       MISC ANCI LLARY       0       0       0       0       76.00         76.01       03951       SLEEP LAB       0       0       0       0       0       76.01         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       0       0       76.02         76.03       03952       WOUND CARE       0       0       0       0       0       0       76.03         90.00       CLINIC		0	C	)	0 (	-	
69.00       06900       ELECTROCARDIOLOGY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       71.00       00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       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	C	)	0 (	۵ ۱	
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0       74.00         76.00       03950       MISC ANCI LLARY       0       0       0       0       76.00         76.01       03951       SLEEP LAB       0       0       0       0       0       76.01         76.02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       0       0       76.02         76.03       03952       WOUND CARE       0       0       0       0       76.02         01TPATI ENT SERVICE COST CENTERS       0       0       0       0       0       90.00         91.00       09100       EMERGENCY       0       0       0       0       90.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0		0	C	)	0 0	۵ ۱	
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       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 ANCI LLARY       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       76.02         76.03       03952       WOUND CARE       0       0       0       0       76.02         70.00       09000       CLI NI C       0       0       0       0       90.00         91.00       09100       EMERGENCY       0       0       0       90.00       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       0       92.00 </td <td></td> <td>0</td> <td>C</td> <td>)</td> <td>0 0</td> <td>-</td> <td></td>		0	C	)	0 0	-	
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       MI SC ANCI LLARY       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       76.02         76.04       03952       WOUND CARE       0       0       0       0       76.02         76.03       03952       WOUND CARE       0       0       0       0       76.03         00TPATIENT SERVICE COST CENTERS       0       0       0       0       90.00       90.00         91.00       09100       EMERGENCY       0       0       0       0       90.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       0       92.00 <td></td> <td>0</td> <td>C</td> <td>)</td> <td>0 0</td> <td>-</td> <td></td>		0	C	)	0 0	-	
74.00       07400       RENAL DI ALYSI S       0       0       0       0       0       74.00         76.00       03950       MISC ANCI LLARY       0       0       0       0       0       76.00         76.01       03951       SLEEP LAB       0       0       0       0       0       76.01         76.02       03552       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       0       0       76.02         76.03       03952       WOUND CARE       0       0       0       0       76.02         76.04       03952       WOUND CARE       0       0       0       0       76.02         76.03       03952       WOUND CARE       0       0       0       0       76.02         76.04       04700       0       0       0       0       0       76.02         76.03       03952       WOUND CARE       0       0       0       0       76.02         70.00       09000       CLI NI C       0       0       0       90.00       91.00         91.00       09100       EMERGENCY       0       0       0       0       92.00 <t< td=""><td></td><td>0</td><td>C</td><td>)</td><td>0 0</td><td>-</td><td></td></t<>		0	C	)	0 0	-	
76.00       03950       MISC ANCILLARY       0       0       0       0       76.00         76.01       03951       SLEEP LAB       0       0       0       0       0       76.01         76.02       03550       PSYCHIATRIC/PSYCHOLOGICAL SERVICES       0       0       0       0       76.02         76.03       03952       WOUND CARE       0       0       0       0       0       76.02         76.03       03952       WOUND CARE       0       0       0       0       0       76.02         76.04       04752       WOUND CARE       0       0       0       0       76.02         76.05       WOUND CARE       0       0       0       0       0       76.03         90.00       CLINIC       COST CENTERS       0       0       0       0       90.00         91.00       09100       EMERGENCY       0       0       0       0       90.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       0       0       92.00		0	C	)	0	-	
76. 01       03951       SLEEP LAB       0       0       0       0       76. 01         76. 02       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0       0       0       0       76. 02         76. 03       03952       WOUND CARE       0       0       0       0       0       76. 03         OUTPATI ENT SERVICE COST CENTERS         90. 00       09000       CLINIC       0       0       0       90. 00       91.00       91.00       91.00       91.00       92.00       0       0       0       92.00       0       0       0       0       92.00       0       92.00       00       0       0       92.00       00       0       92.00       0       92.00       0       0       0       92.00       0       92.00       0       92.00       0       0       0       0       92.00       0       92.00       0       0       0       0       92.00       92.00       0       92.00       0       0       0       0       92.00       92.00       0       92.00       0       92.00       0       92.00       0       92.00       0       0       0       9		0	C	)	0	٥ ١	
76. 02         03550         PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES         0         0         0         0         76. 02           76. 03         03952         WOUND CARE         0         0         0         0         0         0         0         0         0         76. 02           0100         017PATI ENT SERVICE COST CENTERS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		0	C	)	0	٥ ١	
76.03         03952         WOUND CARE         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		0	C	)	0	-	
OUTPATI ENT_SERVICE_COST_CENTERS           90. 00         09000         CLINIC         0         0         0         0         90.00           91. 00         09100         EMERGENCY         0         0         0         0         0         91.00           92. 00         09200         OBSERVATI ON_BEDS_(NON-DI STINCT_PART         0         0         0         0         92.00		0	C	)	0	-	
90. 00         09000         CLINIC         0         0         0         0         90. 00           91. 00         09100         EMERGENCY         0         0         0         0         0         91. 00           92. 00         09200         OBSERVATION         BEDS (NON-DISTINCT PART         0         0         0         0         92. 00		0	(	)	0	0	76.03
91.00         09100         EMERGENCY         0         0         0         91.00         91.00         91.00         92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         0         0         0         0         92.00         0         92.00         0         0         0         0         92.00         0         92.00         0         0         0         0         0         92.00         0         0         0         0         0         0         0         92.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         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	0		00.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 92. 00		0			0	٥ ١	
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	200.00 10tal (THES SO through 199)	I U		1	U U	- U	1200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0047 Period: Worksheet D From 06/01/2019 Part IV Component CCN: 15-5356 To 05/31/2020 Date/Time Prepare	ed.
	ed.
L COMPONENT CLUX: L5-5356 LLO CL573172020 LLATE/ LLME PRENARE	rea.
	nm
Title XVIII Skilled Nursing PPS	pin
Facility	
Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost	
Medical (sum of cols. Outpatient (from Wkst. C, to Charges	
Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col.)	
4) col s. 2, 3, 8) 7)	
and 4) (see	
i nstructions)	
4.00 5.00 6.00 7.00 8.00	
ANCI LLARY SERVICE COST CENTERS	
50. 00 05000 OPERATING ROOM 0 0 24, 041, 550 0. 000000 50	D. 00
51. 00 05100 RECOVERY ROOM 0 0 1, 780, 968 0. 000000 51	1. 00
53. 00 05300 ANESTHESI OLOGY 0 0 0 2, 517, 036 0. 00000 53	3. 00
	4.00
54. 01 03630 ULTRA SOUND 0 0 0 0. 00000 54	4. 01
56. 00 05600 RADI 0I SOTOPE 0 0 0 0 0 0 0 00000 56	6.00
57. 00 05700 CT SCAN 0 0 0 0 0 0.00000 57	7.00
59. 00 05900 CARDIAC CATHETERIZATION 0 0 14, 145, 023 0. 000000 59	9.00
60. 00 06000 LABORATORY 0 0 0 44, 291, 530 0. 000000 60	D. 00
	2.00
	5.00
	6.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 2, 654, 583 0. 000000 67	7.00
	B. 00
	9.00
	1.00
	2.00
	3. 00
74. 00 07400 RENAL DI ALYSI S 0 0 0 725, 995 0. 00000 74	4.00
76.00 03950 MISC ANCILLARY 0 0 0 0 0 0 0.000000 76	6.00
	6. 01
	6. 02
	6. 03
OUTPATIENT SERVICE COST CENTERS	
	D. 00
	1.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 3, 936, 926 0. 000000 92	
	0. 00

APPORTIONMENT OF INPARTENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Priod der CCN: 15-0047 Component CCN: 15-5366 Period: From 06/01/2019 To 05/31/2020 Worksheet D Part IV Date/Time Prepared: 10/2/2020 12:3 p.m. Cost Center Description Outpatient to Charges (col. 6 + col. 7) Inpatient Program Pass-Through Cost (col. 8 x col. 10) Outpatient Program Pass-Through Cost (col. 8 x col. 12) 0.000000 0 0 0 0 0 0 <th>Health Financial Systems</th> <th>ST JOSEPH MEDI</th> <th>CAL CENTER</th> <th></th> <th>In Lie</th> <th>u of Form CMS-:</th> <th>2552-10</th>	Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-:	2552-10
Ancient Source Component CCN: 15-5356 To 05/31/2020 Date/Time Prepared: 11/2/2020 Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Program Pass-Through Costs (col. 10) Skilled Nursing Program Program Pass-Through Costs (col. 9) Outpatient Program Costs (col. 9) Outpatient Program Program Charges Outpatient Program Costs (col. 9)	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PASS	Provider C				
Cost Center Description Outpatient Ratio of Cost (col. 6 + col. 7) Inpatient Program Charges Inpatient Program Charges Duppatient Program Col. 6 + col. 7) Inpatient Program Charges Inpatient Program Charges Duppatient Program Charges Duppatient Program Charge	THROUGH COSTS		Component				norod.
Cost Center Description Outpatient Ratified of Cost to Charges (col. 6 + col. 7) Inpatient Program (Charges (col. 6 + col. 7) Inpatient Program Pass-Through (Cost (col. 8 + col. 7) Outpatient Program (Charges (col. 6 + col. 7) Outpatient (Charges (col. 6 + col. 7) Outpatient 7)			component	JCIN: 15-5350	10 05/31/2020		
Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges (col. 6 + col. 7) Inpatient Program (charges costs (col. 8) Outpatient Program Charges (col. 6) Outpatient Program (charges) 4NCILLARY SERVICE COST CENTERS 0.00000 0 10.00 11.00 12.00 13.00 50.00 0F300 RECOVERY ROM 0.000000 0 0 0 0 51.00 51.00 05300 RESTHESI 0LOGY 0.000000 0 0 0 53.00 54.00 05400 RAD 0LSTOPE 0.000000 0 0 0 57.00 59.00 05900 CRSPI RATORY 0.000000 0 0 0 0 57.00 60.00 06000 RESPI RATHESI ZATION 0.000000 0 0 0 0 0 60.00 60.00 0600 RESPI RATORY THERAPY			Title	XVIII	Skilled Nursing		
Image: Program Program Charges Program Charges (col. 6 + col. 7) Program (charges (col. 6 + col. 7)) Program (charges (col. 7)) Program (col. 7) Program (col. 7							
Image: top of the second sec	Cost Center Description						
ANCLILARY SERVICE COST CENTERS Costs (col. 8 x col. 10) Costs (col. 9 x col. 12) Costs (col. 9 x col. 12) 50.00 05000 OPERATI NG ROOM 0.000000 0							
7) x col. 10) x col. 12) ANCILLARY SERVICE COST CENTERS 9.00 11.00 12.00 13.00 50.00 05000 (PEATI ING ROOM) 0.000000 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 53.00 05300 ARESTHESI OLGGY 0.000000 0 0 0 53.00 54.01 03630 ULTRA SOUND 0.000000 0 0 0 54.01 56.00 05000 RADIOLOGY-DI AGROSTI C 0.000000 0 0 0 54.01 57.00 05000 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 57.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 57.00 62.00 06000 LABORATORY 0.000000 312.060 0 0 62.00 66.00 06500 RESPI RATORY THERAPY 0.000000 420.604 0 0 65.00 66.00 06500 RES			Charges				
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ANCI LLARY SERVICE COST CENTERS Image: Control of the co			10.00		12.00		
50.00 05000 0PERATING ROOM 0.000000 0 0 0 0 0 50.00 51.00 05300 ARECVERY ROOM 0.000000 0 0 0 0 51.00 53.00 05300 ARESTHESILDCGY 0.000000 0 0 0 0 51.00 54.01 03630 ULTAR SOUND 0.000000 0 0 0 0 54.01 56.00 05600 RADIOLOGY-DIAGNOSTIC 0.000000 0 0 0 0 54.01 56.00 05600 RADIOLSGY-TAGNOSTIC 0.000000 0 0 0 0 54.01 57.00 05700 CT SCAN 0.000000 0 0 0 0 57.00 59.00 05000 ARDATORY 0.000000 0 0 0 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 0 66.00 66.00 67.00	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
51:00 05100 RECOVERY ROOM 0.000000 0 0 0 0 51:00 53:00 NARSTHESI OLOGY 0.000000 0 0 0 0 53:00 54:00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 0 54:00 54:01 03630 ULTRA SOUND 0.000000 0 0 0 56:00 56:00 05600 RADI OLSOTOPE 0.000000 0 0 0 56:00 57:00 05700 CTSCAN 0.000000 0 0 0 57:00 59:00 05600 LABORATORY 0.000000 0 0 0 60:00 60:00 06200 WHOLE BLODD & PACKED RED BLODD CELL 0.000000 0 0 0 62:00 65:00 06500 RESPI RATORY THERAPY 0.000000 440,935 0 0 66:00 66:00 06700 0CUPATI ONAL THERAPY 0.000000 454:907 0 0 66:00 67:00 06600 PEECH PATHOLOGY 0.000000 <		0,00000	0		0 0	0	50.00
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59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0			0		0 0		
60.00 LABORATORY 0.00000 312,060 0			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 420,604 0 0 0 65.00 66.00 06400 PHYSI CAL THERAPY 0.000000 440,935 0 0 66.00 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 454,907 0 0 68.00 68.00 68.00 06800 SPEECH PATHOLOGY 0.000000 5,847 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 3,825 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 0 0 74.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.0			312,060		0 0		
66.00 06600 PHYSI CAL THERAPY 0.000000 440,935 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 454,907 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 5,847 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 3,825 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 43,733 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 74.00 76.01 03950 MISC ANCI LLARY 0.000000 0 0 0 76.01 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 76.02 76.03 0395			0		0 0	0	
67.00 06700 OCCUPATIONAL THERAPY 0.000000 454,907 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 5,847 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 3,825 0 0 0 69.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 43,733 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07400 RENAL DIALYSIS 0.000000 0 0 0 73.00 74.00 03950 MISC ANCI LLARY 0.000000 0 0 0 0 74.00 76.01 03951 SLEEP LAB 0.000000 0 0 0 0 76.00 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 0 0 76.02 76.02 03952 WOUND CARE 0.0000000 0 0 0<	65. 00 06500 RESPI RATORY THERAPY	0. 000000	420, 604		0 0	0	65.00
68.00 06800 SPEECH PATHOLOGY 0.000000 5,847 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 3,825 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 43,733 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 RENAL DIALYSIS 0.000000 0 0 0 73.00 74.00 03950 MISC ANCILLARY 0.000000 0 0 0 74.00 76.01 03951 SLEEP LAB 0.000000 0 0 0 76.00 76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0.000000 0 0 0 0 76.02 76.03 03952 WOUND CARE 0.000000 0 0 0 0 76.02 71.00 09000 CLINIC 0.000000 0 0 0 0 0 90.00 <td>66. 00 06600 PHYSI CAL THERAPY</td> <td>0.000000</td> <td>440, 935</td> <td></td> <td>0 0</td> <td>0</td> <td>66.00</td>	66. 00 06600 PHYSI CAL THERAPY	0.000000	440, 935		0 0	0	66.00
69.00 06900 ELECTROCARDIOLOGY 0.000000 3,825 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 43,733 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 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 74.00 76.01 03951 SLEEP LAB 0.000000 0 0 0 76.00 76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0.000000 0 0 0 76.02 76.03 03952 WOUND CARE 0.000000 0 0 0 0 76.02 76.03 03952 WOUND CARE 0.000000 0 0 0 0 76.03 90.00	67.00 06700 OCCUPATI ONAL THERAPY	0.000000	454, 907		0 0	0	67.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 43,733 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 994, 191 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 74.00 76.00 03950 II SC ANCI LLARY 0.000000 0 0 0 76.00 76.01 03951 SLEEP LAB 0.000000 0 0 0 76.01 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 76.01 76.03 03952 WOUND CARE 0.000000 0 0 0 0 76.02 76.03 03952 WOUND CARE 0.000000 0 0 0 0 76.02 76.03 03952 WOUND CARE 0.000000 0 0 0 0 90.00	68.00 06800 SPEECH PATHOLOGY	0.000000	5, 847		0 0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 994, 191 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 74.00 76.00 03950 MI SC ANCI LLARY 0.000000 0 0 0 76.00 76.01 03951 SLEEP LAB 0.000000 0 0 0 76.01 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 76.01 76.03 03952 WOND CARE 0.000000 58,042 0 0 0 76.02 76.03 03952 WOND CARE 0.000000 58,042 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 825	1	0 0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 994, 191 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 0 74.00 76.00 03950 MISC ANCI LLARY 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 58,042 0 0 0 76.03 0017PATI ENT SERVI CE COST CENTERS 0.000000 58,042 0 0 0 76.03 90.00 09000 CLI NI C 0.000000 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 0 0 91.00 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 0 0 0 92.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	43, 733		0 0	0	71.00
74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 74.00 76.00 03950 MISC ANCI LLARY 0.000000 0 0 0 76.00 76.01 03951 SLEEP LAB 0.000000 0 0 0 0 76.01 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 76.02 76.03 03952 WOUND CARE 0.000000 58,042 0 0 0 76.02 70.00 09000 CLI NI C 0.000000 58,042 0 0 0 76.02 90.00 09000 CLI NI C 0.000000 0 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 0 0 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 0 0 0 92.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
76.00 03950 MISC ANCI LLARY 0.000000 0 0 0 76.00 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 0 76.02 76.03 03952 WOUND CARE 0.000000 58,042 0 0 0 76.03 00TPAT I ENT SERVI CE COST CENTERS 0.000000 58,042 0	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	994, 191		0 0	0	73.00
76. 01 03951 SLEEP LAB 0.000000 0 0 0 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 76. 02 76. 03 03952 WOUND CARE 0.000000 58, 042 0 0 0 76. 03 OUTPATIENT SERVICE COST CENTERS 90. 00 00000 CLI NI C 0.000000 0 0 90. 00 90.00 91. 00 09100 EMERGENCY 0.000000 0 0 0 91. 00 92.00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 0 0 0 92.00			0		0 0	0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.00000 0 0 0 0 76. 02 76. 02 76. 02 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03			0		0 0	0	
76. 03 03952 WOUND CARE 0.00000 58,042 0 0 0 76. 03 OUTPATI ENT SERVICE COST CENTERS 0.00000 0 0 0 0 90.00 90.00 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 91.00 91.00 91.00 92.00 0BSERVATI ON BEDS (NON-DI STINCT PART 0.000000 0 0 0 92.0			0		0 0	0	
OUTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC 0.000000 0 0 0 90.00 91. 00 09100 EMERGENCY 0.000000 0 0 0 91.00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0.000000 0 0 0 92.00			0		0 0	0	
90. 00 09000 CLINIC 0.00000 0 0 0 90. 00 91. 00 09100 EMERGENCY 0.000000 0 0 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0.000000 0 0 0 92. 00		0.000000	58, 042		0 0	0	76.03
91.00 09100 EMERGENCY 0.000000 0 0 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0.000000 0 0 0 0 92.00							
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 000000 0 0 0 0 92. 00							
			0				
200.00 Llotal (Lines 50 through 199) L L 2.813.826 0L 0L 0L 0L		0. 000000	0			-	
	200.00 Total (lines 50 through 199)	1 I	2, 813, 826	l	0 0	0	200. 00

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC Component (CN: 15-0047 CCN: 15-5356	Period: From 06/01/2019 To 05/31/2020	Worksheet D Part V Date/Time Pre 11/2/2020 12:	pared: 13 pm
		Title	XVIII	Skilled Nursing Facility	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
·	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				- 1		
50.00 05000 OPERATING ROOM	0. 160063	0		0 0	0	
51.00 05100 RECOVERY ROOM	0. 566541	0		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 629041	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 105288	0		0 0	0	54.00
54.01 03630 ULTRA SOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 184620	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 137518	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 292643	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 185352	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 471287	0		0 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 274287	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 967014	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 104738	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 262874	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 087917	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 128792	0		0 184	0	73.00
74.00 07400 RENAL DIALYSIS	0, 681407	0		0 0	0	74.00
76. 00 03950 MISC ANCILLARY	0. 000000	0		0 0	0	
76. 01 03951 SLEEP LAB	0. 000000	0		0 0	0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	
76. 03 03952 WOUND CARE	1. 071728	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	1.071720			0 0	0	/0.00
90. 00 09000 CLINIC	2. 287963	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 152330	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 416496	0		0 0	0	
200.00 Subtotal (see instructions)	0. 110470	0		0 184	-	200.00
201.00 Less PBP Clinic Lab. Services-Program		0		0 0	0	201.00
Only Charges				0		201.00
202.00 Net Charges (line 200 - line 201)		0		0 184	0	202.00

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-2552-	-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Concernent	CN: 15-0047 CCN: 15-5356	Period: From 06/01/2019 To 05/31/2020	Worksheet D Part V Date/Time Prepared 11/2/2020 12:13 pr	
		Title	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Cost Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	ts Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00	-			
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND 56. 00 05600 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65. 00 06500 RESPI RATORY 64. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 76. 01 03950		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			50. 51. 53. 54. 56. 57. 59. 60. 62. 65. 66. 67. 68. 69. 71. 72. 73. 74. 76. 76. 76.	00 00 01 00 00 00 00 00 00 00 00 00 00 0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program	0 0 0 0 0	0 0 24	6		90. 91. 92. 200. 201.	00 00 00
Only Charges 202.00 Net Charges (line 200 - line 201)	0	24			202.	00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 06/01/2019 To 05/31/2020	Date/Time Pre 11/2/2020 12:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2, 736, 114	C	2, 736, 11	4 13, 276	206.09	30.00
33.00 BURN INTENSIVE CARE UNIT	552, 401		552, 40	1 976	565.98	33.00
40.00 SUBPROVIDER - IPF	431, 250	0	431, 25	0 3, 859	111.75	40.00
44.00 SKILLED NURSING FACILITY	622, 523		622, 52	3 4, 321	144.07	44.00
200.00 Total (lines 30 through 199)	4, 342, 288		4, 342, 28	8 22, 432		200.00
Cost Center Description	I npati ent	Inpatient			-	
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2,052	422, 897				30.00
33.00 BURN INTENSIVE CARE UNIT	149	84, 331				33.00
40. 00 SUBPROVIDER - IPF	130					40.00
44.00 SKILLED NURSING FACILITY	63	9,076				44.00
200.00 Total (lines 30 through 199)	2, 394					200. 00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0047	Peri od:	Worksheet D	
				From 06/01/2019		
				To 05/31/2020	Date/Time Pre 11/2/2020 12:	pared:
		Ti †l	e XIX	Hospi tal	PPS	13 pili
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		$(col \cdot 1 \div col$		column 4)	
	Part II, col.	8)	2)	J		
	26)	, í	, í			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			•			
50.00 05000 OPERATI NG ROOM	988, 927	24, 041, 550	0.04113	84 817, 329	33, 620	50.00
51.00 05100 RECOVERY ROOM	341, 253	1, 780, 968	0. 1916	1 75, 577	14, 481	51.00
53. 00 05300 ANESTHESI OLOGY	12, 438	2, 517, 036	0.00494	133, 822	661	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 042, 191	58, 224, 083	0.01790	1, 639, 980	29, 356	54.00
54.01 03630 ULTRA SOUND	0	0	0.0000	0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0	0	0.0000	0 0	0	56.00
57.00 05700 CT SCAN	0	0	0.0000	0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	170, 552	14, 145, 023	0. 0120	615, 304	7, 419	59.00
60. 00 06000 LABORATORY	895, 205	44, 291, 530	0. 0202	2, 001, 646	40, 457	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	48, 309	842, 806	0. 0573	105, 551	6, 050	62.00
65. 00 06500 RESPI RATORY THERAPY	331, 759	10, 158, 998	0. 03265	57 820, 445	26, 793	65.00
66. 00 06600 PHYSI CAL THERAPY	390, 962	2, 777, 068	0. 14078	32 73, 872	10, 400	66.00
67.00 06700 OCCUPATI ONAL THERAPY	155, 407	2, 654, 583	0. 05854	43 62, 269	3, 645	67.00
68.00 06800 SPEECH PATHOLOGY	56, 520	144, 152	0. 39208	36 10, 135	3, 974	68.00
69. 00 06900 ELECTROCARDI OLOGY	63, 648	3, 057, 976	0. 0208	111, 388	2, 318	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	59, 539	4, 915, 444	0. 0121	3 255, 228	3, 092	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	178, 646	31, 412, 498	0.00568	37 1, 041, 457	5, 923	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	291, 700	47, 319, 867	0.00616	2, 937, 839	18, 109	73.00
74.00 07400 RENAL DIALYSIS	105, 599	725, 995	0. 1454	62, 084	9, 030	74.00
76.00 03950 MISC ANCILLARY	0	0	0.0000	0 0	0	76.00
76.01 03951 SLEEP LAB	0	0	0.0000	0 0	0	76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.0000	0 0	0	76.02
76.03 03952 WOUND CARE	472, 515	2, 105, 748	0. 22439	93 1, 784	400	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	118, 376	161, 302				
91.00 09100 EMERGENCY	918, 882					1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	259, 267					
200.00 Total (lines 50 through 199)	6, 901, 695	297, 564, 764		11, 835, 362	249, 945	200.00

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHEN	R PASS THROUGH COST	TS Provider C		Period: From 06/01/2019 To 05/31/2020		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 33.00 03300 BURN INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF	000000000000000000000000000000000000000	0 0 0		0 0 0 0 0 0	0 0 0	33.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0		44.00
200.00 Total (lines 30 through 199)	0	0)	0 0		200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4,00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	13, 27 97			
40. 00 04000 SUBPROVI DER – I PF	0	0	3, 85		130	
44.00 04400 SKILLED NURSING FACILITY		0	4, 32		63	44.00
200.00 Total (lines 30 through 199)		0	22, 43	2	2, 394	200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 33. 00 03300 BURN INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 44. 00 04400 SKILLED NURSING FACILITY	0 0 0 0					30.00 33.00 40.00 44.00
200.00 Total (lines 30 through 199)	0					200. 00

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
	I ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS	6 Provider C	CN: 15-0047	Period: From 06/01/2019 To 05/31/2020		pared: 13 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	·		Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS			_			
50.00	05000 OPERATING ROOM	0	C)	0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	C)	0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
54.01	03630 ULTRA SOUND	0	C		0 0	0	54.01
56.00	05600 RADI OI SOTOPE	0	C		0 0	0	56.00
57.00	05700 CT SCAN	0	C		0 0	0	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60.00	06000 LABORATORY	0	C		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
74.00	07400 RENAL DI ALYSI S	0	C		0 0	0	74.00
76.00	03950 MI SC ANCI LLARY	0	C		0 0	0	76.00
76.01	03951 SLEEP LAB	0	C		0 0	0	76.01
76.02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C		0 0	0	76.02
76.03	03952 WOUND CARE	0	C		0 0	0	76.03
	OUTPATIENT SERVICE COST CENTERS	· · · ·					1
90.00	09000 CLI NI C	0	С)	0 0	0	90.00
91.00	09100 EMERGENCY	0	C)	0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	C		0 0	0	200. 00

Health Financial Systems	ST JOSEPH MED			In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0047	Peri od:	Worksheet D	
THROUGH COSTS				From 06/01/2019 To 05/31/2020		pared.
					11/2/2020 12:	
	_		e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medical	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7) (see	
			and 4)		instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50. 00 05000 OPERATI NG ROOM	0	C		0 24, 041, 550	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	c		0 1, 780, 968		51.00
53.00 05300 ANESTHESI OLOGY	0	C		0 2, 517, 036	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 58, 224, 083	0. 000000	54.00
54.01 03630 ULTRA SOUND	0	0		0 0	0. 000000	54.01
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0.000000	56.00
57.00 05700 CT SCAN	0	0		0 0	0.000000	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 14, 145, 023	0.000000	59.00
60. 00 06000 LABORATORY	0	0		0 44, 291, 530	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 842, 806	0.000000	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 10, 158, 998		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 777, 068		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 2, 654, 583		
68.00 06800 SPEECH PATHOLOGY	0	0		0 144, 152		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 3, 057, 976		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 4, 915, 444		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0 31, 412, 498		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 47, 319, 867		
74. 00 07400 RENAL DI ALYSI S	0	0		0 725, 995		
76. 00 03950 MI SC ANCI LLARY	0	0		0 0	0.000000	
76. 01 03951 SLEEP LAB	0	0		0 0	0.000000	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	, s		0 0	0.000000	
76. 03 03952 WOUND CARE OUTPATI ENT SERVI CE COST CENTERS	0	0		0 2, 105, 748	0. 000000	76.03
90. 00 09000 CLINIC	0	C		0 161, 302	0. 000000	90.00
90. 00 09100 EMERGENCY	0	-		0 161, 302 0 42, 351, 211		
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		0 42, 351, 211		
200.00 Total (lines 50 through 199)	0			0 297, 564, 764		200.00
	1 0	1 0	1	277, 304, 704	I	200.00

Health Financial Systems	ST JOSEPH MEDIC	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-0047	Period: From 06/01/2019 To 05/31/2020		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		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	
ANCI LLARY SERVI CE COST CENTERS	1 1				-	
50.00 05000 OPERATI NG ROOM	0. 000000	817, 329		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	75, 577		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	133, 822		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 639, 980		0 0	0	54.00
54.01 03630 ULTRA SOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	615, 304		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	2,001,646		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	105, 551		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	820, 445		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	73, 872		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	62, 269		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	10, 135		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	111, 388		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	255, 228		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1,041,457		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2,937,839		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	62,084		0 0	0	74.00
76. 00 03950 MISC ANCI LLARY	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	0	76.02
76.03 03952 WOUND CARE	0. 000000	1, 784		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90, 00 09000 CLINIC	0.000000	5, 512		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	903, 723		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	160, 417		0 0	0	92.00
200.00 Total (lines 50 through 199)		11, 835, 362		0 0	0	200.00
						•

Health Financial Systems	ST JOSEPH MED			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0047	Period: From 06/01/2019 To 05/31/2020		pared: 13 pm
		Titl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		-	1		-	
50. 00 05000 OPERATI NG ROOM	0. 160063			0 853, 589		50.00
51.00 05100 RECOVERY ROOM	0. 566541	0		0 171, 689		51.00
53. 00 05300 ANESTHESI OLOGY	0. 629041	0		0 113, 429		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 105288			0 3, 910, 139		54.00
54.01 03630 ULTRA SOUND	0. 000000			0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0. 000000			0 0	0	56.00
57.00 05700 CT SCAN	0. 000000			0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 184620			0 150, 777		59.00
60. 00 06000 LABORATORY	0. 137518			0 1, 921, 275		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 292643			0 11, 902		62.00
65. 00 06500 RESPI RATORY THERAPY	0. 185352			0 134, 436		65.00
66.00 06600 PHYSI CAL THERAPY	0. 471287			0 4, 871	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 274287			0 3, 612	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 967014			0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 104738			0 181, 460		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 262874			0 98, 889		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 087917			0 334, 846		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 128792			0 1, 068, 828		73.00
74.00 07400 RENAL DIALYSIS	0. 681407			0 10, 212	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			0 0	0	76.02
76.03 03952 WOUND CARE	1. 071728	0		0 91, 791	0	76.03
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLI NI C	2. 287963			0 9, 214		90.00
91.00 09100 EMERGENCY	0. 152330			0 4, 148, 473		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 416496	0		0 216, 481	0	92.00
200.00 Subtotal (see instructions)		0		0 13, 435, 913	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges				0 10 405 010	_	202.00
202.00 Net Charges (line 200 - line 201)	I	0	I	0 13, 435, 913	0	202.00

Health Financial Systems	ST JOSEPH MED				u of Form CMS-255	2-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 06/01/2019 To 05/31/2020	Worksheet D Part V Date/Time Prepar 11/2/2020 12:13	red: pm
		Titl	e XIX	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCILLARY SERVICE COST CENTERS	0.00	7.00	I			
50. 00 05000 OPERATI NG ROOM	0	136, 628			50	0. 00
51.00 05100 RECOVERY ROOM	0	97, 269			51	1.00
53. 00 05300 ANESTHESI OLOGY	0	71, 351			53	3.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	411, 691			54	4.00
54. 01 03630 ULTRA SOUND	0	C			54	4.01
56. 00 05600 RADI 0I SOTOPE	0	C			56	6.00
57. 00 05700 CT SCAN	0	0	1			7.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	27, 836				9.00
60. 00 06000 LABORATORY	0	264, 210	1			0.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 483				2.00
65. 00 06500 RESPI RATORY THERAPY	0	24, 918				5.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 296				6.00
67. 00 06700 OCCUPATIONAL THERAPY	0	991	1			7.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	10,000				8.00 9.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL_SUPPLI ES_CHARGED_TO_PATI ENT	0	19, 006 25, 995				9.00 1.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	25, 995				2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	137, 656	1			2.00 3.00
74. 00 07400 RENAL DIALYSIS	0	6, 959				4.00
76. 00 03950 MISC ANCI LLARY	0	0, ,0,	1			6.00
76. 01 03951 SLEEP LAB	0		1			6. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	1			6. 02
76.03 03952 WOUND CARE	0	98, 375				6. 03
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
90. 00 09000 CLINIC	0	21, 081				0.00
91. 00 09100 EMERGENCY	0					1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	90, 163				2.00
200.00 Subtotal (see instructions)	0	2, 101, 284				0.00
201.00 Less PBP Clinic Lab. Services-Program	0	1			201	1.00
Only Charges	0	2 101 204			200	2.00
202.00 Net Charges (line 200 - line 201)	0	2, 101, 284	1		202	∠. U(

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	NL COSTS	Provider CO	CN: 15-0047 CCN: 15-S047	Period: From 06/01/2019 To 05/31/2020	Worksheet D Part II Date/Time Pre 11/2/2020 12:	
		Ti tl	e XIX	Subprovider - IPF	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)		Program	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	988, 927	24, 041, 550	0.0411	34 0	0	50.00
51.00 05100 RECOVERY ROOM	341, 253	1, 780, 968	0. 1916 ⁻	11 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	12, 438	2, 517, 036	0.00494	12 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1,042,191	58, 224, 083	0.0179	00 17, 003	304	54.00
54.01 03630 ULTRA SOUND	0	0	0.0000	0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.0000		0	56.00
57.00 05700 CT SCAN	0	0	0.0000		0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	170, 552	14, 145, 023	0.0120		0	59.00
60. 00 06000 LABORATORY	895, 205	44, 291, 530			1, 555	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	48, 309				0	62.00
65. 00 06500 RESPI RATORY THERAPY	331, 759				0	65.00
66. 00 06600 PHYSI CAL THERAPY	390, 962	2, 777, 068			1, 261	66.00
67.00 06700 OCCUPATI ONAL THERAPY	155, 407	2, 654, 583			81	67.00
68.00 06800 SPEECH PATHOLOGY	56, 520				309	68.00
69. 00 06900 ELECTROCARDI OLOGY	63, 648	3, 057, 976			62	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	59, 539				2	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	178, 646				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	291, 700				23	
74.00 07400 RENAL DIALYSIS	105, 599	725, 995			0	
76.00 03950 MISC ANCI LLARY	0	0	0.0000		0	76.00
76.01 03951 SLEEP LAB	0	0	0.0000		0	76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.0000		0	76.02
76.03 03952 WOUND CARE	472, 515	2, 105, 748	0. 2243	93 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	118, 376				181	90.00
91.00 09100 EMERGENCY	918, 882				1, 012	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-,			0	
200.00 Total (lines 50 through 199)	6, 642, 428	297, 564, 764		158, 839	4, 790	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS Provider C0:: 15-0047 Period: From 06/01/2017 Period: To 05/01/2017 Period: To 05/01/2017 Worksheet D Pert IV Date Time Prepared: 11/2/2020 Import C0:: 15-0047 Title XIX Subprovider - IPF PPS Import C0:: 15-0047 Title XIX Subprovider - IPF PPS Import C0:: 15-0047 All ied Healt th Anestentist Proceed and Cost All ied Healt th All ustments All ied Healt th All ustments Import C0:: 15-0047 Cost Center Description Non Physician Nursing School Nursing School All ustments All ied Healt th All ustments Import C0:: 15-0047 Cost Center Reson 0 0 0 0 0 Import C0:: 15-0047 Cost Center Reson 0 <t< th=""><th>Health Financial Systems</th><th>ST JOSEPH MED</th><th>ICAL CENTER</th><th></th><th>In Lie</th><th>eu of Form CMS-</th><th>2552-10</th></t<>	Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-	2552-10
Component CCN: 15-S047 To 05/31/2020 Date/Time Prepared: 11/2/2020 12: 13 pm Cost Center Description Non Physician Nursing School Nurs		RVICE OTHER PASS	S Provider C	CN: 15-0047			
Image: construct of the second seco	THROUGH COSTS		Component	CCN: 15-5047			narod
Cost Center Description Non Physician Nursing School Nursing Schol Nursing Schol Nursing School Nursing School Nursing Schol Nursin			component	CCN. 13-3047	10 03/31/2020		
Cost Center Description Non Physician Dursing School Nursing School Nursing School Adjustments All Lied Health Post-Stepdown Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 RECOVERY ROM 0 0 0 0 51.00 51.00 05100 RECOVERY ROM 0 0 0 0 51.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 54.00 05400 RADIOLOGY-DI ANOSTI C 0 0 0 0 54.00 54.00 05400 RADIOLOGY-DI ANOSTI C 0 0 0 0 54.00 54.00 05400 RADIOLOGY-DI ANOSTI C 0 0 0 0 54.00 50.00 05000 CARDIAC CATHETERI ZATI N 0 0 0 0 57.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 62.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 <td< td=""><td></td><td></td><td>Ti tl</td><td>e XIX</td><td></td><td></td><td>i</td></td<>			Ti tl	e XIX			i
Anesthetist Post-Stepdown Adjustments Post-Stepdown Adjustments ANCILLARY SERVICE COST CENTERS .00 2.00 3A 3.00 NOT LLARY SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
Cost Adjustments Adjustments ANCILLARY SERVICE COST CENTERS 2.00 3A 3.00 50.00 05000 (PERATING ROOM 0 0 0 0 0 0 0 0 0 50.00 50.00 0	Cost Center Description			Nursing Scho		Allied Health	
I.OO 2A 2.OO 3A 3.OO 50.00 05000 OPERATI NO. ROOM 0							
ANCILLARY SERVICE COST CENTERS 50.00 05000 (PEATI NG ROOM 0				2.00		2 00	
50.00 OPERATING ROOM 0	ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	3A	3.00	-
51.00 05100 RECOVERY ROOM 0		0			0 0	0	50.00
53.00 ANESTHESI OLOGY 0 0 0 0 53.00 54.00 OS400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 54.01 OS300 LTRA SOUND 0 0 0 0 54.01 56.00 OS400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.01 56.00 S6400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 56.00 57.00 OS700 CTSCAN 0 0 0 0 57.00 60.00 CARDI AC CATHETERI ZATI ON 0 0 0 0 60.00 62.00 MOLOC LABORATORY 0 0 0 0 60.00 65.00 GS500 RSPI RATORY THERAPY 0 0 0 0 62.00 66.00 OG600 PHYSI CAL THERAPY 0 0 0 0 66.00 66.00 GG600 PECH PATHOLOGY 0 0 0 0 0 71.00 71.00 DSV <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>-</td> <td></td>		0				-	
54.00 65400 RADI QLOGY-DI AGNOSTI C 0		0				-	
54.01 03630 ULTRA SOUND 0 0 0 54.01 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 57.00 59.00 0400 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 60.00 LABORATORY 0 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 66.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 68.00 68.00 68.00 68.00 68.00 69.00 0 0 0 0 0 0 0 70.0 68.00 69.00 71.00 72.00 70.0 68.00 69.00 72.00 70.0 69.00 <		0			0 0	-	
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68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 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 SERVICES 0 0 0 0 76.02 03952 WUND CARE 0 0 0 0 0 0 76.03 03952 WUND CARE 0 0 0 0 0	66. 00 06600 PHYSI CAL THERAPY	0	C)	0 0	0	66.00
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03950 MISC ANCI LLARY 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 04.00 CLINIC 0 0 0 0 0 0 76.03 05.00	67.00 06700 OCCUPATI ONAL THERAPY	0	c c)	0 0	0	67.00
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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 MI SC ANCI LLARY 0 0 0 0 76.00 76.01 03951 SLEEP LAB 0 0 0 0 0 76.01 76.02 03952 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76.02 76.03 03952 WOUND CARE 0 0 0 0 76.02 03952 WOUND CARE 0 0 0 0 0 76.02 03952 WOUND CARE 0 0 0 0 0 76.02 0170 DTPATIENT SERVICE COST CENTERS 0 0 0 0 76.02 90.00 OPONO CLI NIC 0 0 0 90.00 91.00 <	69. 00 06900 ELECTROCARDI OLOGY	0	C)	0 0	0	69.00
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 MI SC ANCI LLARY 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 76.02 03952 WOUND CARE 0 0 0 0 0 76.02 76.02 03952 WOUND CARE 0 0 0 0 76.02 76.03 03952 WOUND CARE 0 0 0 0 76.02 76.03 03952 WOUND CARE 0 0 0 0 76.02 79.00 09000 CLI NI C 0 0 0 90.00 91.00 91.00 09100 EMERGENCY 0 0 0 0 92.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C)	0 0	0	71.00
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76.00 03950 MISC ANCILLARY 0 0 0 0 0 76.00 76.01 03951 SLEEP LAB 0 0 0 0 0 76.01 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76.02 76.03 03952 WOUND CARE 0 0 0 0 0 76.03 OUTPATI ENT SERVI CE COST CENTERS OUTPATI ENT SERVI CE COST CENTERS 90.00 00000 CLI NI C 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 91.00 91.00 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 92.00		0	C		0 0	0	
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76. 03 03952 WOUND CARE 0		0	C		0 0	0	
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 92. 00		0	C		0 0	-	
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	200.00 Total (Thes 50 through 199)	0	l C	1	U U	il U	1200. OO

Heal th	Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUC	GH COSTS				From 06/01/2019		
			Component	CCN: 15-S047	To 05/31/2020	Date/Time Pre 11/2/2020 12:	pared:
			Ti †1	e XIX	Subprovider -	PPS	13 pill
				C XIX	IPF	115	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATI NG ROOM	0	0		0 24, 041, 550		•
51.00	05100 RECOVERY ROOM	0	0		0 1, 780, 968		51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 2, 517, 036	0.00000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 58, 224, 083	0.00000	54.00
54.01	03630 ULTRA SOUND	0	0		0 0	0.00000	54.01
56.00	05600 RADI OI SOTOPE	0	0		0 0	0. 000000	56.00
57.00	05700 CT SCAN	0	0	1	0 0	0. 000000	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0 14, 145, 023	0. 000000	59.00
60.00	06000 LABORATORY	0	0	1	0 44, 291, 530	0.00000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 842, 806	0. 000000	62.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 10, 158, 998	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 2, 777, 068	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 654, 583	0. 000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 144, 152		68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 3, 057, 976		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 4, 915, 444	0, 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 31, 412, 498	0. 000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 47, 319, 867	0.00000	
	07400 RENAL DI ALYSI S	0	0		0 725, 995		•
	03950 MISC ANCILLARY	0	0		0 0	0, 000000	•
76.01	03951 SLEEP LAB	0	0		0 0	0. 000000	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0. 000000	
	03952 WOUND CARE	0	0		0 2, 105, 748		•
70.00	OUTPATIENT SERVICE COST CENTERS				2,100,710	0.00000	/0.00
90, 00		0	0		0 161, 302	0.00000	90.00
	09100 EMERGENCY	0	0		42, 351, 211	0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0		0 3, 936, 926		
200.00		0	0		0 297, 564, 764		200.00
200.00			0	1	2, 2, , , , , , , , , , , , , , , , , ,	1	

APPORTI OWENT OF LIPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0047 Component CCN: 15-5047 Period: From 05/31/2020 Worksheet D Part I V Dof/31/2020 Worksheet D Date/Time Prepared: 10/22/2020 12:3 pm Cost Center Description Outpatient to Charges (col. 6 + col 7) Program Pass-Through Costs (col. 8) X col. 100 10.00 10.00	Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
Ancount obord Component CCN: 15-S047 To 05/31/2020 Date/Time Prepared: 11/2/2020 [PER Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 9,00 Inpatient Program Pass-Through Costs (col. 8 x col. 10) Inpatient Program Pass-Through Costs (col. 9 x col. 10) Outpatient Program Pass-Through Costs (col. 9 x col. 10) Outpatient Pass-Thr	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider CO	CN: 15-0047			
Cost Center Description Outpatient Ratio of Cost (col. 6 + col. 7) Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges 50.00 05000 0FERATINC ROOM 0.000000 0	THROUGH COSTS		Component	CON. 15 CO 47			norod.
Cost Center Description Outpatient Ratio of Cost (col. 6 + col. 7) Inpatient Program Charges Inpatient Program Charges Outpatient Program Charges ANCILLARY SERVICE COST CENTERS 0.000000 0 0 0 0 0 0 0 0 0 0 50.00 50.00 50.00 05000 REDVERY ROM 0.000000 0 0 0 0 0 0 51.00 54.00 05300 RADIOLOGY-DI AGNOSTIC 0.000000 0 0 0 0 54.00 56.00 05600 RADIOLOGY-DI AGNOSTIC 0.000000 0 0 0 0 57.00 57.00 05700 CT SCAH 0.000000 0 0 0 0 0 0 0 0 0 0 0 0			Component (JUN: 15-5047	10 05/31/2020		
Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program (Charges) Inpatient Program (Costs (col. 9 x col. 10) Outpatient Program (Costs (col. 9 x col. 10) Outpatient Program (Costs (col. 9 x col. 10) ANCILLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 ANCILLARY SERVICE COST CENTERS 0.000000 0 0 0 0 0 50.00 05000 (DEPRATING ROOM 0.000000 0			Ti tl	e XIX	Subprovider -		
Ratio of Cost to Charges (col. 6 + col. 7) Program (charges 7) Program (charges 7) Pr							
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TO x col . 10 x col . 12 ANCILLARY SERVICE COST CENTERS 9.00 11.00 12.00 13.00 50.00 05000 (PEATING ROOM 0.000000 0 0 0 50.00 51.00 05100 (RECOVERY ROM 0.000000 0 0 0 51.00 53.00 05100 (RECOVERY ROM 0.000000 0 0 0 53.00 54.00 05400 (RADI CLOGY -DI AGNOSTI C 0.000000 0 0 0 54.00 54.00 05600 (RADI CLOGY -DI AGNOSTI C 0.000000 0 0 0 54.00 56.00 0500 (LTS CAN 0.000000 0 0 0 57.00 57.00 0500 (CLS CAN 0.000000 0 0 0 57.00 60.00 06000 (LABORATORY 0.000000 0 0 0 66.00 60.00 06000 (LABORATORY 0.000000 0 0 0 66.00 60.00 06000 (SPECI PATHONA THERAPY 0.000000 8,			Charges				
ANCI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 ANCI LLARY SERVICE COST CENTERS 0					8		
ANCI LLARY SERVICE COST CENTERS Image: Control of the co			10.00		12.00		
50.00 05000 0PERATING ROOM 0.000000 0 0 0 50.00 51.00 05300 RECOVERY ROOM 0.000000 0 0 0 51.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY DI AGNOSTI C 0.000000 0 0 0 54.00 54.01 03630 ULTRA SOUND 0.000000 0 0 0 54.00 54.00 05600 RADI OL CATHETERI ZATION 0.000000 0 0 0 57.00 57.00 05700 CRDI AC CATHETERI ZATION 0.000000 0 0 0 57.00 650.00 6500 RABIPRATORY 0.000000 0 0 0 62.00 6200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 53.00 05300 ANESTHESI OLGGY 0.000000 0 0 0 53.00 54.00 05300 ANESTHESI OLGGY 0.000000 0 0 0 54.00 54.00 05400 RADI LOGY-DI AGNOSTI C 0.000000 0 0 0 54.01 55.00 05600 RADI IS STOPE 0.000000 0 0 0 55.00 57.00 05700 C T SCAN 0.000000 0 0 0 57.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 57.00 62.00 06200 WHOLE BLODD & PACKED RED BLODD CELL 0.000000 0 0 0 66.00 65.00 06500 RESPI RATORY THERAPY 0.000000 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 7.8 0 0 67.00 69.00 06700 CLEPATI ONAL THERAPY 0.000000 7.88 0 0 67.00		0.00000	0		0 0	0	50.00
53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.01 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 0 54.01 56.00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 0 54.01 56.00 05600 RADI OL SOTOPE 0.000000 0 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 0 57.00 69.00 06000 LABORATORY 0.000000 0 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 0 62.00 65.00 06500 RSPI RATORY THERAPY 0.000000 0 0 0 66.00 66.00 06400 PHYSI CAL THERAPY 0.000000 78 0 0 66.00 67.00 06700 0 0 0 0 0 67.00 67.00 68.00 06600 PELETNOCARDI OLOGY 0.000000 1.377<			0				
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57.00 05700 CT SCAN 0.000000 0 0 0 0 57.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0			0		0 0		
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IPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0047 Period: To 05/31/2020 Period: To 05/31/2020 Period: To 05/31/2020 Period: To 05/31/2020 Period: Description Period: Description Period: Description Period: Title XIX Period: Skilled Nursing Period: Period: Title/XIX Period: Description <	Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-	2552-10
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72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 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 ANCI LLARY 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 76.02 76.03 03952 WOUND CARE 0 0 0 0 76.02 70.00 09000 CLI NI C 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 90.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 92.00		0	C		0 0	-	
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 MI SC ANCI LLARY 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 76.02 76.04 03952 WOUND CARE 0 0 0 0 76.02 76.03 03952 WOUND CARE 0 0 0 0 76.03 00TPATIENT SERVICE COST CENTERS 0 0 0 0 90.00 90.00 90.00 90.00 91.00 09100 EMERGENCY 0 0 0 0 90.00 91.00 92.00 92.00 0 0 0 92.00 92.00 92.00 92		0	C		0 0	-	
74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03950 MI SC ANCI LLARY 0 0 0 0 76.00 76.01 03951 SLEEP LAB 0 0 0 0 0 76.01 76.02 03952 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76.02 76.03 03952 WOUND CARE 0 0 0 0 76.02 76.03 03952 WOUND CARE 0 0 0 0 76.02 76.04 09000 CLI NI C 0 0 0 0 90.00 90.00 09000 CLI NI C 0 0 0 90.00 91.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 92.00		0	C		0 0	-	
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 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 0 76.02 76.03 03952 WOUND CARE 0 0 0 0 0 76.02 76.04 03952 WOUND CARE 0 0 0 0 0 76.02 76.03 03952 WOUND CARE 0 0 0 0 76.03 00TPATI ENT SERVICE COST CENTERS 0 0 0 0 0 90.00 90.00 CLINIC 0 0 0 0 90.00 90.00 91.00 09100 EMERGENCY 0 0 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92.00		0	C		0 0	-	
76. 01 03951 SLEEP LAB 0 0 0 0 76. 01 76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76. 02 76. 03 03952 WOUND CARE 0 0 0 0 0 76. 03 OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 90. 00 91.00 91.00 91.00 91.00 92.00 0 0 0 92.00 0 0 0 0 92.00 0 92.00 00 0 0 92.00 00 0 92.00 0 92.00 0 0 0 92.00 0 92.00 0 92.00 0 0 0 0 92.00 0 92.00 0 0 0 0 92.00 92.00 0 92.00 0 0 0 0 92.00 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 <		0	C		0 0	~	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76. 02 76. 03 03952 WOUND CARE 0 0 0 0 0 0 0 0 0 76. 02 01 01 0 0 0 0 0 0 0 76. 03 01 01 01 0 0 0 0 0 76. 03 01 01 01 0 0 0 0 0 0 76. 03 01 01 01 0 0 0 0 90. 00 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 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 92. 00		0	C		0 0	~	
76.03 03952 WOUND CARE 0		0	C		0 0	-	•
OUTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC 0 0 0 0 90.00 91. 00 09100 EMERGENCY 0 0 0 0 0 91.00 92. 00 09200 OBSERVATI ON_BEDS_(NON-DI STINCT_PART 0 0 0 0 92.00		0	C		0 (-	
90. 00 09000 CLINIC 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92. 00		0	C		0 (0	76.03
91.00 09100 EMERGENCY 0 0 0 91.00 91.00 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92.00 0 92.00 0 0 0 0 92.00 0 92.00 0 0 0 0 0 92.00 0 0 0 0 0 0 0 92.00 0				1	0		00.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 92. 00		0		1		~	
		0	Ĺ	1		-	
			~		0		
	200.00 TUTAL (TTHES SO THEOUGH 199)	I U	Ĺ	1	u t	'I 0	1200.00

Health Financial Systems	ST JOSEPH MED			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0047	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-5356	From 06/01/2019 To 05/31/2020		narod
		component	CCN. 15-5550	10 05/31/2020	11/2/2020 12:	
		Titl	e XIX	Skilled Nursing		
				Facility		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS		-		0 04 044 550	0.000000	50.00
50.00 O5000 OPERATING ROOM	0	0		0 24, 041, 550		•
51.00 O5100 RECOVERY ROOM	0	0		0 1, 780, 968		•
53.00 05300 ANESTHESI OLOGY	0	0		0 2, 517, 036		•
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 58, 224, 083		
54. 01 03630 ULTRA SOUND	0	0		0 0	0.000000	
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0.000000	•
57.00 05700 CT SCAN	0	0		0 0	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 14, 145, 023		•
60. 00 06000 LABORATORY	0	0		0 44, 291, 530		•
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 842, 806		•
65. 00 06500 RESPI RATORY THERAPY	0	0		0 10, 158, 998		
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0	0		0 2, 777, 068		
	0	0		0 2, 654, 583		
68. 00 06800 SPEECH PATHOLOGY	0	0		0 144, 152		•
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 3, 057, 976		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 4, 915, 444 0 31, 412, 498		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 47, 319, 867		
74. 00 07400 RENAL DIALYSIS	0	0		0 725, 995		
76. 00 03950 MI SC ANCI LLARY	0	0		0 723, 993	0. 000000	•
76. 01 03951 SLEEP LAB	0				0. 000000	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			0. 000000	•
76. 03 03952 WOUND CARE	0			0 2, 105, 748		
OUTPATIENT SERVICE COST CENTERS	0	0	1	2,103,740	0.00000	1 10.03
90. 00 09000 CLINIC	0	0		0 161, 302	0.00000	90.00
91. 00 09100 EMERGENCY	0	-		0 42, 351, 211		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 3, 936, 926		
200.00 Total (lines 50 through 199)	0	0		0 297, 564, 764		200.00
			1	2,7,007,704	I	1-00.00

Health Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C		Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-5356	From 06/01/2019 To 05/31/2020	Part IV Date/Time Pre	norod.
		component	CCN: 15-5350	To 05/31/2020	11/2/2020 12:	
		Titl	e XIX	Skilled Nursing	PPS	
				Facility		
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)	10.00	x col. 10) 11.00	12.00	x col. 12) 13.00	
ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATI NG ROOM	0.000000	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 439		0 0	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	6, 706		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	21, 634		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	19, 546		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	2, 436		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		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	21, 081		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
76.00 03950 MISC ANCI LLARY	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	0	76.02
76. 03 03952 WOUND CARE	0.000000	0		0 0	0	76.03
	0.000000			0	0	00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0.000000	0		0 0	0	90.00
	0.000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)	0. 000000	0 74, 842		0 0 0 0	0	92.00 200.00
	1 1	74,042	I	U U	0	200.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047	Period: From 06/01/2019 To 05/31/2020		pare
		Title XVIII	Hospi tal	11/2/2020 12: PPS	13 p
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed days			13, 276	
	Inpatient days (including private room days, excluding swing-b Private room days (excluding swing-bed and observation bed day		ivate room dave	13, 276 0	
	do not complete this line.	ys). Th you have only pr	rvate room days,	0	
00	Semi-private room days (excluding swing-bed and observation be			12, 018	4
00	Total swing-bed SNF type inpatient days (including private roor reporting period	om days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			_	
00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room	n davs) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	2, 247	9
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private r	oom davs)	0	10
	through December 31 of the cost reporting period (see instruct	tions)			
00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI		e room davs)	0	12
	through December 31 of the cost reporting period	3	5 /		
00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13
00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)	an (oner daring oning bod	uujo)	0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 c	of the cost	0.00	1 17
00	reporting period	es through becember si t	I the cost	0.00	
00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
	reporting period			0100	
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 Total general inpatient routine service cost (see instructions	5)		17, 304, 357	21
	Swing-bed cost applicable to SNF type services through December	<i>·</i>	ing period (line	0	22
00	5 x line 17)	01 - C + b + + +		0	
00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23
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)			0	
00	Swing-bed cost applicable to NF type services after December 3 x line 20)	al of the cost reporting	period (line 8	0	25
00	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		17, 304, 357	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		iai goo)	0	29
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0.000000	
	Average semi-private room per diem charge (line 20 ÷ line 3)			0.00	
00	Average per diem private room charge differential (line 32 mir	, ,	tions)	0.00	34
	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 17, 304, 357	36
	27 minus line 36)			.,, 304, 337]),
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 202 42	
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	-		1, 303. 43 2, 928, 807	38
	Medically necessary private room cost applicable to the Progra			2, 720, 007	40
00	Total Program general inpatient routine service cost (line 39	+ line 40)		2, 928, 807	41

IPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0047	Peri od:	Worksheet D-1	
				From 06/01/2019 To 05/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Total Inpatient CostI	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
00 NURSERY (title V & XIX only)						42.
Intensive Care Type Inpatient Hospital Ur	ni ts					1.0
00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT						43.
00 CORONARY CARE UNIT 00 BURN INTENSIVE CARE UNIT	5, 094, 094	976	5, 219. 3	6 620	3, 236, 003	
00 SURGI CAL I NTENSI VE CARE UNI T	5, 674, 674	770	5,217.0	020	3, 230, 003	46.
00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description						
00 Program inpatient ancillary service cost	(What D 2 col 2	Line 200)			1.00	48.
00 Total Program inpatient costs (sum of lin			ns)		10, 259, 531	
PASS THROUGH COST ADJUSTMENTS			1137		10,207,001	- 17.
00 Pass through costs applicable to Program	inpatient routine s	services (from	Wkst. D, sum	of Parts I and	813, 992	50.
					F((040	
00 Pass through costs applicable to Program and IV)	inpatient ancillary	y services (Tr	OM WKST. D, S	um of Parts II	566, 348	51.
00 Total Program excludable cost (sum of lin	nes 50 and 51)				1, 380, 340	52.
00 Total Program inpatient operating cost ex	kcluding capital rel	ated, non-phy	sician anesth	etist, and	8, 879, 191	
medical education costs (line 49 minus li	ne 52)					
TARGET AMOUNT AND LIMIT COMPUTATION						
00 Program discharges 00 Target amount per discharge					0.00	
00 Target amount (line 54 x line 55)					0.00	
00 Difference between adjusted inpatient ope	erating cost and tar	rget amount (I	ine 56 minus	line 53)	0	
00 Bonus payment (see instructions)					0	
00 Lesser of lines 53/54 or 55 from the cos	t reporting period e	ending 1996, u	pdated and co	mpounded by the	0.00	59
market basket 00 Lesser of lines 53/54 or 55 from prior ye	ear cost report up	dated by the m	arket hasket		0.00	60
00 f line 53/54 is less than the lower of l				the amount by	0.00	
which operating costs (line 53) are less						
amount (line 56), otherwise enter zero (s	see instructions)					
00 Relief payment (see instructions)00 Allowable Inpatient cost plus incentive plus plus plus plus plus plus plus plus	animont (can instru	ations)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST	Jayment (see mistru	5(10)(5)			0	03
00 Medicare swing-bed SNF inpatient routine	costs through Decer	mber 31 of the	cost reporti	ng period (See	0	64
instructions)(title XVIII only)					_	
00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after Decembe	er 31 of the c	ost reporting	period (See	0	65
00 Total Medicare swing-bed SNF inpatient re	outine costs (line (64 plus line 6	5)(title XVII	lonly) For	0	66
CAH (see instructions)			0)((()())			
00 Title V or XIX swing-bed NF inpatient rou	utine costs through	December 31 c	f the cost re	porting period	0	67.
(line 12 x line 19) 00 Title V or XIX swing-bed NF inpatient rou	iting goots often D	acombox 21 of	the east mana	sting pariod		
00 Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)	utine costs after De	ecember 31 01	the cost repo	rting period	0	68.
00 Total title V or XIX swing-bed NF inpatie	ent routine costs (I	ine 67 + line	68)		0	69
PART III - SKILLED NURSING FACILITY, OTHE	R NURSING FACILITY,	AND ICF/IID	ONLY			
00 Skilled nursing facility/other nursing fa						70
00 Adjusted general inpatient routine servic 00 Program routine service cost (line 9 x li		ne 70 ÷ line	2)			71
00 Medically necessary private room cost app		(line 14 x li	ne 35)			73
00 Total Program general inpatient routine s						74
00 Capital -related cost allocated to inpatio	ent routine service	costs (from W	orksheet B, F	art II, column		75
26, line 45)						-,
00 Per diem capital-related costs (line 75 - 00 Program capital-related costs (line 9 x l	,					76
00 Inpatient routine service cost (line 74 r						78
00 Aggregate charges to beneficiaries for ex	,	rovider record	s)			79
00 Total Program routine service costs for a	•	ost limitation	(line 78 min	us line 79)		80
00 Inpatient routine service cost per diem I		, ,				81
00 Inpatient routine service cost limitation	• •					82
00 Reasonable inpatient routine service cos 00 Program inpatient ancillary services (see	•	<i>>)</i>				83
00 Utilization review - physician compensati		ns)				85
00 Total Program inpatient operating costs						86
PART IV - COMPUTATION OF OBSERVATION BED						
					1, 258	8 87.
00 Total observation bed days (see instructi 00 Adjusted general inpatient routine cost p		Line 2			1, 303. 43	

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 06/01/2019 To 05/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 736, 114	17, 304, 357	0. 15811	7 1, 639, 715	259, 267	90.00
91.00 Nursing School cost	0	17, 304, 357	0.00000	0 1, 639, 715	0	91.00
92.00 Allied health cost	0	17, 304, 357	0.00000	0 1, 639, 715	0	92.00
93.00 All other Medical Education	0	17, 304, 357	0. 00000	0 1, 639, 715	0	93.00

INPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047	Peri od:	Worksheet D-1	
		Component CCN: 15-SO47	From 06/01/2019 To 05/31/2020	Date/Time Prep 11/2/2020 12:	
		Title XVIII	Subprovider - IPF	PPS	
	Cost Center Description		-	1.00	
	PART I – ALL PROVIDER COMPONENTS				
~ ~	INPATIENT DAYS			0.050	
00 00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			3,859	
00	Private room days (excluding private room days, excluding swing Private room days (excluding swing-bed and observation bed d	5,7	ivate room dave	3, 859 0	
00	do not complete this line.	ays). If you have only pr	rvate room days,	0	
00	Semi-private room days (excluding swing-bed and observation	bed days)		3, 859	4
00	Total swing-bed SNF type inpatient days (including private r	oom days) through Decembe	r 31 of the cost	0	5
00	reporting period	and dave) often December	21 of the east	0	
50	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	com days) arter becember	ST OF THE COST	0	6
00	Total swing-bed NF type inpatient days (including private ro	om days) through December	31 of the cost	0	7
	reporting period	3 / 3			
00	Total swing-bed NF type inpatient days (including private ro	om days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (aveluding	cwing bod and	1, 972	9
00	newborn days) (see instructions)	to the Frogram (excluding	Swilly-bed allu	1, 7/2	7
. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instru		5 /		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X		e room dave)	0	12
. 00	through December 31 of the cost reporting period		e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar				
	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT		I	0	
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 o	f the cost	0.00	17
~~	reporting period	ft D 21 - f	++	0.00	10
. 00	Medicare rate for swing-bed SNF services applicable to servi- reporting period	ces after December 31 of	the cost	0.00	115
. 00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of t	he cost	0.00	20
. 00	reporting period		ne cost	0.00	
. 00	Total general inpatient routine service cost (see instruction	ns)		3, 798, 363	21
. 00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost report	ing period (line	0	22
00	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	r 31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 798, 363	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-b	ed and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 m		tions)	0.00	
. 00	Average per diem private room cost differential (line 34×1	ine 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost pet of swing bed cost	and private room cost di	fforontial (line	0 3 708 363	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost di	inerentiar (IINE	3, 798, 363	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				
				984.29	38
	Adjusted general inpatient routine service cost per diem (se				
. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Prog	e 38)		1, 941, 020 0	

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	01 0002111 11201	CAL CENTER Provider C	CN: 15-0047	Peri od:	u of Form CMS- Worksheet D-1	
			CCN: 15-S047	From 06/01/2019 To 05/31/2020	Date/Time Pre	pared
		Ti †l ¢	e XVIII	Subprovider -	11/2/2020 12: PPS	13 pm
			T	I PF		
Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	10.0
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital U	ni ts					42.0
13. 00 INTENSIVE CARE UNIT						43.0
44. 00 CORONARY CARE UNI T				~ ~ ~	0	44.0
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT	0	C	0.	00 0	0	45.0
47.00 OTHER SPECIAL CARE (SPECIFY)						47.0
Cost Center Description					1.00	
18.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3,	line 200)			499, 504	48.0
19.00 Total Program inpatient costs (sum of li			ons)		2, 440, 524	
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program	innationt routing a	onvicos (from	Wkst D su	m of Parts L and	220, 371	50. 0
(111)	i inpatrent routine s	ervices (IIO	TWKSL D, SU		220, 371	50.0
1.00 Pass through costs applicable to Program	n inpatient ancillary	services (fr	om Wkst. D,	sum of Parts II	81, 761	51.0
and IV) 52.00 Total Program excludable cost (sum of li	nes 50 and 51)				302, 132	52.0
53.00 Total Program inpatient operating cost e		ated, non-phy	sician anest	hetist, and	2, 138, 392	
medical education costs (line 49 minus I	ine 52)					
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges					0	54.0
5.00 Target amount per discharge					0.00	55.
6.00 Target amount (line 54 x line 55) 7.00 Difference between adjusted inpatient op	orating cost and tar	act amount (1	ino E4 minus	Lino E2)	0	
8.00 Bonus payment (see instructions)	erating cost and tar	get amount (i	The so minus	TTHE 55)	0	
9.00 Lesser of lines 53/54 or 55 from the cos	t reporting period e	nding 1996, ι	updated and c	ompounded by the	0.00	
market basket 00.00 Lesser of lines 53/54 or 55 from prior y	war cost report und	ated by the m	arkat haskat		0.00	60.
51.00 If line 53/54 is less than the lower of					0.00	
which operating costs (line 53) are less		(lines 54 x	60), or 1% o	f the target		
amount (line 56), otherwise enter zero (52.00 Relief payment (see instructions)	see instructions)				0	62.0
53.00 Allowable Inpatient cost plus incentive		tions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine		bor 21 of the	oct const	ing pariod (Saa	0	64. (
instructions) (title XVIII only)	costs through becen		e cost report	ing period (see	0	04.0
55.00 Medicare swing-bed SNF inpatient routine	e costs after Decembe	r 31 of the c	cost reportin	g period (See	0	65. (
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient r	outine costs (line 6	4 nlus line A	5)(title XVI	ll only) For	0	66. (
CAH (see instructions)						00.
57.00 Title V or XIX swing-bed NF inpatient ro	outine costs through	December 31 c	of the cost r	eporting period	0	67.0
(line 12 x line 19) 58.00 Title V or XIX swing-bed NF inpatient ro	outine costs after De	cember 31 of	the cost rep	orting period	0	68.0
(line 13 x line 20)				5 1	_	
59.00 Total title V or XIX swing-bed NF inpati PART III - SKILLED NURSING FACILITY, OTH					0	69.0
70.00 Skilled nursing facility/other nursing f)		70. (
1.00 Adjusted general inpatient routine servi		ne 70 ÷ line	2)			71.0
2.00 Program routine service cost (line 9 x l3.00 Medically necessary private room cost approximation of the service of the	,	(line 14 x li	ne 35)			72.
74.00 Total Program general inpatient routine	service costs (line	72 + line 73)				74.
75.00 Capital-related cost allocated to inpati	ent routine service	costs (from V	lorksheet B,	Part II, column		75. (
26, line 45) 76.00 Per diem capital-related costs (line 75	÷line 2)					76. (
7.00 Program capital-related costs (line 9 x	line 76)					77.
 8.00 Inpatient routine service cost (line 74 9.00 Aggregate charges to beneficiaries for e 		ovider record	ls)			78. 79.
0.00 Total Program routine service costs for				nus line 79)		80.
1.00 Inpatient routine service cost per diem	limitation			-		81.
32.00 Inpatient routine service cost limitation 33.00 Reasonable inpatient routine service cost	• • • • • •					82. 83.
4.00 Program inpatient ancillary services (se	•	2				84.
35.00 Utilization review - physician compensat	ion (see instruction					85.
36.00 Total Program inpatient operating costs PART IV - COMPUTATION OF OBSERVATION BED		ough 85)				86. (
Total observation bed days (see instruct					0	87. (
88.00 Adjusted general inpatient routine cost		line 2)				88. (
39.00 Observation bed cost (line 87 x line 88)	(see instructions)				0	89.

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 06/01/2019	Worksheet D-1	
		Component (To 05/31/2020		
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	431, 250	3, 798, 363	0. 11353	6 0	0	90.00
91.00 Nursing School cost	0	3, 798, 363	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 798, 363	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 798, 363	0. 00000	0 0	0	93.00

	TION OF INPATIENT OPERATING COST	Provider CCN: 15-0047	Peri od:	Worksheet D-1	
		Component CCN: 15-5356	From 06/01/2019 To 05/31/2020	Date/Time Pre 11/2/2020 12:	
		Title XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed da			4, 321	1.
	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed o		ivata room dave	4, 321 0	2
50	do not complete this line.	uays). It you have only pr	TVate Toolii uays,	0	3
00	Semi-private room days (excluding swing-bed and observation	bed days)		4, 321	4
00	Total swing-bed SNF type inpatient days (including private r	room days) through Decembe	er 31 of the cost	0	5
~	reporting period		21 - 5 + +	0	
00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	dom days) after becember	31 OF the cost	0	6
00	Total swing-bed NF type inpatient days (including private ro	oom days) through December	31 of the cost	0	7
	reporting period			-	
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	1 of the cost	0	8
~ ~	reporting period (if calendar year, enter 0 on this line)			1 10(
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excluding	swing-bed and	1, 196	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	noom days)	0	10
	through December 31 of the cost reporting period (see instru			-	
	Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year,			0	1.
. 00	Swing-bed NF type inpatient days applicable to titles V or > through December 31 of the cost reporting period	Kix only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or >	XIX only (including privat	e room davs)	0	13
	after December 31 of the cost reporting period (if calendar	year, enter 0 on this lir	ie)		
	Medically necessary private room days applicable to the Prog	gram (excluding swing-bed	days)	0	14
	Total nursery days (title V or XIX only)			0	15
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 c	of the cost	0.00	17
	reporting period	-			
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	ces through December 31 of	the cost	0.00	10
. 00	reporting period	the ough becomen an of		0.00	'
. 00	Medicaid rate for swing-bed NF services applicable to servic	ces after December 31 of t	he cost	0.00	20
	reporting period			0 5 4 0 0 0 7	
	Total general inpatient routine service cost (see instructic Swing-bed cost applicable to SNF type services through Decem		ing pariod (line)	3, 563, 387 0	21
. 00	5 x line 17)	inder 31 of the cost report	ing period (ine	0	22
. 00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reportin	g period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	and the cost reporting	period (line 8	0	25
	x line 20)	er er the cost reporting		0	~`
	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		3, 563, 387	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	and and observation had a	argos)	0	28
	Private room charges (excluding swing-bed charges)	bed and observation bed ci	iai yes)	0	29
	Semi-private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0.00000	31
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l	, ,	tions)	0.00 0.00	34
	Private room cost differential adjustment (line 3 x line 35)			0.00	35
	General inpatient routine service cost net of swing-bed cost		fferential (line	3, 563, 387	
	27 minus line 36)				- /
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD				
	Adjusted general inpatient routine service cost per diem (se Program general inpatient routine service cost (line 9 x lir				38
	Medically necessary private room cost applicable to the Proc				40
	,, p	,			

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	ST JOSEPH MED	Provider C	N: 15-0047	Period:	eu of Form CMS- Worksheet D-1	
OMPOTATION OF INPATTENT OPERATING COST			CCN: 15-5356	From 06/01/2019 To 05/31/2020	•	
					11/2/2020 12:	
		litle	XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only)						42. C
Intensive Care Type Inpatient Hospital Uni 3.00 INTENSIVE CARE UNIT						43.0
4.00 CORONARY CARE UNIT						44. C
5. 00 BURN INTENSIVE CARE UNIT 6. 00 SURGICAL INTENSIVE CARE UNIT						45. C
7. 00 OTHER SPECIAL CARE (SPECIFY)						47.0
Cost Center Description					1.00	
8.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3	, line 200)			1.00	48.0
9.00 Total Program inpatient costs (sum of line			ns)			49. C
PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program i	npatient routine	services (from	Wkst. D. su	m of Parts I and		50. C
1.00 Pass through costs applicable to Program i and IV)	npatient ancillar	y services (fr	om Wkst. D,	sum of Parts II		51.0
2.00 Total Program excludable cost (sum of line						52. C
3.00 Total Program inpatient operating cost exc medical education costs (line 49 minus lin		lated, non-phy	sician anest	hetist, and		53. C
TARGET AMOUNT AND LIMIT COMPUTATION	e 52)				1	
4.00 Program di scharges						54.0
5.00 Target amount per discharge 6.00 Target amount (line 54 x line 55)						55.0
7.00 Difference between adjusted inpatient oper	ating cost and ta	rget amount (I	ine 56 minus	line 53)		57.
8.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cost	reporting pariod	onding 1004 u	ndated and a	ompounded by the		58. 59.
9.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period	ending 1996, u	puateu anu c	ompounded by the		59.
0.00 Lesser of lines 53/54 or 55 from prior yea						60.
1.00 If line 53/54 is less than the lower of li which operating costs (line 53) are less t						61.0
amount (line 56), otherwise enter zero (se		- (
2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive pa	vment (see instru	ctions)				62.0
PROGRAM INPATIENT ROUTINE SWING BED COST	Jment (See Thistru					00.0
4.00 Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	osts through Dece	mber 31 of the	cost report	ing period (See		64. (
5.00 Medicare swing-bed SNF inpatient routine c	osts after Decemb	er 31 of the c	ost reportin	g period (See		65.
instructions) (title XVIII only)	tino posto (lino	(1 plug ling (E) (+; + ~ V)/I			
6.00 Total Medicare swing-bed SNF inpatient rou CAH (see instructions)	tine costs (Tine	o4 prus rine o	s)(title xvi	TT ONLY). FOR		66.
7.00 Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 o	f the cost r	eporting period		67.0
line 12 x line 19) 8.00 Title V or XIX swing-bed NF inpatient rout	ine costs after D	ecember 31 of	the cost rep	orting period		68.
(line 13 x line 20)				5 1		
9.00 Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER						69. (
0.00 Skilled nursing facility/other nursing fac	ility/ICF/IID rou	tine service c	ost (line 37)	3, 563, 387	
1.00 Adjusted general inpatient routine service 2.00 Program routine service cost (line 9 x lin		ine 70 ÷ line	2)		824.67 986,305	
3.00 Medically necessary private room cost appl	· ·	(line 14 x li	ne 35)		980, 303	
4.00 Total Program general inpatient routine se	rvice costs (line	72 + line 73)	,		986, 305	
5.00 Capital-related cost allocated to inpatien 26, line 45)	t routine service	costs (from W	orksheet B,	Part II, column	0	75.0
6.00 Per diem capital-related costs (line 75 ÷					0.00	
7.00 Program capital-related costs (line 9 x li 8.00 Inpatient routine service cost (line 74 mi					0	
9.00 Aggregate charges to beneficiaries for exc		rovi der record	s)		0	
0.00 Total Program routine service costs for co	•	ost limitation	(line 78 mi	nus line 79)	0	
1.00 Inpatient routine service cost per diem li 2.00 Inpatient routine service cost limitation)			0.00	
3.00 Reasonable inpatient routine service costs	(see instruction	* .			986, 305	83.
4.00 Program inpatient ancillary services (see		nc)			669, 646 0	
5.00 Utilization review - physician compensation 6.00 Total Program inpatient operating costs (s					1, 655, 951	
PART IV - COMPUTATION OF OBSERVATION BED P	ASS THROUGH COST	<u> </u>			1	
7.00 Total observation bed days (see instructio 8.00 Adjusted general inpatient routine cost pe		line 2)			0 00	87.0 88.0

Health Financial Systems	In Lie	u of Form CMS-2	2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0047	Period: From 06/01/2019	Worksheet D-1	
		Component (CCN: 15-5356	To 05/31/2020		
		Title	XVIII	Skilled Nursing Facility	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	0	0	0.0000	0 0	0	90.00
91.00 Nursing School cost	0	0	0.0000	0 0	0	91.00
92.00 Allied health cost	0	0	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	0	0.0000	0 00	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047	Period: From 06/01/2019	Worksheet D-1	
			To 05/31/2020	Date/Time Pre 11/2/2020 12:	
	Cost Center Description	Title XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
~~	I NPATI ENT DAYS		1	40.07/	
00 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			13, 276 13, 276	1
00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d days)		12, 018	4
00	Total swing-bed SNF type inpatient days (including private roo	m days) through Decembe	er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private roo	m days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	dave) through Docombor	21 of the cost	0	
50	reporting period	<i>y</i> ,		0	
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	31 of the cost	0	8
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 052	Ģ
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	nom davs)	0	10
	through December 31 of the cost reporting period (see instruct	i ons)			
00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13
00	after December 31 of the cost reporting period (if calendar ye	ar, enter O on this lir	ne)		1
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	in (excluding swing-bed	uays)	0 0	14
00	Nursery days (title V or XIX only)			0	16
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	19
	reporting period				
00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19
00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructions	5)		17, 304, 357	21
00	Swing-bed cost applicable to SNF type services through Decembe 5 x line 17)	er 31 of the cost report	ing period (line	0	22
00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
00	Swing-bed cost applicable to NF type services after December 3 x line 20)	of the cost reporting	period (line 8	0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 24		0	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	iine zi minus iine 26)		17, 304, 357	27
	General inpatient routine service charges (excluding swing-bed	l and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	31
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lin	, .		0.00	
00	Private room cost differential adjustment (line 3 x line 35)	,		0	36
	General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	17, 304, 357	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
	Adjusted general inpatient routine service cost per diem (see	-		1, 303. 43	
	Program general inpatient routine service cost (line 9 x line	38)		2, 674, 638	39
	Medically necessary private room cost applicable to the Progra	(line 14 x line 25)	1	0	40

ealth Financial System OMPUTATION OF INPATIE		ST JOSEPH MEDI	Provi der C	CN: 15-0047	Peri od:	eu of Form CMS- Worksheet D-1	
					From 06/01/2019 To 05/31/2020		
				e XIX	Hospi tal	PPS	
Cost Cente	r Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title \							42.
	ype Inpatient Hospital Uni	ts					1 4 2
3.00 INTENSIVE CARE U 4.00 CORONARY CARE UN							43. 44.
5. 00 BURN INTENSIVE (5, 094, 094	976	5, 219. 3	36 149	777, 685	
5. 00 SURGI CAL INTENSI		0,0,1,0,1	,,,,	0,21,11			46.
7.00 OTHER SPECIAL CA	. /						47.
Cost Cente	⁻ Description					1.00	
8.00 Program inpatier	t ancillary service cost (West D-3 col 3	Line 200)			1, 874, 002	2 48.
	patient costs (sum of line			ons)		5, 326, 325	
PASS THROUGH COS	T ADJUSTMENTS						
5	ts applicable to Program i	npatient routine s	ervices (from	n Wkst. D, sur	n of Parts I and	507, 228	3 50.
) 1.00 Pass through cos	ts applicable to Program i	prationt ancillary	sorvicos (fr	om What D	sum of Parts II	249, 945	5 51.
and IV)	ts appricable to Program i	npatrent and riary	Services (II	UNI WKSL. D, S	Sull OF Parts II	249, 943	5 51.
	cludable cost (sum of line	es 50 and 51)				757, 173	3 52.
	patient operating cost exc		ated, non-phy	vsician anesth	netist, and	4, 569, 152	2 53.
	n costs (line 49 minus lir	ne 52)					
4.00 Program discharg	D LIMIT COMPUTATION						54.
5.00 Target amount pe						0.00	
	ine 54 x line 55)					C	
	en adjusted inpatient oper	rating cost and tar	get amount (I	ine 56 minus	line 53)		
0.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							59.
1	53/54 or 55 from prior yea	ar cost report, upd	ated by the m	narket basket		0.00	60.
	less than the lower of li				the amount by	c	61.
	costs (line 53) are less t		(lines 54 x	60), or 1% of	° the target		
	, otherwise enter zero (se see instructions)	e instructions)					62.
	ent cost plus incentive pa	avment (see instruc	tions)				
	T ROUTINE SWING BED COST	2 .	,				
	ed SNF inpatient routine of	costs through Decem	ber 31 of the	e cost reporti	ng period (See	C	64.
instructions)(ti 5.00 Medicare swing-b	tle XVIII only) ed SNF inpatient routine d	costs after Decombo	r 21 of the c	ost roporting	n pariod (Saa	0	65.
instructions) (ti		JUSTS ATTEL DECEMBE		σειτεροιτιή	j perioù (see		05.
	wing-bed SNF inpatient rou	utine costs (line 6	4 plus line 6	5)(title XVII	I only). For	0	66.
CAH (see instruc							
7.00 Title V or XIX s (line 12 x line	wing-bed NF inpatient rout	tine costs through	December 31 c	of the cost re	eporting period	C	67.
	wing-bed NF inpatient rout	tine costs after De	cember 31 of	the cost repo	ortina period	0	68.
(line 13 x line				the cost ropt	in this point ou		
	XIX swing-bed NF inpatier			,		C	69.
	ED NURSING FACILITY, OTHER					1	1 70
Ű	facility/other nursing fac inpatient routine service	2		• •			70.
	service cost (line 9 x lir			_)			72.
	ary private room cost appl						73.
5 5	neral inpatient routine se	•	,				74.
	cost allocated to inpatier	nt routine service	costs (from V	orksheet B, F	art II, column		75.
26, line 45) 5.00 Per diem capital	-related costs (line 75 ÷	line 2)					76.
	related costs (line 9 x li	,					77.
	e service cost (line 74 mi	,					78.
00 0 0	s to beneficiaries for exc			· · · · · · · · · · · · · · · · · · ·	1		79.
U	utine service costs for co e service cost per diem li	•	SCIIMITATION	i (iine /8 mir	ius line /9)		80.
	e service cost limitation						82.
	ient routine service cost	•					83.
.00 Program inpatier	t ancillary services (see	instructions)					84.
	ew - physician compensatio	•					85.
	patient operating costs (s		ough 85)				86.
	ATION OF OBSERVATION BED F n bed days (see instructio					1, 258	8 87.
	inpatient routine cost pe		line 2)			1, 303. 43	
8.00 Adjusted general							

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1		
				From 06/01/2019 To 05/31/2020			
		Titl	e XIX	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	2, 736, 114	17, 304, 357	0. 15811	7 1, 639, 715	259, 267	90.00	
91.00 Nursing School cost	0	17, 304, 357	0.00000	0 1, 639, 715	0	91.00	
92.00 Allied health cost	0	17, 304, 357	0.00000	0 1, 639, 715	0	92.00	
93.00 All other Medical Education	0	17, 304, 357	0. 00000	0 1, 639, 715	0	93.00	

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047	Period:	Worksheet D-1	
		Component CCN: 15-SO47	From 06/01/2019 To 05/31/2020	Date/Time Prep 11/2/2020 12:	
		Title XIX	Subprovider - IPF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		L		
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	we eveluding newbern)		3, 859	1 1.
00	Inpatient days (including private room days, excluding swing-			3, 859	2.
00	Private room days (excluding swing-bed and observation bed d	,	ivate room days,	0,007	3
	do not complete this line.		-		
00 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r		r 31 of the cost	3, 859 0	4
00	reporting period Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	room days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private ro	oom days) through December	31 of the cost	0	7
00	reporting period		1 .6	0	
00	Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December 3	I OF THE COST	0	8
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excluding	swing-bed and	130	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instru	uctions)	5,	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,	enter 0 on this line)	3 /	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or X through December 31 of the cost reporting period		5,	0	
00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog	year, enter 0 on this lin	e)	-	
	Total nursery days (title V or XIX only)	gram (excruding swing-bed	uays)	0	15
	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servi	and through December 21 a	f the east	0.00	1 1 7
. 00	reporting period	ces thi ough becember 31 0	T the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	U U		0.00	
	Medicaid rate for swing-bed NF services applicable to servic reporting period		he cost	0.00	
. 00 . 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem 5 x line 17)	·	ing period (line	3, 798, 363 0	21 22
. 00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	er 31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	per 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	. (iine zi minus line 26)		3, 798, 363	27
. 00	General inpatient routine service charges (excluding swing-b	ed and observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	29
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
00	General inpatient routine service cost/charge ratio (line 27	r ÷ line 28)		0. 000000 0. 00	
. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	1		0.00	
. 00	Average per diem private room charge differential (line 32 m		tions)	0.00	
. 00	Average per diem private room cost differential (line 34 x l			0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minutine 2()		fferential (line	0 3, 798, 363	36 37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
		ILICTMENTS			1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	JUSIMENIS			
3. 00	Adjusted general inpatient routine service cost per diem (se	e instructions)		984.29	
8.00 9.00 0.00		ee instructions) ne 38)		984. 29 127, 958 0	

alth Financial Systems DMPUTATION OF INPATIENT OPERATING COST		CAL CENTER Provider C	CN: 15-0047	Peri od:	eu of Form CMS- Worksheet D-1	
			CCN: 15-S047	From 06/01/2019 To 05/31/2020		
			e XIX	Subprovider -	11/2/2020 12: PPS	13 p
				I PF		
Cost Center Description	Total Inpatient Costli	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	42
.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Ur	ni ts					42.
B. OO INTENSIVE CARE UNIT						43.
I. OO CORONARY CARE UNIT 5. OO BURN INTENSIVE CARE UNIT	0	C	0.0	0 0	0	44.
b. 00 SURGICAL INTENSIVE CARE UNIT	0	C	0.0	0		46
00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3,	line 200)			26, 237	48
.00 Total Program inpatient costs (sum of lin	nes 41 through 48)(s	ee instructio	ons)		154, 195	49
PASS THROUGH COST ADJUSTMENTS 00 Pass through costs applicable to Program	inpatient routine s	ervices (from	n Wkst D sur	of Parts L and	14, 528	50
111)	•					
.00 Pass through costs applicable to Program and IV)	inpatient ancillary	services (fr	om Wkst. D, s	sum of Parts II	4, 790	51
.00 Total Program excludable cost (sum of lin	nes 50 and 51)				19, 318	52
3.00 Total Program inpatient operating cost ex		ated, non-phy	sician anesti	netist, and	134, 877	53
medical education costs (line 49 minus li TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)					
.00 Program discharges					0	
0.00 Target amount per discharge 0.00 Target amount (line 54 x line 55)					0.00	
. 00 Difference between adjusted inpatient ope	erating cost and tar	get amount (I	ine 56 minus	line 53)		
.00 Bonus payment (see instructions)	0					
.00 Lesser of lines 53/54 or 55 from the cos market basket	t reporting period e	nding 1996, ι	pdated and co	ompounded by the	0.00	59
0.00 Lesser of lines 53/54 or 55 from prior ye	ear cost report, upd	ated by the m	arket basket		0.00	60
00 If line 53/54 is less than the lower of l					0	61
which operating costs (line 53) are less amount (line 56), otherwise enter zero (s		(lines 54 x	60), or 1% of	the target		
2.00 Relief payment (see instructions)	,				0	
8.00 Allowable Inpatient cost plus incentive program INPATIENT ROUTINE SWING BED COST	payment (see instruc	tions)			0	63
. 00 Medicare swing-bed SNF inpatient routine	costs through Decem	ber 31 of the	e cost reporti	ng period (See	0	64
instructions)(title XVIII only)						
6.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after Decembe	r 31 of the c	ost reporting	g period (See	0	65
5.00 Total Medicare swing-bed SNF inpatient ro	outine costs (line 6	4 plus line 6	5)(title XVII	I only). For	0	66
CAH (see instructions)	iting costs through	Docombor 21 c	f the cost r	porting poriod	0	67
7.00 Title V or XIX swing-bed NF inpatient rou (line 12 x line 19)	attille costs till ough	December 31 C		eporting period		0/
8.00 Title V or XIX swing-bed NF inpatient rou	utine costs after De	cember 31 of	the cost repo	orting period	0	68
line 13 x line 20) 2.00 Total title V or XIX swing-bed NF inpatio	ent routine costs (L	ine 67 + line	68)		0	69
PART III - SKILLED NURSING FACILITY, OTHE	R NURSING FACILITY,	AND ICF/IID	ONLY		· · · · · · · · · · · · · · · · · · ·	
0.00 Skilled nursing facility/other nursing facility/other nursing facility/other nursing facility.						70
.00 Adjusted general inpatient routine service.00 Program routine service cost (line 9 x li		ne 70 ÷ Trne	2)			71
.00 Medically necessary private room cost app	plicable to Program	•				73
1.00 Total Program general inpatient routine s 5.00 Capital-related cost allocated to inpatie				Part II column		74
26, line 45)	ent routine service		IOI KSHEEL D, I			'5
0.00 Per diem capital-related costs (line 75						76
.00 Program capital-related costs (line 9 x l .00 Inpatient routine service cost (line 74 r						77
. 00 Aggregate charges to beneficiaries for ex		ovider record	ls)			79
.00 Total Program routine service costs for o	•	st limitatior	n (line 78 mir	nus line 79)		80
.00 Inpatient routine service cost per diem I .00 Inpatient routine service cost limitation						81
8.00 Reasonable inpatient routine service cost	, ,)				83
00 Program inpatient ancillary services (see		-)				84
5.00 Utilization review – physician compensati 5.00 Total Program inpatient operating costs						85
PART IV - COMPUTATION OF OBSERVATION BED					I	1 0
7.00 Total observation bed days (see instructi	-				0 0.00	
3.00 Adjusted general inpatient routine cost p		1 :				88

Health Financial Systems	ST JOSEPH MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 06/01/2019	Worksheet D-1	
			Component CCN: 15-SO47		Date/Time Prep 11/2/2020 12:	pared: 13 pm
		Titl	e XIX	Subprovider - IPF	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	431, 250	3, 798, 363	0. 11353	6 0	0	90.00
91.00 Nursing School cost	0	3, 798, 363	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 798, 363	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 798, 363			0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-5356	Period: From 06/01/2019 To 05/31/2020	Worksheet D-1 Date/Time Pre 11/2/2020 12:	pare
		Title XIX	Skilled Nursing Facility	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs. excluding newborn)		4, 321	1 1
	Inpatient days (including private room days, excluding swing			4, 321	2
00	Private room days (excluding swing-bed and observation bed day	ays). If you have only pr	ivate room days,	0	3
00	do not complete this line.	had davic)		4, 321	4
00	Semi-private room days (excluding swing-bed and observation I Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	4, 321	
	reporting period			-	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om dave) through Decombor	21 of the cost	0	-
50	reporting period	un days) thi dugh becember	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8
20	reporting period (if calendar year, enter 0 on this line)			()	
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excluding	swing-bed and	63	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII (only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruct				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, of		oom days) after	0	1
00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
	through December 31 of the cost reporting period	3 3 3 1	3 /	-	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	Tam (exer daring swring bed	uuys)	0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	and through December 21 a	f the cost	0.00	1 1-
. 00	reporting period	ces thi ough becember 31 c	in the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
00	reporting period			0.00	10
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing pariod (line	3, 563, 387 0	
. 00	5 x line 17)	bei 31 01 the cost report	ing period (ine	0	
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportir	g period (line 6	0	23
00	x line 18)			0	
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (iine	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 3, 563, 387	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 20)	I	3, 303, 307	21
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	30
	Average private room per diem charge (line 29 ÷ line 3)	20)		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 mi	, ,	tions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ine 31)		0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 563, 387	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	HISTMENTS			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see		I		38
	Program general inpatient routine service cost per drem (ser				39
	Medically necessary private room cost applicable to the Progr				40
	Total Program general inpatient routine service cost (line 39	oo.)			4

('())(/[D111	Financial Systems TATION OF INPATIENT OPERATING COST	ST JOSEPH MED	ICAL CENTER Provider CO	N. 15_0047	Period:	worksheet D-1		
COMPUT	ATTON OF THEATTENT OFERATING COST			CCN: 15-5356	From 06/01/2019 To 05/31/2020			
						11/2/2020 12:		
			1111	e XIX	Skilled Nursing Facility	PPS		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)		
	1	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.0	
43.00	INTENSIVE CARE UNIT						43.0	
44.00	CORONARY CARE UNI T						44.0	
45.00 46.00	BURN INTENSIVE CARE UNIT						45.0 46.0	
	OTHER SPECIAL CARE (SPECIFY)						47.0	
	Cost Center Description					1.00		
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1.00	48.0	
49.00	Total Program inpatient costs (sum of lines			ns)			49.0	
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D. su	m of Parts I and		50.0	
51.00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II		51.0	
52.00	Total Program excludable cost (sum of lines						52.0	
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		lated, non-phy	sician anest	hetist, and		53.0	
	TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54.00	Program di scharges						54. C	
5.00 6.00	Target amount per discharge Target amount (line 54 x line 55)						55.0	
7.00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)		57.0	
8.00	Bonus payment (see instructions)	5	5 .		,		58.0	
9.00								
0. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket			60.0	
01.00	00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by							
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target			
52.00	Relief payment (see instructions)						62.0	
53.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)				63.0	
54.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of the	cost report	ing period (See		64.0	
	instructions)(title XVIII only)	C C			0 1 1			
5.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	er 31 of the c	ost reportin	g period (See		65.0	
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVI	II only). For		66.	
7 00	CAH (see instructions)	o costs through	December 21 o	f the cost r	oporting pariod		47 (
7.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	le costs through	December 31 0	I the cost I	eporting period		67.0	
8. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost rep	orting period		68. (
59.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	68)			69.0	
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	YINC		1		
0.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of)	3, 563, 387 824. 67		
72.00	Program routine service cost (line 9 x line		The 70 ÷ Time	2)		51, 954		
3. 00	Medically necessary private room cost applic	0	•	ne 35)		0	73. (
74.00	Total Program general inpatient routine serv	•		orkchoot P	Dort II column	51, 954		
75.00	Capital-related cost allocated to inpatient 26, line 45)	FOULTHE SELVICE	CUSIS (ITUII W	ULASHEEL B,	ιαιτι, σοιμπη	622, 523	75.0	
76.00	Per diem capital-related costs (line 75 ÷ li					144.07		
7.00 8.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu					9, 076 42, 878		
9.00	Aggregate charges to beneficiaries for exces		rovi der record	s)		42,070		
0.00	Total Program routine service costs for comp	parison to the c			nus line 79)	42, 878		
1.00 2.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)			0.00		
3.00	Reasonable inpatient routine service cost film tation (i					9, 076		
84.00	Program inpatient ancillary services (see in	istructions)				21, 912	84.	
35.00	Utilization review - physician compensation					0		
	Total Program inpatient operating costs (sum		n ougn 85)			30, 988	86.0	
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THRUUGH CUST						
86.00 87.00 88.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions Adjusted general inpatient routine cost per	5)				0	87.0 88.0	

Heal th Financial Systems ST JOSEPH MEDICAL CENTER In						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0047	Period: From 06/01/2019	Worksheet D-1	
		Component (CCN: 15-5356	To 05/31/2020	Date/Time Pre 11/2/2020 12:	
		Titl	e XIX	Skilled Nursing Facility	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
· ·		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST	_				
90.00 Capital-related cost	0	0	0.0000	0 0	0	90.00
91.00 Nursing School cost	0	0	0.0000	0 0	0	91.00
92.00 Allied health cost	0	0	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	0	0.00000	0 00	0	93.00

Health Financial Systems ST JOSEPH MEDICA	L CENTER		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0047	Peri od:	Worksheet D-3	
			From 06/01/2019		
			To 05/31/2020	Date/Time Pre	pared:
	Title	xviii	Hospi tal	11/2/2020 12: PPS	13 pili
Cost Center Description	nue	Ratio of Cos		Inpati ent	
Cost Center Description		To Charges		Program Costs	
		10 charges		$(col \cdot 1 \times col \cdot$	
			onar ges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1100	2100	0100	
30. 00 03000 ADULTS & PEDIATRICS			5, 573, 239		30.00
33. 00 03300 BURN INTENSIVE CARE UNIT			3, 164, 640		33.00
40. 00 04000 SUBPROVI DER – I PF			0		40.00
ANCI LLARY SERVICE COST CENTERS		1			
50. 00 05000 OPERATI NG ROOM		0. 1600	63 1, 965, 122	314, 543	50.00
51.00 05100 RECOVERY ROOM		0. 5665	41 154,093	87, 300	51.00
53. 00 05300 ANESTHESI OLOGY		0. 6290		123, 697	53,00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1052		366, 374	54.00
54. 01 03630 ULTRA_SOUND		0.0000		0	54.01
56. 00 05600 RADI OI SOTOPE		0.0000		0	56.00
57. 00 05700 CT SCAN		0.0000		0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1846		273, 129	59.00
60. 00 06000 LABORATORY		0. 1375		447, 904	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2926		37, 732	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 1853		388, 722	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 4712		88, 127	66.00
67.00 06700 OCCUPATIONAL THERAPY		0. 2742		45, 179	
68.00 06800 SPEECH PATHOLOGY		0. 9670		25, 832	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1047		21, 696	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT		0. 1047		163, 892	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2828			
72.00 07200 TMPL. DEV. CHARGED TO PATTENTS 73.00 07300 DRUGS CHARGED TO PATTENTS		0. 0879		281, 830	72.00
				786, 252	
		0.6814		366, 444	74.00
76.00 03950 MISC ANCI LLARY		0.0000		0	76.00
76.01 03951 SLEEP LAB		0.0000		0	76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		0	76.02
76. 03 03952 WOUND CARE		1.0717	28 3, 514	3, 766	76.03
		0.0070	(2)	0	
		2.2879		0	90.00
91.00 09100 EMERGENCY		0. 1523		194, 508	
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART		0. 4164		77, 794	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			25, 282, 648	4, 094, 721	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(II ne 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	25, 282, 648		202.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO	CN: 15 0047	Period:	Worksheet D-3)
NPATTENT ANGILLART SERVICE CUST APPORTIONWENT	Provider co	CN. 13-0047	From 06/01/2019	WOLKSHEEL D-3)
	Component (CCN: 15-SO47	To 05/31/2020	Date/Time Pre	pared
				11/2/2020 12:	13 pm
	Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
· ·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	0		1 20 0
0. 00 03000 ADULTS & PEDI ATRI CS			0		30.0
3. 00 03300 BURN I NTENSI VE CARE UNI T			0		33.0
0. 00 04000 SUBPROVIDER - IPF			7, 258, 635		40.0
ANCI LLARY SERVI CE COST CENTERS		0.1(00	(2) 42.042	7 017	1 50 0
0. 00 05000 OPERATI NG ROOM		0.1600		7, 017	
1. 00 05100 RECOVERY ROOM		0.5665		0	
3. 00 05300 ANESTHESI OLOGY		0. 6290		694	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1052		48, 738	
4. 01 03630 ULTRA SOUND		0.0000		0	
6. 00 05600 RADI 0I SOTOPE 7. 00 05700 CT SCAN		0.0000		0	
		0.0000		0	
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1846		0	
0.00 06000 LABORATORY		0. 1375			
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 5. 00 06500 RESPI RATORY THERAPY		0. 2926		0	
		0. 1853		24, 415	
		0. 4712 0. 2742		62, 930	
7. 00 06700 OCCUPATI ONAL THERAPY 8. 00 06800 SPEECH PATHOLOGY		0. 2742		40, 486 20, 601	
9. 00 06900 ELECTROCARDI OLOGY				5, 023	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1047		3, 100	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2828		11, 907	
3. 00 07200 DRUGS CHARGED TO PATIENTS		0. 1287			
4. 00 07400 RENAL DIALYSIS		0. 1287		100, 242	
6. 00 03950 MI SC ANCI LLARY		0.0000		0	
6. 01 03950 MISC ANCIELARY 6. 01 03951 SLEEP LAB		0.0000		0	
6. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		0	
6. 03 03950 WOUND CARE		1. 0717		220	
OUTPATIENT SERVICE COST CENTERS		1.0717.	200 200	220	70.0
0.00 09000 CLINIC		2, 2879	63 0	0	90.0
1. 00 09100 EMERGENCY		0. 1523			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4164		0	
00.00 Total (sum of lines 50 through 94 and 96 through 9	98)	0.4104	3, 156, 883	499, 504	
01.00 Less PBP Clinic Laboratory Services-Program only of			5, 150, 005	477, 304	200.0
JI. OU TESS FOR CITILE LADUIALULY SELVICES-PLOUIAIII UIILY (1	0		1201.0

	DI CAL CENTER			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0047	Peri od:	Worksheet D-3	
	Component	CCN: 15-5356	From 06/01/2019 To 05/31/2020	Date/Time Pre 11/2/2020 12:	pared 13 pm
	Title	e XVIII	Skilled Nursing		
			Facility		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			0		1 30. C
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33.0
40. 00 04000 SUBPROVIDER - IPF			0		40. C
ANCI LLARY SERVI CE COST CENTERS		•		•	1
50. 00 05000 OPERATING ROOM		0. 1600	63 0	0] 50. C
51.00 05100 RECOVERY ROOM		0. 5665	41 0	0	51. C
53. 00 05300 ANESTHESI OLOGY		0. 6290	41 0	0	53. C
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1052	38 79, 682	8, 390	54. C
54.01 03630 ULTRA SOUND		0.0000	0 00	0	54. C
56. 00 05600 RADI 0I SOTOPE		0.0000	0 00	0	56. C
57. 00 05700 CT SCAN		0.0000	0 00	0	57. C
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1846	20 0	0	59. C
50. 00 06000 LABORATORY		0. 1375	18 312, 060	42, 914	60. C
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2926	43 0	0	62. C
55. 00 06500 RESPI RATORY THERAPY		0. 1853	52 420, 604	77, 960	65. C
56. 00 06600 PHYSI CAL THERAPY		0. 4712	87 440, 935	207, 807	66. C
57.00 06700 OCCUPATIONAL THERAPY		0. 2742	87 454, 907	124, 775	67. C
58.00 06800 SPEECH PATHOLOGY		0. 9670	14 5, 847	5, 654	68. C
59. 00 06900 ELECTROCARDI OLOGY		0. 1047	38 3, 825	401	69. C
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2628	74 43, 733	11, 496	71. C
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 0879	17 0	0	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 1287	92 994, 191	128, 044	73.0
4.00 07400 RENAL DIALYSIS		0. 6814	0 70	0	74.C
6. 00 03950 MISC ANCILLARY		0.0000		0	76. C
76.01 03951 SLEEP LAB		0.0000	0 00	0	76. C
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		0	76. C
76.03 03952 WOUND CARE		1.0717	28 58, 042	62, 205	76. C
OUTPATIENT SERVICE COST CENTERS					
20. 00 09000 CLINIC		2.2879		-	
P1. 00 09100 EMERGENCY		0. 1523		0	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4164		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			2, 813, 826	669, 646	
201.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)		0		201. C
202.00 Net charges (line 200 minus line 201)			2, 813, 826		202. C

Health Financial Systems ST JOSEPH MEDICA	AL CENTER		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0047	Peri od:	Worksheet D-3	
			From 06/01/2019		
			To 05/31/2020	Date/Time Pre	pared:
	Ti +1	e XIX	Hospi tal	11/2/2020 12: PPS	is pili
Cost Center Description	1111	Ratio of Cos		Inpati ent	
bost benter bescription		To Charges		Program Costs	
		10 charges		$(col. 1 \times col.$	
			onar ges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1100	2100	0100	
30. 00 03000 ADULTS & PEDI ATRI CS			4, 779, 722		30.00
33. 00 03300 BURN INTENSIVE CARE UNIT			774, 791		33.00
40. 00 04000 SUBPROVI DER – I PF			0		40.00
ANCI LLARY SERVICE COST CENTERS		1			1
50. 00 05000 OPERATI NG ROOM		0. 1600	63 817, 329	130, 824	50.00
51.00 05100 RECOVERY ROOM		0. 5665	41 75, 577	42, 817	51.00
53. 00 05300 ANESTHESI OLOGY		0. 6290		84, 180	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1052		172, 670	
54. 01 03630 ULTRA_SOUND		0.0000		0	•
56. 00 05600 RADI OI SOTOPE		0.0000		0	
57. 00 05700 CT SCAN		0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1846		113, 597	•
60. 00 06000 LABORATORY		0. 1375		275, 262	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2926		30, 889	
65. 00 06500 RESPI RATORY THERAPY		0. 1853		152,071	
66. 00 06600 PHYSI CAL THERAPY		0. 4712		34, 815	
67.00 06700 OCCUPATI ONAL THERAPY		0. 2742		17, 080	•
68. 00 06800 SPEECH PATHOLOGY		0. 9670		9, 801	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1047		11, 667	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1047		67, 093	•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2028			•
73. 00 07200 DRUGS CHARGED TO PATIENTS		0. 0879		91, 562	
				378, 370	
		0.6814		42, 304	•
76.00 03950 MISC ANCI LLARY		0.0000		0	
76.01 03951 SLEEP LAB		0.0000		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		0	
76. 03 03952 WOUND CARE		1.0717	28 1, 784	1, 912	76.03
		0.0070	() 5 510	10 (11	
90. 00 09000 CLINIC		2.2879		12, 611	
91.00 09100 EMERGENCY		0. 1523		137, 664	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4164		66, 813	
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1)		11, 835, 362	1, 874, 002	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	11, 835, 362		202.00

	Disavitation Of	N 15 0017	Devel e d	Wavely a la a to D D	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	JN: 15-0047	Period: From 06/01/2019	Worksheet D-3	
	Component (CCN: 15-S047	To 05/31/2020	Date/Time Pre	pared
				11/2/2020 12:	13 pm
	Titl	e XIX	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	-		
30. 00 03000 ADULTS & PEDIATRICS			0		30.0
33.00 03300 BURN INTENSIVE CARE UNIT			0		33.0
40. 00 04000 SUBPROVIDER - IPF			290, 231		40.0
ANCI LLARY SERVI CE COST CENTERS		0.1/00	()	0	1 50 0
50. 00 05000 OPERATING ROOM		0.1600			
51.00 O5100 RECOVERY ROOM		0.5665		0	
53.00 O5300 ANESTHESI OLOGY		0.6290		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1052			
54. 01 03630 ULTRA SOUND		0.0000		0	
56. 00 05600 RADI OI SOTOPE		0.0000		0	
57.00 05700 CT SCAN		0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1846		0	
		0. 1375			
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2926		0	
55.00 06500 RESPIRATORY THERAPY		0. 1853		0	
66. 00 06600 PHYSI CAL THERAPY		0.4712		4, 222	
57.00 06700 OCCUPATI ONAL THERAPY		0.2742		378	
58.00 06800 SPEECH PATHOLOGY		0.9670		762	
59. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 1047 0. 2628		310	
72.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2828		41	
73. 00 07200 TMPL. DEV. CHARGED TO PATTENTS 73. 00 07300 DRUGS CHARGED TO PATTENTS		0. 1287			
74. 00 07300 RENAL DIALYSIS		0. 6814		483	
76. 00 03950 MISC ANCI LLARY		0.0000		0	
76. 01 03950 MISC ANCIELARY 76. 01 03951 SLEEP LAB		0.0000		0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		0	1
76. 03 03952 WOUND CARE		1. 0717		0	
OUTPATIENT SERVICE COST CENTERS		1.0717.	20 0	0	/0.0
20. 00 09000 CLINIC		2, 2879	63 246	563	90.0
01.00 09100 EMERGENCY		0. 1523			
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1523		7,108	
200.00 Total (sum of lines 50 through 94 and 96 through 98	3)	0.4104	158, 839		
201.00 Less PBP Clinic Laboratory Services-Program only ch			130, 039	20,237	200.0
		1	0		1201.0

Health Financial Systems ST JOSEPH MEDI				eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0047	Peri od:	Worksheet D-3	
	Component	CCN: 15-5356	From 06/01/2019 To 05/31/2020		pared: 13 pm
	Titl	e XIX	Skilled Nursing		10 piii
			Facility		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1			30.0
33. 00 03300 BURN INTENSIVE CARE UNIT					33.0
40. 00 04000 SUBPROVI DER – I PF					40.0
ANCI LLARY SERVI CE COST CENTERS				<u>/</u>	40.0
50. 00 05000 OPERATI NG ROOM		0. 1600	62 (0 0	50.0
51. 00 05100 RECOVERY ROOM		0. 1600			
53. 00 05300 ANESTHESI OLOGY		0. 5885			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 8290		-	
54. 01 03630 ULTRA SOUND		0. 1032		0 0	
56. 00 05600 RADI 0I SOTOPE		0.0000			
57. 00 05700 CT SCAN		0.0000			
57. 00 05700 CT SCAN 59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0000			
50. 00 06000 LABORATORY		0. 1848		-	
52. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 1375		0 922	
55. 00 06500 RESPIRATORY THERAPY		0. 2920			
56. 00 06600 PHYSICAL THERAPY		0. 1853		-	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 4712			
58. 00 06800 SPEECH PATHOLOGY		0. 2742			
59. 00 06900 ELECTROCARDI OLOGY		0. 9070		0 2,330	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1047			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2028			
73. 00 07200 DRUGS CHARGED TO PATIENTS		0. 1287			
74. 00 07400 RENAL DIALYSIS		0. 1287		0 0	1
76. 00 03950 MISC ANCI LLARY		0.0000			
6. 01 03950 MI SC ANCI LLAN		0.0000			
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000			
76. 03 03952 WOUND CARE		1. 0717			
OUTPATIENT SERVICE COST CENTERS		1.0/1/	20		/0.0
20. 00 09000 CLINIC		2.2879	63 (0 0	90.0
91. 00 09100 EMERGENCY		0. 1523			
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1523			
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.4104	74, 842	-	1
200.00 Less PBP Clinic Laboratory Services-Program only charge	os $(lino 61)$		/4,04.	21, 912	200.0
201.00 [Less PBP CITIL'C Laboratory Services-Program only charge 202.00] Net charges (line 200 minus line 201)			74, 842		201.0
202.00 met charges (The 200 minus the 201)		1	/4, 84.	<u>-</u>	1202.0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od: From 06/01/2019 To 05/31/2020		
		Title XVIII	Hospi tal	11/2/2020 12: PPS	13 pm
			110301 101	113	
				1.00	
. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.0
. 00	DRG amounts other than outlier payments for discharges occurr	ring prior to October 1	see	1, 646, 510	
	instructions)		(000	1, 010, 010	
. 02	DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	2, 737, 934	1.0
0.2	instructions)	for discharges securring	nrian ta Oatabar	0	1 1 0
. 03	DRG for federal specific operating payment for Model 4 BPCl f 1 (see instructions)	or discharges occurring	prior to october	0	1.0
. 04	DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	on or after	0	1.0
	October 1 (see instructions)				
. 00	Outlier payments for discharges. (see instructions)			0	2.0
. 01 . 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	ions)		0	2.0
. 02	Outlier payments for discharges occurring prior to October 1	-		97, 833	•
. 04	Outlier payments for discharges occurring on or after October			152, 570	
. 00	Managed Care Simulated Payments			3, 882, 555	
. 00	Bed days available divided by number of days in the cost repo	orting period (see instru	uctions)	84.32	4.0
	Indirect Medical Education Adjustment				
. 00	FTE count for all opathic and osteopathic programs for the mos	st recent cost reporting	period ending on	8.95	5.0
. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet t	be criteria for an add-	on to the can for	0.00	6.0
. 00	new programs in accordance with 42 CFR 413.79(e)		on to the cap for	0.00	0.0
. 00	MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR §412.105(f))(1)(iv)(B)(1)	0.00	7.0
. 01	ACA § 5503 reduction amount to the IME cap as specified under	42 CFR §412.105(f)(1)(i	v)(B)(2) If the	1.89	7.0
	cost report straddles July 1, 2011 then see instructions.			(
. 00	Adjustment (increase or decrease) to the FTE count for allopa			-6.37	8.0
	affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	79(C)(Z)(TV), 04 FR 2034	+0 (Way 12,		
. 01	The amount of increase if the hospital was awarded FTE cap sl	ots under § 5503 of the	ACA. If the cost	0.00	8.0
	report straddles July 1, 2011, see instructions.	-			
. 02	The amount of increase if the hospital was awarded FTE cap ${\sf sl}$	ots from a closed teaching	ng hospi tal	0.00	8.0
00	under § 5506 of ACA. (see instructions)		(0.40	
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	ies (8, 8,01 and 8,02)	see	0.69	9.0
0. 00	FTE count for allopathic and osteopathic programs in the curr	ent vear from vour reco	~ds	0. 42	10.0
1.00	FTE count for residents in dental and podiatric programs.	5 5		0.00	11.0
2.00	Current year allowable FTE (see instructions)			0.42	
3.00	Total allowable FTE count for the prior year.			0.50	
4.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Se	otember 30, 1997,	0.69	14.0
5.00	Sum of lines 12 through 14 divided by 3.			0.54	15.0
	Adjustment for residents in initial years of the program				16.0
7.00	Adjustment for residents displaced by program or hospital clo	osure		0.00	17. C
8.00	Adjusted rolling average FTE count			0.54	
	Current year resident to bed ratio (line 18 divided by line 4	ł).		0.006404	
0.00 1.00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 004162 0. 004162	
2.00	IME payment adjustment (see instructions)			9, 966	
2.00	IME payment adjustment - Managed Care (see instructions)			8, 825	
	Indirect Medical Education Adjustment for the Add-on for § 42	2 of the MMA			
3.00	Number of additional allopathic and osteopathic IME FTE resid	lent cap slots under 42 (CFR 412.105	4.00	23.0
	(f)(1)(iv)(C).			0.07	
4.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the	Lower of Line 22 or Line	24 (222	-0.27	
5.00	instructions)	Tower of The 23 of The	e 24 (See	0.00	25.0
6.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.0
7.00	IME payments adjustment factor. (see instructions)			0.000000	
8.00	IME add-on adjustment amount (see instructions)			0	
8.01	IME add-on adjustment amount - Managed Care (see instructions	5)		0	
9.00	Total IME payment (sum of lines 22 and 28))1)		9, 966	
9. 01	<u>Total IME payment - Managed Care (sum of lines 22.01 and 28.0</u> Disproportionate Share Adjustment	///		8, 825	29.0
0. 00	Percentage of SSI recipient patient days to Medicare Part A p	patient davs (see instru	ctions)	13.86	30. 0
1.00	Percentage of Medicaid patient days (see instructions)		5.1.51157	48.33	
2.00	Sum of lines 30 and 31			62.19	
3.00	Allowable disproportionate share percentage (see instructions	5)		12.00	33. C
4.00	Disproportionate share adjustment (see instructions)			131, 533	1310

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period:	Worksheet E Part A	
			From 06/01/2019 To 05/31/2020	Date/Time Pre 11/2/2020 12:	
		Title XVIII	Hospi tal	PPS	15 μ
		·	Prior to 10/1		
	Uncompensated Care Adjustment		1.00	2.00	
5.00	Total uncompensated care amount (see instructions)		0	0	35.
5. 01	Factor 3 (see instructions)		0.00000000	0.00000000	35.
. 02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se	e 1, 655, 129	1, 305, 861	35
. 03	instructions) Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	553, 222	870, 574	35
. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		1, 423, 796		36
	Additional payment for high percentage of ESRD beneficiary di				
. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	discharges for MS-DRGs	0		40
	652, 682, 683, 684 and 685 (see instructions)		Before 1/1	On/After 1/1	
			1.00	1.01	
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0	0	41
01	instructions)		0	0	11
. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	-DRGS 652, 682, 683, 684	0	0	41
. 00	Divide line 41 by line 40 (if less than 10%, you do not quali	ify for adjustment)	0.00		42
. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	82, 683, 684 an 685. (see	e 0		43
. 00	instructions) Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44
. 00	days)	by The 41 divided by 7	0.00000		44
. 00	Average weekly cost for dialysis treatments (see instructions	s)	0.00	0.00	45
. 00	Total additional payment (line 45 times line 44 times line 4	1.01)	0		46
. 00 . 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s	small rural bospitals	6, 200, 142		47
. 00	only. (see instructions)	smart rurar nospitars	0		40
				Amount	
00	Total normant for innations anarating costs (cost instruction	2)		1.00	49
. 00 . 00	Total payment for inpatient operating costs (see instructions Payment for inpatient program capital (from Wkst. L, Pt. I an			6, 208, 967 389, 188	
. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			007,100	51
. 00	Direct graduate medical education payment (from Wkst. E-4, li	ine 49 see instructions).		21, 441	52
. 00	Nursing and Allied Health Managed Care payment			0	53
. 00 . 01	Special add-on payments for new technologies Islet isolation add-on payment			0	54 54
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line (69)		0	55
. 00	Cost of physicians' services in a teaching hospital (see intr			0	56
. 00	Routine service other pass through costs (from Wkst. D, Pt.)		hrough 35).	0	57
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	
. 00 . 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			6, 619, 596 8, 748	
. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		6, 610, 848	
. 00	Deductibles billed to program beneficiaries	/		477, 180	
. 00	Coinsurance billed to program beneficiaries			17, 930	
. 00	Allowable bad debts (see instructions)			181, 158	
. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		117, 753 91, 637	
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	(1 do (1 0113)		6, 233, 491	
. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0	
. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	. (For SCH see instruction	is)	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tration) adjustment (i potruoti	0	70
). 50). 87	Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration	· •	INSTIUCTIONS)	0	70
. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70
. 89	Pioneer ACO demonstration payment adjustment amount (see ins:	tructions)		Ū.	70
. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
	HSP bonus payment HRR adjustment amount (see instructions)			0	
. 91				0	70
). 91). 92	Bundled Model 1 discount amount (see instructions)			17 101	
). 91). 92). 93). 94	HVBP payment adjustment amount (see instructions) HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			17, 131 -494	70

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider C		Period: From 06/01/2019 To 05/31/2020	Worksheet E Part A Date/Time Pre 11/2/2020 12:	
	Titl∈	XVIII	Hospi tal	PPS	
		FF\	<u>′ (уууу)</u>	Amount	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Ente	r in column 0		0	1.00	70.90
the corresponding federal year for the period prior to 10/			0	0	/0. /
70.97 Low volume adjustment for federal fiscal year (yyyy) (Ente			0	0	70.9
the corresponding federal year for the period ending on or	after 10/1)				
70.98 Low Volume Payment-3				0	
70.99 HAC adjustment amount (see instructions)	(0, 0, 70)			0	
Y1.00 Amount due provider (line 67 minus lines 68 plus/minus lin Y1.01 Sequestration adjustment (see instructions)	ies 69 & 70)			6, 250, 128	
1.02 Demonstration payment adjustment amount after sequestration	n			114, 377 0	
7.03 Sequestration adjustment-PARHM pass-throughs	///			0	71.0
2.00 Interim payments				5, 986, 516	
2.01 Interim payments-PARHM				.,,	72.0
3.00 Tentative settlement (for contractor use only)				0	73.00
'3.01 Tentative settlement-PARHM (for contractor use only)					73.0
4.00 Balance due provider/program (line 71 minus lines 71.01, 7	1.02, 72, and			149, 235	74.00
73) 4.01 Balance due provider/program-PARHM (see instructions)					74 0
74.01 Balance due provider/program-PARHM (see instructions) 75.00 Protested amounts (nonallowable cost report items) in acco	vrdance with			1, 284, 645	74.0 [°] 75.00
CMS Pub. 15-2, chapter 1, §115.2	nuance with			1, 204, 045	/ 3. 00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			I		
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or s	sum of 2.03			0	90.0
plus 2.04 (see instructions)					
1.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
2.00 Operating outlier reconciliation adjustment amount (see in				0	
23.00 Capital outlier reconciliation adjustment amount (see inst 24.00 The rate used to calculate the time value of money (see in	,			0 0.00	
75.00 Time value of money for operating expenses (see instruction				0.00	95.00
26.00 Time value of money for capital related expenses (see instruction				0	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					100.00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	100. 00
01.00 HVBP adjustment factor (see instructions)			0.000000000	0.000000000	101 0
02.00 HVBP adjustment amount for HSP bonus payment (see instruct	i ons)		0		102.00
HRR Adjustment for HSP Bonus Payment					
03.00 HRR adjustment factor (see instructions)			0.0000	0.0000	103.00
04.00 HRR adjustment amount for HSP bonus payment (see instructi			0	<u> </u>	104.00
			0	0	1104.00
Rural Community Hospital Demonstration Project (§410A Demo	nstration) Adju		0	0	
Rural Community Hospital Demonstration Project (§410A Demo 200.00 Is this the first year of the current 5-year demonstration	nstration) Adju			0	
Rural Community Hospital Demonstration Project (§410A Demo 00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.	nstration) Adju			0	
Rural Community Hospital Demonstration Project (§410A Demo 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	nstration) Adju n period under t			0	200. 00
Rural Community Hospital Demonstration Project (§410A Demo 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II,	nstration) Adju n period under t			0	200. 00
Rural Community Hospital Demonstration Project (§410A Demo 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions)	nstration) Adju n period under t line 49)	he 21st			200. 00 201. 00 202. 00
Rural Community Hospital Demonstration Project (§410A Demo 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 202.00 Medicare discharges (see instructions)	nstration) Adju n period under t line 49)	he 21st			200. 00 201. 00 202. 00
Rural Community Hospital Demonstration Project (§410A Demo 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period)	nstration) Adju n period under t line 49)	he 21st		ration	200. 00 201. 00 202. 00 203. 00
Rural Community Hospital Demonstration Project (§410A Demo 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 202.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 204.00 Medicare target amount	nstration) Adju n period under t line 49)	he 21st		ration	200. 00 201. 00 202. 00 203. 00 204. 00
Rural Community Hospital Demonstration Project (§410A Demo 00.00 1s this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 04.00 Medicare target amount 05.00	nstration) Adju n period under t line 49) n in first year	he 21st		ration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
Rural Community Hospital Demonstration Project (§410A Demo 00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 02.00 Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount (line 203 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 204)	nstration) Adju n period under t line 49) n in first year	he 21st		ration	200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0
Rural Community Hospital Demonstration Project (§410A Demo 00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 02.00 Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount (line 203 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 2 Adjustment to Medicare Part A Inpatient Reimbursement	nstration) Adju n period under t line 49) n in first year 205)	he 21st		ration	200. 00 201. 00 202. 00 203. 00 204. 00
Rural Community Hospital Demonstration Project (§410A Demo 00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 02.00 Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount (line 203 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 2 Adjustment to Medicare Part A Inpatient Reimbursement 07.00 Program reimbursement under the §410A Demonstration (see i	nstration) Adju n period under t line 49) n in first year 205) nstructions)	he 21st		ration	200. 01 201. 01 202. 01 203. 01 203. 01 204. 01 205. 01 206. 01 207. 01
Rural Community Hospital Demonstration Project (§410A Demo 00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 02.00 Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) 04.00 Medicare target amount 05.00 Case-mix adjustment factor (see instructions) 06.00 Medicare target amount 07.00 Program reinpatient routine cost cap (line 203 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 204) 07.00 Program reimbursement under the §410A Demonstration (see i 08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 09.00 Adjustment to Medicare IPPS payments (see instructions)	nstration) Adju n period under t line 49) n in first year 205) nstructions)	he 21st		ration	200. 0 201. 0 202. 0 203. 0 205. 0 205. 0 206. 0 206. 0 208. 0 208. 0 209. 0
Rural Community Hospital Demonstration Project (§410A Demo 00.00 1s this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 02.00 Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 04.00 Medicare target amount 05.00 Case-mix adjustment factor (see instructions) 06.00 Medicare target amount 09.00 Adjustment to Medicare Part A Inpatient Reimbursement 07.00 Program reimbursement under the §410A Demonstration (see i 08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 09.00 Adjustment to Medicare IPPS payments (see instructions) 00.00 Reserved for future use	nstration) Adju n period under t line 49) a in first year 205) nstructions) A, line 59)	he 21st		ration	200. 0 201. 0 202. 0 203. 0 205. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0
Rural Community Hospital Demonstration Project (§410A Demo 00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 02.00 Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount (line 203 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 204) 06.00 Medicare Part A Inpatient Reimbursement 07.00 Program reimbursement under the §410A Demonstration (see i 08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 09.00 Adjustment to Medicare IPPS payments (see instructions) 10.00 Reserved for future use 11.00 Total adjustment to Medicare IPPS payments (see instructions)	nstration) Adju n period under t line 49) a in first year 205) nstructions) A, line 59)	he 21st		ration	200. 0 201. 0 202. 0 203. 0 205. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0
Rural Community Hospital Demonstration Project (§410A Demo 00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 02.00 08.00 Case-mix adjustment factor (see instructions) 03.00 Case-mix adjustment factor (see instructions) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount (line 203 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 2 07.00 Program reimbursement under the §410A Demonstration (see i 08.00 Medicare Part A Inpatient Reimbursement 07.00 Program reimbursement under the §410A Demonstration (see i 08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 09.00 Adjustment to Medicare IPPS payments (see instructions) 10.00 Reserved for future use 11.00 Total adjustment to Medicare IPPS payments (see instructions)	nstration) Adju n period under t line 49) n in first year 205) nstructions) A, line 59)	he 21st		ration	200. 0 201. 0 202. 0 203. 0 205. 0 205. 0 205. 0 205. 0 208. 0 209. 0 209. 0 209. 0 209. 0 211. 0
Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 001.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Medicare discharges (see instructions) 003.00 Case-mix adjustment factor (see instructions) 004.00 Medicare target amount factor (see instructions) 005.00 Case-mix adjustment factor (see instructions) 005.00 Case-mix adjustment factor (see instructions) 006.00 Medicare target amount 005.00 Case-mix adjusted target amount (line 203 times line 204) 006.00 Medicare inpatient routine cost cap (line 202 times line 204) 006.00 Medicare Part A Inpatient Reimbursement 007.00 Program reimbursement under the §410A Demonstration (see i 008.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 009.00 Adjustment to Medicare IPPS payments (see instructions) 010.00 Reserved for future use 011.00 Total adjustment to Medicare IPPS payments (see instructions) 010.00 Total adjustment to Medicare Part A IPPS payments (from li	nstration) Adju n period under t line 49) n in first year 205) nstructions) A, line 59)	he 21st		ration	200. 0 201. 0 202. 0 203. 0 205. 0 205. 0 205. 0 207. 0 208. 0 209. 0 209. 0 211. 0 211. 0
Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Cost Reimbursement service costs (from Wkst. D-1, Pt. II, Medicare discharges (see instructions) C01.00 Medicare discharges (see instructions) C03.00 Case-mix adjustment factor (see instructions) C04.00 Medicare target amount C05.00 Case-mix adjustment factor (see instructions) C04.00 Medicare target amount C05.00 Case-mix adjusted target amount (line 203 times line 204) C06.00 Medicare inpatient routine cost cap (line 202 times line 204) C06.00 Medicare part A Inpatient Reimbursement C07.00 Program reimbursement under the §410A Demonstration (see i C08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. C09.00 Adjustment to Medicare IPPS payments (see instructions) C01.00 Reserved for future use C01.00 Total adjustment to Medicare IPPS payments (see instructions)	nstration) Adju n period under t line 49) a in first year 205) nstructions) A, line 59) ons) ne 211)	of the curre		ration	200. 0 201. 0 202. 0 203. 0 205. 0 205. 0 206. 0 207. 0 208. 0 209. 0 209. 0

	Financial Systems ST JOSEPH MEDICAL CENTER In I ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0047 Period:	ieu of Form CMS-2 Worksheet E	2552-10
	From 06/01/20 To 05/31/20	19 Part B 20 Date/Time Pre	
	Title XVIII Hospital	11/2/2020 12: PPS	13 pm
		1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)	12, 333	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4, 316, 459	•
3.00	OPPS payments	2, 635, 588	3.00
4.00	Outlier payment (see instructions)	54, 918	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)	0.000	
6.00	Line 2 times line 5	0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	•
8.00	Transitional corridor payment (see instructions)	0	
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions	0	
10.00	Total cost (sum of lines 1 and 10) (see instructions)	12, 333	•
11.00	COMPUTATION OF LESSER OF COST OR CHARGES	12,000	
	Reasonabl e charges]
	Ancillary service charges	81, 806	
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)	0 81, 806	
14.00	Customary charges	01,000	1 14.00
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasi	s 0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17 00
17.00	Total customary charges (see instructions)	81, 806	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	69, 473	
	instructions)		
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	12, 333	21.00
22.00	Interns and residents (see instructions)	0	1
	Cost of physicians' services in a teaching hospital (see instructions)	0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	2, 690, 506	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	2, 487	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	472, 023	•
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	2, 228, 329	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)	6, 532	28.00
28.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0, 552	
30.00	Subtotal (sum of lines 27 through 29)	2, 234, 861	•
	Primary payer payments	24	•
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	2, 234, 837	32.00
	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	195, 468	•
35.00	Adjusted reimbursable bad debts (see instructions)	127, 054	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	129, 279	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	2, 361, 891	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	
39. 98 39. 99	Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION	0	
40. 00	Subtotal (see instructions)	2, 361, 891	•
40. 01	Sequestration adjustment (see instructions)	43, 223	1
40.02	Demonstration payment adjustment amount after sequestration	0	•
40.03	Sequestration adjustment-PARHM pass-throughs	2, 379, 277	40.03
	Interim payments Interim payments-PARHM	2, 319, 211	41.00
42.00	Tentative settlement (for contractors use only)	0	1
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-60, 609	
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	43.01 44.00
	TO BE COMPLETED BY CONTRACTOR		1
	Original outlier amount (see instructions)	0	90.00
	Outlier reconciliation adjustment amount (see instructions)	0	
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)	0.00	92.00 93.00
93.00			

	Financial Systems ST JOSEPH MEDIC ATI ON OF REI MBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2019	u of Form CMS-: Worksheet E Part B	
		Component CCN: 15-S047	To 05/31/2020	Date/Time Pre 11/2/2020 12:	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			1, 135	1 1.
00	Medical and other services reimbursed under OPPS (see instruc	ti ons)		9, 846	2
00 00	OPPS payments Outlier payment (see instructions)			2, 645 0	
00	Outlier reconciliation amount (see instructions)			0	4
00	Enter the hospital specific payment to cost ratio (see instru	ictions)		0.000	
00	Line 2 times line 5			0	
00 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9
0. 00	Organ acquisitions			0	
. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			1, 135	11
. 00	Reasonable charges Ancillary service charges			8, 813	1 12
3. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0,010	
. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			8, 813	14
6. 00	Aggregate amount actually collected from patients liable for			0	15
. 00	Amounts that would have been realized from patients liable fo had such payment been made in accordance with 42 CFR §413.13(on a chargebasis	0	16
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	.e)		0.000000	17
3. 00	Total customary charges (see instructions)			8, 813	
0. 00	Excess of customary charges over reasonable cost (complete on instructions)	lyifline 18 exceeds li	ne 11) (see	7, 678	19
. 00	Excess of reasonable cost over customary charges (complete on	lyifline 11 exceeds li	ne 18) (see	0	20
. 00	instructions) Lesser of cost or charges (see instructions)			1, 135	21
. 00	Interns and residents (see instructions)			0	
8.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			2, 645	24
. 00	Deductibles and coinsurance amounts (for CAH, see instruction			212	25
. 00	Deductibles and Coinsurance amounts relating to amount on lin			226	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of filles 22		3, 342	27
. 00	Direct graduate medical education payments (from Wkst. E-4, I			0	
0. 00 0. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 3, 342	
. 00	Primary payer payments			3, 342	31
2. 00	Subtotal (line 30 minus line 31)			3, 342	32
3. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		0	33
. 00	Allowable bad debts (see instructions)			0	
. 00	Adjusted reimbursable bad debts (see instructions)			0	
b. 00 7. 00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		0 3, 342	
. 00	MSP-LCC reconciliation amount from PS&R			0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	
9.50 9.97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	IS)		0	39
. 97 . 98	Partial or full credits received from manufacturers for repla	nced devices (see instruc	tions)	0	
9. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39
). 00). 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			3, 342 61	
). 01). 02	Demonstration payment adjustment amount after sequestration			0	
. 03	Sequestration adjustment-PARHM pass-throughs				40
. 00 . 01	Interim payments Interim payments-PARHM			3, 890	41
. 00	Tentative settlement (for contractors use only)			0	
. 01	Tentative settlement-PARHM (for contractor use only)				42
8. 00 8. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-609	43
. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	
	§115.2 TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount (see instructions)			0	
. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	
3.00 3.00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047 Component CCN: 15-5356	Peri od: From 06/01/2019 To 05/31/2020	Worksheet E Part B Date/Time Pre	
		Title XVIII	Skilled Nursing Facility	<u>11/2/2020 12:</u> PPS	<u>13 p</u>
				1.00	
00	PART B - MEDICAL AND OTHER HEALTH SERVICES				1
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		24 0	1. 2.
00	OPPS payments			Ũ	3.
00	Outlier payment (see instructions)				4
D1	Outlier reconciliation amount (see instructions)				4
00 00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ictions)		0	5
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
. 00 . 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 24	10 11
. 00	COMPUTATION OF LESSER OF COST OR CHARGES			21	1
~~	Reasonable charges			104	1 1 2
. 00 . 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 60)		184 0	
. 00	Total reasonable charges (sum of lines 12 and 13)			184	
	Customary charges		1		
. 00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	15
. 00	had such payment been made in accordance with 42 CFR §413.13(1 5	n a chargebasis	0	16
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17
. 00	Total customary charges (see instructions)			184	
. 00	Excess of customary charges over reasonable cost (complete or instructions)	nly if line 18 exceeds li	ne 11) (see	160	19
. 00	Excess of reasonable cost over customary charges (complete or	nly if line 11 exceeds li	ne 18) (see	0	20
	instructions)				
. 00 . 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			24 0	21
. 00	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	
~~	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00 . 00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lir		ructions)	0	25
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	-		24	
	instructions)				
. 00 . 00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)			0	28
. 00	Subtotal (sum of lines 27 through 29)			24	30
. 00	Primary payer payments			0	31
. 00	Subtotal (line 30 minus line 31)	050)		24	32
. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		0	33
. 00	Allowable bad debts (see instructions)			0	
. 00	Adjusted reimbursable bad debts (see instructions)			0	35
. 00 . 00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	tructions)		0 24	36
. 00	MSP-LCC reconciliation amount from PS&R			24	38
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39
. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	39
. 97 . 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	acad davicas (saa instruc	tions)	0	39
. 90 . 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39
. 00	Subtotal (see instructions)			24	40
. 01	Sequestration adjustment (see instructions)			0	40
02	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40
00	Interim payments			36	
	Interim payments-PARHM				41
00 01	Tentative settlement (for contractors use only)			0	42
00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-12	
. 01	Balance due provider/program-PARHM (see instructions)			12	43
. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	44
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)				90
. 00 . 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money				91 92
. 00	Time Value of Money (see instructions)				92
	Total (sum of lines 91 and 93)				94

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	:N: 15-0047	Period: From 06/01/2019 To 05/31/2020		
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Pai	rt 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		5, 986, 51	16	2, 379, 277	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			0	0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider	11				
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04				0	0	3.04
3.05	Dravidan ta Dragnam			0	0	3. 05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
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 3.50-3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 986, 5 ⁻	16	2, 379, 277	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					FO
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)					5.00
	Program to Provider	1				
5.01 5.02	TENTATI VE TO PROVI DER			0	0	5. 01 5. 02
5.02 5.03				0	0	5.02
5.05	Provider to Program	11		0	0	5.00
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		149, 23	35	0	6. 0 ²
6. 02	SETTLEMENT TO PROGRAM		, 20	0	60, 609	6. 02
7.00	Total Medicare program liability (see instructions)		6, 135, 75	-	2, 318, 668	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C)	1. 00	(MO/Day/YF) 2.00	
3.00	Name of Contractor			1.00	2.00	8.00

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0047 CCN: 15-S047	Period: From 06/01/2019 To 05/31/2020		bared
		Title	e XVIII	Subprovider -	PPS	
		Inpatien	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 609, 6	05 0	3, 890 0	1. (2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3. (
02				0	0	3. (
03				0	0	3.0
04				0	0	3.
05				0	0	3.
	Provider to Program		1			
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54 99	Subtatel (sum of lines 2.01.2.40 minus sum of lines			0	0	3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 609, 6	05	3, 890	4.
00	(transfer to Wkst. E or Wkst. E-3, line and column as		1,007,0	05	5, 070	4.
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		1			
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			-	-	_
D1	TENTATI VE TO PROVIDER			0	0	5.
)2)3				0	0	5. 5.
13	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM		1	0	0	5
50 51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on			-		6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		3, 5	48	0	6.
02	SETTLEMENT TO PROGRAM			0	609	6.
00	Total Medicare program liability (see instructions)		1, 613, 1	53	3, 281	7.
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(2	1.00	2.00	

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0047 CCN: 15-5356	Period: From 06/01/ To 05/31/		
					11/2/2020 12:	13 pr
		Title	XVIII	Skilled Nur Facility		
		Inpatien	t Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yy	yy Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		460, 1	20 0	36 0	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
)1	ADJUSTMENTS TO PROVIDER			0	0	3
)2				0	0	
)3				0	0	
)4)5				0	0	
,5	Provider to Program			0	0	1 3
0	ADJUSTMENTS TO PROGRAM			0	0	3
1				0	0	
52				0	0	
53				0	0	
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0 0	0	
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		460, 1	20	36	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
4	Program to Provider TENTATIVE TO PROVIDER				0	1 -
)1)2	TENTATIVE TO PROVIDER			0	0	
)3				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 19	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	
)0	5. 50-5. 98) Determined net settlement amount (balance due) based on			0		6
	the cost report. (1)			0		
)1)2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	0	
)2)0	Total Medicare program liability (see instructions)		460, 1	-	24	
			100, I	Contract		
				Number	· (Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems ST JOSEPH MEDIC	AL CENTER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0047	Period: From 06/01/2019	Worksheet E- Part II	1
			To 05/31/2020	Date/Time Pre 11/2/2020 12:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				_
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	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	is)		32.00
					•

	Financial Systems ST JOSEPH MED ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od:	u of Form CMS-2 Worksheet E-3	
		Component CCN: 15-S047	From 06/01/2019 To 05/31/2020	Part II Date/Time Pre	pare
		Title XVIII	Subprovider -	11/2/2020 12: PPS	13 p
			I PF		
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and m	edical education payments)		1, 791, 773	1
00	Net IPF PPS Outlier Payments			24, 910	2
00	Net IPF PPS ECT Payments			0	3
00	Unweighted intern and resident FTE count in the most recent 15, 2004. (see instructions)	cost report filed on or b	efore November	0.00	4
01	Cap increases for the unweighted intern and resident FTE coprogram or hospital closure, that would not be counted with CFR 412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	4
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs i teaching program" (see instuctions)	n the new program growth p	eriod of a "new	0.00	6
00	Current year's unweighted I&R FTE count for residents withi teaching program" (see instuctions)	n the new program growth p	eriod of a "new	0.00	
00	Intern and resident count for IPF PPS medical education adj	ustment (see instructions)		0.00	8
00	Average Daily Census (see instructions)			10. 543716	9
00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised t	the power of .5150 -1}.		0.00000	
00	Teaching Adjustment (line 1 multiplied by line 10).			0	1
00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11			1, 816, 683	
00 00	Nursing and Allied Health Managed Care payment (see instruc Organ acquisition (DO NOT USE THIS LINE)	(Tron)		0	1:
	Cost of physicians' services in a teaching hospital (see in	ustructions)		0	
00	Subtotal (see instructions)			1, 816, 683	
00	Primary payer payments			0	1
00	Subtotal (line 16 less line 17).			1, 816, 683	18
00	Deducti bl es			128, 040	
00	Subtotal (line 18 minus line 19)			1, 688, 643	
00	Coinsurance			46, 189	
00	Subtotal (line 20 minus line 21)			1, 642, 454	
00 00	Allowable bad debts (exclude bad debts for professional ser Adjusted reimbursable bad debts (see instructions)	vices) (see instructions)		1, 184 770	
	Allowable bad debts for dual eligible beneficiaries (see in	ustructions)		0	
00	Subtotal (sum of lines 22 and 24)			1, 643, 224	2
00	Direct graduate medical education payments (see instruction	is)		1, 043, 224	2
00	Other pass through costs (see instructions)			0	28
00	Outlier payments reconciliation			0	29
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
50	Pioneer ACO demonstration payment adjustment (see instructi			0	30
	Demonstration payment adjustment amount before sequestration	n		0	
00	Total amount payable to the provider (see instructions)			1, 643, 224	
01	Sequestration adjustment (see instructions)			30, 071	
02 00	Demonstration payment adjustment amount after sequestration Interim payments	1		0 1, 609, 605	
00	Tentative settlement (for contractor use only)			1, 009, 005	
00	Balance due provider/program (line 31 minus lines 31.01, 31	.02, 32 and 33)		3, 548	
00	Protested amounts (nonallowable cost report items) in accor §115.2		chapter 1,	0	35
00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2	,		24, 910	50
	Outlier reconciliation adjustment amount (see instructions)			24, 910	
. 00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)				5

	Financial Systems	ST JOSEPH MEDICA			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0047 Component CCN: 15-5356	Period: From 06/01/2019 To 05/31/2020	Worksheet E-3 Part VI Date/Time Pre	
					11/2/2020 12:	13 pm
			Title XVIII	Skilled Nursing	PPS	
				Facility		
					1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLE	EMEMENT - ALL OTHE	R HEALTH SERVICES FOR T	ITLE XVIII PART A		
	SERVICES					
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS))				
1.00	Resource Utilization Group Payment (RUGS)				568, 505	1.0
2.00	Routine service other pass through costs				0	2.0
3.00	Ancillary service other pass through costs				0	3.0
4.00	Subtotal (sum of lines 1 through 3)				568, 505	4.0
	COMPUTATION OF NET COST OF COVERED SERVICES					
5.00	Medical and other services (Do not use this I	line as vaccine co	osts are included in lin	e 1 of W/S E,		5.0
5.00	Part B. This line is now shaded.) Deductible				0	6.0
7.00	Coi nsurance				98, 995	
3.00	Allowable bad debts (see instructions)				90, 995	
9.00 9.00	Reimbursable bad debts for dual eligible bene	eficiaries (see in	ostructions)		0	
10.00	Adjusted reimbursable bad debts for ddar erigible bene				0	
1.00	Utilization review				0	
2.00	Subtotal (sum of lines 4, 5 minus lines 6 and	d 7. plus lines 10) and 11)(see instructio	ns)	469, 510	
3.00	Inpatient primary payer payments	, p			0	
4.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY	Y)			0	14.
4.50	Pioneer ACO demonstration payment adjustment	(see instructions	5)		0	14.
4.99	Demonstration payment adjustment amount befor	re sequestration			0	14.
15.00	Subtotal (see instructions	·			469, 510	15.0
15.01	Sequestration adjustment (see instructions)				9, 390	15. (
5.02	Demonstration payment adjustment amount after	r sequestration			0	15.
5.75	Sequestration for non-claims based amounts (s	see instructions)			0	
6.00	Interim payments				460, 120	
7.00	Tentative settlement (for contractor use only				0	
18.00	Balance due provider/program (line 15 minus l				0	
19. 00		items) in accordar	nce with CMS 19 Pub. 15-	2, chapter 1,	0	19. (
19. 00	Protested amounts (nonallowable cost report i §115.2			2, chapter 1,		0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od:	Worksheet E-3	
			From 06/01/2019 To 05/31/2020	Part VII	
			10 03/31/2020	11/2/2020 12:	
		Title XIX	Hospi tal	PPS	-
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	FRVICES FOR TITLES V OR A		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		0		1 1.
00	Medical and other services			2, 101, 284	2
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	2, 101, 284	
00	Inpatient primary payer payments		0	0	5
00 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		0	2, 101, 284	-
00	COMPUTATION OF LESSER OF COST OR CHARGES			2, 101, 204	1 '
	Reasonabl e Charges				1
00	Routi ne servi ce charges		0		1 8
00	Ancillary service charges		11, 835, 362	13, 435, 913	9
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0	40 405 040	11
. 00	Total reasonable charges (sum of lines 8 through 11)		11, 835, 362	13, 435, 913	12
. 00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment f	for sorvices on a charge	0	0	1 13
. 00	basis	of services of a charge	0	0	
. 00	Amounts that would have been realized from patients liable f	for payment for services o	on O	0	14
	a charge basis had such payment been made in accordance with			-	
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
. 00	Total customary charges (see instructions)		11, 835, 362	13, 435, 913	
. 00	Excess of customary charges over reasonable cost (complete c	only if line 16 exceeds	11, 835, 362	11, 334, 629	17
	line 4) (see instructions)			0	10
. 00	Excess of reasonable cost over customary charges (complete c 16) (see instructions)	only if line 4 exceeds iir	1e 0	0	18
9.00	Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see ins	structions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		0	2, 101, 284	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b		ders.		
2.00	Other than outlier payments		0	0	
8.00	Outlier payments		0	0	
. 00	Program capital payments		0		24
5.00	Capital exception payments (see instructions)		0	0	25
5.00 7.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	
3.00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		0	2, 101, 284	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		- 1 1	, , , , ,	
0. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	0	2, 101, 284	31
2.00	Deducti bl es		0	0	
3.00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
6.00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	and 22)	0	2 101 204	35
5.00 7.00	ELIMINATE SETTLEMENT	inu 33)	0	2, 101, 284 -2, 101, 284	
. 00 3. 00	Subtotal (line 36 \pm line 37)		0	-2, 101, 284	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39
). 00	Total amount payable to the provider (sum of lines 38 and 39	<i>)</i>)	0	0	
. 00	Interim payments	-	0	0	
2.00	Balance due provider/program (line 40 minus line 41)		0	0	
3. 00	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub 15-2,	0	0	
	chapter 1, §115.2				1

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2019	Worksheet E-3 Part VII	
		Component CCN: 15-SO47	To 05/31/2020	Date/Time Pre 11/2/2020 12:	
		Title XIX	Subprovider - IPF	PPS	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR X		2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		0		1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00 00	Inpatient primary payer payments Outpatient primary payer payments		0	0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES		Y	0	- 1
	Reasonable Charges				1
00	Routi ne servi ce charges		0		1 8
00	Ancillary service charges		158, 839	0	
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		158, 839	0	1:
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment fo	or services on a charge	0	0	1:
. 00	basis	r navmant for carvings	n 0	0	14
. 00	Amounts that would have been realized from patients liable fo a charge basis had such payment been made in accordance with		0	0	14
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	42 011 3413.13(e)	0. 000000	0.000000	1
. 00	Total customary charges (see instructions)		158, 839	0	
. 00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	158, 839	0	1
	line 4) (see instructions)	5			
. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds lin	e 0	0	18
	16) (see instructions)				
. 00	Interns and Residents (see instructions)		0	0	
. 00	Cost of physicians' services in a teaching hospital (see inst		0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	2'
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be Other than outlier payments	compreted for PPS provi	olers.	0	22
. 00	Outlier payments		0	0	
. 00	Program capital payments		0	0	2
. 00	Capital exception payments (see instructions)		0		2!
. 00	Routine and Ancillary service other pass through costs		0	0	20
. 00	Subtotal (sum of lines 22 through 26)		0	0	2
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	20
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	o)	0	0	
	Deducti bl es		0	0	
. 00 . 00	Coinsurance Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	3
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	nd 33)	0	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	/	0	0	
. 00	Subtotal (line 36 \pm line 37)		0	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		30
. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40
. 00	Interim payments		0	0	
. 00	Balance due provider/program (line 40 minus line 41)		0	0	
. 00	Protested amounts (nonallowable cost report items) in accorda	nco with CMS Pub 15-2	0	0	43

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od:	Worksheet E-3	
		Component CCN: 15-5356	From 06/01/2019 To 05/31/2020	Part VII Date/Time Pre 11/2/2020 12:	
		Title XIX	Skilled Nursing Facility	PPS	15
			Inpatient	Outpati ent	
			1.00	2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEI COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR X	IX SERVICES		1
00	Inpatient hospital/SNF/NF services		30, 988		1 1
00	Medical and other services		00, 700	0	
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		30, 988	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		30, 988	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				4
	Reasonabl e Charges				4.
00	Routine service charges		74 042	0	8
00 . 00	Ancillary service charges		74, 842	0	10
. 00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		74, 842	0	
. 00	CUSTOMARY CHARGES		74,042	0	1 ''
. 00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	11:
	basi s			-	
. 00	Amounts that would have been realized from patients liable for	r payment for services o	n 0	0	1
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
. 00	Total customary charges (see instructions)		74, 842	0	
. 00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	43, 854	0	1
00	line 4) (see instructions)			0	
. 00	Excess of reasonable cost over customary charges (complete on	IY IT IINE 4 exceeds IIN	e 0	0	18
. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		30, 988	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				17
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	23
00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		2!
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		30, 988	0	20
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from Line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	30, 988	0	
	Deductiblies)	0	0	
	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review		0		3
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	30, 988	0	30
. 00	ELIMINATE SETTLEMENT		-30, 981	0	
00	Subtotal (line 36 ± line 37)		7	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		3
. 00	Total amount payable to the provider (sum of lines 38 and 39)		7	0	
. 00	Interim payments		0	0	
. 00 . 00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accorda		7	0	
		nco with (MS Pub 15_2	0	0	43

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provider C		Period: From 06/01/2019 To 05/31/2020	Worksheet E-4 Date/Time Pre 11/2/2020 12:	pared:
		litle	e XVIII	Hospi tal	PPS	
					1.00	
. 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathi	c programs for	cost reporti	ng periods	7.63	1.00
	ending on or before December 31, 1996.			0.1		
2.00 8.00	Unweighted FTE resident cap add-on for new programs per 42 Amount of reduction to Direct GME cap under section 422 of		1) (see instr	ructions)	0.00	
s. 00 s. 01	Direct GME cap reduction amount under ACA §5503 in accordar		§413.79 (m).	(see	0.00	
. 00	instructions for cost reporting periods straddling 7/1/2011 Adjustment (plus or minus) to the FTE cap for allopathic are	nd osteopathic	programs due	to a Medicare	-6.94	4.00
. 01	<pre>GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)) ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)</pre>			0.00	4. 0 ⁻	
. 02	ACA Section 5506 number of additional direct GME FTE cap slots (see instruct		ructions for	cost reporting	0.00	4.0
i. 00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 4.02 plus applicable subscripts	plus or minus	line 4 plus l	ines 4.01 and	0.69	5.00
. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				0. 42	6.00
. 00	Enter the lesser of line 5 or line 6		Primary Care	e Other	0. 42 Total	7.00
			1.00	2.00	3.00	
8. 00	Weighted FTE count for physicians in an allopathic and oste	eopathi c	0.4	0.00	0.42	8.00
. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, other multiply line 8 times the result of line 5 divided by the a		0.4	0.00	0. 42	9.00
	6.					
0.00 0.01	Weighted dental and podiatric resident FTE count for the cu Unweighted dental and podiatric resident FTE count for the	,		0. 00 0. 00		10.0
1.00	Total weighted FTE count	current year	0.4			11.0
2.00	Total weighted resident FTE count for the prior cost report	ting year (see	0.5			12.0
3. 00	instructions) Total weighted resident FTE count for the penultimate cost year (see instructions)	reporting	0.6	0.00		13.0
4.00	Rolling average FTE count (sum of lines 11 through 13 divid	led by 3).	0.5	0.00		14.0
5.00	Adjustment for residents in initial years of new programs		0.0			15.0
5.01 6.00	Unweighted adjustment for residents in initial years of new Adjustment for residents displaced by program or hospital of		0. 0 0. 0			15. C
6. 00 6. 01	Unweighted adjustment for residents displaced by program of hospital of closure		0.0			16.0
7.00	Adjusted rolling average FTE count		0.5			17.0
8.00 9.00	Per resident amount Approved amount for resident costs		104, 350. 8 56, 34		56, 349	18.0
9.00			50, 34	19 0	50, 349	19.0
		-			1.00	
0.00	Additional unweighted allopathic and osteopathic direct GME Sec. 413.79(c)(4)	E FTE resident	cap slots rec	eived under 42	5.00	20.0
1. 00	Direct GME FTE unweighted resident count over cap (see inst	ructions)			0.00	21.0
2.00	Allowable additional direct GME FTE Resident Count (see ins				0.00	22.0
3.00	Enter the locality adjustment national average per resident	: amount (see i	nstructions)		103, 709. 75	
4.00	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				0 56, 349	
5.00		Inpatient Part	Managed Care	e Managed Care	Total	20.0
		A	Prior to 1/1			
		1.00	2.00	2.01	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD	l	1			
	Inpatient Days (see instructions)	4,839				26.0
27.00 28.00	Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days	16, 853 0. 287130				27. C 28. C
9.00	Program direct GME amount	16, 179			28, 861	
9.00	Percent reduction for MA DGME	10,179	7.0		20,001	29.0
0.00	Reduction for direct GME payments for Medicare Advantage		35		888	30.0
	Net Program direct GME amount	1	1	1	27, 973	1 2 1

Heal th	Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUT	PATIENT DIRECT	Provider CCN: 15-0047	Period:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 06/01/2019 To 05/31/2020	Date/Time Pre	narod
				10 03/31/2020	11/2/2020 12:	
			Title XVIII	Hospi tal	PPS	
					1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMF EDUCATION COSTS)	POSITE RATE - TITLE	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
32.00	Renal dialysis direct medical education cost	ts (from Wkst. B, F	Pt. I, sum of col. 20 an	d 23, lines 74	0	32.00
	and 94)					
33.00	Renal dialysis and home dialysis total charge			74 and 94)	725, 995	
34.00	Ratio of direct medical education costs to t		e 32 ÷ line 33)		0. 000000	
35.00	Medicare outpatient ESRD charges (see instru				0	35.00
36.00	Medicare outpatient ESRD direct medical educ				0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE C	COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)				14, 254, 865	
38.00	Organ acquisition costs (Wkst. D-4, Pt. III,				0	38.00
39.00	Cost of physicians' services in a teaching h	nospital (see instr	ructions)		0	39.00
40.00	Primary payer payments (see instructions)				8, 748	
41.00	Total Part A reasonable cost (sum of lines 3	37 through 39 minus	s line 40)		14, 246, 117	41.00
10.00	Part B Reasonable Cost				4 000 707	40.00
42.00	Reasonable cost (see instructions) Primary payer payments (see instructions)				4, 339, 797	42.00 43.00
43.00 44.00	Total Part B reasonable cost (line 42 minus	1:00 (2)			24 4, 339, 773	
44.00	Total reasonable cost (sum of lines 41 and 4				4, 339, 773	
45.00	Ratio of Part A reasonable cost to total rea		$11 \cdot 1100 45$		0, 766502	
40.00	Ratio of Part B reasonable cost to total rea	•	,		0. 233498	40.00
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BET				0.233490	-7.00
48.00					27, 973	48.00
49.00	Part A Medicare GME payment (line 46 x 48)	(title XVIII only)	(see instructions)		21, 441	
	Part B Medicare GME payment (line 47 x 48)					50.00
00.00			()	ļ	5, 002	20.00

LANCE	Financial Systems ST JOSEPH MED SHEET (If you are nonproprietary and do not maintain	Provider C		eriod:	u of Form CMS-: Worksheet G	
nd-ty Iy)	ype accounting records, complete the General Fund column			rom 06/01/2019 o 05/31/2020	Date/Time Pre 11/2/2020 12:	
		General Fund	Purpose Fund	Endowment Fund	Plant Fund	
1	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
	Cash on hand in banks	-447, 039	0	0	0	1 1
	Temporary investments	, 037 0			0	
	Notes receivable	0	Ö		0	
	Accounts receivable	27, 861, 383	0	0	0	
00	Other recei vabl e	0	0	0	0	5
00	Allowances for uncollectible notes and accounts receivable	-15, 330, 143	0	0	0	6
00	Inventory	2, 631, 734	0	0	0	
	Prepaid expenses	1, 093, 660	0	0	0	
	Other current assets	597, 898	0		0	
	Due from other funds	0	0		0	
	Total current assets (sum of lines 1-10)	16, 407, 493	0	0	0	11
	FI XED ASSETS	1 010 000				1 1 1
	Land improvements	1, 010, 000	0		0	
	Land improvements Accumulated depreciation	412, 126	0		0	
	Buildings	-316, 600 28, 388, 394			0	
	Accumul ated depreciation	-25, 675, 972			0	
	Leasehold improvements	23, 524, 288			0	
	Accumul ated depreciation	-9, 904, 432	0		0	
	Fixed equipment	1, 509, 768			0	
	Accumulated depreciation	0	Ö		0	
	Automobiles and trucks	0	0		0	
	Accumulated depreciation	0	0	0	0	
	Major movable equipment	21, 068, 138	0	0	0	23
00	Accumulated depreciation	-16, 996, 143	0	0	0	24
00	Minor equipment depreciable	8, 212, 683	0	0	0	25
00	Accumulated depreciation	-7, 695, 982	0	0	0	26
00	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0		0	
	Mi nor equi pment-nondepreci abl e	0	0		0	
	Total fixed assets (sum of lines 12-29)	23, 536, 268	0	0	0	30
	OTHER ASSETS					
	Investments	0			0	
	Deposits on Leases Due from owners/officers	0			0	
	Other assets	18, 902, 897	0	0	0	1
	Total other assets (sum of lines 31-34)	18, 902, 897		0	0	
	Total assets (sum of lines 11, 30, and 35)	58, 846, 658			0	
	CURRENT LI ABI LI TI ES	00/0/07000			<u> </u>	
	Accounts payable	1, 259, 058	0	0	0	37
	Salaries, wages, and fees payable	1, 479, 127	0	0	0	38
	Payroll taxes payable	149, 533	0	0	0	39
00	Notes and Loans payable (short term)	0	0	0	0	40
00	Deferred income	0	0	0	0	41
	Accelerated payments	0				42
	Due to other funds	59, 398, 481	0		0	
	Other current liabilities	7,065,498			0	
00	Total current liabilities (sum of lines 37 thru 44)	69, 351, 697	0	0	0	45
~	LONG TERM LIABILITIES					
	Mortgage payable	0	0	0	0	
	Notes payable	-1		0	0	
	Unsecured Loans Other Long term Liabilities	0		0	0	
	Total long term liabilities (sum of lines 46 thru 49)	1		-	0	
	Total liabilities (sum of lines 45 and 50)	69, 351, 696			0	
	CAPITAL ACCOUNTS	07, 001, 070		<u> </u>	0	
	General fund balance	-10, 505, 038				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	57
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	-10, 505, 038		0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	58, 846, 658			0	60

Heal th	Financial Systems	ST JOSEPH MEDI	CAL CENTER			In Lie	u of Form CMS-	2552-10
STATEMENT OF CHANGES IN FUND BALANCES			Provider CC	CN: 15-0047		eriod: com 06/01/2019	Worksheet G-1	pared:
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fund	
1.00	Fund balances at beginning of period	1.00	2.00 19,085,283	3.00		4.00	5.00	1.00
2.00 3.00	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	-29, 590, 321 -10, 505, 038		0 0 0 0	0		2.00 3.00 4.00 5.00 6.00 7.00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 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)	0 0 0 0 0 0	0 -10, 505, 038 0		0 0 0 0 0 0	0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-10, 505, 038			0		19.00
		Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00				
2.00 3.00	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)	6.00 0	7.00 0 0 0 0 0 0 0	8.00	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 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 ST JOSEPH MEDICAL STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Pr			1 1 0047	Do m!		u of Form CMS-2	
STATEN	IENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provider CCI	15-0047	Peri From To	06/01/2019 05/31/2020	Worksheet G-2 Parts I & II Date/Time Pre 11/2/2020 12:	pared:
	Cost Center Description		Inpati ent	(Dutpati ent	Total	
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		29, 027, 9			29, 027, 916	
2.00	SUBPROVIDER - IPF		14, 183, 5	73		14, 183, 573	2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVI DER						4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY		3, 763, 42	27		3, 763, 427	7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		46, 974, 9	16		46, 974, 916	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT						11.00
12.00	CORONARY CARE UNIT						12.00
	BURN INTENSIVE CARE UNIT		12, 310, 40	08		12, 310, 408	
							14.00
	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum c	oflines	12, 310, 40	08		12, 310, 408	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	59, 285, 3		101 701 050	59, 285, 324	17.00
18.00	Ancillary services		116, 333, 30		134, 781, 958	251, 115, 325	
19.00	Outpatient services		8, 907, 42		37, 542, 014	46, 449, 439	19.00
				0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00							24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE OTHER (SPECI FY)			~	0	0	26.00 27.00
27.00 28.00		2 to Wket	184, 526, 1 [°]	14	172, 323, 972	0 356, 850, 088	
20.00	Total patient revenues (sum of lines 17-27)(transfer column G-3, line 1)	S LU WKSL.	164, 520, 1	10	1/2, 323, 9/2	300, 600, 066	20.00
	PART II - OPERATING EXPENSES	I					
29.00	Operating expenses (per Wkst. A, column 3, line 200)				83, 609, 895		29.00
30.00	ADD (SPECIFY)			0	03, 007, 073		30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)			Ŭ	0		36.00
37.00	DEDUCT (SPECIFY)			0	0		37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)			-	o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer			83, 609, 895		43.00
	to Wkst. G-3, line 4)	,,,		1			1

Heal th	Financial Systems	ST JOSEPH MEDICA	L CENTER	In Lie	u of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-0047	Period: From 06/01/2019 To 05/31/2020		
					11/2/2020 12:	13 pm
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	t I, column 3, line	28)		356, 850, 088	1.00
2.00	Less contractual allowances and discounts or	n patients' account	S		304, 407, 359	2.00
3.00	Net patient revenues (line 1 minus line 2)				52, 442, 729	3.00
4.00	Less total operating expenses (from Wkst. G-	-2, Part II, line 4	3)		83, 609, 895	4.00
5.00	Net income from service to patients (line 3	minus line 4)			-31, 167, 166	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellane	eous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gue	ests			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical su	upplies to other th	an patients		0	16.00
17.00	Revenue from sale of drugs to other than pat				0	17.00
18.00	Revenue from sale of medical records and abs	stracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	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	COVID-19 GRANT				1, 511, 850	24.00
24.01	OTHER MISC INCOME				64, 995	24.01
24.50	COVID-19 PHE Funding				0	24.50
25.00	Total other income (sum of lines 6-24)				1, 576, 845	25.00
26.00	Total (line 5 plus line 25)				-29, 590, 321	26.00
	OTHER EXPENSES (SPECIFY)				0	27.00
	Total other expenses (sum of line 27 and sub				0	28.00
29.00	Net income (or loss) for the period (line 20	6 minus line 28)			-29, 590, 321	29.00

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0047	Period: From 06/01/2019 To 05/31/2020				
	Title XVIII	Hospi tal	PPS	io pi		
			1.00			
PART I - FULLY PROSPECTIVE METHOD				-		
CAPITAL FEDERAL AMOUNT			347, 653	1.		
.00 Capital DRG other than outlier .01 Model 4 BPCI Capital DRG other than outlier	Capital DRG other than outlier					
00 Capital DRG outlier payments			0 40, 040	1		
01 Model 4 BPCI Capital DRG outlier payments			40, 040			
00 Total inpatient days divided by number of days in the	e cost reporting period (see inst	ructions)	35.68			
00 Number of interns & residents (see instructions)			0.54			
00 Indirect medical education percentage (see instruction	Indirect medical education percentage (see instructions)					
00 Indirect medical education adjustment (multiply line 1.01) (see instructions)	1, 495	6.				
00 Percentage of SSI recipient patient days to Medicare 30) (see instructions)	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line					
00 Percentage of Medicaid patient days to total days (se		0.00	8.			
00 Sum of lines 7 and 8		0.00				
0 Allowable disproportionate share percentage (see instructions)				10.		
. 00 Disproportionate share adjustment (see instructions)			0			
.00 Total prospective capital payments (see instructions)			389, 188	12.		
			1, 00			
PART II - PAYMENT UNDER REASONABLE COST			1100			
00 Program inpatient routine capital cost (see instructi	ons)		0	1 1.		
00 Program inpatient ancillary capital cost (see instruc			0	2.		
00 Total inpatient program capital cost (line 1 plus lin	ne 2)		0			
00 Capital cost payment factor (see instructions)			0			
00 Total inpatient program capital cost (line 3 x line 4	1)		0	5.		
			1.00			
PART III - COMPUTATION OF EXCEPTION PAYMENTS						
00 Program inpatient capital costs (see instructions) 00 Program inpatient capital costs for extraordinary cir	cumetanese (cos i netructions)		0			
00 Program inpatient capital costs for extraordinary cir 00 Net program inpatient capital costs (line 1 minus lir	,		0			
00 Applicable exception percentage (see instructions)			0.00	-		
00 Capital cost for comparison to payments (line 3 x lin	ne 4)		0.00			
00 Percentage adjustment for extraordinary circumstances			0.00			
00 Adjustment to capital minimum payment level for extra	aordinary circumstances (line 2 x	line 6)	0	7.		
00 Capital minimum payment level (line 5 plus line 7)			0	-		
00 Current year capital payments (from Part I, line 12,			0			
.00 Current year comparison of capital minimum payment le	1 1 3 1		0			
.00 Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14)		,	0			
			0			
	e enter the amount on this line		0			
0.00 Current year exception payment (if line 12 is positiv				1 14		
8.00 Current year exception payment (if line 12 is positiv 9.00 Carryover of accumulated capital minimum payment level	el over capital payment for the f	following period	0	• •		
8.00 Current year exception payment (if line 12 is positiv A.00 Carryover of accumulated capital minimum payment lever (if line 12 is negative, enter the amount on this line	el over capital payment for the f ne)	ollowing period				
8.00 Current year exception payment (if line 12 is positiv 9.00 Carryover of accumulated capital minimum payment level	el over capital payment for the f ne) (see instructions)	ollowing period	0	15		