		EXPIRES 03-	31-2022
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	From 06/01/2020	Worksheet S Parts I-III Date/Time P 10/29/2021	repared
PART I - COST REPORT STATUS			
Provider 1. [X] Electronically prepared cost report	Date: 10/29/2	021 Time:	5: 12 p

PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST JOSEPH MEDICAL CENTER (15-0047) for the cost reporting period beginning 06/01/2020 and ending 05/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
Ti tl	ρ
D-+-	
Date	l e e e e e e e e e e e e e e e e e e e

			Title	XVIII			
	Cost Center Description		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	524, 636	-73, 241	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
200.00	Total	0	524, 636	-73, 241	0	0	200. 00

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

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0047 Peri od: Worksheet S-2 From 06/01/2020 Part I 05/31/2021 Date/Time Prepared: 10/29/2021 5:12 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 700 BROADWAY STREET 1.00 PO Box: 1.00 State: IN 2.00 City: FORT WAYNE Zip Code: 46802 County: ALLEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST JOSEPH MEDICAL 150047 23060 07/01/1996 N 3.00 CENTER Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 06/01/2020 05/31/2021 20.00 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Υ Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter

22.04

23 00

3

N

in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

Which method is used to determine Medicaid days on lines 24 and/or 25

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

22.04 Did this hospital receive a geographic reclassification from urban to

MCRI F32 - 16. 12. 172. 3

yes or "N" for no.

yes or "N" for no.

23 00

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0047 Peri od: Worksheet S-2 From 06/01/2020 Part I Date/Time Prepared: 05/31/2021 10/29/2021 5:12 pm NAHE 413.85 Worksheet A Pass-Through Qualification Y/N Line # Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2 Y/N IME IME Direct GME Direct GME 3. 00 4.00 1.00 2.00 5.00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61 06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweighted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) 62.01 0.00 62.01 Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) N 63.00 Unwei ghted Ratio (col. 1/ Unwei ghted FTES FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 2.00 1.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0. 00 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio

of (column 1 divided by (column 1 + column 2)). (see instructions)

Heal th Financial Systems

ST JOSEPH MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0047

Period:
From 06/01/2020
To 05/31/2021

Program Name

Program Code

Unweighted
FTEs
Nonprovider
Site

In Lieu of Form CMS-2552-10

Worksheet S-2
Part I
Date/Time Prepared:
10/29/2021 5: 12 pm

(col. 3/
(col. 3 + col.
4))

				To	05/31/2021	Date/Time Pre 10/29/2021 5:	pared: 12 pm
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs	FTEs in	(col. 3 + col.	
				Nonprovi der Si te	Hospi tal	4))	
		1. 00	2.00	3. 00	4. 00	5. 00	1
65. 00	Enter in column 1, if line 63	11.00	2100	0.00	0. 00		65. 00
	is yes, or your facility						
	trained residents in the base						
	year period, the program name associated with primary care						
	FTEs for each primary care						
	program in which you trained						
	residents. Enter in column 2,						
	the program code. Enter in column 3, the number of						
	unweighted primary care FTE						
	residents attributable to						
	rotations occurring in all						
	non-provider settings. Enter in column 4, the number of						
	unweighted primary care						
	resident FTEs that trained in						
	your hospital. Enter in column						
	5, the ratio of (column 3 divided by (column 3 + column						
	4)). (see instructions)						
				Unweighted	Unwei ghted	Ratio (col. 1/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
				Si te			
				1. 00	2. 00	3. 00	
	Section 5504 of the ACA Current		n Nonprovider Settings	sEffective fo	r cost reporti	ng periods	
66. 00	beginning on or after July 1, 20 Enter in column 1 the number of		ry care resident	0.00	0. 00	0. 000000	66. 00
	FTEs attributable to rotations o	ccurring in all nonpr	rovider settings.				
	Enter in column 2 the number of						
	FTEs that trained in your hospit (column 1 divided by (column 1 +						
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	,
				FTEs	FTEs in	(col. 3 + col.	
				Nonprovi der Si te	Hospi tal	4))	
		1. 00	2.00	3. 00	4.00	5. 00	-
67. 00	Enter in column 1, the program		2100	0.00	0. 00		67. 00
	name associated with each of						
	your primary care programs in						
	which you trained residents. Enter in column 2, the program						
	code. Enter in column 3, the						
	number of unweighted primary						
	care FTE residents attributable						
	to rotations occurring in all non-provider settings. Enter in						
	column 4, the number of						
	unweighted primary care						
	resident FTEs that trained in						
	your hospital. Enter in column 5, the ratio of (column 3						
	divided by (column 3 + column						
	4)). (see instructions)						
					1.00	0 2.00 3.00	
	Inpatient Psychiatric Facility P	PS			<u> </u>		
70. 00	Is this facility an Inpatient Ps		PF), or does it conta	ain an IPF subp	rovi der? N		70. 00
74 00	Enter "Y" for yes or "N" for no						74 00

71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see Ν 0 71.00 Ν 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.

76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for Ν 75.00 Ν Ν 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

OSPI TAI	_ AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0047	Peri od: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part I Date/Time Pro 10/29/2021 5	epared
					1.00	
). 00 . 00	ong Term Care Hospital PPS s this a long term care hospital (LTCH)? Enter "Y" for yes s this a LTCH co-located within another hospital for part or Y" for yes and "N" for no.			ng period? Enter	N N	80. 81.
5. 00 I 5. 00 D	EFRA Providers s this a new hospital under 42 CFR Section §413.40(f)(1)(i) id this facility establish a new Other subprovider (excluded		,		N	85. 86.
. 00 I	413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. s this hospital an extended neoplastic disease care hospital	cl assi fi ed	under sectio	n	N	87.
1	886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XI X	
Т	itle V and XIX Services			1.00	2.00	
. 00 D	oes this facility have title V and/or XIX inpatient hospital	servi ces? E	nter "Y" for	N	Y	90.
12	es or "N" for no in the applicable column. s this hospital reimbursed for title V and/or XIX through th	ne cost repor	t either in	N	Y	91.
f	ull or in part? Enter "Y" for yes or "N" for no in the appli	cable column				
	re title XIX NF patients occupying title XVIII SNF beds (duanstructions) Enter "Y" for yes or "N" for no in the applicat		ion)? (see		N	92.
. 00 D	oes this facility operate an ICF/IID facility for purposes o		d XIX? Enter	N	N	93.
	Y" for yes or "N" for no in the applicable column. oes title V or XIX reduce capital cost? Enter "Y" for yes, a	and "N" for n	o in the	N	N	94.
	pplicable column. f line 94 is "Y", enter the reduction percentage in the appl	icable colum	n	0. 00	0.00	95.
. 00 D	oes title V or XIX reduce operating cost? Enter "Y" for yes			N N	N N	96.
1	pplicable column. fline 96 is "Y", enter the reduction percentage in the appl	icable colum	n	0. 00	0.00	97.
. 00 D	oes title V or XIX follow Medicare (title XVIII) for the int tepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo olumn 1 for title V, and in column 2 for title XIX.	erns and res	idents post	Y	Y	98.
. 01 D	oes title V or XIX follow Medicare (title XVIII) for the rep , Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit itle XIX.				Y	98.
. 02 D	oes title V or XIX follow Medicare (title XVIII) for the cal ed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or or title V, and in column 2 for title XIX.			Y	Y	98.
. 03 D	oes title V or XIX follow Medicare (title XVIII) for a criti eimbursed 101% of inpatient services cost? Enter "Y" for yes or title V, and in column 2 for title XIX.				N	98.
. 04 D	on the V, and in column 2 for the XIX. oes title V or XIX follow Medicare (title XVIII) for a CAH r utpatient services cost? Enter "Y" for yes or "N" for no in n column 2 for title XIX.			N d	N	98.
. 05 D	oes title V or XIX follow Medicare (title XVIII) and add bac kst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co olumn 2 for title XIX.				Y	98.
3. 06 D P	oes title V or XIX follow Medicare (title XVIII) when cost r ts. I through IV? Enter "Y" for yes or "N" for no in column olumn 2 for title XIX.			Y	Y	98.
	ural Providers oes this hospital qualify as a CAH?			N		105.
6. 00 I	f this facility qualifies as a CAH, has it elected the all-i	nclusive met	hod of payme	1		106.
7. 00 C t C	or outpatient services? (see instructions) olumn 1: If line 105 is Y, is this facility eligible for cos raining programs? Enter "Y" for yes or "N" for no in column olumn 2: If column 1 is Y and line 70 or line 75 is Y, do y pproved medical education program in the CAH's excluded IPF	1. (see ins ou train I&R	tructions) s in an			107.
E	nter "Y" for yes or "N" for no in column 2. (see instructions a this a rural hospital qualifying for an exception to the C	ons)	. ,	2 N		108.
	FR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupation		Respi ratory	1.00.
		1. 00	2. 00	3. 00	4. 00	
t	f this hospital qualifies as a CAH or a cost provider, are herapy services provided by outside supplier? Enter "Y" or yes or "N" for no for each therapy.					109.
					1.00	
	id this hospital participate in the Rural Community Hospital	Domonetrati	on project (84104	1.00 N	110.

MCRIF32 -	16. 12.	172.3

Health Financial Systems ST JOSEPH MEDIC.	AL CENTER		In Lie	u of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Peri od: From 06/01/2020 To 05/31/2021	Worksheet S Part I Date/Time P 10/29/2021	repared:
	'	<u>'</u>	1.00		J. 12 p
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos" "Y" for yes or "N" for no in column 1. If the response to coluintegration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	t reporting pumn 1 is Y, eicipating in	period? Enter enter the column 2.	1.00 N	2.00	111.00
		1. 00	2. 00	3.00	
112.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting portion of the current cost reporting portion (Property of the Column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	eri od? "Y", enter	N			112. 00
115.00 s this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers; the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) " percent ncl udes) based on	N			0 115. 00
116.00 s this facility classified as a referral center? Enter "Y" for "N" for no.	or yes or	N			116. 00
117.00 s this facility legally-required to carry malpractice insuran "Y" for yes or "N" for no.	nce? Enter	N			117. 00
118.00 Is the mal practice insurance a claims-made or occurrence police			1		118. 00
if the policy is claim-made. Enter 2 if the policy is occurred	nce.	Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 122, 4	2. 00 70 113, 700	3.00	0118.01
110. 01 ELST allounts of marpractice premiums and pard 1035es.		122, 4	70 113, 700		0110.01
118.02 Are mal practice premiums and paid losses reported in a cost of	enter other t	than the	1. 00 N	2.00	118. 02
Administrative and General? If yes, submit supporting schedul 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 I §3121 and applicable amendments? (see instructions) Enter in a "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no.	le listing co Harmless prov column 1, "Y" lifies for th	ost centers vision in ACA ' for yes or ne Outpatient		N	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implan-	table devices	s charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as define Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.			N		122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 132.00 If this is a Medicare certified islet transplant center, enter 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 (0P0), enter the and termination date, if applicable, in column 2. All Providers	er the certificathe certificath	cation date cation date cation date cation date cation date in tification cation date n column 1			125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00 132. 00 133. 00 134. 00
140.00 Are there any related organization or home office costs as dechapter 10? Enter "Y" for yes or "N" for no in column 1. If you are claimed, enter in column 2 the home office chain number.	es, and home	office costs	Y	HB1848	140. 00

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0047 Peri od: Worksheet S-2 From 06/01/2020 Part I 05/31/2021 Date/Time Prepared: To 10/29/2021 5:12 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141.00 Name: COMMUNITY HEALTH SYSTEMS Contractor's Name: WPS, INC. Contractor's Number: 10301 141 00 142.00 Street: 4000 MERIDIAN BLVD PO Box: 142.00 143.00 City: FRANKLIN State: 37067 143. 00 Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 of costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00

near the final matron recliner ogy (in r) rincontrive in the finer real receivery and reministration	7101		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167. 00	
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"),	enter the	İ	168. 00
reasonable cost incurred for the HIT assets (see instructions)		İ	
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p	İ	168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		İ	
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	"), enter the	9. (99169.00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting			170. 00
period respectively (mm/dd/yyyy)			
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N		0 171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter		İ	
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section		İ	
1876 Medicare days in column 2. (see instructions)		İ	

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

1.00

campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

	Financial Systems ST JOSEPH MED AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 15-0047	Peri od: From 06/01/2020 To 05/31/2021	w of Form CMS- Worksheet S-2 Part II Date/Time Pre 10/29/2021 5:	epared:
				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	l for all NO re	esponses. Ente	r all dates in t	the	
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of	the cost	N		1.0
	proporting porrou: 11 yes, enter the date of the change in t	cordiiir 2. (See	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2. 0
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provion officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
			Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports	1.61 1.5 1.11	1			
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	N			4. 00
. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5.0
	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If wes is th	ne provider is	N		6.00
. 00	the legal operator of the program?	11 yes, 15 th	ic provider 13	14		0.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		I during the	N N		7. 00 8. 00
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	Υ		9. 0
0. 00	Was an approved Intern and Resident GME program initiated of	or renewed in t	he current	N		10.0
1 00	cost reporting period? If yes, see instructions.	O Din on Ann	uray and	N		11 0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& K In an App	proved	N		11.0
	reaching Frogram on worksheet A: IT yes, see Instructions.				Y/N	
					1. 00	
	Bad Debts					
2. 00	Is the provider seeking reimbursement for bad debts? If yes				Υ	12. 0
3. 00	If line 12 is yes, did the provider's bad debt collection p	oolicy change d	luring this co	st reporting	N	13.0
	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments.	ents waived? If	yes, see ins	tructi ons.	N	14. 0
	Bed Complement Did total beds available change from the prior cost reporti	, , , , , , , , , , , , , , , , , , , ,	yes, see inst		Y t B	15. 0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data				00	
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	09/09/2021	Y	09/09/2021	16. 0
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 0
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 0

Heal th	Financial Systems ST JOSEPH MED	DICAL CENTER		In Lie	u of Form CMS-	2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCM	l: 15-0047	Peri od: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part II Date/Time Pre 10/29/2021 5:	epared:		
		Descrip	ti on	Y/N	Y/N	12 5		
		0		1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N 1.00	Date 2.00	Y/N 3. 00	Date			
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	4. 00	21. 00		
	records? If yes, see instructions.							
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPT CHILDRENS HO	SPI TALS)					
22. 00	Have assets been relifed for Medicare purposes? If yes, see	nstructions			N	22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		s made dur	ing the cost	N	23. 00		
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during t	nis cost re	porting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost report	ng period?	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost reportin	g period? I	f yes, see	N	26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporting	period? If	yes, submit	N	27. 00		
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit er	ntered into duri	ng the cost	reporti ng	N	28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		t Service R	eserve Fund)	N	29. 00		
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	ructions urity with new d	ebt? If yes	, see	N	30. 00		
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new d	ebt? If yes	, see	N	31. 00		
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		through co	ntractual	N	32. 00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.		to competi	tive bidding? If	N	33. 00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	orovi der-ba	sed physicians?	N	34. 00		
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		s with the	provi der-based	N	35. 00		
				Y/N	Date			
	U 066: C+-			1. 00	2. 00			
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36.00		
	If line 36 is yes, has a home office cost statement been pr	repared by the h	ome office?			37. 00		
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			Υ Υ	12/31/2020	38. 00		
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office? I	f yes, see	N		40. 00		
	1.00 2.00							
	Cost Report Preparer Contact Information					1:		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VI CTORI A		ROMANKO		41. 00		
42. 00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTI	H 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_ROMANI	KO@CHS. NET	43. 00		

Heal th	Financial Systems ST JOSEPH	H MEDI	CAL CENTER			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CCN	l: 15-0047		i od: m 06/01/2020	Worksheet S-2 Part II	!
					To			pared:
							10/29/2021 5:	12 pm
			3.00)				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position		ANAGER, REVENUE	E MANAGEMENT	Γ			41. 00
	held by the cost report preparer in columns 1, 2, and 3	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 cos	st						43.00
	report preparer in columns 1 and 2, respectively.							

Health Financial Systems ST JOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 06/01/2020 | Part | To 05/31/2021 | Date/Time Prepared: Provider CCN: 15-0047

Component							To 05/31/2021	Date/Time Pr 10/29/2021 5		
Component										2 piii
Component										
1.00		Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours			
1.00 Hospi tal Adul ts & Peds. (col umns 5, 6, 7 and 8		·	Line Number			Avai I abl e				
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LOP room available beds)			1.00		2.00	3.00	4. 00	5. 00		
Hospice days)(šee instructions for col. 2 for the portion of LDP room available beds) 2.00 HMC and other (see instructions) 3.00 MC IPS Outprovider 4.00 4.00 1	1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		61	22, 265	0.00		0	1. 00
For the portion of LDP room available beds) 2.00 MM and other (see instructions) 3.00 MM in PS Subprovider 3.00 4.00 MM in PS Subprovider 4.00 MM in PS Subprovider 5.500 5.00 Hospital Adults & Peds. Swing Bed SNF 5.500 6.00 Hospital Adults & Peds. Swing Bed NF 6.10 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 MITENSI VE CARE UNIT 9.00 0		8 exclude Swing Bed, Observation Bed and								
2.00		1 3 / `								
3.00 HMO IPF Subprovider									-	
4.00 HMO IRF Subprovider									-	
5.00 Hospit al Adult 1s & Peds. Swing Bed SNF 0.00									-	
6. 00 Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) 7. 00									-	
7.00									- 1	
beds) (see instructions) 8										
8.00 INTENSIVE CARE UNIT	7. 00				61	22, 265	0.00	P	0	7. 00
9.00 CORONARY CARE UNIT 33.00 0 0 0.00 0 10.00									-	
10. 00 BURN INTENSIVE CARE UNIT 33.00 0 0 0.00 0 10.00 11.00 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 OURSERY 14.00 Total (see instructions) 61 22,265 0.00 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 15.00 CAH visits 0 16.00 CAH visits 0 16.00 CAH visits 0 16.00 CAH visits 0 16.00 CAH visits 0 16.00 CAH visits 0 16.00 CAH visits 0 CAH visi									-	
11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 OTHER LONG FACILITY 19. 00 SKILLED NURSING FACILITY 19. 00 SKILLED NURSING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Tri ps 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total anciliary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days										
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13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 10.00 THER LONG TERM CARE 10.00 OTHER LONG TERM CARE 10.00 OTHER LONG TERM CARE 10.00 OWABULATORY SURGICAL CENTER (D. P.) 12.00 OWABULATORY SURGICAL CENTER (D. P.) 18.00 OWABULATORY SURGICAL CENTER (D. P.) 18.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULATORY SURGICAL CENTER (D. P.) 19.00 OWABULA									-	
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15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IPR 18. 00 SUBPROVIDER 19. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 33. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 30. 01 Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days 33. 00 LTCH non-covered days		1				00.04				
16. 00 SUBPROVI DER - I PF 40. 00 0 0 16. 00 17. 00 18. 00 17. 00 18. 00 19. 00		· · · · · · · · · · · · · · · · · · ·			61	22, 265	0.00)		
17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SXILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE 24. 10 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 17. 00 O O O O O O O O O O O O O O O O O O		1	40.00						- 1	
18.00 SUBPROVI DER 18.00 19.00 19.00 19.00		1	40. 00		0	1)		O	
19. 00 SKILLED NURSING FACILITY		1							-	
20.00 NURSING FACILITY 20.00 21.00 21.00 22.00 21.00 22.00 22.00 4MBULATORY SURGICAL CENTER (D.P.) 23.00 24.00 4MSULATORY SURGICAL CENTER (D.P.) 23.00 24.10 4MSULATORY SURGICAL CENTER (D.P.) 24.00 24.10 25.00 24.10 25.00 26.00		1	44.00		0					
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 44.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 21.00 22.00 22.00 23.00 24.10 25.00 26.25 26.00 27.00 26.25 27.00 28.00 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00		1	44.00		0		7		٥Į	
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 31. 00 LTCH non-covered days 32. 00 LTCH non-covered days 33. 00 22. 00 23. 00 24. 00 24. 00 24. 00 24. 00 24. 10 25. 00 26. 25 25. 00 26. 00 26. 25 27. 00 26. 25 27. 00 26. 25 27. 00 27. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 29. 00 28. 00 29. 00 2		1							-	
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 29. 00 Employee discount days (see instructions) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 23. 00 24. 00 24. 10 25. 00 26. 00 27. 00 28. 00 29. 00 61 61 61 61 72. 00 73. 00 74. 00 75		1							-	
24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 28. 00 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 Labor & delivery days (see instructions) 31. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 30. 00 24. 10 24. 10 24. 10 24. 10 24. 10 24. 10 25. 00 26. 05 27. 00 26. 05 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 30. 00 31. 00 32. 01 33. 00 32. 01 33. 00 33. 00		1							-	
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 28. 00 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 Utal (sum of lines 14-26) 31. 00 Utal (sum of lines 14-26) 32. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 30. 00 31. 00 32. 01 33. 00 33. 00 34. 10 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00 39. 00 30		` ′							-	
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days		1	20.00						-	
26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 26. 00 26. 25 27. 00 61 28. 00 28. 00 29. 00 30. 00 31. 00 31. 00 32. 00 32. 01 32. 01 33. 00 33. 00			30.00						-	
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00									ł	
27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 31. 00 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00			90.00							
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00			89.00		41				ᅦ	
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00					01					
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 30.00 0 0 0 0 31.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,							٩	
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 31.00 0 0 0 32.00 32.01 0 33.00									-	
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.00 0 0 0 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									-	
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.01					0				-	
outpati ent days (see instructions) 33.00 LTCH non-covered days 33.00					U	1	ή		-	
33.00 LTCH non-covered days 33.00	JZ. UI									JZ. U1
	33 00								-	33 00
									- 1	33. 01

Health Financial Systems ST JOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 06/01/2020 | Part I | Date/Time Prepared: | Provider CCN: 15-0047

				1	0 05/31/2021	10/29/2021 5:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	, <u>, , , , , , , , , , , , , , , , , , </u>
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 355	1, 070	9, 766			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 057	4, 294				2.00
3.00	HMO I PF Subprovi der	1,037	4, 274 O				3. 00
4. 00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	o o	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 355	1, 070	9, 766			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00		0	0	0			10.00
11. 00							11. 00
12. 00	, ,						12. 00
13.00		4 055	4 070	0.7//	0.00	040 54	13.00
14. 00		1, 355	1, 070	9, 766		218. 54	1
15. 00 16. 00		0	0	0		0.00	15. 00 16. 00
17. 00		U	U	U	0.00	0.00	17. 00
18. 00							18. 00
19. 00		0	0	0	0.00	0.00	1
20.00			, and the second	· ·	0.00	0.00	20.00
21. 00							21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			12			24. 10
25. 00							25. 00
26. 00							26. 00
26. 25		0	0	0			
27. 00	,			400	0. 83	218. 54	
28. 00	1	0	0	498			28. 00 29. 00
29. 00 30. 00	· ·	٩		19			30.00
31. 00	1 . 3			0			31. 00
32. 00	1 . 3	0	0	0			32.00
32. 00	Total ancillary labor & delivery room			0			32. 00
52.01	outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33. 00
	LTCH site neutral days and discharges	0					33. 01

				To	05/31/2021	Date/Time Prep 10/29/2021 5:	
		Full Time Equivalents	<u>'</u>	Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	234	1, 239	2, 053	1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			213	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00	0	224	1 220	2.052	13.00
14. 00	Total (see instructions)	0. 00	0	234	1, 239	2, 053	
15. 00	CAH visits	0.00	0		0	0	15. 00
16.00	SUBPROVI DER - I PF	0. 00	0	0	0	0	16.00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00 19. 00	SUBPROVI DER	0. 00					18. 00 19. 00
	SKILLED NURSING FACILITY	0.00					
20.00	NURSING FACILITY OTHER LONG TERM CARE						20. 00 21. 00
21. 00 22. 00	HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE						24. 00
24. 00	HOSPICE (non-distinct part)						24. 00
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Fristruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. UI	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			i o			33. 01
	,				'	'	1

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 06/01/2020 Part II
To 05/31/2021 Date/Time Prepared: 10/29/2021 5: 12 pm

						05/31/2021	10/29/2021 5:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries	Adj usted Sal ari es		Average Hourly Wage (col. 4 ÷	
			·	(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1. 00	2.00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	15, 310, 237	0	15, 310, 237	454, 558. 00	33. 68	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3.00
4. 00	B Physician-Part A -		0	0	0	0.00		
4. 01	Administrative Physicians - Part A - Teaching		0			0. 00		
5. 00	Physician and Non Physician-Part B		0	_	_	0.00	l	
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6. 00
7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7. 01
8. 00	programs) Home office and/or related		0	0	0	0.00	0. 00	8. 00
9. 00	organization personnel	44. 00	0	1	_	0.00	•	
10. 00	Excluded area salaries (see instructions)		0	0	0	0. 00	0.00	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		80, 322	. 0	80, 322	1, 046. 00	76. 79	11. 00
12. 00	Care Contract Labor: Top Level		140, 000	0	140, 000	800.00	175. 00	12.00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		1, 551, 671	0	1, 551, 671	21, 323. 00	72. 77	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14. 01	Home office salaries		1, 324, 953	i e	1, 324, 953	44, 841. 00	l	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	_	0	0. 00 0. 00	l	
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0. 00	16. 01
	- Teaching Home office contract		0	0	0	0.00		16. 02
10. 02	Physicians Part A - Teaching WAGE-RELATED COSTS					0.00	0.00	10.02
17. 00	Wage-related costs (core) (see instructions)		3, 209, 440	0	3, 209, 440			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00	Excluded areas		0	1	0			19.00
20.00	Non-physician anesthetist Part		0		0			20.00
21. 00	Non-physician anesthetist Part B		0	0	0			21.00
22. 00	Physician Part A - Administrative		-	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		0		0			24.00
25. 00	Interns & residents (in an approved program)		0	0	Ō			25. 00
25. 50	Home office wage-related (core)		344, 298	o	344, 298			25. 50
25. 51	Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	O	0			25. 52
	wage-related (core)			l				I

Number N							o 05/31/2021	Date/Time Pre 10/29/2021 5:	
1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A core - Teaching - wage-related (core) 0 0 0 0 0 0 0 0 0									
1.00 2.00 3.00 4.00 5.00 6.00			Number	Reported					
1.00 2.00 3.00 4.00 5.00 6.00								col. 5)	
25.53 Home office: Physicians Part A						- /			
- Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department			1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
Core OVERHEAD COSTS - DIRECT SALARIES	25. 53	,		0	0	0			25. 53
26. 00 Employee Benefits Department 4. 00 175, 940 0 175, 940 4, 222. 00 41. 67 26. 00									
26.00 Empl oyee Benefit to Department 4.00 175, 940 0 175, 940 4, 222.00 41.67 26.00 27.00 Admin istrative & General 5.00 2, 275, 149 -378, 072 1, 897, 077 67, 446.00 28.13 27.00 28.00 Admin istrative & General under contract (see inst.) 303, 760 0 303, 760 709.00 428.43 28.00 29.00 Main tenance & Repairs 6.00 0 0 0 0.00 0.00 29.00 30.00 Operation of Plant 7.00 948,519 0 948,519 37,942.00 25.00 30.00 31.00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 0.00 31.00 32.00 Housekeeping 9.00 481,237 0 481,237 26,921.00 17.88 32.00 33.00 Bietary 10.00 0 0 0 0.00 0.00 0.00 0.00 0.00 33.00 36.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
27. 00 Administrative & General				475.040	_	175 040		1	
28. 00 Administrative & General under contract (see inst.) 29. 00 Maintenance & Repairs 6. 00 30. 00 Operation of Plant 7. 00 948,519 0 0 948,519 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 . ,			l .		·		
Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see inst.) Contract (see instructions) Contract			5. 00				· ·		
29. 00 Maintenance & Repairs 6. 00 0 0 0.00 0.00 29. 00 30. 00 Operation of Plant 7. 00 948, 519 0 948, 519 37, 942. 00 25. 00 30. 00 31. 00 Laundry & Linen Service 8. 00 0 0 0 0.00 0.00 0.00 31. 00 32. 00 Housekeepi ng 9. 00 481, 237 0 481, 237 26, 921. 00 17. 88 32. 00 30. 00 Housekeepi ng under contract (see instructions) 0 0 0 0.00 0.00 0.00 33. 00 34. 00 Di etary under contract (see instructions) 512, 032 0 512, 032 24, 959. 00 20. 51 35. 00 36. 00 Cafeteria 11. 00 0 0 0 0.00 0.00 0.00 20. 51 35. 00 37. 00 Maintenance of Personnel 12. 00 0 0 0 0.00 0.00 0.00 0.00 0.00 37. 00 38. 00	28. 00			303, 760	0	303, 760	709.00	428. 43	28. 00
30.00 Operation of Plant 7.00 948,519 0 948,519 37,942.00 25.00 30.00 31.00 Laundry & Linen Service 8.00 0 0 0 0 0 0.00 31.00 32.00 Housekeeping 9.00 481,237 0 481,237 26,921.00 17.88 32.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			, , ,						
31.00 Laundry & Linen Service		•		0	0	0		l .	
32.00 Housekeeping under contract (see instructions) 34.00 Die tary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursing Administration 39.00 Central Services and Supply 40.00 Pharmacy 40.00 Social Service 41.00 Social Service 42.00 Social Service 30.00 A81, 237		•		948, 519	0	948, 519	·	l .	
33.00 Housekeeping under contract (see instructions) 34.00 Die tary				0	0	0		l .	
34.00 Di etary 10.00 0 0 0 0 0 0 0 0 0			9. 00	481, 237	0	481, 237	· ·	l .	
34. 00 Di etary 10. 00 0 0 0 0. 00 0. 00 34. 00 35. 00 Di etary under contract (see instructions) 512, 032 0 512, 032 24, 959. 00 20. 51 35. 00 36. 00 Cafeteria 11. 00 0 0 0 0. 00 0. 00 36. 00 37. 00 Mai ntenance of Personnel 12. 00 0 0 0 0. 00 0. 00 0. 00 37. 00 38. 00 Nursi ng Admi ni strati on 13. 00 1, 120, 784 378, 072 1, 498, 856 29, 053. 00 51. 59 38. 00 39. 00 Central Services and Supply 14. 00 134, 762 0 134, 762 6, 279. 00 21. 46 39. 00 41. 00 Medi cal Records & Medi cal 16. 00 58, 443 0 58, 443 2, 873. 00 20. 34 41. 00 Records Li brary 17. 00 386, 775 0 386, 775 8, 152. 00 47. 45 42. 00	33. 00			0	0	0	0.00	0.00	33. 00
35. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 11. 00 0 0 0 0 0 0. 00 0. 00 36. 00 37. 00 Mai ntenance of Personnel 12. 00 0 0 0 0 0. 00 0. 00 37. 00 38. 00 Nursi ng Admi ni strati on 13. 00 1, 120, 784 378, 072 1, 498, 856 29, 053. 00 51. 59 38. 00 39. 00 Central Services and Supply 14. 00 134, 762 0 134, 762 6, 279. 00 21. 46 39. 00 40. 00 Pharmacy 15. 00 649, 571 0 649, 571 12, 089. 00 53. 73 40. 00 Records Li brary 42. 00 Soci al Service 17. 00 386, 775 0 386, 775 8, 152. 00 47. 45 42. 00		1 `							
instructions) 36.00 Cafeteria 11.00 0 0 0 0 0.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 1,120,784 378,072 1,498,856 29,053.00 51.59 38.00 39.00 Central Services and Supply 14.00 134,762 0 134,762 6,279.00 21.46 39.00 40.00 Pharmacy 15.00 649,571 0 649,571 12,089.00 53.73 40.00 41.00 Medical Records & Medical 16.00 58,443 0 58,443 2,873.00 20.34 41.00 Records Library 42.00 Social Service 17.00 386,775 0 386,775 8,152.00 47.45 42.00			10. 00	0	0	0			
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 0. 00 0. 00 37. 00 38. 00 Nursi ng Administration 13. 00 1, 120, 784 378, 072 1, 498, 856 29, 053. 00 51. 59 38. 00 39. 00 Central Services and Supply 14. 00 134, 762 0 134, 762 6, 279. 00 21. 46 39. 00 40. 00 Pharmacy 15. 00 649, 571 0 649, 571 12, 089. 00 53. 73 40. 00 41. 00 Medi cal Records & Medi cal Records Li brary 16. 00 58, 443 0 58, 443 2, 873. 00 20. 34 41. 00 42. 00 Soci al Service 17. 00 386, 775 0 386, 775 8, 152. 00 47. 45 42. 00	35. 00			512, 032	0	512, 032	24, 959. 00	20. 51	35. 00
38. 00 Nursing Administration 13. 00 1, 120, 784 378, 072 1, 498, 856 29, 053. 00 51. 59 38. 00 39. 00 Central Services and Supply 14. 00 134, 762 0 134, 762 6, 279. 00 21. 46 39. 00 40. 00 Pharmacy 15. 00 649, 571 0 649, 571 12, 089. 00 53. 73 40. 00 41. 00 Medical Records & Medical Records & Medical Records Library 42. 00 Social Service 17. 00 386, 775 0 386, 775 8, 152. 00 47. 45 42. 00	36.00		11. 00	0	0	0	0.00	0.00	36. 00
39.00 Central Services and Supply 14.00 134,762 0 134,762 6,279.00 21.46 39.00 40.00 Pharmacy 15.00 649,571 0 649,571 12,089.00 53.73 40.00 41.00 Records & Medical Records & Medical Records & Medical Service 17.00 386,775 0 386,775 8,152.00 47.45 42.00 42.00 43.40 43.	37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
40. 00 Pharmacy 15. 00 649, 571 0 649, 571 12, 089. 00 53. 73 40. 00 41. 00 Records Li brary 16. 00 800 17. 00 386, 775 12. 089. 00 58, 443 2, 873. 00 20. 34 41. 00 42. 00 Soci al Servi ce 17. 00 386, 775 0 386, 775 8, 152. 00 47. 45 42. 00	38. 00	Nursing Administration	13. 00	1, 120, 784	378, 072	1, 498, 856	29, 053. 00	51. 59	38. 00
40. 00 Pharmacy 15. 00 649, 571 0 649, 571 12, 089. 00 53. 73 40. 00 41. 00 Records Li brary 16. 00 806 i al Service 17. 00 386, 775 0 386, 775 0 386, 775 8, 152. 00 8, 152. 00 47. 45 42. 00	39. 00	Central Services and Supply	14. 00	134, 762	0	134, 762	6, 279. 00	21. 46	39. 00
41. 00 Medi cal Records & Medi cal Records & Medi cal Records Li brary 16. 00 58, 443 0 58, 443 2, 873. 00 20. 34 41. 00 42. 00 Soci al Servi ce 17. 00 386, 775 0 386, 775 8, 152. 00 47. 45 42. 00	40.00		15. 00	649, 571	0	649, 571	12, 089, 00	53. 73	40.00
Records Li brary 42.00 Soci al Servi ce 17.00 386, 775 0 386, 775 8, 152.00 47. 45 42.00	41.00	1		·	l .		· ·		
42. 00 Social Service 17. 00 386, 775 0 386, 775 8, 152. 00 47. 45 42. 00				,			, , , , , ,		
	42.00		17. 00	386, 775	0	386, 775	8, 152. 00	47. 45	42.00
	43.00	Other General Service	18. 00		l e	0		0.00	43.00

| Period: | Worksheet S-3 | From 06/01/2020 | Part III | To 05/31/2021 | Date/Time Prepared:

					11	05/31/2021	10/29/2021 5:	
		Worksheet A	Amount	Reclassi fi cati	Adjusted	Pai d Hours	Average Hourly	
					,			
		Line Number	Reported	on of Salaries			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		16, 126, 029	0	16, 126, 029	480, 226. 00	33. 58	1. 00
	instructions)							
2.00	Excluded area salaries (see		0	0	0	0.00	0.00	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		16, 126, 029	0	16, 126, 029	480, 226. 00	33. 58	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		3, 096, 946	0	3, 096, 946	68, 010. 00	45. 54	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		3, 553, 738	0	3, 553, 738	0.00	22. 04	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		22, 776, 713	0	22, 776, 713	548, 236. 00	41. 55	6. 00
7.00	Total overhead cost (see		7, 046, 972	0	7, 046, 972	220, 645. 00	31. 94	7. 00
	instructions)							

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0047	Peri od: Worksheet S-3
		From 06/01/2020 Part IV
		T- 0F /21 /2021 D-+- /T: D

	To 05/31/2021	Date/Time Prep 10/29/2021 5:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS	•	
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	307, 452	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		1
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	1, 641, 876	8. 02
8. 03	Health Insurance (Purchased)	0	1
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	6, 764	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11, 381	11. 00
	Accident Insurance (If employee is owner or beneficiary)	5, 431	12.00
	Disability Insurance (If employee is owner or beneficiary)	5, 099	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
	'Workers' Compensation Insurance	176, 566	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	ı
	Non cumulative portion)		
	TAXES		1
17. 00	FICA-Employers Portion Only	831, 634	17. 00
18.00	Medicare Taxes - Employers Portion Only	194, 495	18. 00
	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	28, 742	20.00
	OTHER		1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3, 209, 440	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
		•	

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu (of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0047	From 06/01/2020 P To 05/31/2021 D	Norksheet S-3 Part V Date/Time Prepared:

		0 05/31/2021	10/29/2021 5:	
	Cost Center Description	Contract Labor		•
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	80, 322	3, 209, 440	1. 00
2.00	Hospi tal	80, 322	3, 209, 440	2. 00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swi ng Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17.00	Renal Di al ysi s	0	0	17.00
18. 00	Other	0	0	18. 00

	Financial Systems ST JOSEPH MEDICAL CENTAL UNCOMPENSATED AND INDIGENT CARE DATA Prov	ider CCN: 15-0047	Peri od:	u of Form CMS-2 Worksheet S-10	
10321	AL UNCOMPENSATED AND INDIGENT CARE DATA PLOV	Tuer CCN: 15-0047	From 06/01/2020	worksneet 5-10	U
			To 05/31/2021	Date/Time Prep 10/29/2021 5:	pared: 12 pm
				1. 00	
	Uncompensated and indigent care cost computation			1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	by line 202 colum	n 8)	0. 309103	1.00
	Medicaid (see instructions for each line)				
2. 00	Net revenue from Medicaid		11, 434, 073		
3.00	Did you receive DSH or supplemental payments from Medicaid?	. 10	Y	3.0	
1.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from M		ai d?	N 1 466 041	4.0
5. 00 5. 00	Medicaid charges	iedi cai d		1, 466, 941 82, 888, 507	5. 0 6. 0
7. 00	Medicaid cost (line 1 times line 6)			25, 621, 086	
3. 00	Difference between net revenue and costs for Medicaid program (line	e 7 minus sum of li	nes 2 and 5: if	12, 720, 072	
	< zero then enter zero)			, ,,,	
	Children's Health Insurance Program (CHIP) (see instructions for ea	nch line)			
9. 00	Net revenue from stand-alone CHIP			0	
10.00	· ·			0	10.0
11.00	Stand-alone CHIP cost (line 1 times line 10)	11 minus lino O	if a zoro thon	0	11. 0 12. 0
12.00	Difference between net revenue and costs for stand-alone CHIP (line enter zero)	e ii minus iine 9;	ii < Zero then	U	12.0
	Other state or local government indigent care program (see instruct	ions for each line)		
13. 00	Net revenue from state or local indigent care program (Not included			0	13. 0
4.00	Charges for patients covered under state or local indigent care pro	ogram (Not included	in lines 6 or	0	14.0
	10)				
15. 00				0	
16. 00		nt care program (li	ne 15 minus line	0	16. 0
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP ar	nd state/local indi	gent care program	ıs (see	
	instructions for each line)				
17. 00				0	
18.00			(6.11	0	
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local inc 8, 12 and 16)	digent care program	s (sum of lines	12, 720, 072	19.0
	0, 12 and 10)	Uni nsured	Insured	Total (col. 1	
		pati ents	pati ents	+ col . 2)	
		1.00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)	7 000 0	al	7 000 070	
20. 00	3	ty 7, 909, 9	79 0	7, 909, 979	20.0
21. 00	(see instructions) Cost of patients approved for charity care and uninsured discounts	(see 2, 444, 9	98 0	2, 444, 998	21 0
1.00	instructions)	2, 444, 7	70	2, 444, 990	21.00
22. 00		as 7, 3	30 0	7, 330	22. 00
	charity care				
23. 00	Cost of charity care (line 21 minus line 22)	2, 437, 6	68 0	2, 437, 668	23. 0
				1 00	
24. 00	Does the amount on line 20 column 2, include charges for patient da	1. 00 N	24. 00		
14.00	imposed on patients covered by Medicaid or other indigent care prod	IN	24.00		
25. 00	If line 24 is yes, enter the charges for patient days beyond the instay limit		m's length of	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see instruc	ctions)		8, 080, 260	26. 00
27. 00	Medicare reimbursable bad debts for the entire hospital complex (se	· ·		141, 831	27. 0
27. 01	Medicare allowable bad debts for the entire hospital complex (see i			218, 201	27. 0
00 00	Non-Medicare bad debt expense (see instructions)			7, 862, 059	
28. 00		(caa instructions)	2, 506, 556	29.00
29. 00		(See Thistructions	,		
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line 3	·	,	4, 944, 224 17, 664, 296	30. 0

	Financial Systems	21 JOSEPH MEDI				eu or form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co	CN: 15-0047 P	eri od:	Worksheet A	
					rom 06/01/2020		
					o 05/31/2021	Date/Time Pre	
				1		10/29/2021 5:	12 pm
	Cost Center Description	Sal ari es	0ther	lotal (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1 00	00100 CAP REL COSTS-BLDG & FIXT		6, 376, 398	6, 376, 398	1, 490, 104	7.0// 502	1.00
1.00				1			
2.00	00200 CAP REL COSTS-MVBLE EQUIP		9, 020, 715	1		9, 625, 986	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	175, 940	56, 124	232, 064	2, 157, 143	2, 389, 207	4. 00
5.01	00590 REVENUE CYCLE	666, 946	4, 809, 750	5, 476, 696	-149, 678	5, 327, 018	5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	10, 303	48, 764	59, 067	0	59, 067	5. 02
5.03	00591 ADMINISTRATIVE AND GENERAL	1, 597, 900	12, 683, 748	1			
7. 00	00700 OPERATION OF PLANT	948, 519	2, 254, 795	1			1
		740, 317		1			1
8.00	00800 LAUNDRY & LINEN SERVICE	101 007	125, 459	1		,	
9. 00	00900 HOUSEKEEPI NG	481, 237	185, 756	1			
10.00	01000 DI ETARY	0	963, 104	963, 104	-222, 415	740, 689	10.00
11.00	01100 CAFETERI A	0	0	0	218, 120	218, 120	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 120, 784	114, 009	1, 234, 793	377, 881	1, 612, 674	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	134, 762	386, 700	1			
15. 00	01500 PHARMACY	649, 571	1, 288, 919	1			
				1			1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	58, 443	269, 002	1			
17. 00	01700 SOCIAL SERVICE	386, 775	57, 349	444, 124	-350	443, 774	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 955, 729	2, 755, 323	7, 711, 052	-3, 949	7, 707, 103	30.00
33.00	03300 BURN INTENSIVE CARE UNIT	o	0	0	0	0	33. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
44. 00	04400 SKILLED NURSING FACILITY		0	0			
44.00	ANCI LLARY SERVI CE COST CENTERS	O _I		1	1 0		1 44. 00
EO 00	05000 OPERATING ROOM	95, 105	140 220	244, 334	21 224	212 100	FO 00
50.00		95, 105	149, 229				
51. 00	05100 RECOVERY ROOM	U	0	_	_		
53. 00	05300 ANESTHESI OLOGY	0	636, 561	1		000,00.	
54.00	05400 RADI OLOGY-DI AGNOSTI C	441, 021	375, 587	816, 608	207, 385	1, 023, 993	54.00
54.01	03630 ULTRA SOUND	176, 208	77, 585	253, 793	-253, 793	0	54. 01
56.00	05600 RADI OI SOTOPE	-463	5, 739	5, 276	-5, 276	0	56. 00
57.00	05700 CT SCAN	199, 649	90, 349	289, 998	-289, 998	l 0	57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	42, 033	365, 411	1			1
60. 00	06000 LABORATORY	988, 614	875, 486	1			1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	700, 014		1			
		500 (70	38, 597	1		00,077	
65. 00	06500 RESPI RATORY THERAPY	508, 670	121, 159	1			
66. 00	06600 PHYSI CAL THERAPY	84, 930	8, 513	1			
67.00	06700 OCCUPATI ONAL THERAPY	44, 883	3, 521	48, 404	0	48, 404	67. 00
68.00	06800 SPEECH PATHOLOGY	12, 854	1, 359	14, 213	0	14, 213	68. 00
69.00	06900 ELECTROCARDI OLOGY	53, 877	5, 588	59, 465	0	59, 465	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	21, 893	21, 893	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0				
74. 00	1 1	0	20.055	_			
	07400 RENAL DI ALYSI S	0	30, 055	1	0		1
	03950 MI SC ANCI LLARY	0	0	_	0	0	
	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	20, 294	1, 945	22, 239	-11	22, 228	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	6, 865	836	7, 701	0	7, 701	90.00
	09100 EMERGENCY	1, 448, 788	1, 291, 537				1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 440, 700	1, 271, 337	2, 140, 323	1, 475	2, 750, 052	92. 00
92.00							72.00
440.00	SPECIAL PURPOSE COST CENTERS	45 040 007	45 474 070	/		(0.705.000	
118.00		15, 310, 237	45, 474, 972	60, 785, 209	0	60, 785, 209	1178.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
194.00	07950 MEALS ON WHEELS	ol	0	0	0	0	194. 00
200.00		15, 310, 237	45, 474, 972	60, 785, 209	0	60, 785, 209	200.00
					•		

Heal th	Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lieu	of Form CMS	-2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CCN:	15-0047	Peri od:	Worksheet A	
					From 06/01/2020	Doto/Time Do	anamad.
					To 05/31/2021	Date/Time Pr 10/29/2021 5	
	Cost Center Description	Adjustments	Net Expenses				
	·	(See A-8) F	or Allocation				
		6.00	7. 00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	-2, 426, 397	5, 440, 105				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-4, 275, 623	5, 350, 363				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-4, 663	2, 384, 544				4. 00
5. 01	00590 REVENUE CYCLE	39, 027	5, 366, 045				5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	043,404	59, 067				5. 02
5. 03 7. 00	OO591 ADMINISTRATIVE AND GENERAL OO700 OPERATION OF PLANT	-942, 496 -15, 367	9, 369, 143 3, 718, 651				5. 03 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	-41, 522	83, 937				8.00
9. 00	00900 HOUSEKEEPI NG	0	665, 854				9. 00
10. 00	01000 DI ETARY	Ö	740, 689				10.00
11. 00	01100 CAFETERI A	0	218, 120				11. 00
13. 00	01300 NURSING ADMINISTRATION	o	1, 612, 674				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	244, 563				14. 00
15.00	01500 PHARMACY	0	846, 117				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-28	318, 584				16. 00
17.00	01700 SOCIAL SERVICE	0	443, 774				17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	212, 582	212, 582				22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	-1, 255, 974	6, 451, 129				30. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0				33. 00
40. 00	04000 SUBPROVI DER - I PF	0	0				40. 00
44. 00	04400 SKI LLED NURSI NG FACI LI TY	0	0				44. 00
FO 00	ANCILLARY SERVICE COST CENTERS	12.750	100 250				
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	-13, 750 0	199, 350 0				50. 00 51. 00
53. 00	05300 ANESTHESI OLOGY	0	636, 561				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 023, 993				54. 00
54. 01	03630 ULTRA SOUND	Ö	0				54. 01
56. 00	05600 RADI OI SOTOPE	o	0				56. 00
57.00	05700 CT SCAN	O	0				57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	-45, 144	294, 648				59. 00
60.00	06000 LABORATORY	-2, 550	1, 806, 107				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	38, 597				62. 00
65.00	06500 RESPI RATORY THERAPY	0	627, 073				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	92, 298				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	48, 404				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	14, 213				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	59, 465				69. 00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	21, 893				71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	25, 715				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	800, 230				73. 00
74. 00 76. 00	07400 RENAL DIALYSIS 03950 MISC ANCILLARY	0	30, 055 0				74.00
	03951 SLEEP LAB	0	0				76. 00 76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76. 01
	03952 WOUND CARE	0	22, 228				76. 02
, 0. 03	OUTPATIENT SERVICE COST CENTERS	<u> </u>	۷۷, ۷۷				T 70.03
90 00	09000 CLINIC	nl	7, 701				90.00
	09100 EMERGENCY	-848, 815	1, 890, 017				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	3.5,575	., ,				92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		-9, 620, 720	51, 164, 489				118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0				192. 00
	07950 MEALS ON WHEELS	0	0				194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-9, 620, 720	51, 164, 489				200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 06/01/2020 To 05/31/2021 Date/Time Prepared: Provider CCN: 15-0047

					10	05/31/2021	10/29/2021 5: 12 pm
	Cook Conton	Increases	C-1	0+1			
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00			
	A - EMPLOYEE BENEFITS	0.00		0.00			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 158, 394			1. 00
2.00		0.00	0	<u>0</u> 2, 158, 394			2. 00
	C - LEASE AND RENTAL		<u> </u>	2, 130, 394			
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	594, 843			1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	112, 074			2.00
3. 00 4. 00		0. 00 0. 00	0	0			3. 00 4. 00
5. 00		0.00	0	0			5. 00
6.00		0.00	0	0			6. 00
7.00		0.00	0	0			7. 00
8. 00 9. 00		0. 00 0. 00	0	0			8. 00 9. 00
10. 00		0.00	0	o			10.00
11. 00		0.00	0	0			11. 00
12.00		0.00	0	0			12.00
13. 00		0.00	0	706, 917			13. 00
	D - OTHER CAPITAL COSTS		<u> </u>	700, 717			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	231, 071			1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 146, 959			2.00
3. 00	CAP REL COSTS-MVBLE EQUIP		0	1 <u>0, 4</u> 28 1, 388, 458			3. 00
	E - REPAIRS & MAINTENANCE		<u> </u>	1,000,100			
1.00	OPERATION OF PLANT	7. 00	0	461, 795			1. 00
2.00		0.00	0	0			2.00
3. 00 4. 00		0. 00 0. 00	0	0			3. 00 4. 00
5. 00		0.00	o	Ö			5. 00
6.00		0.00	0	0			6. 00
7.00		0. 00 0. 00	0	0			7.00
8. 00 9. 00		0.00	ol Ol	0			8. 00 9. 00
10. 00		0.00	O	O			10. 00
11. 00		0.00	0	0			11. 00
12. 00 13. 00		0. 00 0. 00	0	0			12. 00 13. 00
14. 00		0.00	0	0			14. 00
15. 00		0.00	Ö	Ö			15. 00
16. 00		0.00	0	0			16. 00
17. 00 18. 00		0. 00 0. 00	0	0			17. 00 18. 00
19. 00		0.00	0	0			19. 00
	0			461, 795			
4 00	F - CNO WAGES RECLASS	40.00	070 070				4.00
1. 00	NURSING ADMINISTRATION		37 <u>8, 0</u> 72 378, 072	<u>0</u>			1. 00
	G - MEDICAL SUPPLIES		370, 072	<u> </u>			
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	21, 893			1. 00
2.00	PATIENT IMPL. DEV. CHARGED TO	72.00	0	25, 715			2.00
2. 00	PATIENTS	72. 00	U	25, 715			2. 00
3.00	OPERATING ROOM	<u>50.</u> 00	0	<u>419</u>			3. 00
	0		0	48, 027			
1. 00	H - DRUGS AND IV COSTS DRUGS CHARGED TO PATIENTS	73. 00	ol	800, 230			1. 00
1.00	0 FATTENTS		0	800, 230			1.00
	J - RADI OLOGY						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	375, 394	28, 925			1.00
2. 00	RADI OI SOTOPE	<u>56.</u> 00	<u>4</u> 63 375, 857	<u>6, 1</u> 77 35, 102			2. 00
	K - DIETARY		373,037	33, 102			
1.00	CAFETERI A	11.00	0	218, 120			1.00
	O M. HITH LITTER PERILAGE		0	218, 120			
1. 00	M - UTILITIES RECLASS OPERATION OF PLANT	7. 00	ol	53, 524			1.00
2.00	C. EIGHTON OF FEMALE	0.00	0	0			2. 00
3. 00		0.00	0	0			3. 00
	0		0	53, 524			
1. 00	N - NON-CAPITALIZED EQUIPMENT OPERATION OF PLANT	7.00	0	15, 816			1.00
2.00	O EXATION OF FLANT	0.00	0	0			2. 00
3. 00		0. 00	Ö	o			3. 00
	'		·	· · · · · · · · · · · · · · · · · · ·			·

Heal th Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0047 Period: From 06/01/2020 To 05/31/2021 Date/Time Prepared: 10/29/2021 5: 12 pm

						10/29/2021 5	:12 pm_
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	TOTALS		0	15, 816			
500.00	Grand Total: Increases		753, 929	5, 886, 383			500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0047

						Date/lime Prepared: 10/29/2021 5:12 pm
	Coot Conton	Decreases	Calary	Othor	Wko+ A 7 Dof	
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - EMPLOYEE BENEFITS	7.00	0.00	7.00	10.00	
1.00	ADMINISTRATIVE AND GENERAL	5. 03	0	2, 158, 373	0	1. 00
2.00	REVENUE CYCLE	5. 01	0_	21		2. 00
	0		0	2, 158, 394		
1 00	C - LEASE AND RENTAL	E 02	ما	22 220	10	1 00
1. 00 2. 00	ADMINISTRATIVE AND GENERAL OPERATION OF PLANT	5. 03 7. 00	0	22, 229 431		1.00
3.00	DI ETARY	10.00	0	1, 445		3. 00
4. 00	NURSING ADMINISTRATION	13. 00	o	190		4. 00
5.00	PHARMACY	15. 00	o	292, 143	0	5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	173		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	145, 706		7. 00
8.00	LABORATORY	60.00	0	42, 235		8.00
9. 00 10. 00	MEDICAL RECORDS & LIBRARY WOUND CARE	16. 00 76. 03	O O	8, 833 11		9.00
11. 00	REVENUE CYCLE	5. 01	0	295		11.00
12. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	192, 054		12. 00
13. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	1, 172		13. 00
	0			706, 917		
	D - OTHER CAPITAL COSTS					
1.00	ADMINISTRATIVE AND GENERAL	5. 03	0	1, 388, 458		1.00
2.00		0.00	0	0		2.00
3. 00			0	<u></u> <u>0</u> 1, 388, 458	12	3. 00
	E - REPAIRS & MAINTENANCE		<u> </u>	1, 300, 430		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	79	0	1. 00
2.00	REVENUE CYCLE	5. 01	O	132, 813		2. 00
3.00	ADMINISTRATIVE AND GENERAL	5. 03	0	17, 926	0	3. 00
4.00	HOUSEKEEPI NG	9. 00	0	1, 139		4. 00
5.00	NURSI NG ADMI NI STRATI ON	13. 00	0	1	0	5. 00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	63, 828		6.00
7. 00 8. 00	ADULTS & PEDIATRICS DIETARY	30. 00 10. 00	0	3, 776 2, 850		7. 00 8. 00
9. 00	OPERATING ROOM	50.00	0	2, 650 16, 713		9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	o	18, 328		10.00
11. 00	ULTRA SOUND	54. 01	o	59, 581	0	11. 00
12.00	RADI OI SOTOPE	56.00	0	11, 916	0	12. 00
13.00	CT SCAN	57. 00	0	73, 251	0	13. 00
14.00	LABORATORY	60.00	0	13, 208		14. 00
15.00	RESPIRATORY THERAPY	65.00	0	1, 880		15. 00
16.00	PHYSICAL THERAPY	66.00	0	1, 145		16.00
17. 00 18. 00	CARDI AC CATHETERI ZATI ON SOCI AL SERVI CE	59. 00 17. 00	0	41, 518 350		17. 00 18. 00
19. 00	EMERGENCY	91.00	0	1, 493		19. 00
17.00	0		 	461, 795		17100
	F - CNO WAGES RECLASS			·		
1.00	ADMINISTRATIVE AND GENERAL	503	378, 072	0	0	1. 00
	TOTALS		378, 072			
	G - MEDICAL SUPPLIES	44.00				4.00
1. 00 2. 00	CENTRAL SERVICES & SUPPLY RESPIRATORY THERAPY	14. 00 65. 00	0	21, 017 876		1. 00 2. 00
3. 00	CARDIAC CATHETERIZATION	59.00	0	26, 134		3. 00
3.00	0		— — ў			3.00
	H - DRUGS AND IV COSTS			,		
1.00	PHARMACY	15.00	0	800, 230		1. 00
	0			800, 230		
1 00	J - RADI OLOGY	F. 5.1	47/ 005	40.05		
1.00	ULTRA SOUND	54. 01	176, 208	18, 004		1.00
2. 00	CT_SCAN	<u>57.</u> 00	199, 649 375, 857	1 <u>7, 0</u> 98 35, 102		2. 00
	K - DIETARY		373,037	33, 102		
1.00	DI ETARY	10.00	0	218, 120	0	1. 00
	0			218, 120		
	M - UTILITIES RECLASS					
1.00	ADMINISTRATIVE AND GENERAL	5. 03	0	4, 626		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	32, 900		2.00
3.00	REVENUE CYCLE		0	1 <u>5, 9</u> 98 53, 524		3. 00
	N - NON-CAPITALIZED EQUIPMENT		U	53, 524		
1.00	REVENUE CYCLE	5. 01	O	551	0	1. 00
2. 00	ADMINISTRATIVE AND GENERAL	5. 03	Ö	325		2. 00
3.00	OPERATING ROOM	50.00		14, 940		3. 00
	TOTALS		0	15, 816		
500.00	Grand Total: Decreases		753, 929	5, 886, 383		500. 00

| Period: | Worksheet A-7 | From 06/01/2020 | Part | To 05/31/2021 | Date/Time Prepared:

				To	05/31/2021		
				Acqui si ti ons		10/29/2021 5: 3	12 pm
		Begi nni ng	Purchases	Donation	Total	Disposals and	
		Bal ances	i ui chases	Donation	iotai	Retirements	
		1.00	2, 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	9, 348, 028	0	0	0	0	1. 00
2.00	Land Improvements	1, 775, 835	o	0	0	ol	2. 00
3.00	Buildings and Fixtures	28, 584, 244	2, 054	0	2, 054	72, 994	3. 00
4.00	Building Improvements	31, 942, 549	66, 398	0	66, 398	78, 064	4. 00
5.00	Fixed Equipment	18, 572, 892	0	0	0	197, 696	5. 00
6.00	Movable Equipment	69, 415, 582	133, 357	0	133, 357	4, 535, 347	6. 00
7.00	HIT designated Assets	2, 833, 813	21, 867	0	21, 867	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	162, 472, 943	223, 676	0	223, 676	4, 884, 101	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	162, 472, 943	223, 676	0	223, 676	4, 884, 101	10. 00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
	DART I ANALYSIS OF GUANGES IN CARLTAL ASSET	6.00	7. 00				
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						1 00
1.00	Land	9, 348, 028	0				1.00
2.00	Land Improvements	1, 775, 835	0				2. 00 3. 00
3. 00 4. 00	Buildings and Fixtures	28, 513, 304	0				4.00
4. 00 5. 00	Building Improvements	31, 930, 883	0				5.00
6.00	Fixed Equipment	18, 375, 196 65, 013, 592	0				6.00
7. 00	Movable Equipment HIT designated Assets	2, 855, 680	0				7. 00
8.00	Subtotal (sum of lines 1-7)	157, 812, 518	0				8. 00
9. 00	Reconciling Items	137,012,310	0				9. 00
10. 00	Total (line 8 minus line 9)	157, 812, 518	0				10.00
10.00	Tiotal (Title o milias Title 7)	137, 312, 310	Ч			ı	10.00

Heal th	Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0047	Peri od: From 06/01/2020 To 05/31/2021	Worksheet A-7 Part II Date/Time Pre 10/29/2021 5:	pared:
			SU	IMMARY OF CAP	PLTAL		
	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	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	6, 376, 398	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	9, 020, 715	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	15, 397, 113	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	(SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	6, 376, 398				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9, 020, 715				2. 00
0 00	T 1 1 (C 1: 4 0)		45 007 440	I			

0 0

6, 376, 398 9, 020, 715 15, 397, 113

1. 00 2. 00 3. 00

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

Heal th	n Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
					From 06/01/2020 To 05/31/2021	Part III Date/Time Pre	nared·
						10/29/2021 5:	
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col			
		1.00	2.00	2) 3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	3.00	4.00	5.00	
1.00	CAP REL COSTS-BLDG & FLXT	71, 568, 049	0	71, 568, 04	9 0. 453500	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	86, 244, 469					2. 00
3.00	Total (sum of lines 1-2)	157, 812, 518	0	157, 812, 51	8 1. 000000	0	3. 00
		ALLOCA.	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	,		Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CI				0 000 000	440.074	4 00
1. 00 2. 00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	0	0		0 2, 882, 280		1. 00 2. 00
3. 00	Total (sum of lines 1-2)	0	0		0 4, 756, 608 0 7, 638, 888		2. 00 3. 00
3.00	Total (Sull of Titles 1-2)	0	<u> </u>	I JMMARY OF CAPI		073, 401	3.00
			50	JIMINATE OF CALL	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11 00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11.00	12. 00	13.00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	1, 067, 721	231, 071	1, 146, 95	9 0	5, 440, 105	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1,007,721	1		0	5, 350, 363	2. 00
3.00	Total (sum of lines 1-2)	1, 067, 721	1		-		
	1	, , , , , , , , , , , , , , , , , , , ,		, , , , , , ,	-1	.,	

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-From 06/01/2020 Date/Time Pt Provider CCN: 15-0047

1.00 Investment COSTS-BLDG 2.00 Investment COSTS-MVBL 3.00 Investment (chapter 2 4.00 Trade, qua di scounts 5.00 Refunds an expenses (6.00 Rental of	ntity, and time (chapter 8) d rebates of	Basi s/Code (2) 1.00	Amount 2.00	Expense Classification on To/From Which the Amount is Cost Center 3.00 CAP REL COSTS-BLDG & FIXT	Line #	10/29/2021 5: - 10/29/2021 5: - Wkst. A-7 Ref.	12 μιι
1.00 Investment COSTS-BLDG 2.00 Investment COSTS-MVBL 3.00 Investment (chapter 2 4.00 Trade, qua di scounts 5.00 Refunds an expenses (6.00 Rental of	income - CAP REL & FIXT (chapter 2) income - CAP REL E EQUIP (chapter 2) income - other) ntity, and time (chapter 8) d rebates of		Amount 2.00	Cost Center 3.00	Li ne # 4.00		
1.00 Investment COSTS-BLDG 2.00 Investment COSTS-MVBL 3.00 Investment (chapter 2 4.00 Trade, qua di scounts 5.00 Refunds an expenses (6.00 Rental of	income - CAP REL & FIXT (chapter 2) income - CAP REL E EQUIP (chapter 2) income - other) ntity, and time (chapter 8) d rebates of		2.00	3.00	4. 00		
1.00 Investment COSTS-BLDG 2.00 Investment COSTS-MVBL 3.00 Investment (chapter 2 4.00 Trade, qua di scounts 5.00 Refunds an expenses (6.00 Rental of	income - CAP REL & FIXT (chapter 2) income - CAP REL E EQUIP (chapter 2) income - other) ntity, and time (chapter 8) d rebates of		2.00	3.00	4. 00		
1.00 Investment COSTS-BLDG 2.00 Investment COSTS-MVBL 3.00 Investment (chapter 2 4.00 Trade, qua di scounts 5.00 Refunds an expenses (6.00 Rental of	income - CAP REL & FIXT (chapter 2) income - CAP REL E EQUIP (chapter 2) income - other) ntity, and time (chapter 8) d rebates of		2.00	3.00	4. 00		
2.00 Investment COSTS-MVBL 3.00 Investment (chapter 2 Trade, quadi scounts 5.00 Refunds an expenses (6.00 Rental of	& FIXT (chapter 2) income - CAP REL E EQUIP (chapter 2) income - other) ntity, and time (chapter 8) d rebates of	1.00	0			5 00	
2.00 Investment COSTS-MVBL 3.00 Investment (chapter 2 Trade, quadi scounts 5.00 Refunds an expenses (6.00 Rental of	& FIXT (chapter 2) income - CAP REL E EQUIP (chapter 2) income - other) ntity, and time (chapter 8) d rebates of			ON REE GOOTS BEDG & TTXT	1. 00	0	1. 00
COSTS-MVBL Investment (chapter 2 4.00 Trade, qua di scounts 5.00 Refunds an expenses (6.00 Rental of	E EQUIP (chapter 2) income - other) ntity, and time (chapter 8) d rebates of		0	 			
3.00 Investment (chapter 2 4.00 Trade, qua di scounts 5.00 Refunds an expenses (6.00 Rental of	income - other) ntity, and time (chapter 8) d rebates of			CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
4.00 Trade, quadi scounts 5.00 Refunds an expenses (6.00 Rental of	ntity, and time (chapter 8) d rebates of		0		0. 00	0	3. 00
5.00 Refunds an expenses (6.00 Rental of	d rebates of		0		0. 00	0	4. 00
expenses (6.00 Rental of			0		0. 00	0	5. 00
			0				
	provider space by (chapter 8)		0		0. 00	0	6. 00
7. 00 Tel ephone	servi ces (pay	A	-832	ADMINISTRATIVE AND GENERAL	5. 03	0	7. 00
stations e	xcluded) (chapter						
8.00 Tel evi si on	and radio service	А	-15, 367	OPERATION OF PLANT	7. 00	0	8. 00
(chapter 2 9.00 Parking Id	t (chapter 21)		0		0. 00	0	9. 00
	ased physician	A-8-2	-2, 154, 620			0	10. 00
adjustment 11.00 Sale of sc	rap, waste, etc.		0		0. 00	0	11. 00
(chapter 2	3) gani zati on	A-8-1	964, 933			0	12. 00
transactio	ns (chapter 10)	A-0-1					
	d linen service employees and guests		0		0. 00 0. 00	0	13. 00 14. 00
15.00 Rental of	quarters to employee		0		0. 00	Ö	15. 00
and others 16.00 Sale of me	dical and surgical		0		0. 00	0	16. 00
supplies t	o other than						
patients 17.00 Sale of dr	ugs to other than		0		0. 00	0	17. 00
patients	dical records and	В	20	MEDICAL DECODDS & LIDDADY	14 00	0	18. 00
18.00 Sale of me abstracts	urcar records and	В	-20	MEDICAL RECORDS & LIBRARY	16. 00	U	16.00
	d allied health (tuition, fees,		0		0. 00	0	19. 00
books, etc	.)						
	d allied health (tuition, fees,		0		0. 00	0	19. 01
books, etc	.)		0.05				
20.00 Vending ma 21.00 Income from	chines m imposition of	В	-235 0	ADMINISTRATIVE AND GENERAL	5. 03 0. 00	0	20. 00 21. 00
interest,	finance or penalty						
charges (c 22.00 Interest e	xpense on Medicare		0		0. 00	0	22. 00
	ts and borrowings to care overpayments						
23.00 Adjustment	for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	sts in excess of (chapter 14)						
24.00 Adjustment	for physi cal	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	sts in excess of (chapter 14)						
25.00 Utilizatio			0	*** Cost Center Deleted ***	114. 00		25. 00
(chapter 2	' compensation 1)						
26.00 Depreciati COSTS-BLDG	on - CAP REL	A	-3, 558, 379	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27.00 Depreciati	on - CAP REL	А	-4, 405, 243	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
COSTS-MVBL 28.00 Non-physic	E EQUIP ian Anesthetist		Ω	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 Physi ci ans	' assi stant		0		0. 00	0	29. 00
	for occupational sts in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
limitation	(chapter 14)			ADULTO A DEDLATOLOG	22		00.05
30.99 Hospice (n	on-distinct) (see ns)	A	-11, 613	ADULTS & PEDIATRICS	30. 00		30. 99
31.00 Adjustment	for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	costs in excess of (chapter 14)						

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0047 Peri od: Worksheet A-8 From 06/01/2020 05/31/2021 Date/Time Prepared: 10/29/2021 5:12 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 2.00 3.00 4.00 5.00 32.00 CAH HIT Adjustment for 0.00 32. 00 Depreciation and Interest 33.00 PARKING GARAGE & MISC INCOME В -14, 935 ADMINISTRATIVE AND GENERAL 5.03 33.00 33. 01 MARKETING & RECRUITING EXPENSE Α -114, 786 ADMINI STRATI VE AND GENERAL 5.03 33.01 33. 02 **PENALTIES** -72 ADMINISTRATIVE AND GENERAL 5.03 33. 02 Α 0 FITNESS REVENUE -7, 008 ADMINISTRATIVE AND GENERAL 33.03 33.03 В 5.03 33.04 SENI OR CIRCLE Α -725 ADMINISTRATIVE AND GENERAL 5.03 0 33.04 33. 05 SILVER RECOVERY В -3, 462 ADMINISTRATIVE AND GENERAL 33.05 5.03 PATIENT PHONE WAGE COSTS -8, 412 ADMINI STRATI VE AND GENERAL 33.06

-9, 620, 720

-1, 763 EMPLOYEE BENEFITS DEPARTMENT

-111 CAP REL COSTS-MVBLE EQUIP

-348 CAP REL COSTS-MVBLE EQUIP

3, 689 ADMINISTRATIVE AND GENERAL

-2, 560 ADMINISTRATIVE AND GENERAL

-79, 061 ADMINISTRATIVE AND GENERAL

-206, 882 ADMI NI STRATI VE AND GENERAL

-2, 900 EMPLOYEE BENEFITS DEPARTMENT

5.03

4.00

2.00

2.00

5.03

4.00

5.03

5.03

5.03

33.07

33.08

33.09

33.10

33.11

33. 12

33. 13

33.16

50.00

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PATIENT PHONES BENEFITS

PATIENT TV DEPRECIATION

PHYSICIAN RECRUITING

INTEREST INCOME ADD BACK

LOBBYING EXPENSE IN DUES

CHARITABLE CONTRIBUTIONS

(Transfer to Worksheet A, column 6, line 200.)

NONALLOWABLE LEGAL EXPENSES

TOTAL (sum of lines 1 thru 49)

PATIENT PHONE DEPRECIATION

33.06

33.07

33. 08

33.09

33.10

33. 11

33. 12

33. 13

33. 16

50.00

⁽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.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0047 Peri od: Worksheet A-8-1 From 06/01/2020 To 05/31/2021 Date/Time Prepared: OFFICE COSTS

				0 05/31/2021	10/29/2021 5:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	12 0
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		<u>, </u>			
1. 00		li .	CAPITAL-RELATED INTEREST	1, 067, 721	0	1. 00
2.00			PASI CAPITAL COSTS - BLDG &	3, 577	0	2. 00
3. 00		li .	PASI CAPITAL COSTS - MOVEABL	438	0	3. 00
4. 00		REVENUE CYCLE	PASI OPERATING COSTS	303, 572	264, 545	4. 00
4. 01			SHARED SERVICE CENTER ALLOCA	1, 079, 375	1, 127, 953	4. 01
4. 02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL-BLDG & FIXTURES	60, 684	0	4. 02
4.03	2. 00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL-MVBLE EQUIP	141, 157	0	4. 03
4.04	5. 03	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	1, 520, 094	0	4. 04
4.05	5. 03	ADMINISTRATIVE AND GENERAL	MALPRACTICE COSTS	236, 170	452, 690	4. 05
4.06	2. 00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	208, 544	220, 060	4. 06
4.07	5. 03	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	629, 624	4. 07
4.08	5. 03	ADMINISTRATIVE AND GENERAL	401K FEES	0	5, 774	4. 08
4.09	5. 03	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	44, 014	4. 09
4. 10	5. 03	ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	916, 192	4. 10
4. 11	5. 03	ADMINISTRATIVE AND GENERAL	HIIM ALLOCATION	0	152, 987	4. 11
4. 12	5. 03	ADMINISTRATIVE AND GENERAL	CONTRACT MANAGEMENT	0	4, 152	4. 12
4. 13	5. 03	ADMINISTRATIVE AND GENERAL	PASI LIEN UNIT COLLECTION FE	0	9, 468	4. 13
4. 14	8. 00	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICES	85, 446	126, 968	4. 14
4. 15	22. 00	I&R SERVICES-OTHER PRGM COST	I&R COSTS BILLED BY THE FWME	212, 582	0	4. 15
5.00	TOTALS (sum of lines 1-4).			4, 919, 360	3, 954, 427	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

1103 110	t been posted to worksheet A,	cor anno r anazor 2, tric anioar	it arrowabic sii	oura be marcated in corumn 4	or this part.	
				Related Organization(s) and/	or Home Office	
						l
			_			
	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

	Comonic undor the tro minimum		
6.00	В	0.00 CHS, INC 100.0	0 6.00
7.00	В	0.00 PASI 100.0	0 7.00
8.00	С	33.00 SHARED_LAUNDRY 33.0	0 8.00
9.00		0.00	0 9.00
10.00		0.00	0 10.00
100.00	G. Other (financial or		100.00
	non-fi nanci al) speci fy:		

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

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

0 9 9 0 4 02 4 02 60,684 4.03 141, 157 4.03 4.04 1, 520, 094 4.04 0 4.05 4.05 -216, 520 10 4.06 -11,5164.06 4.07 -629, 624 0 4.07 0 4.08 -5, 774 4.08 0 4 09 -44.014 4 09 4.10 -916, 192 4. 10 -152, 987 0 4.11 4.11 0 -4, 152 4.12 4.12 -9, 468 4.13 4.13 4.14 -41, 522 0 4.14 4.15 212, 582 4.15 5.00 964, 933 5.00

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

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

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

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

6.00	OWNER	6.00
	DEBT COLLECTION	7.00
8.00	LAUNDRY	8.00
9.00		9.00
9. 00 10. 00		10.00
100.00		100.00

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

| Peri od: | Worksheet A-8-2 | From 06/01/2020 | To 05/31/2021 | Date/Time Prepared:

						To 05/31/202	1 Date/Time Pro 10/29/2021 5:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi ona	I Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
					·		Hours	
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	1, 244, 361	1, 244, 3		-1		
2.00	50. 00	OPERATING ROOM	13, 750	13, 7) c	0	2. 00
3.00	1	CARDIAC CATHETERIZATION	45, 144	45, 1		o c	ή	
4.00	60. 00	LABORATORY	2, 550	2, 5	50) c	0	4. 00
5.00	91. 00 EMERGENCY		848, 815	848, 8	15	o c	0	5. 00
6.00	0.00		0		0	o c	0	6. 00
7.00	0.00		0		0	o c	0	7. 00
8.00	0.00		0		0	o c	0	8. 00
9.00	0.00		0		0	o c	0	9. 00
10.00	0.00		0		0	o c	0	10.00
200.00			2, 154, 620				0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost	
		l denti fi er	Limit		CE Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	
1.00		ADULTS & PEDIATRICS	0		0			
2. 00		OPERATING ROOM	0		-			4
3. 00		CARDI AC CATHETERI ZATI ON	0		0	1	ή	
4.00		LABORATORY	0		0		0	
5. 00		EMERGENCY	0		0		0	
6. 00	0.00		0		0		0	
7. 00	0. 00		0		0		0	
8. 00	0. 00		0		0		0	
9.00	0. 00		0		0		0	9. 00
10.00	0. 00		0		0		0	
200.00	W . A	0 1 0 1 (D)	0	A 11 1 1 DO	0 0) (0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RC		Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00	-	
1. 00		ADULTS & PEDIATRICS	0	101.00	0 (1	1. 00
2. 00		OPERATING ROOM	0		0		1	2.00
3. 00		CARDI AC CATHETERI ZATI ON	0		0	45, 144		3. 00
4. 00	1	LABORATORY	0		0	2, 550		4. 00
5. 00		EMERGENCY			0	1		5. 00
6. 00	0.00	LINE NO LIVOT				040,013	1	6.00
7. 00	0.00							7. 00
8. 00	0.00						á	8.00
9. 00	0.00						á	9. 00
10. 00	0.00						á	10.00
200.00	0.00		0		9	2, 154, 620	á	200.00
200.00	1		1	I	١,	2, 134, 020	' I	1 200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0047 Peri od: Worksheet B From 06/01/2020 Part I Date/Time Prepared: 05/31/2021 10/29/2021 5:12 pm CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** REVENUE CYCLE Cost Center Description for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 5, 440, 105 1 00 00100 CAP REL COSTS-BLDG & FLXT 5, 440, 105 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 5, 350, 363 5, 350, 363 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 384, 544 61, 574 60, 558 2, 506, 676 4.00 00590 REVENUE CYCLE 5, 909, 730 5 01 5, 366, 045 218, 411 214 808 110, 466 5 01 5.02 00560 PURCHASING RECEIVING AND STORES 59, 067 151, 696 149, 194 1, 706 0 5.02 5.03 00591 ADMINISTRATIVE AND GENERAL 9, 369, 143 118, 019 116, 073 202, 039 0 5.03 7.00 00700 OPERATION OF PLANT 3, 718, 651 2,077,416 2,043,146 157, 102 0 7.00 00800 LAUNDRY & LINEN SERVICE 83.937 48.343 47 545 8 00 0 8 00 9.00 00900 HOUSEKEEPI NG 665, 854 731, 917 719, 843 79, 707 Ω 9.00 01000 DI ETARY 740, 689 10.00 10.00 228, 641 224, 869 01100 CAFETERI A 11.00 218, 120 11.00 0 01300 NURSING ADMINISTRATION 13.00 1, 612, 674 83, 768 82.387 248, 254 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 244, 563 22, 320 0 14.00 01500 PHARMACY 15.00 846, 117 107, 588 15.00 01600 MEDICAL RECORDS & LIBRARY 318.584 137.004 9. 680 16, 00 16,00 134, 744 0 17 00 01700 SOCIAL SERVICE 443 774 C 64,061 0 17 00 212, 582 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDLATRICS 6, 451, 129 529, 346 520, 614 820, 810 1, 129, 210 30.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 04000 SUBPROVIDER - IPF 40.00 40.00 0 0 0 0 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 199, 350 0 0 15, 752 5, 905 50.00 05100 RECOVERY ROOM 51.00 51.00 53.00 05300 ANESTHESI OLOGY 636, 561 0 100 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,023,993 215, 058 211, 510 135, 222 1, 436, 133 54.00 03630 ULTRA SOUND 54.01 54.01 56.00 05600 RADI OI SOTOPE 0 0 0 Ω 56.00 05700 CT SCAN 57 00 Ω 0 Λ 57 00 59.00 05900 CARDI AC CATHETERI ZATI ON 294, 648 23, 956 23, 561 6, 962 1, 459 59.00 06000 LABORATORY 1, 806, 107 184, 069 181, 032 1, 149, 889 60.00 163, 743 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 10, 086 9, 920 9, 681 62.00 38.597 62.00 06500 RESPIRATORY THERAPY 627, 073 74, 791 73, 558 84.251 215, 659 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 92, 298 97, 182 95, 579 14,067 15, 890 66.00 67.00 06700 OCCUPATIONAL THERAPY 48, 404 37, 200 36, 586 7, 434 11, 556 67.00 06800 SPEECH PATHOLOGY 14, 090 1, 640 68 00 14 213 14 327 2 129 68 00 69.00 06900 ELECTROCARDI OLOGY 59, 465 13, 635 13, 410 8, 924 64, 436 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 21, 893 19,888 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 25, 715 0 1, 573 72.00 C 07300 DRUGS CHARGED TO PATIENTS 800 230 32, 229 73 00 31, 697 0 654.894 73 00 07400 RENAL DIALYSIS 74.00 30,055 26, 227 25, 794 0 3, 327 74.00 03950 MISC ANCILLARY 0 76.00 76.00 0 0 0 03951 SLEEP LAB 76.01 0 0 76.01 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.02 0 0 76 02 76.03 03952 WOUND CARE 22, 228 112,070 110, 221 3, 361 2, 473 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 7, 701 27, 740 09000 CLINIC 27, 283 1. 137 11.028 90.00 09100 EMERGENCY 1, 890, 017 91.00 172, 195 169, 354 239, 961 1, 174, 989 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 51, 164, 489 5, 426, 900 5, 337, 376 2, 506, 676 5, 909, 730 118. 00 118,00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 13, 205 12, 987 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 0 0 0 0 194.00 194.00 07950 MEALS ON WHEELS O 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201 00 TOTAL (sum lines 118 through 201) 5, 440, 105 5, 350, 363 2, 506, 676 5, 909, 730 202. 00 202.00 51, 164, 489

				10	05/31/2021	10/29/2021 5:	
	Cost Center Description	PURCHASI NG	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	, <u>, , , , , , , , , , , , , , , , , , </u>
	р	RECEIVING AND		AND GENERAL	PLANT	LINEN SERVICE	
		STORES					
		5. 02	5A. 02	5. 03	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 REVENUE CYCLE						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	361, 663					5. 02
5. 03	00591 ADMINISTRATIVE AND GENERAL	12, 885	9, 818, 159				5. 03
7.00	00700 OPERATION OF PLANT	2, 198	7, 998, 513		9, 897, 848	407.454	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	10, 931	190, 756		170, 101	406, 154	8. 00
9.00	00900 HOUSEKEEPI NG	5, 092	2, 202, 413		2, 575, 340	0	9.00
10.00	01000 DI ETARY	63, 472	1, 257, 671		804, 501	0	10.00
11.00	01100 CAFETERI A	0	218, 120		204 750	0	11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	266 25, 082	2, 027, 349 291, 965		294, 750 0	0	13. 00 14. 00
15. 00	01500 PHARMACY	25,062	953, 705		0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	28	600, 040		482, 067	0	16. 00
17. 00	01700 SOCIAL SERVICE	18	507, 853		402,007	0	17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		212, 582		0	Ö	22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	212, 302	30, 400	<u> </u>		22.00
30. 00	03000 ADULTS & PEDI ATRI CS	40, 137	9, 491, 246	2, 253, 819	1, 862, 570	124, 912	30. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	_	0	0	33. 00
40. 00	04000 SUBPROVI DER - I PF		0		0	Ö	40. 00
44. 00	04400 SKILLED NURSING FACILITY	l ol	0		0	Ō	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	19, 087	240, 094	57, 013	0	2, 747	50. 00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	636, 661	151, 182	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 988	3, 025, 904	718, 534	756, 708	62, 297	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	38, 028	388, 614		84, 293	294	59. 00
60.00	06000 LABORATORY	78, 229	3, 563, 069		647, 669	0	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	5, 939	74, 223		35, 489	0	62.00
65. 00	06500 RESPI RATORY THERAPY	6, 479	1, 081, 811		263, 163	0	65. 00
66.00	06600 PHYSI CAL THERAPY	5	315, 021		341, 946	0	66.00
67. 00	06700 OCCUPATIONAL THERAPY	0	141, 180		130, 893	0	67.00
68.00	06800 SPEECH PATHOLOGY	32	46, 431		50, 410	0	68. 00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	191 3, 369	160, 061 45, 150		47, 977 0	743 0	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 309	27, 288		0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1, 519, 050		113, 401	0	73.00
74. 00	07400 RENAL DIALYSIS	10	85, 413	· ·	92, 281	0	74.00
76. 00	03950 MI SC ANCI LLARY		00, 110		,2, 201	Ö	76.00
76. 01	03951 SLEEP LAB		0	o o	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	O	0	0	0	0	
	03952 WOUND CARE	75	250, 428	59, 467	394, 331	0	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	48	74, 937	17, 795	97, 607	0	90. 00
91.00	09100 EMERGENCY	46, 074	3, 692, 590	876, 846	605, 889	215, 161	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		361, 663	51, 138, 297	9, 811, 939	9, 851, 386	406, 154	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26, 192		46, 462		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	07950 MEALS ON WHEELS	0	0	0	0	0	194. 00
200.00	1 1		0		0	_	200.00
201. 00 202. 00		241 442	U 51 144 400	0 010 150	0 007 040		201. 00
202. UL	TOTAL (Suil TITIES TTO LITTUUGIT 201)	361, 663	51, 164, 489	9, 818, 159	9, 897, 848	400, 154	₁ 202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 06/01/2020 | Part |
| To 05/31/2021 | Date/Time Prepared: | 10/29/2021 | 5: 12 pm

				'	0 03/31/2021	10/29/2021 5:	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
	'				ADMI NI STRATI ON		
						SUPPLY	
		9. 00	10.00	11. 00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						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	00900 HOUSEKEEPI NG	5, 300, 740					9. 00
10.00	01000 DI ETARY	596, 226	2, 957, 046				10.00
11. 00	01100 CAFETERI A	o	0	269, 915			11.00
13.00	01300 NURSING ADMINISTRATION	218, 443	0	23, 029	3, 044, 987		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	O	0	5, 366		366, 661	14.00
15. 00	01500 PHARMACY	l ol	0	10, 324		0	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	357, 266	0	2, 452		42	1
17. 00	01700 SOCIAL SERVICE	0	0	6, 966		28	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		0	0,700	0	0	1
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	9					1 22.00
30. 00	03000 ADULTS & PEDIATRICS	1, 380, 373	1, 851, 313	119, 763	2, 220, 602	60, 879	30.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0			0	1
40. 00	04000 SUBPROVI DER - I PF		0			l ő	1
44. 00	04400 SKILLED NURSING FACILITY		0			l ő	1
44.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0				1 44. 00
50. 00	05000 OPERATING ROOM	0	0	320	991	28, 951	50.00
51. 00	05100 RECOVERY ROOM		0			0	1
53. 00	05300 ANESTHESI OLOGY		0	0		l ő	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	560, 806	0	20, 577	2, 051	6, 048	1
54. 01	03630 ULTRA SOUND	300,000	0	20,377		0,040	
56. 00	05600 RADI OI SOTOPE		0	٥	-	0	1
57. 00	05700 CT SCAN		0		0	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	62, 471	0	1, 457	0	57, 680	
60. 00	06000 LABORATORY	479, 995	0	29, 728		118, 656	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	26, 302	0	27, 720		9, 008	1
65. 00	06500 RESPIRATORY THERAPY	195, 033	0	12, 581	0	9, 828	1
66. 00	06600 PHYSI CAL THERAPY	253, 421	0	1, 404	0	7, 626	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	97, 006	0	640	ı .	0	1
68. 00	06800 SPEECH PATHOLOGY	37, 360	0	444		49	1
69. 00	06900 ELECTROCARDI OLOGY	35, 556	0	1, 173		290	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	35, 550	0	1, 1/3		5, 109	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0		_	5, 109	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	84, 043	0	0	0		1
74.00	07400 RENAL DIALYSIS	68, 391	0	0	0	15	1
76.00	03950 MISC ANCILLARY	00, 391	0	0	0	0	1
		0	0	0	0		
76. 01	03951 SLEEP LAB	0	0	0	0	1	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	292, 244	0	0 409		0	1
76. 03	03952 WOUND CARE	292, 244	U	1 409	0	114	76. 03
00 00	OUTPATIENT SERVICE COST CENTERS	72 220	0	170		72	00.00
90.00	09000 CLI NI C 09100 EMERGENCY	72, 338 449, 032	0				1
91.00		449, 032	U	33, 104	709, 196	69, 884	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
110 00	SPECIAL PURPOSE COST CENTERS	F 0// 00/	1 054 010	0/0.615	2 244 627	0// //-	110 00
118.00		5, 266, 306	1, 851, 313	269, 915	3, 044, 987	366, 661	1118.00
400.55	NONREI MBURSABLE COST CENTERS	2			=		100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	34, 434	0				190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	530, 776				192. 00
	07950 MEALS ON WHEELS	0	574, 957	0	0	0	194. 00
200.00							200. 00
201.00		0	0				201. 00
202.00	TOTAL (sum lines 118 through 201)	5, 300, 740	2, 957, 046	269, 915	3, 044, 987	366, 661	J202. 00

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

				Т	o 05/31/2021	Date/Time Pre 10/29/2021 5:	
					INTERNS &	10/29/2021 3.	12 piii
					RESI DENTS		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-OTHER	Subtotal	
			RECORDS &		PRGM COSTS		
		1F 00	LI BRARY	17. 00	APPRV	24. 00	
	GENERAL SERVICE COST CENTERS	15. 00	16. 00	17.00	22.00	24.00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 REVENUE CYCLE						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	OO591 ADMINISTRATIVE AND GENERAL OO700 OPERATION OF PLANT						5. 03
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY	1, 190, 497					15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	1, 584, 353				16. 00
17. 00	01700 SOCI AL SERVI CE	0	0				17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV I NPATIENT ROUTINE SERVICE COST CENTERS	0	0) <u> </u>	263, 062		22. 00
30. 00	03000 ADULTS & PEDIATRICS		302, 726	747, 589	263, 062	20, 678, 854	30.00
33. 00	03300 BURN INTENSIVE CARE UNIT		302, 720) 747,307		l	33.00
40. 00	04000 SUBPROVI DER - I PF	o	0	1			40. 00
44.00	04400 SKILLED NURSING FACILITY	O	0) c	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	1, 583				
51.00	05100 RECOVERY ROOM	0	0				51.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C		27 385, 043	1		787, 870 5, 537, 968	1
54. 01	03630 ULTRA SOUND		000,010	1	_	0,007,700	54. 01
56.00	05600 RADI OI SOTOPE	o	O	ol c	0	0	56. 00
57.00	05700 CT SCAN	O	0) c	0	0	57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	391	1		687, 481	59. 00
60.00	06000 LABORATORY	0	308, 270			5, 993, 477	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	2, 595			165, 242	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	57, 815 4, 260			1, 877, 119 990, 864	1
67. 00	06700 OCCUPATI ONAL THERAPY		3, 098			406, 342	1
68. 00	06800 SPEECH PATHOLOGY	o	440			146, 160	1
69. 00	06900 ELECTROCARDI OLOGY	o	17, 274	· c	0	301, 082	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 332	. c	0	66, 312	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	422			34, 190	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 190, 497	175, 568		_	3, 443, 274	l .
74. 00 76. 00	07400 RENAL DIALYSIS 03950 MISC ANCILLARY	0	892 0	1		267, 274 0	74. 00 76. 00
	03951 SLEEP LAB		0			0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		Ö		o o	l e	
	03952 WOUND CARE	o	663	1			
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	2, 956	1			1
	09100 EMERGENCY	0	314, 998	S C	0	6, 966, 700	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
118.00		1, 190, 497	1, 584, 353	747, 589	263, 062	49, 945, 448	118. 00
	NONREI MBURSABLE COST CENTERS	., 170, 177	., 55 1, 555	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	200, 002	1, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O	1			
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	1			
	07950 MEALS ON WHEELS	0	0	0	0	574, 957	194. 00 200. 00
200. 00 201. 00	1 1		0				200.00
201.00		1, 190, 497	1, 584, 353	747, 589	263, 062	l	
50	, , , , , , , , , , , , , , , , , , ,		, ,	, 50 /			

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0047 Peri od: Worksheet B From 06/01/2020 Part I Date/Time Prepared: 05/31/2021 10/29/2021 5:12 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00590 REVENUE CYCLE 5.01 5. 01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00591 ADMINISTRATIVE AND GENERAL 5.03 5.03 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 01000 DI ETARY 10.00 10.00 11. 00 01100 CAFETERIA 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS -263, 062 20, 415, 792 30.00 03300 BURN INTENSIVE CARE UNIT 33 00 33 00 Ω 40.00 04000 SUBPROVIDER - IPF 0 0 40.00 04400 SKILLED NURSING FACILITY 0 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 331, 699 50 00 05100 RECOVERY ROOM 51.00 0 51.00 05300 ANESTHESI OLOGY 787, 870 53.00 00000000000000000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 5, 537, 968 54.00 03630 ULTRA SOUND 54.01 0 54.01 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 57.00 57.00 59.00 05900 CARDIAC CATHETERIZATION 687.481 59.00 06000 LABORATORY 5, 993, 477 60 00 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 165, 242 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 1, 877, 119 65.00 06600 PHYSI CAL THERAPY 990, 864 66.00 66.00 06700 OCCUPATI ONAL THERAPY 406, 342 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 146, 160 68.00 69.00 06900 ELECTROCARDI OLOGY 301, 082 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 66, 312 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 34, 190 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 443, 274 73.00 07400 RENAL DIALYSIS 74.00 267, 274 74.00 03950 MISC ANCILLARY 76.00 C 76.00 76.01 03951 SLEEP LAB 76.01 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES Ω 76.02 76.02 997<u>, 656</u> 03952 WOUND CARE 0 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 265, 884 90.00 0 91.00 09100 EMERGENCY 91.00 6, 966, 700 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 -263, 062 49, 682, 386 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 113, 308 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 530, 776 192. 00 194.00 07950 MEALS ON WHEELS 0 574, 957 194.00 Cross Foot Adjustments 200 00 0 200 00 Ω

-263, 062

50, 901, 427

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

201.00

202.00

| Period: | Worksheet B | From 06/01/2020 | Part II | To 05/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

				To	05/31/2021	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		10/29/2021 5:	12 pili
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1. 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	61, 574	60, 558	122, 132	122, 132	4. 00
5. 01	00590 REVENUE CYCLE	0	218, 411		433, 219	5, 382	5. 01
5. 02 5. 03	OO560 PURCHASING RECEIVING AND STORES OO591 ADMINISTRATIVE AND GENERAL	0	151, 696 118, 019		300, 890 234, 092	9, 844	5. 02 5. 03
7. 00	00700 OPERATION OF PLANT	0	2, 077, 416		4, 120, 562	7, 655	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	48, 343		95, 888	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	731, 917		1, 451, 760	3, 884	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	228, 641	224, 869 0	453, 510 0	0	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	Ö	83, 768	-	166, 155	12, 096	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	1, 088	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	137, 004	0 134, 744	0 271, 748	5, 242 472	15. 00 16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	271,710	3, 121	17. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	529, 346	520, 614	1, 049, 960	39, 991	30. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	1	1, 047, 700	0	33. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	-	0	0	40. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00	05000 OPERATING ROOM	0	0	0	0	767	50. 00
51. 00	05100 RECOVERY ROOM	0	0	1	0	0	51. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 215, 058	0 211, 510	0 426, 568	0 6, 588	53. 00 54. 00
54. 00	03630 ULTRA SOUND	0	215, 038		420, 500	0, 388	54. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00 59. 00	05700 CT SCAN 05900 CARDI AC CATHETERI ZATI ON	0	0 23, 956	22 541	0 47, 517	339	57. 00 59. 00
60.00	06000 LABORATORY	0	184, 069		365, 101	7, 978	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	10, 086		20, 006	0	62. 00
65. 00	06500 RESPIRATORY THERAPY	0	74, 791		148, 349	4, 105	65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	0	97, 182 37, 200		192, 761 73, 786	685 362	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	14, 327		28, 417	104	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	13, 635		27, 045	435	69. 00
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	Ö	32, 229	-	63, 926	0	73. 00
74.00	07400 RENAL DIALYSIS	0	26, 227	25, 794	52, 021	0	74.00
76. 00 76. 01	03950 MISC ANCILLARY 03951 SLEEP LAB	0		0	0	0	76. 00 76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	Ö	ő	0	0	76. 02
76. 03	03952 WOUND CARE	0	112, 070	110, 221	222, 291	164	76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	T 0	27, 740	27, 283	55, 023	55	90. 00
	09100 EMERGENCY	0			341, 549	11, 692	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	T 0	5, 426, 900	5, 337, 376	10, 764, 276	122, 132	110 00
110.00	NONREI MBURSABLE COST CENTERS	. 0	5, 420, 900	0, 337, 370	10, 704, 270	122, 132	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 205	12, 987	26, 192		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 MEALS ON WHEELS	0	0	0	0		192. 00 194. 00
200.00			١		ol		200. 00
201.00	Negative Cost Centers		0	0	O	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	0	5, 440, 105	5, 350, 363	10, 790, 468	122, 132	202. 00

Provider CCN: 15-0047

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 06/01/2020 | Part II |
| To 05/31/2021 | Date/Time Prepared: 10/29/2021 5:12 pm

				''	03/31/2021	10/29/2021 5:	
	Cost Center Description	REVENUE CYCLE	PURCHASI NG	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	, , , , , , , , , , , , , , , , , , ,
			RECEIVING AND	AND GENERAL	PLANT	LINEN SERVICE	
			STORES				
		5. 01	5. 02	5. 03	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 REVENUE CYCLE	438, 601					5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	.00,00.	300, 973				5. 02
5. 03	00591 ADMINISTRATIVE AND GENERAL	0	10, 722				5. 03
7. 00	00700 OPERATION OF PLANT	0	1, 830				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	9, 096		71, 824	177, 983	8.00
9. 00	00900 HOUSEKEEPI NG	0	4, 237		1, 087, 424	0	9. 00
10. 00	01000 DI ETARY	0	52, 820		339, 696	0	10.00
11. 00	01100 CAFETERI A	0	0 0		337, 070	0	11.00
13. 00	01300 NURSING ADMINISTRATION	0	222		124, 456	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	20, 873		124, 430	0	14. 00
15. 00	01500 PHARMACY	0	20, 073		0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	23		203, 550	0	16.00
	01700 SOCIAL SERVICE	0			203, 330	_	17. 00
17. 00		0	15 0		0	0	•
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	U	U	1, 309	U	0	22. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	02.012	22 401	F0.4/2	70/ 450	F4 720	1 20 00
30.00	03000 ADULTS & PEDI ATRI CS	83, 812	33, 401		786, 459	54, 738	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
40.00	04000 SUBPROVI DER - I PF	0	0		0	0	40.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	100	45.00			4 004	
50.00	05000 OPERATING ROOM	438	15, 884		0	1, 204	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
53. 00	05300 ANESTHESI OLOGY	10/ 5/0	0	-,	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	106, 560	3, 318	18, 637	319, 516	27, 300	1
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	108			35, 592	129	•
60. 00	06000 LABORATORY	85, 347	65, 106		273, 474	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	719	4, 942		14, 985	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	16, 007	5, 392		111, 119	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 179	4		144, 385	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	858	0	870	55, 269	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	122	27		21, 286	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 783	159		20, 258	326	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 476	2, 803	278	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	117	0	168	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	48, 608	0	9, 356	47, 883	0	73. 00
74.00	07400 RENAL DIALYSIS	247	8	526	38, 965	0	74. 00
76.00	03950 MISC ANCILLARY	0	0	0	0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	0	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	76. 02
76.03	03952 WOUND CARE	184	63	1, 542	166, 504	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	819	40	462	41, 214	0	90. 00
91.00	09100 EMERGENCY	87, 210	38, 342	22, 743	255, 833	94, 286	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		438, 601	300, 973	254, 497	4, 159, 692	177, 983	118.00
	NONREI MBURSABLE COST CENTERS					,	
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	161	19, 618	Ω	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	Ö		17, 010		192. 00
	07950 MEALS ON WHEELS	n	0		n		194. 00
200.00		J			J		200.00
201.00		n	n	n	n	n	201. 00
202.00		438, 601	300, 973	254, 658	4, 179, 310	177, 983	
00	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	.55, 501			., ., ,, ,, ,	, .00	,

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0047

Period: Worksheet B From 06/01/2020 Part II To 05/31/2021 Date/Time Prepared:

10/29/2021 5:12 pm Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL SERVICES & ADMI NI STRATI ON **SUPPLY** 9.00 10.00 11.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00590 REVENUE CYCLE 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 5.03 00591 ADMINISTRATIVE AND GENERAL 5.03 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 2, 560, 870 9 00 01000 DI ETARY 288, 046 1, 141, 818 10.00 10.00 01100 CAFETERI A 11.00 1.343 11.00 13.00 01300 NURSING ADMINISTRATION 105, 533 115 421, 063 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 27 23, 786 14.00 01500 PHARMACY 15.00 0 51 15.00 0 0 01600 MEDICAL RECORDS & LIBRARY 16.00 172,601 C 12 3 16.00 17.00 01700 SOCIAL SERVICE 17.00 35 15, 508 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 666, 880 714, 856 595 307, 066 3, 949 30.00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 0 0 0 04000 SUBPROVI DER - I PF 0 40.00 40.00 0 0 0 0 04400 SKILLED NURSING FACILITY 44.00 0 0 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 137 1, 878 50.00 0 51.00 05100 RECOVERY ROOM 0 0 51.00 0 0 05300 ANESTHESI OLOGY 53.00 0 0 0 0 Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 270, 934 0 102 284 392 54.00 54.01 03630 ULTRA SOUND 0 0 ol 0 54.01 0 05600 RADI OI SOTOPE 0 56.00 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 57.00 05900 CARDIAC CATHETERIZATION 59.00 30, 180 0 3,742 59.00 60 00 06000 LABORATORY 231 893 148 7 699 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 12, 707 0 584 62.00 06500 RESPIRATORY THERAPY 94, 224 0 0 0 0 0 0 0 638 65.00 65.00 63 06600 PHYSI CAL THERAPY 66.00 122, 432 0 66.00 06700 OCCUPATIONAL THERAPY 46 865 67 00 3 0 67 00 2 68.00 06800 SPEECH PATHOLOGY 18,049 3 68.00 06900 ELECTROCARDI OLOGY 17, 178 19 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 331 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 72 00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 40,602 0 73.00 74.00 07400 RENAL DIALYSIS 33,041 0 0 74.00 03950 MISC ANCILLARY 76.00 0 0 76, 00 0 0 0 76.01 03951 SLEEP LAB 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 141, 187 76.03 OUTPATIENT SERVICE COST CENTERS 34, 948 90.00 09000 CLI NI C n 90.00 91.00 09100 EMERGENCY 216, 935 165 98, 068 4, 533 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 544, 235 714, 856 1, 343 421, 063 23, 786 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 16,635 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 204, 951 0 0 0 192.00 194.00 07950 MEALS ON WHEELS 0 222, 011 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 0 201.00 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) 2, 560, 870 1, 141, 818 1, 343 421, 063 23, 786 202. 00

| Peri od: | Worksheet B | From 06/01/2020 | Part | I | | Date/Time Prepared: | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

				Т	o 05/31/2021	Date/Time Pre 10/29/2021 5:	
					INTERNS &	10/2//2021 3.	12 piii
					RESI DENTS		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-OTHER	Subtotal	
			RECORDS &		PRGM COSTS		
		15. 00	16. 00	17. 00	APPRV 22. 00	24.00	
	GENERAL SERVICE COST CENTERS	10.00	10.00	17.00	22.00	21.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
1	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00590 REVENUE CYCLE 00560 PURCHASING RECEIVING AND STORES						5. 01 5. 02
	00590 PORCHASTNG RECEIVING AND STOKES			•			5. 02
	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
1	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY						10.00
1	01100 CAFETERIA 01300 NURSING ADMINISTRATION						11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY						14. 00
	01500 PHARMACY	11, 167					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	O	652, 105				16. 00
1	01700 SOCIAL SERVICE	0	0	,			17. 00
	02200 1&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1, 309		22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	124 500	21 000		2 044 574	20.00
	03300 BURN INTENSIVE CARE UNIT	0	124, 598 0	1		3, 946, 576 0	1
	04000 SUBPROVI DER - I PF	O	Ö	1		Ö	1
	04400 SKILLED NURSING FACILITY	0	0	0		0	44. 00
	ANCILLARY SERVICE COST CENTERS						
1	05000 OPERATING ROOM	0	652	1		22, 441	
	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0	0 11			0 3, 939	51. 00 53. 00
1	05300 ANESTHEST OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	158, 486			1, 338, 685	1
4	03630 ULTRA SOUND	l o	0	i		0	1
56. 00	05600 RADI OI SOTOPE	O	0	O		0	56. 00
	05700 CT SCAN	0	0	0		0	57. 00
1	05900 CARDI AC CATHETERI ZATI ON	0	161	l .		151, 814	1
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	126, 879 1, 068	l .		1, 185, 570 55, 468	
	06500 RESPI RATORY THERAPY	0	23, 796	l .		410, 356	1
1	06600 PHYSI CAL THERAPY	O	1, 753	l .		465, 146	1
	06700 OCCUPATIONAL THERAPY	O	1, 275	l .		179, 288	1
	06800 SPEECH PATHOLOGY	0	181	1		68, 477	1
	06900 ELECTROCARDI OLOGY	0	7, 110	l .		78, 305	1
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 194 174	_		7, 082 459	1
	07300 DRUGS CHARGED TO PATIENTS	11, 167	72, 261			293, 803	1
1	07400 RENAL DIALYSIS	0	367	0		125, 176	1
	03950 MISC ANCILLARY	0	0	0		0	76. 00
	03951 SLEEP LAB	0	0	1 0		0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			l	76. 02
	03952 WOUND CARE DUTPATIENT SERVICE COST CENTERS	0	273	0		532, 217	76. 03
	09000 CLINIC	0	1, 217	0		133, 784	90.00
	09100 EMERGENCY	O	129, 649	1		1, 301, 005	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
F	SPECIAL PURPOSE COST CENTERS		/50 /	0	=1	40.000.50	140.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	11, 167	652, 105	21, 809	0	10, 299, 591	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O	0		62 606	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES		Ö	l .		204, 951	1
194. 00	07950 MEALS ON WHEELS	O	0	O		222, 011	194. 00
200. 00	Cross Foot Adjustments				1, 309		200. 00
201.00	Negative Cost Centers	0	(52.425	0	1 200		201. 00
202. 00	TOTAL (sum lines 118 through 201)	11, 167	652, 105	21, 809	1, 309	10, 790, 468	J202. 00

ST JOSEPH MEDICAL CENTER

| Period: | Worksheet B | From 06/01/2020 | Part II | To 05/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

				To 05/31/2021	Date/Time Prepared:
	Cost Center Description	Intern &	Total		10/29/2021 5: 12 pm
	p	Residents Cost			
		& Post			
		Stepdown			
		Adjustments 25.00	26. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 REVENUE CYCLE				4. 00 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	00900 HOUSEKEEPI NG				9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A				10.00
13. 00	01300 NURSING ADMINISTRATION				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY				14. 00
15.00	01500 PHARMACY				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00	01700 SOCIAL SERVICE				17. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV				22. 00
30. 00	O3000 ADULTS & PEDIATRICS	O	3, 946, 576		30.00
33. 00	03300 BURN INTENSIVE CARE UNIT		0, 710, 676		33.00
40.00	04000 SUBPROVI DER - I PF	o	0		40.00
44.00	04400 SKILLED NURSING FACILITY	0	0		44. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS		22 441		50.00
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0	22, 441 0		50. 00 51. 00
53. 00	05300 ANESTHESI OLOGY		3, 939		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	1, 338, 685		54.00
54. 01	03630 ULTRA SOUND	o	0		54. 01
56.00	05600 RADI OI SOTOPE	0	0		56. 00
57. 00	05700 CT SCAN	0	151 014		57. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	151, 814 1, 185, 570		59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		55, 468		62. 00
65. 00	06500 RESPIRATORY THERAPY	O	410, 356		65. 00
66.00	06600 PHYSI CAL THERAPY	0	465, 146		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	179, 288		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	68, 477		68. 00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		78, 305 7, 082		69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		459		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	293, 803		73. 00
74.00	07400 RENAL DIALYSIS	0	125, 176		74. 00
76. 00	03950 MISC ANCILLARY	0	0		76. 00
	03951 SLEEP LAB	0	0		76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03952 WOUND CARE	0	0 532, 217		76. 02 76. 03
70.03	OUTPATIENT SERVICE COST CENTERS	<u> </u>	332, 217		76.03
90.00	09000 CLI NI C	0	133, 784		90.00
	09100 EMERGENCY	0	1, 301, 005		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)	0	10, 299, 591		110 00
1 18. UC	NONREIMBURSABLE COST CENTERS	ı U	10, 299, 591		118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	62, 606		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	204, 951		192. 00
	07950 MEALS ON WHEELS	0	222, 011		194. 00
200.00	, ,	0	1, 309		200. 00
201. 00 202. 00			0 10, 790, 468		201. 00 202. 00
202.00	TOTAL (Sum Titles The through 201)	١	10, 770, 400		_{[202} , 00

Heal th	Fi nan	cial Systems	ST JOSEPH MEDI	ICAL CENTER		In Lie	eu of Form CMS-	2552-10
		TION - STATISTICAL BASIS				Peri od:	Worksheet B-1	
						From 06/01/2020 To 05/31/2021		nared:
			_			10 03/31/2021	10/29/2021 5:	12 pm
			CAPITAL REL	ATED COSTS				
		Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	REVENUE CYCLE	PURCHASI NG	
		cost center bescription	(SQUARE FOO	(SQUARE FOO	BENEFITS	(GROSS CHAR	RECEIVING AND	
			TAGE)	TAGE)	DEPARTMENT	GES)	STORES	
			Í	ŕ	(GROSS		(COSTED	
					SALARI ES)		REQUIS.)	
	CENED	AL SERVICE COST CENTERS	1. 00	2. 00	4.00	5. 01	5. 02	
1.00		CAP REL COSTS-BLDG & FIXT	416, 929					1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP	110,727	416, 929				2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	4, 719	4, 719	15, 134, 29	7		4. 00
5. 01		REVENUE CYCLE	16, 739	16, 739	1		l e	5. 01
5. 02		PURCHASING RECEIVING AND STORES	11, 626	11, 626	•			5. 02
5. 03 7. 00		ADMINISTRATIVE AND GENERAL OPERATION OF PLANT	9, 045 159, 213	9, 045 159, 213			,	
8. 00		LAUNDRY & LINEN SERVICE	3, 705	3, 705	•	0 0	71, 038	
9. 00		HOUSEKEEPI NG	56, 094	56, 094	1	-		
10.00	01000	DI ETARY	17, 523	17, 523		0	412, 505	10.00
11. 00	1	CAFETERI A	0	C		0	ľ	
13.00		NURSI NG ADMI NI STRATI ON	6, 420	6, 420			.,	
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0		134, 76 649, 57		163, 012 0	
16. 00		MEDICAL RECORDS & LIBRARY	10, 500	10, 500	•		180	
17. 00		SOCIAL SERVICE	0	10, 000	386, 77		l	
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0	C	•	0 0		
		IENT ROUTINE SERVICE COST CENTERS			_			
30.00		ADULTS & PEDI ATRI CS	40, 569	40, 569	1 ' '			
33. 00		BURN INTENSIVE CARE UNIT	0	C	1	0		
40. 00 44. 00		SUBPROVIDER - IPF SKILLED NURSING FACILITY	0	(1	0 0		
44.00		LARY SERVICE COST CENTERS	<u> </u>		4	0 0		1 44.00
50.00		OPERATI NG ROOM	0	C	95, 10	5 160, 598	124, 047	50.00
51.00		RECOVERY ROOM	O	C		0	0	51.00
53. 00	1	ANESTHESI OLOGY	0	C		0 2, 732	l	
54.00		RADI OLOGY-DI AGNOSTI C	16, 482	16, 482	816, 41		1	1
54. 01 56. 00		ULTRA SOUND RADI OI SOTOPE	0	(0	0	
57. 00		CT SCAN	0	C		0 0	0	
59. 00		CARDI AC CATHETERI ZATI ON	1, 836	1, 836	42, 03	39, 668		
60.00		LABORATORY	14, 107	14, 107	988, 61	4 31, 274, 181	508, 417	60.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	773	773		0 263, 308	· ·	
65. 00		RESPI RATORY THERAPY	5, 732	5, 732	•			
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	7, 448 2, 851	7, 448 2, 851	•		l e	66. 00 67. 00
68. 00	1	SPEECH PATHOLOGY	1, 098	1, 098	1		i e	
69. 00	1	ELECTROCARDI OLOGY	1, 045	1, 045	1		l e	
	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	O	C	1	540, 900		
		IMPL. DEV. CHARGED TO PATIENTS	0	C	1	0 42, 778	l .	
73.00		DRUGS CHARGED TO PATIENTS	2, 470	2, 470		0 17, 811, 533		
74. 00 76. 00		RENAL DIALYSIS MISC ANCILLARY	2, 010	2, 010		90, 483	64	74. 00 76. 00
76. 01		SLEEP LAB				0 0		1
		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	C		0 0	Ō	
76. 03	03952	WOUND CARE	8, 589	8, 589	20, 29	4 67, 272	489	76. 03
		TIENT SERVICE COST CENTERS						
90.00		CLI NI C	2, 126	2, 126				
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	13, 197	13, 197	1, 448, 78	8 31, 956, 828	299, 437	91. 00 92. 00
72.00		AL PURPOSE COST CENTERS						72.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	415, 917	415, 917	15, 134, 29	7 160, 730, 630	2, 350, 464	118. 00
		MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 012	1, 012		0	l	190.00
		PHYSICIANS' PRIVATE OFFICES MEALS ON WHEELS	0	(1	0 0		192. 00 194. 00
200.00		Cross Foot Adjustments	١		1	0	0	200.00
201.00		Negative Cost Centers						201. 00
202.00	ol .	Cost to be allocated (per Wkst. B,	5, 440, 105	5, 350, 363	2, 506, 67	6 5, 909, 730	361, 663	202. 00
		Part I)	40.040007	40.000700		0.00/7/0		
203.00	1	Unit cost multiplier (Wkst. B, Part I)	13. 048037	12. 832792			l	
204.00	1	Cost to be allocated (per Wkst. B, Part II)			122, 13	2 438, 601	300, 973	204.00
205.00	,	Unit cost multiplier (Wkst. B, Part			0. 00807	0. 002729	0. 128048	205. 00
		11)						
206.00	1	NAHE adjustment amount to be allocated						206. 00
		(per Wkst. B-2)	ı l		I	I	I	I

Health Financial Systems	ST JOSEPH MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od: From 06/01/2020	Worksheet B-1		
					Date/Time Pre 10/29/2021 5:		
	CAPITAL REL	ATED COSTS					
Cost Center Description	BLDG & FIXT (SOUARE 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 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Provider CCN: 15-0047

				11	0 05/31/2021	Date/lime Pre 10/29/2021 5:	
	Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM.COST)	OPERATION OF PLANT (SQUARE FOO TAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOO TAGE)	
	Ta	5A. 03	5. 03	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00 5. 01 5. 02 5. 03 7. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 22. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 REVENUE CYCLE 00560 PURCHASING RECEIVING AND STORES 00591 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	-9, 818, 159 0 0 0 0 0 0 0 0 0	7, 998, 513 190, 756 2, 202, 413 1, 257, 671 218, 120 2, 027, 349 291, 965 953, 705 600, 040 507, 853	215, 587 3, 705 56, 094 17, 523 0 6, 420 0 0	135, 595 0 0 0 0 0 0 0	155, 788 17, 523 0 6, 420 0 10, 500	2. 00 4. 00 5. 01 5. 02 5. 03 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 22. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0 401 047	40.570	41 700	40.5/0	1 20 00
30. 00 33. 00	03000 ADULTS & PEDIATRICS 03300 BURN INTENSIVE CARE UNIT	0		40, 569 0		40, 569 0	30. 00 33. 00
40. 00	04000 SUBPROVI DER - I PF	Ö		0	_	ő	40.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	1 0	240, 094	0	917	0	50.00
50.00			240, 094	0	917		51.00
53. 00	05300 ANESTHESI OLOGY	0	636, 661	0	0	0	53. 00
54.00	1 1	0	3, 025, 904	16, 482	20, 798		54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56. 00 57. 00	05600 RADI 0I SOTOPE 05700 CT SCAN	0	0	0	0		56. 00 57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	388, 614	1, 836	98		59.00
60.00	06000 LABORATORY	0	3, 563, 069		0	14, 107	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	74, 223				62. 00
65. 00	+ I	0	1, 081, 811	5, 732		5, 732	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	315, 021 141, 180	7, 448 2, 851	0	7, 448 2, 851	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	46, 431	1, 098	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	160, 061	1, 045	248	1	1
71. 00	l l	0	45, 150		0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	27, 288 1, 519, 050		0	0 2, 470	72. 00 73. 00
74.00	1	0	85, 413			2, 470	74.00
76. 00	1 1	0	0	0	0	0	76. 00
76. 01		0	1	0	0	0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	ı	0 8, 589	0	0	76. 02
70.03	03952 WOUND CARE OUTPATIENT SERVICE COST CENTERS	0	250, 428	0, 309	U	8, 589	76. 03
90.00		0	74, 937	2, 126	0	2, 126	90.00
91. 00		0	3, 692, 590	13, 197	71, 832	13, 197	
92. 00							92.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	-9, 818, 159	41, 320, 138	214, 575	135, 595	154, 776	118 00
110.00	NONREI MBURSABLE COST CENTERS	7,010,107	11,020,100	211,070	100,070	101,770	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26, 192	1, 012	0		190. 00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
200. 00	DO7950 MEALS ON WHEELS Cross Foot Adjustments	0	0	0	U	U	194. 00 200. 00
201.00	1 1						201.00
202.00			9, 818, 159	9, 897, 848	406, 154	5, 300, 740	202. 00
	Part I)			45 044454	0.005044	0.4.00=0.40	
203. 00 204. 00			0. 237461 254, 658	45. 911154 4, 179, 310		l	
204.00	Part II)		254, 056	4, 179, 310	177, 903	2, 300, 670	204.00
205.00	1 1 7		0. 006159	19. 385724	1. 312607	16. 438172	205. 00
20/ 5	NAUE adjustment amount to be all control						20/ 22
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00							207. 00
	Parts III and IV)						

Heal th	Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST A	ILLOCATION - STATISTICAL BASIS		Provi der C		eriod: rom 06/01/2020 o 05/31/2021	Worksheet B-1 Date/Time Pre 10/29/2021 5:	pared:
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (GROSS	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	12 piii
				SALARI ES)	REQUIS.)		
	GENERAL SERVICE COST CENTERS	10.00	11. 00	13. 00	14. 00	15. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 01	OO4OO						4. 00 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
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	77, 105					10.00
11.00	01100 CAFETERI A	0	15, 190	1			11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY		1, 29 <i>6</i> 302		1, 571, 059		13. 00 14. 00
15. 00	01500 PHARMACY	O	581		0	892, 281	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	138	1	180	0	1
17. 00 22. 00	O1700 SOCIAL SERVICE O2200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	392 (1	120 0	0	
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u>, </u>	<u> </u>	0	22.00
30. 00	03000 ADULTS & PEDIATRICS	48, 273	6, 740	3, 465, 189	260, 851	0	
33. 00 40. 00	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	(1	0	0	
44. 00	04400 SKILLED NURSING FACILITY	0	C		0	0	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	18	1	124, 047	0	
51. 00 53. 00	O5100 RECOVERY ROOM O5300 ANESTHESI OLOGY		(0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	1, 158	3, 200	25, 916	0	54. 00
54. 01	03630 ULTRA SOUND	0	C	0	0	0	54. 01
56. 00 57. 00	05600	0	(0	0	0	56. 00 57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	82		247, 144	0	59.00
60.00	06000 LABORATORY	0	1, 673		508, 417	0	60.00
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY	0	708	1	38, 597 42, 109	0	
66. 00	06600 PHYSI CAL THERAPY	0	700	1	42, 109	0	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	36		0	0	67. 00
68. 00	O6800 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY	0	25		208	0	
69. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	66		1, 242 21, 893	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	892, 281	
74. 00 76. 00	07400 RENAL DIALYSIS 03950 MISC ANCILLARY	0	(64	0	
76. 01	03951 SLEEP LAB	0	C	o o	Ö	0	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	
76. 03	03952 WOUND CARE OUTPATIENT SERVICE COST CENTERS	0	23	8 0	489	0	76. 03
90. 00	09000 CLINIC	0	10	0	314	0	90.00
91. 00	09100 EMERGENCY	0	1, 863	1, 106, 680	299, 437	0	
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
118. 00		48, 273	15, 190	4, 751, 618	1, 571, 059	892, 281	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	13, 840	C	0	0		192. 00
200.00	07950 MEALS ON WHEELS Cross Foot Adjustments	14, 992	C) 0	U	0	194. 00 200. 00
201.00	, ,						201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 957, 046	269, 915	3, 044, 987	366, 661	1, 190, 497	
203. 00 204. 00	Cost to be allocated (per Wkst. B,	38. 350898 1, 141, 818	17. 76925 <i>6</i> 1, 343		0. 233385 23, 786	1. 334218 11, 167	203. 00 204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part 	14. 808612	0. 088413	0. 088615	0. 015140	0. 012515	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00							207. 00

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

					T		Date/Time Prep 10/29/2021 5:1	
					INTERNS &	_	10/2//2021 0.	Z piii
					RESI DENTS			
		Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-OTHER			
			RECORDS & LI BRARY	(TOTAL PATIENT	PRGM COSTS APPRV			
			(GROSS CHAR	DAYS)	(ROTATIONS)			
			GES)	ŕ	, ,			
	CENED	AL CEDIU CE COCT CENTERC	16. 00	17. 00	22. 00			
		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1. 00
	1	CAP REL COSTS-MVBLE EQUIP						2. 00
	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
		REVENUE CYCLE						5. 01
		PURCHASING RECEIVING AND STORES						5. 02
		ADMINISTRATIVE AND GENERAL OPERATION OF PLANT						5. 03 7. 00
	1	LAUNDRY & LINEN SERVICE						8. 00
9.00		HOUSEKEEPI NG						9. 00
10.00	1	DIETARY						10.00
	1	CAFETERIA NURSING ADMINISTRATION						11. 00 13. 00
		CENTRAL SERVICES & SUPPLY						14. 00
		PHARMACY						15. 00
		MEDICAL RECORDS & LIBRARY	160, 730, 630					16. 00
	1	SOCIAL SERVICE	0	9, 766				17. 00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRV I ENT ROUTINE SERVICE COST CENTERS	0	0	100			22. 00
30. 00		ADULTS & PEDIATRICS	30, 711, 755	9, 766	100			30. 00
		BURN INTENSIVE CARE UNIT	0	0				33.00
		SUBPROVI DER - I PF	0	0				40.00
		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0	0			44. 00
		OPERATING ROOM	160, 598	0	0			50. 00
		RECOVERY ROOM	0	0	0			51.00
	1	ANESTHESI OLOGY	2, 732		_			53.00
54.00	1	RADI OLOGY-DI AGNOSTI C ULTRA SOUND	39, 059, 699	0	0			54.00
	1	RADI OI SOTOPE	0					54. 01 56. 00
57. 00		CT SCAN	Ö	Ö	Ö			57. 00
	1	CARDI AC CATHETERI ZATI ON	39, 668	0	0			59. 00
60.00	1	LABORATORY	31, 274, 181	0	0			60.00
62. 00 65. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL RESPIRATORY THERAPY	263, 308 5, 865, 404		0			62. 00 65. 00
66. 00		PHYSI CAL THERAPY	432, 178		0			66. 00
		OCCUPATIONAL THERAPY	314, 290	0	0			67.00
	1	SPEECH PATHOLOGY	44, 599	0	0			68. 00
		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	1, 752, 492 540, 900	0	0			69. 00 71. 00
		IMPL. DEV. CHARGED TO PATIENTS	42, 778		0			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17, 811, 533		0			73. 00
		RENAL DIALYSIS	90, 483	l e	0			74. 00
		MISC ANCILLARY SLEEP LAB	0	0				76. 00
		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0					76. 01 76. 02
		WOUND CARE	67, 272	1				76. 03
		TIENT SERVICE COST CENTERS		,				
	1	CLINIC	299, 932					90.00
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	31, 956, 828	0	0			91. 00 92. 00
72.00		AL PURPOSE COST CENTERS						72.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	160, 730, 630	9, 766	100			118. 00
400.00		IMBURSABLE COST CENTERS	_					400 00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0	0			190. 00 192. 00
	1	MEALS ON WHEELS	0		0			194. 00
200.00		Cross Foot Adjustments						200. 00
201.00	1	Negative Cost Centers						201. 00
202. 00		Cost to be allocated (per Wkst. B, Part I)	1, 584, 353	747, 589	263, 062			202. 00
203. 00		Unit cost multiplier (Wkst. B, Part I)	0. 009857	76. 550174	2, 630. 620000			203. 00
204. 00		Cost to be allocated (per Wkst. B,	652, 105					204. 00
205 62		Part II)	0.004055	2 222451	10 000000			205 22
205. 00		Unit cost multiplier (Wkst. B, Part	0. 004057	2. 233156	13. 090000			205. 00
206.00		NAHE adjustment amount to be allocated					ļ	206. 00
		(per Wkst. B-2)						

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od: From 06/01/2020	Worksheet B-1	
				To 05/31/2021	Date/Time Pre 10/29/2021 5:	
			INTERNS &			
			RESI DENTS			
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-OTHE	R		
	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)						

Health Financial Systems	ST JOSEPH MEDICAL CENTER		In Lieu	of Form CMS-2	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN		om 06/01/2020 05/31/2021	Worksheet C Part I Date/Time Prep 10/29/2021 5:1	
	Title	XVIII	Hospi tal	PPS	

					To 05/31/2021	Date/Time Pre 10/29/2021 5:	pared: 12 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00	03000 ADULTS & PEDIATRICS	20, 415, 792		20, 415, 79	2 0	,,	
33. 00	03300 BURN INTENSIVE CARE UNIT	0			0	0	
40. 00	04000 SUBPROVI DER - I PF	0			0	0	
44. 00	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	T			. [
50. 00	05000 OPERATING ROOM	331, 699		331, 69		00.,0,,	
51. 00	05100 RECOVERY ROOM	0			0	0	
53. 00	05300 ANESTHESI OLOGY	787, 870		787, 87		787, 870	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 537, 968		5, 537, 96	8 0	5, 537, 968	
54. 01	03630 ULTRA SOUND	0			0	0	1
56. 00	05600 RADI OI SOTOPE	0			0	0	56. 00
57. 00	05700 CT SCAN	0			0	0	57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	687, 481		687, 48		687, 481	
60.00	06000 LABORATORY	5, 993, 477		5, 993, 47		5, 993, 477	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	165, 242		165, 24		165, 242	
65. 00	06500 RESPI RATORY THERAPY	1, 877, 119	0	.,		1, 877, 119	
66. 00	06600 PHYSI CAL THERAPY	990, 864	0	990, 86		990, 864	
67. 00	06700 OCCUPATI ONAL THERAPY	406, 342	0	406, 34		406, 342	
68. 00	06800 SPEECH PATHOLOGY	146, 160	0	146, 16		146, 160	
69. 00	06900 ELECTROCARDI OLOGY	301, 082		301, 08		301, 082	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 312		66, 31		66, 312	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	34, 190		34, 19		34, 190	
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 443, 274		3, 443, 27		3, 443, 274	1
74. 00	07400 RENAL DI ALYSI S	267, 274		267, 27	4 0	267, 274	
76. 00	03950 MISC ANCILLARY	0			0	0	
76. 01	03951 SLEEP LAB	0			0	0	1
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0	0	1 , 0. 02
76. 03	03952 WOUND CARE	997, 656		997, 65	6 0	997, 656	76. 03
	OUTPATIENT SERVICE COST CENTERS				+		
90. 00	09000 CLI NI C	265, 884		265, 88			
91. 00	09100 EMERGENCY	6, 966, 700		6, 966, 70		0,,00,,00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	990, 557		990, 55		990, 557	
200.00		50, 672, 943	0	,,			
201.00	1	990, 557		990, 55		990, 557	
202.00	Total (see instructions)	49, 682, 386	0	49, 682, 38	6 0	49, 682, 386	202. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0047	Peri od: Worksheet C		

COMPUTA	ATTON OF RATTO OF COSTS TO CHARGES		Provider C	1	From 06/01/2020 To 05/31/2021	Part I Date/Time Pre 10/29/2021 5:	
		_		e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6. 00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	28, 998, 295		28, 998, 29	5		30. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0			c	 -	33. 00
40. 00	04000 SUBPROVI DER - I PF	0			c	 -	40.00
44. 00	04400 SKILLED NURSING FACILITY	0			C		44. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	113, 736	46, 862	160, 59		0.000000	
51. 00	05100 RECOVERY ROOM	0	0		0.000000	0.000000	51. 00
53.00	05300 ANESTHESI OLOGY	2, 732	0	2, 73	2 288. 385798	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 589, 883	33, 469, 816	39, 059, 69	9 0. 141782	0.000000	54. 00
54. 01	03630 ULTRA SOUND	0	0		0.000000	0.000000	54. 01
	05600 RADI 0I SOTOPE	0	0		0.000000	0.000000	56. 00
57. 00	05700 CT SCAN	0	0		0.000000	0.000000	57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 942	35, 726	39, 66	17. 330871	0.000000	59. 00
60. 00	06000 LABORATORY	8, 685, 259	22, 588, 922	31, 274, 18	0. 191643	0.000000	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	137, 614	125, 694	263, 30	0. 627562	0.000000	62. 00
65. 00	06500 RESPI RATORY THERAPY	5, 052, 369	813, 035	5, 865, 40	4 0. 320032	0.000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	397, 375	34, 803	432, 17		0.000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	288, 348	25, 942	314, 29	1. 292889	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	44, 599	0	44, 59	9 3. 277204	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	419, 565	1, 332, 927	1, 752, 49	0. 171802	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	505, 789	35, 111	540, 90	0. 122596	0.000000	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	42, 778	0	42, 77	0. 799243	0.000000	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	12, 019, 964	5, 791, 569	17, 811, 53	0. 193317	0.000000	73. 00
74. 00	07400 RENAL DIALYSIS	84, 528	5, 955	90, 48	2. 953859	0.000000	74. 00
76. 00	03950 MISC ANCILLARY	0	0)	0.000000	0.000000	76. 00
76. 01	03951 SLEEP LAB	0	0)	0.000000	0.000000	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	0	1	0. 000000	0.000000	76. 02
76. 03	03952 WOUND CARE	405	66, 867	67, 27	14. 830182	0.000000	76. 03
Ī	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	28, 038	271, 894	299, 93	0. 886481	0.000000	90. 00
91.00	09100 EMERGENCY	4, 177, 979	27, 778, 849	31, 956, 82	0. 218003	0.000000	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	548, 759	1, 164, 701	1, 713, 46	0. 578103	0.000000	92. 00
200.00		67, 141, 957	93, 588, 673				200.00
201.00	Less Observation Beds						201.00
202. 00	l e e e e e e e e e e e e e e e e e e e	67, 141, 957	93, 588, 673	160, 730, 63	ol l		202. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER			In Lieu of Form CMS-2552-1		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CC	N: 15-0047	From 06/01/2020	Worksheet C Part I Date/Time Prepared:	

10/29/2021 5: 12 pm Title XVIII Hospital PPS Title XVIII Title XVIII Hospital PPS Title XVIII Hospital PPS Title XVIII Hospital PPS Title XVIII Hospital PPS Title XVIII Hospital PPS Title XVIII Title XVIII Hospital PPS Title XVIII Title XVIII Hospital PPS Title XVIII Title XVIII Hospital PPS Title XVIII Title XVIII Hospital PPS Title XVIII Title XVIII Hospital PPS Title XVIII Title XVIII Hospital PPS Title XVIII Title XVIII Title XVIII Title XVIII Title XVIII Title XVIII Title XVIII Title XVIII Hospital PPS Title XVIII
Ratio 11.00
11.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00
30. 00 03000 ADULTS & PEDIATRICS 30. 00 33. 00 03300 BURN INTENSIVE CARE UNIT 33. 00
33.00 03300 BURN INTENSIVE CARE UNIT
40. 00 04000 SUBPROVI DER - I PF 40. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY 44. 00
ANCILLARY SERVICE COST CENTERS
50. 00 05000 OPERATI NG ROOM 2. 065399 50. 00
51. 00 05100 RECOVERY ROOM 0. 000000 51. 00
53. 00 05300 ANESTHESI OLOGY 288. 385798 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 141782 54. 00
54. 01 03630 ULTRA SOUND 0. 000000 54. 01
56. 00 05600 RADI 0I SOTOPE 0. 000000 56. 00
57. 00 05700 CT SCAN 0. 000000 57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 17. 330871 59. 00
60. 00 06000 LABORATORY
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 627562 62. 00
65. 00 06500 RESPI RATORY THERAPY
66. 00 06600 PHYSI CAL THERAPY 2. 292722 66. 00
67. 00 06700 0CCUPATI ONAL THERAPY
68. 00 06800 SPEECH PATHOLOGY 3. 277204 68. 00
69. 00 06900 ELECTROCARDI OLOGY
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 122596 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 799243 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 193317 73. 00
74. 00 07400 RENAL DI ALYSI S 2. 953859 74. 00
76. 00 03950 MI SC ANCI LLARY 0. 000000 76. 00
76. 01 03951 SLEEP LAB
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 76. 02
76. 03 03952 WOUND CARE 14. 830182 76. 03
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C 0. 886481 90. 00
91. 00 09100 EMERGENCY
92. 00 09200 085ERVATI ON BEDS (NON-DI STI NCT PART
200.00 Subtotal (see instructions)
201. 00 Less Observation Beds
202.00 Total (see instructions)

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0047	Period: Worksheet C From 06/01/2020 Part I To 05/31/2021 Date/Time Prepared: 10/29/2021 5:12 pm		

					To 05/31/2021	Date/Time Pre 10/29/2021 5:	
-			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	F	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	.,				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	20, 415, 792		20, 415, 79	92 0	20, 415, 792	30. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0			0 0	0	33. 00
40.00	04000 SUBPROVI DER - I PF	0			0 0	0	40. 00
44.00	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	331, 699		331, 69	99 0	331, 699	50. 00
51.00	05100 RECOVERY ROOM	0			0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	787, 870		787, 87	70 0	787, 870	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 537, 968		5, 537, 90	58 0	5, 537, 968	54.00
54. 01	03630 ULTRA SOUND	0			0 0	0	54. 01
56.00	05600 RADI OI SOTOPE	0			0 0	0	56. 00
57.00	05700 CT SCAN	0			0 0	0	57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	687, 481		687, 48	31 0	687, 481	59. 00
60.00	06000 LABORATORY	5, 993, 477		5, 993, 47	77 0	5, 993, 477	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	165, 242		165, 24	12 0	165, 242	62. 00
65.00	06500 RESPI RATORY THERAPY	1, 877, 119	0	1, 877, 1°	19 0	1, 877, 119	65. 00
66.00	06600 PHYSI CAL THERAPY	990, 864	0	990, 80	64 0	990, 864	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	406, 342	0	406, 34	12 0	406, 342	67. 00
68.00	06800 SPEECH PATHOLOGY	146, 160	0	146, 16	50 0	146, 160	68. 00
69.00	06900 ELECTROCARDI OLOGY	301, 082		301, 08	32 0	301, 082	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 312		66, 3	12 0	66, 312	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	34, 190		34, 19	90 0	34, 190	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 443, 274		3, 443, 2	74 0	3, 443, 274	73. 00
74.00	07400 RENAL DIALYSIS	267, 274		267, 27	74 0	267, 274	74. 00
76.00	03950 MISC ANCILLARY	0			0 0	0	76. 00
76. 01	03951 SLEEP LAB	0			0 0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0 0	0	76. 02
76. 03	03952 WOUND CARE	997, 656		997, 65	56 0	997, 656	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00		265, 884		265, 88	34 0	265, 884	90. 00
91.00		6, 966, 700		6, 966, 70	00	6, 966, 700	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	990, 557		990, 5	57	990, 557	92.00
200.00		50, 672, 943	0	,,-		50, 672, 943	
201.00		990, 557		990, 5		990, 557	
202.00	Total (see instructions)	49, 682, 386	0	49, 682, 38	36 0	49, 682, 386	202. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0047	Peri od: Worksheet C		

					From 06/01/2020 To 05/31/2021	Part I Date/Time Pre 10/29/2021 5:	pared: 12 pm
		_		e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		6.00	7. 00	8.00	9.00	Rati o 10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
	03000 ADULTS & PEDIATRICS	28, 998, 295		28, 998, 29!	5		30.00
	03300 BURN INTENSIVE CARE UNIT	20, 770, 270		20, 770, 270			33. 00
	04000 SUBPROVI DER - I PF	0					40.00
	04400 SKILLED NURSING FACILITY	0					44. 00
	ANCILLARY SERVICE COST CENTERS	-,			-1		
	05000 OPERATING ROOM	113, 736	46, 862	160, 598	2. 065399	0.000000	50. 00
51.00	05100 RECOVERY ROOM	0	0		0. 000000	0.000000	51. 00
53.00	05300 ANESTHESI OLOGY	2, 732	0	2, 732	288. 385798	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 589, 883	33, 469, 816	39, 059, 699	0. 141782	0.000000	54.00
54. 01	03630 ULTRA SOUND	0	0	(0. 000000	0.000000	54. 01
	05600 RADI OI SOTOPE	0	0	(0.000000	56. 00
	05700 CT SCAN	0	0	(0.00000	0.000000	
	05900 CARDI AC CATHETERI ZATI ON	3, 942	35, 726			0.000000	59. 00
	06000 LABORATORY	8, 685, 259	22, 588, 922			0. 000000	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	137, 614	125, 694			0. 000000	62. 00
	06500 RESPI RATORY THERAPY	5, 052, 369	813, 035			0. 000000	1
	06600 PHYSI CAL THERAPY	397, 375	34, 803			0. 000000	66. 00
	06700 OCCUPATI ONAL THERAPY	288, 348	25, 942			0. 000000	67. 00
	06800 SPEECH PATHOLOGY	44, 599	0	,		0. 000000	
	06900 ELECTROCARDI OLOGY	419, 565	1, 332, 927			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	505, 789	35, 111			0. 000000	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	42, 778	0			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	12, 019, 964	5, 791, 569			0. 000000	
	07400 RENAL DI ALYSI S	84, 528	5, 955			0. 000000	74.00
	03950 MISC ANCILLARY	0	0	9	0.00000	0.000000	1
	03951 SLEEP LAB	0	0	9	0.00000	0.000000	1
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	105	0	(7.07	0.00000	0.000000	76. 02
	03952 WOUND_CARE DUTPATLENT_SERVICE_COST_CENTERS	405	66, 867	67, 272	14. 830182	0. 000000	76. 03
	09000 CLINIC	28, 038	271, 894	299, 932	0. 886481	0. 000000	90.00
	09100 EMERGENCY	4, 177, 979	271, 894				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	548, 759	1, 164, 701				
200.00	Subtotal (see instructions)	67, 141, 957	93, 588, 673				200.00
201.00	Less Observation Beds	07, 141, 737	75, 555, 675	100, 750, 050	1		201.00
202. 00	Total (see instructions)	67, 141, 957	93, 588, 673	160, 730, 630			202.00
	1 (2.7	, , 0 , 0		1	!	

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0047	From 06/01/2020 To 05/31/2021	Worksheet C Part I Date/Time Prepared:	

				10 05/31/2021	10/29/2021 5:12 pm
			Title XIX	Hospi tal	PPS
Cost	Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	ROUTINE SERVICE COST CENTERS				
	TS & PEDIATRICS				30.00
	INTENSIVE CARE UNIT				33.00
	ROVIDER - IPF				40.00
	LED NURSING FACILITY				44. 00
	SERVICE COST CENTERS				
50. 00 05000 OPER		2. 065399			50. 00
51. 00 05100 RECO		0. 000000			51. 00
53. 00 05300 ANES		288. 385798			53. 00
	OLOGY-DI AGNOSTI C	0. 141782			54. 00
54. 01 03630 ULTR		0. 000000			54. 01
56. 00 05600 RADI		0. 000000			56. 00
57. 00 05700 CT S		0. 000000			57. 00
	IAC CATHETERIZATION	17. 330871			59. 00
60. 00 06000 LAB0		0. 191643			60.00
	E BLOOD & PACKED RED BLOOD CELL	0. 627562			62. 00
	I RATORY THERAPY	0. 320032			65. 00
	I CAL THERAPY	2. 292722			66. 00
	PATI ONAL THERAPY	1. 292889			67. 00
1 1	CH PATHOLOGY	3. 277204			68. 00
	TROCARDI OLOGY	0. 171802			69. 00
1 1	CAL SUPPLIES CHARGED TO PATIENT	0. 122596			71. 00
	. DEV. CHARGED TO PATIENTS	0. 799243			72. 00
	S CHARGED TO PATIENTS	0. 193317			73. 00
74. 00 07400 RENA		2. 953859			74.00
76. 00 03950 MI SC		0. 000000			76. 00
76. 01 03951 SLEE		0. 000000			76. 01
	HI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 02
76. 03 03952 WOUN		14. 830182			76. 03
	SERVICE COST CENTERS				
90. 00 09000 CLI N		0. 886481			90.00
91. 00 09100 EMER		0. 218003			91. 00
	RVATION BEDS (NON-DISTINCT PART	0. 578103			92. 00
	otal (see instructions)				200. 00
	Observation Beds				201. 00
202. 00 Tota	I (see instructions)				202. 00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE CO	ST TO CHARGE RATIOS NET OF	Provider CCN: 15-0047	Peri od:	Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 06/01/2020	

REDUCT	IONS FOR MEDICAID ONLY				rom 06/01/2020		nanad.
					o 05/31/2021	Date/Time Pre 10/29/2021 5:	pared: 12 nm
			Ti tl	e XIX	Hospi tal	PPS	12 piii
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
		(Wkst. B, Part			Reduction	Reduction	
		I, col. 26)		Cost (col. 1 -		Amount	
			Í	col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	<u> </u>					
50.00	05000 OPERATING ROOM	331, 699	22, 441	309, 258	C	0	50.00
51.00	05100 RECOVERY ROOM	o	0	C	C	0	51.00
53.00	05300 ANESTHESI OLOGY	787, 870	3, 939	783, 931	C	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 537, 968	1, 338, 685	4, 199, 283	C	0	54.00
54. 01	03630 ULTRA SOUND	o	0	C	C	0	54. 01
56.00	05600 RADI 0I SOTOPE	o	0	C	C	0	56.00
57.00	05700 CT SCAN	o	0	l c	C	0	57. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	687, 481	151, 814	535, 667	C	0	59. 00
60.00	06000 LABORATORY	5, 993, 477	1, 185, 570	4, 807, 907	C	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	165, 242	55, 468	109, 774		0	62. 00
65.00	06500 RESPI RATORY THERAPY	1, 877, 119	410, 356	1, 466, 763	C	0	65. 00
66.00	06600 PHYSI CAL THERAPY	990, 864	465, 146	525, 718	C	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	406, 342	179, 288	227, 054	. C	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	146, 160	68, 477	77, 683	C	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	301, 082	78, 305	222, 777	C	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 312	7, 082	59, 230	C	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	34, 190	459	33, 731	C	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 443, 274	293, 803	3, 149, 471	C	0	73. 00
74.00	07400 RENAL DIALYSIS	267, 274	125, 176	142, 098	C	0	74. 00
76.00	03950 MISC ANCILLARY	o	0	C	C	0	76. 00
76. 01	03951 SLEEP LAB	o	0	l c	C	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	0	l c	C	0	76. 02
76. 03	03952 WOUND CARE	997, 656	532, 217	465, 439	C	0	76. 03
	OUTPATIENT SERVICE COST CENTERS					•	
90.00	09000 CLI NI C	265, 884	133, 784	132, 100	C	0	90.00
91.00	09100 EMERGENCY	6, 966, 700	1, 301, 005	5, 665, 695	C	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	990, 557	191, 485	799, 072	. C	0	92. 00
200.00	Subtotal (sum of lines 50 thru 199)	30, 257, 151	6, 544, 500	23, 712, 651	C	0	200. 00
201.00	Less Observation Beds	990, 557	191, 485	799, 072	. C	0	201. 00
202.00	Total (line 200 minus line 201)	29, 266, 594	6, 353, 015	22, 913, 579	c c	0	202. 00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 15-0047	From 06/01/2020	Worksheet C Part II Date/Time Prepared:

					10 00/01/2021	10/29/2021 5:	12 pm
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
			(Worksheet C,				
		Operating Cost		Ratio (col. 6			
		Reduction	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	331, 699	160, 598				50. 00
	05100 RECOVERY ROOM	0	0				51. 00
53. 00	05300 ANESTHESI OLOGY	787, 870	2, 732	•			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 537, 968	39, 059, 699	0. 14178:	2		54.00
54. 01	03630 ULTRA SOUND	0	0	0. 000000	O		54. 01
56. 00	05600 RADI 0I SOTOPE	0	0	0.00000	O		56. 00
57. 00	05700 CT SCAN	0	0	0.00000	O		57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	687, 481	39, 668	17. 33087	1		59. 00
60.00	06000 LABORATORY	5, 993, 477	31, 274, 181	0. 19164:	3		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	165, 242	263, 308	0. 62756	2		62. 00
65.00	06500 RESPI RATORY THERAPY	1, 877, 119	5, 865, 404	0. 32003:	2		65. 00
66.00	06600 PHYSI CAL THERAPY	990, 864	432, 178	2. 29272	2		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	406, 342	314, 290	1. 29288	9		67. 00
68. 00	06800 SPEECH PATHOLOGY	146, 160	44, 599	3. 27720	4		68. 00
69. 00	06900 ELECTROCARDI OLOGY	301, 082	1, 752, 492	0. 17180:	2		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 312	540, 900	0. 12259	5		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	34, 190	42, 778	0. 79924	3		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 443, 274	17, 811, 533	0. 19331	7		73. 00
74.00	07400 RENAL DIALYSIS	267, 274	90, 483	2. 95385	9		74.00
76. 00	03950 MISC ANCILLARY	0	0	0. 00000	O		76. 00
76. 01	03951 SLEEP LAB	0	0	0.00000	o l		76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.00000	o l		76. 02
76. 03	03952 WOUND CARE	997, 656	67, 272	14. 83018	2		76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	265, 884	299, 932	0. 88648	1		90. 00
91.00	09100 EMERGENCY	6, 966, 700	31, 956, 828	0. 21800	3		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	990, 557	1, 713, 460	0. 57810	3		92.00
200.00	Subtotal (sum of lines 50 thru 199)	30, 257, 151	131, 732, 335				200. 00
201.00		990, 557	0				201. 00
202.00	Total (line 200 minus line 201)	29, 266, 594	131, 732, 335				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	Provi der Co		Period: From 06/01/2020 To 05/31/2021	Date/Time Pre	
		Title	xVIII	Hospi tal	10/29/2021 5: PPS	12 pm
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Total Patient Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	3, 946, 576	0	3, 946, 57	6 10, 264		30.00
33.00 BURN INTENSIVE CARE UNIT	0			0	0.00	
40. 00 SUBPROVI DER - I PF	0	0		0	0.00	
44.00 SKILLED NURSING FACILITY	0			0	0.00	
200.00 Total (lines 30 through 199)	3, 946, 576		3, 946, 57	6 10, 264		200. 00
Cost Center Description	Inpatient Program days	Inpatient Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
LABORT SAIT DOUTLAND OFFICE ORDER OFFICE	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	4 055	F04 044				00.00
30. 00 ADULTS & PEDI ATRI CS	1, 355	521, 011				30.00
33. 00 BURN INTENSIVE CARE UNIT	0					33.00
40. 00 SUBPROVIDER - I PF	0		1			40.00
44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	1, 355	521, 011	1			44. 00 200. 00
200. 00 Total (Tries 30 till ough 199)	1, 355	521,011	I			J200. 00

Heal th	Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10						
	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Period: From 06/01/2020 To 05/31/2021	Worksheet D Part II Date/Time Pre 10/29/2021 5:	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.		to Charges	Program	Capital Costs (column 3 x column 4)	
		26)		,			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS				-		
50.00	05000 OPERATING ROOM	22, 441	160, 598	0. 13973	4 15, 153	2, 117	50.00
51.00	05100 RECOVERY ROOM	0	0	0.00000	0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	3, 939	2, 732	1. 44180	1 378	545	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 338, 685	39, 059, 699	0. 03427	3 873, 017	29, 921	54. 00
54. 01	03630 ULTRA SOUND	0	0	0.00000	0 0	0	54. 01
56.00	05600 RADI 0I SOTOPE	0	0	0.00000		0	56. 00
57.00	05700 CT SCAN	0	0	0.00000	0 0	0	57. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	151, 814	39, 668			0	59. 00
60.00	06000 LABORATORY	1, 185, 570	31, 274, 181	0. 03790			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	55, 468					
65. 00	06500 RESPI RATORY THERAPY	410, 356	5, 865, 404	0.06996			65. 00
66. 00	06600 PHYSI CAL THERAPY	465, 146	432, 178	1. 07628	98, 092	105, 575	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	179, 288	314, 290	0. 57045	71, 763	40, 937	67. 00
68.00	06800 SPEECH PATHOLOGY	68, 477	44, 599	1. 53539	9, 852	15, 127	68. 00
69.00	06900 ELECTROCARDI OLOGY	78, 305	1, 752, 492	0. 04468	51, 374	2, 295	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 082	540, 900	0. 01309	3 125, 201	1, 639	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	459	42, 778	0. 01073	0 10, 242	110	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	293, 803	17, 811, 533	0. 01649	2, 300, 789	37, 952	73. 00
	07400 RENAL DIALYSIS	125, 176	90, 483	1. 38342	20, 251	28, 016	74. 00
76.00	03950 MISC ANCILLARY	0	0	0.00000	0 0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	0.00000	0 0	0	76. 01
7/ 02	DOSE O DEVOLULATRI CAREVOLIDI OCLICALI SERVILORO	1		0 00000	اما	1 ^	7/ 02

532, 217

133, 784

1, 301, 005 191, 485

6, 544, 500

0

67, 272

299, 932 31, 956, 828 1, 713, 460 131, 732, 335

0.000000

7. 911419

0. 446048

0. 040711 0. 111753

0 0 0

438, 387

88, 183

6, 708, 048

0 76. 02

0 76. 03

17, 847 91. 00 9, 855 92. 00

431, 735 200. 00

90.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

76.03

200.00

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

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

03952 WOUND CARE
OUTPATIENT SERVICE COST CENTERS

Health Financial Systems	ST JOSEDIJ MED	J CAL CENTED		ا ما	w of Form CMC	DEED 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ST JOSEPH MED SS THROUGH COS			Period: From 06/01/2020 To 05/31/2021	wof Form CMS-2 Worksheet D Part III Date/Time Pre 10/29/2021 5:	pared:
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
, , , , , , , , , , , , , , , , , , ,	Post-Stepdown	3	Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1, 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0			0	0	33. 00
40. 00 04000 SUBPROVI DER - PF	0	0			0	40.00
44. 00 04400 SKILLED NURSING FACILITY	0	٥			Ŭ	44. 00
200.00 Total (lines 30 through 199)					0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Pationt	Per Diem (col.	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Days	3 + coi . 0)	110graiii bays	
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0		10, 26	4 0.00	1, 355	30.00
33. 00 03300 BURN INTENSIVE CARE UNIT			10, 20	0.00		
40. 00 04000 SUBPROVI DER - PF	0			0.00	l	40.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0			0.00		44. 00
200.00 Total (lines 30 through 199)			10, 26			200.00
Cost Center Description	Inpati ent	U	10, 20	4	1, 300	200.00
COST Center Description	Program					
	Pass-Through					
	Cost (col. 7 x					
	cost (cor. 7 x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	1				33.00
	-					
	0	l .				40.00
	0	l .				44.00
200.00 Total (lines 30 through 199)	0	I				200. 00

 Heal th Financial
 Systems
 ST JOSEPH MEDICAL

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS
 ST JOSEPH MEDICAL CENTER Provider CCN: 15-0047

| Peri od: | Worksheet D | Part IV | To | 05/31/2021 | Date/Time Prepared: | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 1 THROUGH COSTS

				'	0 03/31/2021	10/29/2021 5:	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician N	lursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0	(0	0	51. 00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
54. 01	03630 ULTRA SOUND	0	0	(0	0	54. 01
56.00	05600 RADI 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	0	0	(0	0	59. 00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	C	0	0	74. 00
76.00	03950 MISC ANCILLARY	0	0	C	0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	C	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	76. 02
76. 03	03952 WOUND CARE	0	0	C	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	0	0	90. 00
91.00	09100 EMERGENCY	0	0	(0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(0	92.00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Heal th Financial Systems
All Other Medical Education Cost Sum of col s. Cost (sum of col s. 1, 2, 3, and 4) Cost (sum of col s. 2, 3, and 4) Sum of col s. 1, 2, 3, and 4) Sum of col s. 2, 3, and 4) Sum of col s. 3, and 4) Sum of col s. 2, 3, and 4) Sum of col s. 3, and 4) Sum of col s. 3, and 4) Sum of col s. 2, 3, and 4) Sum of col s. 3, and
Medical Education Cost 1, 2, 3, and 2, 3, and 4 Cost (sum of col s. 2, 3, and 4) Cost (sum of col s. 2, 3, and 4, step (sum of col s. 2, 3, and 4, step (sum of col s. 2, 3, and 4, step (sum of col s. 2, 3, and 4, step (sum of col s. 2, 3, and 4, step (sum of col s. 2, 3, and 4, step (sum of col s. 2, 3, and 4, step (sum of col s. 2, 3, and 4, step (sum of col s. 2, 3, and 4, step (sum of col s. 2, 3, and 4, step (sum of col s. 2, 3, and 6, sum of col s. 2, and s. 2, and s. 2, and s. 2, and s. 2, and s. 2, and s. 2, and s. 2, and s. 2, and s. 2, and s. 2, and
Education Cost 1, 2, 3, and Cost (sum of col s. 2, 3, and 4) Part I, col . (col . 5 + col . 7) (see instructions)
ANCI LLARY SERVI CE COST CENTERS ANCI LLARY SERVI CE COST CENTERS
ANCI LLARY SERVI CE COST CENTERS
ANCI LLARY SERVI CE COST CENTERS ANCI LLARY SERVI CE COST CENTERS
ANCILLARY SERVICE COST CENTERS
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 OPERATI NG ROOM 0 0 160, 598 0.000000 50.00 51. 00 05100 RECOVERY ROOM 0 0 0 0 0.000000 51.00 53. 00 05300 ANESTHESI OLOGY 0 0 0 2, 7322 0.000000 53.00 54. 00 05400 RADI OLOGY-DIA GROOSTI C 0 0 0 39, 059, 699 0.000000 54.00 54. 01 03630 ULTRA SOUND 0 0 0 0 0.000000 54.01 56. 00 05600 RADI OI 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 39, 668 0.000000 59.00 60. 00 06000 LABORATORY 0 0 0 31, 274, 181 0.000000 60.00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0
51. 00 05100 RECOVERY ROOM 0 0 0 0.000000 51. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 2,732 0.000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 39,059,699 0.000000 54. 00 54. 01 03630 ULTRA SOUND 0 0 0 0 0.000000 54. 00 56. 00 05600 RADI OI SOTOPE 0 0 0 0 0.000000 54. 00 57. 00 05700 CT SCAN 0 0 0 0 0.000000 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 39, 668 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 31, 274, 181 0.000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 263, 308 0.000000 65. 00 65. 00
53. 00 05300 ANESTHESI OLOGY 0 0 2, 732 0.000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 39, 059, 699 0.000000 54.00 54. 01 03630 ULTRA SOUND 0 0 0 0 0.000000 54.01 56. 00 05600 RADI OI 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 39, 668 0.000000 59.00 60. 00 06000 LABORATORY 0 0 0 31, 274, 181 0.000000 60.00 62. 00 06500 RESPI RATORY THERAPY 0 0 0 5, 865, 404 0.000000 62.00 65. 00 066. 00 066.00 PHYSI CAL THERAPY 0 0 0 314, 290 0.000000 </td
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 0 39, 059, 699 0.000000 54. 00 54. 01 03630 ULTRA SOUND 0 0 0 0.000000 54. 01 56. 00 05600 RADI OI 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 39, 668 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 31, 274, 181 0.000000 60. 00 62. 00 06500 RESPI RATORY THERAPY 0 0 0 263, 308 0.000000 65. 00 65. 00 066. 00 066. 00 066. 00 0 0 432, 178 0.000000 65. 00 67. 00 067.00 0CCUPATI ONAL THERAPY 0 0 0 314, 290 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 442, 599 0.0000
54. 01 03630 ULTRA SOUND 0 0 0 0.000000 54. 01 56. 00 05600 RADI OI 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 39, 668 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 31, 274, 181 0.000000 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 263, 308 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 5, 865, 404 0.000000 65. 00 66. 00 067.00 06700 OCCUPATI ONAL THERAPY 0 0 314, 290 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 445, 599 0.000000 68. 00
56. 00 05600 RADI OI SOTOPE 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 39, 668 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 31, 274, 181 0.000000 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 263, 308 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 5, 865, 404 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 432, 178 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 314, 290 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 44, 599 0.000000 68. 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 39, 668 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 31, 274, 181 0.000000 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 263, 308 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 5, 865, 404 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 432, 178 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 314, 290 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 44, 599 0.000000 68. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 39, 668 0.000000 59.00 60. 00 06000 LABORATORY 0 0 0 31, 274, 181 0.000000 60.00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 263, 308 0.000000 62.00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 5, 865, 404 0.000000 65.00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 314, 290 0.000000 67.00 68. 00 06800 SPEECH PATHOLOGY 0 0 44, 599 0.000000 68.00
60. 00 06000 LABORATORY 0 0 0 31, 274, 181 0.000000 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 263, 308 0.000000 62. 00 65. 00 65. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 44, 599 0.000000 68. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 44, 599 0.000000 68. 00 68. 00 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 263, 308 0.000000 62. 00 65. 00 65. 00 665. 00 666. 00 666. 00 666. 00 666. 00 667. 00 667. 00 668. 00
65. 00 06500 RESPI RATORY THERAPY 0 0 0 5,865,404 0.000000 65. 00 66. 00 66. 00 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 314, 290 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 44, 599 0.000000 68. 00 68. 00 0680
66. 00 06600 PHYSI CAL THERAPY 0 0 0 432, 178 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 314, 290 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 44, 599 0.000000 68. 00 0 0 0 0 0 0 0 0 0
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 314, 290 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 44, 599 0.000000 68. 00
68. 00 06800 SPEECH PATHOLOGY 0 0 44, 599 0. 000000 68. 00
69 ON NASON FLECTROCARDIOLOGY N O O O O O O O O O O O O O O O O O O
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 540,900 0.000000 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 42, 778 0.000000 72. 00
73. 00 07300 DRUGS CHARGED TO PATLENTS 0 0 17, 811, 533 0. 000000 73. 00
74. 00 07400 RENAL DI ALYSI S 0 0 90, 483 0. 000000 74. 00
76. 00 03950 MI SC ANCI LLARY 0 0 0 0 0. 000000 76. 00
76. 01 03951 SLEEP LAB 0 0 0 0 0. 000000 76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0.000000 76. 02
76. 03 03952 WOUND CARE 0 0 0 67, 272 0. 000000 76. 03

0 0 0

0 0 0

299, 932 31, 956, 828 1, 713, 460

131, 732, 335

 0. 000000
 90. 00

 0. 000000
 91. 00

 0. 000000
 92. 00

200.00

92. 00 | 09200 | 085ERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

90. 00 OUTPATIENT SERVICE COST CENTERS
90. 00 O9000 CLINIC

91. 00 09100 EMERGENCY

Hoal th	Financial Systems	ST JOSEPH MEDI	CAL CENTED		In Lie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER' THROUGH COSTS			Provi der CC		Period: From 06/01/2020 To 05/31/2021	Worksheet D Part IV Date/Time Pre 10/29/2021 5:	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)	10.00	x col. 10)	10.00	x col . 12)	
	ANOLILIADY CEDYLOG COCT CENTERS	9. 00	10.00	11. 00	12.00	13. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.000000	45.450		07.040		F0 00
50.00	05000 OPERATING ROOM	0. 000000	15, 153		0 27, 863	0	
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
53.00	05300 ANESTHESI OLOGY	0. 000000	378		0 2 22 222	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0.000000	873, 017		0 2, 832, 332	0	54. 00 54. 01
56. 00	05600 RADI OI SOTOPE	0. 000000 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. 000000	0		0	0	59.00
60.00	06000 LABORATORY	0. 000000	1, 365, 528		0 793, 928	-	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	1, 365, 526 9, 181		0 7,979	0	62.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	1, 230, 657		0 80, 562	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	98, 092		0 2, 253	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	71, 763		0 1, 116	_	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	9, 852		1, 110	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	51, 374		0 161, 589	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	125, 201		0 6, 462	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	10, 242		0, 402	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 300, 789		0 387, 820	0	73.00
74. 00	07400 RENAL DIALYSIS	0. 000000	20, 251		0 307, 020	0	74.00
76. 00	03950 MISC ANCILLARY	0. 000000	20, 231			0	76.00
76. 00	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	Ö	76. 02
76. 03	03952 WOUND CARE	0. 000000	0		o o	0	76. 03

0. 000000

0. 000000 0. 000000

438, 387 88, 183

6, 708, 048

0 0 0

43, 536

1, 703, 857 139, 150

6, 188, 447

0

90.00

0 91.00 0 92.00

0 200. 00

76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES
76. 03 03952 WOUND CARE

OUTPATI ENT SERVI CE COST CENTERS

90. 00 09000 CLI NI C

91.00 | 09100 | EMERGENCY 92.00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 200.00 | Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0047 Peri od: Worksheet D From 06/01/2020 Part V 05/31/2021 Date/Time Prepared: 10/29/2021 5:12 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2. 065399 27, 863 57, 548 50.00 0 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 05300 ANESTHESI OLOGY 288. 385798 0 53 00 53 00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 141782 2, 832, 332 401, 574 54.00 54.01 03630 ULTRA SOUND 0.000000 0 0 0 54.01 56.00 05600 RADI OI SOTOPE 0.000000 0 0 Ω 0 56 00 05700 CT SCAN 0 57.00 0.000000 C 0 57.00 59.00 05900 CARDIAC CATHETERIZATION 17. 330871 0 0 59.00 06000 LABORATORY 60.00 0. 191643 793, 928 9,000 0 152, 151 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 7, 979 0.627562 5, 007 62 00 0 62 00 65.00 06500 RESPIRATORY THERAPY 0.320032 80, 562 0 25, 782 65.00 06600 PHYSI CAL THERAPY 2. 292722 2, 253 0 66.00 0 5, 166 66.00 06700 OCCUPATIONAL THERAPY 1. 292889 0 1, 443 67.00 67.00 1, 116 0 06800 SPEECH PATHOLOGY 68.00 68.00 3. 277204 0 69.00 06900 ELECTROCARDI OLOGY 0.171802 161, 589 0 0 27, 761 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 122596 0 71.00 6, 462 792 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 799243 0 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.193317 387, 820 0 74, 972 73.00 8, 150 73.00 74.00 07400 RENAL DIALYSIS 2. 953859 0 0 74.00 03950 MISC ANCILLARY 0.000000 0 76.00 76.00 0 0 0 03951 SLEEP LAB 0 76.01 0.000000 0 0 76.01 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.02 0.000000 C 0 0 76.02 03952 WOUND CARE 14.830182 0 0 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0.886481 38.594 43, 536 0 183 91.00 09100 EMERGENCY 0.218003 1, 703, 857 0 371, 446 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.578103 139, 150 80, 443 92.00 200.00 Subtotal (see instructions) 6, 188, 447 9,000 8, 333 1, 242, 679 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

6, 188, 447

9,000

8, 333

1, 242, 679 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0047	From 06/01/2020	Worksheet D Part V Date/Time Prepared: 10/29/2021 5:12 pm

					To 05/31/2021	Date/Time Pro 10/29/2021 5:	epared:
-			Title	XVIII	Hospi tal	PPS	. <u> </u>
		Cost	_				
	Cost Center Description	Subject To Ded. & Coins. D	Cost Reimbursed Services Not Subject To ed. & Coins. (see inst.) 7.00				
	ANCILLARY SERVICE COST CENTERS			1			
	D5000 OPERATING ROOM	0	0	ł			50.00
	D5100 RECOVERY ROOM	0	0				51.00
	D5300 ANESTHESI OLOGY	0	0				53. 00
	D5400 RADI OLOGY-DI AGNOSTI C D3630 ULTRA SOUND	0	0				54. 00 54. 01
	05600 RADI OI SOTOPE	0	0				56. 00
	05700 CT SCAN	0	0				57. 00
	05900 CARDI AC CATHETERI ZATI ON		0				59.00
	06000 LABORATORY	1, 725	0				60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62. 00
	06500 RESPIRATORY THERAPY	l ol	0				65. 00
	06600 PHYSI CAL THERAPY	O	0				66. 00
67.00	06700 OCCUPATIONAL THERAPY	O	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
	D7300 DRUGS CHARGED TO PATIENTS	0	1, 576				73. 00
	07400 RENAL DIALYSIS	0	0				74. 00
	03950 MI SC ANCI LLARY	0	0				76. 00
	03951 SLEEP LAB	0	0				76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76. 02
	03952 WOUND CARE	0	0				76. 03
	DUTPATIENT SERVICE COST CENTERS D9000 CLINIC		162	Ι			90.00
	09100 EMERGENCY		0	1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92. 00
200.00	Subtotal (see instructions)	1, 725	1, 738				200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0	., 700				201. 00
202. 00	Only Charges Net Charges (line 200 - line 201)	1, 725	1, 738				202. 00

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 06/01/2020 To 05/31/2021		
			e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capi tal	Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B, Part II, col. 26)		Related Cost (col. 1 - col 2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30. 00 ADULTS & PEDIATRICS	3, 946, 576	0	3, 946, 57	6 10, 264	384. 51	30.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 00
40. 00 SUBPROVI DER - I PF	0	0		0	0.00	40. 00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30 through 199)	3, 946, 576		3, 946, 57	6 10, 264		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	6. 00	6) 7. 00	_			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	1, 070	411, 426				30.00
33. 00 BURN INTENSIVE CARE UNIT	0	0				33. 00
40. 00 SUBPROVI DER - I PF	0	Ö	i			40. 00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
200.00 Total (lines 30 through 199)	1, 070	411, 426				200. 00

Health Financial Systems ST JOSEPH MEDICAL				In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 06/01/2020		
				To 05/31/2021	Date/Time Pre 10/29/2021 5:	parea:
		Ti +I	e XIX	Hospi tal	PPS	12 piii
Cost Center Description	Capi tal	Total Charges			Capital Costs	
oost conten bescription		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.			column 4)	
	Part II, col.	8)	2)		.,	
	26)	- 7				
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				<u>'</u>		
50. 00 05000 OPERATI NG ROOM	22, 441	160, 598	0. 13973	4 7, 957	1, 112	50. 00
51.00 05100 RECOVERY ROOM	0	0	0.00000	0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	3, 939	2, 732	1. 44180	1 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 338, 685	39, 059, 699	0. 03427	3 664, 485	22, 774	54. 00
54. 01 03630 ULTRA SOUND	0	0	0.00000	0 0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0.00000	0 0	0	56. 00
57. 00 05700 CT SCAN	0	0	0.00000	0 0	0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	151, 814	39, 668	3. 82711	5 0	0	59. 00
60. 00 06000 LABORATORY	1, 185, 570	31, 274, 181	0. 03790	9 1, 005, 878	38, 132	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	55, 468	263, 308	0. 21065	8 29, 102	6, 131	62. 00
65. 00 06500 RESPIRATORY THERAPY	410, 356	5, 865, 404	0. 06996	2 737, 127	51, 571	65.00
66. 00 06600 PHYSI CAL THERAPY	465, 146	432, 178	1. 07628	3 42, 792	46, 056	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	179, 288	314, 290	0. 57045	4 29, 797	16, 998	67.00
68. 00 06800 SPEECH PATHOLOGY	68, 477	44, 599	1. 53539	3 2, 885	4, 430	68. 00
69. 00 06900 ELECTROCARDI OLOGY	78, 305	1, 752, 492	0. 04468	2 41, 725	1, 864	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 082	540, 900	0. 01309	3 65, 998	864	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	459	42, 778	0. 01073	0 4, 767	51	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	293, 803	17, 811, 533	0. 01649	5 1, 747, 959	28, 833	73. 00
74.00 07400 RENAL DIALYSIS	125, 176	90, 483	1. 38342	0 38, 086	52, 689	74.00
76.00 03950 MISC ANCILLARY	0	0	0.00000	0	0	76. 00
76. 01 03951 SLEEP LAB	0	0	0.00000	0	0	76. 01
74 02 02FF0 DSVCIII ATDLC (DSVCIIO) OCLCAL SEDVI CES		l	1 0 00000			7/ 02

532, 217

133, 784

1, 301, 005 191, 485

6, 544, 500

0

67, 272

299, 932 31, 956, 828 1, 713, 460 131, 732, 335

0.000000

7. 911419

0. 446048

0. 040711 0. 111753

0 0 0

2, 193 511, 101 54, 776

4, 986, 628

0 76. 02

0 76. 03

978

20, 807 91. 00 6, 121 92. 00

299, 411 200. 00

90.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES

03952 WOUND CARE
OUTPATIENT SERVICE COST CENTERS

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

76. 02

76.03

200.00

Health Financial Systems	ST JOSEPH MED				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				From 06/01/2020 To 05/31/2021	Part III	nanad.
				To 05/31/2021	Date/Time Pre 10/29/2021 5:	pareu:
		Ti tl	e XIX	Hospi tal	PPS	12 piii
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
'	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		•				
30. 00 03000 ADULTS & PEDI ATRI CS	C	0) (0	0	30.00
33. 00 03300 BURN INTENSIVE CARE UNIT				0	0	33. 00
40. 00 04000 SUBPROVI DER - 1 PF				0	0	40.00
44.00 04400 SKILLED NURSING FACILITY				0	,	44. 00
200.00 Total (lines 30 through 199)				0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
oost ochtor beschiptron	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Jayo	0 . 00 0)	g. a bayo	
	instructions)	mi nus col . 4)				
	4.00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00				
30. 00 03000 ADULTS & PEDIATRICS	C		10, 264	0.00	1, 070	30.00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0.00		
40. 00 04000 SUBPROVI DER - PF				0.00		
44.00 04400 SKILLED NURSING FACILITY]			0.00		
200.00 Total (lines 30 through 199)			10, 264			200. 00
Cost Center Description	I npati ent			-1	1, 2.2	
0001 0011101 20001 pt on	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	0.00	1				

30. 00 33. 00

40. 00 44. 00 200. 00

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)
 Heal th Financial
 Systems
 ST JOSEPH MEDICAL

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS
 ST JOSEPH MEDICAL CENTER Provider CCN: 15-0047

THROUGH COSTS

					10 00/01/2021	10/29/2021 5:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician N	lursing School	Nursing Schoo	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS				_		
	05000 OPERATI NG ROOM	0	0		0	0	50.00
51. 00	05100 RECOVERY ROOM	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	59. 00
60.00	06000 LABORATORY	0	0		0 0	0	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	O	0		0 0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	o	0		o o	0	65. 00
66.00	06600 PHYSI CAL THERAPY	o	0		o o	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		o o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	O	0		o o	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	0		o o	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0		o o	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0		o o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		ol o	o	73. 00
74. 00	07400 RENAL DIALYSIS	o	0		o o	0	74. 00
	03950 MISC ANCILLARY	o	0		o o	0	76. 00
	03951 SLEEP LAB	o	0		o o	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	0		o o	0	76. 02
76. 03	03952 WOUND CARE	o	0		o o	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90. 00
91. 00	09100 EMERGENCY	o	0		o o	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				o	Ö	92.00
200.00	1		0		o o	0	200. 00
	1 1 (1 9	<u> </u>	•	-1		

Health Financial Systems ST JOSEPH MEDICAL CENTER In Lieu of Form CMS-2552-10							
APPORT	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER GH COSTS				Period: From 06/01/2020 To 05/31/2021	Worksheet D Part IV	pared:
				e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	F 00	/ 00	7.00	instructions)	
	ANOLLI ADV. CEDVI OF COCT. CENTEDO	4.00	5. 00	6. 00	7. 00	8. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 0	0	ı	1/0 500	0.00000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 160, 598 0 0	l .	
53.00	05300 ANESTHESI OLOGY		0		0 2, 732		
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0		0 39, 059, 699		1
54. 00	03630 ULTRA SOUND	0	0		0 39,039,699	0.00000	1
56. 00	05600 RADI OI SOTOPE		0			0.00000	
57. 00	05700 CT SCAN		0		0	0.00000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		0 39, 668		
60.00	06000 LABORATORY		0		0 31, 274, 181		1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 263, 308		1
65. 00	06500 RESPIRATORY THERAPY	0	0		0 5, 865, 404		
66. 00	06600 PHYSI CAL THERAPY	0	0		0 432, 178		
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 314, 290		
68. 00	06800 SPEECH PATHOLOGY	0	0		0 44, 599		
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 1, 752, 492		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 540, 900		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	,	0 42, 778		
	07300 DRUGS CHARGED TO PATIENTS	0	0	,	0 17, 811, 533	l .	
74. 00	07400 RENAL DIALYSIS	0	Ö	,	0 90, 483		
76.00	03950 MISC ANCILLARY	0	0		0	0.000000	76. 00
76. 01	03951 SLEEP LAB	0	0		o o	0.000000	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		o o	0.000000	76. 02
76. 03	03952 WOUND CARE	0	0		0 67, 272	0.000000	76. 03

0 0 0

0.000000

0.000000

0.000000

299, 932 31, 956, 828 1, 713, 460

131, 732, 335

90.00

91. 00

92.00

200.00

91. 00 09100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

90. 00 OUTPATIENT SERVICE COST CENTERS
90. 00 O9000 CLINIC

Heal th	Financial Systems	ST JOSEPH MEDI	CAL CENTER		In Lie	u of Form CMS-:	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS	Provi der CC		Period: From 06/01/2020 To 05/31/2021	Worksheet D Part IV Date/Time Pre 10/29/2021 5:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0. 000000	7, 957		0	0	50. 00
51. 00	05100 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	664, 485		0	0	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. 000000	0		0	0	59. 00
60.00	06000 LABORATORY	0. 000000	1, 005, 878		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	29, 102		0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	737, 127		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	42, 792		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	29, 797		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	2, 885		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	41, 725		0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	65, 998		0 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 767		0 0	0	72. 00
70 00	DELCO DIVINO DIVIDOED TO DATI ENTO	0 000000	4 747 050	1		۱ .	70 00

0. 000000

0. 000000

0. 000000

0. 000000

0. 000000

0. 000000

0.000000

0. 000000 0. 000000 1, 747, 959

38, 086

2, 193 511, 101

54, 776

4, 986, 628

0

0

0

0 0 0

0 0 0 0 73.00

0 74.00

0

0 76.01

0 76.02

0

0 90.00

0 91.00 0 92.00

76.00

76. 03

0 200. 00

73. 00 07300 DRUGS CHARGED TO PATIENTS

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES

03952 WOUND CARE
OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

74.00 07400 RENAL DIALYSIS

03951 SLEEP LAB

90. 00 09000 CLINIC

91.00 09100 EMERGENCY

76.00

76.02

76.03

200.00

03950 MISC ANCILLARY

Health Financial Systems	ST JOSEPH MEDICA		In Lieu of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0047	Peri od:	Worksheet D

	inancial Systems	ST JOSEPH MEL	DICAL CENTER		In Lie	eu of Form CMS-2	<u> 2552-10</u>
APPORTI C	DNMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
					From 06/01/2020		
				-	To 05/31/2021		
-						10/29/2021 5:	12 pm
			litt	e XIX	Hospi tal	PPS	
			550 5 1 1	Charges	<u> </u>	Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(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	
	NCILLARY SERVICE COST CENTERS						
50. 00 0!	5000 OPERATING ROOM	2. 065399	0		2, 115	0	50.00
51.00 0	5100 RECOVERY ROOM	0. 000000	0		0	0	51.00
53. 00 0!	5300 ANESTHESI OLOGY	288. 385798	0		0	0	53.00
54. 00 0!	5400 RADI OLOGY-DI AGNOSTI C	0. 141782	. 0		2, 933, 952	0	54.00
54. 01 03	3630 ULTRA SOUND	0. 000000	0		0 0	0	54. 01
	5600 RADI OI SOTOPE	0. 000000	1		0	0	56. 00
	5700 CT SCAN	0. 000000			0	٥	57. 00
	5900 CARDI AC CATHETERI ZATI ON	17. 330871	1			٥	59.00
	6000 LABORATORY	0. 191643			1, 370, 313	0	60.00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 627562	1		1, 370, 313	l .	62.00
	6500 RESPI RATORY THERAPY	0. 320032	1				1
	·	1	1		131, 433	l .	65. 00
	6600 PHYSI CAL THERAPY	2. 292722			1, 714		66.00
	6700 OCCUPATIONAL THERAPY	1. 292889			2, 303	0	67. 00
	6800 SPEECH PATHOLOGY	3. 277204			0	0	68. 00
	6900 ELECTROCARDI OLOGY	0. 171802			96, 396		69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 122596			2, 439	0	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 799243			0		72. 00
	7300 DRUGS CHARGED TO PATIENTS	0. 193317	0		935 445, 935	0	73. 00
	7400 RENAL DIALYSIS	2. 953859	0		3, 574	0	74. 00
76. 00 03	3950 MISC ANCILLARY	0. 000000	0		0	0	76. 00
76. 01 03	3951 SLEEP LAB	0. 000000	0		0	0	76. 01
76. 02 03	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	76. 02
	3952 WOUND CARE	14. 830182	0		0	0	76. 03
Ol	UTPATIENT SERVICE COST CENTERS		•		•		
90.00	9000 CLI NI C	0. 886481	0		0 6, 075	0	90.00
91.00 0	9100 EMERGENCY	0. 218003	0		2, 469, 239	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 578103			102, 652		1
200.00	Subtotal (see instructions)	1.2.0100	1		7, 580, 483		200.00
201.00	Less PBP Clinic Lab. Services-Program				n ., 555, 166	l	201.00
201.00	Only Charges						
202.00	Net Charges (line 200 - line 201)		0		7, 580, 483	0	202. 00
202.00	1.101 3.1di ges (11110 200 11110 201)	1	1 9	1	7, 555, 405	1	1-02.00

Health Financial Systems	ST JOSEPH MEDICA	AL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der CC	CN: 15-0047	From 06/01/2020	Worksheet D Part V Date/Time Pre 10/29/2021 5:	
		Ti tl	e XIX	Hospi tal	PPS	
	Costs					

			10 05/31/2021	10/29/2021 5: 12 pm
		Title XIX	Hospi tal	PPS
	Costs	6		
Cost Center Description	Cost	Cost		
·	Rei mbursed	Rei mbursed		
	Servi ces S	Services Not		
	Subject To	Subject To		
	Ded. & Coins. De	ed. & Coins.		
	(see inst.)	(see inst.)		
	6. 00	7. 00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	4, 368		50.00
51.00 05100 RECOVERY ROOM	O	O		51.00
53. 00 05300 ANESTHESI OLOGY	O	O		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	O	415, 982		54. 00
54.01 03630 ULTRA SOUND	O	О		54. 01
56. 00 05600 RADI OI SOTOPE	o	o		56. 00
57. 00 05700 CT SCAN	o	o		57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	o		59. 00
60. 00 06000 LABORATORY	o	262, 611		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	7, 746		62. 00
65. 00 06500 RESPIRATORY THERAPY	o	42, 063		65. 00
66. 00 06600 PHYSI CAL THERAPY	o	3, 930		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	2, 978		67.00
68. 00 06800 SPEECH PATHOLOGY	o	o		68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	16, 561		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	299		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	o		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	86, 207		73. 00
74. 00 07400 RENAL DIALYSIS	o	10, 557		74. 00
76. 00 03950 MISC ANCILLARY	o	o		76. 00
76. 01 03951 SLEEP LAB	o	o		76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	o		76. 02
76. 03 03952 WOUND CARE	o	o		76. 03
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0	5, 385		90.00
91. 00 09100 EMERGENCY	O	538, 302		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	O	59, 343		92. 00
200.00 Subtotal (see instructions)	O	1, 456, 332		200. 00
201.00 Less PBP Clinic Lab. Services-Program	n O			201. 00
Only Charges				
202.00 Net Charges (line 200 - line 201)	o	1, 456, 332		202. 00
	•	*		•

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0047	Period: From 06/01/2020	Worksheet D-1	
			Date/Time Pre 10/29/2021 5:	
	Title XVIII	Hospi tal	PPS	

		Title XVIII	Hospi tal	10/29/2021 5: PPS	12 pm
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			10, 264	1. 00 2. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and observation bed day do not complete this line.		ivate room days,	10, 264 0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		9, 766	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)			0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	o the Program (excluding	swi ng-bed and	1, 355	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period			0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar year).	ear, enter O on this lin	e)	0	13.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	20, 415, 792 0	21. 00 22. 00
23. 00	$5\ x$ line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3 $^{\circ}$	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		20, 415, 792	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
	Semi -private room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 - line 3)	F 11 ne 28)		0. 000000 0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x line		1 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	20, 415, 792	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 989. 07	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		2, 695, 190	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 2, 695, 190	40. 00 41.00
-1 1. UU	Trotal Trogram general Tripation Croutine Service Cost (Title 39		I	2,073,170	71.00

MPUTATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0047	Peri od:	Worksheet D-1	
				From 06/01/2020 To 05/31/2021	Date/Time Pre 10/29/2021 5:	
		Title	e XVIII	Hospi tal	PPS	12 pi
Cost Center Description	Total	Total	Average Per		Program Cost	
	Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
	1. 00	2.00	col. 2) 3.00	4. 00	<u>4)</u> 5. 00	
.00 NURSERY (title V & XIX only)			2.22		<u> </u>	42.
Intensive Care Type Inpatient Hospital Uni	ts					
00 INTENSIVE CARE UNIT						43.
OO CORONARY CARE UNIT OO BURN INTENSIVE CARE UNIT	0		0. (00	0	44. 45.
00 SURGICAL INTENSIVE CARE UNIT			0.1	50	O	46.
OO OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description						
00 Danasas i anati ant anni 11 ann anni 12 anni 1	Wi-+ D 21 1	2 11 200)			1.00	40
.00 Program inpatient ancillary service cost (.00 Total Program inpatient costs (sum of line			ne)		1, 958, 869 4, 654, 059	
PASS THROUGH COST ADJUSTMENTS	:3 41 till ough 40)	(See Thistruction) is j		4, 034, 037	47.
OO Pass through costs applicable to Program i	npatient routine	services (from	n Wkst. D, sur	m of Parts I and	521, 011	50.
[11]						l
00 Pass through costs applicable to Program i and IV)	npatient ancillar	ry services (fr	om Wkst. D,	sum of Parts II	431, 735	51.
and iv) 00 Total Program excludable cost (sum of line	es 50 and 51)				952, 746	52.
00 Total Program inpatient operating cost exc		elated, non-phy	sician anestl	netist, and	3, 701, 313	
medical education costs (line 49 minus lin						
TARGET AMOUNT AND LIMIT COMPUTATION					-	١.,
00 Program discharges 00 Target amount per discharge					0 0. 00	
00 Target amount (line 54 x line 55)					0.00	1
OO Difference between adjusted inpatient oper	ating cost and ta	arget amount (I	ine 56 minus	line 53)	0	1
00 Bonus payment (see instructions)					0	
00 Lesser of lines 53/54 or 55 from the cost	reporting period	ending 1996, u	updated and co	ompounded by the	0. 00	59
market basket 00 Lesser of lines 53/54 or 55 from prior yea	ır cost report. um	odated by the m	narket basket		0.00	60
00 If line 53/54 is less than the lower of li				the amount by	0	1
which operating costs (line 53) are less t		ts (lines 54 x	60), or 1% of	f the target		
amount (line 56), otherwise enter zero (se 00 Relief payment (see instructions)	e instructions)				0	62
00 Allowable Inpatient cost plus incentive pa	vment (see instru	uctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST						
00 Medicare swing-bed SNF inpatient routine o	costs through Dece	ember 31 of the	e cost reporti	ng period (See	0	64
instructions)(title XVIII only) 00 Medicare swing-bed SNF inpatient routine o	acts after Decemb	or 21 of the	oct roportin	a pariod (Saa	0	65
00 Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	JUSTS ALLEL DECENIE	ber 31 of the C	ost reportin	g perrou (see	Ü	05
OO Total Medicare swing-bed SNF inpatient rou	itine costs (line	64 plus line 6	55)(title XVI	II only). For	0	66
CAH (see instructions)						
OD Title V or XIX swing-bed NF inpatient rout	ine costs through	n December 31 d	of the cost re	eporting period	0	67
(line 12 x line 19) Title V or XIX swing-bed NF inpatient rout	ine costs after [December 31 of	the cost repo	ortina period	0	68
(line 13 x line 20)						
OO Total title V or XIX swing-bed NF inpatier		•			0	69
PART III - SKILLED NURSING FACILITY, OTHER				\		70
00 Skilled nursing facility/other nursing fac 00 Adjusted general inpatient routine service)		70 71
00 Program routine service cost (line 9 x lin	•	70 1 11110	2)			72
00 Medically necessary private room cost appl	icable to Program	•				73
OO Total Program general inpatient routine se						74
OO Capital-related cost allocated to inpatier 26, line 45)	it routine service	e costs (from V	worksneet B, I	rart II, column		75
00 Per diem capital-related costs (line 75 ÷	line 2)					76
00 Program capital -related costs (line 9 x li						77
00 Inpatient routine service cost (line 74 mi						78
On Aggregate charges to beneficiaries for exc				aug Line 70)		79
00 Total Program routine service costs for co 00 Inpatient routine service cost per diem li	•	cost limitation	ı (IINe /8 mii	nus iine /9)		80
00 Inpatient routine service cost per diem in		1)				82
OReasonable inpatient routine service costs	* .	* .				83
00 Program inpatient ancillary services (see	instructions)	ŕ				84
00 Utilization review - physician compensatio	•					85
00 Total Program inpatient operating costs (s PART IV - COMPUTATION OF OBSERVATION BED P		rougn 85)				86
00 Total observation bed days (see instruction					498	0.7
OO LIGIAL ODSELVATION DEG GAVS USEE THSTITUTION	11131				470	O /

498 87. 00 1, 989. 07 88. 00 990, 557 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems	ST JOSEPH MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 06/01/2020 To 05/31/2021	Date/Time Pre 10/29/2021 5:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	3, 946, 576	20, 415, 792	0. 19331	0 990, 557	191, 485	90.00
91.00 Nursing School cost	0	20, 415, 792	0.00000	990, 557	0	91.00
92.00 Allied health cost	0	20, 415, 792	0.00000	990, 557	0	92.00
93.00 All other Medical Education	0	20, 415, 792	0. 00000	990, 557	0	93. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0047	Peri od: From 06/01/2020	Worksheet D-1	
		To 05/31/2021	Date/Time Pre 10/29/2021 5:	
	Title XIX	Hospi tal	PPS	
Cost Center Description				

		Title XIX	Hospi tal	10/29/2021 5: PPS	12 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			10, 264	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and observation bed day do not complete this line.		ivate room days,	10, 264 0	2. 00 3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		9, 766	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	3 .		0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swi ng-bed and	1, 070	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	i ons)		0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period			0	12.00
13. 00 14. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this lin	e)	0	13. 00 14. 00
15. 00	Total nursery days (title V or XIX only)	alli (excruding swing-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medical drate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	20, 415, 792 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	·		0	23. 00
	x line 18)	•		0	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	·			24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3×1 ine 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		0 20, 415, 792	26. 00 27. 00
29 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	l and observation had ch	argos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed ch	ai yes)	0	29. 00
	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 d	- line 28)		0.000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	20, 415, 792	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 989. 07	38. 00
39. 00	Program general inpatient routine service cost per diem (see	•		2, 128, 305	
40. 00	Medically necessary private room cost applicable to the Progra	•		2, 120, 303	40. 00
	Total Program general inpatient routine service cost (line 39	•		2, 128, 305	

OMPUTATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0047	Peri od: From 06/01/2020	Worksheet D-1	
				To 05/31/2021	Date/Time Pre 10/29/2021 5:	
		Ti tl	e XIX	Hospi tal	PPS	12 piii
Cost Center Description	Total	Total Inpatient Days	Average Per		Program Cost (col. 3 x col.	
	impatrent cost	Impatrent bays	col . 2)	-	4)	
OO NUDCEDY (+: +1 o V o VIV only)	1. 00	2. 00	3.00	4. 00	5. 00	42.0
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	ts					42.0
3.00 INTENSIVE CARE UNIT						43.0
4.00 CORONARY CARE UNIT 5.00 BURN INTENSIVE CARE UNIT	0		0.	00 0	0	44. 0 45. 0
5.00 SURGICAL INTENSIVE CARE UNIT	0	_	0.	00	0	46.0
7.00 OTHER SPECIAL CARE (SPECIFY)						47. C
Cost Center Description					1. 00	
3.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3	3, line 200)			1, 318, 183	48.0
9.00 Total Program inpatient costs (sum of line			ons)		3, 446, 488	•
PASS THROUGH COST ADJUSTMENTS D. 00 Pass through costs applicable to Program i	nnationt routing	sorvices (from	Wkst D su	m of Darte L and	411, 426	 50. c
	inpatrent routine	services (1101	i wkst. D, sui	ii or rarts r and	411, 420	30.0
1.00 Pass through costs applicable to Program i	npatient ancillar	ry services (fr	om Wkst. D,	sum of Parts II	299, 411	51.0
and IV) 2.00 Total Program excludable cost (sum of line	es 50 and 51)				710, 837	52. C
3.00 Total Program inpatient operating cost exc	cluding capital re	elated, non-phy	sician anest	hetist, and	2, 735, 651	
medical education costs (line 49 minus lir TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)					
4.00 Program discharges					0	54. (
5.00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55).00 Difference between adjusted inpatient oper	anting coat and to	wast smallet (1	ino E/ minuo	Line E2)	0	56. 57.
.00 Difference between adjusted inpatient oper.00 Bonus payment (see instructions)	atting cost and ta	arget amount (i	The 56 minus	11 ne 53)	0	58.
.00 Lesser of lines 53/54 or 55 from the cost	reporting period	endi ng 1996, u	pdated and c	ompounded by the	0.00	
market basket .00 Lesser of lines 53/54 or 55 from prior yea	ar cost renort ur	ndated by the m	narket hasket		0. 00	60.
.00 If line 53/54 is less than the lower of li				the amount by	0.00	61.
which operating costs (line 53) are less to		ts (lines 54 x	60), or 1% o	f the target		
amount (line 56), otherwise enter zero (se .00 Relief payment (see instructions)	ee instructions)				0	62.
8.00 Allowable Inpatient cost plus incentive pa	ayment (see instru	uctions)			0	63.
PROGRAM INPATIENT ROUTINE SWING BED COST .00 Medicare swing-bed SNF inpatient routine of	costs through Dece	mhar 31 of the	cost report	ing period (See	0	64.
instructions) (title XVIII only)	Losts through bece	siliber 51 of the	cost report	riig perrou (See	0	04.
.00 Medicare swing-bed SNF inpatient routine	costs after Decemb	per 31 of the o	ost reportin	g period (See	0	65.
instructions)(title XVIII only) 5.00 Total Medicare swing-bed SNF inpatient rou	utine costs (line	64 plus line 6	5)(title XVI	II only). For	0	66.
CAH (see instructions)	•	•	, ,	•	-	
7.00 Title V or XIX swing-bed NF inpatient rout (line 12 x line 19)	tine costs through	n December 31 c	of the cost r	eporting period	0	67.
3.00 Title V or XIX swing-bed NF inpatient rout	ine costs after [December 31 of	the cost rep	orting period	0	68.
(line 13 x line 20)	at mouting costs (ilina (7. lina	(0)		0	
.00 Total title V or XIX swing-bed NF inpatier PART III - SKILLED NURSING FACILITY, OTHER					0	69.
00 Skilled nursing facility/other nursing facility	cility/ICF/IID rou	utine service d	cost (line 37)		70.
00 Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.
.00 Program routine service cost (line 9 x lir .00 Medically necessary private room cost appl		n (line 14 x li	ne 35)			72. 73.
.00 Total Program general inpatient routine se	9	•	,			74.
00 Capital-related cost allocated to inpatier	nt routine service	e costs (from W	lorksheet B, I	Part II, column		75.
26, line 45) 00 Per diem capital-related costs (line 75 ÷	line 2)					76.
.00 Program capital-related costs (line 9 x li	ne 76)					77.
On Inpatient routine service cost (line 74 mi On Aggregate charges to beneficiaries for exc	· ·	rovi dor rocces	le)			78. 79.
OD Aggregate charges to beneficiaries for exc OD Total Program routine service costs for co			*	nus line 79)		80.
.00 Inpatient routine service cost per diem li	mi tati on		,	/		81.
.00 Inpatient routine service cost limitation	•	· * .				82.
.00 Reasonable inpatient routine service costs .00 Program inpatient ancillary services (see		15)				83. 84.
.00 Utilization review - physician compensation		ons)				85.
.00 Total Program inpatient operating costs (s		rough 85)				86.
PART IV - COMPUTATION OF OBSERVATION BED F Total observation bed days (see instruction)					498	0.7

498 87. 00 1, 989. 07 88. 00 990, 557 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems	ST JOSEPH MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 06/01/2020 To 05/31/2021	Date/Time Prep 10/29/2021 5:	pared: 12 pm_
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	3, 946, 576	20, 415, 792	0. 19331	0 990, 557	191, 485	90.00
91.00 Nursing School cost	0	20, 415, 792	0.00000	990, 557	0	91.00
92.00 Allied health cost	0	20, 415, 792	0.00000	990, 557	0	92.00
93.00 All other Medical Education	0	20, 415, 792	0.00000	990, 557	0	93. 00

	Financial Systems	ST JOSEPH MEDICAL CENTER			u of Form CMS-	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 15-0047	Peri od: From 06/01/2020	Worksheet D-3	
				To 05/31/2021	Date/Time Pre 10/29/2021 5:	
		Ti tI	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	INDATI ENT DOUTING CEDVICE COCT CENTERS		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS			4 902 420		30.00
30.00	03300 BURN INTENSIVE CARE UNIT			4, 803, 439 0		30.00
40. 00	l i			0		40. 00
40.00	ANCI LLARY SERVI CE COST CENTERS			0		40.00
50. 00	05000 OPERATI NG ROOM		2. 0653	99 15, 153	31, 297	50.00
51.00	05100 RECOVERY ROOM		0.0000	· ·	0	1
53. 00	05300 ANESTHESI OLOGY		288. 3857		109, 010	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1417		123, 778	
54. 01	03630 ULTRA SOUND		0.0000		0	1
56. 00	05600 RADI OI SOTOPE		0.0000		Ō	
57.00	05700 CT SCAN		0.0000		0	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON		17. 3308	71 0	0	59.00
60.00	06000 LABORATORY		0. 1916	43 1, 365, 528	261, 694	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 6275	62 9, 181	5, 762	
65.00	06500 RESPIRATORY THERAPY		0. 3200		393, 850	65. 00
66.00	06600 PHYSI CAL THERAPY		2. 2927	22 98, 092	224, 898	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		1. 2928	89 71, 763	92, 782	67. 00
68. 00	06800 SPEECH PATHOLOGY		3. 2772			
69. 00			0. 1718		8, 826	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1225	96 125, 201	15, 349	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7992		8, 186	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1933			
74.00	07400 RENAL DIALYSIS		2. 9538		59, 819	
76. 00	03950 MI SC ANCI LLARY		0.0000		0	
76. 01	03951 SLEEP LAB		0.0000		0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		0	
76. 03	03952 WOUND CARE		14. 8301	82 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS		1		_	
	09000 CLINIC		0.8864			90.00

0. 218003 0. 578103

438, 387

88, 183

6, 708, 048

6, 708, 048

1, 958, 869 200. 00

91.00

92. 00

201. 00

202. 00

95, 570

50, 979

91. 00 09100 EMERGENCY

200.00

201.00 202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

Health Financial Systems	ST JOSEPH MEDICAL CENTER			eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0047	Peri od: From 06/01/2020	Worksheet D-3	
			To 05/31/2021	Date/Time Pre 10/29/2021 5:	
	Ti tI	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			3, 386, 378		30.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
40. 00 04000 SUBPROVI DER - 1 PF			0		40. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		2. 06539		16, 434	50. 00
51.00 05100 RECOVERY ROOM		0.00000		0	51. 00
53. 00 05300 ANESTHESI OLOGY		288. 38579		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14178		94, 212	54. 00
54. 01 03630 ULTRA SOUND		0. 00000		0	54. 01
56. 00 05600 RADI OI SOTOPE		0.00000		0	56. 00
57. 00 05700 CT SCAN		0. 00000		0	57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		17. 33087		0	59. 00
60. 00 06000 LABORATORY		0. 19164			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 62756	· ·		
65. 00 06500 RESPIRATORY THERAPY		0. 32003			
66. 00 06600 PHYSI CAL THERAPY		2. 29272	· ·		
67. 00 06700 OCCUPATI ONAL THERAPY		1. 29288	· ·		67. 00
68.00 06800 SPEECH PATHOLOGY		3. 27720			
69. 00 06900 ELECTROCARDI OLOGY		0. 17180			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 12259		8, 091	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 79924	4, 767	3, 810	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 19331	1, 747, 959	337, 910	73. 00
74.00 07400 RENAL DIALYSIS		2. 95385	38, 086	112, 501	74. 00
76. 00 03950 MISC ANCILLARY		0.00000	00	0	76. 00
76. 01 03951 SLEEP LAB		0.00000		0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.00000		0	76. 02
76. 03 03952 WOUND CARE		14. 83018	32 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 88648			90.00
01 00 00100 EMERCENCY		0 21000	12 511 101	111 /22	01 00

2, 193 511, 101 54, 776

4, 986, 628

4, 986, 628

0. 218003 0. 578103

1, 944 111, 422 31, 666

1, 318, 183 200. 00

91.00

92. 00

201.00

202. 00

91. 00 09100 EMERGENCY

200.00

201.00

202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

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

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu o	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	From 06/01/2020 Por To 05/31/2021 Do	orksheet E art A ate/Time Prepared: 0/29/2021 5:12 pm

PART A. I NEAT PAT HOSPITAL SERVICES INDEE I PPS 1.00				00, 01, 2021	10/29/2021 5:	12 pm
Next A - IMPATIBN HOSPITAL SERVICES WIDER IPPS 0 1.0			Title XVIII	Hospi tal	PPS	
Next A - IMPATIBN HOSPITAL SERVICES WIDER IPPS 0 1.0					1. 00	
1.00 Instructions 1.01 Instructions 1.02 Instructions 1.02 Instructions 1.02 Instructions 1.03 Instructions 1.03 Instructions 1.04 Instructions 1.05 Instructions		PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
Instructions) 1.02 IDAS accounts other than outlier payments for discharges occurring on or after October 1 (see 1.364,389 1.02 (instructional specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.03 Instructional specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 2.00 Dutil are payments for discharges. (see instructions) 2.01 Dutil are payments for of scharges occurring prior to October 1 (see instructions) 2.02 Dutil are payments for discharges occurring on or after october 1 (see instructions) 2.03 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.04 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.05 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.06 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.06 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.06 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.07 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.08 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.09 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.00 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.00 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.00 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.00 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.00 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.00 Dutil are payments for discharges occurring on or after October 1 (see instructions) 3.00 Dutil are payments for discharges occurring on or after October 1 (see instruc	1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.02 DNK amounts other than outlier payments for discharges occurring on or after October 1 (see 1,364,389 1.02 1.03	1.01		ing prior to October 1 (s	see	512, 200	1. 01
Instructions	4 00				4 0/4 000	4 00
DRC for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (asset instructions) 1 (asset instructions) 1 (asset instructions) 1 (asset instructions) 1 (asset instructions) 2 (asset instructions) 2 (asset instructions) 2 (asset instructions) 3 (asset instructions) 4 (asset instructions) 4 (asset instructions) 4 (asset instructions) 4 (asset instructions) 5 (asset instructions) 6 (asset instructions) 6 (asset instructions) 7 (asset i	1.02	. ,	ing on or after uctober	ı (see	1, 364, 389	1.02
1 (see instructions)	1 03		or discharges occurring i	orior to October	0	1 03
1.04 Disc for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04	1.00		or arsenarges occurring p	STITULE TO GOLOBOL	Ŭ	1.00
2.00 Outlier payments for discharges (see Instructions) 0.20 Outlier payment for discharges for Model 4 BPCI (see instructions) 7. 23 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 7. 23 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 7. 23 2.03 Outlier payments for discharges occurring on or after October 1 (see instructions) 168. 088 2.04 1.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 59. 60 Outlier payments for discharges occurring on or after October 1 (see instructions) 59. 60 Country of Outlier payments for discharges occurring period (see instructions) 59. 60 Outlier payments for discharges occurring on or after October 1 (see instructions) 59. 60 Country of Outlier payments for Outlier payments of Outlier payments for Outlier payments of Outlier payments for Outlier payments of Outlier payments of Outlier payments of Outlier payments of Outlier payments of Outlier payments of Outlier payments of Outlier payments of Outlier payments outlier payments of Outlier payments outlier payments outlier pay	1.04		or discharges occurring o	on or after	0	1. 04
2.01 Outlier rescondilation amount 0 2.01						
2.02 2.03 Outlier payments for discharges soccurring prior to October 1 (see Instructions) 7.253 2.03 2.04 2.05		, ,				
2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 7.23 2.03 Column 168.066 2.04 Outlier payments for discharges occurring on a rafter October 1 (see instructions) 1.603.988 3.00 All Discharges occurring on a rafter October 1 (see instructions) 59.60 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 59.60 4.00 The Count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/37/1996 (see instructions) 8.05 5.00 The Count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/37/1996 (see instructions) 7.00 A.05 5.00 The programs in accordance with 42 CFR 413.79(e) 7.01 A.05 5.05 Count for all opathic and osteopathic programs for a cost report straddles July 1, 2011 then see instructions. 7.01 A.05 5.05 Foreign and the first payment of the IME cap as specified under 42 CFR 431.205(f(1)(1)(1)(8)(1) 0.00 7.					-	
2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 168,068 2.00		, ,	•		ū	1
Managed Car's Simulated Payments 1,603,598 3,00 4,00 8ed days available divided by number of days in the cost reporting period (see instructions) 59,00 4,00						1
Bed days available divided by number of days in the cost reporting period (see instructions) 59.60 4.00			r (see rhstructions)			1
Indirect Medical Education Adjustment S.00 First Count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see Instructions) S.00 First Count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413. 79(e) O.00 ACA \$ 5003 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) O.00 7.00 ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost cost report stradied sully 1, 2011 then see instructions O.00 Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for Adjustment (Increase)		, ,	rting period (see instru	rtions)		
FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs. In accordance with 42 CFR 413, 79(e) 7.00 MAM. Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). Teamount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the doot under \$ 5506 of ACA. (see instructions). Adjustment (increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions). OF FTE count for residents in dental and podiatric programs. OF FTE count for allopathic and osteopathic programs. OF FTE count for residents in dental and podiatric programs. OF FTE count for residents in dental and podiatric programs. OF FTE count for residents in initial years of the program OF FTE count for residents in initial years of the program OF FTE count for residents in initial years of the program OF FTE count for residents in initial years of the program OF FTE Count for residents in initial years of the program OF FTE COUNT OF FTE Count for the perior year. OF FTE COUNT OF	4.00		tring period (see riistru	211 0113)	37.00	4.00
or before 12/31/1996, (see instructions) or before 12/31/1996 (see instructions) or before 12/31/1996 (see instructions) or before 12/31/1996 (see instructions) or before 12/31/1996 (see instructions) new programs in accordance with 42 CFR 413.79(e) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost cost report straddles July 1, 2011 then see instructions Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (Mby 12, 1998), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost under \$ 5506 of ACA. (see instructions) 9. 0 Sum of lines \$ Dius 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.69 0.00 lines of lines \$ Dius 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.69 0.00 lines of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.69 0.00 lines of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.69 0.00 lines of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.69 0.00 lines of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.69 0.00 lines of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.69 0.00 lines of lines 6 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.69 0.00 lines 0.00 minus minus lines (8, 8, 01 and 8, 02) (see 0.69 0.00 lines 0.00 minus minus lines (8, 8, 01 and 8, 02) (see 0.00 0.00 lines 0.00 minus minus lines (8, 8, 01 and 8, 02) (see 0.00 0.00 lines 0.00 minus minus lines 0.00 lines 0.00 lines 0.00 lines 0.00 line	5.00		t recent cost reporting (period ending on	8. 95	5.00
new programs n accordance with 42 CFR 413.79(e) 0.00 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost report straddle sully 1, 2011 then see instructions, affiliated programs for affiliated programs in accordance with 42 CFR 413.75(d), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 8.02 The count for allopathic and osteopathic programs in the current year from your records 8.02 The count for allopathic and osteopathic programs in the current year from your records 8.03 10.00 11.00 1			3 1			
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(2) if the cost report straddles July 1, 2011 then see instructions. 8.00 All street of the s	6.00	FTE count for allopathic and osteopathic programs that meet ti	he criteria for an add-o	n to the cap for	0.00	6. 00
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cost report straddles July 1, 2011 then see instructions. 8. 00 All ustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for affil lated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (Mugust 1, 2002). 8. 01 The amount of increase if the hospital was awarded FIE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 Index amount of increase if the hospital was awarded FIE cap slots from a closed teaching hospital of under § 5506 of ACA. (see Instructions). 9. 00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.69 9.00 instructions). 9. 00 FIE count for all opathic and osteopathic programs in the current year from your records 0.83 10.00 Current year allowable FIE (see Instructions). 9. 01 Current year allowable FIE (see Instructions). 9. 02 Current year allowable FIE count for the propult imate year if that year ended on or after September 30, 1997, otherwise enter zero. 9. 03 Sum of lines 12 through 14 divided by 3. 9. 05 Sum of lines 12 through 14 divided by 3. 9. 05 Sum of lines 12 through 14 divided by 3. 9. 05 Sum of lines 12 through 14 divided by 3. 9. 06 Adj ustment for residents in initial years of the program 0.00 17.00 Adj ustment for residents in initial years of the program 0.00 17.00 Adj ustment for residents in sinitial years of the program 0.00 17.00 Adj ustment for residents in sinitial years of the program 0.00 17.00 Current year resident to bed ratio (see instructions) 0.004981 2.00 17.00 Current year resident to bed ratio (see instructions) 0.004981 2.00 17.00 Current year resident to bed ratio (see instructions) 0.004981 2.00 17.00 Current year resident to bed ratio (see instructions) 0.004981 2.00 17.00 Current year resident to bed ratio (see instructions) 0.004981 2.00 17.00 Current year resident to bed ratio (see instructions) 0.004981 2.00 17.00 Current year resident to bed ratio (see instructions) 0.00498		l · · · · · · · · · · · · · · · · · · ·				1
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14.00						1
Otherwise enter zero. Sum of lines 12 through 14 divided by 3. 0.54 15.00 16.00 16.00 16.00 16.00 17.00 20		, ,	ar ended on or after Sep	tember 30. 1997.		1
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34.00 Disproportionate share adjustment (see instructions) 56,298 34.00)			ı
	34. 00	Disproportionate share adjustment (see instructions)			56, 298	34.00

	Financial Systems ST JOSEPH MEDIC ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od: From 06/01/2020 To 05/31/2021		pared:
		Title XVIII	Hospi tal	PPS	12 piii
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35. 00 35. 01 35. 02	Total uncompensated care amount (see instructions) Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enterinstructions)	er zero on this line) (se	0. 000000000 e 1, 305, 861	0. 000000000	35. 01
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amount Total uncompensated care (sum of columns 1 and 2 on line 35.0	03)	435, 287 942, 814		35. 03 36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 6		gn 46) 0		40. 00
	instructions)		Before 1/1	On/After 1/1	
	I		1. 00	1. 01	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)	583, 684 an 685. (see	0	0	41.00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	-DRGs 652, 682, 683, 684	0	0	41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions)		0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instructions	s)	0.00	0.00	45. 00
46.00	Total additional payment (line 45 times line 44 times line 41	1.01)	2 057 202		46. 00 47. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	3, 057, 302		48.00
	only. (see instructions)			Amount	
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions			3, 062, 669	
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I ar Exception payment for inpatient program capital (Wkst. L, Pt.			186, 453 0	ı
52.00	Direct graduate medical education payment (from Wkst. E-4, li			13, 731	52. 00
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0 85, 098	53. 00 54. 00
54. 01	Islet isolation add-on payment			03,078	54. 01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6			0	55. 00
56.00	Cost of physicians' services in a teaching hospital (see intr		h	0	56.00
57. 00 58. 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt.		nrougn 35).	0	
59. 00	Total (sum of amounts on lines 49 through 58)	, 200,		3, 347, 951	
60.00	Primary payer payments			5, 844	1
61. 00 62. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		3, 342, 107	1
63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			214, 276 16, 211	1
64. 00	Allowable bad debts (see instructions)			137, 691	64. 00
65.00	Adjusted reimbursable bad debts (see instructions)			89, 499	
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63)	tructions)		52, 699 3, 201, 119	
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	3, 201, 119	1
	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69. 00
69. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.00	Dural Community Hoonital Demonstration Design (C4404 5	TALLODI AMINETMANT (CAA	instructions)	0	70. 50
70. 00 70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see		1 0	70 87
70.00	Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	tration) adjustment (see		0	70. 87 70. 88
70. 00 70. 50 70. 87 70. 88 70. 89	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	, ,		0	70. 88 70. 89
70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	, ,		0	70. 88 70. 89 70. 90
70. 00 70. 50 70. 87 70. 88 70. 89	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	, ,		0	70. 88 70. 89 70. 90 70. 91
70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	, ,		0 0	70. 88 70. 89 70. 90 70. 91 70. 92 70. 93

Heal th	Financial Systems	ST JOSEPH MEDICA	L CENTER		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CO	CN: 15-0047	Period: From 06/01/2020 To 05/31/2021		
			Title	XVIII	Hospi tal	PPS	
				FFY	(уууу)	Amount	
					0	1. 00	
70. 96	Low volume adjustment for federal fiscal year the corresponding federal year for the period		column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year the corresponding federal year for the period				0	0	70. 97
70. 98	Low Volume Payment-3					0	70. 98
70. 99	HAC adjustment amount (see instructions)					0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 pl	lus/minus lines 6	9 & 70)			3, 199, 703	71.00
71. 01	Sequestration adjustment (see instructions)					0	71. 01
	Demonstration payment adjustment amount after	sequestrati on				0	71. 02

71.03

	71. 03	Sequestration adjustment-PARHM pass-throughs		2 475 047	71. 03
	72.00			2, 675, 067	72.00
	72. 01	Interim payments-PARHM Tentative settlement (for contractor use only)		0	
	73. 00 73. 01	Tentative settlement-PARHM (for contractor use only)		0	73.00
	74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		524, 636	1
	74.00	73)		324, 030	74.00
	74. 01	Balance due provider/program-PARHM (see instructions)			74. 01
	75. 00	Protested amounts (nonallowable cost report items) in accordance with		703, 978	75. 00
		CMS Pub. 15-2, chapter 1, §115.2			
		TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
,	90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.00
	01 00	plus 2.04 (see instructions)		0	01 00
	91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	
	92.00	Operating outlier reconciliation adjustment amount (see instructions) Capital outlier reconciliation adjustment amount (see instructions)		0	1
	93. 00 94. 00	The rate used to calculate the time value of money (see instructions)			94.00
	95. 00	Time value of money for operating expenses (see instructions)		0.00	
		Time value of money for capital related expenses (see instructions)			1
	70.00	Time value of money for capital related expenses (see first actions)	Prior to 10/1	On/After 10/1	70.00
			1. 00	2.00	
-		HSP Bonus Payment Amount	1.00	1 2.00	
	100.00	HSP bonus amount (see instructions)	(0	100.00
		HVBP Adjustment for HSP Bonus Payment		1	1
	101. 00	HVBP adjustment factor (see instructions)	0. 0000000000	0.000000000	101.00
	102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102. 00
		HRR Adjustment for HSP Bonus Payment			1
	103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
	104.00	HRR adjustment amount for HSP bonus payment (see instructions)	(0	104. 00
		Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
:	200. 00	Is this the first year of the current 5-year demonstration period under the 21st			200. 00
		Century Cures Act? Enter "Y" for yes or "N" for no.			1
		Cost Reimbursement		T	
		Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
		Medicare discharges (see instructions)			202. 00
-	203.00	Case-mix adjustment factor (see instructions)			203. 00
		Computation of Demonstration Target Amount Limitation (N/A in first year of the cuiperiod)	rrent 5-year demons	tration	
	204. 00	Medicare target amount			204. 00
		Case-mix adjusted target amount (line 203 times line 204)			205. 00
		Medicare inpatient routine cost cap (line 202 times line 205)			206.00
		Adjustment to Medicare Part A Inpatient Reimbursement	<u> </u>		1
:	207. 00	Program reimbursement under the §410A Demonstration (see instructions)			207. 00
:	208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
:	209. 00	Adjustment to Medicare IPPS payments (see instructions)			209. 00
	210. 00	Reserved for future use			210. 00
	211. 00	Total adjustment to Medicare IPPS payments (see instructions)			211. 00
		Comparision of PPS versus Cost Reimbursement			
		Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
		Low-volume adjustment (see instructions)			213. 00
	218. 00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)		218. 00
		(line 212 minus line 213) (see instructions)		ļ	I

71.03 | Sequestration adjustment-PARHM pass-throughs

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	Peri od: Worksheet E From 06/01/2020 Part B To 05/31/2021 Date/Time Prepared:

			10 03/31/2021	10/29/2021 5:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		<u>. </u>	1.00	
1.00	Medical and other services (see instructions)			3, 463	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		1, 242, 679	2. 00
3.00	OPPS payments			521, 507	3. 00
4.00	Outlier payment (see instructions)			2, 266	4. 00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruct	i ana)		0. 000	4. 01 5. 00
6. 00	Line 2 times line 5	i ons)		0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			3, 463	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			17, 333	12 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)			17, 333	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pa			0	15. 00
16. 00	Amounts that would have been realized from patients liable for	payment for services on	a chargebasis	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
18. 00	Total customary charges (see instructions)			17, 333	18.00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lin	e 11) (see	13, 870	19.00
	instructions)		, ,		
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	e 18) (see	0	20. 00
21 00	instructions)			2 4/2	21 00
21. 00 22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			3, 463	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			523, 773	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			811	
26. 00	Deductibles and Coinsurance amounts relating to amount on line	•		85, 983	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plinstructions)	us the sum of lines 22	and 23] (see	440, 442	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		3, 680	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			444, 122	
31. 00	Primary payer payments			418	
32. 00	Subtotal (line 30 minus line 31)			443, 704	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	S)		0	22 00
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			80, 510	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			52, 332	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		29, 212	36. 00
37.00	Subtotal (see instructions)			496, 036	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			-137	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50 39. 97
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	d davicas (saa instruct	i one)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	d devices (see mistract	10113)	0	39. 99
40. 00	Subtotal (see instructions)			496, 173	40.00
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41.00	Interim payments			569, 414	
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01 42. 00
42. 00	Tentative settlement (for contractors use only)			0	42.00
43. 00	Balance due provider/program (see instructions)			-73, 241	
43. 01	Balance due provider/program-PARHM (see instructions)			2, =	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, c	hapter 1,	0	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR				00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
91.00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0.00	93. 00
	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems ST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 06/01/2020 Part I
To 05/31/2021 Date/Time Prepared: 10/29/2021 5: 12 pm Provider CCN: 15-0047

					10/29/2021 5:	12 pm_
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	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		2, 675, 06		569, 414	1. 00
2.00	Interim payments payable on individual bills, either		(O	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		(O	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				O	0	3. 04
3.05			(0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				O	0	3. 51
3. 52				O	0	3. 52
3. 53				O	0	3. 53
3.54				O	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(O	0	3. 99
4.00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		2, 675, 06 ⁻	7	569, 414	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		2, 675, 06	/	309, 414	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			O	0	5. 01
5. 02				O	0	5. 02
5.03			(O	0	5. 03
E E0	Provider to Program TENTATIVE TO PROGRAM			1	0	5. 50
5. 50 5. 51	I ENTATIVE TO PROGRAM			0	0	5. 50
5. 51				0		5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
0. 77	5. 50-5. 98)		· ·			0. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		524, 63	6	0	6. 01
6.02	SETTLEMENT TO PROGRAM			O	73, 241	6. 02
7.00	Total Medicare program liability (see instructions)		3, 199, 70	3	496, 173	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor)	1. 00	2. 00	0.00
8.00	Name of Contractor					8. 00

Heal th	Financial Systems ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0047 Period: From 06/01/2020 To 05/31/2021				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	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	-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	-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 cline 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
22.00	Polones due provider (line 0 (er line 10) minus line 20 and l	ina 21) (aaa imatmustian)		22.00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	ST JOSEPH MEDICAL CENTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	Peri od: Worksheet E-3 From 06/01/2020 Part VII To 05/31/2021 Date/Time Prepared:

			Го 05/31/2021	Date/Time Pre 10/29/2021 5:	
		Title XIX	Hospi tal	PPS	
		·	Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			1, 456, 332	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	1, 456, 332	
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		0	1, 456, 332	7. 00
	Reasonable Charges				
8.00	Routine service charges		3, 386, 378		8.00
9. 00	Ancillary service charges		4, 986, 628	7, 580, 483	
10. 00	Organ acquisition charges, net of revenue		0	7,000,100	10.00
	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		8, 373, 006	7, 580, 483	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis			_	
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15. 00	a charge basis had such payment been made in accordance with 42 Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		8, 373, 006	7, 580, 483	1
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	8, 373, 006	6, 124, 151	1
	line 4) (see instructions)	The to execus	0,0,0,000	0, 12., 10.	
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		0	1, 456, 332	21. 00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c Other than outlier payments	completed for PPS provide	ers.	0	22.00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		Ö	O	24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	1, 456, 332	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	1, 456, 332	
32. 00	Deducti bl es		0	0	
33. 00 34. 00			0	0	
35. 00	Utilization review		0	U	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	o	1, 456, 332	1
	ELIMINATE SETTLEMENT		o	-1, 456, 332	
	Subtotal (line 36 ± line 37)		0	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40. 00
41.00	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41)		0	0	•
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				I

	Financial Systems ST JOSEPH MED GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider C	CN: 15 0047	In Lie Period:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS	Provider C		From 06/01/2020 To 05/31/2021	Date/Time Prep 10/29/2021 5:	pared:
		Title	xVIII	Hospi tal	PPS	12 piii
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathi ending on or before December 31, 1996.	c programs for	cost reporti	ng periods	7. 63	1.00
. 00	Unweighted FTE resident cap add-on for new programs per 42		1) (see instr	uctions)	0. 00	
. 00 . 01	Amount of reduction to Direct GME cap under section 422 of Direct GME cap reduction amount under ACA §5503 in accordan) 8/13 70 (m)	(500	0. 00 0. 00	
. 01	instructions for cost reporting periods straddling 7/1/2011)			0.00	3.0
. 00	Adjustment (plus or minus) to the FTE cap for allopathic an GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (programs due	to a Medicare	-6. 94	4.0
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see in		cost reporti	ng periods	0. 00	4.0
. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap sl	ote (soo inst	ructions for	cost roporting	0. 00	4.0
. 02	periods straddling 7/1/2011)	ots (see mst	Tuctions for	cost reporting	0.00	4.0.
5. 00	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	Unweighted resident FTE count for allopathic and osteopathi	c programs for	the current	year from your	0. 83	6.0
	records (see instructions)	. 0		,	0. (0	7.0
. 00	Enter the lesser of line 5 or line 6		Primary Care	Other	0. 69 Total	7. 0
	Two to the total of the total o		1.00	2.00	3. 00	
. 00	Weighted FTE count for physicians in an allopathic and oste program for the current year.	eopathi c	0.8	0.00	0. 83	8.0
. 00	If line 6 is less than 5 enter the amount from line 8, othe multiply line 8 times the result of line 5 divided by the a		0. 6	9 0.00	0. 69	9. 0
0. 00	6. Weighted dental and podiatric resident FTE count for the cu	irrent vear		0.00		10.0
0. 01	Unweighted dental and podiatric resident FTE count for the			0.00		10.0
1.00	Total weighted FTE count	(0.6			11.0
2. 00	Total weighted resident FTE count for the prior cost report instructions)	ing year (see	0. 4	2 0.00		12.0
3. 00	Total weighted resident FTE count for the penultimate cost	reporting	0. 5	0. 00		13. 0
4. 00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divid	led by 3).	0.5	4 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 c		0.0			15. 0 16. 0
6. 01	Unweighted adjustment for residents displaced by program or		0.0			16. 0
7. 00	closure Adjusted rolling average FTE count		0.5	4 0.00		 17. 0
8. 00	Per resident amount		105, 676. 1			18. 0
9. 00	Approved amount for resident costs		57, 06	5 0	57, 065	19. 0
					1. 00	
0. 00	Additional unweighted allopathic and osteopathic direct GME	FTE resident	cap slots rec	eived under 42	5. 00	20. 0
1. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see inst	ructions)			0. 14	21.0
2. 00	Allowable additional direct GME FTE Resident Count (see ins	structions)			0. 14	22. 0
3. 00 4. 00	Enter the locality adjustment national average per resident Multiply line 22 time line 23	amount (see i	nstructions)		105, 092. 06 14, 713	1
5. 00	Total direct GME amount (sum of lines 19 and 24)				71, 778	
		Inpatient Part A	Managed Care Prior to 1/1	On or after	Total	
		1. 00	2. 00	1/1 2. 01	3. 00	
4 00	COMPUTATION OF PROGRAM PATIENT LOAD	4 055		/ 704		2/ 0/
6. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	1, 355	32	6 731		26.0
7. 00	Total Inpatient Days (see instructions)	9, 766				27.0
8. 00	Ratio of inpatient days to total inpatient days Program direct GME amount	0. 138747 9, 959			17, 728	28. 0 29. 0
9. 01	Percent reduction for MA DGME	7, 939	4.0		17,720	29.0
0.00	Reduction for direct GME payments for Medicare Advantage		9	8 219	317	1
1.00	Net Program direct GME amount		I		17, 411	J 31. 00

Heal th	Financial Systems ST JOSEPH MEDICA	AL CENTER	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0047	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 06/01/2020 To 05/31/2021	Date/Time Prep 10/29/2021 5:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI EDUCATION COSTS)	`		CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B,	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
	and 94)			00.400	
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.		74 and 94)	90, 483	
34. 00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ IIne 33)		0. 000000	
	00 Medicare outpatient ESRD charges (see instructions)			0	35. 00 36. 00
36.00	.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				36.00
	Part A Reasonable Cost	ONLY			
37. 00				4, 654, 059	37 00
38. 00	1			4, 054, 057	38.00
	.00 Cost of physicians' services in a teaching hospital (see instructions)			0	39. 00
	00 Primary payer payments (see instructions)			5. 844	40. 00
	.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			4, 648, 215	
	Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)			1, 246, 142	42.00
43.00	Primary payer payments (see instructions)			418	43.00
	Total Part B reasonable cost (line 42 minus line 43)			1, 245, 724	
	Total reasonable cost (sum of lines 41 and 44)			5, 893, 939	
	Ratio of Part A reasonable cost to total reasonable cost (lin	,		0. 788643	
47. 00	Ratio of Part B reasonable cost to total reasonable cost (lin			0. 211357	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART	RT B			
	Total program GME payment (line 31)			17, 411	
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			13, 731	
50. 00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)	l	3, 680	50. 00

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

Provider CCN: 15-0047

Peri od: Worksheet G From 06/01/2020 To 05/31/2021 Date/Time Prepared: 10/29/2021 5: 12 pm

oni y)					10/29/2021 5:	12 pm
		General Fund	Speci fi c	Endowment Fund	Pl ant Fund	
		1.00	Purpose Fund 2.00	3. 00	4.00	
	CURRENT ASSETS	1.00	2.00	0.00	1. 00	
1.00	Cash on hand in banks	-297, 631	(0	0	
2.00	Temporary investments	0	(
3.00	Notes receivable	0		0	0	
4.00	Accounts receivable	19, 870, 980		0	0	1
5. 00 6. 00	Other receivable	0 220 002			0	
7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-9, 228, 083 1, 512, 173				
8. 00	Prepai d expenses	492, 452			0	
9. 00	Other current assets	851, 300		o o	l o	
10.00	Due from other funds	0		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	13, 201, 191	(0	0	11. 00
	FIXED ASSETS					
12.00	Land	1, 010, 000	1			1
13.00	Land improvements	412, 126	1	-		
14. 00 15. 00	Accumulated depreciation Buildings	-316, 600 28, 390, 448	1	0	0	
16. 00	Accumulated depreciation	-32, 035, 562	1			
17. 00	Leasehold improvements	23, 512, 367	1	-	Ö	
18. 00	Accumulated depreciation	-11, 567, 911	1	o o	Ö	
19.00	Fi xed equipment	1, 508, 715	i (0	0	19. 00
20.00	Accumulated depreciation	0) (0	0	
21. 00	Automobiles and trucks	0	1	0	0	
22. 00	Accumulated depreciation	0	1	0	0	
23. 00	Maj or movable equipment	17, 351, 982	1	0	0	
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-14, 252, 761 7, 671, 064	1	1		
26. 00	Accumulated depreciation	-7, 767, 524		1		
27. 00	HIT designated Assets	0			l ő	
28. 00	Accumul ated depreciation	O		0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	0) (0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	13, 916, 344	. (0	0	30. 00
	OTHER ASSETS		.1	J		
31. 00	Investments	0				
32. 00 33. 00	Deposits on leases Due from owners/officers	0	1	0	0	
34. 00	Other assets	13, 739, 386	1	_	0	1
35. 00	Total other assets (sum of lines 31-34)	13, 739, 386		1	Ö	
36.00	Total assets (sum of lines 11, 30, and 35)	40, 856, 921	1	0	0	36.00
	CURRENT LIABILITIES		,			
37. 00	Accounts payable	601, 747	1	0		1
38. 00	Salaries, wages, and fees payable	1, 377, 128	1	0	ľ	
39. 00	Payroll taxes payable (chart tarm)	146, 605		0	0	1
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	0				
42. 00	Accel erated payments	0			Ĭ	42. 00
43. 00	Due to other funds	63, 219, 901		o	0	1
44.00	Other current liabilities	7, 115, 057	1	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	72, 460, 438	3	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0		٦	0	
47. 00 48. 00	Notes payable	0	1	0 0		1
49. 00	Unsecured Loans Other Long term Liabilities					
50.00	Total long term liabilities (sum of lines 46 thru 49)	0		-	l	1
51. 00	Total liabilities (sum of lines 45 and 50)	72, 460, 438		o o	l	
	CAPITAL ACCOUNTS					
52.00	General fund balance	-31, 603, 517	'			52. 00
53.00	Specific purpose fund			O C		53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted			0		55. 00 56. 00
56.00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	
58. 00	Plant fund balance - reserve for plant improvement,					
55. 00	replacement, and expansion					55.00
59. 00	Total fund balances (sum of lines 52 thru 58)	-31, 603, 517	' (0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	40, 856, 921		0	0	60. 00
	[59]		1			

Provider CCN: 15-0047

Peri od: Worksheet G-1 From 06/01/2020 Date/Time Prepared:

					То	05/31/2021	Date/Time Prep 10/29/2021 5:	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	iz piii
				·				
		1.00	0.00	2.00		4 00	F 00	
1 00	Trund halanan at hankankan as anni ad	1.00	2. 00 -10, 505, 038	3. 00		4. 00	5. 00	1. 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		- 10, 505, 038 -21, 098, 479			U		2. 00
3.00	Total (sum of line 1 and line 2)	1	-31, 603, 517			0		3. 00
4. 00	Additions (credit adjustments) (specify)	0	-31,003,317		0	O	0	4. 00
5. 00	That trons (or car trady as timents) (specify)				0		o o	5. 00
6.00					0		o	6. 00
7.00		0			0		O	7. 00
8.00		0			0		0	8.00
9.00		0			0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11. 00	Subtotal (line 3 plus line 10)		-31, 603, 517			0		11. 00
12.00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13. 00		0			0		0	13. 00
14. 00		0			0		0	14. 00
15.00		0			0		0	15.00
16. 00 17. 00		0			0		0	16. 00 17. 00
18.00	Total deductions (sum of lines 12-17)	١	0		U	0	U	17. 00
19. 00	Fund balance at end of period per balance	1	-31, 603, 517			0		19. 00
17.00	sheet (line 11 minus line 18)		-31,003,317			O		17.00
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2)	0	0		0			3. 00
4. 00 5. 00	Additions (credit adjustments) (specify)		0					4. 00 5. 00
6. 00			0					6. 00
7. 00		1	0					7. 00
8. 00			0					8. 00
9. 00			0					9. 00
10.00	Total additions (sum of line 4-9)	o	-		0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14.00			0					14.00
15.00			0					15.00
16. 00			0					16.00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	0			U			19. 00
	sheet (line 11 minus line 18)	1	l	1	I		l	

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

			10 05/31/2021	10/29/2021 5:	
	Cost Center Description	Inpatient	Outpati ent	Total	
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	·			
	General Inpatient Routine Services				
1.00	Hospi tal	28, 998, 29	5	28, 998, 295	1. 00
2.00	SUBPROVI DER - I PF			0	2.00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY			0	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)	28, 998, 29	5	28, 998, 295	10.00
	Intensive Care Type Inpatient Hospital Services	, , ,			
11.00	INTENSIVE CARE UNIT				11. 00
12.00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT			0	13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lir	ies (0	16. 00
	11-15)			_	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	28, 998, 29	5	28, 998, 295	17. 00
18. 00	Ancillary services	33, 388, 88		97, 762, 114	18. 00
19. 00	Outpatient services	4, 754, 776		33, 970, 220	19. 00
20. 00	RURAL HEALTH CLINIC		0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	21. 00
22. 00	HOME HEALTH AGENCY			· ·	22. 00
23. 00	AMBULANCE SERVI CES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	CONTRACTED HOSPI CE	96, 75	5 0	96, 755	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to				28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		· · · · · · · · · · · · · · · · · · ·		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		60, 785, 209		29. 00
30.00	ADD (SPECIFY)				30. 00
31.00					31. 00
32.00					32. 00
33.00					33. 00
34.00					34.00
35.00					35. 00
36.00	Total additions (sum of lines 30-35)		o		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39.00					39. 00
40.00					40.00
41. 00					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)(t	ransfer	60, 785, 209		43.00
	to Wkst. G-3, line 4)				
		•	•	·	

	Financial Systems	ST JOSEPH MEDICAL CENTER		u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0047	Peri od: From 06/01/2020	Worksheet G-3	
			To 05/31/2021		
	<u> </u>			10/29/2021 5:	12 pm
				4.00	
1. 00	Total patient revenues (from Wkst. G-2, Part	L column 2 line 20)		1. 00 160, 827, 384	1. 00
2.00	Less contractual allowances and discounts on			133, 522, 058	
3.00	Net patient revenues (line 1 minus line 2)	patrents accounts		27, 305, 326	
4. 00	Less total operating expenses (from Wkst. G-2	Dort II line 42)		60, 785, 209	
5. 00	Net income from service to patients (line 3 m			-33, 479, 883	ı
5.00	OTHER I NCOME	Tilus Title 4)		-33, 477, 003	3.00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneo	us communication services		0	
9. 00	Revenue from television and radio service	as communication services		Ö	1
	Purchase di scounts			0	
	Rebates and refunds of expenses			0	1
	Parking lot receipts			0	
	Revenue from Laundry and Linen service			0	1
	Revenue from meals sold to employees and gues	ts		0	
	Revenue from rental of living quarters			0	ı
	Revenue from sale of medical and surgical sup	olies to other than patients		0	
	Revenue from sale of drugs to other than pati			0	17. 00
18. 00	Revenue from sale of medical records and abst			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, e	tc.)		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and	d canteen		0	20.00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER MISC GAIN/LOSS			-30, 833	24. 00
24. 50	COVI D-19 PHE Funding			12, 412, 237	
25.00	Total other income (sum of lines 6-24)			12, 381, 404	1
26.00	Total (line 5 plus line 25)			-21, 098, 479	26. 00
27 00	OTHED			0	27 00

0 27. 00 0 28. 00 -21, 098, 479 29. 00

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

27. 00 OTHER

	n Financial Systems ST JOSEPH MEDI LATION OF CAPITAL PAYMENT	Provi der CCN: 15-0047	Peri od:	w of Form CMS-2 Worksheet L	
			From 06/01/2020 To 05/31/2021	Parts I-III Date/Time Pre	
		Title XVIII	Hospi tal	10/29/2021 5: PPS	12 pm
		II the Aviii	110Spi tai	I FF3	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			140, 307	1.00
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			0 45, 136	
2.00	Model 4 BPCI Capital DRG outlier payments			45, 130	
3.00	Total inpatient days divided by number of days in the cost in	renorting period (see inst	tructions)	26. 81	
4. 00	Number of interns & residents (see instructions)	reper tring period (see riis)	11 40 (1 0113)	0. 68	
5. 00	Indirect medical education percentage (see instructions)			0. 72	
6. 00	Indirect medical education adjustment (multiply line 5 by th 1.01) (see instructions)	ne sum of lines 1 and 1.01	I, columns 1 and	1, 010	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet E	E, part A line	0. 00	7. 00
8. 00	Percentage of Medicaid patient days to total days (see instr	ructions)		0.00	
9. 00	Sum of lines 7 and 8			0. 00	
10.00	3 (0.00	
11.00	, , , , , , , , , , , , , , , , , , ,			104 453	
12. 00	Total prospective capital payments (see instructions)			186, 453	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3. 00 4. 00				0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	
5.00	Total Tripatrent program capital cost (Trile 3 x Trile 4)			0	3.00
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstar	ncos (soo instructions)		0	
3.00	Net program inpatient capital costs for extraordinary circumstar	ices (see Histractions)		0	
4. 00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordinar	•	(line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8.00
9. 00	Current year capital payments (from Part I, line 12, as appl			0	
10.00	Current year comparison of capital minimum payment level to	1 1 3 1	,	0	
11. 00	Worksheet L, Part III, line 14)		,	0	
				0	
			,	0	
12. 00 13. 00	THATTYOUGH OF ACCUMULATED CANITAL MINIMUM NAVMENT LEVEL OVER	capital payment for the f	on owing period	0	14.00
13. 00 14. 00	(if line 12 is negative, enter the amount on this line)				15 00
13. 00 14. 00 15. 00	(if line 12 is negative, enter the amount on this line)	nstructions)		0	