### ST. JOSEPHS REG MED CENTER PLYMOUTH

In Lieu of Form CMS-2552-10

OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0076 Worksheet S Peri od. From 07/01/2020 Parts I-III AND SETTLEMENT SUMMARY 06/30/2021 Date/Time Prepared: То 11/30/2021 12:37 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 11/30/2021 Time: 12:37 pm use only ] Manually prepared cost report 2. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [ 

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

PART II - CERTIFICATION

MISREPRESENTATION OF 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 OF 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. JOSEPHS REG MED CENTER PLYMOUTH (15-0076) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 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.

[X] 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.

0 3		5	0	0
(Si gned)	ROBERT SINK			
	Officer or	Admi ni strato	or of Provi	der(s)
	CF0			
Ti tl	е			
	(Dated when	report is el	ectroni cal	ly signed.)

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	254, 709	-11, 162	0	0	1.00
2.00	Subprovider - 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
200.00	Total	0	254, 709	-11, 162	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	ler CCN		Period: From 07/01/		Workshe Part I	eet S-2	2
						To 06/30/	2021	Date/Ti 11/30/2		
	1.00	2.00		3.00			4.00			
	Hospital and Hospital Health Care Co									1
00 00	Street: 1915 LAKE AVENUE City: PLYMOUTH	PO Box:670 State: IN	Zip Cod	o. 1654	63 Count	ty: MARSHALL				1.
50	city. Fermoorn	Component Name	CCN	CBS			Payme	nt Syst	em (P.	<u> </u>
			Number	Numb		Certified		0, or		
							V	XVIII	XIX	
		1.00	2.00	3.0	0 4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer		45007/	0000	15 4	07 (04 (400)	N			
0	Hospi tal	ST. JOSEPHS REG MED CENTER PLYMOUTH	150076	9991	15 1	07/01/1996	N	P	P	3
0	Subprovider - IPF	CENTER PETWOOTH								4
0	Subprovider - IRF									5
00	Subprovider - (Other)									6
0	Swing Beds - SNF									7
0	Swing Beds - NF									8
0	Hospital-Based SNF									9
00	Hospital-Based NF									10
00	Hospital-Based OLTC Hospital-Based HHA									11
00 00	Separately Certified ASC									12
	Hospi tal -Based Hospi ce									14
00	Hospital -Based Health Clinic - RHC									15
	Hospital-Based Health Clinic - FQHC									16
00	Hospital-Based (CMHC) I									17
00	Renal Dialysis									18
00	Other							<u> </u>		19
						From: 1.00		To 2. (		-
00	Cost Reporting Period (mm/dd/yyyy)					07/01/2		06/30		20
	Type of Control (see instructions)					1	020	00/00/	2021	21
					1.00	2.00		3. (	00	
00	Inpatient PPS Information Does this facility qualify and is it	currently receiving n	avments for	- 1	Y	N				22
00	disproportionate share hospital adju				1	1				22
	§412.106? In column 1, enter "Y" fo			.						
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo									
01	Did this hospital receive interim un				Y	Y				22
	cost reporting period? Enter in colu									
	the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N									
	reporting period occurring on or aft			JUST						
. 02	Is this a newly merged hospital that			-e	Ν	N				22
	payments to be determined at cost re									
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob									
	or "N" for no, for the portion of th October 1.	ne cost reporting perio	d on or art	ter						
03	Did this hospital receive a geograph	nic reclassification fr	om urban to	,	Ν	N		Ν	1	22
00	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin			er						
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									
	Does this hospital contain at least counted in accordance with 42 CFR 41		•							
	yes or "N" for no.	2 soj. Enter in corum								
04	Did this hospital receive a geograph	nic reclassification fr	om urban to	b						22
	rural as a result of the revised OMB									
	adopted by CMS in FY 2021? Enter in									1
	for the portion of the cost reportin			er						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft									1
	Does this hospital contain at least			15						
	bees in a noopi tai contain at reast									
	counted in accordance with 42 CFR 41									1
	counted in accordance with 42 CFR 41 yes or "N" for no.						1			
00	yes or "N" for no. Which method is used to determine Me	edicaid days on lines 2				3 N				23
00	yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	dicaid days on lines 2 of admission, 2 if cen	sus days, c	or 3		3 N				23
00	yes or "N" for no. Which method is used to determine Me	dicaid days on lines 2 of admission, 2 if cen of identifying the day	sus days, c s in this c	or 3		3 N				23

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA I	Provider CC	N: 15-0076	Peri od:	101 (202)		sheet	S-2	
					From 07 To 06	/30/202	1 Date	/Time 0/2021		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid		cai d 📋	Othe Medica days	r iid	
		1.00	2.00	3.00	4.00	5. (	20	6.00	)	
. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state	77	63 0			4	915		49 2	24. 25.
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.									
						/Rural : 1.00	S Date	 2.00	ogr	
00	Enter your standard geographic classification (not wa		at the beg	jinning of t		1.00	2	2.00	2	26.
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status - "2" for r cation in d	ural. If ap column 2.	pplicable,			2			27.
. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status ir	n		0		3	35.
						nni ng:	E	ndi ng:		
00	Enter applicable beginning and ending dates of SCH st	atus Subs	crint line	36 for numb		. 00		2.00		36
of periods in excess of one and enter subsequent dates. 7.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0									37	
01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								3	37
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								3	38
						Y/N 1.00		Y/N		
00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no alumn 1 for disperses prior to octob	, (ii), or the mileage i)? Enter n adjustmen	(iii)? Ent requiremer in column 2 t? Enter "Y	er in colum nts in 2 "Y" for ye (" for yes c	ime in es or	Y N		<u>2.00</u> Y		39. 40.
	"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.			es or in i	or					
	-					V 1. (			I X 00	
00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for disp	roporti onat	e share in	accordanc	e N	1	1	N 4	45
00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					n N	1	ı	N 4	46
00 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment					N				47 48
00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic Teator "N" for point of the provise other "N" for point of the provise other the pro	e to column ograms in cable CRs)	1 is "Y", the prior y	or if this /ear or penu	hospital Iltimate				Ę	56
	Enter "Y" for yes; otherwise, enter "N" for no in col		ng which re			1			Ę	57
00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N th of this ( (", complet) , if appli	cost report e Worksheet cable.	ing period? E-4. If co	? Enter" olumn 2 is	Y"				
00	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N ch of this (", complet , if appli oursement fo	cost report e Worksheet cable. or physicia	ing period? E-4. If co	? Enter" olumn 2 is	Y"	1		Ę	58

ealth Financial Systems ST. JOSEPHS HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		CENTER PLYMOL	CN: 15-0076 Pe	eri od:	Worksheet S-2	
			T	rom 07/01/2020 o 06/30/2021	Part I Date/Time Pre 11/30/2021 12	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
b0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	see If column 1	N			60.00
	Y/N	IME	Direct GME	IME	Direct GME	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1.00 N	2.00	3.00	4.00	5.00 0.00	61.00
column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 0 <sup>-</sup>
instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 0
<ul> <li>1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)</li> </ul>						61.0
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
<ul> <li>1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program name.</li> </ul>				0.00		61. 1
<ol> <li>the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> </ol>						
ACA Provisions Affecting the Health Resources and Ser		Admi ni strati ca	(HDSA)		1.00	
2.00 Enter the number of FTE residents that your hospital	trai nec			od for which	0.00	62.0
your hospital received HRSA PCRE funding (see instruct 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	Teachi ram. (s	<u>see instruction</u>		your hospital	0.00	62.0
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co			N Ratio (col. 1/ (col. 1 + col. 2)) 3.00	63. (
Section 5504 of the ACA Base Year FTE Residents in No						
period that begins on or after July 1, 2009 and befor 4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y trair -primar all nor non-pr columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0. 00	0. 000000	64.0

	EX IDENTIFICATION DA		Fr	riod: om 07/01/2020	Worksheet S-2 Part I	
			To	06/30/2021	Date/Time Pre 11/30/2021 12	epareo 2:37 p
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	1
			Nonprovider Site	Hospi tal	4))	
00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	1
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 FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Settin	gsEffective fo	r cost reporti	ng periods	
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-primai al. Enter in column (	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	1
00 Enter in column 1, the program name associated with each of			0.00	0.00	0. 000000	07.
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)						
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				1.0	0 2 00 3 00	-
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)			tain an LPE subn	1. Of	0 2.00 3.00	70
<pre>which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	ychiatric Facility (1 the facility have ar efore November 15, 20 umn 2: Did this faci R 412.424 (d)(1)(iii) cate which program yo	n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for	ing program in th yes or "N" for no s in a new teach yes or "N" for no	rovider? N ne most p. (see ng p.	0 2.00 3.00	
<pre>which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	ychiatric Facility (1 the facility have an efore November 15, 20 umn 2: Did this faci R 412.424 (d)(1)(iii) cate which program yo y PPS nabilitation Facility	n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for ear began during thi	ing program in th yes or "N" for n s in a new teach yes or "N" for n s cost reporting	rovider? N ne most p. (see ng p.		70.71.75.

# Health Financial Systems ST. JOSEPHS REG MED CENTER PLYMOUTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0076 Period: Worksheet S-2

-0076	Perio	a:	worksneet	5-2
	From	07/01/2020	Part I	
	То	06/30/2021	Date/Time	Prepared:
			11/30/202	1 12:37 pm

			_		-
Long Term Care Hospital PPS				1.00	-
80.00 Is this a long term care hospital (LTCH)? Enter "Y" 81.00 Is this a LTCH co-located within another hospital for "Y" for yes and "N" for no. TEFRA Providers			period? Enter	N N	80. 00 81. 00
85.00 Is this a new hospital under 42 CFR Section §413.40(f 86.00 Did this facility establish a new Other subprovider (			r "N" for no.	N	85. 00 86. 00
<pre>\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>	hospital classified	under section		Ν	87.00
			V	XI X	
			1.00	2.00	_
90.00 Does this facility have title V and/or XIX inpatient yes or "N" for no in the applicable column.	hospital services? E	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX th full or in part? Enter "Y" for yes or "N" for no in t			Ν	Ν	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF b instructions) Enter "Y" for yes or "N" for no in the	eds (dual certificat			Ν	92.00
93.00 Does this facility operate an ICF/IID facility for pu "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	Ν	Ν	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" fo applicable column.	r yes, and "N" for n	o in the	Ν	Ν	94.00
95.00 If line 94 is "Y", enter the reduction percentage in 96.00 Does title V or XIX reduce operating cost? Enter "Y"			0. 00 N	0. 00 N	95.00 96.00
<ul> <li>applicable column.</li> <li>97.00  f line 96 is "Y", enter the reduction percentage in</li> <li>98.00 Does title V or XIX follow Medicare (title XVIII) for stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter</li> </ul>	the interns and res	idents post	0. 00 Y	0. 00 Y	97.00 98.00
<ul> <li>column 1 for title V, and in column 2 for title XIX.</li> <li>98.01 Does title V or XIX follow Medicare (title XVIII) for C, Pt. I? Enter "Y" for yes or "N" for no in column 1</li> </ul>	1 5	5	Y	Y	98. 01
<pre>title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" fo</pre>			Y	Y	98. 02
<ul> <li>for title V, and in column 2 for title XIX.</li> <li>98.03 Does title V or XIX follow Medicare (title XVIII) for reimbursed 101% of inpatient services cost? Enter "Y"</li> </ul>			N	Ν	98. 03
<ul> <li>for title V, and in column 2 for title XIX.</li> <li>98.04 Does title V or XIX follow Medicare (title XVIII) for outpatient services cost? Enter "Y" for yes or "N" fo</li> </ul>	a CAH reimbursed 10 r no in column 1 for	1% of title V, and	Ν	Ν	98.04
<ul> <li>in column 2 for title XIX.</li> <li>98.05 Does title V or XIX follow Medicare (title XVIII) and Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for</li> </ul>			Y	Y	98.05
<ul> <li>column 2 for title XIX.</li> <li>98.06 Does title V or XIX follow Medicare (title XVIII) whe Pts. I through IV? Enter "Y" for yes or "N" for no in column 2 for title XIX.</li> </ul>			Y	Y	98.06
Rural Providers					
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected t	he all_inclusive met	hod of navment	N		105.00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible training programs? Enter "Y" for yes or "N" for no in Column 2: If column 1 is Y and line 70 or line 75 is approved medical education program in the CAH's exclu	for cost reimbursem column 1. (see ins Y, do you train l&R	ent for I&R tructions) s in an			107.00
Enter "Y" for yes or "N" for no in column 2. (see in 108.00 Is this a rural hospital qualifying for an exception CFR Section §412.113(c). Enter "Y" for yes or "N" for	structions) to the CRNA fee sche		Ν		108.00
	Physi cal	Occupational	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provide therapy services provided by outside supplier? Enter for yes or "N" for no for each therapy.		2.00	3.00	4.00	109.00
			-	1 00	-
110.00 Did this hospital participate in the Rural Community Demonstration)for the current cost reporting period? complete Worksheet E, Part A, lines 200 through 218, applicable.	Enter "Y" for yes or	"N" for no. If	yes,	<u>1.00</u> N	110.00
			I		

Health Financial Systems         ST. JOSEPHS REG MED CENTER PLYMOU           HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA         Provider CC		In_Li€ Period:	eu of Form CMS Worksheet S-	
	F	rom 07/01/2020 o 06/30/2021	Part I	epared:
				<u>2.37 pm</u>
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	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 Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
17.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00
In the portey is cranin-made. Enter 2 in the portey is occurrence.	Premiums	Losses	Insurance	
	1.00	2.00	3.00	_
18.01 List amounts of malpractice premiums and paid losses:			0.00	0118.0
		1.00	2.00	_
18.02 Are mal practice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein.		N		118.0
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y"	' for yes or ne Outpatient	N	N	119. C 120. C
Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost implantable devices	s charged to	Y		121.0
patients? Enter "Y" for yes or "N" for no. 22.00Does the cost report contain healthcare related taxes as defined in §1903( Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.		Ν		122. 0
Transplant Center Information	for no lf	NI		105 0
25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.0
26.00 If this is a Medicare certified kidney transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.				126.0
27.00  f this is a Medicare certified heart transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.				127.0
28.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.				128. 0
	cation date in			129. 0
				130. 0
column 1 and termination date, if applicable, in column 2. 30.00 f this is a Medicare certified pancreas transplant center, enter the cert	tification			1000 0
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the ce				131.0
<ul> <li>column 1 and termination date, if applicable, in column 2.</li> <li>30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2.</li> <li>31.00 If this is a Medicare certified intestinal transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2.</li> <li>32.00 If this is a Medicare certified islet transplant center, enter the certification date.</li> </ul>	erti fi cati on			
<ul> <li>30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2.</li> <li>31.00 If this is a Medicare certified intestinal transplant center, enter the certified intestinal transplant center.</li> </ul>	ertification cation date			131. 0 132. 0 133. 0 134. 0

Health Financial Systems	ST. JOSEPHS RE	EG MED CE	ENTER PLYMOU	ТН			In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX			Provider CC			eri od:		Worksheet S-2	
					TC		7/01/2020 5/30/2021	Part I Date/Time Pre	epared:
1.00								11/30/2021 12	2:37 pm
<u> </u>	organization enter	<u>2.00</u>	les 141 throu	uah 143	the nam	e and	3.00	of the	
home office and enter the home offi	ce contractor name a	and cont	ractor numbe	er.					
141.00 Name: SAINT JOSEPH REG MEDICAL CTI	R Contractor's Nar			I ANS Cor	tractor	's Nu	mber: 0800	1	141.00
142.00 Street: 5215 HOLY CROSS PARKWAY	PO Box:	SERVI	CE INSURAN						142.00
143.00 Ci ty: MI SHAWAKA	State:	I N		Zip	Code:		4654	5	143.00
								1.00	-
144.00 Are provider based physicians' cost	s included in Workst	heet A?						1.00 Y	144.00
		74		6			1.00	2.00	1.45.00
145.00 If costs for renal services are cla inpatient services only? Enter "Y"					lis				145.00
no, does the dialysis facility incl	ude Medicare utiliza								
period? Enter "Y" for yes or "N" f					0				1.4.4 00
146.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in							N		146.00
yes, enter the approval date (mm/dc		up. 10	2, 01149101 1	, j.e.					
								1 00	-
147.00 Was there a change in the statistic	al basis? Enter "Y"	for yes	or "N" for	no.				1.00 N	147.00
148.00 Was there a change in the order of								N	148.00
149.00 Was there a change to the simplifie	ed cost finding metho	od? Ente						N	149.00
			Part A 1.00	-	<u>t B</u> 00		tle V 3.00	Title XIX 4.00	-
Does this facility contain a provid			emption from	n the a	oplicati	on of	the lowe	r of costs	
or charges? Enter "Y" for yes or "N	" for no for each c	omponent				See 42			455 00
155.00Hospi tal 156.00Subprovider - IPF			N N		N N		N N	N N	155.00 156.00
157. 00 Subprovi der – IRF			N		N		N	N	157.00
158. 00 SUBPROVI DER									158.00
159.00 SNF 160.00 HOME_HEALTH_AGENCY			N N		N N		N N	N	159.00 160.00
161. 00 CMHC			N .		N		N	N	161.00
								1.00	-
Multicampus								1.00	
165.00 Is this hospital part of a Multican	npus hospital that ha	as one o	r more campu	ises in	di ffere	nt CB	SAs?	Ν	165.00
Enter "Y" for yes or "N" for no.	Name		County	Stat	0 7i p	Code	CBSA	FTE/Campus	
-	0		1.00	2.00		00	4.00	5. 00	1
166.00 If line 165 is yes, for each								0.00	0166.00
campus enter the name in column 0, county in column 1, state in									
column 2, zip code in column 3,									
CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
								1.00	
Health Information Technology (HIT)						Act		V	1/7 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 105						enter	the	Y	167.00 168.00
reasonable cost incurred for the HI	T assets (see instru	uctions)							
168.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?						hard	shi p		168. 01
169.00 If this provider is a meaningful us						"), e	nter the	9.9	9169.00
transition factor. (see instruction						-			
							gi nni ng 1. 00	Endi ng 2. 00	-
170.00 Enter in columns 1 and 2 the EHR be	eginning date and end	ding dat	e for the re	porting	1		1.00	2.00	170.00
period respectively (mm/dd/yyyy)		<u> </u>							
							1.00	2.00	-
171.00 If line 167 is "Y", does this provi	der have any days for	or indiv	iduals enrol	led in			N N		0171.00
section 1876 Medicare cost plans re	eported on Wkst. S-3,	, Pt. I,	line 2, col	. 6? Er					
"Y" for yes and "N" for no in colum 1876 Medicare days in column 2. (se		yes, en	ter the numb	per of s	section				
poro modicare days in cordinin 2. (Se						I	I		1

	Financial Systems ST. JOSEPHS REG MEL AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider C	CN: 15-0076	Peri od:	Worksheet S-2	2
				From 07/01/2020		
				To 06/30/2021	Date/Time Pre 11/30/2021 12	
				Y/N	Date	2.37
				1.00	2.00	-
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente			-
	mm/dd/yyyy format.		•			
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1
	reporting period? If yes, enter the date of the change in c	olumn 2. (see				_
			Y/N	Date	V/I	_
00		0.16	1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum		N			2
	voluntary or "I" for involuntary.	ii 5, v 10				
00	Is the provider involved in business transactions, includin	a management	N			3
00	contracts, with individuals or entities (e.g., chain home o					
	or medical supply companies) that are related to the provid	er or its				
	officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and othe					
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert	ified Public	Y	A		4
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f	or Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date ava	ilable in				
00	column 3. (see instructions) If no, see instructions.	ront from	N			5
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		IN IN			0
	Those on the fired financial statements? If yes, submit fec			Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for nursing school? Column 2:	lf ves. is th	ne provider is	N		76
	the legal operator of the program?	<b>J</b> • • •				
00	Are costs claimed for Allied Health Programs? If "Y" see in	structions.		Ν		7
00	Were nursing school and/or allied health programs approved		during the	Ν		8
	cost reporting period? If yes, see instructions.		-			
00	Are costs claimed for Interns and Residents in an approved	0	al education	N		9
	program in the current cost report? If yes, see instruction					
. 00	Was an approved Intern and Resident GME program initiated o	r renewed in t	the current	N		10
00	cost reporting period? If yes, see instructions.	0 Din on Ang	veo ved	N		11
. 00	Are GME cost directly assigned to cost centers other than I	& R IN an App	loved	N		11
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	-
	Bad Debts				1.00	
. 00		see instruct	ions		Y	12
. 00				st reportina	Ň	13
	period? If yes, submit copy.					
. 00	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? If	yes, see ins	tructions.	N	14
	Bed Complement					
. 00	Did total beds available change from the prior cost reporti	ng period?lf	yes, see inst	ructions.	N	15
		Par	rt A	Par	rt B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
		Y	10/01/2021	Y	10/01/2021	16
. 00						
. 00	If either column 1 or 3 is yes, enter the paid-through					
00	date of the PS&R Report used in columns 2 and 4 .(see		1	N		17
	date of the PS&R Report used in columns 2 and 4 .(see instructions)	N				
	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	Ν		IN		1
	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Ν		N		
	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		N		
. 00	date of the PS&R Report used in columns 2 and 4 .(see 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 in columns 2 and 4. (see instructions)					10
. 00	date of the PS&R Report used in columns 2 and 4 .(see 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 in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18
. 00	date of the PS&R Report used in columns 2 and 4 (see 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 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					18
. 00 . 00 . 00	date of the PS&R Report used in columns 2 and 4 (see 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 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					18
. 00	date of the PS&R Report used in columns 2 and 4 (see 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 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 cost report? If yes, see instructions.	Ν		Ν		18
. 00	date of the PS&R Report used in columns 2 and 4 (see 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 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					

Health Financial Systems

ST.	JOSEPHS	REG	MED	CENTER	PLYMOUTH

In Lieu of Form CMS-2552-10

Heal th	Financial Systems ST. JOSEPHS REG ME	D CENTER PLYMO	JTH	In Lie	eu of Form CM	<u>S-2552-10</u>
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	1	Period: From 07/01/2020		
				To 06/30/2021	Date/Time P 11/30/2021	
		Descr	iption	Y/N	Y/N	12.07 pm
			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
	Report data for other beser be the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's	N	2.00	N		21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made duri	ng the cost		23.00
24.00	Were new leases and/or amendments to existing leases entere	ed into during	this cost rep	orting period?		24.00
25.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	ting period?	lfyes, see		25.00
26.00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during th	he cost reporti	ng period? If	ves, see		26.00
	instructions.					
27.00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If y	yes, submit		27.00
28 00	Interest Expense Were new Loans, mortgage agreements or letters of credit er	ntered into dur	ing the cost	reporting		28.00
	period? If yes, see instructions.					
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.	urity with new	debt? If yes,	see		30.00
31.00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see		31.00
	instructions. Purchased Services					
32.00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through con	tractual		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competiti	ive bidding? If		33.00
	no, see instructions.					_
04 00	Provi der-Based Physi ci ans					- 24.00
34.00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	provider-base	ed physicians?		34.00
25 00	If line 34 is yes, were there new agreements or amended exi	isting agroomor	te with the p	rovidor basod		35.00
35.00	physicians during the cost reporting period? If yes, see in		its with the pi	lovi del -based		35.00
	physicians during the observepenting periodi in yes, eee in			Y/N	Date	
				1.00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			36. 00 37. 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	d of the home o	offi ce.			38.00
39.00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compor	nents? If yes,			39.00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see			40.00
		1	00		00	
	Cost Report Preparer Contact Information	I	00	2.	00	
41.00	Enter the first name, last name and the title/position	TRACY		WORKMAN		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
42.00	respectively. Enter the employer/company name of the cost report	SAINT JOSEPH H	IEALTH SYSTEM			42.00
43, 00	preparer. Enter the telephone number and email address of the cost	574-335-4652		WORKMANT@SJRMC	. COM	43.00
. 5. 00	report preparer in columns 1 and 2, respectively.					10.00

Heal th	Financial Systems	ST. JOSEPHS REG MED	D CENTER PLYMOUTH		In Lieu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	IT QUESTI ONNAI RE	Provider CCN: 15-		Period:	Worksheet S-2	
					rom 07/01/2020 fo 06/30/2021	Part II Date/Time Pre 11/30/2021 12	pared: :37 pm_
			3.00				
	Cost Report Preparer Contact Information	1					
41.00	Enter the first name, last name and the	title/position	SENIOR REIMBURSEMENT	ANALYST			41.00
	held by the cost report preparer in col	umns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the	cost report					42.00
	preparer.						
43.00	Enter the telephone number and email ad	dress of the cost					43.00
	report preparer in columns 1 and 2, res	pecti vel y.					

IOSPI T	Financial Systems ST AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider C	CN: 15-0076	In Lie Period:	Worksheet S-3	
					From 07/01/2020 To 06/30/2021	Part I Date/Time Pre 11/30/2021 12	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	38	13, 87	0 0.00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 5.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0 0	5. 00 6. 00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		38	13, 87	0 0.00	0	7.00
3.00 9.00 10.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T	31.00	7	2, 55	5 0.00	0	8.00 9.00 10.00
11.00 12.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	34.00	0		0 0.00	0	12.00
13.00 14.00 15.00	NURSERY Total (see instructions) CAH visits	43. 00	45	16, 42	5 0.00	0 0 0	13.00 14.00 15.00
16.00 17.00 18.00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER						16.00 17.00 18.00
19.00 20.00 21.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE						19.0 20.0 21.0
22.00 23.00 24.00	HOME HEALTH AGENCY AMBULATORY SURGI CAL CENTER (D. P. ) HOSPI CE						22. 0 23. 0 24. 0
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00					24. 1 25. 0
26.00 26.25 27.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89. 00	45			0	26.0 26.2 27.0
8.00 9.00	Observation Bed Days Ambulance Trips					0	28.0 29.0
30.00 31.00 32.00	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions)		0		0		30.00 31.00 32.00
32. 01 33. 00	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days						32.0 <sup>°</sup> 33.0
	LTCH site neutral days and discharges						33.0

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	:N: 15-0076	Period: From 07/01/2020 To 06/30/2021		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00 26.00 26.25 27.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SCILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	1, 405 1, 659 0 0 0 1, 405 447 0 1, 852 0 1, 852 0	102 795 0 0 0 102 0 163 265 0	4, 12 4, 12 1, 22 4( 5, 7)	0 0 20 20 0 32 72 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 286. 13	15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 24. 00 24. 00 24. 00 25. 00 26. 00 26. 25 27. 00
28.00 29.00 30.00 31.00 32.00 32.01	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	252 49		25 50 0 32 0		28. 00 29. 00 30. 00 31. 00 32. 00 32. 0
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and di scharges	0 0					33. 0 33. 0

F	AL DATA	Provider CCN: 15-0076		Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/30/2021 12	
	Full Time Equivalents		Di s	charges		
Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Workers	40.00	10.00	11.00	Patients	
00 Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00	14.00 26 359	15.00 1,724	1.0
<ul> <li>8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)</li> <li>MM0 and other (see instructions)</li> <li>HM0 IPF Subprovider</li> <li>HM0 IRF Subprovider</li> <li>HM0 IRF Subprovider</li> <li>Hospital Adults &amp; Peds. Swing Bed SNF</li> <li>Hospital Adults and Peds. (exclude observation beds) (see instructions)</li> <li>INTENSIVE CARE UNIT</li> <li>CORONARY CARE UNIT</li> <li>SURGICAL INTENSIVE CARE UNIT</li> <li>OU Total SPECIAL CARE (SPECIFY)</li> <li>OU Total (see instructions)</li> <li>OU Total (see instructions)</li> <li>OU THER SPECIAL CARE (SPECIFY)</li> <li>OU SUBPROVIDER - IPF</li> <li>OU SUBPROVIDER - IPF</li> <li>OU SUBPROVIDER - IRF</li> <li>OU SUBPROVIDER - IRF</li> <li>OU NURSING FACILITY</li> <li>OU NURSING FACILITY</li> <li>OU NURSING FACILITY</li> <li>OU NURSING FACILITY</li> <li>OU AHBULATORY SURGICAL CENTER (D. P. )</li> <li>HOM HEALTH AGENCY</li> <li>OU AMBULATORY SURGICAL CENTER (D. P. )</li> <li>OU CMHC - CMHC</li> <li>OU RURAL HEALTH CLINIC</li> <li>SE FEDERALLY QUALIFIED HEALTH CENTER</li> <li>OU OBSERVAL</li> <li>OU SUBAL TOR BAD AND AND AND AND AND AND AND AND AND A</li></ul>	100. 00 0. 00 100. 00	C	4(			$\begin{array}{c} 2. \ 0\\ 3. \ 0\\ 4. \ 0\\ 5. \ 0\\ 6. \ 0\\ 7. \ 0\\ 8. \ 0\\ 9. \ 0\\ 10. \ 0\\ 11. \ 0\\ 12. \ 0\\ 13. \ 0\\ 14. \ 0\\ 15. \ 0\\ 14. \ 0\\ 16. \ 0\\ 17. \ 0\\ 20. \ 0\\ 21. \ 0\\ 22. \ 0\\ 23. \ 0\\ 24. \ 0\\ 24. \ 1\\ 25. \ 0\\ 24. \ 0\\ 24. \ 1\\ 25. \ 0\\ 24. $

Health Financial Syste

## ST INSERHS REG MED CENTER PLYMOLITH

Heal th	Financial Systems	ST.	JOSEPHS REG ME	D CENTER PLYMOU	JTH	In Lie	eu of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION				CN: 15-0076 F	eriod: rom 07/01/2020 o 06/30/2021	Worksheet S-3 Part II	pared.
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	19, 143, 371	0	19, 143, 371	595, 145. 27	32. 17	1.00
2.00	instructions) Non-physician anesthetist Part		C	0	c	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		C	0	с	0.00	0. 00	3.00
4.00	Physician-Part A - Administrative		37, 300	0	37, 300	266.00	140. 23	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		C 344, 989		C 344, 989			
6.00	Physician-Part B Non-physician-Part B for		C	0	, c	0.00	0.00	6.00
0.00	hospi tal -based RHC and FQHC services					0.00	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	C	0	C	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved		C	0	C	0.00	0.00	7.01
8.00	programs) Home office and/or related		C	0	c	0. 00	0. 00	8.00
9.00	organization personnel SNF	44.00	C	0	-	0.00		
10.00	Excluded area salaries (see instructions)		695, 924	0	695, 924	26, 551. 66	26. 21	10.00
11.00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		354, 780		354, 780	5, 490. 00	64.62	11.00
	Care							
12.00	Contract labor: Top level management and other management and administrative services		106, 733	0	106, 733	2, 333. 00	45.75	12.00
13.00	Contract Labor: Physician-Part A - Administrative		515, 051	0	515, 051	10, 670. 00	48. 27	13.00
14.00	Home office and/or related organization salaries and		C	0	с	0.00	0. 00	14.00
14.01	wage-related costs Home office salaries		4, 381, 373	0	4, 381, 373	101, 497. 00	/3 17	14.01
14.01	Related organization salaries		4, 301, 373 C	0	4, 301, 373	0.00	0. 00	14.02
15.00	Home office: Physician Part A - Administrative		C	0	C			
16.00	Home office and Contract Physicians Part A - Teaching		C	0	C	0.00	0.00	16.00
16. 01	Home office Physicians Part A - Teaching		C	0	C	0.00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		C	0	C	0.00	0.00	16. 02
17.00	WAGE-RELATED COSTS Wage-related costs (core) (see instructions)		8, 253, 773	0	8, 253, 773			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19. 00 20. 00	Èxcluded areas Non-physician anesthetist Part		389, 871 C	0	389, 871 C			19.00 20.00
21.00	A Non-physician anesthetist Part		C	0	c			21.00
22.00	B Physician Part A - Administrative		3, 909	0	3, 909	,		22.00
22. 01	Physician Part A - Teaching		C	0	c			22.01
23.00 24.00	Physician Part B Wage-related costs (RHC/FQHC)		91, 249	0	91, 249			23.00 24.00
25.00	Interns & residents (in an approved program)		C	0	c			25.00
25. 50	Home office wage-related (core)		1, 182, 625	0	1, 182, 625	,		25. 50
25. 51	Related organization wage-related (core)		C	0	с			25. 51
25. 52	Home office: Physician Part A - Administrative -		C	0	C	)		25. 52
	wage-related (core)				I		I	

## Health Financial Systems

### ST. JOSEPHS REG MED CENTER PLYMOUTH

In Lieu of Form CMS-2552-10

	TTHANCTAL SYSTEMS	31	JUSEFIIS KEG MEI	D CENTER FETWOR				
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		'eri od:	Worksheet S-3	
						rom 07/01/2020		
					T	o 06/30/2021		
				, I			11/30/2021 12	
		Wkst. A Line		Recl assi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0	C			25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE	ES						
26.00	Employee Benefits Department	4.00	20, 225	0	20, 225	9.50	2, 128. 95	26.00
27.00	Administrative & General	5.00	2,068,896	0	2, 068, 896	65, 723. 38	31.48	27.00
28.00	Administrative & General under		236, 673	0	236, 673	1, 729. 00	136.88	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0	c c	0.00	0.00	29.00
30.00	Operation of Plant	7.00	329, 812	0	329, 812	12, 021. 17	27.44	30.00
31.00	Laundry & Linen Service	8.00		0	0	0.00		31.00
32.00	Housekeeping	9.00	413, 498	0	413, 498			32.00
33.00	Housekeeping under contract	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	0		0.00		33.00
00.00	(see instructions)		0			0.00	0.00	00.00
34.00	Di etary	10.00	333, 466	0	333, 466	19, 765. 15	16 87	34.00
35.00	Dietary under contract (see	10.00	003, 400		333, 400	0.00		35.00
55.00	instructions)		0			0.00	0.00	33.00
36.00	Cafeteria	11.00	0	0		0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00				0.00		
37.00	Nursing Administration	12.00			477, 867			
	5			0	477,007			
39.00	Central Services and Supply	14.00		0	740.005	0.00		39.00
40.00	Pharmacy	15.00			719, 295			40.00
41.00	Medical Records & Medical	16.00	249, 961	0	249, 961	9, 593. 75	26.05	41.00
	Records Library			-	_			
42.00	Social Service	17.00		0	0	0.00		42.00
43.00	Other General Service	18.00	0	0	( C	0.00	0.00	43.00

iospi t	AL WAGE INDEX INFORMATION			Provider CO	F	Period: rom 07/01/2020 o 06/30/2021		
		Worksheet A	Amount	Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				1		
. 00	Net salaries (see instructions)		19, 035, 055	0	19, 035, 055	590, 660. 27	32. 23	1.00
. 00	Excluded area salaries (see instructions)		695, 924	0	695, 924	26, 551. 66	26. 21	2.0
. 00	Subtotal salaries (line 1 minus line 2)		18, 339, 131	0	18, 339, 131	564, 108. 61	32. 51	3.0
. 00	Subtotal other wages & related costs (see inst.)		5, 357, 937	0	5, 357, 937	119, 990. 00	44. 65	4.0
. 00	Subtotal wage-related costs (see inst.)		9, 440, 307	0	9, 440, 307	0.00	51.48	5.0
. 00	Total (sum of lines 3 thru 5)		33, 137, 375	0	33, 137, 375	684, 098. 61	48.44	6.0
. 00	Total overhead cost (see instructions)		4, 849, 693	0	4, 849, 693	161, 564. 64	30. 02	7.0

OSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0076	Peri od: From 07/01/2020 To 06/30/2021	11/30/2021 12	pare
				Amount	
				Reported 1.00	
	PART IV - WAGE RELATED COSTS			1.00	
	Part A - Core List				
	RETIREMENT COST				1
00	401K Employer Contributions			878, 806	1 1.
00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2
00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3.
00	Qualified Defined Benefit Plan Cost (see instructions)			325, 708	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				1
00	401K/TSA Plan Administration fees			0	5
00	Legal /Accounting/Management Fees-Pension Plan			0	6
00	Employee Managed Care Program Administration Fees			227, 314	7
	HEALTH AND INSURANCE COST				
00	Health Insurance (Purchased or Self Funded)			0	8
01	Health Insurance (Self Funded without a Third Party Administra			0	8
02	Health Insurance (Self Funded with a Third Party Administrator)	)		4, 057, 065	
03	Health Insurance (Purchased)			0	8
00	Prescription Drug Plan			782, 596	
. 00	Dental, Hearing and Vision Plan			150, 209	
. 00	Life Insurance (If employee is owner or beneficiary)			25, 846	
. 00	Accident Insurance (If employee is owner or beneficiary)			0	12
. 00	Disability Insurance (If employee is owner or beneficiary)			766, 153	
. 00	Long-Term Care Insurance (If employee is owner or beneficiary)			0	14
. 00	'Workers' Compensation Insurance			104, 855	
. 00	Retirement Health Care Cost (Only current year, not the extraon Non cumulative portion)	rdinary accruai require	ed by FASB 106.	39, 883	16
	TAXES				
. 00	FICA-Employers Portion Only			1, 368, 694	1 17
. 00	Medicare Taxes - Employers Portion Only			1, 308, 094	18
. 00	Unemployment Insurance			0	19
	State or Federal Unemployment Taxes			0	20
	OTHER				
. 00	Executive Deferred Compensation (Other Than Retirement Cost Rep instructions))	ported on lines 1 throu	igh 4 above. (see	0	21
. 00	Day Care Cost and Allowances			0	22
. 00	Tuition Reimbursement			11, 674	
. 00	Total Wage Related cost (Sum of lines 1 -23)			8, 738, 803	
	Part B - Other than Core Related Cost				1

	Financial Systems	SI. JUSEPHS RE	G MED CENTER PLYMOUTH	-	u of Form CMS-2	
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0076	Peri od:	Worksheet S-3	
				From 07/01/2020 To 06/30/2021	Part V Date/Time Pre	narad
				10 00/ 30/ 2021	11/30/2021 12	
	Cost Center Description			Contract Labor		
				1.00	2.00	
	PART V - Contract Labor and Benefit Co	st				
	Hospital and Hospital-Based Component	I denti fi cati on:				
1.00	Total facility's contract labor and be	enefit cost		354, 780	8, 738, 803	1.00
2.00	Hospi tal			354, 780	8, 738, 803	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF					4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis					17.00
18.00	Other			0	0	18.00

Heal th	Fi nanci al	Systems	5

### ST. JOSEPHS REG MED CENTER PLYMOUTH

In Lieu of Form CMS-2552-10

HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	:N: 15-0076	Peri od:	Worksheet S-1	0			
				From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:			
					11/30/2021 12				
					1.00				
1.00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by Li	no 202 colum	2 9)	0. 237328	1.00			
1.00	Medicaid (see instructions for each line)	videu by iii		10)	0.237320	1.00			
2.00	Net revenue from Medicaid				9, 216, 805	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y Y	3.00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	tal payments	s from Medic	ai d?	Ý	4.00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments f				0				
6.00									
7.00		8, 503, 242	7.00						
8.00									
	< zero then enter zero)								
	Children's Health Insurance Program (CHIP) (see instructions for each line)								
9.00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0				
10. 00 11. 00		0							
12.00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP	(lipo 11 mi)	nus lino 0:	f < zoro thon					
12.00	enter zero)		lus ITTE 7,		0	12.00			
	Other state or local government indigent care program (see ins	tructions fo	or each line	)					
13.00	Net revenue from state or local indigent care program (Not inc				0	13.00			
14.00	Charges for patients covered under state or local indigent car	re program (I	Not included	in lines 6 or	0	14.00			
	10)				0	15.00			
15.00									
16.00	Difference between net revenue and costs for state or local ir	ndigent care	program (li	ne 15 minus line	0	16.00			
	13; if < zero then enter zero)								
	Grants, donations and total unreimbursed cost for Medicaid, CH instructions for each line)	IP and state		gent care program	ns (see				
17.00	Private grants, donations, or endowment income restricted to f	unding char	ity care		0	17.00			
18.00	Government grants, appropriations or transfers for support of				0				
19.00	Total unreimbursed cost for Medicaid, CHIP and state and loca			s (sum of lines	0				
	8, 12 and 16)								
			Uni nsured	Insured	Total (col. 1				
			<u>patients</u> 1.00	patients 2.00	+ col . 2) 3.00				
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00				
20.00	Charity care charges and uninsured discounts for the entire fa	cility	2, 800, 7	37 351, 314	3, 152, 051	20.00			
201 00	(see instructions)	.orreg	2,000,		0, 102, 001	20.00			
21.00	Cost of patients approved for charity care and uninsured disco	ounts (see	664, 6	93 351, 314	1, 016, 007	21.00			
	instructions)								
22.00	Payments received from patients for amounts previously writter	n off as		0 0	0	22.00			
~~ ~~	chari ty care			00 054 044	1 01 ( 007	00.00			
23.00	Cost of charity care (line 21 minus line 22)		664, 6	93 351, 314	1, 016, 007	23.00			
					1.00				
24.00	Does the amount on line 20 column 2, include charges for patie	ent days bev	ond a length	of stay limit	N 1.00	24.00			
21.00	imposed on patients covered by Medicaid or other indigent care		ond a rongen	or stuy rimit		21.00			
25.00			care progra	m's length of	0	25.00			
	stay limit	-							
26.00	Total bad debt expense for the entire hospital complex (see in				5, 683, 466				
27.00	Medicare reimbursable bad debts for the entire hospital comple				150, 667				
27.01	Medicare allowable bad debts for the entire hospital complex (	see instruc	tions)		231, 796				
28.00	Non-Medicare bad debt expense (see instructions)				5, 451, 670				
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (see	Instructions	)	1, 374, 963				
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			2, 390, 970 2, 390, 970				
51.00	Trotar an ernibur seu and uncompensated care cost (Trine 19 prus 1	116 30)			2, 370, 970	1 31.00			

	Financial Systems ST. SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	JOSEPHS REG MED F EXPENSES	CENTER PLYMOL Provider C	CN: 15-0076 P	In Lie eriod: rom 07/01/2020	u of Form CMS-2 Worksheet A	2552-10
					o 06/30/2021	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	11/30/2021 12 Recl assi fi ed Tri al Bal ance (col. 3 +-	. 37 pii
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		0	0		1, 528, 764	1.00
2.00 3.00	00300 OTHER CAP REL COSTS		0	0	2, 085, 995	2, 085, 995 0	2.00 3.00
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT	20, 225	-15, 998	4, 227	15, 998	20, 225	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 068, 896	18, 160, 922	20, 229, 818		18, 878, 775	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	329, 812 0	2, 224, 640 177, 528			2, 118, 994 177, 080	7.00 8.00
9.00	00900 HOUSEKEEPING	413, 498	267, 092			679, 429	
10.00	01000 DI ETARY	333, 466	334, 543			646, 621	10.00
11.00	01100 CAFETERI A	0	0	0	0	0	11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0 477, 867	0 227, 952	0 705, 819	132 400	0 572, 419	12.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	477,807	227, 932	/05, 819	-133, 400	572, 419	13.00
15.00	01500 PHARMACY	719, 295	2, 598, 825	3, 318, 120	-2, 422, 033	896, 087	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	249, 961	89, 919	339, 880	0	339, 880	
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 20.00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0	0	0	0	0	19.00 20.00
20.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 730, 597	1, 050, 562	3, 781, 159	-916, 534	2 964 625	20.00
30.00	03100 I NTENSI VE CARE UNI T	971,052	355, 305			2, 864, 625 1, 312, 379	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0			0	34.00
43.00	04300 NURSERY	0	0	0	402, 745	402, 745	43.00
F0 00	ANCI LLARY SERVICE COST CENTERS	1 050 (75		F F1F 000	(() 75(	4 052 072	
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	1, 950, 675 0	3, 565, 154	5, 515, 829	-663, 756 402, 746	4, 852, 073 402, 746	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 112, 688	760, 050	1, 872, 738		1, 537, 445	
55.00	05500 RADI OLOGY-THERAPEUTI C	397, 241	725, 148	1, 122, 389		905, 441	55.00
57.00	05700 CT SCAN	93, 123	108, 059			157, 543	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	37, 602 1, 619, 478	189, 462 3, 604, 337			94, 825 5, 192, 076	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 019, 478	3,004,337	0, 223, 813	-31, 739	5, 192, 070	62.30
65.00	06500 RESPI RATORY THERAPY	577, 789	271, 405	849, 194	-29, 190	820, 004	65.00
65.01	06501 SLEEP LAB	0	48, 294			46, 730	
66. 00 66. 01	06600 PHYSI CAL THERAPY	963, 355	333, 682			1, 284, 339	66.00 66.01
66. 02	06601 PHYSI CAL THERAPY - LI FEPLEX 06602 PHYSI CAL THERAPY - CULVER MI LI TARY	369, 246 14, 094	268, 118 7, 129			630, 612 21, 223	
67.00	06700 OCCUPATI ONAL THERAPY	132, 978	29, 062			158, 158	
68.00	06800 SPEECH PATHOLOGY	73, 076	14, 194			87, 270	68.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	-63, 766	-63, 766		0	71.00
72.00	07200 TMPL. DEV. CHARGED TO PATTENTS	0	0		391, 224 2, 721, 432	391, 224 2, 721, 432	
76.97	07697 CARDI AC REHABI LI TATI ON	134, 708	142, 970	277, 678		262, 978	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	65, 316	65, 316	76. 98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
90. 01	OUTPATIENT SERVICE COST CENTERS	5, 971	1, 463	7, 434	-16	7, 418	90.01
90.01	09002 ATHLETI C TRAI NERS	117, 467	61, 453			178, 920	
90.03	09003 SAINT JOSEPH HEALTH CENTER	713, 349	316, 166	1, 029, 515	-10, 214	1, 019, 301	90.03
90.04	09004 WOUND CARE	164, 142	720, 688			726, 629	90.04
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 655, 796	2, 254, 676	3, 910, 472	-648, 631	3, 261, 841	91.00 92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	18, 447, 447	38, 829, 034	57, 276, 481	73, 081	57, 349, 562	118.00
100.00	NONREI MBURSABLE COST CENTERS						100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 283, 304	1, 461 619, 107		0 -771	1, 461 901, 640	190.00 190.01
	1900 PHYSICIANS' PRIVATE OFFICES	203, 304	017, 107	,411	- / / 1		190.01
192.01	19201 FOUNDATION ADMINISTATION	Ō	0	0	0	0	192.01
	19202 HOSPI TALI ST	0	0	0	0		192.02
	19203 INTENSIVIST 19204 FOOT & ANKLE SPORTS MED PLY	0	0 104, 728	0 468, 104	0	0 468, 104	192.03
	07950 PLYMOUTH MOB-4	363, 376 0	104, 728			468, 104 33, 796	
	07951 COMMUNI TY OUTREACH & PARTNERSHIP	49, 244	13, 719			62, 963	194.01
200.00	D TOTAL (SUM OF LINES 118 through 199)	19, 143, 371	39, 674, 155			58, 817, 526	200. 00

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CCN	: 15-0076	Period: From 07/01/2020	Worksheet A	
					To 06/30/2021	Date/Time Prep 11/30/2021 12:	
	Cost Center Description	Adjustments	Net Expenses		,	11/30/2021 12.	57
		(See A-8) 6.00	For Allocation 7.00				
	GENERAL SERVICE COST CENTERS	0.00	7.00				
00	00100 CAP REL COSTS-BLDG & FIXT	593, 781	2, 122, 545				1.
00	00200 CAP REL COSTS-MVBLE EQUIP	0	2, 085, 995				2.
00	00300 OTHER CAP REL COSTS	0					3.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-48, 264					4.
00	00500 ADMI NI STRATI VE & GENERAL	-4, 357, 342					5.
00 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	0 2, 118, 994				6 7
00	00800 LAUNDRY & LINEN SERVICE	0					8
00	00900 HOUSEKEEPING	-62, 604					9
00	01000 DI ETARY	-154, 405					10
	01100 CAFETERI A	0	0				11
00	01200 MAI NTENANCE OF PERSONNEL	0	0				12
00	01300 NURSING ADMINISTRATION	0	572, 419				13
	01400 CENTRAL SERVICES & SUPPLY	0	0				14
	01500 PHARMACY	-18, 204					15
	01600 MEDICAL RECORDS & LIBRARY	0	339, 880				16
	01700 SOCIAL SERVICE	0	0				17
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0				19
	02000 INDESTING SCHOOL 02100 I & RSERVI CES-SALARY & FRINGES APPRV	0	0				20 21
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22
	02300 PARAMED ED PRGM-(SPECIFY)	0	0				23
	INPATIENT ROUTINE SERVICE COST CENTERS	-	1 -1				
00	03000 ADULTS & PEDI ATRI CS	0	2, 864, 625				30
00	03100 INTENSIVE CARE UNIT	-25, 168	1, 287, 211				31
	03400 SURGI CAL INTENSI VE CARE UNI T	0	0				34
00	04300 NURSERY	0	402, 745				43
~ ~	ANCI LLARY SERVI CE COST CENTERS	4 004 550					
	05000 OPERATING ROOM	-1, 386, 552					50
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0					52
	05500 RADI OLOGY-DI AGNOSTI C	-494, 838	1, 537, 445 410, 603				54 55
	05700 CT SCAN	-474, 030					57
	05900 CARDI AC CATHETERI ZATI ON	0					59
00	06000 LABORATORY	-365					60
30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62
00	06500 RESPI RATORY THERAPY	-22,010	797, 994				65
	06501 SLEEP LAB	0	46, 730				65
	06600 PHYSI CAL THERAPY	-28,060					66
	06601 PHYSI CAL THERAPY - LI FEPLEX	0	630, 612				66
	06602 PHYSI CAL THERAPY - CULVER MI LI TARY	0	21, 223				66
00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	158, 158 87, 270				67 68
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	07,270				71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	391, 224				72
	07300 DRUGS CHARGED TO PATIENTS	0					73
	07697 CARDI AC REHABI LI TATI ON	-10					76
98	07698 HYPERBARI C OXYGEN THERAPY	0					76
	07699 LI THOTRI PSY	0					76
	OUTPATIENT SERVICE COST CENTERS						
	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	7, 418				90
	09002 ATHLETIC TRAINERS	-152, 738					90
	09003 SAINT JOSEPH HEALTH CENTER	-899					90
	09004 WOUND CARE	0 41 EE4	726, 629				90
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	-41, 554	3, 220, 287				91 92
00	SPECIAL PURPOSE COST CENTERS						12
3. 00		-6, 199, 232	51, 150, 330			1	118
	NONREI MBURSABLE COST CENTERS	2,, 202					
. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 461			1	190
	19001 LIFEPLEX FITNESS FORUM	-535, 765					190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192
2. 01	19201 FOUNDATI ON ADMI NI STATI ON	0	0				192
	19202 HOSPI TALI ST	0	0				192
	19203 I NTENSI VI ST	0	0				192
	19204 FOOT & ANKLE SPORTS MED PLY	78					192
1.00	07950 PLYMOUTH MOB-4	0	33, 796				194 194
	07951 COMMUNITY OUTREACH & PARTNERSHIP	0	62, 963				

SI FI CATI ONS			Provider CCN: 15-	From 07/01/2	Worksheet A-6
				To 06/30/2	2021 Date/Time Prepar 11/30/2021 12:37
Cost Center	Line #	Sal ary	Other		
2.00	3.00	4.00	5.00		
A - Negative Balances			45.000		
EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15, 998		1
MEDI CAL SUPPLI ES CHARGED TO	71.00	0	63, 766		2
TOTALS	+	— —  — <sub>0</sub>	79,764		
B - Implantable Devices	I	0	//,/04		
IMPL. DEV. CHARGED TO	72.00	0	391, 224		1
PATIENTS					
	0.00	0	0		2
	0.00	0	0		3
$\square = = = = = = =$	0.00	0			4
TOTALS		0	391, 224		
C - Drugs Charged to Patients					
LABORATORY	60.00	0	2,874		1
DRUGS CHARGED TO PATIENTS	73.00	0	2, 721, 432		2
	0.00	0	0		3
	0.00	0	0		4
	0. 00 0. 00	0	0		5
	0.00	0	0		
	0.00	0	0		8
	0.00	0	0		9
	0.00	0	9		10
	0.00	0	0		11
	0.00	0	0		12
TOTALS		0			
E - Building Depreciation					
CAP REL COSTS-BLDG & FIXT	1.00	0	1, 247, 146		1
	0.00	0	0		2
	0.00	0	0		3
	0.00	0	0		4
	0.00	0	0		5
	0.00	0	0		6
	0.00	0			
	0.00	0	0		8
	0.00	0	-		(
	0.00	0	0		1(
	0.00	0	0		1
	0.00	0	0		12
	0. 00 0. 00	0	0		13
	0.00	0	0		1
	0.00	0			1
	0.00	0			1
	0.00	0	0		18
TOTALS		— — — o	1, 247, 146		
F - Equipment Depreciation					
CAP REL COSTS-MVBLE EQUIP	2.00		2, 085, 995		1
					1
					1
					1
					1
					1
					1
					1
					1
					1
					1
					2
					2
					22
					23
					24
					25
			2,085,995		1 20

 ST. JOSEPHS REG MED CENTER PLYMOUTH
 In Lieu of Form CMS-2552-10

 Provi der CCN: 15-0076
 Period: From 07/01/2020
 Worksheet A-6

					To 06/30/2021 Date/Time Pr 11/30/2021 1	epared: 2:37 pm
		Increases				
	Cost Center	Line #	Sal ary	0ther		
	2.00	3.00	4.00	5.00		
	I - Nursery and Labor/Deliver	У				
1.00	NURSERY	43.00	281, 392	121, 353		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	281, 392	<u>121, 3</u> 54		2.00
	TOTALS		562, 784	242, 707		
	K - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		281, 618		1.00
2.00						2.00
			0	281, 618		
	N - Hyperbaric Oxygen					
1.00	HYPERBARI C OXYGEN THERAPY		2 <u>9, 6</u> 81	<u> </u>		1.00
			29, 681	35, 635		
500.00	Grand Total: Increases		592, 465	7, 088, 395		500.00

Health Financial Systems RECLASSIFICATIONS

# ST. JOSEPHS REG MED CENTER PLYMOUTH Provi der CCN: 15-0076 Peri od:

In Lieu of Form CMS-2552-10 Worksheet A-6

RECLAS	SIFICATIONS			Provider	CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet A-6 Date/Time Prepared:
		Decreases					11/30/2021 12:37 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	<u>.</u>	
	6.00 A - Negative Balances	7.00	8.00	9.00	10.00		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	79, 764		0	1.00
2.00		0.00	0	0		0	2.00
	TOTALS		0	79, 764		]	
	B - Implantable Devices				1	-1	
1.00 2.00	OPERATING ROOM	50.00 59.00	0	322, 106 5		0	1.00
2.00	CARDIAC CATHETERIZATION WOUND CARE	90. 04	0	ت 67, 958		ol	3.00
4.00	EMERGENCY	91.00	0	1, 155		0	4.00
	TOTALS		0	391, 224			11.00
	C - Drugs Charged to Patients				1	1	
1.00	PHARMACY	15.00	0	2, 365, 122		0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	35, 200		0	2.00
3.00 4.00	INTENSIVE CARE UNIT OPERATING ROOM	31.00 50.00	0	11, 367 54, 540		0	3.00 4.00
4.00 5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	124, 141		0	4.00
6.00	CT SCAN	57.00	Ő	36, 219		0	6.00
7.00	RESPI RATORY THERAPY	65.00	0	3, 592		0	7.00
8.00	PHYSI CAL THERAPY	66.00	0	1, 389		o	8.00
9.00	OUTPATIENT TREATMENT &	90. 01	0	16		0	9.00
10.00	INFUSION CTR	00.00		7 700			40.00
10.00 11.00	SAINT JOSEPH HEALTH CENTER WOUND CARE	90. 03 90. 04	0	7, 798 13, 008		0	10.00
12.00	EMERGENCY	90.04		71, 914		ol	12.00
12.00	TOTALS		0	2, 724, 306			12.00
	E - Building Depreciation	I	-1		I.	ł	
1.00		0.00	0	0		9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	313, 215		0	2.00
3.00	OPERATION OF PLANT	7.00	0	380, 431		0	3.00
4.00 5.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	1, 161 3, 454		0	4.00 5.00
6.00	NURSING ADMINISTRATION	13.00	0	55, 235		0	6.00
7.00	PHARMACY	15.00	Ő	825		0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	17, 395		0	8.00
9.00	OPERATING ROOM	50.00	0	41, 955		o	9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	10, 929		0	10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	0	12, 995		0	11.00
12.00	LABORATORY	60.00	0	1, 122		0	12.00
13.00 14.00	SLEEP LAB PHYSICAL THERAPY	65.01 66.00	0	408 4, 774		0	13.00
15.00	PHYSICAL THERAPY - LIFEPLEX	66.01	0	2, 498		o	15.00
16.00	WOUND CARE	90.04	0	11, 919		0	16.00
17.00	EMERGENCY	91.00	0	325, 169		o	17.00
18.00	PLYMOUTH MOB-4	194.00	0	<u> </u>		ol	18.00
	TOTALS		0	1, 247, 146			
1.00	F - Equipment Depreciation					9	1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00		676, 446		7	2.00
3.00	OPERATION OF PLANT	7.00		55, 027			3.00
4.00	LAUNDRY & LINEN SERVICE	8.00		448			4.00
5.00	DI ETARY	10.00		17, 934			5.00
6.00	NURSING ADMINISTRATION	13.00		78, 165			6.00
7.00		15.00		56, 086			7.00
8.00 9.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00 31.00		58, 448 2, 611			8. 00 9. 00
10.00	OPERATING ROOM	50.00		245, 155			10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00		200, 223			11.00
12.00	RADI OLOGY-THERAPEUTI C	55.00		203, 953			12.00
13.00	CT SCAN	57.00		7,420			13.00
14.00	CARDIAC CATHETERIZATION	59.00		132, 234			14.00
15.00		60.00		33, 491			15.00
16.00	RESPIRATORY THERAPY	65.00		25, 598			16.00
17.00 18.00	SLEEP LAB PHYSICAL THERAPY	65. 01 66. 00		1, 156 6, 535			17.00 18.00
18.00	PHYSICAL THERAPY PHYSICAL THERAPY - LIFEPLEX	66.01		4, 254			19.00
20.00	OCCUPATI ONAL THERAPY	67.00		3, 882			20.00
21.00	CARDI AC REHABI LI TATI ON	76.97		14, 700			21.00
22.00	SAINT JOSEPH HEALTH CENTER	90. 03		2, 416			22.00
23.00	EMERGENCY	91.00		250, 393			23.00
23.00 24.00 25.00	LIFEPLEX FITNESS FORUM PLYMOUTH MOB-4	190. 01 194. 00		771 8, 649			24.00 25.00

Heal th	Financial Systems	ST.	JOSEPHS REG MEI	D CENTER PLYMO	UTH	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (	CCN: 15-0076	Period:	Worksheet A-	6
						From 07/01/2020 To 06/30/2021	Date/Time Pr 11/30/2021 1	epared: 2:37 pm
		Decreases						
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	I - Nursery and Labor/Deliver	су.						
1.00	ADULTS & PEDIATRICS	30.00	562, 784	242, 707		0		1.00
2.00		0.00	0	0		0		2.00
	TOTALS		562, 784	242, 707				
	K - Interest Expense							
1.00					1	1		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00		281,618				2.00
			0	281, 618				
	N - Hyperbaric Oxygen							
1.00	WOUND CARE	90.04	29, 681	35, 635				1.00
			29, 681	35, 635				
500.00	Grand Total: Decreases		592, 465	7, 088, 395				500.00

In Lieu of Form CMS-2552-10 Worksheet A-7

Heal th	Financial Systems SI.	JUSEPHS REG MEL	CENTER PLYMOL	ЛН	In Lie	EU OT FORM CMS	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 07/01/2020 To 06/30/2021		pared:
				Acquisition	IS		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES					
1.00	Land	477, 930	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	45, 077, 670	0		0 0	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	28, 025, 403	0		0 0	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	73, 581, 003	0		0 0	0	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	73, 581, 003	0		0 0	0	10.00
		Ending Balance	Fully			•	
		J	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES					
1.00	Land	477, 930	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	45, 077, 670	17, 230, 315				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	28, 025, 403	14, 979, 983				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	73, 581, 003	32, 210, 298				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	73, 581, 003	32, 210, 298				10.00
	•						

Heal th Financia	l Systems		
RECONCI LI ATI ON	OF CAPITAL	COSTS	CENTERS

### ST. JOSEPHS REG MED CENTER PLYMOUTH Provi der CCN: 15-0076

In Lieu of Form CMS-2552-10 Period: Worksheet A-7 From 07/01/2020 Part II To 06/20/2011 Pote/Time Proposed

				To 06/30/2021		
		SL	IMMARY OF CAPI	TAL		
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 WOR	SHEET A, COLUM	12, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(	0 0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(	0 0	0	2.00
3.00 Total (sum of lines 1-2)	0	0	(	0 0	0	3.00
	SUMMARY OF	CAPI TAL				
Cost Center Description	0ther 1	Fotal (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMN	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00  Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems	ST. JOSEPHS REG MEL	D CENTER PLYMOU	JIH	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2020	Worksheet A-7 Part III	
				To 06/30/2021		oarod
			'	10 00/ 30/ 2021	11/30/2021 12:	
	COME	PUTATION OF RAT	TL0S	ALLOCATION OF		07 pm
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col.			
			2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COST	S CENTERS		_			
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(	1. 000000	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(	0. 000000	0	2.00
3.00 Total (sum of lines 1-2)	0	0	(	1. 000000	0	3.00
	ALLOCA	FION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
•		Capi tal -Rel ate	cols. 5			
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COST	S CENTERS		•			
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(	2, 122, 545	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(	2, 085, 995	0	2.00
3.00 Total (sum of lines 1-2)	0	0		4, 208, 540		3.00
		SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
'		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
			· · ·	d Costs (see	through 14)	
				instructions)	J ,	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COST	S CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(	0 0	2, 122, 545	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 0	2, 085, 995	2.00
3.00 Total (sum of lines 1-2)	0	0		0 0	4, 208, 540	
					.,, 0.10]	2.20

	Financial Systems	ST. J	IOSEPHS REG ME	D CENTER PLYMOUTH		u of Form CMS-2	
ADJUST	MENTS TO EXPENSES				Period: From 07/01/2020 To 06/30/2021	Worksheet A-8 Date/Time Pre 11/30/2021 12	pared:
				Expense Classification on To/From Which the Amount is			or pin
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00 B	<u>2.00</u> -281,618	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 11	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		O	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00		
4.00	(chapter 2) Trade, quantity, and time		0		0.00		
	discounts (chapter 8)		Ū				
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00		
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -1, 893, 923		0.00	0 0	
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	-60, 735			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -154, 386		0.00 10.00		
15.00	Rental of quarters to employee and others	b	0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17. 00	patients Sale of drugs to other than patients	В	-18, 204	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19. 00	Nursing and allied health education (tuition, fees,		C		0.00	0	19. 00
20.00	books, etc.) Vending machines	В	0	CAFETERI A	11.00		
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
22.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
23.00	therapy costs in excess of limitation (chapter 14)	A-0-3	U		03.00		23.00
24.00	Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		O	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00		29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
32.00	Limitation (chapter 14) CAH HIT Adjustment for		C		0.00	0	32.00
	Depreciation and Interest						

### ST LOSEPHS REG MED CENTER PLYMOUTH

In lieu of Form CMS\_2552\_10

Health Financial Systems		ST	JOSEPHS REG ME	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES				Provider CCN: 15-0076	Peri od:	Worksheet A-8	
					From 07/01/2020		
					To 06/30/2021	Date/Time Pre 11/30/2021 12	
				Expense Classification o	n Worksheet A	117 307 2021 12	. <u>57 pm</u>
				To/From Which the Amount is			
					···· <b>,</b> ····		
			A	Cost Costor	1: //		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY)	1.00	2.00		0,00		33.00
55.00	(3)		0		0.00	0	33.00
33.01	Other Operating Rev -	В	-22.010	RESPI RATORY THERAPY	65.00	0	33.01
	Respiratory Care - Rent	_	,			_	
33.02	Other Operating Rev -	В	-113, 346	RADI OLOGY-THERAPEUTI C	55.00	0	33.02
	Radiation Oncology - Rent						
33.03	Other Operating Rev - Physical	В	-28, 060	PHYSI CAL THERAPY	66.00	0	33.03
	Therapy						
33.04	Other Operating Rev - Athletic	В	-152, 738	ATHLETIC TRAINERS	90.02	0	33.04
	Trainers						
33.05	Other Operating Rev -	В	-62,604	HOUSEKEEPING	9.00	0	33.05
33.06	Housekeeping Other Operating Rev -	В	2 007	ADMI NI STRATI VE & GENERAL	5.00	0	33, 06
33.00	Administration	D	-2,907	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.07	Other Operating Rev - Vending	В	_10	DI ETARY	10.00	0	33.07
33.08	OTHER REVENUE	В		LABORATORY	60.00		
33.09	OTHER REVENUE	B		RESPIRATORY THERAPY	65.00		
33.10	Other Operating Rev - Saint	В		SAINT JOSEPH HEALTH CENTER	90.03		
	Joseph Heal th Center						
33. 11	Other Operating Rev - Foot &	В	78	FOOT & ANKLE SPORTS MED PLY	192.04	0	33.11
	Ankle Sports Med						
33. 12	Other Operating Revenue -	В	-10	CARDIAC REHABILITATION	76.97	0	33.12
	Cardiac Rehab LifePlex		_			_	
33. 13	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.13
33. 14	(3) Other Revenue - LifePlex	В	E2E 74E	LIFEPLEX FITNESS FORUM	190.01	0	33. 14
33.14	Other Revenue JESSE	В		PHYSICAL THERAPY	66.00		
33.15	Gain Loss on Sale of Asset	В		CAP REL COSTS-MVBLE EQUIP	2.00		
34.00	PROVIDER TAX	A		ADMINISTRATIVE & GENERAL	5.00		
34.10	Provi der Tax	A		ADMI NI STRATI VE & GENERAL	5.00		
35.00	Donations	A		ADMI NI STRATI VE & GENERAL	5.00		
35.10	Property Tax	A		ADMI NI STRATI VE & GENERAL	5.00		35.10
50.00	TOTAL (sum of lines 1 thru 49)		-6, 734, 919		0.00	l	50.00
	(Transfer to Worksheet A,		-, , , , , ,				
	column 6, line 200.)						

 column 6, line 200.)
 |

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

(2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	ST. JOSEPHS REG M	ED CENTER PLYMOUTH	In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0076	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 12	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00			HO NON CAPITAL COSTS	7, 390, 126		
2.00	5.00	ADMINISTRATIVE & GENERAL	WORKERS COMP	93, 553	77, 981	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	INSURANCE	41, 569	131, 202	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	PENSION	27, 547	29, 449	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	RETIREE HEALTH COSTS	0	39, 639	3. 02
3.03	1.00	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS	875, 399	0	3.03
3.04	4.00	EMPLOYEE BENEFITS DEPARTMENT		0	48, 264	3.04
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			8, 428, 194	8, 488, 929	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.

has not been posted to worksheet A, cordinas i anayor 2, the amount arrowable should be mareated in cordinary of this part.									
				Related Organization(s) and/	i i				
				, , , , , , , , , , , , , , , , , , ,		í -			
						i i			
						1			
						i i			
		•.							
	Symbol (1)	Name	Percentage of	Name	Percentage of	i i			
			Ownership		Ownership	i i			
	1.00	2.00		4.00					
	1.00	2.00	3.00	4.00	5.00	i			
	B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFLCE:			1			

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

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

1 Of mout						
6.00	G		0.00	TRINITY HEALTH	0.00	6.00
7.00	G		0.005	SJRMC – INC	0.00	7.00
8.00	G	SJRMC - SB	0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					1

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

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

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

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

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

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

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

part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

6.00	6.00
7.00	7.00
8.00	8.00 9.00
9.00	9.00
10.00	10.00
8.00 9.00 10.00 100.00	100.00

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

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

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

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

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

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

Health Financial Systems ST. JOSEPHS REG MED CENTER PLYMOUTH In Lieu of Form CMS-2552-10 STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0076 Peri od: Worksheet A-8-1 From 07/01/2020 Data /Tima Dranar

					10	06/30/2021	Date/lime Pr 11/30/2021 1	epared: 2:37 pm
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6.00	7.00						
	A. COSTS INCUR	RED AND ADJUST	IENTS REQUIRED AS A RESULT OF 7	RANSACTIONS WITH RELATED	ORGAN	IZATIONS OR (	CLAI MED	
	HOME OFFICE CO	STS:						
1.00	-772, 268	0						1.00
2.00	15, 572	0						2.00
3.00	-89, 633	0						3.00
3.01	-1, 902	0						3.01
3.02	-39,639	0						3. 02
3.03	875, 399	9						3.03
3.04	-48, 264	0						3.04
4.00	0	0						4.00
5 00	-60 735	1						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.

-60, 735 5.00 

OFFICE COSTS

Related Organization(s) and/or Home Office

> Type of Business 6.00

Health Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT

In Lieu of Form CMS-2552-10 Worksheet A-8-2

Heal th	Financial Syste	ems ST.	JOSEPHS REG MI	ED CENTER PLYMO	UTH	In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider C		Peri od:	Worksheet A-8	3-2
						From 07/01/2020		
						To 06/30/2021		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	11/30/2021 12 Physi ci an/Prov	
	WKSL A LINE #	I denti fi er	Remuneration	Component	Component	RUE AIIIOUITI	ider Component	
		ruentinei	Reliturier at 1 Off	component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7,00	
1 00		I NTENSI VE CARE UNI T	46, 080		<u> </u>			1.00
1.00								
2.00		OPERATING ROOM	1, 386, 552	1, 386, 552	C	,		
3.00	0.00		0	0	C	e e e e e e e e e e e e e e e e e e e	0	
4.00		RADI OLOGY-THERAPEUTI C	380, 492	381, 492	-1,000			
5.00		LABORATORY	1, 867	0	1, 867	260, 300		
6.00	0.00		0	0	C	0	0	
7.00		EMERGENCY	93, 705		97,013			
8.00	5.00	ADMINISTRATIVE & GENERAL	66, 193	54, 650	11, 543	179,000	86	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			1, 974, 889		155, 503		957	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	31.00	INTENSIVE CARE UNIT	20, 912	1, 046	C	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	C	0	0	2.00
3.00	0.00		0	0	C	0	0	3.00
4.00	55.00	RADI OLOGY-THERAPEUTI C	861	43	C	0	0	4.00
5.00	60.00	LABORATORY	1, 502	75	C	0	0	5.00
6.00	0.00		0	0	C	0	0	6.00
7.00	91.00	EMERGENCY	52, 151	2, 608	C	0	0	7.00
8.00	5.00	ADMI NI STRATI VE & GENERAL	7, 401	370	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			82, 827	4, 142	C	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	31.00	I NTENSI VE CARE UNI T	0	20, 912	25, 168	25, 168		1.00
2.00	50,00	OPERATING ROOM	0	0	C			2.00
3.00	0,00		0	0	C	0	,	3.00
4.00		RADI OLOGY - THERAPEUTI C	0	861	0	381, 492		4.00
5.00		LABORATORY	n	1, 502	365			5.00
6.00	0.00			0	000	000	1	6.00
7.00		EMERGENCY		52, 151	44, 862	0	1	7.00
8.00		ADMI NI STRATI VE & GENERAL		7, 401	44, 802			8.00
8.00 9.00	0.00	ADMINI SINATI VE & GENERAL		/, 401 0	4, 142		1	9.00
9.00 10.00	0.00			0		0		9.00
	0.00				74, 537	1, 893, 923		200.00
200.00	I	l	0	82, 827	/4, 03/	1,093,923		200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 07/01/2020 o 06/30/2021	Worksheet B Part I Date/Time Pre 11/30/2021 12	pared: :37 pm
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS	0.400 545	0 400 545				1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP	2, 122, 545 2, 085, 995	2, 122, 545	2, 085, 995			1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-28, 039	0		-28, 039		4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	14, 521, 433	238, 267	234, 164	0	14, 993, 864	5.00
6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 0PERATION OF PLANT	0 2, 118, 994	0 450, 625	0 442, 865	0	0 3, 012, 484	
8.00 00800 LAUNDRY & LINEN SERVICE	177, 080	430, 023 8, 068		0	193, 077	8.00
9.00 00900 HOUSEKEEPI NG	616, 825	3, 994		0	624, 744	•
10. 00  01000  DI ETARY 11. 00  01100   CAFETERI A	492, 216	27, 918	27,437	0	547, 571 0	•
12. 00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	
13. 00 01300 NURSI NG ADMI NI STRATI ON	572, 419	0	0	0	572, 419	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
15. 00  01500   PHARMACY 16. 00  01600   MEDI CAL_RECORDS & LI BRARY	877, 883 339, 880	16, 522 33, 469		0	910, 643 406, 242	•
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	1
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
20. 00 02000 NURSI NG SCHOOL 21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0	0	0	0	
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS	2, 864, 625	258, 117	253, 672	0	3, 376, 414	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 287, 211	49, 499		0	1, 385, 357	
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	-	0	0	
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	402, 745	0	0	0	402, 745	43.00
50. 00 05000 OPERATI NG ROOM	3, 465, 521	256, 280	251, 867	0	3, 973, 668	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	402, 746	0	0	0	402, 746	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 537, 445	96, 707		0	1, 729, 194	•
55. 00  05500  RADI OLOGY-THERAPEUTI C 57. 00  05700  CT_SCAN	410, 603 157, 543	120, 485 5, 578		0	649, 498 168, 603	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	94, 825	28, 264		0	150, 867	•
60.00 06000 LABORATORY 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	5, 191, 711	57, 860	56, 863	0	5, 306, 434	•
62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 65. 00 06500 RESPI RATORY THERAPY	797, 994	44, 160	43, 399	0	0 885, 553	•
65. 01 06501 SLEEP LAB	46, 730	0	0	0	46, 730	
66.00 06600 PHYSI CAL THERAPY	1, 256, 279	77, 842	76, 502	0	1, 410, 623	
66.01 06601 PHYSICAL THERAPY - LIFEPLEX 66.02 06602 PHYSICAL THERAPY - CULVER MILITARY	630, 612 21, 223	0	0	0	630, 612 21 223	66. 01 66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	158, 158	0	0	0	158, 158	
68. 00 06800 SPEECH PATHOLOGY	87, 270	0	0	0	87, 270	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0 391, 224	0	0	0	0 391, 224	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 721, 432	0	0	0	2, 721, 432	
76. 97 07697 CARDI AC REHABI LI TATI ON	262, 968	0	0	0	262, 968	
76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY	65, 316 0	7, 229 0	7, 105 0	0	79, 650 0	
OUTPATIENT SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·			
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR 90. 02 09002 ATHLETIC TRAINERS	7,418	0	0	0	7, 418	
90. 03 09003 SAINT JOSEPH HEALTH CENTER	26, 182 1, 018, 402	0	0	0	26, 182 1, 018, 402	
90. 04 09004 WOUND CARE	726, 629	34, 388	33, 796	0	794, 813	
91.00 09100 EMERGENCY	3, 220, 287	109, 264	107, 382	0	3, 436, 933	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECIAL PURPOSE COST CENTERS					0	92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	51, 150, 330	1, 924, 536	1, 891, 396	0	50, 785, 761	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	1 461	2 520	2 494	0	6 177	190.00
190. 01 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 461 365, 875	2, 530 0	2, 486 0	0	365, 875	•
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	195, 479	192, 113	0	387, 592	192.00
192. 01 19201 FOUNDATI ON ADMINI STATI ON	0	0	0	0		192.01
192. 02 19202 H0SPI TALI ST 192. 03 19203 I NTENSI VI ST		0	0 0	0		192. 02 192. 03
192.04 19204 FOOT & ANKLE SPORTS MED PLY	468, 182	0	0	o	468, 182	192. 04
194. 00 07950 PLYMOUTH MOB-4	33, 796	0	0	0		194.00
194.01 07951 COMMUNITY OUTREACH & PARTNERSHIP 200.00  Cross Foot Adjustments	62, 963	0	0	0		194. 01 200. 00
	I		I	l	0	1-00.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	ST. JOSEPHS REG ME	Provider CCN: 15-0076 Period: From 07/01. To 06/30.		Period: From 07/01/2020		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL REI BLDG & FIXT	LATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
201.00 Negative Cost Centers		0	(	-28, 039	-28, 039	201.00
202.00 TOTAL (sum lines 118 through 20	1) 52, 082, 60	2, 122, 545	2, 085, 995	-28, 039	52, 082, 607	202.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 07/01/2020 o 06/30/2021	Worksheet B Part I Date/Time Pre 11/30/2021 12	pared: 37 pr
	Cost Center Description	ADMI NI STRATI VE <u>&amp; GENERAL</u> 5. 00	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPI NG 9.00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
. 00	00500 ADMINI STRATI VE & GENERAL	14, 993, 864					5.0
. 00	00600 MAI NTENANCE & REPAI RS	0	0				6.0
. 00	00700 OPERATI ON OF PLANT	1, 216, 938	0	4, 229, 422			7.0
. 00	00800 LAUNDRY & LINEN SERVICE	77, 996	0	23, 802			8.0
. 00	00900 HOUSEKEEPI NG	252, 375	0	11, 783		888, 902	9.0
0.00	01000 DI ETARY	202, 373	0	82, 360		17, 457	10.0
	01100 CAFETERI A	221, 200	0	02, 300	0	0	11.0
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.0
	01300 NURSI NG ADMI NI STRATI ON	231, 237	0	0	0	0	13.0
	01400 CENTRAL SERVICES & SUPPLY	231, 237	0	0	0	0	14. C
	01500 PHARMACY	367, 868	0	48, 742	0	-	14. C
	01600 MEDICAL RECORDS & LIBRARY		0	48, 742 98, 737	0	10, 331 20, 928	16. C
	01700 SOCIAL SERVICE	164, 108	0		0		
		0	0	0	0	0	17.0
	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.0
	02000 NURSI NG SCHOOL	0	0	0	0	0	20.0
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.0
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.0
3.00	02300 PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23. (
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 0/0 050		7/4 470	44.407	4/4 005	
	03000 ADULTS & PEDIATRICS	1, 363, 953	0	761, 472		161, 395	30.0
	03100 I NTENSI VE CARE UNI T	559, 636	0	146, 027	7, 234	30, 951	31.0
	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.0
3.00	04300 NURSERY	162, 695	0	0	976	0	43. (
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	1, 605, 223	0	756, 053		160, 249	50. (
	05200 DELIVERY ROOM & LABOR ROOM	162, 695	0	0	_,	0	52.0
	05400 RADI OLOGY-DI AGNOSTI C	698, 534	0	285, 296		60, 470	54.
	05500 RADI OLOGY-THERAPEUTI C	262, 374	0	355, 443		75, 338	55.0
7.00	05700 CT SCAN	68, 110	0	16, 455		3, 488	57.0
9.00	05900 CARDI AC CATHETERI ZATI ON	60, 945	0	83, 382	932	17, 673	59. (
0.00	06000 LABORATORY	2, 143, 596	0	170, 692	62, 978	36, 179	60. (
2.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.
5.00	06500 RESPI RATORY THERAPY	357, 732	0	130, 276	14, 597	27, 613	65.0
5.01	06501 SLEEP LAB	18, 877	0	0	622	0	65.(
6.00	06600 PHYSI CAL THERAPY	569, 842	0	229, 643	6, 047	48, 674	66. (
6. 01	06601 PHYSI CAL THERAPY - LI FEPLEX	254, 745	0	0	4, 698	0	66. (
6. 02	06602 PHYSICAL THERAPY - CULVER MILITARY	8, 573	0	0	145	0	66.
7.00	06700 OCCUPATIONAL THERAPY	63, 890	0	0	1, 098	0	67.
8.00	06800 SPEECH PATHOLOGY	35, 254	0	0	283	0	68.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.0
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	158, 041	0	0	3, 876	0	72.
3.00	07300 DRUGS CHARGED TO PATIENTS	1, 099, 363	0	0	24, 375	0	73.
	07697 CARDI AC REHABI LI TATI ON	106, 230	0	0	1, 050	0	76.
6. 98	07698 HYPERBARI C OXYGEN THERAPY	32, 176	0	21, 327	1, 153	4, 520	76.
6. 99	07699 LI THOTRI PSY	0	0	0	0	0	76.
	OUTPATIENT SERVICE COST CENTERS						
D. 01	09001 OUTPATIENT TREATMENT & INFUSION CTR	2, 997	0	0	0	0	90.
0. 02	09002 ATHLETI C TRAI NERS	10, 577	0	0	0	0	90.
0. 03	09003 SAINT JOSEPH HEALTH CENTER	411, 399	0	0	1, 016	0	90.
0. 04	09004 WOUND CARE	321,077	0	101, 449	3, 497	21, 503	90.
1.00	09100 EMERGENCY	1, 388, 401	0	322, 339		68, 321	91.
1.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
	07200 0DSERVATION DEDS (NON DISTINCT TART	· · · · · · · · · · · · · · · · · · ·					
	SPECIAL PURPOSE COST CENTERS					765, 090	118.
2. 00	SPECIAL PURPOSE COST CENTERS	14, 458, 657	0	3, 645, 278	291, 330	705,040	
2.00 18.00 90.00	SPECIAL PURPOSE COST CENTERS           SUBTOTALS (SUM OF LINES 1 through 117)           NONREIMBURSABLE COST CENTERS           19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 616	0	7, 462	0	1, 582	
2.00 18.00 90.00 90.01	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 LIFEPLEX FITNESS FORUM	2, 616 147, 801	0	7, 462	0	1, 582 0	190.
2.00 18.00 90.00 90.01 92.00	SPECIAL PURPOSE COST CENTERS           SUBTOTALS (SUM OF LINES 1 through 117)           NONREIMBURSABLE COST CENTERS           19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN           19001         LIFEPLEX FITNESS FORUM           19200         PHYSICIANS' PRIVATE OFFICES	2, 616	0	7, 462 0 576, 682	0 0 0	1, 582 0 122, 230	190. 192.
2.00 18.00 90.00 90.01 92.00 92.01	SPECIAL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         19001 LI FEPLEX FI TNESS FORUM         19200 PHYSI CI ANS' PRI VATE OFFI CES         19201 FOUNDATI ON ADMI NI STATI ON	2, 616 147, 801	0 0 0 0	7, 462	0 0 0 0	1, 582 0 122, 230 0	190. 192. 192.
2.00 18.00 90.00 90.01 92.01 92.01 92.02	SPECI AL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         19001 LI FEPLEX FI TNESS FORUM         19200 PHYSI CI ANS' PRI VATE OFFI CES         19201 FOUNDATI ON ADMI NI STATI ON         19202 HOSPI TALI ST	2, 616 147, 801	0	7, 462 0 576, 682	0 0 0	1, 582 0 122, 230 0 0	190. 192. 192. 192.
2.00 18.00 90.00 90.01 92.01 92.01 92.02	SPECIAL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         19001 LI FEPLEX FI TNESS FORUM         19200 PHYSI CI ANS' PRI VATE OFFI CES         19201 FOUNDATI ON ADMI NI STATI ON	2, 616 147, 801	0 0 0 0	7, 462 0 576, 682 0	0 0 0 0	1, 582 0 122, 230 0 0	190. 192. 192. 192.
2.00 18.00 90.00 90.01 92.00 92.01 92.02 92.02	SPECI AL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         19001 LI FEPLEX FI TNESS FORUM         19200 PHYSI CI ANS' PRI VATE OFFI CES         19201 FOUNDATI ON ADMI NI STATI ON         19202 HOSPI TALI ST	2, 616 147, 801	0 0 0 0	7, 462 0 576, 682 0	0 0 0 0 2, 027	1, 582 0 122, 230 0 0 0	190. 192. 192. 192. 192.
2.00 18.00 90.00 90.01 92.00 92.01 92.02 92.03 92.04	SPECI AL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN         19001       LI FEPLEX FITNESS FORUM         19200       PHYSI CI ANS' PRI VATE OFFICES         19201       FOUNDATI ON ADMI NI STATI ON         19202       HOSPI TALI ST         19203       I NTENSI VI ST	2, 616 147, 801 156, 574 0 0 189, 129	0 0 0 0	7, 462 0 576, 682 0	0 0 0 2, 027 616	1, 582 0 122, 230 0 0 0 0 0	190. 192. 192. 192. 192. 192.
2.00 18.00 90.00 90.01 92.00 92.01 92.02 92.03 92.04 94.00	SPECIAL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN         19001       LIFEPLEX FITNESS FORUM         19200       PHYSI CIANS' PRI VATE OFFICES         19201       FOUNDATION ADMINISTATION         19202       HOSPITALIST         19203       INTENSI VIST         19204       FOOT & ANKLE SPORTS MED PLY         07950       PLYMOUTH MOB-4	2, 616 147, 801 156, 574 0 0 0	0 0 0 0	7, 462 0 576, 682 0	0 0 0 2, 027 616 902	1, 582 0 122, 230 0 0 0 0 0 0 0	190. 192. 192. 192. 192. 192. 192.
2.00 18.00 90.00 90.01 92.00 92.01 92.02 92.03 92.04 94.00 94.01	SPECI AL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         19001 LI FEPLEX FI TNESS FORUM         19200 PHYSI CI ANS' PRI VATE OFFI CES         19201 FOUNDATI ON ADMI NI STATI ON         19202 HOSPI TALI ST         19203 INTENSI VI ST         19204 FOOT & ANKLE SPORTS MED PLY         07950 PLYMOUTH MOB-4         07951 COMMUNI TY OUTREACH & PARTNERSHI P	2, 616 147, 801 156, 574 0 0 0 189, 129 13, 652	0 0 0 0	7, 462 0 576, 682 0	0 0 0 2, 027 616 902	1, 582 0 122, 230 0 0 0 0 0 0 0 0 0	190. 192. 192. 192. 192. 192. 192. 194.
2.00 18.00 90.00 92.00 92.01 92.02 92.03 92.04 94.00 94.01 00.00	SPECIAL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         19001 LI FEPLEX FITNESS FORUM         19200 PHYSI CI ANS' PRI VATE OFFICES         19201 FOUNDATI ON ADMI NI STATI ON         19202 HOSPI TALI ST         19203 I NTENSI VI ST         19204 FOOT & ANKLE SPORTS MED PLY         07950 PLYMOUTH MOB-4         07951 COMMUNI TY OUTREACH & PARTNERSHI P         Cross Foot Adj ustments	2, 616 147, 801 156, 574 0 0 0 189, 129 13, 652	0 0 0 0	7, 462 0 576, 682 0	0 0 0 2, 027 616 902	1, 582 0 122, 230 0 0 0 0 0 0 0 0 0 0	190.
2.00 18.00 90.00 90.01 92.00 92.01 92.02 92.03 92.04 94.00	SPECIAL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN         19001 LIFEPLEX FITNESS FORUM         19200 PHYSICIANS' PRIVATE OFFICES         19201 FOUNDATION ADMINISTATION         19202 HOSPITALIST         19203 INTENSIVIST         19204 FOOT & ANKLE SPORTS MED PLY         07950 PLYMOUTH MOB-4         07951 COMMUNITY OUTREACH & PARTNERSHIP         Cross Foot Adjustments         Negative Cost Centers	2, 616 147, 801 156, 574 0 0 0 189, 129 13, 652	0 0 0 0	7, 462 0 576, 682 0	0 0 0 2, 027 616 902 0 0 0 0	1, 582 0 122, 230 0 0 0 0 0 0 0 0 0 0	190 192 192 192 192 192 194 194 200 201

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Heal th	Financial Systems ST.	JOSEPHS REG MED	CENTER PLYM	HTUC		In Lieu	u of Form CMS-	-2552-10
	ALLOCATION - GENERAL SERVICE COSTS			CCN: 15-0076		riod: om 07/01/2020	Worksheet B Part I Date/Time Pre 11/30/2021 12	epared:
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE PERSONNEL		NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
		10.00	11.00	12.00		13.00	14.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1		1				1.00
2.00 4.00 5.00 6.00 7.00 8.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE							2.00 4.00 5.00 6.00 7.00 8.00
9.00	00900 HOUSEKEEPI NG							9.00
10.00		868, 607						10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0		0	0			11.00
12.00	01300 NURSI NG ADMI NI STRATI ON	0			0	803, 656		12.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0		0	0	000,000	C	
15.00	01500 PHARMACY	0		0	0	24, 345	C	
16.00	01600 MEDICAL RECORDS & LIBRARY	0		0	0	16, 773	C	16.00
17.00	01700 SOCIAL SERVICE	0		0	0	0	C	
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0		0	0	0	0	
20.00 21.00	02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0		0	0	0	C	
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0			0	0	0	
23.00	02300 PARAMED ED PRGM- (SPECI FY)	0		0	õ	0	C	
	INPATIENT ROUTINE SERVICE COST CENTERS			-				
30.00	03000 ADULTS & PEDIATRICS	654, 076		0	0	118, 342	C	
31.00	03100 I NTENSI VE CARE UNI T	139, 310		0	0	45, 717	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0		0	0	0	0	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0		<u> </u>	0	12, 661	0	43.00
50.00	05000 OPERATING ROOM	67, 548		0	0	91, 313		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	Ő	12, 661	C	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0	0	48, 974	C	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0	0	15, 592	C	
57.00	05700 CT SCAN	0		0	0	4, 967	0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0		0	0	2, 198	C	0 / 00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0	110, 243	C	
65.00	06500 RESPIRATORY THERAPY	0		0	õ	29, 555	C	
65.01	06501 SLEEP LAB	0		0	0	0	C	65.01
66.00	06600 PHYSI CAL THERAPY	0		0	0	48, 201	C	
66.01	06601 PHYSI CAL THERAPY - LI FEPLEX	0		0	0	17, 139	0	
66. 02 67. 00	06602 PHYSI CAL THERAPY - CULVER MILLITARY	0		0	0	611 5 007	(	00.02
68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0			0	5, 007 2, 443	C	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	õ	2, 110		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	C	72.00
	07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	C	
	07697 CARDI AC REHABI LI TATI ON	0		0	0	7,653	0	
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0		0	0	1, 425 0	0	) 76.98 ) 76.99
, 5. 77	OUTPATIENT SERVICE COST CENTERS	0		<u> </u>	<u> </u>	U U		10.77
90. 01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0		0	0	366	C	90.01
	09002 ATHLETI C TRAI NERS	0		0	0	9, 241	C	
	09003 SAINT JOSEPH HEALTH CENTER	0		0	0	37, 779	0	
	09004 WOUND CARE	0		0	0	6, 514	0	
91.00		7,673		0	0	83, 659	C	91.00 92.00
92.00	09200 0BSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS							92.00
118.00		868, 607		0	0	753, 379	(	0 118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	(	190. 00
	19001 LIFEPLEX FITNESS FORUM	0		0	0	35, 214		0 190. 01
	19200 PHYSI CLANS' PRI VATE OFFI CES	0		0	0	0		192.00
	19201 FOUNDATION ADMINISTATION	0		0	U	0		192.01
	2 19202 HOSPI TALI ST 3 19203 I NTENSI VI ST	0		0	0	0		) 192. 02 ) 192. 03
	19204 FOOT & ANKLE SPORTS MED PLY	0		ŏ	0	11, 440		192.03
	07950 PLYMOUTH MOB-4	0		0	õ	0		194.00
	07951 COMMUNI TY OUTREACH & PARTNERSHI P	0		0	0	3, 623		0 194. 01
200.00								200.00
201.00		0		0	0	0		201.00
202.00	) TOTAL (sum lines 118 through 201)	868, 607		0	0	803, 656	(	202.00

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COST A	ALLOCATION - GENERAL SERVICE COSTS	1	Provider C	-	Period: From 07/01/2020 Fo 06/30/2021	Worksheet B Part I Date/Time Pre 11/30/2021 12	2:37 pm
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVIC	E NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
. 00	00600 MAI NTENANCE & REPAI RS						6.00
. 00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
. 00	00900 HOUSEKEEPI NG						9.00
0. 00	01000 DI ETARY						10.00
1. 00	01100 CAFETERI A						11.00
2.00	01200 MAINTENANCE OF PERSONNEL						12.00
3.00	01300 NURSING ADMINISTRATION						13.00
4.00	01400 CENTRAL SERVICES & SUPPLY	1 9 ( 1 9 9 9					14.00
5.00	01500 PHARMACY	1, 361, 929	70/ 700				15.00
6.00	01600 MEDICAL RECORDS & LIBRARY	0	706, 788				16.00
7.00 9.00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0		17.00
9.00	02000 NURSI NG SCHOOL	0	0			o	
1.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			0	20.00
2.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
3.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.00
0.00	INPATIENT ROUTINE SERVICE COST CENTERS						20.00
0. 00	03000 ADULTS & PEDI ATRI CS	0	33, 891		0 0	0	30. 00
1.00	03100 I NTENSI VE CARE UNI T	0	17, 343		0 0	0	
4.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0 0	0	34.00
3. 00	04300 NURSERY	0	2, 341	(	0 0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
0. 00	05000 OPERATING ROOM	0	95, 018	(	0 0	0	50.00
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	5, 003		0 0	0	52.00
4.00	05400 RADI OLOGY-DI AGNOSTI C	0	60, 322		0 0	0	
5.00	05500 RADI OLOGY-THERAPEUTI C	902	34, 399		0 0	0	
7.00	05700 CT SCAN	0	92, 931		0 0	0	
9.00	05900 CARDI AC CATHETERI ZATI ON	147	2, 233		0 0	0	
0.00	06000 LABORATORY	0	150, 916		0 0	0	
2.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0			0	
5.00 5.01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	0	34, 993 1, 491			0	
6.00	06600 PHYSI CAL THERAPY	0	1, 491			0	
6.01	06601 PHYSI CAL THERAPY - LI FEPLEX	0	11, 262			0	
5. 02	06602 PHYSI CAL THERAPY - CULVER MILLITARY	0	349			0	
7.00	06700 OCCUPATI ONAL THERAPY	0	2, 632		0 0	0	
	06800 SPEECH PATHOLOGY	o	677		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	9, 292	(	0 0	0	
3.00	07300 DRUGS CHARGED TO PATIENTS	1, 358, 921	58, 433	(	0 0	0	73.00
5. 97	07697 CARDI AC REHABI LI TATI ON	0	2, 516	(	0 0	0	76.97
6. 98	07698 HYPERBARI C OXYGEN THERAPY	0	2, 764		0 0	0	
6. 99	07699 LI THOTRI PSY	0	0	(	0 0	0	76.99
	OUTPATIENT SERVICE COST CENTERS	-	-		-	-	
0.01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0		0	0	
		0	0			0	
		0	2,436			0	
0.04 1.00	09004 WOUND CARE 09100 EMERGENCY	0	8, 382 54, 171			0	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	54, 171	l '	0	0	92.00
2.00	SPECIAL PURPOSE COST CENTERS						72.00
18.00		1, 359, 970	698, 290	(	0 0	0	118.00
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0 0	0	190.00
	19001 LIFEPLEX FITNESS FORUM	0	0	(	0 0		190.01
	19200 PHYSICIANS' PRIVATE OFFICES	О	0		0 0		192.00
	19201 FOUNDATION ADMINISTATION	О	0		0 0	0	192. 01
92.02	19202 HOSPI TALI ST	О	4, 859	(	0 0	0	192. 02
92.03	19203 I NTENSI VI ST	0	1, 477	(	0 0		192. 03
	19204 FOOT & ANKLE SPORTS MED PLY	1, 959	2, 162	(	0 0		192. 04
	07950 PLYMOUTH MOB-4	0	0	(	0 0		194.00
	07951 COMMUNI TY OUTREACH & PARTNERSHIP	0	0	(	0 0		194. 01
00.00					0		200. 00
		0	0		0 0	0	201.00
01.00 02.00		1, 361, 929	706, 788		0 0		202.00

COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0076	15-0076 Period: Worksheet B From 07/01/2020 Part I To 06/30/2021 Date/Time Pr			
		INTERNS & F	RESIDENTS			11/30/2021 12	: 37 pm	
	Cost Center Description	SERVI CES-SALARS Y & FRI NGES APPRV 21.00		PARAMED ED PRGM 23.00	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments 25.00		
	GENERAL SERVICE COST CENTERS	21.00	22.00	23.00	24.00	25.00		
1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00	
16.00 17.00 19.00 20.00 21.00 22.00 23.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0		16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00	
30.00 31.00	03000 ADULTS & PEDIATRICS	0	0		0 6, 483, 680 0 2, 331, 575			
34.00	03100 I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 2, 331, 575 0 0		1	
43.00	04300 NURSERY	0	0		0 581, 418	0	43.00	
E0 00	ANCI LLARY SERVI CE COST CENTERS	0	0	1	0 6, 788, 708	0	50.00	
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 6, 788, 708 0 585, 192			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 2, 907, 953			
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 1, 407, 895			
57.00	05700 CT SCAN	0	0		0 393, 319			
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0 318, 377 0 7, 981, 038		59.00 60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 7,981,038			
65.00	06500 RESPI RATORY THERAPY	0	0		0 1, 480, 319	-		
65.01	06501 SLEEP LAB	0	0		0 67, 720	0	65.01	
66.00	06600 PHYSI CAL THERAPY	0	0		0 2, 327, 525			
66. 01 66. 02	06601 PHYSI CAL THERAPY - LI FEPLEX 06602 PHYSI CAL THERAPY - CULVER MI LI TARY	0	0		0 918, 456 0 30, 901			
67.00		0	0		0 230, 785	-	67.02	
68.00	06800 SPEECH PATHOLOGY	0	0		0 125, 927			
71.00		0	0		0 0	0		
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 562, 433 0 5, 262, 524			
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 380, 417			
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 143, 015			
76.99	07699 LI THOTRI PSY	0	0		0 0	0	76.99	
90. 01	OUTPATIENT SERVICE COST CENTERS		0		0 10 791	0	90.01	
90.01		0	0		0 10, 781 0 46, 000		1	
90.03		0	0		0 1, 471, 032		90.03	
90.04	09004 WOUND CARE	0	0		0 1, 257, 235			
91.00 92.00		0	0		0 5, 384, 094	0		
92.00	SPECIAL PURPOSE COST CENTERS					0	92.00	
118. 0	SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 49, 478, 319	0	118. 00	
100 0	NONREI MBURSABLE COST CENTERS				0 18 137	^	190.00	
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1 19001 LIFEPLEX FITNESS FORUM		0		0 18, 137 0 548, 890		190.00	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 1, 243, 078		192.00	
192.0	1 19201 FOUNDATION ADMINISTATION	0	0		0 0	0	192.01	
		0	0		0 6, 886		192.02	
	3 19203 INTENSIVIST 4 19204 FOOT & ANKLE SPORTS MED PLY	0	0		0 2,093 0 673,774		192.03 192.04	
	07950 PLYMOUTH MOB-4	0	0		0 47, 448		192.04	
	07951 COMMUNITY OUTREACH & PARTNERSHIP	0	0		0 92, 021	0	194.01	
200.0		0	0		0 0	0	200.00	

# ST. JOSEPHS REG MED CENTER PLYMOUTH Provi der CCN: 15-0076 Peri od:

					From 07/01/2020 To 06/30/2021		pared.
						11/30/2021 12	
		INTERNS &	RESI DENTS				
Cost Center	Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
		Y & FRINGES	PRGM COSTS	PRGM		Residents Cost	
		APPRV	APPRV			& Post	
						Stepdown	
						Adjustments	
		21.00	22.00	23.00	24.00	25.00	
201.00 Negative Co	ost Centers	0	0		0 -28, 039	0	201.00
202.00   TOTAL (sum	lines 118 through 201)	0	0		0 52, 082, 607	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-0076	Period:WorksheetFrom 07/01/2020Part ITo06/30/2021Date/Time	Prepared:
Cost Center Description	Total		11/30/2021	12:37 pm
GENERAL SERVICE COST CENTERS	26.00			
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
5.00 00500 ADMINI STRATI VE & GENERAL				5.00
6.00 00600 MAI NTENANCE & REPAI RS				6.00
7.00 00700 OPERATION OF PLANT				7.00
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY				9.00
10. 00  01000  DI ETARY 11. 00  01100  CAFETERI A				10.00
12.00 01200 MAINTENANCE OF PERSONNEL				12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON				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
19.00 01900 NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000 NURSI NG SCHOOL				20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV				21.00
22.00 02200 I & SERVICES-OTHER PRGM COSTS APPRV				22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)				23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	( 100 ( 00			
30. 00 03000 ADULTS & PEDIATRICS	6, 483, 680			30.00
31. 00  03100  INTENSI VE CARE UNI T 34. 00  03400  SURGI CAL I NTENSI VE CARE UNI T	2, 331, 575			31.00
43. 00 04300 NURSERY	581, 418			43.00
ANCI LLARY SERVICE COST CENTERS	301,410			43.00
50. 00 05000 OPERATI NG ROOM	6, 788, 708			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	585, 192			52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 907, 953			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 407, 895			55.00
57.00 05700 CT SCAN	393, 319			57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	318, 377			59.00
60. 00 06000 LABORATORY	7, 981, 038			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			62.30
65. 00 06500 RESPIRATORY THERAPY	1, 480, 319			65.00
65. 01 06501 SLEEP LAB	67,720			65.01
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	2, 327, 525			66. 00 66. 01
66. 02 06602 PHYSICAL THERAPY - CULVER MILITARY	918, 456 30, 901			66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	230, 785			67.00
68. 00 06800 SPEECH PATHOLOGY	125, 927			68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	562, 433			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 262, 524			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	380, 417			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	143, 015			76. 98
76. 99 07699 LI THOTRI PSY	0			76. 99
OUTPATIENT SERVICE COST CENTERS	1			
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	10, 781			90.01
90. 02 09002 ATHLETI C TRAI NERS	46,000			90.02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	1, 471, 032			90.03
90. 04 09004 WOUND CARE 91. 00 09100 EMERGENCY	1, 257, 235			90.04 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 384, 094			91.00
SPECIAL PURPOSE COST CENTERS				92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	49, 478, 319			118.00
NONREI MBURSABLE COST CENTERS	47,470,517			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18, 137			190. 00
190. 01 19001 LI FEPLEX FI TNESS FORUM	548, 890			190.01
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 243, 078			192.00
192. 01 19201 FOUNDATION ADMINISTATION	0			192.01
192. 02 19202 HOSPI TALI ST	6, 886			192. 02
192. 03 19203 I NTENSI VI ST	2, 093			192. 0
192.04 19204 FOOT & ANKLE SPORTS MED PLY	673, 774			192. 04
194.0007950 PLYMOUTH MOB-4	47, 448			194.00
104 01070F1 COMMUNITY OUTDEACH & DADTNEDCHLD				1101 01
194. 01 07951 COMMUNI TY OUTREACH & PARTNERSHIP	92, 021			
200.00 Cross Foot Adjustments	0			200.00
				194.01 200.00 201.00 202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0076 Period: From 07/01/2 To 06/30/2 CAPITAL RELATED COSTS Cost Center Description Directly Assigned New Capital Related Costs Provider CCN: 15-0076 Period: From 07/01/2 To 06/30/2 Subtotal	021 Date/Time Prepared: 11/30/2021 12:37 pm EMPLOYEE
Cost Center Description Directly Assigned New Capital Related Costs	
	BENEFI TS DEPARTMENT
0 1.00 2.00 2A	4.00
GENERAL SERVICE COST CENTERS	
1.00 00100 CAP REL COSTS-BLDG & FIXT	1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P	2.00
4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT 0 0 0	0 0 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 0 238, 267 234, 164 472,	
6. 00         00600         MAI NTENANCE & REPAIRS         0         0         0           7. 00         00700         0PERATI ON OF PLANT         0         450, 625         442, 865         893,	0 0 6.00 490 0 7.00
	490         0         7.00           997         0         8.00
	919 0 9.00
	355 0 10.00
11. 00 01100 CAFETERIA 0 0 0	0 0 11.00
12. 00 01200 MAINTENANCE OF PERSONNEL 0 0 0	0 0 12.00
13. 00 (01300) NURSI NG ADMI NI STRATI ON 0 0 0	0 0 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0	0 0 14.00
	760 0 15.00
	362 0 16.00
17.00 01700 SOCIAL SERVICE 0 0 0	0 0 17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0	0 0 19.00
20. 00 02000 NURSI NG SCHOOL 0 0	0 0 20.00
21.00 02100 I & SERVICES-SALARY & FRINGES APPRV 0 0 0	0 0 21.00
22. 00 02200 I & SERVICES-OTHER PRGM COSTS APPRV 0 0 0	0 0 22.00
23.00 02300 PARAMED ED PRGM-(SPECI FY) 0 0 0	0 0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 0 258, 117 253, 672 511,	
	146 0 31.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T 0 0 0	0 0 34.00
43.00 04300/NURSERY 0 0 0	0 0 43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 0 256, 280 251, 867 508,	147 0 50.00
50.00         05000         0PERATING ROOM         0         256, 280         251, 867         508,           52.00         05200         DELIVERY ROOM & LABOR ROOM         0         0         0         0	0 0 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 96, 707 95, 042 191,	
54. 00 05400 RAD 0L0G1-DI ROROSTI C 0 70, 707 75, 042 117,	
	060 0 57.00
	042 0 59.00
60. 00 06000 LABORATORY 0 57, 860 56, 863 114,	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0	0 0 62.30
65. 00 06500 RESPI RATORY THERAPY 0 44, 160 43, 399 87,	559 0 65.00
65. 01 06501 SLEEP LAB 0 0 0	0 0 65.01
66. 00 06600 PHYSI CAL THERAPY 0 77, 842 76, 502 154,	344 0 66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX 0 0 0	0 0 66.0
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY 0 0 0	0 0 66.02
67.00   06700  0CCUPATI ONAL THERAPY 0 0 0	0 0 67.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0	0 0 68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0	0 0 71.00
72. 00         07200         I MPL.         DEV.         CHARGED         TO         O <td>0 0 72.00 0 73.00</td>	0 0 72.00 0 73.00
73. 00         07300         DRUGS         CHARGED         TO         O	0 0 73.00 0 76.97
	334 0 76.98
76. 99 07699 LI THOTRI PSY 0 0 0	0 0 76.99
OUTPATI ENT SERVICE COST CENTERS	
90. 01 09001 0UTPATI ENT TREATMENT & INFUSION CTR 0 0 0	0 0 90.0
90. 02 09002 ATHLETI C TRAINERS 0 0 0	0 0 90.02
90. 03 09003 SAINT JOSEPH HEALTH CENTER 0 0 0	0 90.03
90. 04 09004 WOUND CARE 0 34, 388 33, 796 68,	184 0 90.04
91.00 09100 EMERGENCY 0 109, 264 107, 382 216,	646 0 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0 92.00
SPECIAL PURPOSE COST CENTERS	
SUBTOTALS         (SUM OF LINES 1 through 117)         0         1, 924, 536         1, 891, 396         3, 815,	932 0 118.00
NONREI MBURSABLE COST CENTERS	
	016 0 190. 00
190. 01 19001 LI FEPLEX FI TNESS FORUM 0 0 0	0 0 190. 0
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 195, 479 192, 113 387,	
192. 01 19201 FOUNDATI ON ADMI NI STATI ON 0 0 0	0 0 192.0
192. 0219202 HOSPITALIST 0 0 0	0 0 192.02
	0 0 192. 03
	010000
192. 04 19204 FOOT & ANKLE SPORTS MED PLY 0 0 0	0 0 192.04
192. 03     19203     INTENSI VI ST     0     0     0       192. 04     19204     FOOT & ANKLE SPORTS MED PLY     0     0     0       194. 00     07950     PLYMOUTH MOB-4     0     0     0       194. 01     07951     COMMUNITY VOLTOFACH & DADTNEPSHID     0     0     0	0 0 194.00
192.04         19204         FOOT & ANKLE SPORTS MED PLY         0         0         0           194.00         07950         PLYMOUTH MOB-4         0         0         0           194.01         07951         COMMUNI TY OUTREACH & PARTNERSHIP         0         0         0	0 0 194.00 0 0 194.01
192.04         19204         FOOT & ANKLE SPORTS MED PLY         0         0         0         0           194.00         07950         PLYMOUTH MOB-4         0         0         0         0	0 0 194.00

Health Financial Systems ST. JOSEPHS REG MED CENTER PLYMOUTH				JTH	In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS			Provider C		Period: From 07/01/2020	Worksheet B Part II		
						Date/Time Pre	pared: :37 pm	
			CAPI TAL REI	ATED COSTS				
	Cost Center Description	Di rectly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT		
		Related Costs						
		0	1.00	2.00	2A	4.00		
202.00	TOTAL (sum lines 118 through 201)	0	2, 122, 545	2, 085, 99	5 4, 208, 540	0	202.00	

LLOC	ATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0076 P F T	eriod: rom 07/01/2020 p 06/30/2021	Worksheet B Part II Date/Time Pre 11/30/2021 12	pared
	Cost Center Description	ADMI NI STRATI VE M & GENERAL 5.00	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPI NG 9.00	
	GENERAL SERVICE COST CENTERS						
. 00	00100 CAP REL COSTS-BLDG & FIXT						1.C
. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. C
. 00	00500 ADMINISTRATIVE & GENERAL	472, 431					5. C
. 00	00600 MAI NTENANCE & REPAI RS	0	0				6.0
. 00	00700 OPERATION OF PLANT	38, 343	0	931, 833			7.0
. 00	00800 LAUNDRY & LINEN SERVICE	2,457	0	5, 244	23, 698		8.0
. 00	00900 HOUSEKEEPING	7, 952	0	2, 596	0	18, 467	9.0
0.00	01000 DI ETARY	6, 969	0	18, 146	2	363	
1.00		0	0	0	o	0	11.0
2.00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12.0
3.00		7, 286	0	0	0	0	
4.00		0	0	0	0	0	14.0
5.00		11, 591	0	10, 739	0	215	
6.00		5, 171	0	21, 754	0	435	
7.00		0,171	0	21,701	0	0	17.0
9.00		0	0	0	0	0	19.0
0.00		0	0	0	0	0	20.0
1.00		0	0	0	0	0	21.0
2.00		0	0	0	0	0	22.0
3.00		0	0	0	0	0	23.0
5.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	<u> </u>	0	23.0
0. 00		42, 975	0	167, 768	1, 133	3, 353	30. (
1.00			0		580		1
		17, 633	0	32, 173	580	643	
4.00		U E 10(	-	0	-	0	34.0
3.00		5, 126	0	0	78	0	43. (
~ ~~	ANCI LLARY SERVICE COST CENTERS	F0 F77	0	1// 575	2 170	2, 220	
0.00		50, 577	0	166, 575	3, 178	3, 329	
2.00		5, 126	0	0	167	0	
4.00		22, 009	0	62, 857	2, 017	1, 256	
5.00		8, 267	0	78, 312	1, 150	1, 565	
7.00		2, 146	0	3, 625	3, 108	72	
9.00		1, 920	0	18, 371	75	367	
0.00	06000 LABORATORY	67, 553	0	37, 607	5, 108	752	
2.30		0	0	0	0	0	62.
5.00	06500 RESPI RATORY THERAPY	11, 271	0	28, 703	1, 170	574	65.0
5. 01	06501 SLEEP LAB	595	0	0	50	0	65.0
6.00	06600 PHYSI CAL THERAPY	17, 954	0	50, 595	485	1, 011	66.
6. 01	06601 PHYSI CAL THERAPY - LI FEPLEX	8, 026	0	0	377	0	66.
6. 02		270	0	0	12	0	66.
7.00		2, 013	0	0	88	0	67.
8.00		1, 111	0	0	23	0	68.
1. 00		0	0	0	0	0	
2.00		4, 979	0	0	311	0	1 12.
3.00		34, 638	0	0	1, 954	0	
	07697 CARDI AC REHABI LI TATI ON	3, 347	0	0	84	0	
	07698 HYPERBARI C OXYGEN THERAPY	1, 014	0	4, 699	92	94	
6. 99	07699 LI THOTRI PSY	0	0	0	0	0	76.
	OUTPATIENT SERVICE COST CENTERS	1					
0. 01		94	0	0	0	0	90.
	09002 ATHLETI C TRAI NERS	333	0	0	0	0	90.
	09003 SAINT JOSEPH HEALTH CENTER	12, 962	0	0	81	0	90.
0. 04	09004 WOUND CARE	10, 116	0	22, 351	280	447	90.
	09100 EMERGENCY	43, 745	0	71, 018	1, 812	1, 419	91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
	SPECIAL PURPOSE COST CENTERS						
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	455, 569	0	803, 133	23, 415	15, 895	118.
	NONREI MBURSABLE COST CENTERS						1
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	82	0	1, 644	0	33	190.
	1 19001 LI FEPLEX FI TNESS FORUM	4,657	0	0	0		190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	4, 933	0	127, 056	0	2, 539	
	19201 FOUNDATION ADMINISTATION	0	0	0	0		192.
	2 19202 HOSPI TALI ST	0	0	0	162		192.
	3 19203 I NTENSI VI ST	0	0	0	49		192.
	419204 FOOT & ANKLE SPORTS MED PLY	5, 959	0	0	72		192.
	007950 PLYMOUTH MOB-4	430	0	0	/2		192.
			0	0	0		
94.00			()	0	0	0	194.
94.00 94.0	107951 COMMUNITY OUTREACH & PARTNERSHIP	801	Ŭ		I		1200
94.00 94.0 <sup>°</sup> 00.00	Cross Foot Adjustments	801	0			-	200.
94.00 94.0	Cross Foot Adjustments Negative Cost Centers	0 472, 431	0	0 931, 833	0 23, 698		201.

Heal th	Fina	nci	al S	yste	ems		
			CADI	TAI	DEL	ATED	

near th	Financial Systems ST	JOSEPHS REG MED	CENTER PLYM	DUTH		In Lieu	」of Form CMS-	2552-10
	ATION OF CAPITAL RELATED COSTS		Provi der	CCN: 15-0076		iod: m 07/01/2020 06/30/2021	Worksheet B Part II Date/Time Pre 11/30/2021 12	pared:
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE PERSONNEL		NURSI NG MI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
		10.00	11.00	12.00		13.00	14.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	80, 835 0 0		0	0	7, 286		2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01600 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS			0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 221 152 0 0 0 0 0 0		14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00
30.00	03000 ADULTS & PEDIATRICS	60, 870		0	0	1, 074	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	12, 965		0	0	414	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0		0	0	0	0	1
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0		0	0	115	0	43.00
50.00	05000 OPERATI NG ROOM	6, 286		0	0	828	0	50.00
$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 00\\ 62.\ 30\\ 65.\ 00\\ 65.\ 01\\ \end{array}$	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06501 SLEEP LAB	0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	115 444 141 45 20 999 0 268 0		54.00 55.00 57.00 59.00 60.00 62.30 65.00 65.01
72.00 73.00 76.97 76.98	06600 PHYSI CAL THERAPY 06601 PHYSI CAL THERAPY - LI FEPLEX 06602 PHYSI CAL THERAPY - CULVER MI LI TARY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY 0UTPATI ENT SERVICE COST CENTERS			0 0 0 0 0 0 0 0 0 0 0 0		437 155 6 45 22 0 0 0 0 0 9 13 0		66. 01 66. 02 67. 00 68. 00 71. 00 72. 00 73. 00 76. 97 76. 98
90. 03 90. 04 91. 00	09001 OUTPATIENT TREATMENT & INFUSION CTR 09002 ATHLETIC TRAINERS 09003 SAINT JOSEPH HEALTH CENTER 09004 WOUND CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0 714		0 0 0 0 0	0 0 0 0	3 84 343 59 758	0 0 0 0 0	90.02 90.03 90.04
118.00	SPECIAL PURPOSE COST CENTERS	80, 835		0	0	6, 830	0	118.00
190. 01 192. 00 192. 01 192. 02 192. 03 192. 04 194. 00	19000GIFT, FLOWER, COFFEE SHOP & CANTEEN19001LIFEPLEX FITNESS FORUM19200PHYSICIANS' PRIVATE OFFICES19201FOUNDATION ADMINISTATION219202HOSPITALIST319203INTENSIVIST19204FOOT & ANKLE SPORTS MED PLY007950PLYMOUTH MOB-407951COMMUNITY OUTREACH & PARTNERSHIP0Cross Foot Adjustments0Negative Cost Centers	0 0 0 0 0 0 0 0 0 80, 835			0 0 0 0 0 0 0 0 0 0 0	0 319 0 0 0 104 0 33 3 0 7, 286		190. 00 190. 01 192. 00 192. 01 192. 02 192. 03 192. 04 194. 00 194. 01 200. 00 201. 00 202. 00

1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	TI ON OF CAPITAL RELATED COSTS Cost Center Description GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-WVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	PHARMACY 15.00	MEDICAL RECORDS & LIBRARY 16.00	F	Period: From 07/01/2020 o 06/30/2021 NONPHYSICIAN ANESTHETISTS		2:37 pm
2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS		RECORDS & LI BRARY				
2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	15.00	16.00	17 00			
2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS			17.00	19.00	20.00	
2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						1.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS						2.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS						4.00
6.00 7.00 8.00 9.00 10.00 11.00 12.00	00600 MAI NTENANCE & REPAI RS						5.00
8.00 9.00 10.00 11.00 12.00	00700 OPERATION OF PLANT						6.00
9.00 10.00 11.00 12.00							7.00
10. 00 11. 00 12. 00	00800 LAUNDRY & LINEN SERVICE						8.00
11. 00 12. 00	00900 HOUSEKEEPI NG						9.00
12.00	01000 DI ETARY						10.00
	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL						11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY	55, 526					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	93, 874				16.00
	01700 SOCI AL SERVI CE	0	0	C	)		17.00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0		19.00
	02000 NURSI NG SCHOOL	0	0	0		0	
	02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV	0	0				21.00
	02300 PARAMED ED PRGM-(SPECIFY)	0	0				22.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0			1	23.00
30.00	03000 ADULTS & PEDI ATRI CS	0	4, 503	0	)		30.00
31.00	03100 INTENSIVE CARE UNIT	0	2, 304	( C			31.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0	C				34.00
43.00	04300 NURSERY	0	311		)		43.00
50.00	ANCI LLARY SERVI CE COST CENTERS		10 (0)			1	1 50 00
50.00 52.00	05000 OPERATING ROOM	0	12, 626				50.00
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	665 8, 015				52.00 54.00
	05500 RADI OLOGY-THERAPEUTI C	37	4, 571				55.00
	05700 CT SCAN	0	12, 348				57.00
	05900 CARDI AC CATHETERI ZATI ON	6	297		)		59.00
60.00	06000 LABORATORY	0	20, 013				60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	-			62.30
65.00	06500 RESPI RATORY THERAPY	0	4,650				65.00
65. 01 66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	0	198 1, 926				65.01 66.00
	06601 PHYSI CAL THERAPY - LIFEPLEX	0	1, 496				66.01
	06602 PHYSI CAL THERAPY - CULVER MILITARY	o	46				66.02
67.00	06700 OCCUPATI ONAL THERAPY	О	350		)		67.00
	06800 SPEECH PATHOLOGY	0	90	C	)		68.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	)		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 235				72.00
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	55, 403	7, 764 334				73.00
	07698 HYPERBARI C OXYGEN THERAPY	0	367				76.98
	07699 LI THOTRI PSY	o	007				76.99
	OUTPATIENT SERVICE COST CENTERS						1
	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	C		)		90.01
	09002 ATHLETI C TRAI NERS	О	0	-	0		90.02
	09003 SAINT JOSEPH HEALTH CENTER	0	324				90.03
	09004 WOUND CARE	0	1, 114				90.04
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7, 198	C			91.00 92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		55, 446	92, 745	(	0	0	118.00
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C				190.00
	19001 LIFEPLEX FITNESS FORUM	0	0				190.01
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
	19201 FOUNDATION ADMINISTATION	0	0				192.01
	19202 HOSPI TALI ST 19203 I NTENSI VI ST	0	646 196				192.02 192.03
	19203 FITENSIVIST 19204 FOOT & ANKLE SPORTS MED PLY	80	287		Ó		192.03
	07950 PLYMOUTH MOB-4	0	287				192.04
	07951 COMMUNITY OUTREACH & PARTNERSHIP	o	0		þ		194.01
200.00	Cross Foot Adjustments				0		200.00
201.00		о	C	C			201.00
202.00	TOTAL (sum lines 118 through 201)	55, 526	93, 874	(	0	0	202.00

 In Lieu of Form CMS-2552-10

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 Period:

 Worksheet B

					From 07/01/2020 To 06/30/2021	Part II Date/Time Pre 11/30/2021 12	parec :37 m
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
6	CHERAL CERVILOF COST CENTERS	21.00	22.00	23.00	24.00	25.00	
-	GENERAL SERVICE COST CENTERS						1.
	DO200 CAP REL COSTS-BEDG & TEXT						2.
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.
	DO500 ADMINISTRATIVE & GENERAL						5.
00 0	DO600 MAINTENANCE & REPAIRS						6.
	DO700 OPERATION OF PLANT						7.
	DO800 LAUNDRY & LINEN SERVICE						8.
	DO900 HOUSEKEEPING						9.
	D1000 DI ETARY						10.
							11.
	01200 MAINTENANCE OF PERSONNEL						12. 13.
	D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY						13.
	D1500 PHARMACY						15.
	01600 MEDICAL RECORDS & LIBRARY						16.
	01700 SOCIAL SERVICE						17.
	01900 NONPHYSICIAN ANESTHETISTS						19.
. 00 0	D2000 NURSI NG SCHOOL						20.
. 00 0	D2100 I &R SERVICES-SALARY & FRINGES APPRV	0					21.
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		0				22.
	02300 PARAMED ED PRGM-(SPECIFY)				0		23.
	NPATIENT ROUTINE SERVICE COST CENTERS				700 4/5		1 00
	03000 ADULTS & PEDIATRICS				793, 465		
	D3100 INTENSIVE CARE UNIT D3400 SURGICAL INTENSIVE CARE UNIT				164, 858	0	
	04300 NURSERY				5, 630	0	
	ANCI LLARY SERVICE COST CENTERS				5,030	0	43.
	D5000 OPERATING ROOM				751, 546	0	50.
	D5200 DELIVERY ROOM & LABOR ROOM				6, 073		
	05400 RADI OLOGY-DI AGNOSTI C				288, 347	0	54.
. 00 0	05500 RADI OLOGY-THERAPEUTI C				332, 938	0	55.
00 0	D5700 CT SCAN				32, 404	0	57.
	05900 CARDI AC CATHETERI ZATI ON				77, 098		
	D6000 LABORATORY				246, 755		
	06250 BLOOD CLOTTING FOR HEMOPHILIACS				0	0	
	06500 RESPI RATORY THERAPY				134, 195		
	06501 SLEEP LAB				843	0	
	06600 PHYSICAL THERAPY 06601 PHYSICAL THERAPY - LIFEPLEX				226, 752 10, 054	0   0	
	06602 PHYSICAL THERAPY - CULVER MILITARY				334		
	06700 OCCUPATI ONAL THERAPY				2, 496		
	06800 SPEECH PATHOLOGY				1, 246		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0	0	
. 00 0	D7200 IMPL. DEV. CHARGED TO PATIENTS				6, 525	0	72.
00 0	07300 DRUGS CHARGED TO PATIENTS				99, 759	0	73.
	07697 CARDIAC REHABILITATION				3, 834		
	07698 HYPERBARI C OXYGEN THERAPY				20, 613		
	07699 LI THOTRI PSY				0	0	76.
	DUTPATIENT SERVICE COST CENTERS				97	0	00
	D9001 OUTPATIENT TREATMENT & INFUSION CTR				417		
	09003 SAINT JOSEPH HEALTH CENTER				13, 710		
	09004 WOUND CARE				102, 551	0	
	D9100 EMERGENCY				343, 310		
	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.
S	SPECIAL PURPOSE COST CENTERS						
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 3, 665, 850	0	118.
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				6, 775		190.
	19001 LIFEPLEX FITNESS FORUM				4, 976		190.
	19200 PHYSICIANS' PRIVATE OFFICES				522, 120		192.
	19201 FOUNDATION ADMINISTATION				0		192.
	19202 HOSPI TALI ST				808		192.
	19203 INTENSIVIST 19204 FOOT & ANKLE SPORTS MED PLY				245 6, 502		192. 192.
	D7950 PLYMOUTH MOB-4				6, 502		192.
	D7950 PLYMOUTH MOB-4 D7951 COMMUNITY OUTREACH & PARTNERSHIP				834		194.
1 010		1			0.04	. 0	11/4.

Health Fina	ancial Systems ST	. JOSEPHS REG MED	CENTER PLYMOL	JTH	In Lie	eu of Form CMS-2	2552-10
ALLOCATION	OF CAPITAL RELATED COSTS		Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Pre 11/30/2021 12	
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	0		0 4, 208, 540	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0076	Period:WorksheetFrom 07/01/2020Part IITo06/30/2021Date/Time	
Cost Center Description	Total		11/30/2021	
GENERAL SERVICE COST CENTERS	26.00			
1. 00 00100 CAP REL COSTS-BLDG & FIXT				1.0
2. 00 00200 CAP REL COSTS-MVBLE EQUIP				2.
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.
5. 00 00500 ADMI NI STRATI VE & GENERAL				5.0
5. 00 00600 MAI NTENANCE & REPAI RS				6.
7. 00 00700 OPERATION OF PLANT				7.0
3. 00 00800 LAUNDRY & LINEN SERVICE				8.
2. 00 00900 HOUSEKEEPING				9.1
10. 00 01000 DI ETARY				10.
11. 00 01100 CAFETERIA				11.
12.00 01200 MAINTENANCE OF PERSONNEL				12.
13.00 01300 NURSING ADMINISTRATION				13.
14.00 01400 CENTRAL SERVICES & SUPPLY				14.
15. 00 01500 PHARMACY				15.
16.00 01600 MEDICAL RECORDS & LIBRARY				16.
17.00 01700 SOCIAL SERVICE				17.
19.00 01900 NONPHYSICIAN ANESTHETISTS				19.
20. 00 02000 NURSING SCHOOL				20.
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV				21.
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV				22.
23.00 02300 PARAMED ED PRGM-(SPECIFY)				23.
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	793, 465			30.
31.00 03100 INTENSIVE CARE UNIT	164, 858			31.
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			34.
13. 00 04300 NURSERY	5, 630			43.
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	751, 546			50.
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 073			52.
54. 00 05400 RADI OLOGY-DI AGNOSTI C	288, 347			54.
55. 00 05500 RADI OLOGY-THERAPEUTI C	332, 938			55.
57.00 05700 CT SCAN	32, 404			57.
59. 00 05900 CARDI AC CATHETERI ZATI ON	77, 098			59.
50. 00 06000 LABORATORY	246, 755			60.
52.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			62.
55. 00 06500 RESPI RATORY THERAPY	134, 195			65.
55. 01 06501 SLEEP LAB	843			65.
56. 00 06600 PHYSI CAL THERAPY	226, 752			66.
56. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	10, 054			66.
56. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	334			66.
57.00 06700 OCCUPATI ONAL THERAPY	2, 496			67.
58.00 06800 SPEECH PATHOLOGY	1, 246			68.
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 525			72.
73.00 07300 DRUGS CHARGED TO PATIENTS	99, 759			73.
76. 97 07697 CARDI AC REHABI LI TATI ON	3, 834			76.
76. 98 07698 HYPERBARI C OXYGEN THERAPY	20, 613			76.
76. 99 07699 LI THOTRI PSY	0			76.
OUTPATIENT SERVICE COST CENTERS				
PO. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	97			90.
0. 02 09002 ATHLETI C TRAI NERS	417			90.
0. 03 09003 SAINT JOSEPH HEALTH CENTER	13, 710			90.
0. 04 09004 WOUND CARE	102, 551			90.
P1. 00 09100 EMERGENCY	343, 310			91.
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92.
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 11	7) 3, 665, 850			118.
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 775			190.
190.01 19001 LIFEPLEX FITNESS FORUM	4, 976			190.
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	522, 120			192.
192. 01 19201 FOUNDATI ON ADMINI STATI ON	0			192.
192. 02 19202 HOSPI TALI ST	808			192.
192. 03 19203 I NTENSI VI ST	245			192.
92.04 19204 FOOT & ANKLE SPORTS MED PLY	6, 502			192.
94.0007950 PLYMOUTH MOB-4	430			194.
194.0107951 COMMUNI TY OUTREACH & PARTNERSHIP	834			194.
200.00 Cross Foot Adjustments	0			200.
	0			
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0			201. 202.

	LLOCATION - STATISTICAL BASIS		Provider CC	F	Period: From 07/01/2020 Fo 06/30/2021	Worksheet B-1 Date/Time Pre 11/30/2021 12	pare
		CAPI TAL REL	ATED COSTS			111/00/2021 12	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM COST)	
		1.00	2.00	SALARI ES) 4.00	5A	5.00	
0	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	JA JA	5.00	-
	00100 CAP REL COSTS-BLDG & FIXT	2,008,830					1 1
	00200 CAP REL COSTS-MVBLE EQUIP	_,,	2, 008, 830				2
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	19, 123, 146			4
00	00500 ADMINISTRATIVE & GENERAL	225, 502	225, 502	2, 068, 896	-14, 993, 864	37, 116, 782	5
	00600 MAINTENANCE & REPAIRS	0	0	C	0 0	0	6
1	00700 OPERATION OF PLANT	426, 483		329, 812	2 0	3, 012, 484	
1	00800 LAUNDRY & LINEN SERVICE	7,636		0	0 0	193, 077	
1	00900 HOUSEKEEPING	3, 780				624, 744	
	01000 DI ETARY 01100 CAFETERI A	26, 422	26, 422	333, 466		547, 571 0	
	01200 MAINTENANCE OF PERSONNEL	0	0				
	01300 NURSI NG ADMI NI STRATI ON	0	0	477, 867			
	01400 CENTRAL SERVICES & SUPPLY	0	0	(),,001	0	0,2,11	
	01500 PHARMACY	15, 637	15, 637	719, 295	-	910, 643	
	01600 MEDICAL RECORDS & LIBRARY	31, 676		249, 961		406, 242	
7.00	01700 SOCIAL SERVICE	0	0	C	0 0	0	
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	C	0 0	0	19
	02000 NURSI NG SCHOOL	0	0	C	0 0	0	
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	C	0 0	0	1
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	(	0		
	02300 PARAMED_ED_PRGM-(SPECIFY) INPATIENT_ROUTINE_SERVICE_COST_CENTERS	0	0	(	0 0	0	23
	03000 ADULTS & PEDIATRICS	244, 288	244, 288	2, 167, 813	3 0	3, 376, 414	30
	03100 INTENSIVE CARE UNIT	46, 847		971, 052			
	03400 SURGI CAL I NTENSI VE CARE UNI T	10,047	40, 047	//1,032	0 0		
	04300 NURSERY	0	-	281, 392			
	ANCI LLARY SERVI CE COST CENTERS				1		
0. 00	05000 OPERATING ROOM	242, 550	242, 550	1, 950, 675	ō 0	3, 973, 668	50
	05200 DELIVERY ROOM & LABOR ROOM	0	0	281, 392	2 0	402, 746	52
	05400 RADI OLOGY-DI AGNOSTI C	91, 526		1, 112, 688		.,,	
	05500 RADI OLOGY-THERAPEUTI C	114,030		397, 241		649, 498	
	05700 CT SCAN	5, 279		93, 123		168, 603	
	05900 CARDI AC CATHETERI ZATI ON	26, 750				150, 867	
	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	54, 760	54, 760	1, 619, 478		5, 306, 434 0	
	06500 RESPIRATORY THERAPY	41, 794	41, 794	577, 789	-	885, 553	
	06501 SLEEP LAB	0		077,702		46, 730	
	06600 PHYSI CAL THERAPY	73, 672	73, 672	963, 355	-		
	06601 PHYSI CAL THERAPY - LI FEPLEX	0	0	369, 246			
	06602 PHYSI CAL THERAPY - CULVER MILI TARY	0	0	14, 094		21, 223	
7.00	06700 OCCUPATI ONAL THERAPY	0	0	132, 978	3 0	158, 158	67
	06800 SPEECH PATHOLOGY	0	0	73, 076	0	87, 270	
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	-		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0		
	07300 DRUGS CHARGED TO PATIENTS	0	0		0		
	07697 CARDI AC REHABI LI TATI ON	0	0	134, 708		262, 968	
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	6, 842	6, 842	29, 681		79, 650	
	OT699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0	(	ν <u>υ</u> 0	0	76
-	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0	5, 971	0	7, 418	90
	09002 ATHLETI C TRAI NERS	0	0	117, 467			
	09003 SAINT JOSEPH HEALTH CENTER	0	Ő	713, 349			
	09004 WOUND CARE	32, 546	32, 546	134, 461			
	09100 EMERGENCY	103, 410					
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	SPECIAL PURPOSE COST CENTERS					a= ==	
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 821, 430	1, 821, 430	18, 427, 222	-14, 993, 864	35, 791, 897	1118
	NONREIMBURSABLE COST CENTERS	0.004	2.004	-		/ 477	1100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 394	2, 394				
	19001 LIFEPLEX FITNESS FORUM 19200 PHYSICIANS' PRIVATE OFFICES	185,006	105 004	283, 304			
	19200 PHYSICIANS' PRIVATE OFFICES 19201 FOUNDATION ADMINISTATION	185,006	185, 006			387, 592	192
	1920 HOSPI TALI ST						192
	19202   INTENSI VI ST	0		r c			192
	19203 FINTENSIVIST 19204 FOOT & ANKLE SPORTS MED PLY	0		363, 376		468, 182	
	07950 PLYMOUTH MOB-4	0	0	(	0 0	33, 796	
	07951 COMMUNITY OUTREACH & PARTNERSHIP	0	0	49, 244	0	62, 963	
74. U I II			, v		, s		1

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

201.00

202.00

203.00

204.00

205.00

206.00

207.00

ST. JOSEPHS REG MED CENTER PLYMOUTH In Lieu of Form CMS-2552-10 Provider CCN: 15-0076 Peri od: Worksheet B-1 From 07/01/2020 To 06/30/2021 Date/Time Prepared: 11/30/2021 12:37 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP EMPLOYEE Reconci I i ati on ADMI NI STRATI VE Cost Center Description (SQUARE FEET) (SQUARE FEET) **BENEFITS** & GENERAL DEPARTMENT (ACCUM COST) (GROSS SALARI ES) 1.00 2.00 4.00 5A 5.00 Negative Cost Centers 201.00 14, 993, 864 202. 00 2, 122, 545 2,085,995 -28, 039 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) 1.056608 1.038413 0.000000 0. 403965 203. 00 Cost to be allocated (per Wkst. B, 472, 431 204.00 С Part II) Unit cost multiplier (Wkst. B, Part 0. 012728 205. 00 0.000000 ||)NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207.00

Health Financial	Systems
MOLTADOLIA T200	

		JOSEPHS REG MEI	D CENTER PLYMOL	JTH	In Lie	eu of Form CMS-2	2552-10
COST ALI	LOCATION - STATISTICAL BASIS		Provider CO	F	eriod: rom 07/01/2020 o 06/30/2021	Worksheet B-1 Date/Time Pre 11/30/2021 12	pared:
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (GROSS REVE	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	. 37 pm
		6.00	7.00	NUE) 8.00	9.00	10.00	
G	SENERAL SERVICE COST CENTERS				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
5.00 0	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00 0	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	1, 356, 845				6.00 7.00
9.00 0	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	0	7,636 3,780	0	1, 345, 429		8.00 9.00
	D1100 CAFETERIA	0	26, 422	13, 752	26, 422	16, 074 0	10.00 11.00
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
	01500 PHARMACY	0	15, 637		15, 637		15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	31, 676		31, 676		16.00
	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17.00 19.00
	D2000 NURSI NG SCHOOL	0			0	0	20.00
	02100 I & R SERVI CES-SALARY & FRI NGES APPRV	0	0	0	0	0	21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00 0	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
	NPATIENT ROUTINE SERVICE COST CENTERS		1	1	1	1	
	03000 ADULTS & PEDIATRICS	0					
	03100 INTENSIVE CARE UNIT	0	46, 847				
	03400 SURGI CAL I NTENSI VE CARE UNI T 04300 NURSERY	0			0	-	34.00 43.00
	NCI LLARY SERVICE COST CENTERS	0	0	090, 924	0	0	43.00
	D5000 OPERATI NG ROOM	0	242, 550	28, 372, 143	242, 550	1, 250	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
1	05400 RADI OLOGY-DI AGNOSTI C	0	91, 526			0	54.00
5.00 0	05500 RADI OLOGY-THERAPEUTI C	0	114, 030	10, 271, 538	114, 030	0	55.00
	05700 CT SCAN	0	5, 279				57.00
	05900 CARDI AC CATHETERI ZATI ON	0	26, 750		26, 750		59.00
	06000 LABORATORY	0	54, 760		54, 760		60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0	41 704		41 704	0	62.30 65.00
	06501 SLEEP LAB	0	41, 794	10, 448, 845 445, 346	41, 794		65. 0
	06600 PHYSI CAL THERAPY	0	73, 672		73, 672	-	66.00
	06601 PHYSI CAL THERAPY - LIFEPLEX	0	0	3, 362, 726	0	0	66.01
	06602 PHYSI CAL THERAPY - CULVER MILITARY	0	0	104, 064	0	0	66.0
7.00 0	06700 OCCUPATI ONAL THERAPY	0	0	785, 823	0	0	67.00
8.00 0	06800 SPEECH PATHOLOGY	0	0	202, 230	0	0	68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	2, 774, 533	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	17, 447, 818	0	0	73.00
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	0	751, 388 825, 268	U 4 942	0	76.97 76.98
	07699 LI THOTRI PSY	0	6, 842	025, 200	6, 842	0	76.9
	DUTPATIENT SERVICE COST CENTERS	0	0	0	0		/0. //
	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0	0	0	0	90.01
	09002 ATHLETI C TRAI NERS	0	0	0	0	0	90.02
0. 03 0	09003 SAINT JOSEPH HEALTH CENTER	0	0	727, 492	0	0	90.03
	09004 WOUND CARE	0	32, 546		32, 546	0	90.0
	09100 EMERGENCY	0	103, 410	16, 175, 409	103, 410	142	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS	0	1 1/0 //5	200 404 202	1 150 000	1/ 074	110 00
18.00	SUBTOTALS (SUM OF LINES 1 through 117) IONREI MBURSABLE COST CENTERS	0	1, 169, 445	208, 494, 292	1, 158, 029	16, 074	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 394	0	2, 394	0	190.00
1	19001 LI FEPLEX FI TNESS FORUM	0	0	0	2,0,1		190.01
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	185, 006	o o	185, 006		192.00
	19201 FOUNDATION ADMINISTATION	0	0	0	0		192. 01
	19202 HOSPI TALI ST	0	0	1, 450, 733	0		192. 0
	19203 I NTENSI VI ST	0	0	440, 907	0		192. 0
	19204 FOOT & ANKLE SPORTS MED PLY	0	0	645, 577	0		192. 04
	07950 PLYMOUTH MOB-4	0	0	0	0		194.00
	07951 COMMUNI TY OUTREACH & PARTNERSHI P	0	0	0	0	0	194. 0 <sup>.</sup>
00.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	0	4, 229, 422	294, 875	888, 902	868, 607	202.00
	Part I)						

#### Health Financial Systems COST ALLOCATION - STATISTICAL BASIS

#### ST. JOSEPHS REG MED CENTER PLYMOUTH Provider CCN: 15-0076 Period:

COST AL	CUST ALLUCATION - STATISTICAL BASIS		Provider C		eriod: rom 07/01/2020	WORKSNEET B-I	
					o 06/30/2021	Date/Time Pre 11/30/2021 12	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS REVE			
				NUE)			
		6.00	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	3. 117100	0. 001397	0. 660683	54.038012	203.00
204.00	Cost to be allocated (per Wkst. B,	0	931, 833	23, 698	18, 467	80, 835	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 686765	0.000112	0. 013726	5. 028929	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Health Financial	Systems
MOLTADOLIA T200	

Health Financial Systems ST.	JOSEPHS REG ME	D CENTER PLY	'MOU <sup>-</sup>	TH	In Lie	u of Form CMS-	2552-1
COST ALLOCATION - STATISTICAL BASIS		Provi der	- CC		eriod:	Worksheet B-1	
				Fr   Tc	om 07/01/2020 06/30/2021	Date/Time Pre	epared:
	1					11/30/2021 12	
Cost Center Description		MAI NTENANCE		NURSI NG	CENTRAL	PHARMACY	
	(MEALS SERVED)	PERSONNEL (NUMBER	- /	ADMI NI STRATI ON	SERVI CES & SUPPLY	(COSTED REQUIS.)	
		HOUSED)		(DIRECT NRSING	(COSTED	REGOLD. )	
				HRS)	REQUIS.)		
	11.00	12.00		13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS		1					1 1 0
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP							1.0
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT							4.0
5. 00 00500 ADMI NI STRATI VE & GENERAL							5.0
6.00 00600 MAI NTENANCE & REPAI RS							6.0
7.00 00700 OPERATION OF PLANT							7.0
B. 00 00800 LAUNDRY & LINEN SERVICE							8.0
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY							9.0
11. 00 01100 CAFETERIA	20, 185						11.0
12.00 01200 MAINTENANCE OF PERSONNEL	20,100		0				12.0
13. 00 01300 NURSING ADMINISTRATION	444	-	0	19, 741			13.0
14.00 01400 CENTRAL SERVICES & SUPPLY	C		0	0	211, 017, 757		14.0
15. 00 01500 PHARMACY	598		0	598	52	2, 499, 965	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	412		0	412	0	0	
17.00 01700 SOCIAL SERVICE 19.00 01900 NONPHYSICIAN ANESTHETISTS	0		0	0	0	0	
20. 00 02000 NURSI NG SCHOOL			0	0	0	0	
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV			0	0	0	0	
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV			Ő	0	0	0	
23.00 02300 PARAMED ED PRGM-(SPECIFY)	C		0	0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS		1					
30. 00 03000 ADULTS & PEDI ATRI CS	2, 907		0	2, 907	10, 119, 875	0	
31. 00 03100 I NTENSI VE CARE UNI T	1, 123		0	1, 123	5, 178, 495	0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	211	)	0	0 211	0 409 024	0	
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	311		U	311	698, 924	0	43.0
50. 00 05000 OPERATI NG ROOM	2,243		0	2, 243	28, 372, 143	0	50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	311		0	311	1, 493, 755	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 203		0	1, 203	18, 012, 010	0	54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	383		0	383	10, 271, 538	1, 656	
57. 00 05700 CT SCAN	122		0	122	27, 748, 785	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	54 2, 708		0	54 2, 708	666, 907 45, 035, 852	269 0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	2,700		0	2,708	45, 055, 852	0	
65. 00 06500 RESPIRATORY THERAPY	726		o	726	10, 448, 845	0	
65. 01 06501 SLEEP LAB	C		0	0	445, 346	0	65.0
66. 00 06600 PHYSI CAL THERAPY	1, 184		0	1, 184	4, 328, 298	0	66.0
56. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	421		0	421	3, 362, 726	0	
66. 02 06602 PHYSI CAL THERAPY - CULVER MI LI TARY	15		0	15	104, 064	0	
67. 00 06700 OCCUPATI ONAL THERAPY	123		0	123	785, 823	0	
58.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	60		0	60 0	202, 230	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0	0	2, 774, 533	0	
73.00 07300 DRUGS CHARGED TO PATIENTS			o	0	17, 447, 818	2, 494, 444	
76. 97 07697 CARDI AC REHABI LI TATI ON	188		0	188	751, 388	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	35		0	35	825, 268	0	
76. 99 07699 LI THOTRI PSY	C	)	0	0	0	0	76.9
OUTPATIENT SERVICE COST CENTERS		1		0		-	
20. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR 20. 02 09002 ATHLETIC TRAINERS	9		0	9	0	0	
20. 03 09002 ATHLETIC TRAINERS	227 928		0	227 928	727, 492	0	
20. 04 09004 WOUND CARE	160		0	160	2, 502, 964	0	
91.00 09100 EMERGENCY	2,055		Ő	2,055	16, 175, 409	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART							92.0
SPECIAL PURPOSE COST CENTERS	-	-					
18.00 SUBTOTALS (SUM OF LINES 1 through 117)	18, 950		0	18, 506	208, 480, 540	2, 496, 369	118. C
NONREI MBURSABLE COST CENTERS		1	0	~	0		100 0
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 90.01 19001 LIFEPLEX FITNESS FORUM	865		0	0 865	0		190. C
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	000		0	005	0		190.0
192. 01 19200 PHYSICIANS PRIVATE OFFICES			0	0	0		192.0
192. 02 19202 HOSPI TALI ST			Ő	0	1, 450, 733		192.0
192. 03 19203 I NTENSI VI ST	C		0	0	440, 907		192.0
192.04 19204 FOOT & ANKLE SPORTS MED PLY	281		0	281	645, 577	3, 596	192. 0
194.0007950 PLYMOUTH MOB-4	C		0	0	0		194. 0
194. 01 07951 COMMUNI TY OUTREACH & PARTNERSHI P	89		0	89	0	0	194.0
200.00 Cross Foot Adjustments							200. 0
201.00 Negative Cost Centers				1			201.0

Heal th Fi	nancial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMOU	JTH	In Lie	u of Form CMS-2	2552-10
COST ALLC	OCATION - STATISTICAL BASIS			Period: Worksheet B-1			
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 12	
	Cost Center Description		MAINTENANCE OF		CENTRAL	PHARMACY	
		(MEALS SERVED)		ADMI NI STRATI O		(COSTED	
			(NUMBER		SUPPLY	REQUIS.)	
			HOUSED)	(DIRECT NRSIN	`		
				HRS)	REQUIS.)		
		11.00	12.00	13.00	14.00	15.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	803, 65	6 0	1, 361, 929	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	40. 70999	4 0.000000	0. 544779	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	7, 28	6 0	55, 526	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 36908	0 0. 000000	0. 022211	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Heal t	n Financial Systems ST.	JOSEPHS REG ME	D CENTER PLYMOU	JTH	In Lie	u of Form CMS-	2552-10
COST	ALLOCATION - STATISTICAL BASIS		Provider C	Period: Worksheet B-1 From 07/01/2020			
					-rom 07/01/2020 Fo 06/30/2021	Date/Time Pre	nared
					10 00/ 50/ 2021	11/30/2021 12	
						INTERNS &	
						RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL SERVI CE		NURSING SCHOOL		
		RECORDS &		ANESTHETI STS		Y & FRINGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
		(GROSS REVE		TIME)	TIME)	(ASSI GNED	
		NUE)	17.00	10.00		TI ME)	
	GENERAL SERVICE COST CENTERS	16.00	17.00	19.00	20.00	21.00	
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
4.00 5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00							10.00
11.00							11.00
12.00							12.00
13.00							12.00
14.00							1
							14.00
15.00		011 017 705					15.00
16.00		211, 017, 705					16.00
17.00		0	0				17.00
19.00		0	0	0	ן		19.00
20.00		0	0		0		20.00
21.00		0	0			0	1
22.00		0	0				22.00
23.00		0	0				23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	10, 119, 875	0	0	0 0	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 178, 495	0	0	0 0	0	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0 0	0	34.00
43.00	04300 NURSERY	698, 924	0	(	0 0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS	1					
50.00		28, 372, 143		C		0	
52.00		1, 493, 755	0	0	0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 012, 010	0	0	0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	10, 271, 538	0	C	0 0	0	55.00
57.00	05700 CT SCAN	27, 748, 785	0	0	0 0	0	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	666, 907	0	0	0 0	0	59.00
60.00	06000 LABORATORY	45, 035, 852	0	0	0 0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0 0	0	62.30
65.00	06500 RESPI RATORY THERAPY	10, 448, 845	0	C	0 0	0	65.00
65.01	06501 SLEEP LAB	445, 346	0	C	0 0	0	65.01
66.00	06600 PHYSI CAL THERAPY	4, 328, 298	0	( C	0 0	0	66.00
66. 01	06601 PHYSI CAL THERAPY - LI FEPLEX	3, 362, 726	0	0	0 0	0	66.01
66. 02	06602 PHYSI CAL THERAPY - CULVER MILITARY	104, 064	0	( C	0 0	0	66.02
67.00	06700 OCCUPATI ONAL THERAPY	785, 823	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	202, 230		0	0 0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0 0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 774, 533	0	(	0	0	
	07300 DRUGS CHARGED TO PATIENTS	17, 447, 818		(	0	0	
	07697 CARDI AC REHABI LI TATI ON	751, 388			0	0	1
76.98		825, 268			0	0	1
	07699 LI THOTRI PSY	023, 200	0	(		0	
, 0. //	OUTPATIENT SERVICE COST CENTERS	0			- 0	0	1
90 01	09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0	(	0 0	0	90.01
	09002 ATHLETIC TRAINERS		0			0	
	09003 SAINT JOSEPH HEALTH CENTER	727, 492	0			0	1
	09003 SAINT JUSEPH HEALTH CENTER	2, 502, 964				0	1
		2, 502, 964				0	1
		1 10.170.409	0			0	91.00
91.00						<u> </u>	J 72.00
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS			r		0	110 00
	09200         OBSERVATI ON BEDS         (NON-DI STI NCT PART           SPECI AL PURPOSE         COST         CENTERS           0         SUBTOTALS         (SUM OF LI NES 1 through 117)	208, 480, 488	0	(	0 0	0	118.00
92. 00 118. 0	09200       OBSERVATI ON BEDS (NON-DI STI NCT PART         SPECI AL PURPOSE COST CENTERS         0       SUBTOTALS (SUM OF LI NES 1 through 117)         NONREI MBURSABLE COST CENTERS	208, 480, 488	1				
92.00 118.0 190.0	09200         OBSERVATI ON BEDS (NON-DI STI NCT PART           SPECI AL PURPOSE COST CENTERS         0           SUBTOTALS (SUM OF LI NES 1 through 117)           NONREI MBURSABLE COST CENTERS           0         GI FT, FLOWER, COFFEE SHOP & CANTEEN		0	(	0 0	0	190. 00
92.00 118.0 190.0 190.0	O9200         OBSERVATI ON BEDS (NON-DI STI NCT PART           SPECI AL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LI NES 1 through 117)           NONREI MBURSABLE COST CENTERS         0           1 19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN           1 19001         LI FEPLEX FI TNESS FORUM	208, 480, 488	1			0	190. 00 190. 01
92.00 118.0 190.0 190.0 192.0	O9200         OBSERVATION         BEDS         (NON-DISTINCT PART           SPECIAL         PURPOSE         COST         CENTERS           0         SUBTOTALS         SUM OF LINES 1         through 117)           NONREI         MBURSABLE         COST         CENTERS           0         19000         GIFT, FLOWER, COFFEE         SHOP & CANTEEN           1         19001         LIFEPLEX         FITNESS         FORUM           0         19200         PHYSICIANS'         PRIVATE         OFFICES	208, 480, 488	1		0 0	0 0 0	190. 00 190. 01 192. 00
92.00 118.0 190.0 190.0 192.0 192.0	O9200         OBSERVATION         BEDS         (NON-DISTINCT PART           SPECIAL         PURPOSE         COST         CENTERS           0         SUBTOTALS         (SUM OF LINES 1 through 117)           NONREI         MBURSABLE         COST         CENTERS           0         19000         GIFT,         FLOWER,         COFFEE         SHOP & CANTEEN           1         19001         LIFEPLEX         FITNESS         FORUM         0         19200           0         19201         FOUNDATI ON         ADMINISTATION         SADMINISTATION	208, 480, 488 0 0 0 0 0 0 0	0 0 0 0 0		0 0	0 0 0 0	190. 00 190. 01 192. 00 192. 01
92.00 118.0 190.0 190.0 192.0 192.0 192.0	09200         OBSERVATI ON BEDS (NON-DI STI NCT PART           SPECI AL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LI NES 1 through 117)           NONREI MBURSABLE COST CENTERS         0           19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN           19001         LI FEPLEX FI TNESS FORUM           0         19200           PHYSI CI ANS' PRI VATE OFFICES           1         19201           FOUNDATI ON ADMI NI STATI ON           2         19202	208, 480, 488 0 0 0 0 0 1, 450, 733			0 0	0 0 0 0 0 0	190. 00 190. 01 192. 00 192. 01 192. 02
92.00 118.0 190.0 190.0 192.0 192.0 192.0 192.0	09200         OBSERVATI ON BEDS (NON-DI STI NCT PART           SPECI AL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LI NES 1 through 117)           NONREI MBURSABLE COST CENTERS         0           19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN           19001         LI FEPLEX FI TNESS FORUM           0         PHYSI CI ANS' PRI VATE OFFI CES           19202         FOUNDATI ON ADMI NI STATI ON           2         19203           I NTENSI VI ST	208, 480, 488 0 0 0 0 1, 450, 733 440, 907	0 0 0 0 0 0 0 0		0 0	0 0 0 0 0 0 0 0	190. 00 190. 01 192. 00 192. 01 192. 02 192. 03
92.00 118.0 190.0 190.0 192.0 192.0 192.0 192.0 192.0	09200         OBSERVATION         BEDS         (NON-DISTINCT PART           SPECIAL         PURPOSE         COST         CENTERS           0         SUBTOTALS         (SUM OF LINES 1 through 117)           NONREI         MBURSABLE         COST         CENTERS           0         19000         GIFT,         FLOWER,         COFFEE         SHOP & CANTEEN           1         19001         LIFEPLEX         FITNESS         FORUM         0           0         19200         PHYSI CIANS'         PRI VATE         OFFICES           1         19201         FOUNDATION         ADMI NI STATION           2         19202         HOSPI TALI ST           3         19203         INTENSI VI ST           4         19204         FOOT & ANKLE         SPORTS         MED         PLY	208, 480, 488 0 0 0 0 0 1, 450, 733	0 0 0 0 0 0 0 0		0 0	0 0 0 0 0 0 0 0 0	190. 00 190. 01 192. 00 192. 01 192. 02 192. 03 192. 04
92.00 118.0 190.0 190.0 192.0 192.0 192.0 192.0 192.0 192.0 194.0	09200         OBSERVATION         BEDS         (NON-DISTINCT PART           SPECIAL         PURPOSE         COST         CENTERS           0         SUBTOTALS         (SUM OF LINES 1 through 117)           NONREI         MBURSABLE         COST         CENTERS           0         19000         GIFT,         FLOWER,         COFFEE         SHOP & CANTEEN           1         19001         LIFEPLEX         FITNESS         FORUM         0         19200         PHYSICIANS'         PRIVATE         OFFICES           1         19201         FOUNDATION         ADMINISTATION         2         19202         HOSPITALIST           3         19203         INTENSIVIST         4         19204         FOOT & ANKLE         SPORTS         MED         PLY           0         07950         PLYMOUTH         MOB-4         4         4         4	208, 480, 488 0 0 0 0 1, 450, 733 440, 907	0 0 0 0 0 0 0 0		0 0	0 0 0 0 0 0 0 0 0 0 0	190. 00 190. 01 192. 00 192. 01 192. 02 192. 03 192. 04 194. 00
92.00 118.0 190.0 190.0 192.0 192.0 192.0 192.0 192.0 192.0 194.0	09200         OBSERVATION         BEDS         (NON-DISTINCT PART           SPECIAL         PURPOSE         COST         CENTERS           0         SUBTOTALS         (SUM OF LINES 1 through 117)           NONREI         MBURSABLE         COST         CENTERS           0         19000         GIFT,         FLOWER,         COFFEE         SHOP & CANTEEN           1         19001         LIFEPLEX         FITNESS         FORUM         19200         PHYSICIANS'         PRIVATE         OFFICES           1         19201         FOUNDATION         ADMINISTATION         2         19202         HOSPITALIST           3         19203         INTENSIVIST         4         19204         FOOT & ANKLE         SPORTS         MED         PLY           0         07950         PLYMOUTH         MOB-4         1         07951         COMMUNITY         OUTREACH & PARTNERSHIP	208, 480, 488 0 0 0 0 1, 450, 733 440, 907	0 0 0 0 0 0 0 0		0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	190. 00 190. 01 192. 00 192. 01 192. 02 192. 03 192. 04

COST ALLO	CATION - STATISTICAL BASIS		Provider CO		Period: From 07/01/2020	Worksheet B-1	
					To 06/30/2021		
						I NTERNS & RESI DENTS	
	Cost Center Description		SOCI AL SERVI CE			SERVI CES-SALAR	
		RECORDS &	(TIME ODENT)	ANESTHETI STS		Y & FRI NGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
		(GROSS REVE NUE)		TIME)	TI ME)	(ASSIGNED TIME)	
		16.00	17.00	19.00	20.00	21.00	
201.00	Negative Cost Centers						201. 0
202.00	Cost to be allocated (per Wkst. B, Part I)	706, 788	0	(	0 0	0	202. 0
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 003349	0. 000000	0. 000000	0. 000000	0. 000000	203. 0
204.00	Cost to be allocated (per Wkst. B, Part II)	93, 874	0	(	0 0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000445	0. 000000	0.00000	0. 000000	0. 000000	205. 0
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206. 0
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.00000		207. 00

				me Prepar
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM (ASSI GNED	021 12 37
		(ASSIGNED TIME)	TIME)	
		22.00	23.00	
	GENERAL SERVICE COST CENTERS			
	00100 CAP REL COSTS-BLDG & FIXT			1
	00200 CAP REL COSTS-MVBLE EQUIP			2
	00400 EMPLOYEE BENEFITS DEPARTMENT			4
	00500 ADMINI STRATI VE & GENERAL			5
	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT			6
	00800 LAUNDRY & LINEN SERVICE			7
	00900 HOUSEKEEPING			9
	01000 DI ETARY			10
	01100 CAFETERI A			11
	01200 MAINTENANCE OF PERSONNEL			12
	01300 NURSING ADMINISTRATION			13
	01400 CENTRAL SERVICES & SUPPLY			14
				15
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE			16
	01900 NONPHYSICIAN ANESTHETISTS			19
	02000 NURSI NG SCHOOL			20
	02100 I&R SERVICES-SALARY & FRINGES APPRV			21
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0		22
	02300 PARAMED ED PRGM-(SPECIFY)		0	23
	INPATIENT ROUTINE SERVICE COST CENTERS			
	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	0	0	30
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	34
	04300 NURSERY	0	0	43
	ANCI LLARY SERVICE COST CENTERS	-	-	
. 00	05000 OPERATING ROOM	0	0	50
	05200 DELIVERY ROOM & LABOR ROOM	0	0	52
	05400 RADI OLOGY-DI AGNOSTI C	0	0	54
	05500 RADI OLOGY-THERAPEUTI C	0	0	55
	05700 CT SCAN 05900 CARDI AC CATHETERI ZATI ON	0	0	57
	06000 LABORATORY	0	0	60
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	o	62
	06500 RESPI RATORY THERAPY	0	0	65
. 01	06501 SLEEP LAB	0	0	65
	06600 PHYSI CAL THERAPY	0	0	66
	06601 PHYSI CAL THERAPY - LI FEPLEX	0	0	66
	06602 PHYSI CAL THERAPY - CULVER MILITARY	0	0	66
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	67
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	ő	72
	07300 DRUGS CHARGED TO PATIENTS	Ő	ō	73
. 97	07697 CARDI AC REHABI LI TATI ON	0	o	76
	07698 HYPERBARI C OXYGEN THERAPY	0	0	76
-		0	0	76
	OUTPATIENT SERVICE COST CENTERS 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0	
	09002 ATHLETIC TRAINERS	0		90
	09003 SAINT JOSEPH HEALTH CENTER	0	0	90
	09004 WOUND CARE	0	ő	90
	09100 EMERGENCY	0	0	91
	09200 OBSERVATION BEDS (NON-DISTINCT PART			 92
E E	SPECIAL PURPOSE COST CENTERS	1		
8.00		0	0	 118
	NONREI MBURSABLE COST CENTERS			100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 LIFEPLEX FITNESS FORUM	0	0	190
	19200 PHYSICIANS' PRIVATE OFFICES	0		190
	19200 FURSICIANS FRIVATE OFFICES	0	0	192
	19202 HOSPI TALI ST	0	õ	192
	19203 I NTENSI VI ST	0	0	192
2.04	19204 FOOT & ANKLE SPORTS MED PLY	0	o	192
4.00	07950 PLYMOUTH MOB-4 07951 COMMUNI TY OUTREACH & PARTNERSHI P	0	0	194
				194

NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)

201.00 202.00 203.00 204.00 205.00

206.00

207.00

ancial Systems ST.	JOSEPHS REG MED	CENTER PLYMOU	ITH	In Lie	u of Form CMS-	2552-10
ATION - STATISTICAL BASIS		Provider CC	CN: 15-0076	Period: From 07/01/2020 To 06/30/2021		epared:
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV (ASSI GNED TI ME)	PARAMED ED PRGM (ASSI GNED TI ME)				
Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	22.00 0	23.00				201. 00 202. 00
Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0. 000000 0	0. 000000 0				203. 00 204. 00
Unit cost multiplier (Wkst. B, Part   )	0. 000000	0. 000000				205. 00 206. 00
NAHE adjustment amount to be allocated		0				206.

0. 000000

206.00

207.00

Hearth Frhancial Systems SI.	JUSEPHS REG MEI	D CENTER PLYMOL	ЛН	In Lie	U OT FORM CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/30/2021 12	pared: :37 pm
		Title	× XVIII	Hospi tal	PPS	
				Costs	110	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
cost center bescription	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.	Auj.		Disariowance		
	26)					
	1.00	2.00	2.00	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	( 100 ( 00	1	( 100 ( 0		( 100 ( 00	0.0.00
30. 00 03000 ADULTS & PEDIATRICS	6, 483, 680		6, 483, 68			
31.00 03100 I NTENSI VE CARE UNI T	2, 331, 575		2, 331, 57			
34.00 03400 SURGI CAL INTENSI VE CARE UNI T	0			0 0	0	
43. 00 04300 NURSERY	581, 418		581, 41	8 0	581, 418	43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	6, 788, 708		6, 788, 70	8 0	6, 788, 708	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	585, 192		585, 19	2 0	585, 192	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 907, 953		2, 907, 95	3 0	2, 907, 953	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 407, 895		1, 407, 89	5 0	1, 407, 895	55.00
57. 00 05700 CT SCAN	393, 319		393, 31		393, 319	
59. 00 05900 CARDI AC CATHETERI ZATI ON	318, 377		318, 37		318, 377	
60. 00 06000 LABORATORY	7, 981, 038		7, 981, 03		7, 981, 403	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	7, 901, 030		7, 701, 03	0 0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	1, 480, 319		1, 480, 31		1, 480, 319	
65. 01 06500 RESPIRATORY THERAPT	67, 720				67, 720	
		-				
66.00 06600 PHYSI CAL THERAPY	2, 327, 525				2, 327, 525	
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	918, 456				918, 456	
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	30, 901				30, 901	66. 02
67.00 06700 OCCUPATI ONAL THERAPY	230, 785		230, 78		230, 785	
68.00 06800 SPEECH PATHOLOGY	125, 927	0	125, 92	7 0	125, 927	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	562, 433		562, 43	3 0	562, 433	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 262, 524		5, 262, 52	4 0	5, 262, 524	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	380, 417		380, 41	7 0	380, 417	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	143,015		143, 01		143,015	76.98
76. 99 07699 LI THOTRI PSY	0			0 0	0	
OUTPATI ENT SERVICE COST CENTERS	-		1	-1 -		
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	10, 781		10, 78	1 0	10, 781	90.01
90. 02 09002 ATHLETI C TRAI NERS	46,000		46, 00		46,000	
90. 03 09003 SAINT JOSEPH HEALTH CENTER	1, 471, 032		1, 471, 03		1, 471, 032	
90. 03 09003 SATNI JUSEPH HEALTH CENTER 90. 04 09004 WOUND CARE						
	1, 257, 235		1, 257, 23		1, 257, 235	
91.00 09100 EMERGENCY	5, 384, 094		5, 384, 09			
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	1, 485, 974		1, 485, 97		1, 485, 974	92.00
200.00 Subtotal (see instructions)	50, 964, 293		00,701,27			
201.00 Less Observation Beds	1, 485, 974		1, 485, 97		1, 485, 974	
202.00 Total (see instructions)	49, 478, 319	0	49, 478, 31	9 70, 395	49, 548, 714	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 15-0076         Period :rm 07/01/2020 To 06/30/2021         Period :rm 07/01/2	Health Financial Systems ST.	JOSEPHS REG MED	CENTER PLYMOL	JTH	In Lie	u of Form CMS-	2552-10
To         06/30/2021         Date/Time Prepared: 11/30/2021 12:37 pm           Cost Center Description         Title XVIII         Hospital         PPS           Cost Center Description         Inpatient         Outpatient         To 1000         Ratio         PPS           30.00         G3000 ADULTS & PEDIATRICS         6.00         7.00         8.00         9.00         10.00           30.00         G3000 ADULTS & PEDIATRICS         6.00         7.00         8.00         9.00         10.00           30.00         G3000 ADULTS & PEDIATRICS         6.306,915         5.778,495         30.00         31.00           31.00         D3100 INTERSIVE CARE UNIT         5.778,495         5.778,495         31.00         31.00           30.00         G3000 OPERATING ROOM         5.137,708         23.234,435         28.372,143         0.239274         0.000000         50.00           50.00         D5000 DELIVERY MOM & LABOR ROOM         1.434,785         58.970         1.437,755         0.391759         0.000000         50.00           50.00         D5000 CARDIAC CATHERAPUTIC         33.384         10.237,758         0.137768         0.000000         55.00           50.00         D5000 CARDIAC CATHERAPUTIC         3.38,471         3.436,710,2714         <	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C			Worksheet C	
Instruction         Instruction <thinstruction< th=""> <thinstruction< th=""></thinstruction<></thinstruction<>							
Instrument         Title         Hespital         PPS           Cost Center Description         Inpatient         Outpatient         Total (col. 6)         Cost or 0ther Ratio         TEFRA Inpatient Ratio         TEFRA Inpatient Ratio <td></td> <td></td> <td></td> <td>-</td> <td>To 06/30/2021</td> <td>Date/Time Pre</td> <td>pared:</td>				-	To 06/30/2021	Date/Time Pre	pared:
Cost Center Description         Charges Inpati ent Outpati ent Outpati ent Dipati ent Outpati ent Netto Cost Center Description         TeFRA Inpati ent Ratio         TEFRA Inpati ent Ratio         TEFRA Inpati ent Ratio           0:000         03000 ADULTS & PEDI ATRI CS 030000 ADULTS & PEDI ATRI CS 03000 ADULTS & PEDI ATRI CS 03000 OUNTERSI VE CARE UNI T 00 03400 SURGICAL INTENSI VE CARE UNI T 00 03400 SURGICAL INTENSI VE CARE UNI T 00 05300 UNESERY         8.306, 915 5, 178, 495 5, 00 05500 DELI VEEY ROM & LABOR ROM ANCILLARY SERVICE COST CENTERS 50.00 05500 DELI VEEY ROM & LABOR ROM 51, 00 05700 DELI VEEY ROM & LABOR ROM 55, 00 05500 ADULOGV-THERAPEUTI C 52, 00 05500 CT SCAM 54, 00 5500 CT SCAM 55, 00 05500 ADULOGV-THERAPEUTI C 55, 00 05500 CT SCAM 54, 00 5600 CLE VEEY ROM & LABOR ROM 55, 00 05500 CT SCAM 59, 00 05500 CLE VEEY ROM & LABOR ROM 59, 00 05500 CLE VEEY ROM & LABOR ROM 59, 00 05500 CLE VEEY ROM 50, 00 05500 CLE VEE				20/11/			:37 pm
Cost Center Description         Inpatient         Outpatient         Total         Cost or Other Ratio         TEFRA Inpatient Ratio           INPATIENT ROUTINE SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           00         03000         JUBITS & FERDIATRICS         8.306,915         8.306,915         9.00         10.00           1.00         03100         INTENSIVE CAPE UNIT         5.178,495         31.00         31.00           40.0         03400         URESERV         698,924         698,924         43.00           40.0         03500         URESTRY         698,924         698,924         43.00           50.00         05200         DERATING ROOM         1.434,788         556,656         18,012,010         0.161445         0.000000         52.00           51.00         05500         DERATING ROOM         1.434,788         556,973,11,403,755         0.37759         0.000000         52.00           52.00         05500         RADI CLGY-THERAPEUTIC         33.384         10.238,171,330         27,748,785         0.137768         0.000000         52.00           59.00         05500 CLBOHADICLGY-THERAPEUTIC         33.384         10.238,171,330         27,748,785         0.137768 <t< td=""><td></td><td></td><td></td><td>XVIII</td><td>Hospi tai</td><td>PPS</td><td></td></t<>				XVIII	Hospi tai	PPS	
Image: Instant of the service cost centers         6.00         7.00         8.00         9.00         10.00           30.00         03000 ADULTS & PEDI ATRI CS         8.306,915         8.306,915         5.178,495         5.178,495         31.00           34.00         03400 SURGI CAL INTENSIVE CARE UNIT         5.178,495         5.178,495         31.00           34.00         03400 SURGI CAL INTENSIVE CARE UNIT         698,924         48.00         48.00           AMACHLARY SERVICE COST CENTERS         5.137,708         23,234,435         28,372,143         0.239274         0.000000           50.00         05000 DELIVERY MOR & LABOR ROOM         1,434,785         58,970         1,493,755         0.000000         52.00           50.00         05400 DELIVERY MOR & LABOR ROOM         1,433,785         51,71,708         23,710,33,241         0.14144         0.000000         52.00           50.00         05400 CARDI LOGY-THERAPEUTIC         33,384         10,238,154         10.271,538         0.011444         0.000000         55.00           50.00         05500 CARDI ACCATHERAPEUTIC         33,384         10.238,154         10.271,538         0.011444         0.000000         55.00           50.00         05000 CARDI ACCATHERAPEUTIC         33,384         10.237,158         0.						TEEDA	
INPATIENT ROUTINE SERVICE COST CENTERS         0         10.00         10.00           10 00 00000 ADULTS & PEDIATRICS         8.306,915         8.306,915         30.00           11 00 03100 INTENSIVE CARE UNIT         5,178,495         5,178,495         5,178,495           10 03100 UNTENSIVE CARE UNIT         698,924         698,924         698,924           04300 NURSERY         698,924         698,924         698,924           04300 NURSERY         000000         5,137,708         23,234,435         28,372,143         0.239274         0.000000           50.00 05000 DEELVERY ROOM & LABOR ROOM         1,434,785         558,070         1,493,775         0.31775         0.000000         52.00           51.00 0500 DELIVERY ROOM & LABOR ROOM         1,434,785         558,070         1,493,775         0.31776         0.000000         54.00           52.00 05500 RADIOLGOY-THERAPEUTIC         33,844         10,281,534         0.114747         0.000000         57.00           57.00 05500 CARDI AC CATHETERI ZATI ON         56,847         610,060         666,070         0.477393         0.000000         65.00           65.00 06500 LABORATORY         8,42,435         63,552,497         4,53,46         0.182062         0.0000000         65.00         66.01         0.000000	Cost Center Description	Inpatient	outpatient				
INPATIENT ROUTINE SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           30.00         03000 JADULTS & PEDIATRICS         8.306,915         5.178,495         5.178,495         5.178,495         31.00           31.00         03400 JURGICAL, INTENSIVE CARE UNIT         698,924         698,924         698,924         34.00           AMOLILLARY SERVICE COST CENTERS         698,924         698,924         698,924         34.00           50.00         05000 DELIVERY NOM & LABOR ROOM         5,137,708         23,234,435         28,372,143         0.239274         0.000000         52.00           51.00         05000 DELIVERY NOM & LABOR ROOM         1434,785         58,970         1,493,755         0.317759         0.000000         52.00           52.00         05200 CRADI AC CATHERAPEUTIC         33,384         10,238,154         10,238,154         10,217,538         0.137068         0.000000         55.00           59.00         06500 CARDI AC CATHERER ZATION         56,847         610,060         666,907         0.477393         0.000000         59.00           60.00         00000 CARDI AC CATHERER ZATION         8,442,435         36,593,417         45.336         45.036,20         0.000000         65.00         0.0000000         65.00<				+ COI. /)	Ratio		
INPATI ENT ROUTINE SERVICE COST CENTERS         Image of the service of the ser		( 00	7 00	0.00	0.00		
30.00         02000   ADULTS & PEDI ATR ICS         8.306,915         8.306,915         30.00         31.00           31.00         03400   INTENSI VE CARE UNI T         5,178,495         5,178,495         31.00           43.00         04300   NURSSI VE CARE UNI T         698,924         698,924         43.00           ANCILLARY SERVICE COST CENTERS         698,924         098,924         0.000000         43.00           50.00         05000   DELIVERY NOM & LABOR ROOM         1.434,785         58,970         1.493,755         0.391759         0.0000000         55.00           55.00         05500 RADI LOGY-HERAPEUTI C         33.34         10,238,154         10,271,538         0.13706         0.000000         55.00           57.00         05500 CARDI AC CARIPEUTI C         33.34         10,238,154         10,271,538         0.13706         0.000000         55.00           59.00 D5500 CRADI AC CATHETERI ZATI ON         56,647         610,600         666,907         0.477393         0.000000         57.00           50.00 D5500 RESPI RATORY         8,342,435         36,593,417         7,312,074         45.035,52         0.177215         0.000000         62.30           61.00 0600 RESPI RATORY         8,422,435         36,593,417         7,312,074         45.035,62		6.00	7.00	8.00	9.00	10.00	
11.00       03100  INTENSIVE CARE UNIT       5,178,495       5,178,495       31.00         43.00       04300  SURGICAL INTENSIVE CARE UNIT       698,924       698,924       43.00         43.00       04300  NURSERY       698,924       698,924       43.00         MICI LLARY SERVICE COST CENTERS       5,137,708       23,234,435       28,372,143       0.239274       0.000000       50.00         52.00       05200  DELI VERY ROUM & LABOR ROOM       1,434,785       58,970       1,493,755       0.391759       0.000000       50.00         55.00       05500  RADI LOGY-THERAPEUTIC       33,384       10.238,154       10.271,538       0.11014       0.000000       57.00         57.00       05700  CT SCAN       4,403,455       36,593,417       45.035,852       0.177215       0.000000       60.000       60.000       60.000       60.000       60.000       60.000       60.000       60.000       60.000       60.000       65.00       65.01       0.05000       CATHERAPY       3,136,771       7,312,074       10.448,84       0.141673       0.000000       62.00       65.01       65.01       65.01       65.01       65.01       65.01       65.01       65.01       65.01       65.01       65.01       65.01       65.01		0.204.015		0.206.01	-		1 20 00
34.00       OctAOO SURG CAL INTENSIVE CARE UNIT       O       0       34.00         43.00       Oddoo NURSER       698,924       698,924       43.00         ANCILLARY SERVICE COST CENTERS       5,137,708       23,234,435       28,372,143       0.239274       0.000000       50.00         50.00       05000 DELVICERY ROM & LABOR ROM       1,434,785       58,970       1,493,755       0.391759       0.000000       52.00         50.00       05000 RADI LLOGY-PILKARDSTIC       2,375,454       15,636,556       18,012,010       0.161445       0.000000       55.00         50.00       05000 CARDI CLOGY-HERAPEUTIC       33,384       10,238,154       10,271,748,785       0.014174       0.000000       59.00         50.00       05000 CARDI CLOGY-HERAPEUTIC       3,384       10,238,154       10,271,748,785       0.014174       0.000000       59.00         50.00       05000 CARDI CLOGY-THERAPEUTIC       3,384       10,237,748,785       0.0177215       0.000000       60.00       66.00       66.00       66.00       66.500       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00							•
43.00       04300       04300       04582RY       698,924       698,924       698,924       43.00         50.00       05000       DFRATI NG ROM       5,137,708       23,234,435       28,372,143       0.239274       0.000000       52.00         54.00       052000       DELI VERY ROM & LABOR ROM       1,434,785       58,970       1,493,755       0.391759       0.000000       54.00         55.00       05500 RADI OLOCY-THERAPEUTI C       33,384       10,238,154       10,271,538       0.137068       0.000000       55.00         57.00       05700 CT SCAN       4,038,455       23,710,330       27,748,785       0.014174       0.000000       57.00         62.30       05500 BLOD CLOTTING FOR HEMOPHILLIACS       0       0       0       0.000000       62.00         65.00       05600 FLSEPI RATORY THERAPY       3,136,771       7,312,074       10,448,845       0.141673       0.000000       65.00         66.01       06600 PHYSI CAL THERAPY       472,029       3,856,269       4,326,2786       0.527746       0.000000       66.01         66.02       06600 PHYSI CAL THERAPY       LIFERAPY       966       3,361,760       3,362,726       0.273128       0.000000       66.01       66.01       66.01		5, 178, 495		5, 178, 49			
ANCL LLARY SERVICE COST CENTERS           ANC LLARY SERVICE COST CENTERS           0         05000         OPERATING ROOM         5,137,708         23,234,435         28,372,143         0.239274         0.000000         52.00           52.00         DELIVERY ROM & LABOR ROOM         1,434,785         568,970         1,493,755         0.391759         0.000000         52.00           55.00         DS5000 RADI OLOCY-DI EKNOSTI C         2,375,454         15,636,556         18,012,010         0.161445         0.000000         55.00           57.00         DS700 CT SCAN         4,038,455         23,710,330         27,748,785         0.014174         0.000000         59.00           60.00         CARDI AC CATHETERI ZATI ON         56,647         610,066         666,907         0.477393         0.000000         65.00           65.00         OBCOD CLETTING FOR HEMOPHI LLACS         0         0         0         0.000000         65.01           66.10         OBCOI RESPI RATORY THERAPY         31,36,771         7,312,074         10,448,845         0.141673         0.000000         65.01           66.01         OBCOI RESPI RATORY THERAPY         472,029         3,861,760         3,362,726         0.273128         0.0000000         66.01           66		0		(00.00)	5		
50 00       05000       0PERATI NG ROOM       5, 137, 708       23, 234, 435       28, 372, 143       0, 239274       0, 000000       50, 00         52 00       05200       DELIVERY ROOM & LABOR ROOM       1, 434, 785       58, 970       1, 493, 755       0, 391759       0, 000000       52, 00         55 00       05500       RADI OLOGY - THERAPEUTI C       33, 384       10, 238, 154       10, 271, 538       0, 131445       0, 000000       55, 00         57 00       05700 C T SCAN       4, 038, 455       23, 710, 330       27, 748, 785       0, 011414       0, 000000       57, 00         59 00       04600       LABORTORY       8, 442, 435       36, 593, 417       45, 035, 852       0, 177215       0, 000000       60, 00         60 0       06000       LABORTORY       8, 442, 435       36, 593, 417       445, 346       0, 141673       0, 000000       65, 00         65 00       06500       RESPI RATORY THERAPY       472, 029       3, 856, 269       4, 328, 298       0, 537746       0, 000000       66, 00         66 01       06600       PHYSI CAL THERAPY       LIFPLEX       966       3, 61, 760       3, 62, 726       0, 000000       66, 00         66 02       06602       PHYSI CAL THERAPY       LIFP		698, 924		698, 92	4		43.00
52.00       05200       DELIVERY ROOM & LABOR ROOM       1,434,785       55,970       1,493,755       0.391759       0.000000       52.00         54.00       05400       RADI OLOGY-THERAPEUTI C       2,375,454       15,636,556       18,012,201       0.161445       0.000000       54.00         57.00       05500       RADI OLOGY-THERAPEUTI C       33,384       10,238,154       0.137068       0.014174       0.000000       57.00         59.00       05500       CARDIAC CATHETERIZATI ON       56.847       610,060       666,907       0.477393       0.000000       60.00         60.00       06000       LABORATORY       8,442,435       36,593,417       45,035,852       0.177215       0.000000       66.00         65.01       06501       SLEEP LAB       0       445,346       445,346       0.141673       0.000000       66.00         66.01       06601       PHYSI CAL THERAPY       11 FEPLEX       966       3,361,760       3,362,726       0.273128       0.000000       66.00         66.02       06602       PHYSI CAL THERAPY       11 FEPLEX       966       3,361,760       3,362,726       0.273128       0.000000       66.00         66.02       06602       PHYSI CAL THERAPY       11 FEP							
54.00       05400       RADI OLOGY-DI AGNOSTI C       2, 375, 454       15, 636, 556       18, 012, 010       0.161445       0.000000       54.00         55.00       0500       RADI OLOGY-THERAPEUTI C       33, 384       10, 238, 154       10, 271, 538       0.137068       0.000000       55.00         57.00       05700       CT SCAN       4, 038, 455       23, 710, 330       27, 748, 785       0.014174       0.000000       59.00         60.00       CABORATORY       8, 442, 435       36, 593, 417       45, 035, 852       0.177215       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       3, 136, 771       7, 312, 074       10, 448, 845       0.141673       0.000000       65.00         65.01       06600       PHYSI CAL THERAPY       472, 029       3, 856, 269       4, 328, 298       0.537746       0.000000       66.00         66.01       06600       PHYSI CAL THERAPY       CULYER M LI TARY       966       3, 361, 760       3, 362, 726       0.273128       0.000000       66.00         66.02       06600       PHYSI CAL THERAPY       CULYER M LI TARY       966       3, 361, 760       3, 362, 726       0.273128       0.000000       66.00         66.02       06600							1
55:00       RADI OLGGY-THERAPEUTI C       33,384       10,238,154       10,271,538       0.137068       0.000000       55.00         57:00       05700       CT SCAN       4,038,455       23,710,330       27,748,785       0.014174       0.000000       59.00         60:00       CABDRAC CATHETERI ZATI 0N       56.847       610,060       666,907       0.477393       0.000000       62.00         62:00       06500       RESPI RATORY THERAPY       8,442,435       36,593,417       45.035,852       0.177215       0.000000       65.00         65:01       06500       RESPI RATORY THERAPY       3,136,771       7,312,074       10,448,845       0.141673       0.000000       65.00         66:01       06600       PHYSI CAL THERAPY       472,029       3,856,294       3,362,726       0.273128       0.000000       66.01         66:02       06600       PHYSI CAL THERAPY - CULVER MI LI TARY       0       104,064       104,064       0.296942       0.000000       67.00         66:00       06600       PHYSI CAL THERAPY       173,036       612,787       788,823       0.223046       0.000000       67.00         66:00       06700       0CCUPATI ONAL THERAPY       55,634       146,596       222,230 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
57.00       05700       CT SCAN       4,038,455       23,710,330       27,748,785       0.014174       0.000000       57.00         59.00       06000       LABORATORY       8,422,435       36,593,417       45,035,852       0.177215       0.000000       62.30         62.30       06500       CLOSTING FOR HEMOPHILIACS       0       0       0.000000       0.000000       62.30         65.00       06500       RESPIRATORY THERAPY       3,136,771       7,312,074       10,448,845       0.1167215       0.000000       65.01         66.01       06600       PHYSI CAL THERAPY       472,029       3,856,269       4,328,298       0.537746       0.000000       66.00         66.01       06602       PHYSI CAL THERAPY - LIFEPLEX       966       3,361,760       3,362,726       0.273128       0.000000       66.00         66.02       06602       PHYSI CAL THERAPY - CULVER MILITARY       0       014,064       104,064       0.296942       0.000000       67.00         67.00       0C700       0CULPATIONAL THERAPY       173,038       612,787       785,823       0.293686       0.000000       67.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       596,994       2,774,533       0.20							
59.00       OS900       CARDI AC CATHETERI ZATI ON       56, 847       610, 060       666, 907       0.477393       0.000000       59.00         60.00       O6000       LABORATORY       8, 442, 33       36, 593, 417       45, 035, 852       0.177215       0.000000       60.000         65.00       O6250       BLODO CLOTTI NG FOR HEMOPHI LI ACS       0       0       0.000000       0.000000       65.00         65.01       O6500       RESPI RATORY THERAPY       3, 136, 771       7, 312, 074       10, 448, 845       0.141673       0.000000       65.00         65.01       O6600       PHYSI CAL THERAPY       472, 029       3, 856, 269       4, 328, 298       0.537746       0.000000       66.01         66.02       O6600       PHYSI CAL THERAPY       LIFEPLEX       966       3, 361, 760       3, 362, 726       0.273128       0.000000       66.01         66.00       O6700       OCCUPHYSI CAL THERAPY       CULVER MI LI TARY       0       104, 064       104, 064       0.296942       0.000000       67.00         68.00       O6800       SPEECH PATHOLOGY       55, 634       146, 596       202, 230       0.622692       0.000000       7.00         71.00       O7100       MEDI CAL SUPPLI ES CHARGED TO P							1
60.00       06000       LABORATORY       8, 442, 435       36, 593, 417       45, 035, 852       0.177215       0.000000       60.00         62.30       06250       BLODD CLOTTI NG FOR HEMOPHI LI ACS       0       0       0       0.000000       65.00         65.00       06500       RSSP RATORY THERAPY       3, 136, 771       7, 312, 074       10, 448, 845       0.141673       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       472, 029       3, 856, 269       4, 328, 298       0.537746       0.000000       66.01         66.01       06600       PHYSI CAL THERAPY       - LIFEPLEX       966       3, 361, 777       785, 823       0.293686       0.000000       66.02         66.02       06602       PHYSI CAL THERAPY       - LIFEPLEX       966       3, 361, 787       785, 823       0.293686       0.000000       66.02         67.00       06700       0CUCUPATI INAL THERAPY       173, 036       612, 787       785, 823       0.293686       0.000000       66.02         67.00       07000       IMPL. DEV. CHARGED TO PATI ENTS       596, 994       2, 774, 533       0.202713       0.000000       7.00         71.00       07300       DRUSC SHARGED TO PATI ENTS       596, 994 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
62.30       06250       BLOOD CLOTTING FOR HEMOPHILIACS       0       0       0       0.000000       0.000000       62.30         65.00       06500       RESPIRATORY THERAPY       3, 136, 771       7, 312, 074       10, 448, 845       0.141673       0.000000       65.00         65.01       05501       SLEEP LAB       0       445, 346       445, 346       0.152062       0.000000       65.01         66.01       06600       PHYSI CAL THERAPY       LIFEPLEX       966       3, 361, 760       3, 362, 726       0.273128       0.000000       66.01         66.02       06700       OCCUPATI ONAL THERAPY       LIFEPLEX       966       3, 361, 760       3, 362, 726       0.273128       0.000000       66.02         67.00       06700       OCCUPATI ONAL THERAPY       11 FRAPY       173, 036       612, 787       785, 823       0.293686       0.000000       67.00         68.00       08000       SPEECH PATHOLOGY       55, 634       146, 596       202, 230       0.622692       0.000000       67.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       596, 994       2, 177, 539       2, 774, 533       0.202713       0.000000       71.00         73.00       07300							
65:00       06500       RESPI RATORY THERAPY       3, 136, 771       7, 312, 074       10, 448, 845       0. 141673       0.000000       65:00         65:01       06500       SLEEP LAB       0       445, 346       445, 346       0.52062       0.000000       65:01         66:00       06600       PHYSI CAL THERAPY       LI FERPLEX       966       3, 361, 760       3, 362, 726       0.273128       0.000000       66:01         66:02       06602       PHYSI CAL THERAPY       CULVER MI LI TARY       0       104, 064       104, 064       0.296942       0.000000       66:02         67:00       06C00       DCCUPATI ONAL THERAPY       173, 036       612, 787       785, 823       0.293686       0.000000       67.00         68:00       06800       SPECH PATHOLOGY       55, 634       146, 596       202, 230       0.622692       0.000000       71.00         71:00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       596, 994       2, 177, 539       2, 774, 533       0.202713       0.000000       73.00         70:097       CARDI AC REHABI LI TATI ON       6, 590, 825       10, 856, 933       17, 447, 818       0.301615       0.000000       73.00         70:797       0.697       CARDI AC REHA		8, 442, 435	36, 593, 417	45, 035, 85			
65.01       06501       SLEEP LAB       0       445,346       445,346       0.152062       0.000000       65.01         66.00       06600       PHYSI CAL THERAPY       472,029       3,856,269       4,328,298       0.537746       0.000000       66.01         66.01       06600       PHYSI CAL THERAPY - LIFEPLEX       966       3,361,760       3,362,726       0.273128       0.000000       66.01         67.00       06700       0CCUPATI ONAL THERAPY       1173,036       612,787       785,823       0.293886       0.000000       67.00         68.00       0800       SPEECH PATHOLOGY       55,634       146,596       202,230       0.622692       0.000000       68.00         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0.000000       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       596,994       2,177,539       2,774,533       0.202713       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       6,590,825       10,856,993       17,447,818       0.301615       0.000000       73.00         76.97       CARDI AC REHABI LI TATI ON       825,268       825,268       825,268       0.17	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0. 000000	0.00000	62.30
66.00       06600       PHYSI CAL THERAPY       472,029       3,856,269       4,328,298       0.537746       0.000000       66.00         66.01       06601       PHYSI CAL THERAPY - LIFEPLEX       966       3,361,760       3,362,726       0.273128       0.000000       66.01         66.02       06602       PHYSI CAL THERAPY - CULVER MILITARY       0       104,064       104,064       0.296942       0.000000       66.02         67.00       0CCUPATIONAL THERAPY       173,036       612,787       785,823       0.293686       0.000000       67.00         68.00       06800       SPECH PATHOLOGY       55,634       146,596       202,230       0.622692       0.000000       68.00         71.00       07100       MEUS CHARGED TO PATI ENT       0       0       0       0.000000       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       596,994       2,177,539       2,774,533       0.202713       0.000000       73.00         76.97       CARDI AC REHABI LI TATI ON       861       750,527       751,388       0.506286       0.000000       76.99         76.98       07699       LI THOTRI PSY       0       825,268       825,268       0.173295       0.000000       76.99 <td></td> <td>3, 136, 771</td> <td>7, 312, 074</td> <td>10, 448, 84</td> <td>5 0. 141673</td> <td>0.00000</td> <td>65.00</td>		3, 136, 771	7, 312, 074	10, 448, 84	5 0. 141673	0.00000	65.00
66.01       06601       PHYSI CAL THERAPY - LIFEPLEX       966       3, 361, 760       3, 362, 726       0. 273128       0. 000000       66. 01         66.02       06602       PHYSI CAL THERAPY - CULVER MI LITARY       0       104, 064       104, 064       0. 296942       0. 000000       66. 02         67.00       06700       OCUPATI ONAL THERAPY       173, 036       612, 787       785, 823       0. 293686       0. 000000       67. 00         68.00       OFECH PATHOLOGY       55, 634       146, 596       202, 230       0. 622692       0. 000000       88. 00         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0.000000       0. 000000       71. 00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       596, 994       2, 177, 539       2, 774, 533       0. 202713       0. 000000       73. 00         76.97       CARDI AC REHABI LI TATI ON       861       750, 527       751, 388       0. 506286       0. 000000       76. 97         76.98       HYPERBARI C 0XYGEN THERAPY       0       0       0       0. 000000       76. 97         76.98       07697       LI THOTRI PSY       0       0       0       0. 000000       0. 000000		0			6 0. 152062	0. 000000	65.01
66.02       06602       PHYSI CAL THERAPY - CULVER MI LITARY       0       104,064       104,064       0.296942       0.000000       66.02         67.00       06700       0CCUPATI ONAL THERAPY       173,036       612,787       785,823       0.293686       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       55,634       146,596       202,230       0.622692       0.000000       68.00         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       596,994       2,177,539       2,774,533       0.202713       0.000000       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       6,590,825       10,856,993       17,447,818       0.301615       0.000000       76.97         76.97       07697       CARDI AC REHABI LI TATI ON       861       750,527       751,388       0.506286       0.000000       76.98         76.99       07699       LI THOTRI PSY       0       0       0.000000       0.000000       76.98         70.01       09001       OUTPATI ENT TREATMENT & INFUSION CTR       0       0       0.000000       0.000000       0.000000<	66. 00 06600 PHYSI CAL THERAPY	472, 029	3, 856, 269	4, 328, 29	B 0. 537746	0.00000	66.00
67.00       06700       0CCUPATIONAL THERAPY       173,036       612,787       785,823       0.293686       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       55,634       146,596       202,230       0.622692       0.000000       68.00         71.00       MDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0.000000       0.000000       71.00         72.00       IMPL. DEV. CHARGED TO PATI ENTS       596,994       2,177,539       2,774,533       0.202713       0.000000       72.00         73.00       OT300       DRUGS CHARGED TO PATI ENTS       6,590,825       10,856,993       17,447,818       0.301615       0.000000       73.00         76.97       CARDI AC REHABI LI TATI ON       861       750,527       751,388       0.506286       0.000000       76.97         76.98       07699       LITHOTRI PSY       0       0       0       0.000000       76.98         76.99       D7699       LITHOTRI PSY       0       0       0       0.000000       76.98         70.01       O9001       OUTPATI ENT SERVICE COST CENTERS       0       0       0.000000       0.000000       90.02         90.02       O9002       ATHLETI C TRAI NERS       0	66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	966	3, 361, 760	3, 362, 72	6 0. 273128	0. 000000	66.01
68.00       06800       SPEECH PATHOLOGY       55, 634       146, 596       202, 230       0. 622692       0. 000000       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       0.000000       0. 000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       596, 994       2, 177, 539       2, 774, 533       0. 202713       0. 000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       6, 590, 825       10, 856, 993       17, 447, 818       0. 301615       0. 000000       73.00         76.97       O7697       CARDI AC REHABI LI TATI ON       861       750, 527       751, 388       0. 506286       0. 000000       76.97         76.98       07699       LI THOTRI PSY       0       825, 268       825, 268       0. 173295       0. 000000       76.98         90.01       09001       OUTPATI ENT TREATMENT & INFUSION CTR       0       0       0       0.000000       90.01         90.02       09002       ATHLETI C TRAI NERS       0       727, 492       727, 492       0.000000       90.02         90.03       09003       SAI NT JOSEPH HEALTH CENTER       0       727, 492       727, 492 <t< td=""><td>66. 02 06602 PHYSI CAL THERAPY - CULVER MILI TARY</td><td>0</td><td>104, 064</td><td>104, 06</td><td>4 0. 296942</td><td>0.00000</td><td>66. 02</td></t<>	66. 02 06602 PHYSI CAL THERAPY - CULVER MILI TARY	0	104, 064	104, 06	4 0. 296942	0.00000	66. 02
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       0.000000       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       596,994       2,177,539       2,774,533       0.202713       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       6,590,825       10,856,993       17,447,818       0.301615       0.000000       73.00         76.97       07697       CARDI AC REHABI LI TATI ON       861       750,527       751,388       0.506286       0.000000       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       825,268       0.173295       0.000000       76.98         90.01       09001       OUTPATI ENT SERVICE COST CENTERS       0       0       0       0.000000       0.000000       90.01         90.01       09001       OUTPATI ENT TREATMENT & INFUSION CTR       0       0       0       0.000000       90.02       90.02       0.000000       0.000000       90.02         90.03       09003       SAINT JOSEPH HEALTH CENTER       0       727,492       727,492       2.022059       0.000000       90.04         91.00       09100       EMERGENCY       2,	67.00 06700 OCCUPATI ONAL THERAPY	173, 036	612, 787	785, 82	0. 293686	0. 000000	67.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       596,994       2,177,539       2,774,533       0.202713       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       6,590,825       10,856,993       17,447,818       0.301615       0.000000       73.00         76.97       07697       CARDIAC REHABILITATION       861       750,527       751,388       0.506286       0.000000       76.97         76.98       07698       HYPERBARIC OXYGEN THERAPY       0       825,268       0.173295       0.000000       76.98         76.99       07699       LITHOTRIPSY       0       0       0       0       0.000000       76.98         90.01       09001       OUTPATIENT SERVICE COST CENTERS       0       0       0       0.000000       90.01         90.02       09002       ATHLETIC TRAINERS       0       0       0       0.000000       0.000000       90.02         90.03       09003       SAINT JOSEPH HEALTH CENTER       18,175       2,484,789       2,502,964       0.502298       0.000000       90.04         91.00       09100       EMERGENCY       2,543,100       13,632,309       16,175,409       0.332857       0.000000       92.00 <td>68.00 06800 SPEECH PATHOLOGY</td> <td>55, 634</td> <td>146, 596</td> <td>202, 23</td> <td>0. 622692</td> <td>0.00000</td> <td>68.00</td>	68.00 06800 SPEECH PATHOLOGY	55, 634	146, 596	202, 23	0. 622692	0.00000	68.00
73.00       07300       DRUGS CHARGED TO PATIENTS       6, 590, 825       10, 856, 993       17, 447, 818       0. 301615       0.000000       73.00         76.97       07697       CARDI AC REHABILITATION       861       750, 527       751, 388       0. 506286       0.000000       76.97         76.98       07698       HYPERBARI C 0XYGEN THERAPY       0       825, 268       825, 268       0. 173295       0.000000       76.98         70.00       0TFATI ENT SERVICE COST CENTERS       0       0       0       0.000000       0.000000       76.98         90.01       0P001       OUTPATI ENT TREATMENT & INFUSION CTR       0       0       0       0.000000       90.01         90.02       09002       ATHLETI C TRAINERS       0       727, 492       727, 492       2.022059       0.000000       90.02         90.04       09004       WOUND CARE       18, 175       2, 484, 789       2, 502, 964       0.502298       0.000000       90.04         91.00       MERGENCY       2, 543, 100       13, 632, 309       16, 175, 409       0.332857       0.000000       92.00         92.00       09200       RERGENCY       2, 543, 100       13, 632, 309       16, 175, 409       0.32857       0.000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0. 000000	0. 000000	71.00
73.00       07300       DRUGS CHARGED TO PATIENTS       6,590,825       10,856,993       17,447,818       0.301615       0.000000       73.00         76.97       07697       CARDI AC REHABILITATION       861       750,527       751,388       0.506286       0.000000       76.97         76.98       07698       HYPERBARIC OXYGEN THERAPY       0       825,268       825,268       0.173295       0.000000       76.98         76.99       0TFMTIENT SERVICE COST CENTERS       0       0       0       0.000000       76.98         90.01       09001       OUTPATIENT TREATMENT & INFUSION CTR       0       0       0.000000       90.01         90.02       09002       ATHLETI C TRAINERS       0       727,492       727,492       2.022059       0.000000       90.02         90.04       09004       WOUND CARE       18,175       2,484,789       2,502,964       0.502298       0.000000       90.04         91.00       09200       OBSERVATION BEDS (NON-DI STINCT PART       300,200       1,512,760       1,812,960       0.819640       0.000000       92.00         92.00       09200       BSERVATION BEDS (NON-DI STINCT PART       300,200       1,512,760       1,812,960       0.819640       0.000000       92	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	596, 994	2, 177, 539	2, 774, 53	3 0. 202713	0. 000000	72.00
76. 97         07697         CARDI AC REHABILITATION         861         750, 527         751, 388         0. 506286         0.000000         76. 97           76. 98         07698         HYPERBARI C 0XYGEN THERAPY         0         825, 268         825, 268         0.173295         0.000000         76. 98           76. 99         07699         LI THOTRI PSY         0         0         0         0         0.000000         76. 99           0UTPATIENT SERVICE COST CENTERS         90. 01         0UTPATIENT TREATMENT & INFUSION CTR         0         0         0         0.000000         0.000000         90. 01           90. 01         09002         ATHLETI C TRAINERS         0         0         0         0.000000         90. 01           90. 03         09003         SAINT JOSEPH HEALTH CENTER         0         727, 492         727, 492         2.022059         0.000000         90. 03           90. 04         09004         WOND CARE         18, 175         2, 484, 789         2, 502, 964         0.502298         0.000000         90. 03           91. 00         09100         EMERGENCY         2, 543, 100         13, 632, 309         16, 175, 409         0.332857         0.000000         92. 00           92.00         08200 <td></td> <td>6, 590, 825</td> <td></td> <td></td> <td></td> <td>0. 000000</td> <td>73.00</td>		6, 590, 825				0. 000000	73.00
76. 98         07698         HYPERBARI C 0XYGEN THERAPY         0         825, 268         825, 268         0.173295         0.000000         76. 98           76. 99         07699         LI THOTRI PSY         0         0         0         0         0.000000         0.000000         76. 98           90. 01         09001         OUTPATI ENT SERVICE COST CENTERS         0         0         0         0.000000         0.000000         90. 01           90. 01         09001         OUTPATI ENT TREATMENT & INFUSION CTR         0         0         0         0.000000         0.000000         90. 01           90. 02         09002         ATHLETI C TRAINERS         0         0         0         0.000000         0.000000         90. 02           90. 03         09003         SAINT JOSEPH HEALTH CENTER         0         727, 492         727, 492         2.022059         0.000000         90. 03           90. 04         WOND CARE         18, 175         2, 484, 789         2, 502, 964         0.502298         0.000000         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART         300, 200         1, 512, 760         1, 812, 960         0. 819640         0.000000         92. 00           200. 00 <td>76. 97 07697 CARDI AC REHABI LI TATI ON</td> <td>861</td> <td>750, 527</td> <td></td> <td></td> <td>0. 000000</td> <td>76.97</td>	76. 97 07697 CARDI AC REHABI LI TATI ON	861	750, 527			0. 000000	76.97
76. 99         07699         LI THOTRI PSY         0         0         0.000000         0.000000         76. 99           OUTPATI ENT SERVICE COST CENTERS         0         0         0         0.000000         0.000000         90.01           90. 01         09001         OUTPATI ENT TREATMENT & INFUSION CTR         0         0         0.000000         0.000000         90.01           90. 02         09002         ATHLETI C TRAINERS         0         0         0.000000         0.000000         90.02           90. 03         09003         SAINT JOSEPH HEALTH CENTER         0         727,492         727,492         2.022059         0.000000         90.03           90. 04         09004         WOUND CARE         18,175         2,484,789         2,502,964         0.502298         0.000000         90.04           91. 00         09100         EMERGENCY         2,543,100         13,632,309         16,175,409         0.332857         0.000000         91.00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART         300,200         1,512,760         1,812,960         0.819640         0.000000         92.00           200. 00         Subtotal (see instructions)         49,591,993         158,888,495         208,480,	76, 98 07698 HYPERBARI C OXYGEN THERAPY	0	825, 268			0, 000000	76.98
OUTPATI ENT         SERVICE         COST         CENTERS           90.01         09001         OUTPATI ENT TREATMENT & INFUSION CTR         0         0         0.000000         0.000000         90.01           90.02         09002         ATHLETI C         TRAINERS         0         0         0         0.000000         0.000000         90.02           90.03         09003         SAINT         JOSEPH         HEALTH CENTER         0         727,492         727,492         2.022059         0.000000         90.03           90.04         09004         WOUND CARE         18,175         2,484,789         2,502,964         0.502298         0.000000         90.04           91.00         OP1000         EMERGENCY         2,543,100         13,632,309         16,175,409         0.332857         0.000000         90.04           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         300,200         1,512,760         1,812,960         0.819640         0.000000         92.00           200.00         Subtotal (see instructions)         49,591,993         158,888,495         208,480,488         200.00         201.00		0					1
90. 01         09001         0UTPATI ENT TREATMENT & INFUSION CTR         0         0         0         0.000000         0.000000         90. 01           90. 02         09002         ATHLETI C TRAINERS         0         0         0         0.000000         0.000000         90. 02           90. 03         09003         SAINT JOSEPH HEALTH CENTER         0         727, 492         727, 492         2.022059         0.000000         90. 03           90. 04         09004         WOUND CARE         18, 175         2, 484, 789         2, 502, 964         0.502298         0.000000         90. 04           91. 00         09100         EMERGENCY         2, 543, 100         13, 632, 309         16, 175, 409         0.332857         0.000000         92. 00           92. 00         09200         BSERVATI ON BEDS (NON-DI STINCT PART         300, 200         1, 512, 760         1, 812, 960         0.819640         0.000000         92. 00           200. 00         Subtotal (see instructions)         49, 591, 993         158, 888, 495         208, 480, 488         200. 00         201. 00		-					
90.02       09002       ATHLETIC TRAINERS       0       0       0       0.000000       0.000000       90.02         90.03       09003       SAINT JOSEPH HEALTH CENTER       0       727,492       727,492       2.022059       0.000000       90.03         90.04       09004       WOUND CARE       18,175       2,484,789       2,502,964       0.502298       0.000000       90.04         91.00       09100       EMERGENCY       2,543,100       13,632,309       16,175,409       0.332857       0.000000       92.00         92.00       09200       BSERVATI ON BEDS (NON-DI STINCT PART       300,200       1,512,760       1,812,960       0.819640       0.000000       92.00         200.00       Less Observation Beds       49,591,993       158,888,495       208,480,488       201.00       201.00		0	0		0 00000	0 00000	90 01
90.03       09003       SAINT JOSEPH HEALTH CENTER       0       727,492       727,492       2.022059       0.000000       90.03         90.04       09004       WOUND CARE       18,175       2,484,789       2,502,964       0.502298       0.000000       90.04         91.00       09100       EMERGENCY       2,543,100       13,632,309       16,175,409       0.332857       0.000000       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       300,200       1,512,760       1,812,960       0.819640       0.000000       92.00         200.00       201.00       Less Observation Beds       49,591,993       158,888,495       208,480,488       201.00       201.00		0	0				
90. 04         09004         WOUND CARE         18, 175         2, 484, 789         2, 502, 964         0.502298         0.000000         90. 04           91. 00         09100         EMERGENCY         2, 543, 100         13, 632, 309         16, 175, 409         0.332857         0.000000         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         300, 200         1, 512, 760         1, 812, 960         0.819640         0.000000         92. 00           200. 00         201. 00         Less Observation Beds         49, 591, 993         158, 888, 495         208, 480, 488         201. 00         201. 00		0	727 492	727 49			
91. 00         09100         EMERGENCY         2, 543, 100         13, 632, 309         16, 175, 409         0. 332857         0. 000000         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         300, 200         1, 512, 760         1, 812, 960         0. 819640         0. 000000         92. 00           200. 00         Subtotal (see instructions)         49, 591, 993         158, 888, 495         208, 480, 488         208, 480, 488         201. 00		-					
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         300, 200         1, 512, 760         1, 812, 960         0. 819640         0. 000000         92. 00           200. 00         Subtotal (see instructions)         49, 591, 993         158, 888, 495         208, 480, 488         0. 819640         200. 00         200. 00           201. 00         Less Observation Beds         0. 00000         92. 00         201. 00							
200.00         Subtotal (see instructions)         49, 591, 993         158, 888, 495         208, 480, 488         200.00         201.00           201.00         Less Observation Beds         49, 591, 993         158, 888, 495         208, 480, 488         200.00         201.00							1
201.00 Less Observation Beds 201.00						0.00000	
		47, 371, 993	100,000,490	200, 400, 400	U C		1
		40 501 002	150 000 105	208 400 40	R		1
		47, 371, 773	130, 000, 493	200, 400, 400		I	1202.00

Health Financial Systems S	T. JOSEPHS REG MED	CENTER PLYMOUTH	In Lieu of Form CMS-2552-1		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 12:37 pm	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient		incopi cui		
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30.00	
31.00 03100 INTENSIVE CARE UNIT				31.00	
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00	
43. 00 04300 NURSERY				43.00	
ANCI LLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 239274			50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 391759			52.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 161445			54.00	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 137068			55.00	
57.00 05700 CT SCAN	0. 014174			57.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 477393			59.00	
60. 00 06000 LABORATORY	0. 177223			60.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62.30	
65. 00 06500 RESPI RATORY THERAPY	0. 141673			65.00	
65.01 06501 SLEEP LAB	0. 152062			65.01	
66. 00 06600 PHYSI CAL THERAPY	0. 537746			66.00	
66. 01 06601 PHYSI CAL THERAPY – LI FEPLEX	0. 273128			66. 01	
66. 02 06602 PHYSI CAL THERAPY - CULVER MILI TARY	0. 296942			66. 02	
67.00 06700 OCCUPATI ONAL THERAPY	0. 293686			67.00	
68.00 06800 SPEECH PATHOLOGY	0. 622692			68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 202713			72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 301615			73.00	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 506286			76.97	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 173295			76. 98	
76. 99 07699 LI THOTRI PSY	0. 000000			76.99	
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0.000000			90.01	
90. 02 09002 ATHLETI C TRAI NERS	0. 000000			90.02	
90. 03 09003 SAINT JOSEPH HEALTH CENTER	2. 022059			90.03	
90. 04 09004 WOUND CARE	0. 502298			90.04	
91.00 09100 EMERGENCY	0. 335630			91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 819640			92.00	
200.00 Subtotal (see instructions)				200.00	
201.00 Less Observation Beds				201.00	
202.00 Total (see instructions)				202.00	
· · · ·				•	

Health	Financial Systems SI.	JUSEPHS REG MEI	D CENTER PLYMOU	ЛН	In Lie	U OT FORM CMS	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/30/2021 12	pared: :37 pm
			Ti †I	e XIX	Hospi tal	PPS	
					Costs	115	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	cost center bescription	(from Wkst. B,	Adj.		Di sal I owance	10101 00313	
		Part I, col.	Auj.		DI Sal I Owalice		
		26)					
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
		6, 483, 680	1	4 402 40	0 0	( 402 ( 00	20.00
	03000 ADULTS & PEDIATRICS			6, 483, 68		6, 483, 680	
	D3100 I NTENSI VE CARE UNI T	2, 331, 575		2, 331, 57			
	03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	
	D4300 NURSERY	581, 418		581, 41	8 0	581, 418	43.00
	ANCILLARY SERVICE COST CENTERS	i.			1		
	D5000 OPERATING ROOM	6, 788, 708		6, 788, 70		6, 788, 708	
52.00	D5200 DELIVERY ROOM & LABOR ROOM	585, 192		585, 19	02 0	585, 192	52.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	2, 907, 953		2, 907, 95	0	2, 907, 953	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 407, 895		1, 407, 89	05 0	1, 407, 895	55.00
57.00	D5700 CT SCAN	393, 319		393, 31	9 0	393, 319	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	318, 377		318, 37	7 0	318, 377	
60.00	26000 LABORATORY	7, 981, 038		7, 981, 03	8 365	7, 981, 403	60.00
62.30	D6250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	62.30
	06500 RESPI RATORY THERAPY	1, 480, 319	0	1, 480, 31	9 0	1, 480, 319	
	D6501 SLEEP LAB	67,720		67, 72		67, 720	
	06600 PHYSI CAL THERAPY	2, 327, 525				2, 327, 525	
	D6601 PHYSI CAL THERAPY - LIFEPLEX	918, 456		918, 45		918, 456	
	06602 PHYSI CAL THERAPY - CULVER MILITARY	30, 901				30, 901	
	06700 OCCUPATIONAL THERAPY	230, 785		230, 78		230, 785	
	06800 SPEECH PATHOLOGY	125, 927		125, 92		125, 927	
					· · · · · · · · · · · · · · · · · · ·		
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	562, 433		562, 43		562, 433	
	07300 DRUGS CHARGED TO PATIENTS	5, 262, 524		5, 262, 52		5, 262, 524	
	07697 CARDI AC REHABI LI TATI ON	380, 417		380, 41		380, 417	
	07698 HYPERBARI C OXYGEN THERAPY	143, 015		143, 01		143, 015	
	07699 LI THOTRI PSY	0			0 0	0	76. 99
	DUTPATIENT SERVICE COST CENTERS	-	1	1			
	09001 OUTPATIENT TREATMENT & INFUSION CTR	10, 781		10, 78	0	10, 781	90.01
90.02	09002 ATHLETI C TRAI NERS	46,000		46, 00	0 0	46, 000	90.02
	09003 SAINT JOSEPH HEALTH CENTER	1, 471, 032		1, 471, 03	0	1, 471, 032	90.03
90.04	09004 WOUND CARE	1, 257, 235		1, 257, 23	5 0	1, 257, 235	90.04
91.00	D9100 EMERGENCY	5, 384, 094		5, 384, 09		5, 428, 956	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 485, 974		1, 485, 97		1, 485, 974	92.00
200.00	Subtotal (see instructions)	50, 964, 293					
201.00	Less Observation Beds	1, 485, 974		1, 485, 97		1, 485, 974	
202.00	Total (see instructions)	49, 478, 319					
		1,		1,			

Health Financial Systems ST.	JOSEPHS REG MED	CENTER PLYMOL	JIH	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 07/01/2020 To 06/30/2021	Part I Date/Time Pre	norod.
				10 06/30/2021	11/30/2021 12	
		Titl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. d	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS				_1		
30. 00 03000 ADULTS & PEDIATRICS	8, 306, 915		8, 306, 91			30.00
31. 00 03100 INTENSIVE CARE UNIT	5, 178, 495		5, 178, 49	5		31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0		34.00
43. 00 04300 NURSERY	698, 924		698, 92	4		43.00
ANCI LLARY SERVI CE COST CENTERS	1 1		I			-
50. 00 05000 OPERATI NG ROOM	5, 137, 708	23, 234, 435			0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 434, 785	58, 970			0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 375, 454	15, 636, 556			0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	33, 384	10, 238, 154			0. 000000	
57.00 05700 CT SCAN	4, 038, 455	23, 710, 330			0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	56, 847	610, 060			0. 000000	
60. 00 06000 LABORATORY	8, 442, 435	36, 593, 417			0.00000	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0. 000000	0.000000	
65. 00 06500 RESPI RATORY THERAPY	3, 136, 771	7, 312, 074			0.000000	
65. 01 06501 SLEEP LAB	0	445, 346			0.000000	
66. 00 06600 PHYSI CAL THERAPY	472, 029	3, 856, 269	4, 328, 29		0. 000000	
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	966	3, 361, 760			0. 000000	
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0	104, 064	104, 06		0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	173, 036	612, 787			0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	55, 634	146, 596	202, 23		0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0.000000	0.00000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	596, 994	2, 177, 539			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 590, 825	10, 856, 993	17, 447, 81	8 0. 301615	0.00000	73.00
76. 97 07697 CARDIAC REHABILITATION	861	750, 527	751, 38	8 0. 506286	0.000000	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	825, 268	825, 26	8 0. 173295	0.000000	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0.000000	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0		0 0. 000000	0.000000	90.01
90. 02 09002 ATHLETI C TRAI NERS	0	0		0 0. 000000	0.000000	
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0	727, 492			0.000000	
90. 04 09004 WOUND CARE	18, 175	2, 484, 789	2, 502, 96	4 0. 502298	0.000000	90.04
91. 00 09100 EMERGENCY	2, 543, 100	13, 632, 309	16, 175, 40	9 0. 332857	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	300, 200	1, 512, 760	1, 812, 96	0 0. 819640	0. 000000	92.00
200.00 Subtotal (see instructions)	49, 591, 993	158, 888, 495	208, 480, 48	8		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	49, 591, 993	158, 888, 495	208, 480, 48	8		202.00

Health Financial Sy	stems ST.	JOSEPHS REG MED	CENTER PLYMOUTH	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATI	0 OF COSTS TO CHARGES		Provider CCN: 15-0076	Peri od:	Worksheet C
				From 07/01/2020	Part I
				To 06/30/2021	Date/Time Prepared:
			Title XIX	Hospi tal	<u>11/30/2021 12:37 pm</u> PPS
Cost C	enter Description	PPS Inpatient		HOSPITAL	PPS
COST C	enter bescription	Ratio			
		11,00			
	UTINE SERVICE COST CENTERS	11.00			
	& PEDIATRICS				30.00
	I VE CARE UNIT				31.00
	AL INTENSIVE CARE UNIT				34.00
43.00 04300 NURSER					43.00
	RVICE COST CENTERS				43:00
50. 00 05000 OPERATI		0. 239274			50.00
	RY ROOM & LABOR ROOM	0. 391759			52.00
	DGY-DI AGNOSTI C	0. 161445			54.00
	DGY-THERAPEUTIC	0. 137068			55.00
57.00 05700 CT SCAL		0. 014174			57.00
	C CATHETERI ZATI ON	0. 477393			59.00
60. 00 06000 LABORA		0. 177223			60.00
	CLOTTING FOR HEMOPHILIACS				62.30
		0. 000000 0. 141673			65.00
	ATORY THERAPY				
65.01 06501 SLEEP I		0. 152062			65.01
66.00 06600 PHYSI C/		0. 537746			66.00
	AL THERAPY - LIFEPLEX	0. 273128			66.01
	AL THERAPY - CULVER MILITARY	0. 296942			66.02
	TIONAL THERAPY	0. 293686			67.00
68.00 06800 SPEECH		0. 622692			68.00
	L SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
	DEV. CHARGED TO PATIENTS	0. 202713			72.00
	CHARGED TO PATIENTS	0. 301615			73.00
	C REHABILITATION	0. 506286			76.97
	ARIC OXYGEN THERAPY	0. 173295			76.98
76. 99 07699 LI THOTI		0. 000000			76. 99
	ERVICE COST CENTERS				
	IENT TREATMENT & INFUSION CTR	0. 000000			90.01
90. 02 09002 ATHLET		0. 000000			90.02
	JOSEPH HEALTH CENTER	2. 022059			90.03
90.04 09004 WOUND (		0. 502298			90.04
91.00 09100 EMERGE		0. 335630			91.00
	ATION BEDS (NON-DISTINCT PART	0. 819640			92.00
	al (see instructions)				200.00
	bservation Beds				201.00
202.00   Total	(see instructions)				202.00

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE FEDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C	CN: 15-0076	Period: From 07/01/2020 To 06/30/2021		narod
				10 00/30/2021	11/30/2021 12	2:37 p
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Co	st Capital	Operating Cost	
	(Wkst. B, Part				Reducti on	
	I, col. 26)	II col. 26)		-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
D. 00 05000 OPERATING ROOM	6, 788, 708				0	1
2.00 05200 DELIVERY ROOM & LABOR ROOM	585, 192				0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 907, 953	288, 347	2, 619, 6	06 C	0	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	1, 407, 895	332, 938	3 1, 074, 9	57 C	0 0	55.0
7.00 05700 CT SCAN	393, 319	32, 404	360, 9	15 C	0	57.
9. 00 05900 CARDI AC CATHETERI ZATI ON	318, 377	77, 098	3 241, 2	79 C	0	59.
D. 00 06000 LABORATORY	7, 981, 038	246, 755	7, 734, 2	83 0	0 0	60.
2. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	o o	62.
5. 00 06500 RESPI RATORY THERAPY	1, 480, 319	134, 195	1, 346, 1	24 0	0	
5. 01 06501 SLEEP LAB	67, 720					
5. 00 06600 PHYSI CAL THERAPY	2, 327, 525					
5. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	918, 456					
5. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	30, 901	334			-	
7. 00 06700 OCCUPATI ONAL THERAPY	230, 785				0	
3. 00 06800 SPEECH PATHOLOGY	125, 927					
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,210				
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	562, 433			0		
3. 00 07300 DRUGS CHARGED TO PATIENTS	5, 262, 524					
5. 97 07697 CARDI AC REHABILI TATI ON	380, 417					
5. 98 07698 HYPERBARI C OXYGEN THERAPY	143, 015				-	
5. 99 07699 LI THOTRI PSY	143, 015			0 0	-	
OUTPATIENT SERVICE COST CENTERS	0	L(	<u>ין</u>	0 0	٠ <u>ــــــــــــــــــــــــــــــــــــ</u>	/0.
0.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	10, 781	97	7 10, 6	84 (	0	90.
D. 02 09002 ATHLETIC TRAINERS	46,000				-	
	1, 471, 032				0	
0.04 09004 WOUND CARE	1, 257, 235				-	1
1.00 09100 EMERGENCY	5, 384, 094				-	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 485, 974				0	1
00.00 Subtotal (sum of lines 50 thru 199)	41, 567, 620					200.
01.00 Less Observation Beds	1, 485, 974					201.
D2.00 Total (line 200 minus line 201)	40, 081, 646	2, 701, 897	7 37, 379, 7	49 C	0 0	202.

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F EDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C		In Lie Period: From 07/01/2020 To 06/30/2021	Date/Time Prepare 11/30/2021 12:37
			e XIX	Hospi tal	PPS
Cost Center Description		Total Charges	Outpatient		
	Capital and	(Worksheet C,			
	Operating Cost			6	
	Reduction	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS			1		
0. 00 05000 OPERATI NG ROOM	6, 788, 708				50.
2.00 05200 DELIVERY ROOM & LABOR ROOM	585, 192				52.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 907, 953				54.
5. 00 05500 RADI OLOGY-THERAPEUTI C	1, 407, 895	10, 271, 538			55.
7.00 05700 CT SCAN	393, 319				57.
9. 00 05900 CARDI AC CATHETERI ZATI ON	318, 377	666, 907			59.
0. 00 06000 LABORATORY	7, 981, 038	45, 035, 852	0. 1772	15	60.
2.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0.0000	00	62.
5. 00 06500 RESPI RATORY THERAPY	1, 480, 319	10, 448, 845	0. 1416	73	65.
5.01 06501 SLEEP LAB	67, 720	445, 346	0. 1520	62	65.
6. 00 06600 PHYSI CAL THERAPY	2, 327, 525	4, 328, 298	0. 5377	46	66.
6. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	918, 456	3, 362, 726	0. 2731	28	66.
6. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	30, 901	104, 064	0. 2969	42	66.
7.00 06700 OCCUPATI ONAL THERAPY	230, 785	785, 823	0. 2936	86	67.
8.00 06800 SPEECH PATHOLOGY	125, 927	202, 230	0. 6226	92	68.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	0.0000	00	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	562, 433	2, 774, 533	0. 2027	13	72.
3.00 07300 DRUGS CHARGED TO PATIENTS	5, 262, 524	17, 447, 818		15	73.
6. 97 07697 CARDI AC REHABI LI TATI ON	380, 417	751, 388	0. 5062	86	76.
6. 98 07698 HYPERBARI C OXYGEN THERAPY	143,015	825, 268	0. 1732	95	76.
6. 99 07699 LI THOTRI PSY	0	0			76.
OUTPATIENT SERVICE COST CENTERS					
0. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	10, 781	C	0.0000	00	90.
0. 02 09002 ATHLETIC TRAINERS	46,000	0			90.
0. 03 09003 SAINT JOSEPH HEALTH CENTER	1, 471, 032	-			90.
0. 04 09004 WOUND CARE	1, 257, 235				90.
1. 00 09100 EMERGENCY	5, 384, 094				91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 485, 974	1, 812, 960			92.
00.00 Subtotal (sum of lines 50 thru 199)	41, 567, 620				200.
01.00 Less Observation Beds	1, 485, 974				200. 201.
02.00 Total (line 200 minus line 201)	40, 081, 646				201.

Health Financial Systems	ST. JOSEPHS REG MED	JOSEPHS REG MED CENTER PLYMOUTH			In Lieu of Form CMS-2552			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider C		Period: From 07/01/2020 Fo 06/30/2021	Date/Time Pre 11/30/2021 12			
			XVIII	Hospi tal	PPS			
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.			
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)			
	(from Wkst. B,		Related Cost					
	Part II, col.		(col. 1 - col.					
	26)		2)					
	1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 ADULTS & PEDIATRICS	793, 465	C	793, 46	5 5, 345	148.45	30.00		
31.00 INTENSIVE CARE UNIT	164, 858		164, 85	3 1, 220	135.13	31.00		
34.00 SURGICAL INTENSIVE CARE UNIT	0		(	0 0	0.00	34.00		
43.00 NURSERY	5, 630		5, 63	D 432	13.03	43.00		
200.00 Total (lines 30 through 199)	963, 953		963, 95	6, 997		200.00		
Cost Center Description	I npati ent	I npati ent						
	Program days	Program						
		Capital Cost						
		(col. 5 x col.						
		6)						
	6.00	7.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 ADULTS & PEDIATRICS	1, 405	208, 572				30.00		
31.00 INTENSIVE CARE UNIT	447	60, 403				31.00		
34.00 SURGICAL INTENSIVE CARE UNIT	0	C				34.00		
43.00 NURSERY	0	C				43.00		
200.00 Total (lines 30 through 199)	1, 852	268, 975				200.00		

Health Financial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMOU	JTH	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COST		Provider CCN: 1		Peri od:	Worksheet D	
				From 07/01/2020 To 06/30/2021		pared:
					11/30/2021 12	:37 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	751, 546	28, 372, 143	0. 02648	1, 397, 766	37,025	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	6,073					•
54.00 05400 RADI OLOGY-DI AGNOSTI C	288, 347					•
55. 00 05500 RADI OLOGY-THERAPEUTI C	332, 938					
57.00 05700 CT SCAN	32, 404	27, 748, 785	0.00110	1, 531, 708	1, 789	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	77,098	666, 907	0. 11560	23, 790	2, 750	59.00
60. 00 06000 LABORATORY	246, 755	45, 035, 852	0.0054	<b>79</b> 3, 033, 135	16, 619	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	134, 195	10, 448, 845	0. 01284	683, 501	8, 778	65.00
65. 01 06501 SLEEP LAB	843				0	65.01
66. 00 06600 PHYSI CAL THERAPY	226, 752	4, 328, 298			11, 044	
66. 01 06601 PHYSI CAL THERAPY – LI FEPLEX	10, 054					66. 01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILI TARY	334				-	66. 02
67.00 06700 OCCUPATI ONAL THERAPY	2, 496					67.00
68.00 06800 SPEECH PATHOLOGY	1, 246					68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	6, 525					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	99, 759					
76. 97 07697 CARDI AC REHABI LI TATI ON	3, 834				4	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	20, 613					76.98
76. 99 07699 LI THOTRI PSY	0	0	0.0000	0 0	0	76.99
0UTPATI ENT SERVICE COST CENTERS 90. 01 09001 0UTPATI ENT TREATMENT & INFUSION CTR	97		0.0000	0 0	0	90.01
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR 90. 02 09002 ATHLETIC TRAINERS	417					
90. 02 09002 ATHLETTC TRAINERS 90. 03 09003 SAINT JOSEPH HEALTH CENTER	13, 710				0	90.02
90. 04 09004 WOUND CARE	102, 551					
91. 00 09100 EMERGENCY	343, 310					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	181, 852					
200.00 Total (lines 50 through 199)	2, 883, 749			11, 345, 864		
	2,000,717	1	1	1, 00, 001		1-201.00

31.00       03100       INTENSIVE CARE UNIT       0       0       0       0       31.00       31.00         34.00       03400       SURGICAL INTENSIVE CARE UNIT       0       0       0       0       0       34.00         43.00       04300       NURSERY       0       0       0       0       0       0       34.00         200.00       Total (Lines 30 through 199)       0 <td< th=""><th>Health Financial Systems</th><th>ST. JOSEPHS REG MED</th><th>CENTER PLYMOU</th><th>JTH</th><th>In Lie</th><th>eu of Form CMS-</th><th>2552-10</th></td<>	Health Financial Systems	ST. JOSEPHS REG MED	CENTER PLYMOU	JTH	In Lie	eu of Form CMS-	2552-10
Cost Center Description         Nursing School Nursing School Nursing School Alustments         Allied Health Allied Health Cost         Allied Lealth Cost           30.00         030001 ADULTS & PEDIATRICS         1A         1.00         2A         2.00         3.00           31.00         030001 NUTSS VE CARE UNIT         0	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT	HER PASS THROUGH COST			From 07/01/2020 To 06/30/2021	Part III Date/Time Pre 11/30/2021 12	
Impart ent routine service cost centers         Post-Stepdown Adjustments         Cost Adjustments         Medical Education Cost Education Cost           INPATI ENT ROUTINE SERVICE COST CENTERS         0         0         0         3.00           31.00         03000 ADULTS & PEDIATRICS         0 <t< td=""><td></td><td></td><td>Title</td><td>XVIII</td><td>Hospi tal</td><td>PPS</td><td></td></t<>			Title	XVIII	Hospi tal	PPS	
Adjustments         Adjustments         Education Cost           1A         1.00         2A         2.00         3.00           30.00         03000 ADULTS & PEDIATRICS         0	Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
INPATI ENT ROUTI NE SERVI CE COST CENTERS         0         2A         2.00         3.00           30.00         03000 ADULTS & PEDIATRICS         0		Post-Stepdown	U	Post-Stepdowr	n Cost	Medi cal	
INPATIENT ROUTINE SERVICE COST CENTERS         0		Adjustments		Adjustments		Education Cost	
30. 00         3000         ADULTS & PEDIATRICS         0<		1A	1.00	2A	2.00	3.00	
31.00       03100       INTENSIVE CARE UNIT       0       0       0       0       0       31.00         34.00       03400       SURGICAL INTENSIVE CARE UNIT       0       0       0       0       0       0       31.00         200.00       Total (lines 30 through 199)       0	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		·			
34.00       03400       SURGI CAL INTENSIVE CARE UNIT       0	30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
34.00       03400       SURGI CAL INTENSIVE CARE UNIT       0	31.00 03100 INTENSIVE CARE UNIT	0	0		o o	0	31.00
43.00         04300         NURSERY         0		0	0		0 0	0	
200.00         Total (lines 30 through 199)         0		0	0		0 0	-	
Cost Center Description         Swing-Bed Adjustment Amount (see instructions)         Total Costs (sum of cols. 1 through 3, minus col. 4)         Total Patient Days         Per Diem (col. 5 ÷ col. 6)         Inpatient Program Days           30.00         0000 ADULTS & PEDIATRICS         0         0.00         7.00         8.00           31.00         03000 ADULTS & PEDIATRICS         0         0         5.345         0.00         1,405         30.00           34.00         03400 SURGICAL INTENSIVE CARE UNIT         0         0         0         0         34.00         0         4.320         0.00         43.20         0.00         0         4.300         4.00         4.00         4.00         0         0         0         0         34.00         34.00         34.00         34.00         34.00         0         4.00         0         0         0         0         34.00         34.00         34.00         4.90         4.90         43.00         0         43.00         0         4.99         0         4.99         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00		0	0			-	
Adj uštment Amount (see instructions)         Days         5 + col.         Program Days           INPATI ENT ROUTI NE SERVI CE COST CENTERS         0         6.00         7.00         8.00           30.00         03000 ADULTS & PEDI ATRICS         0         0         5,345         0.00         1,405         30.00           31.00         03000 ADULTS & PEDI ATRICS         0         0         5,345         0.00         1,405         30.00           34.00         03400 SURGI CAL I NTENSI VE CARE UNI T         0         1,220         0.00         0         34.00           200.00         Total (Lines 30 through 199)         0         0         432         0.00         0         43.00           200.00         Total (Lines 30 through 199)         0         6,997         1,852         200.00         0         45.00         45.00           200.00         Total (Lines Service COST CENTERS         0         6,997         1,852         200.00         43.00           200.00         Total (Lines Service COST CENTERS         0         30.00         30.00         30.00         30.00         30.00         30.00           30.00         03000 ADULTS & PEDI ATRICS         0         0         30.00         31.00         30.00	Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col		200.00
Amount (see instructions)         1 through 3, minus col. 4)         3 </td <td>cost center bescription</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	cost center bescription						
INPATI ENT ROUTI NE SERVICE COST CENTERS         0         0         0.00         5.00         6.00         7.00         8.00           30.00         03000 ADULTS & PEDI ATRICS         0         0         5.345         0.00         1,405         30.00           31.00         03100 INTENSI VE CARE UNI T         0         1,220         0.00         44.73         31.00           34.00         03400 SURGI CAL INTENSI VE CARE UNI T         0         0         0.00         0         34.00           200.00         Total (lines 30 through 199)         0         6,997         1,852         200.00           Cost Center Description         Inpati ent Program Pass-Through Cost (col. 7 x col. 8)         9.00         30.00         30.00           30.00         03000 ADULTS & PEDI ATRICS         0         30.00 <t< td=""><td></td><td></td><td><b>V</b></td><td>Days</td><td>5 ÷ cor. 0)</td><td>110graiii Days</td><td></td></t<>			<b>V</b>	Days	5 ÷ cor. 0)	110graiii Days	
4.00         5.00         6.00         7.00         8.00           30.00         03000         ADULTS & PEDIATRICS         0         0         5,345         0.00         1,405         30.00           31.00         03100         INTENSI VE CARE UNI T         0         1,220         0.00         44.77         31.00           34.00         03400         SURGI CAL INTENSI VE CARE UNI T         0         0         0.00         44.77         31.00           34.00         04300         NURSERY         0         0         0.00         0         43.00           200.00         Total (Lines 30 through 199)         Inpati ent Program Pass-Through Cost Center Description         Inpati ent Program Pass-Through Cost (col. 7 x col. 8)         9.00         30.00         30.00           30.00         03000 ADULTS & PEDIATRICS         0         30.00         30.00         31.00         34.00         43.00         43.00         43.00         43.00							
INPATI ENT ROUTI NE SERVICE COST CENTERS           30.00         03000 ADULTS & PEDI ATRI CS         0         0         5, 345         0.00         1, 405         30.00           31.00         03100 INTENSI VE CARE UNI T         0         1, 220         0.00         447         31.00           34.00         03400 SURGI CAL INTENSI VE CARE UNI T         0         0         0, 00         0         34.00           200.00         Total (Lines 30 through 199)         0         0         432         0.00         0         43.00           200.00         Total (Lines 30 through 199)         Inpati ent Program         Program         Pass-Through Cost (Col. 7 x col. 8)         9.00         30.00				6.00	7 00	<u> </u>	
30. 00       03000       ADULTS & PEDIATRICS       0       0       5, 345       0. 00       1, 405       30. 00         31. 00       03100       INTENSI VE CARE UNIT       0       1, 220       0. 00       447       31. 00         34. 00       03400       SURGI CAL INTENSI VE CARE UNIT       0       0       0.00       0       34. 00         43. 00       04300       NURSERY       0       43. 00       0       43. 00       0       43. 00       0       43. 00       0       43. 00       0       43. 00       0       43. 00       0       43. 00       0       43. 00       0       0       0       0       0       0       0       43. 00       0       43. 00       0       43. 00       0       43. 00       0       43. 00       0       43. 00       0 <t< td=""><td>INPATIENT ROUTINE SERVICE COST CENTERS</td><td>4.00</td><td>5.00</td><td>0.00</td><td>7.00</td><td>0.00</td><td></td></t<>	INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
31.00       03100       INTENSI VE CARE UNIT       0       1,220       0.00       447       31.00         34.00       03400       SURGI CAL INTENSI VE CARE UNIT       0       0       0.00       0       34.00         43.00       04300       NURSERY       0       432       0.00       0       43.00         200.00       Total (lines 30 through 199)       0       6,997       1,852       200.00         Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8)       1       1       1       1         30.00       03000       ADULTS & PEDIATRICS       0       30.00       31.00       31.00         31.00       03000       ADULTS & PEDIATRICS       0       31.00       31.00       31.00         34.00       03400       SURGICAL INTENSIVE CARE UNIT       0       31.00       31.00         34.00       03400       SURGICAL INTENSIVE CARE UNIT       0       31.00       34.00         34.00       04300       NURSERY       0       34.00       34.00		0	0	5 34	5 0.00	1 405	30.00
34. 00       03400       SURGI CAL INTENSI VE CARE UNIT       0       0       0.00       0       34.00         43. 00       04300       NURSERY       0       432       0.00       0       43.00         200. 00       Total (Lines 30 through 199)       0       6,997       1,852       200.00         Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8)       9.00       0       30.00         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       03000       ADULTS & PEDIATRICS       0         31. 00       03400       SURGI CAL INTENSIVE CARE UNIT       0       31.00         34. 00       04300       NURSERY       0       34.00		0	0				
43. 00       04300       NURSERY       0       432       0.00       0       43.00         200. 00       Total (lines 30 through 199)       0       6,997       1,852       200.00         Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8)       9.00       1         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       03000       ADULTS & PEDIATRICS       0         31. 00       03000       SURGICAL INTENSIVE CARE UNIT       0       31.00       31.00         34. 00       04300       NURSERY       0       43.00			0				
200.00         Total (lines 30 through 199)         0         6,997         1,852 200.00           Cost Center Description         Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00         Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00         Impatient Program Pass-Through Cost (col. 7 x col. 8) 9.00         Impatient Pass-Through Cost (col. 7 x col. 8) 9.00         Impatient Pass-Through Cost (col. 7 x col. 8) 9.00         Impatient Pas			0				
Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       03000 03000         ADULTS & PEDIATRICS       0 31.00         31.00       03100         34.00       03400         VARGICAL INTENSIVE CARE UNIT       0 34.00         30.00       04300			0				
INPATI ENT ROUTI NE SERVI CE COST CENTERS       30. 00     03000     ADULTS & PEDI ATRI CS     0       31. 00     03100     INTENSI VE CARE UNI T     0       34. 00     03400     SURGI CAL INTENSI VE CARE UNI T     0       43. 00     04300     NURSERY     0		Lawet's and	0	0,99	/	1,852	200.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS         0         30.00         03000 ADULTS & PEDI ATRI CS         0         31.00         31.00         03100 INTENSI VE CARE UNI T         0         34.00         34.00         04300 NURSERY         0         34.00	Cost Center Description						
INPATI ENT ROUTI NE SERVI CE COST CENTERS         0         30.00         03000 ADULTS & PEDI ATRI CS         0         30.00         31.00         31.00         34.00         03400 SURGI CAL INTENSI VE CARE UNI T         0         34.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS         9.00           30.00         03000 ADULTS & PEDI ATRI CS         0         30.00           31.00         03100 I NTENSI VE CARE UNI T         0         31.00           34.00         03400 SURGI CAL I NTENSI VE CARE UNI T         0         34.00           43.00         04300 NURSERY         0         43.00							
9.00           INPATIENT ROUTINE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS         0         30.00           31.00         03100         INTENSIVE CARE UNIT         0         31.00         31.00           34.00         03400         SURGICAL INTENSIVE CARE UNIT         0         34.00         34.00           43.00         04300         NURSERY         0         43.00         43.00							
INPATIENT ROUTINE SERVICE COST CENTERS           30. 00         03000         ADULTS & PEDIATRICS         0         30. 00           31. 00         03100         INTENSIVE CARE UNIT         0         31. 00           34. 00         03400         SURGICAL INTENSIVE CARE UNIT         0         34. 00           43. 00         04300         NURSERY         0         43. 00							
30. 00       03000       ADULTS & PEDIATRICS       0       30. 00         31. 00       03100       INTENSIVE CARE UNIT       0       31. 00         34. 00       03400       SURGICAL INTENSIVE CARE UNIT       0       34. 00         43. 00       04300       NURSERY       0       43. 00		9.00					
31.00       03100       INTENSIVE CARE UNIT       0       31.00         34.00       03400       SURGICAL INTENSIVE CARE UNIT       0       34.00         43.00       04300       NURSERY       0       43.00							200.000
34.00         03400         SURGICAL INTENSIVE CARE UNIT         0         34.00           43.00         04300         NURSERY         0         43.00		-					
43. 00 04300 NURSERY 0 43. 00		-					
		0					
200.00   Total (lines 30 through 199)   0   200.00							
		-					

Health Financial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMO	JTH	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		S Provider C		Period: From 07/01/2020 To 06/30/2021		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing 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						
50.00 05000 OPERATI NG ROOM	0	0	)	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	l o		0 0	0	55.00
57.00 05700 CT SCAN	0	c c		0 0	0	57.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	c c		0 0	0	59.00
60. 00 06000 LABORATORY	0	l a		0 0	0	60,00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	l d		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	l d		0 0	0	65.00
65. 01 06501 SLEEP LAB	0			0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0			0 0	0	66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	0			0 0	0	66, 01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0			0 0	0	66.02
67. 00 06700 OCCUPATI ONAL THERAPY	0			0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0			0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0			0 0	-	76.99
OUTPATIENT SERVICE COST CENTERS		<u> </u>	1	0 0	ŬŬ	/0. //
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0		0 0	0	90.01
90. 02 09002 ATHLETI C TRAI NERS	0			0 0	0	90.02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0				0	90.03
90. 04 09004 WOUND CARE	0				0	90.04
91. 00 09100 EMERGENCY	0				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	C		0 0	-	200.00
	0	1 0	1	0	0	200.00

	. JOSEPHS REG ME				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	SERVICE OTHER PAS	S Provider C	CN: 15-0076	Period: From 07/01/2020	Worksheet D Part IV	
				To 06/30/2021		pared: ·37 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent			
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	5.00	( 00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS 50.00 OPERATI NG ROOM				0 00 070 140	0.00000	50.00
	0	0		0 28, 372, 143 0 1, 493, 755		
		0				
54. 00  05400  RADI OLOGY-DI AGNOSTI C 55. 00  05500  RADI OLOGY-THERAPEUTI C		0				•
57. 00 05500 RADIOLOGY-THERAPEUTIC 57. 00 05700 CT SCAN		0				
57. 00 105700 CT SCAN 59. 00 105900 CARDI AC CATHETERI ZATI ON	0	0		0 27, 748, 785 0 666, 907		
60. 00 06000 LABORATORY	0	0		0 45, 035, 852		
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 45,035,852	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0	0		0 10, 448, 845		
65. 01 06501 SLEEP LAB	0	0		0 445, 346		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 328, 298		
66. 01 06601 PHYSICAL THERAPY - LIFEPLEX		0		0 4, 328, 298		•
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY		0		0 104,064		
67. 00 06700 OCCUPATI ONAL THERAPY		0		0 785, 823		•
68. 00 06800 SPEECH PATHOLOGY		0		0 202, 230		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0.000000	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 2,774,533		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 17, 447, 818		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 751, 388		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 825, 268		•
76. 99 07699 LI THOTRI PSY	0	0		0 0		•
OUTPATIENT SERVICE COST CENTERS						1
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0		0 0	0.000000	90.01
90. 02 09002 ATHLETI C TRAI NERS	0	0		0 0	0. 000000	90.02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0	0		0 727, 492	0. 000000	90.03
90. 04 09004 WOUND CARE	0	0		0 2, 502, 964	0. 000000	90.04
91. 00 09100 EMERGENCY	0	0		0 16, 175, 409	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 1, 812, 960	0. 000000	92.00
200.00 Total (lines 50 through 199)		0	1	0 194, 296, 154	1	200.00

	JOSEPHS REG MED				u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0076	Period: From 07/01/2020		
				To 06/30/2021	Date/Time Pre 11/30/2021 12	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1		-	
50. 00 05000 OPERATI NG ROOM	0. 000000	1, 397, 766		0 5, 157, 483		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	12, 244		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	934, 778		0 2, 926, 313		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	17, 873		0 2, 902, 794	0	55.00
57.00 05700 CT SCAN	0. 000000	1, 531, 708		0 5, 965, 594	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	23, 790		0 199, 741	0	59.00
60. 00 06000 LABORATORY	0. 000000	3, 033, 135		0 3, 041, 870	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 000000	683, 501		0 2, 011, 095	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0 101, 281	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	210, 817		0 2,731	0	66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	0. 000000	640		0 3, 665	0	66. 01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0. 000000	0		0 0	0	66. 02
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	82, 740		0 1, 490	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	27, 963		0 2, 289	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	200, 132		0 461, 571	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 172, 628		0 3, 396, 421	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	861		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 226, 968	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0. 000000	0		0 0	0	90.01
90. 02 09002 ATHLETIC TRAINERS	0. 000000	0		0 0	0	90.02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0. 000000	0		0 0	0	90.03
90. 04 09004 WOUND CARE	0. 000000	4, 223		0 832, 470		90.04
91. 00 09100 EMERGENCY	0. 000000	859, 445		0 2, 233, 029		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	151, 620		0 400, 829	0	92.00
200.00 Total (lines 50 through 199)		11, 345, 864		0 29, 867, 634	0	200.00

			D CENTER PLYMOL			u of Form CMS-	2552-10
APPORTIC	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0076	Period: From 07/01/2020	Worksheet D Part V	
					To 06/30/2021	Date/Time Pre	pared.
					10 00/00/2021	11/30/2021 12	:37 pm
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	NCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0. 239274	5, 157, 483		0 0	1, 234, 052	
	5200 DELIVERY ROOM & LABOR ROOM	0. 391759			0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0. 161445	2, 926, 313		0 0	472, 439	1
	05500 RADI OLOGY-THERAPEUTI C	0. 137068			0 0	397, 880	
57.00 0	05700 CT SCAN	0. 014174	5, 965, 594		2 0	84, 556	57.00
59.00 0	5900 CARDI AC CATHETERI ZATI ON	0. 477393	199, 741		0 0	95, 355	
60.00 0	6000 LABORATORY	0. 177215	3, 041, 870	3, 66	53 0	539, 065	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65.00 0	06500 RESPI RATORY THERAPY	0. 141673	2, 011, 095		0 0	284, 918	65.00
65.01 0	06501 SLEEP LAB	0. 152062	101, 281		0 0	15, 401	65.01
66.00 0	06600 PHYSI CAL THERAPY	0. 537746	2, 731		0 0	1, 469	66.00
66.01 0	06601 PHYSI CAL THERAPY - LI FEPLEX	0. 273128	3, 665		0 0	1, 001	66.01
66.02 0	06602 PHYSI CAL THERAPY - CULVER MILI TARY	0. 296942	0		0 0	0	66.02
67.00 0	06700 OCCUPATI ONAL THERAPY	0. 293686	1, 490		0 0	438	67.00
68.00 0	06800 SPEECH PATHOLOGY	0. 622692	2, 289		0 0	1, 425	68.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 202713	461, 571		0 0	93, 566	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	0. 301615	3, 396, 421		0 7,023	1, 024, 412	73.00
	07697 CARDI AC REHABI LI TATI ON	0. 506286	0		0 0	0	76.97
76.98 0	7698 HYPERBARI C OXYGEN THERAPY	0. 173295	226, 968		0 0	39, 332	76.98
	7699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
0	UTPATIENT SERVICE COST CENTERS			_			
90.01 0	9001 OUTPATIENT TREATMENT & INFUSION CTR	0. 000000	0		0 0	0	90.01
90.02 0	9002 ATHLETIC TRAINERS	0. 000000	0		0 0	0	90.02
90.03 0	9003 SAINT JOSEPH HEALTH CENTER	2. 022059	0		0 0	0	90.03
90.04 0	9004 WOUND CARE	0. 502298	832, 470		0 0	418, 148	90.04
	9100 EMERGENCY	0. 332857	2, 233, 029		1 0	743, 279	91.00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 819640	400, 829		0 0	328, 535	
200.00	Subtotal (see instructions)		29, 867, 634	3, 66	56 7, 023	5, 775, 271	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		29, 867, 634	3,66	6 7,023	5, 775, 271	202 00

Health Financial Systems ST.	JOSEPHS REG MEI	O CENTER PLYMO	UTH	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND			CN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/30/2021 12	epared:
			<u>XVIII</u>	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00	-			
ANCI LLARY SERVI CE COST CENTERS						
50.00       05000       OPERATI NG ROOM         52.00       05200       DELI VERY ROOM & LABOR ROOM         54.00       05400       RADI OLOGY-DI AGNOSTI C         55.00       05500       RADI OLOGY-THERAPEUTI C         57.00       05700       CT SCAN         59.00       06500       CARDI AC CATHETERI ZATI ON         60.00       06000       LABORATORY         62.30       06250       BLOOD CLOTTI NG FOR HEMOPHI LI ACS         65.00       06500       RESPI RATORY THERAPY         65.01       06600       PHYSI CAL THERAPY         65.01       06600       PHYSI CAL THERAPY         66.01       06600       PHYSI CAL THERAPY         66.02       06600       PHYSI CAL THERAPY         67.00       06CUPATI ONAL THERAPY         68.00       06800       SPECH PATHOLOGY         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS         73.00       07300       DRUGS CHARGED TO PATI ENTS         73.00       07697       CARDI AC REHABI LI TATI ON         76.97       07697       LARGED TO PATI ENTS         76.97       07699       LI THOTRI PSY </td <td>0 0 0 0 0 0 649 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td></td> <td></td> <td></td> <td></td> <td>50.00 52.00 54.00 55.00 55.00 60.00 62.30 65.01 66.00 65.01 66.02 67.00 68.00 71.00 72.00 73.00 76.97 76.98 76.99</td>	0 0 0 0 0 0 649 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					50.00 52.00 54.00 55.00 55.00 60.00 62.30 65.01 66.00 65.01 66.02 67.00 68.00 71.00 72.00 73.00 76.97 76.98 76.99
	0					00.01
90. 0109001OUTPATIENT TREATMENT & INFUSION CTR90. 0209002ATHLETIC TRAINERS90. 0309003SAINT JOSEPH HEALTH CENTER90. 0409004WOUND CARE91. 0009100EMERGENCY92. 0009200OBSERVATION BEDS (NON-DISTINCT PART200. 00Subtotal (see instructions)201. 00Less PBP Clinic Lab. Services-Program	0 0 0 0 0 0 649 0					90. 01 90. 02 90. 03 90. 04 91. 00 92. 00 200. 00 201. 00
0nly Charges 202.00 Net Charges (line 200 - line 201)	649	2, 118	3			202.00

Health Financial Systems	ST. JOSEPHS REG MED	CENTER PLYMO	JTH	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS			Period: From 07/01/2020 Fo 06/30/2021	Date/Time Pre 11/30/2021 12	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	793, 465	C	793, 46	5 5, 345	148.45	30.00
31.00 INTENSIVE CARE UNIT	164, 858		164, 858	3 1, 220	135.13	31.00
34.00 SURGICAL INTENSIVE CARE UNIT	0		(	0 0	0.00	34.00
43.00 NURSERY	5,630		5, 630	432	13.03	43.00
200.00 Total (lines 30 through 199)	963, 953		963, 953	6, 997		200.00
Cost Center Description	I npati ent	I npati ent			•	
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	102	15, 142				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
43.00 NURSERY	163	2, 124				43.00
200.00 Total (lines 30 through 199)	265	17, 266				200.00

Health Financial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMOU	JTH	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre	pared:
					11/30/2021 12	:37 pm
	0.111		e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost	Total Charges			Capital Costs	
	(from Wkst. B,	(from Wkst. C, Part I, col.		Program . Charges	(column 3 x column 4)	
	Part II, col.		2)	. Charges		
	26)	0)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50. 00 05000 OPERATI NG ROOM	751, 546	28, 372, 143	0. 02648	959, 555	25, 418	50,00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	6,073					52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	288, 347				3, 890	
55. 00 05500 RADI OLOGY-THERAPEUTI C	332, 938					55.00
57.00 05700 CT SCAN	32, 404	27, 748, 785	0.00110	477, 563	558	57.00
59.00 05900 CARDI AC CATHETERI ZATI ON	77,098	666, 907	0. 11560	3, 440	398	59.00
60. 00 06000 LABORATORY	246, 755	45, 035, 852	0.0054	889, 921	4, 876	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	134, 195	10, 448, 845	0. 01284	13 275, 536	3, 539	65.00
65.01 06501 SLEEP LAB	843	445, 346	0. 00189	93 0	0	65.01
66.00 06600 PHYSI CAL THERAPY	226, 752	4, 328, 298	0.05238	38 20, 142	1, 055	66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX	10, 054	3, 362, 726	0.0029	90 0	0	66. 01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	334	104, 064	0.0032	0 0	0	66. 02
67.00 06700 OCCUPATI ONAL THERAPY	2, 496	785, 823	0.0031	4, 945	16	67.00
68.00 06800 SPEECH PATHOLOGY	1, 246	202, 230	0.00616	2, 400	15	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 525				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	99, 759				2, 882	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	3, 834				-	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	20, 613				-	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.0000	000	0	76.99
OUTPATIENT SERVICE COST CENTERS	1					
90.01 09001 OUTPATIENT TREATMENT & INFUSION CTR	97					
90. 02 09002 ATHLETI C TRAI NERS	417		0.0000		-	90. 02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	13, 710				0	90.03
90. 04 09004 WOUND CARE	102, 551					90.04
91. 00 09100 EMERGENCY	343, 310					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	181, 852					92.00
200.00   Total (lines 50 through 199)	2, 883, 749	194, 296, 154	I	3, 812, 999	52, 074	200.00

	ST. JOSEPHS REG MEL				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COST	rs Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part III Date/Time Pre 11/30/2021 12	pared: :37 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Healt	h Allied Health	All Other	
	Post-Stepdown	U U	Post-Stepdow		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	I		1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	1 30. OC
31.00 03100 I NTENSI VE CARE UNI T	0	0		0 0	0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0			0	
43. 00 04300 NURSERY	0	0		0 0	0	
	0	0		0 0	-	200.00
200.00 Total (lines 30 through 199)	0	U	T		-	200. 00
Cost Center Description	Swi ng-Bed	Total Costs		t Per Diem (col.	Inpati ent	
	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		ā			100	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	0,0			
31.00 03100 INTENSIVE CARE UNIT		0	1, 22			
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0 0.00		
43. 00 04300 NURSERY		0	43			43.00
200.00 Total (lines 30 through 199)		0	6, 99	7	265	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					1 30. OC
31.00 03100 I NTENSI VE CARE UNI T	0					31.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
43. 00 04300 NURSERY						43.00
	0					
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems ST.	JOSEPHS REG MEI	D CENTER PLYMO	JTH	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	S Provider C		Period: From 07/01/2020 To 06/30/2021		pared: :37 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	C	)	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	l o		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0			0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
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	60,00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0				0	62.30
65. 00 06500 RESPIRATORY THERAPY	0				0	65.00
65. 01 06501 SLEEP LAB	0				0	65.01
66. 00 06600 PHYSI CAL THERAPY	0			0 0	0	66.00
66. 01 06601 PHYSICAL THERAPY - LIFEPLEX	0			0 0	0	66.01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILITARY	0			0 0	0	66.02
67. 00 06700 OCCUPATIONAL THERAPY	0			0 0	0	67.02
68. 00 06800 SPEECH PATHOLOGY	0			0 0	-	67.00 68.00
	0			0 0	0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR	0	0		0 0		90. 01
90. 02 09002 ATHLETI C TRAI NERS	0	0		0 0	0	90. 02
90. 03 09003 SAINT JOSEPH HEALTH CENTER	0	0		0 0	0	90. 03
90. 04 09004 WOUND CARE	0	0		0 0	0	90.04
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

		e XIX Total Outpatient Cost (sum of cols. 2, 3, and 4) 6.00	(from Wkst. C,	Date/Time Prep 11/30/2021 12: PPS Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions) 8.00 0.000000 0.000000 0.000000 0.000000 0.000000	50. 00 52. 00 54. 00 55. 00 55. 00 59. 00 60. 00 62. 30 65. 01
i cal ( on Cost	Total Cost (sum of cols. 1, 2, 3, and 4) 5.00	e XIX Total Outpatient Cost (sum of cols. 2, 3, and 4) 6.00	To 06/30/2021 Hospi tal Total Charges (from Wkst. C, Part I, col. 8) 7.00 28,372,143 1,493,755 18,012,010 10,271,538 27,748,785 666,907 45,035,852 0 10,448,845	Date/Time Prep 11/30/2021 12: PPS Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions) 8.00 0.000000 0.000000 0.000000 0.000000 0.000000	37 pm 50.00 52.00 54.00 55.00 57.00 59.00 60.00 62.30 65.00
i cal ( on Cost	Total Cost (sum of cols. 1, 2, 3, and 4) 5.00	Total Outpatient Cost (sum of cols. 2, 3, and 4) 6.00	Total Charges (from Wkst. C, Part I, col. 8) 7.00 28, 372, 143 1, 493, 755 18, 012, 010 10, 271, 538 27, 748, 785 666, 907 45, 035, 852 0 0	11/30/2021 12: PPS Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions) 8.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	50.00 52.00 54.00 55.00 57.00 59.00 60.00 62.30 65.00
i cal ( on Cost	Total Cost (sum of cols. 1, 2, 3, and 4) 5.00	Total Outpatient Cost (sum of cols. 2, 3, and 4) 6.00	Total Charges (from Wkst. C, Part I, col. 8) 7.00 28, 372, 143 1, 493, 755 18, 012, 010 10, 271, 538 27, 748, 785 666, 907 45, 035, 852 0 0	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions) 8.00 0.000000 0.000000 0.000000 0.000000 0.000000	52.00 54.00 55.00 57.00 59.00 60.00 62.30 65.00
i cal ( on Cost	(sum of cols. 1, 2, 3, and 4) 5.00	Outpatient Cost (sum of cols. 2, 3, and 4) 6.00	(from Wkst. C, Part I, col. 8) 7.00 28,372,143 1,493,755 18,012,010 10,271,538 27,748,785 666,907 45,035,852 0 0 10,448,845	to Charges (col. 5 ÷ col. 7) (see instructions) 8.00 0.000000 0.000000 0.000000 0.000000 0.000000	$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 00\\ 62.\ 30\\ 65.\ 00\\ \end{array}$
on Cost	1, 2, 3, and 4) 5.00	Cost (sum of col s. 2, 3, and 4) 6.00	Part I, col. 8) 7.00 28,372,143 1,493,755 18,012,010 10,271,538 27,748,785 666,907 45,035,852 0 10,448,845	(col. 5 + col. 7) (see instructions) 8.00 0.000000 0.000000 0.000000 0.000000 0.000000	52.00 54.00 55.00 57.00 59.00 60.00 62.30 65.00
00	4) 5.00	col s. 2, 3, and 4) 6.00	8) 7.00 28,372,143 1,493,755 18,012,010 10,271,538 27,748,785 666,907 45,035,852 0 10,448,845	7) (see instructions) 8.00 0.000000 0.000000 0.000000 0.000000 0.000000	52.00 54.00 55.00 57.00 59.00 60.00 62.30 65.00
	5.00	and 4) 6.00	7.00 28,372,143 1,493,755 18,012,010 10,271,538 27,748,785 666,907 45,035,852 0 0 10,448,845	(see i nstructions) 8.00 0.000000 0.000000 0.000000 0.000000 0.000000	52.00 54.00 55.00 57.00 59.00 60.00 62.30 65.00
	0	6.00 (( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	28, 372, 143           1, 493, 755           18, 012, 010           10, 271, 538           27, 748, 785           666, 907           45, 035, 852           0           10, 448, 845	i nstructions) 8.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	52.00 54.00 55.00 57.00 59.00 60.00 62.30 65.00
	0		28, 372, 143           1, 493, 755           18, 012, 010           10, 271, 538           27, 748, 785           666, 907           45, 035, 852           0           10, 448, 845	8.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	52.00 54.00 55.00 57.00 59.00 60.00 62.30 65.00
	0		28, 372, 143           1, 493, 755           18, 012, 010           10, 271, 538           27, 748, 785           666, 907           45, 035, 852           0           10, 448, 845	0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000	52.00 54.00 55.00 57.00 59.00 60.00 62.30 65.00
	-		1,493,755           18,012,010           2,71,538           27,748,785           666,907           45,035,852           0           10,448,845	0.000000 0.000000 0.000000 0.000000 0.000000	52.00 54.00 55.00 57.00 59.00 60.00 62.30 65.00
	-		1,493,755           18,012,010           2,71,538           27,748,785           666,907           45,035,852           0           10,448,845	0.000000 0.000000 0.000000 0.000000 0.000000	$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 00\\ 62.\ 30\\ 65.\ 00\\ \end{array}$
	0 0 0 0 0 0 0 0		18, 012, 010           10, 271, 538           27, 748, 785           666, 907           45, 035, 852           0           10, 448, 845	0.000000 0.000000 0.000000 0.000000 0.000000	54.00 55.00 57.00 59.00 60.00 62.30 65.00
	0 0 0 0 0 0 0	( ( ( ( (	10, 271, 538           27, 748, 785           666, 907           45, 035, 852           0           10, 448, 845	0.000000 0.000000 0.000000 0.000000 0.000000	55.00 57.00 59.00 60.00 62.30 65.00
	0 0 0 0 0 0 0	( ( ( (	27, 748, 785           666, 907           45, 035, 852           0           10, 448, 845	0. 000000 0. 000000 0. 000000 0. 000000 0. 000000	57.00 59.00 60.00 62.30 65.00
	0 0 0 0 0 0	(	666, 907           45, 035, 852           0           10, 448, 845	0. 000000 0. 000000 0. 000000 0. 000000	59.00 60.00 62.30 65.00
	0 0 0 0	(	0 45, 035, 852 0 0 10, 448, 845	0. 000000 0. 000000 0. 000000	60.00 62.30 65.00
0 0 0	0 0 0 0	(	0 0 10, 448, 845	0. 000000 0. 000000	62. 30 65. 00
0	0 0		10, 448, 845	0.000000	65.00
0	0	(			
0	U				
	0		445, 346		66.00
0	0				66.00
0	0	(	3, 362, 726 104, 064		66.02
0	0	(	785, 823		67.00
0	0	(	202, 230		68.00
0	0	(	0 202, 230	0.000000	71.00
0	0	(	2, 774, 533		72.00
0	0		17, 447, 818		72.00
0	0		751, 388		76.97
0	0		825, 268		76.98
0	0		023,200		76.99
	<u> </u>		5 0	0.000000	/0. //
0	0	(		0,00000	90. 01
0					90.02
0	0		0		90.02
0	0				90.04
	0				91.00
())	0				92.00
0				0.00000	
				0 0 0 0 0 0 0 0 0 0 0 0 727, 492 0 0 0 0 2, 502, 964	0         0

Heal th Financial Systems     ST. JOSEPHS REG MED CENTER PLYMOUTH     In Lieu of Form CMS-2552-       APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS     Provider CCN: 15-0076     Period: From 07/01/2020 To 06/30/2021 12: 37 p     Part IV Date/Time Prepared 11/30/2021 12: 37 p
Title XIX Hospital PPS
Cost Center Description Outpatient Inpatient Inpatient Outpatient Outpatient Outpatient
Ratio of Cost Program Program Program Program
to Charges Charges Pass-Through Charges Pass-Through
(col. 6 ÷ col.)         Costs (col. 8         Costs (col. 9
7) x col 10 x col 12)
9.00 10.00 11.00 12.00 13.00
ANCI LLARY SERVI CE COST CENTERS
50.00         OPERATING ROOM         0.000000         959, 555         0         0         0         50.00           52.00         D5200         DELLVERY ROOM & LABOR ROOM         0.000000         0
54.00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         242, 975         0         0         54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 1, 362 0 0 55. 0
57. 00 05700 CT SCAN 0. 000000 477, 563 0 0 57. 0
59. 00 05900 (CARDI AC CATHETERI ZATI ON 0.000000 3, 440 0 0 0 59. 0
60.00         06000         LABORATORY         0.000000         889, 921         0         <
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0. 000000 0 0 0 0 62. 3
65. 00 06500 RESPI RATORY THERAPY 0. 000000 275, 536 0 0 0 65. 0
65. 01 06501 SLEEP LAB 0. 000000 0 0 0 65. 0
66. 00         06600         PHYSI CAL         THERAPY         0.000000         20, 142         0         0         0         66. 0
66. 01 06601 PHYSI CAL THERAPY - LIFEPLEX 0. 000000 0 0 0 66. 0
66. 02 06602 PHYSI CAL THERAPY - CULVER MI LI TARY 0. 000000 0 0 0 66. 0
67. 00 06700 OCCUPATIONAL THERAPY 0. 000000 4, 945 0 0 0 67. 0
68. 00         06800         SPEECH         PATHOLOGY         0.000000         2, 400         0         0         68. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 000000 0 0 0 71. 0
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 000000 0 0 0 72. 0
73. 00         O7300         DRUGS         CHARGED         TO         PATI ENTS         0. 000000         503, 982         0         0         0         73. 0
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 0 0 0 76. 9
76. 98         07698         HYPERBARI C 0XYGEN THERAPY         0. 000000         0         0         0         0         76. 9
76. 99         O7699         LI THOTRI PSY         O. 000000         O <tho< th="">         O</tho<>
OUTPATIENT SERVICE COST CENTERS
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR 0. 000000 0 0 0 0 90. 0
90. 02 09002 ATHLETI C TRAI NERS 0. 000000 0 0 0 0 90. 0
90. 03 09003 SAINT JOSEPH HEALTH CENTER 0. 000000 0 0 0 90. 0
90. 04 09004 WOUND CARE 0. 000000 11, 774 0 0 0 90. 0
91.00 09100 EMERGENCY 0.000000 419,404 0 0 0 91.0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 000000 0 0 0 0 92. 0
200.00   Total (lines 50 through 199)   3,812,999 0 0 0 0200.0

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021 Hospital	Worksheet D-1 Date/Time Pre 11/30/2021 12 PPS	pared:
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00 2.00 3.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed day do not complete this line.	-bed and newborn days)	ivate room days,	5, 345 5, 345 0	1.00 2.00 3.00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation I Total swing-bed SNF type inpatient days (including private ro reporting period		er 31 of the cost	4, 120 0	4.00 5.00
6.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private ro reporting period	om days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	8. 0
9.00	Total inpatient days including private room days applicable in newborn days) (see instructions)	to the Program (excluding	g swing-bed and	1, 405	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		oom days)	0	10. 0
11.00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year, o	only (including private r	room days) after	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or X through December 31 of the cost reporting period		e room days)	0	12.0
13.00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13.0
	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	ces through December 31 d	of the cost	0.00	17.0
18.00	reporting period Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18.0
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19. 0
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	he cost	0.00	20. 0
21. 00 22. 00	reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		ing period (line	6, 483, 680 0	21. 0 22. 0
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	ng period (line 6	0	23. 0
24.00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	er 31 of the cost reporti	ng period (line	0	24.0
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 0
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 6, 483, 680	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28. 0
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 0 30. 0
31.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0. 000000 0. 00	31. 0 32. 0
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.0
	Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l		ctions)	0.00 0.00	
36.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost		fferential (line	0 6, 483, 680	36. 0
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			.,,	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				
	Adjusted general inpatient routine service cost per diem (ser Program general inpatient routine service cost (line 9 x line			1, 213. 04 1, 704, 321	38. 0 39. 0
	Medically necessary private room cost applicable to the Prog			1, 704, 321	39.0 40.0
41.00	Total Program general inpatient routine service cost (line 3	9 + line 40)		1, 704, 321	41.0

	ST.	JOSEPHS	REG	MED	CENTER	PLYMOUTH
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		JOSEPHS REG ME				eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		eri od:	Worksheet D-1	
					rom 07/01/2020 o 06/30/2021		pared:
						11/30/2021 12	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		Inpatrent Cost	Inpatrent Days	Diem (col. 1 ÷ col. 2)		(COL 3 X COL. 4)	
		1.00	2.00	3.00	4.00	5.00	<u> </u>
42.00	NURSERY (title V & XIX only)	0	C	0.00			42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2, 356, 743	1, 220	1, 931. 76	447	863, 497	
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	c c	0.00		0	45.00
46.00 47.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	0		0.00	0	0	46.00
47.00	Cost Center Description		<u> </u>				47.00
	·····					1.00	
	Program inpatient ancillary service cost (Wk					2, 426, 459	
49.00	Total Program inpatient costs (sum of lines	41 through 48)(	(see instructio	ons)		4, 994, 277	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	convious (from	Wkat D cum	of Dorte L and	268, 975	50.00
50.00			Services (IIO	I WKSL. D, SUII	UI PAILS I ANU	200, 975	50.00
51.00	Pass through costs applicable to Program ing	atient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	140, 557	51.00
	and IV)		5				
52.00	Total Program excludable cost (sum of lines					409, 532	
53.00	Total Program inpatient operating cost exclu		elated, non-phy	vsician anesthe	tist, and	4, 584, 745	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	ine 56 minus l	ine 53)	0	57.00
58.00	Bonus payment (see instructions)					0	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	updated and com	pounded by the	0.00	59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport ur	adatod by the m	arkat backat		0.00	60.00
61.00	If line 53/54 is less than the lower of line				he amount by	0.00	
01.00	which operating costs (line 53) are less that						01.00
	amount (line 56), otherwise enter zero (see				5		
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doc	ombor 21 of the	cost roportin	a pariod (Soo	0	64.00
04.00	instructions) (title XVIII only)	tis through beet			g period (see	0	04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the c	ost reporting	period (See	0	65.00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routir	e costs through	December 31 c	of the cost ren	orting period	0	67.00
07.00	(line 12 x line 19)	le costs through	i beceniber 51 c	in the cost rep	or tring period	0	07.00
68.00	Title V or XIX swing-bed NF inpatient routir	e costs after [	December 31 of	the cost repor	ting period	0	68.00
	(line 13 x line 20)						
69.00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service of	3					71.00
72.00	Program routine service cost (line 9 x line			,			72.00
73.00	Medically necessary private room cost applic						73.00
74.00	Total Program general inpatient routine serv	•					74.00
75.00	Capital-related cost allocated to inpatient	routine service	e costs (from V	iorksheet B, Pa	rt II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76.00
77.00	Program capital -related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minu						78.0
79.00	Aggregate charges to beneficiaries for exces		provider record	ls)			79.00
80.00	Total Program routine service costs for comp		cost limitation	n (line 78 minu	s line 79)		80.0
81.00	Inpatient routine service cost per diem limi						81.0
82.00	Inpatient routine service cost limitation (I						82.00
83.00	Reasonable inpatient routine service costs (		15)				83.00
01 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84.00 85.00
84.00 85.00	physician compensation						86.00
84.00 85.00 86.00	Total Program inpatient operating costs (sun						
85.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS						
85.00 86.00 87.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions	S THROUGH COST				1, 225	
85.00 86.00 87.00 88.00	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST ;) diem (line 27 +	÷line 2)			1, 225 1, 213. 04 1, 485, 974	88.00

Health Financial Systems ST.	JOSEPHS REG MEI	CENTER PLYMOU	ITH	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1	
				Fo 06/30/2021	Date/Time Pre 11/30/2021 12	pared: :37 pm
	_	Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	793, 465	6, 483, 680	0. 12237	9 1, 485, 974	181, 852	90.00
91.00 Nursing School cost	0	6, 483, 680	0.00000	1, 485, 974	0	91.00
92.00 Allied health cost	0	6, 483, 680	0.00000	1, 485, 974	0	92.00
93.00 All other Medical Education	0	6, 483, 680	0.00000	1, 485, 974	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0076	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre 11/30/2021 12	pared:
	Cost Center Description	Title XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00 2.00 3.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	bed and newborn days)	ivate room days,	5, 345 5, 345 0	2.00
4.00 5.00	do not complete this line. Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	4, 120 0	
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	8. 00
9.00	Total inpatient days including private room days applicable t newborn days) (see instructions)	the Program (excluding	swing-bed and	102	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct	tions)	5 /		10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	•	-	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		5 /		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 y Medically necessary private room days applicable to the Progr	vear, enter O on this lir	ie)	0	13.00 14.00
14.00	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)		14.00
16.00	Nursery days (title V or XIX only)				16.00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to servic construct an applied	es after December 31 of	the cost	0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	he cost	0.00	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)		ing period (line	6, 483, 680 0	21. 00 22. 00
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	er 31 of the cost reporti	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		0 6, 483, 680	1
28. 00 29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed ch	arges)	0	28.00 29.00
30.00	Semi -pri vate room charges (excl udi ng swi ng-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00 34.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33) (see instruc	tions)	0.00 0.00	
35.00	Average per diem private room cost differential (line 34 x li			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	<i>,</i>		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	6, 483, 680	1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see			1, 213. 04	
39.00	Program general inpatient routine service cost (line 9 x line			123, 730	
40.00	Medically necessary private room cost applicable to the Progr	•		122 720	1
4 I. UU	Total Program general inpatient routine service cost (line 39	+ 11 ne 40)		123, 730	41.00

COMPUTATI		JUSEPHS REG MEL				U OT FORM CMS-2	
	ON OF INPATIENT OPERATING COST		Provider C		eriod: rom 07/01/2020	Worksheet D-1	
						Date/Time Pre	pare
						11/30/2021 12	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days			(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4.00	4) 5.00	<u> </u>
2.00 NUF	RSERY (title V & XIX only)	581, 418					42.
Lnt	ensive Care Type Inpatient Hospital Units		+52	1, 343.00	105	217, 370	72.
	TENSI VE CARE UNI T	2, 356, 743	1, 220	1, 931. 76	0	0	43.
	RONARY CARE UNIT	_,,	.,			_	44.
	RN INTENSIVE CARE UNIT						45.
6. 00 SUF	RGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.
7. 00 OTH	HER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
						1.00	
	ogram inpatient ancillary service cost (W					786, 637	
	tal Program inpatient costs (sum of lines	41 through 48)(	<u>see instructio</u>	ns)		1, 129, 745	49.
	S THROUGH COST ADJUSTMENTS					17.0//	
	ss through costs applicable to Program inp	batient routine	services (from	WKST. D, SUM	of Parts I and	17, 266	50.
 1.00  Pas	⊧) ss through costs applicable to Program inp	pationt ancillar	w sorvicos (fr	om What D au	m of Parts II	52, 074	51.
	d IV)		y services (II	UNI WKSL. D, SU	I UI Parts II	52,074	51.
	tal Program excludable cost (sum of lines	50 and 51)				69, 340	52.
	tal Program inpatient operating cost exclu		lated non-phy	sician anesthe	tist and	1, 060, 405	
	dical education costs (line 49 minus line		in a coa, non phy		trot, and	1,000,100	00.
	RGET AMOUNT AND LIMIT COMPUTATION						
1.00 Pro	ogram discharges					0	54.
5.00 Tar	rget amount per discharge					0.00	55.
. 00 Tar	rget amount (line 54 x line 55)					0	56
	fference between adjusted inpatient operat	ting cost and ta	rget amount (I	ine 56 minus l	ine 53)	0	
	nus payment (see instructions)					0	
	sser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, u	pdated and com	pounded by the	0.00	59.
	rket basket						
	sser of lines 53/54 or 55 from prior year					0.00	
	line 53/54 is less than the lower of line					0	61.
	ch operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	the target		
	bunt (line 56), otherwise enter zero (see	Instructions)				0	10
	lief payment (see instructions)	mont (coo instru	(ations)			0	
	owable Inpatient cost plus incentive paym DGRAM INPATIENT ROUTINE SWING BED COST					0	03.
	dicare swing-bed SNF inpatient routine cos	ste through Doco	mbor 21 of the	cost roportin	a poriod (Soo	0	64.
	structions) (title XVIII only)	sts through bece		cost reporting	j period (See	0	04.
	dicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the c	ost reporting	neriod (See	0	65.
	structions)(title XVIII only)			ost reporting		Ű	00.
	tal Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	onlv). For	0	66.
	+ (see instructions)				5,		1 00.
	tle V or XIX swing-bed NF inpatient routir	o costs through				0	00.
7.00   Ti †	ne 12 x line 19)	ie costs thi ough	December 31 d	f the cost rep	orting period	0	
		le costs through	December 31 c	of the cost rep	orting period		
(l i	tle V or XIX swing-bed NF inpatient routir	0			0.1		67.
3.00 (1 i (1 i (1 i	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20)	ne costs after D	ecember 31 of	the cost repor	0.1	0	67. 68.
(1 i 3. 00 Ti † (1 i 9. 00 To†	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient	ne costs after D routine costs (	ecember 31 of line 67 + line	the cost repor	0.1	0	67. 68.
(1 i 3. 00 Ti 1 (1 i 9. 00 To 1 PAR	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT III - SKILLED NURSING FACILITY, OTHER N	ne costs after D routine costs ( JURSING FACILITY	ecember 31 of line 67 + line , AND ICF/IID	the cost repor 68) ONLY	0.1	0	67. 68. 69.
(1 i . 00 Ti † (1 i . 00 To† PAR . 00 Ski	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT III - SKILLED NURSING FACILITY, OTHER N Iled nursing facility/other nursing facil	ne costs after D routine costs ( IURSING FACILITY ity/ICF/IID rou	ecember 31 of line 67 + line , AND ICF/IID tine service c	the cost repor 68) ONLY cost (line 37)	0.1	0	67. 68. 69. 70.
(1 i . 00 Ti (1 i . 00 To PAR . 00 Ski . 00 Adj	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient TIII - SKILLED NURSING FACILITY, OTHER N Iled nursing facility/other nursing facil usted general inpatient routine service of	ne costs after D routine costs ( IURSING FACILITY ity/ICF/IID rou cost per diem (I	ecember 31 of line 67 + line , AND ICF/IID tine service c	the cost repor 68) ONLY cost (line 37)	0.1	0	67 68 69 70 71
(1 i 3. 00 Ti (1 i 2. 00 To PAR 0. 00 Ski 1. 00 Adj 2. 00 Pro	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT III - SKILLED NURSING FACILITY, OTHER N lled nursing facility/other nursing facil usted general inpatient routine service co ogram routine service cost (line 9 x line	ne costs after D routine costs ( <u>JURSING FACILITY</u> ity/ICF/IID rou cost per diem (I 71)	lecember 31 of <u>line 67 + line</u> , <u>AND ICF/IID</u> tine service c ine 70 ÷ line	the cost repor e 68) ONLY cost (line 37) 2)	0.1	0	67 68 69 70 71 72
(1 i . 00 Tot . 00 Ski . 00 Adj . 00 Pro	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient TIII - SKILLED NURSING FACILITY, OTHER N Iled nursing facility/other nursing facil usted general inpatient routine service o ogram routine service cost (line 9 x line dically necessary private room cost applic	ne costs after D routine costs ( IURSING FACILITY ity/ICF/IID rou cost per diem (I 71) cable to Program	lecember 31 of <u>line 67 + line</u> <u>AND ICF/IID</u> tine service c ine 70 ÷ line u (line 14 x li	the cost repor e 68) ONLY cost (line 37) 2) ne 35)	0.	0	67. 68. 69. 70. 71. 72. 73.
(1 i . 00 Tot . 00 FAR . 00 Ski . 00 Adj . 00 Pro . 00 Meo . 00 Tot	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT III - SKILLED NURSING FACILITY, OTHER N lled nursing facility/other nursing facil usted general inpatient routine service co ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service	ne costs after D routine costs ( IURSING FACILITY ity/ICF/IID rou cost per diem (I 71) cable to Program /ice costs (line	lecember 31 of <u>AND ICF/IID</u> tine service c ine 70 ÷ line (line 14 x li 272 + line 73)	the cost repor <u>e 68)</u> ONLY cost (line 37) 2) ne 35)	ting period	0	67 68 69 70 71 72 73 74
(1 i 3. 00 Ti (1 i 0. 00 To PAR 0. 00 Ski 0. 00 Adj 2. 00 Pro 3. 00 Meo 5. 00 Cap	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT III - SKILLED NURSING FACILITY, OTHER N lled nursing facility/other nursing facil usted general inpatient routine service ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service bital-related cost allocated to inpatient	ne costs after D routine costs ( IURSING FACILITY ity/ICF/IID rou cost per diem (I 71) cable to Program /ice costs (line	lecember 31 of <u>AND ICF/IID</u> tine service c ine 70 ÷ line (line 14 x li 272 + line 73)	the cost repor <u>e 68)</u> ONLY cost (line 37) 2) ne 35)	ting period	0	67. 68. 69. 70. 71. 72. 73. 74.
(1 i 3. 00 Ti (1 i 0. 00 To 0. 00 Ski 0. 00 Ski 0. 00 Adj 0. 00 Pro 0. 00 To 0. 00 To 0. 00 Cap 2. 00 Cap	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient XTIII - SKILLED NURSING FACILITY, OTHER N lled nursing facility/other nursing facil usted general inpatient routine service ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service ital-related cost allocated to inpatient line 45)	ne costs after D routine costs ( <u>IURSING FACILITY</u> ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service	lecember 31 of <u>AND ICF/IID</u> tine service c ine 70 ÷ line (line 14 x li 272 + line 73)	the cost repor <u>e 68)</u> ONLY cost (line 37) 2) ne 35)	ting period	0	67. 68. 69. 70. 71. 72. 73. 74. 75.
(1 i . 00 Tot PAR . 00 Ski . 00 Adj . 00 Pro . 00 Meo . 00 Tot . 00 Cap . 26, . 00 Pen	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT III - SKILLED NURSING FACILITY, OTHER N lled nursing facility/other nursing facil usted general inpatient routine service ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service bital-related cost allocated to inpatient	ne costs after D routine costs ( IURSING FACILITY ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2)	lecember 31 of <u>AND ICF/IID</u> tine service c ine 70 ÷ line (line 14 x li 272 + line 73)	the cost repor <u>e 68)</u> ONLY cost (line 37) 2) ne 35)	ting period	0	67. 68. 69. 70. 71. 72. 73. 74. 75. 76.
(1 i . 00 [1 i 1 . 00 [70] PAR . 00 Ski . 00 Adj . 00 Pro . 00 Cap . 00 Cap . 00 Per . 00 Per	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT III - SKILLED NURSING FACILITY, OTHER M Iled nursing facility/other nursing facil usted general inpatient routine service of gram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service bital-related cost allocated to inpatient line 45) r diem capital-related costs (line 75 ÷ line ogram capital-related costs (line 9 x line	ne costs after D routine costs ( <u>JURSING FACILITY</u> ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76)	lecember 31 of <u>AND ICF/IID</u> tine service c ine 70 ÷ line (line 14 x li 272 + line 73)	the cost repor <u>e 68)</u> ONLY cost (line 37) 2) ne 35)	ting period	0	67 68 69 70 71 72 73 74 75 76 77
(1 i . 00 [1 i . 00 <b>Control</b> . 00 <b>Ski</b> . 00 <b>Ski</b> . 00 <b>Adj</b> . 00 <b>Control</b> . 00 <b>Control</b> . 00 <b>Control</b> . 00 <b>Control</b> . 00 <b>Prot</b> . 00 <b>Prot</b>	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT III - SKILLED NURSING FACILITY, OTHER M Used general inpatient routine service of ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service bital-related cost allocated to inpatient line 45) r diem capital-related costs (line 75 ÷ li	ne costs after D routine costs ( NURSING FACILITY ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76) us line 77)	lecember 31 of <u>AND ICF/IID</u> tine service c ine 70 ÷ line (line 14 x li 22 + line 73) costs (from W	the cost repor 668) ONLY cost (line 37) 2) ne 35) Vorksheet B, Pa	ting period	0	67 68 69 70 71 72 73 74 75 76 77 78
(1 i . 00 [1 i . 00 [2 i]] [2 i]]	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient TIII - SKILLED NURSING FACILITY, OTHER M Iled nursing facility/other nursing facil usted general inpatient routine service of ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service tal -related cost allocated to inpatient line 45) r diem capital-related costs (line 75 ÷ line optian -related costs (line 9 x line boatient routine service cost (line 74 minu	ne costs after D routine costs ( <u>NURSING FACILITY</u> ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76) us line 77) as costs (from p	Pecember 31 of line 67 + line , AND ICF/IID tine service c ine 70 ÷ line 1 (line 14 x li 2 72 + line 73) 2 costs (from W	the cost repor 668) ONLY cost (line 37) 2) ne 35) Vorksheet B, Pa	ting period	0	67 68 69 70 71 72 73 74 75 76 77 78 79
(1 i (1 i (	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient TII - SKILLED NURSING FACILITY, OTHER M Iled nursing facility/other nursing facil usted general inpatient routine service of ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service tal -related cost allocated to inpatient line 45) r diem capital-related costs (line 75 ÷ li ogram capital -related costs (line 9 x line satient routine service cost (line 74 minu gregate charges to beneficiaries for excess	ne costs after D routine costs ( IURSING FACILITY ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76) us line 77) ss costs (from p parison to the c	Pecember 31 of line 67 + line , AND ICF/IID tine service c ine 70 ÷ line 1 (line 14 x li 2 72 + line 73) 2 costs (from W	the cost repor 668) ONLY cost (line 37) 2) ne 35) Vorksheet B, Pa	ting period	0	67 68 69 70 71 72 73 74 75 76 77 78 79 80
(1 i . 00 [1 i . 00 [2 i . 0] [2 i . 0] [2 i . 0]	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT 111 - SKILLED NURSING FACILITY, OTHER M Iled nursing facility/other nursing facil usted general inpatient routine service of ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service tal -related cost allocated to inpatient line 45) r diem capital-related costs (line 75 ÷ li ogram capital -related costs (line 74 minu gregate charges to beneficiaries for exces tal Program routine service costs for comp	ne costs after D routine costs ( <u>IURSING FACILITY</u> ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76) us line 77) ss costs (from p parison to the c tation	ecember 31 of <u>Line 67 + Line</u> <u>AND ICF/IID</u> tine service c ine 70 ÷ Line (Line 14 x Li 72 + Line 73) costs (from W	the cost repor 668) ONLY cost (line 37) 2) ne 35) Vorksheet B, Pa	ting period	0	67 68 69 70 71 72 73 74 75 76 77 78 79 80 81
(1 i 3. 00 [1 i 0. 00 [2 i 0. 00 [2 i 0. 00 [3 ki 0. 00 [3 ki] 0. 00 [3 ki 0. 00 [3 ki] 0. 0	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT II - SKILLED NURSING FACILITY, OTHER M Iled nursing facility/other nursing facil usted general inpatient routine service co ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service tal -related cost allocated to inpatient line 45) r diem capital -related costs (line 75 ÷ li ogram capital -related costs (line 74 minu gregate charges to beneficiaries for exces tal Program routine service cost for compo atient routine service cost per diem limi	ne costs after D routine costs ( IURSING FACILITY ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76) us line 77) ss costs (from p parison to the c tation ine 9 x line 81	Pecember 31 of <u>line 67 + line</u> <u>AND ICF/IID</u> tine service c ine 70 ÷ line (line 14 x li 72 + line 73) costs (from W provider record ost limitation )	the cost repor 668) ONLY cost (line 37) 2) ne 35) Vorksheet B, Pa	ting period	0	67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82.
(1 i 3. 00 [1 i 2. 00 <b>Por</b> <b>PAR</b> 0. 00 Ski 1. 00 Adj 2. 00 Pro 3. 00 Mec 1. 00 To 5. 00 Cap 2. 60 Pro 3. 00 Pro 3.	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT 111 - SKILLED NURSING FACILITY, OTHER M Used general inpatient routine service of ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service oital-related cost allocated to inpatient line 45) r diem capital-related costs (line 75 ÷ li ogram capital-related costs (line 74 minu gregate charges to beneficiaries for excess tal Program routine service cost for compositient routine service cost per diem line is allower of the service cost per diem line obtainent routine service cost limitation (li	ne costs after D routine costs ( IURSING FACILITY ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76) us line 77) ss costs (from p parison to the c tation ine 9 x line 81 (see instruction	Pecember 31 of <u>line 67 + line</u> <u>AND ICF/IID</u> tine service c ine 70 ÷ line (line 14 x li 72 + line 73) costs (from W provider record ost limitation )	the cost repor 668) ONLY cost (line 37) 2) ne 35) Vorksheet B, Pa	ting period	0	67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83.
(1 i 3. 00 [1 i 2. 00 70 PAG 5. 00 Ski 1. 00 Adj 2. 00 Pro 3. 00 To 1. 00 Inp 2. 00 Inp 3. 00 Re 4. 00 Pro	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT 111 - SKILLED NURSING FACILITY, OTHER M Iled nursing facility/other nursing facil usted general inpatient routine service of gram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service oital-related cost allocated to inpatient line 45) r diem capital-related costs (line 75 ÷ line patient routine service cost (line 74 minin gregate charges to beneficiaries for excess tal Program routine service cost per diem limi patient routine service cost per diem limi patient routine service cost per diem limi	ne costs after D routine costs ( <u>IURSING FACILITY</u> ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76) us line 77) ss costs (from p parison to the c tation ine 9 x line 81 (see instructions)	Pecember 31 of <u>line 67 + line</u> <u>AND ICF/IID</u> tine service of ine 70 ÷ line (line 14 x li 272 + line 73) costs (from We provider record ost limitation ) (s)	the cost repor 668) ONLY cost (line 37) 2) ne 35) Vorksheet B, Pa	ting period	0	67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84.
(1 i 3. 00 Ti (1 i (1 i 0. 00 To PAR 0. 00 Ski 1. 00 Adj 2. 00 Pro 3. 00 Meo 4. 00 To 5. 00 Per 7. 00 Pro 3. 00 Ing 9. 00 Agg 0. 00 Ing 2. 00 Ing 3. 00 Rea 4. 00 Pro 5. 00 Rea 4. 00 Pro 5. 00 Viti	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient TII - SKILLED NURSING FACILITY, OTHER M Iled nursing facility/other nursing facil usted general inpatient routine service of ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service oital-related cost allocated to inpatient line 45) r diem capital-related costs (line 75 ÷ line optient routine service cost (line 74 minu gregate charges to beneficiaries for excess tal Program routine service costs for compo tatient routine service cost per diem line optient routine service cost limitation (l asonable inpatient routine services (see in	ne costs after D routine costs ( <u>JURSING FACILITY</u> ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76) us line 77) ss costs (from p parison to the c tation ine 9 x line 81 (see instruction structions) (see instructio	Hecember 31 of Line 67 + line , AND ICF/IID tine service c ine 70 ÷ line 1 (line 14 x li 272 + line 73) 2 costs (from W provider record ost limitation ) s) ms)	the cost repor 668) ONLY cost (line 37) 2) ne 35) Vorksheet B, Pa	ting period	0	67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85.
(1 i         3. 00       Ti         (1 i         (2 i)         (1 i)         (2 i)         (2 i)         (3 i)         (4 i)         (5 i)         (2 i)         (2 i)         (3 i)         (4 i)         (5 i)         (1 i)         (2 i)         (2 i)         (3 i)         (4 i)         (5 i)         (5 i)         (5 i)         (5 i)	the V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient TII - SKILLED NURSING FACILITY, OTHER M Iled nursing facility/other nursing facil usted general inpatient routine service of ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service of the cost allocated to inpatient line 45) r diem capital-related costs (line 75 ÷ line gragate charges to beneficiaries for excess tal Program routine service cost prior obtaient routine service cost per diem limi catient routine service cost service costs ( line 45) r diem capital-related costs (line 74 minu gregate charges to beneficiaries for excess tal Program routine service cost per diem limi catient routine service cost per diem limi catient routine service cost per diem limi catient routine service cost service costs ( limitation ( lasonable inpatient routine services (see in lization review - physician compensation	ne costs after D routine costs ( <u>IURSING FACILITY</u> ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76) us line 77) ss costs (from p parison to the c tation ine 9 x line 81 (see instructions) (see instructions) (see instruction	Hecember 31 of Line 67 + line , AND ICF/IID tine service c ine 70 ÷ line 1 (line 14 x li 272 + line 73) 2 costs (from W provider record ost limitation ) s) ms)	the cost repor 668) ONLY cost (line 37) 2) ne 35) Vorksheet B, Pa	ting period	0	67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85.
(1 i 3. 00 (1 i 9. 00 700 PAR 0. 00 Ski 1. 00 Adj 2. 00 Prc 3. 00 Cap 2. 00 Pcc 3. 00 Cap 2. 00 Pcc 3. 00 Cap 2. 00 Pcc 3. 00 Pcc 3. 00 Pcc 3. 00 Ing 9. 00 Agg 0. 00 Ing 9. 00 Agg 0. 00 Ing 7. 00 Pcc 5. 00 Uti 6. 00 Pcc 7. 00 Tcc PAR 7. 00 Tcc PAR 7. 00 Tcc PAR 7. 00 Tcc PAR 7. 00 Tcc PAR 7. 00 Tcc PAR 7. 00 Tcc	the V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT 111 - SKILLED NURSING FACILITY, OTHER M Used general inpatient routine service of ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service of tal related cost allocated to inpatient line 45) r diem capital -related costs (line 75 ÷ line opatient routine service cost (line 77 ± line patient routine service cost (line 74 minn gregate charges to beneficiaries for excess tal Program routine service cost per diem limi patient routine service cost per diem limi patient routine service cost per diem limi patient routine service cost service (see in line tal) related copersion (line 74 minn patient routine service cost service (see in lization review - physician compensation tal Program inpatient operating costs (sum RT IV - COMPUTATION OF OBSERVATION BED PAS tal observation bed days (see instructions	ne costs after D routine costs ( IURSING FACILITY ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76) us line 77) ss costs (from p oarison to the c tation ine 9 x line 81 (see instruction no flines 83 th SS THROUGH COST s)	Pecember 31 of Line 67 + line , AND ICF/IID tine service c ine 70 ÷ line 1 (line 14 x li 2 72 + line 73) 2 costs (from W provider record ost limitation ) (s) ms) rough 85)	the cost repor 668) ONLY cost (line 37) 2) ne 35) Vorksheet B, Pa	ting period	0	67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87.
(1 i 3. 00 Tot (1 i 9. 00 Tot PAR 0. 00 Ski 1. 00 Adj 2. 00 Pro 3. 00 Mec 4. 00 Tot 5. 00 Per 7. 00 Pro 3. 00 Adj 2.6, 5. 00 Per 7. 00 Tot 3. 00 Rea 4. 00 Pro 5. 00 Ing 2. 00 Ing 3. 00 Rea 4. 00 Pro 5. 00 Utot 5. 00 Utot 5. 00 Tot 5. 00 Tot 7. 00 Tot 5. 00 Adj 9. 00 Adj 9. 00 Adj 9. 00 Adj 9. 00 Adj 9. 00 Tot 9. 00 Tot	tle V or XIX swing-bed NF inpatient routin ne 13 x line 20) tal title V or XIX swing-bed NF inpatient RT 111 - SKILLED NURSING FACILITY, OTHER M Used general inpatient routine service of ogram routine service cost (line 9 x line dically necessary private room cost applic tal Program general inpatient routine service of tal related cost allocated to inpatient line 45) r diem capital-related costs (line 75 ÷ li ogram capital-related costs (line 74 minu gregate charges to beneficiaries for excess tal Program routine service cost per diem limi batient routine service cost per diem limi batient routine service cost per diem limi batient routine service cost service costs ( line 14 to the service cost service costs ( line 74 minu gregate charges to beneficiaries for excess tal Program routine service cost service costs ( line 14 to the service cost service cost service) tal relatent routine service cost service costs ( line 14 to the service cost service) tal routine service cost service cost service) tal routine service cost service cost service tal routine service cost service cost service) tal routine service cost service cost service) tal program inpatient routine services (see and tal program inpatient operating costs ( service) tal routine service cost service) tal Program inpatient operating cost service) tal program inpatient operat	ne costs after D routine costs ( IURSING FACILITY ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (line routine service ne 2) e 76) us line 77) so costs (from p parison to the c tation ine 9 x line 81 (see instructions) (see instruction nof lines 83 th SS THROUGH COST s) diem (line 27 ÷	Pecember 31 of line 67 + line , AND ICF/IID tine service c ine 70 ÷ line 1 (line 14 x li 27 + line 73) 2 costs (from W provider record ost limitation ) ps) ms) rough 85) line 2)	the cost repor 668) ONLY cost (line 37) 2) ne 35) Vorksheet B, Pa	ting period	0	67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88.

Health Financial Systems ST.	JOSEPHS REG MEI	CENTER PLYMOU	ITH	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1	
				Fo 06/30/2021	Date/Time Pre 11/30/2021 12	pared: :37 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	793, 465	6, 483, 680	0. 12237	9 1, 485, 974	181, 852	90.00
91.00 Nursing School cost	0	6, 483, 680	0.00000	1, 485, 974	0	91.00
92.00 Allied health cost	0	6, 483, 680	0.00000	1, 485, 974	0	92.00
93.00 All other Medical Education	0	6, 483, 680	0.00000	1, 485, 974	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Pre 11/30/2021 12	pared:
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			2, 681, 099		30.00
31. 00 03100 I NTENSI VE CARE UNI T			1, 865, 725		31.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
					43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 2392	4 1, 397, 766	334, 449	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 39175		4, 797	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 16144		150, 915	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 13706		2, 450	
57. 00 05700 CT SCAN		0. 01417		21, 710	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 47739			59.00
60. 00 06000 LABORATORY		0. 17722		537, 541	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	62.30
65. 00 06500 RESPI RATORY THERAPY		0. 1416		96, 834	65.00
65. 01 06501 SLEEP LAB		0. 15206		0	65.01
66. 00 06600 PHYSI CAL THERAPY		0. 53774	6 210, 817	113, 366	66.00
66. 01 06601 PHYSI CAL THERAPY - LI FEPLEX		0. 27312	.8 640	175	66. 01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILI TARY		0. 29694	2 0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY		0. 29368	86 82, 740	24, 300	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 62269	2 27, 963	17, 412	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.0000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2027		40, 569	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 30161		655, 297	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 50628		436	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 17329		0	76.98
76. 99 07699 LI THOTRI PSY		0.0000	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS		0.0000		0	00.01
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR		0.0000		0	90.01
90. 02 09002 ATHLETIC TRAINERS		0.0000		0	90. 02 90. 03
90. 03 09003 SAINT JOSEPH HEALTH CENTER 90. 04 09004 WOUND CARE		2. 02205 0. 50229		-	90.03
90. 04 09004 WOOND CARE 91. 00 09100 EMERGENCY				2, 121	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 33563 0. 81964		288, 456 124, 274	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.01902	11, 345, 864	2, 426, 459	
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		n, 545, 804	2, 420, 437	200.00
202.00 Net charges (line 200 minus line 201)			11, 345, 864		201.00
		1	11,010,004	I	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Pre 11/30/2021 12	
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			2, 425, 930		30.00
31. 00 03100 I NTENSI VE CARE UNI T			519, 761		31.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
43.00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS		0 0000		220 507	
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 23927 0. 39175		229, 597 0	50. 00 52. 00
54. 00  05200 DELIVERY ROOM & LABOR ROOM 54. 00  05400 RADI OLOGY-DI AGNOSTI C		0. 39175		39, 227	52.00 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 13706		187	54.00 55.00
57. 00   05700  CT_SCAN		0. 01417		6, 769	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 47739		1, 642	59.00
60. 00 06000 LABORATORY		0. 17722		157, 714	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0. 00000		0	62.30
65. 00 06500 RESPI RATORY THERAPY		0. 14167		39, 036	65.00
65. 01 06501 SLEEP LAB		0. 15206		0,,000	65.01
66. 00 06600 PHYSI CAL THERAPY		0. 53774		10, 831	66.00
66. 01 06601 PHYSI CAL THERAPY – LI FEPLEX		0. 27312		0	66. 01
66. 02 06602 PHYSI CAL THERAPY - CULVER MILI TARY		0. 29694	2 0	0	66. 02
67.00 06700 OCCUPATI ONAL THERAPY		0. 29368	4, 945	1, 452	67.00
68.00 06800 SPEECH PATHOLOGY		0. 62269	2, 400	1, 494	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 20271	3 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 30161		152, 009	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 50628	36 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 17329		0	76. 98
76. 99 07699 LI THOTRI PSY		0.0000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90. 01 09001 OUTPATIENT TREATMENT & INFUSION CTR		0.0000		0	90.01
90. 02 09002 ATHLETI C TRAI NERS		0.0000		0	90.02
90. 03 09003 SAINT JOSEPH HEALTH CENTER		2.02205		0	90.03
90. 04 09004 WOUND CARE		0. 50229		5, 914	90.04
91.00 09100 EMERGENCY		0. 33563		140, 765 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (sum of lines 50 through 94 and 96 throug	h 08)	0. 81964		0 786, 637	92.00
200.00 Total (sum of lines 50 through 94 and 96 throug 201.00 Less PBP Clinic Laboratory Services-Program onl			3, 812, 999		200.00 201.00
202.00 Net charges (line 200 minus line 201)	y charges (Time OT)		3, 812, 999		201.00
202.00 [Net charges (The 200 minus the 201)		I	5, 012, 777		202.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0076 Period:	u of Form CMS-2 Worksheet E	2002-10
	From 07/01/2020 To 06/30/2021	Part A Date/Time Pre	pared:
		11/30/2021 12 PPS	
	Ti tle XVIII Hospi tal	PP3	
		1.00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	4, 227, 827	1.01
1.02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	0	1.02
	instructions)	_	
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1.04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	-
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	8, 765	
2.04 3.00	Outlier payments for discharges occurring on or after October 1 (see instructions) Managed Care Simulated Payments	0 3, 593, 167	
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	41.64	
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0.00	6.00
	new programs in accordance with 42 CFR 413.79(e)		
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0.00 0.00	
7.01	cost report straddles July 1, 2011 then see instructions.	0.00	/.01
8.00	Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for	0.00	8.00
	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).		
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0.00	8.01
8.02	report straddles July 1, 2011, see instructions.	0.00	8. 02
0.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	0.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
	FTE count for residents in dental and podiatric programs.		11.00
	Current year allowable FTE (see instructions)		12.00
	Total allowable FTE count for the prior year. Total allowable FTE count for the popultimate year if that year anded on an after September 20, 1007		13.00 14.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
	Adjustment for residents in initial years of the program	0.00	16.00
	Adjustment for residents displaced by program or hospital closure		17.00
	Adjusted rolling average FTE count		18.00
19.00 20.00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)	0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	
	IME payment adjustment (see instructions)	0	
22. 01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		0.0.00
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$ .	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see	0.00	25.00
26.00	instructions) Posidont to bod ratio (divide line 25 by line 4)	0.000000	26.00
	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)	0.000000	
	IME add-on adjustment amount (see instructions)	0.000000	1
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	0	
	Total IME payment ( sum of lines 22 and 28)	0	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
30.00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.85	30.00
	Percentage of Medicaid patient days (see instructions)	3.85 18.78	
	Sum of Lines 30 and 31	22.63	
		7.88	
33.00	Allowable disproportionate share percentage (see instructions)	7.00	00.00

Heal th Financial Systems

ST.	JOSEPHS	REG	MED	CENTER	PLYMOUTH

Hear th	FINANCIAL SYSTEMS ST. JUSEPHS REG MED CENTER PLYMOUTH	In Lie	U OF FORM CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Date/Time Pre	
		llooni tol	11/30/2021 12	: 37 pm
	Title XVIII	Hospital	PPS	
		Prior to 10/1		
	Uncompared to a Adjustment	1.00	2.00	
25 00	Uncompensated Care Adjustment	0	0	25 00
35.00	Total uncompensated care amount (see instructions)	0	-	35.00
35.01	Factor 3 (see instructions)	0. 00000000		
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see	831, 827	510, 674	35.02
35. 03	instructions) Pro rata share of the hospital uncompensated care payment amount (see instructions)	209, 093	201 054	35.03
	Total uncompensated care (sum of columns 1 and 2 on line 35.03)			36.00
30.00	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 throug	591,049		30.00
40, 00	Total Medicare di scharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see	0		40.00
40.00	instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see	0		41.00
41.00	instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684	0	0	41.01
41.01	an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see	0.00		43.00
40.00	instructions)	0		+5.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7	0.000000		44.00
	days)	0100000		1.1.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4, 910, 929		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals	0		48.00
	only. (see instructions)			
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		4, 910, 929	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		318, 122	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		106, 537	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 th	rough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		5, 335, 588	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5, 335, 588	61.00
62.00	Deductibles billed to program beneficiaries		549, 216	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
	Allowable bad debts (see instructions)			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		51, 032	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8, 448	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4, 837, 404	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (se	e instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions	5)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see i	nstructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0	70. 91
70. 92	Bundled Model 1 discount amount (see instructions)		0	70. 92
70.93	HVBP payment adjustment amount (see instructions)		-24, 528	70.93
70.94	HRR adjustment amount (see instructions)		0	
70.95	Recovery of accelerated depreciation		0	70.95
			-	-

## ST. JOSEPHS REG MED CENTER PLYMOUTH

Health Financial Systems ST. JOSEPHS REG MED	CENTER PLYMOU	JIH		u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Pre	narodi
			10 00/ 30/ 2021	11/30/2021 12	:37 pm
	Title	2 XVIII	Hospi tal	PPS	
		FFA	(уууу)	Amount	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i			02020	<u>1.00</u> 681,867	70.96
the corresponding federal year for the period prior to 10/1)		-	2020	001,007	/0. /0
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			2021	51, 940	70. 97
70.98 Low Volume Payment-3				0	
70.99 HAC adjustment amount (see instructions)	(0 0 70)			0	70.99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 71.01 Sequestration adjustment (see instructions)	69 & 70)			5, 546, 683 0	71.00 71.0
71.02 Demonstration payment adjustment amount after sequestration				0	71.0
71.03 Sequestration adjustment-PARHM pass-throughs				Ū	71.0
72.00  Interim payments				5, 291, 974	
72.01 Interim payments-PARHM					72. 0 <sup>.</sup>
73.00 Tentative settlement (for contractor use only)				0	73.00
73.01 Tentative settlement-PARHM (for contractor use only)					73.01
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.0 73)	)2, 72, and			254, 709	
74.01 Balance due provider/program-PARHM (see instructions)				0/0.010	74.01
75.00 Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	ance with			368, 912	/5.00
PO.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2 03	1		0	90.00
plus 2.04 (see instructions)	01 2.00			0	/0.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
92.00 Operating outlier reconciliation adjustment amount (see instr	ructions)			0	92.0
93.00 Capital outlier reconciliation adjustment amount (see instruc				0	93.0
94.00 The rate used to calculate the time value of money (see instr	,			0.00	•
95.00 Time value of money for operating expenses (see instructions)				0	95.00
96.00  Time value of money for capital related expenses (see instruc	ctions)			0	96.00
		•	Prior to 10/1	$\Omega p / Aftor 10 / 1$	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
HSP Bonus Payment Amount		•			
100.00 HSP bonus amount (see instructions)				2.00	
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	100. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions)			0. 000000000	2.00 0 0.000000000	100. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction	ns)		1.00	2.00 0 0.000000000	100. 00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> </ul>	ns)		1.00 0 0.0000000000 0	2.00 0 0.000000000 0	100. 00 101. 00 102. 00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>103.00 HRR adjustment factor (see instructions)</li> </ul>			0. 000000000	2.00 0.000000000 0 0.0000	100. 00 101. 00 102. 00 103. 00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>103.00 HRR adjustment factor (see instructions)</li> </ul>	5)	stment	1.00 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000	100. 00 101. 00 102. 00 103. 00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> </ul>	s) cration) Adju		1.00 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000	100. 00 101. 00 102. 00 103. 00 104. 00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>105.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>105.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>106.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>107.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>108.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>109.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> </ul>	š) rration) Adju eriod under t		1.00 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000	100. 00 101. 00 102. 00 103. 00 104. 00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>105.00 HRR adjustment factor (see instructions)</li> <li>106 HRR adjustment factor (see instructions)</li> <li>107.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>108.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>109 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment factor (see instructions)</li> <li>105.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>105.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>106.00 HRR adjustment factor (see instructions)</li> <li>107.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir</li> </ul>	š) rration) Adju eriod under t		1.00 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000	100.00 101.00 102.00 103.00 104.00 200.00 201.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>105.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>106.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>107.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>108.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>109.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>109.00 Us this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>109.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 202.00 Medicare discharges (see instructions)</li> </ul>	š) rration) Adju eriod under t		1.00 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0	100.00 101.00 102.00 103.00 200.00 200.00 201.00 202.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment for HSP bonus payment (see instruction HRR Adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>105.00 HRR adjustment 200.00 Is this the first year of the current 5-year demonstration payment (see instructions)</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 202.00 Medicare discharges (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> </ul>	s) rration) Adju eriod under t ne 49)	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.000000000 0 0.0000 0	100.00 101.00 102.00 103.00 200.00 200.00 201.00 202.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment for HSP bonus payment (see instruction HRR Adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 200.00 Is this the first year of the current 5-year demonstration pro Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir 202.00 Medicare discharges (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> </ul>	s) rration) Adju eriod under t ne 49)	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.000000000 0 0.0000 0	100.00 101.00 102.00 103.00 200.00 200.00 201.00 202.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 202.00 Medicare discharges (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A in period)</li> </ul>	s) rration) Adju eriod under t ne 49)	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.000000000 0 0.0000 0	100.00 101.00 102.00 103.00 200.00 200.00 201.00 202.00 203.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>105.00 Lis this the first year of the current 5-year demonstration perform the century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>105.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 202.00 Medicare discharges (see instructions)</li> <li>103.00 Case-mix adjustment factor (see instructions)</li> <li>104.00 Computation of Demonstration Target Amount Limitation (N/A ir period)</li> <li>104.00 Medicare target amount</li> </ul>	s) rration) Adju eriod under t ne 49)	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.0000000000 0 0.0000 0	100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>105.00 Is this the first year of the current 5-year demonstration performance (see instructions)</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 202.00 Medicare discharges (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>204.00 Medicare target amount</li> <li>205.00 Case-mix adjusted target amount (line 203 times line 204)</li> </ul>	s) cration) Adju eriod under t ne 49) n first year	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.0000000000 0 0.0000 0	100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment factor (see instructions)</li> <li>105.00 Ls this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>202.00 Medicare discharges (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A in period)</li> <li>204.00 Medicare target amount</li> <li>205.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>207.00 Medicare part A Inpatient Reimbursement</li> </ul>	s) rration) Adju eriod under t ne 49) n first year	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.0000000000 0 0.0000 0	100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 203.00 204.00 205.00 206.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment for HSP bonus payment (see instruction HRR Adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>105.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>200.00 Is this the first year of the current 5-year demonstration percentary Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 202.00 Medicare discharges (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>204.00 Medicare target amount</li> <li>205.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>203.00 Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>204.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>205.00 Program reimbursement under the §410A Demonstration (see instructions)</li> </ul>	s) rration) Adju eriod under t ne 49) n first year	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.0000000000 0 0.0000 0	100.00 101.00 102.00 103.00 200.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>200.00 Is this the first year of the current 5-year demonstration payment (see inpatient service costs (from Wkst. D-1, Pt. II, Iir 202.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 202.00 Medicare discharges (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>204.00 Medicare target amount</li> <li>205.00 Case-mix adjustment factor (see instructions)</li> <li>206.00 Medicare target amount</li> <li>207.00 Program reinbursement under the §410A Demonstration (see instructions)</li> <li>207.00 Program reinbursement under the \$410A Demonstration (see instructions)</li> </ul>	s) rration) Adju eriod under t ne 49) n first year	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0 0.0000 0	100.00 101.00 102.00 103.00 200.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment (see instruction HRR adjustment for HSP Bonus payment (see instructions)</li> <li>103.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>200.00 Is this the first year of the current 5-year demonstration procentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 202.00 Medicare discharges (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>204.00 Medicare target amount</li> <li>205.00 Case-mix adjustment routine cost cap (line 203 times line 204)</li> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>207.00 Program reimbursement under the §410A Demonstration (see inst</li> <li>207.00 Program reimbursement under the §410A Demonstration (see inst</li> <li>208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,</li> <li>209.00 Adjustment to Medicare IPPS payments (see instructions)</li> </ul>	s) rration) Adju eriod under t ne 49) n first year	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 205.00 206.00 206.00 207.00 208.00 209.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 202.00 Medicare discharges (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>204.00 Medicare target amount</li> <li>205.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>207.00 Program reimbursement under the §410A Demonstration (see inst 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>209.00 Adjustment to Medicare IPPS payments (see instructions)</li> </ul>	s) rration) Adju eriod under t ne 49) n first year ) tructions) line 59)	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 206.00 207.00 208.00 209.00 209.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>105.00 Ls this the first year of the current 5-year demonstration performed century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin period)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A in period)</li> <li>204.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>207.00 Program reimbursement under the §410A Demonstration (see inst</li> <li>208.00 Medicare Part A Inpatient Reimbursement</li> <li>209.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>209.00 Reserved for future use</li> <li>201.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	s) rration) Adju eriod under t ne 49) n first year ) tructions) line 59)	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 205.00 206.00 207.00 208.00 209.00 210.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment factor (see instructions)</li> <li>105.00 HRR adjustment factor (see instructions)</li> <li>106.00 HRR adjustment factor (see instructions)</li> <li>107.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>208.00 Is this the first year of the current 5-year demonstration period)</li> <li>209.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin period)</li> <li>204.00 Medicare target amount</li> <li>205.00 Case-mix adjustment factor (see instructions)</li> <li>206.00 Medicare target amount (line 203 times line 204)</li> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>207.00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>208.00 Medicare Part A Inpatient Reimbursement</li> <li>209.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>209.00 Total adjustment to Medicare IPPS payments (see instructions)</li> <li>209.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	s) rration) Adju eriod under t ne 49) n first year h tructions) line 59)	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 211.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 202.00 Medicare discharges (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>207.00 Program reimbursement under the §410A Demonstration (see inst 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>210.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	s) rration) Adju eriod under t ne 49) n first year h tructions) line 59)	he 21st	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	100.00 101.00 102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 210.00 211.00 211.00
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment factor (see instructions)</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 202.00 Medicare discharges (see instructions)</li> <li>203.00 Case-mix adjustment factor (see instructions)</li> <li>204.00 Medicare target amount</li> <li>205.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>207.00 Program reimbursement under the §410A Demonstration (see inst 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>209.00 Reserved for future use</li> <li>211.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	s) rration) Adju eriod under t ne 49) n first year tructions) line 59) 211)	of the currer	1.00 0.000000000 0.0000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	100. 00 101. 00 102. 00

Heal	th	Fina	nci al	System	ns
LOW	VO	LUME	CALCU	LATION	<b>EXHIBIT</b>

## ST. JOSEPHS REG MED CENTER PLYMOUTH

LOW VO	LUME CALCULATION EXHIBIT 4			Provider CC	F	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Exhibi Date/Time Pre	pared:
				Title	XVIII	Hospi tal	11/30/2021 12 PPS	: 37 pm
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
1 00	DDC amounts at here there suit is a	0	1.00	2.00	3.00	4.00	5.00	1.00
1.00	DRG amounts other than outlier payments	1.00	0	0	C	0 0	0	1.00
1.01	DRG amounts other than outlier payments for discharges	1.01	4, 227, 827	0	4, 227, 827	,	4, 227, 827	1. 01
1.02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	0	0		0	0	1. 02
1.03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	O	0	C		0	1.03
1.04	October 1 DRG for Federal specific operating payment for Model 4	1. 04	0	0		0	0	1. 04
2.00	BPCI occurring on or after October 1 Outlier payments for	2.00						2.00
	discharges (see instructions) Outlier payments for	2. 02	0	0	С	0	0	
2.02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2.03	8, 765	0	8, 765		8, 765	2. 02
2.03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2.04	0	0		0	0	2. 03
3.00	instructions) Operating outlier	2. 01	0	0	C	0 0	0	3.00
4.00	reconciliation Managed care simulated payments	3.00	3, 593, 167	0	3, 593, 167	0	3, 593, 167	4.00
	Indirect Medical Education Adju	ustment						
	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0.00000	0. 000000		5.00
	IME payment adjustment (see instructions) IME payment adjustment for	22. 00 22. 01	0	0	C	0	0	6. 00 6. 01
	managed care (see instructions)							
	Indirect Medical Education Adju IME payment adjustment factor	27.00	0. 000000	0.000000		0. 000000		7.00
	(see instructions) IME adjustment (see	28.00	0	0.000000	0.000000	0	0	
8.01	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	C	0 0	0	8. 01
	instructions) Total IME payment (sum of	29.00	0	0	C	0 0	0	9.00
9. 01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	С	0 0	0	9. 01
	8.01) Disproportionate Share Adjustme	nt						-
	Allowable disproportionate share percentage (see	33.00	0. 0788	0. 0788	0. 0788	. 0788		10.00
11. 00	instructions) Disproportionate share adjustment (see instructions)	34.00	83, 288	0	83, 288	B 0	83, 288	11.00
	Uncompensated care payments	36.00	591, 049	0	209, 093	381, 956	591, 049	11.01
	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	D beneficiary 0	di scharges 0	C	0 0	0	12.00
	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	4, 910, 929 0	0 0	4, 528, 973 C	381, 956 0 0	4, 910, 929 0	
15.00	(see instructions) Total payment for inpatient operating costs (see	49.00	4, 910, 929	0	4, 528, 973	381, 956	4, 910, 929	15.00
	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	318, 122	0	318, 122	2 0	318, 122	16. 00

LOW VO	LUME CALCULATION EXHIBIT 4			Provider C	CN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Exhibi Date/Time Pre 11/30/2021 12	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
17 00	Casal al add an assumenta from	0	1.00	2.00	3.00	4.00	5.00	17.00
17.00	Special add-on payments for new technologies	54.00	106, 537	0	106, 53	0	106, 537	17.00
17.01	Net organ aquisition cost							17.01
	Credits received from	68.00	0	0		0 0	0	•
	manufacturers for replaced	00100	0	0		0	0	
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	0	0		0 0	0	18.00
	adjustment amount (see							
	instructions)			_				
19.00	SUBTOTAL	W (C		0	4, 953, 63	2 381, 956	5, 335, 588	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4,00	5.00	
20.00	Capital DRG other than outlier	1.00	316, 088	0			316,088	20.00
	Model 4 BPCI Capital DRG other	1.01	0	0		0 0	0	
	than outlier							
21.00	Capital DRG outlier payments	2.00	2, 034	0	2, 03	4 0	2,034	21.00
21. 01	Model 4 BPCI Capital DRG	2.01	0	0		0 0	0	21.01
	outlier payments					_		
22.00	Indirect medical education	5.00	0. 0000	0.0000	0.000	0.0000		22.00
23.00	percentage (see instructions) Indirect medical education	6.00	0	0		0 0	0	23.00
23.00	adjustment (see instructions)	0.00	0	0		0 0	0	23.00
24.00	Al I owabl e di sproporti onate	10.00	0, 0000	0.0000	0.000	0.0000		24.00
	share percentage (see							
	instructions)							
25.00	Disproportionate share	11.00	0	0		0 0	0	25.00
	adjustment (see instructions)							
26.00	Total prospective capital	12.00	318, 122	0	318, 12	2 0	318, 122	26.00
	payments (see instructions)	W/S E, Part A	(Amounto to E					
		line	Part A)					
		0	1.00	2.00	3.00	4,00	5.00	
27.00	Low volume adjustment factor		1100	2.00	0, 13765		0100	27.00
28.00	Low volume adjustment	70.96			681, 86	7	681, 867	28.00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29. 00	Low volume adjustment	70.97				51, 940	51, 940	29.00
	(transfer amount to Wkst. E,							
100 00	Pt. A, line)		N/					100.00
100.00	Transfer low volume		Y		1			100.00

		A, Line	WKST. E, PT. A)	10/01	after 10/01	and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	1.00	2.00	0.00	1.00	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4, 227, 827	4, 227, 827		4, 227, 827	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0	0		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2. 01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	8, 765	8, 765		8, 765	2. 02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	3, 593, 167	3, 593, 167	0	3, 593, 167	4.00
F 00	Indirect Medical Education Adjustment	01.00	0.000000	0.000000	0.000000		F 00
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see	22.00	0	0	0	0	6. 01
0.01	instructions)	22101	0	Ū	0		0.01
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor (see	27.00	0. 000000	0. 000000	0.00000		7.00
	instructions)						
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed	28.01	0	0	0	0	8. 01
9.00	care (see instructions) Total IME payment (sum of lines 6 and 8)	29.00		0	0	0	9.00
9.00 9.01	Total IME payment for managed care (sum of	29.00	0	0	0	0	9.00
9.01	lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment		I	<u> </u>	1		
10.00		33.00	0. 0788	0. 0788	0. 0788		10. 00
11.00	Disproportionate share adjustment (see instructions)	34.00	83, 288	83, 288	0	83, 288	11.00
11.01	Uncompensated care payments	36.00	591, 049	209, 093	381, 956	591, 049	11.01
	Additional payment for high percentage of ESF						10
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4, 910, 929	4, 528, 973	381, 956	4, 910, 929	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	· · · · · · · · · · · · · · · · · · ·	49.00	4, 910, 929	4, 528, 973	381, 956	4, 910, 929	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	318, 122	318, 122	0	318, 122	16.00
17.00	Special add-on payments for new technologies	54.00	106, 537	106, 537	0	106, 537	
17.01 17.02		60 00	0	0	0	0	17. 01 17. 02
17.02	replaced devices for applicable MS-DRGs	68.00		0	U	0	17.02
18.00	Capital outlier reconciliation adjustment	93.00	0	0	о	0	18.00
19.00	amount (see instructions) SUBTOTAL			4, 953, 632	381, 956	5, 335, 588	19.00

20. 01         Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments         1.01         0         0         0         20.01           21. 00         Capital DRG outlier payments         2.00         2.034         0         2.034         0         2.034         21.00           21. 01         Model 4 BPCI Capital DRG outlier payments         2.00         2.00         0         0         0         0         0         0         2.034         21.00         0         0         0         0         2.00         2.034         0         0         0         0         0         0         2.034         21.00         0         0         0         0         0         2.00         2.00         11.01         0         0         0         0         0         0         0         22.00         23.00         10.00         0.0000         0.0000         0.0000         0         0         25.00         10.00         0         0         0         0         0         0         25.00         11.00         0         0         0         0         25.00         13.8,122         318,122         0         318,122         26.00         27.00         28.00         1.00         2.00	Health Financial Systems ST. HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	JOSEPHS REG MEI TION EXHIBIT 5	Provider CC	CN: 15-0076	Period: From 07/01/2020 To 06/30/2021	u of Form CMS-: Worksheet E Part A Exhibi Date/Time Pre 11/30/2021 12	t 5 pared:
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$			Title	XVIII	Hospi tal	PPS	
0         1.00         2.00         3.00         4.00           20.00         Capital DRG other than outlier         1.00         316,088         0         316,088         0         0         0         20.01           20.01         Model 4 BPCI Capital DRG other than outlier         1.01         0         0         0         0         0         0         20.01           21.01         Model 4 BPCI Capital DRG outlier payments         2.00         2.034         2.034         0         2.034         2.034         0         2.034         21.01           22.00         Indirect medical education percentage (see instructions)         5.00         0.0000         0         0         0         0         22.00           23.00         Indirect medical education adjustment (see instructions)         6.00         0         0         0         0         0         22.00         23.00           26.00         Topoportionate share adjustment (see instructions)         11.00         0         0         0         0         27.00         28.00         Low volume adjustment prior to 0.ctober 1         70.96         681,867         681,867         681,867         51,940         51,940         51,940         51,940         51,940         51,940 <t< td=""><td></td><td>Wkst. L, line</td><td></td><td></td><td></td><td></td><td></td></t<>		Wkst. L, line					
20.00         Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier 1.00         1.00         316,088         316,088         0         316,088         0		0		2,00	3,00	4,00	
20. 01         Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments         1.01         0         0         0         20.01           21. 00         Capital DRG outlier payments         2.00         2.034         0         2.034         0         2.034         21.00           21. 01         Model 4 BPCI Capital DRG outlier payments         2.00         2.00         0         0         0         0         0         0         2.034         21.00         0         0         0         0         2.00         2.034         0         0         0         0         0         0         2.034         21.00         0         0         0         0         0         2.00         2.00         11.01         0         0         0         0         0         0         0         22.00         23.00         10.00         0.0000         0.0000         0.0000         0         0         25.00         10.00         0         0         0         0         0         0         25.00         11.00         0         0         0         0         25.00         13.8,122         318,122         0         318,122         26.00         27.00         28.00         1.00         2.00	20.00 Capital DRG other than outlier	1.00	316, 088		8 0	316, 088	20.00
21.00       Capital DRG outilier payments Model 4 BPCI Capital DRG outilier payments 22.00       2.00       2.034       2.034       0       2.034       2.034       0       2.034       21.01         22.00       Indirect medical education percentage (see instructions)       0       0       0       0       0       0       0       0       0       22.01         23.00       Indirect medical education adjustment (see instructions)       6.00       0       0       0       0       0       0       0       0       23.00       23.00       24.00       All lowable disproportionate share percentage (see instructions)       0       0       0       0       0       0       0       0       0       23.00       25.00       25.00       21.01       24.00       21.01       25.00       25.00       25.00       25.00       21.01       20.01       20.01       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       21.01       27.00       27.00       20.01       21.01       27.00       21.01       27.00       20.00       3.00       4.00       27.02       27.00       20.00       3.00       4.00       27.02       27.01       20.00       20.01       3.00		1.01	0		0 0		
21.01       Model 4 BPCI Capital DRG outlier payments instructions)       2.01       0       0       0       0       0       21.01         22.00       Indirect medical education percentage (see instructions)       5.00       0.0000       0.0000       0.0000       22.00         23.00       Indirect medical education adjustment (see instructions)       6.00       0       0       0       0       23.00         24.00       Allowable disproportionate share percentage (see instructions)       10.00       0.0000       0.0000       0.0000       24.00         25.00       Disproportionate share adjustment (see instructions)       11.00       0       0       0       0       0       25.00         26.00       Total prospective capital payments (see       12.00       318,122       318,122       0       318,122       26.00         27.00       28.00       Low volume adjustment prior to October 1       70.96       681,867       681,867       51,940       27.00         29.00       Low volume adjustment for HSP bonus payment (see instructions)       70.96       681,867       681,867       51,940       21.00       30.01       27.00         30.01       HWBP payment adjustment for HSP bonus payment (see instructions)       70.97       51,940       51,940			2.034	2. 03	4 0		
22.00         Indirect medical education percentage (see instructions)         5.00         0.0000         0.0000         0.0000         22.00           23.00         Indirect medical education adjustment (see instructions)         6.00         0         0         0         0         0         0         0         23.00         23.00         23.00         23.00         23.00         23.00         23.00         24.00         23.00         24.00         25.00         0.0000         0.0000         0.0000         24.00         25.00         26.00         20.00			0	_/	0 0		
23.00       instructions)       indirect medical education adjustment (see instructions)       6.00       0       0       0       0       23.00         24.00       Allowable disproportionate share percentage (see instructions)       10.00       0.0000       0.0000       0.0000       24.00         25.00       Disproportionate share adjustment (see instructions)       11.00       0       0       0       0       25.00         26.00       Total prospective capital payments (see instructions)       12.00       318,122       318,122       0       318,122       26.00         27.00       28.00       Low volume adjustment prior to October 1       0       1.00       2.00       3.00       4.00       28.00         27.00       Low volume adjustment prior to October 1       70.96       681,867       681,867       681,867       28.00         29.00       Low volume adjustment for HSP bonus       70.97       51.940       51.940       51.940       51.940       51.940       28.00         30.01       HVBP payment adjustment for HSP bonus       70.94       0       0       0       0       0       0       0       0       0       0       31.01         11.00       HR adjustment for HSP bonus payment (see       70.94			0 0000	0,000	0,000	Ū	
23.00       Indirect medical education adjustment (see instructions)       6.00       0       0       0       0       23.00       24.00       24.00       24.00       24.00       24.00       0       0.0000       0.0000       0.0000       0.0000       24.00       24.00         25.00       Disproportionate share adjustment (see instructions)       11.00       0       0       0       0       0       25.00         26.00       Total prospective capital payments (see instructions)       12.00       318,122       318,122       0       318,122       26.00         27.00       Low volume adjustment prior to 0ctober 1       70.96       681,867       681,867       681,867       681,867       681,867       28.00       28.00       29.00       29.00       20.00       30.00       4.00       29.00       20.00       30.00       24.00       30.00       4.00       28.00       20.00 <t< td=""><td></td><td>0.00</td><td>010000</td><td>01000</td><td>0.0000</td><td></td><td>22.00</td></t<>		0.00	010000	01000	0.0000		22.00
24.00       Allowable disproportionate share percentage (see instructions)       10.00       0.0000       0.0000       0.0000       24.00         25.00       Disproportionate share adjustment (see instructions)       11.00       0       0       0       0       25.00         26.00       Total prospective capital payments (see instructions)       12.00       318,122       318,122       0       318,122       26.00         27.00       Vector of the adjustment prior to 0 ctober 1       A line       (Ant. from Wkst. E, Pt. A)       0       4.00       27.00         28.00       Low volume adjustment prior to 0 ctober 1       70.96       681,867       681,867       681,867       28.00         29.00       Low volume adjustment (see instructions)       70.97       51,940       51,940       51,940       51,940       51,940       51,940       30.01       29.00       0 </td <td>23.00 Indirect medical education adjustment (see</td> <td>6.00</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>23.00</td>	23.00 Indirect medical education adjustment (see	6.00	0		0 0	0	23.00
25.00       [see instructions]       11.00       0       0       0       25.00         26.00       Total prospective capital payments (see instructions)       12.00       318,122       318,122       0       318,122       26.00         26.00       Total prospective capital payments (see instructions)       12.00       318,122       318,122       0       318,122       26.00         27.00							
25.00         Disproportionate share adjustment (see instructions) Total prospective capital payments (see         11.00         0         0         0         0         25.00           26.00         Total prospective capital payments (see instructions)         12.00         318,122         318,122         0         318,122         26.00           27.00         Wkst. E, Pt. A, line         (Amt. from Wkst. E, Pt. A)         0         1.00         2.00         3.00         4.00         27.00           28.00         Low volume adjustment prior to October 1         70.96         681,867         681,867         681,867         28.00         28.00         51,940         51,940         28.00         29.00         29.00         10.00         0         0         0         0         0         0         0         0         0         29.00         20.00         20.00         20.00         20.01         20.01         20.01         20.01         20.01		10.00	0.0000	0.000	0.0000		24.00
26.00         instructions) Total prospective capital payments (see instructions)         12.00         318,122         318,122         0         318,122         26.00           27.00         27.00         27.00         20.00         3.00         4.00         27.00         28.00         4.00         28.00         4.00         28.00         28.00         28.00         28.00         28.00         28.00         28.00         28.00         29.00         24.528         -24.528         0         -24.528         30.00         28.00         30.01         HVBP payment adjustment for HSP bonus         70.90         0         0         0         0         31.00         31.00         31.00         31.00         31.00         31.01							
26.00         Total prospective capital payments (see instructions)         12.00         318,122         318,122         0         318,122         26.00           27.00         wkst. E, Pt. A)         (Amt. from wkst. E, Pt. A)         (Amt. from wkst. E, Pt. A)         27.00         27.00         27.00         27.00         27.00         27.00         27.00         27.00         28.00         27.00         20.00         3.00         4.00         27.00         28.00         27.00         28.00         27.00         28.00         27.00         28.00         27.00         28.00         27.00         28.00         27.00         28.00         28.00         27.00         28.00         27.00         28.00         28.00         27.00         28.00         29.00         29.00         3.00         4.00         29.00         <		11.00	0		0 0	0	25.00
instructions)         Instructions         West for a construction         (Amt. from Wkst. E, Pt. A)         (Amt. from Wkst. E, Pt. A)         200 <td></td> <td>10.00</td> <td></td> <td></td> <td></td> <td></td> <td></td>		10.00					
Wkst. E, Pt. A, line         (Amt. from Wkst. E, Pt. A)           27.00         28.00         Low volume adjustment prior to October 1         70.96         681,867         681,867         681,867         28.00           29.00         Low volume adjustment on or after October 1         70.97         51,940         51,940         51,940         29.00         0         0         29.00         0		12.00	318, 122	318, 12	2 0	318, 122	26.00
A)         B)         B)<		Wkst. E, Pt.	(Amt. from				
0         1.00         2.00         3.00         4.00           27.00         28.00         Low volume adjustment prior to October 1         70.96         681,867         681,867         681,867         28.00         28.00         Low volume adjustment on or after October 1         70.96         681,867         681,867         51,940         51,940         51,940         29.00         51,940         51,940         51,940         51,940         29.00         0		A, Line	Wkst. E, Pt.				
27.00       28.00       Low volume adjustment prior to October 1       70.96       681,867       681,867       51,940       28.00       681,867       51,940       51,940       51,940       29.00       51,940       51,940       51,940       51,940       51,940       29.00       -24,528       -24,528       0       -24,528       0       -24,528       0       -24,528       0			A)				
28.00       Low volume adjustment prior to October 1       70.96       681,867       681,867       681,867       28.00         29.00       Low volume adjustment on or after October 1       70.96       681,867       51,940       51,940       51,940       29.00         30.00       HVBP payment adjustment (see instructions)       70.93       -24,528       -24,528       0       -24,528       0 <t< td=""><td></td><td>0</td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td></td></t<>		0	1.00	2.00	3.00	4.00	
29.00       Low volume adjustment on or after October 1       70.97       51,940       51,940       51,940       29.00         30.00       HVBP payment adjustment (see instructions)       70.93       -24,528       -24,528       0       -24,528       30.00         30.01       HVBP payment adjustment for HSP bonus       70.90       0       0       0       0       30.01         10       HRR adjustment for HSP bonus payment (see instructions)       70.94       0       0       0       0       31.00         11.00       HRR adjustment for HSP bonus payment (see       70.91       0       0       0       0       31.01         Instructions)       70.91       0       0       0       0       0       31.01         IRR adjustment for HSP bonus payment (see       70.91       0       0       0       0       31.01         IRR adjustment for HSP bonus payment (see       70.91       0       0       0       0       31.01         IRR adjustment for HSP bonus payment (see       70.91       0       0       0       0       31.01         Instructions)       Instructions       70.99       0       0       3.00       4.00       4.00       32.00         32.00 <td>27.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>27.00</td>	27.00						27.00
30.00       HVBP payment adjustment (see instructions)       70.93       -24,528       -24,528       0       -24,528       30.00         30.01       HVBP payment adjustment for HSP bonus       70.93       70.90       0       0       0       0       0       30.01         31.00       HRR adjustment (see instructions)       70.94       0       0       0       0       31.00         31.01       HRR adjustment for HSP bonus payment (see       70.91       0       0       0       0       31.00         101       HRR adjustment for HSP bonus payment (see       70.91       0       0       0       0       31.01         22.00       HAC Reduction Program adjustment (see       70.99       0       1.00       2.00       3.00       4.00         32.00       HAC Reduction Program adjustment (see       70.99       0       0       0       32.00       32.00       32.00       32.00       32.00       32.00       32.00       0       0       32.00       32.00       32.00       32.00       0       0       32.00       32.00       32.00       32.00       32.00       32.00       32.00       32.00       32.00       32.00       32.00       32.00       32.00       32.00 <td>28.00 Low volume adjustment prior to October 1</td> <td>70. 96</td> <td>681, 867</td> <td>681, 86</td> <td>7</td> <td>681, 867</td> <td>28.00</td>	28.00 Low volume adjustment prior to October 1	70. 96	681, 867	681, 86	7	681, 867	28.00
30.01       HVBP payment adjustment for HSP bonus payment (see instructions)       70.90       0       0       0       0       30.01         31.00       HRR adjustment (see instructions)       70.94       0       0       0       0       31.00         31.01       HRR adjustment for HSP bonus payment (see       70.94       0       0       0       0       31.01         instructions)       70.91       0       0       0       0       0       31.01         Instructions)       0       1.00       2.00       3.00       4.00       0         32.00       HAC Reduction Program adjustment (see instructions)       70.99       0       0       0       32.00	29.00 Low volume adjustment on or after October 1	70. 97	51, 940		51, 940	51, 940	29.00
payment (see instructions)       70.94       0       0       0       31.00         31.00       HRR adjustment (see instructions)       70.94       0       0       0       0       31.00         HRR adjustment for HSP bonus payment (see instructions)       70.91       0       0       0       0       31.00         Instructions)       Instructions       0       1.00       2.00       3.00       4.00         32.00       HAC Reduction Program adjustment (see instructions)       70.99       0       0       0       32.00	30.00 HVBP payment adjustment (see instructions)	70.93	-24, 528	-24, 52	.8 0	-24, 528	30.00
31.00       HRR adjustment (see instructions)       70.94       0       0       0       0       31.00         31.01       HRR adjustment for HSP bonus payment (see instructions)       70.91       0       0       0       0       31.01         (Amt. to Wkst. E, Pt. A)         O       1.00       2.00       3.00       4.00         32.00       HAC Reduction Program adjustment (see instructions)       70.99       0       0       0       32.00	30.01 HVBP payment adjustment for HSP bonus	70.90	0		0 0	0	30.01
31.01       HRR adjustment for HSP bonus payment (see instructions)       70.91       0       0       0       0       31.01         (Amt. to Wkst. E, Pt. A)         0       1.00       2.00       3.00       4.00       32.00         32.00       HAC Reduction Program adjustment (see instructions)       70.99       0       0       0       32.00       3.00       4.00       0	payment (see instructions)						
31.01       HRR adjustment for HSP bonus payment (see instructions)       70.91       0       0       0       0       31.01         (Amt. to Wkst. E, Pt. A)         0       1.00       2.00       3.00       4.00       32.00         HAC Reduction Program adjustment (see instructions)	31.00  HRR adjustment (see instructions)	70. 94	0		0 0	0	31.00
Image: second		70. 91	0		0 0	0	31.01
Image: constraint of the section of the sec	instructions)						
0         1.00         2.00         3.00         4.00           32.00         HAC Reduction Program adjustment (see instructions)         70.99         0         0         0         32.00						(Amt. to Wkst.	
32.00 HAC Reduction Program adjustment (see 70.99 0 0 0 32.00 instructions)						E, Pt. A)	
instructions)			1.00	2.00	3.00	4.00	
		70.99			0 0	0	32.00
			N				100.00

	inancial Systems ST. JOSEPHS REG MED C ION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0076	Period: From 07/01/2020	Worksheet E	
			To 06/30/2021		
		Title XVIII	Hospi tal	PPS	
				1.00	
PA	ART B - MEDICAL AND OTHER HEALTH SERVICES				
	edical and other services (see instructions)			2,767	1.
1	edical and other services reimbursed under OPPS (see instruc PPS payments	ctions)		5, 775, 271 4, 945, 505	
	utlier payment (see instructions)			8, 307	
	utlier reconciliation amount (see instructions)			0	
1	nter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
	ine 2 times line 5			0	
	um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions)			0.00	
1	ncillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
	rgan acquisitions			0	
	otal cost (sum of lines 1 and 10) (see instructions)			2, 767	11
	DMPUTATION OF LESSER OF COST OR CHARGES				-
	ncillary service charges			10, 689	1 12
. 00 Or	rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13
	otal reasonable charges (sum of lines 12 and 13)			10, 689	14
	ustomary charges ggregate amount actually collected from patients liable for	navmont for sorvices on	a chargo basis	0	15
	mounts that would have been realized from patients liable for			0	
	ad such payment been made in accordance with 42 CFR §413.13(		g	[	
	atio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	otal customary charges (see instructions)	alvifling 10 overede li	no 11) (coo	10, 689	
	xcess of customary charges over reasonable cost (complete on nstructions)	ily if ille 18 exceeds il	ne II) (see	7, 922	19
	xcess of reasonable cost over customary charges (complete on	nly if line 11 exceeds li	ne 18) (see	0	20
lir	nstructions)	-			
	esser of cost or charges (see instructions)			2, 767	
	nterns and residents (see instructions) ost of physicians' services in a teaching hospital (see inst	tructions)		0	
	otal prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			4, 953, 812	
	DMPUTATION OF REIMBURSEMENT SETTLEMENT				1
	eductibles and coinsurance amounts (for CAH, see instruction			0	
	eductibles and Coinsurance amounts relating to amount on lin ubtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	• · · ·		890, 236 4, 066, 343	
	nstructions)			1,000,010	
	irect graduate medical education payments (from Wkst. E-4, I			0	
	SRD direct medical education costs (from Wkst. E-4, line 36)	)			29
	ubtotal (sum of lines 27 through 29) rimary payer payments			4, 066, 343 3, 244	
	ubtotal (line 30 minus line 31)			4, 063, 099	
	LOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	omposite rate ESRD (from Wkst. I-5, line 11)			0	
	llowable bad debts (see instructions) djusted reimbursable bad debts (see instructions)			153, 285 99, 635	
	llowable bad debts for dual eligible beneficiaries (see inst	tructions)		85, 217	
	ubtotal (see instructions)			4, 162, 734	
	SP-LCC reconciliation amount from PS&R			0	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ioneer ACO demonstration payment adjustment (see instruction	) )		0	39
1	emonstration payment adjustment amount before sequestration	13)		0	
	artial or full credits received from manufacturers for repla	aced devices (see instruc	tions)	0	
	ECOVERY OF ACCELERATED DEPRECIATION			0	
1	ubtotal (see instructions)			4, 162, 734	
	equestration adjustment (see instructions) emonstration payment adjustment amount after sequestration			0	
	equestration adjustment-PARHM pass-throughs				40
1	nterim payments			4, 173, 896	
1	nterim payments-PARHM			_	41
1	entative settlement (for contractors use only) entative settlement-PARHM (for contractor use only)			0	42
	alance due provider/program (see instructions)			-11, 162	
3. 01 Ba	alance due provider/program-PARHM (see instructions)				43
	rotested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	44
	115.2 D BE COMPLETED BY CONTRACTOR			l	1
	riginal outlier amount (see instructions)			0	90
i. UU TOr	<b>o</b>			0	
1	utlier reconciliation adjustment amount (see instructions)				1 00
1.00 0u 2.00 Th	utlier reconciliation adjustment amount (see instructions) he rate used to calculate the Time Value of Money ime Value of Money (see instructions)			0.00 0	

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 12	pare
			XVIII	Hospi tal	PPS	1
		Inpatien	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4,00	
00	Total interim payments paid to provider		5, 291, 9		4, 173, 896	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		<u> </u>			
01	ADJUSTMENTS TO PROVIDER			0	0	3
02				0	0	3
03				0	0	3
04				0	0	3
05				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		5, 291, 9	7.4	4, 173, 896	4
00	(transfer to Wkst. E or Wkst. E-3, line and column as		5, 291, 9	/4	4, 173, 090	4
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR				1	
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			_		
01	TENTATI VE TO PROVIDER			0	0	5
02 03				0	0	5
03	Provider to Program		<u> </u>	0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		254, 70		0	6
02	SETTLEMENT TO PROGRAM			0	11, 162	6
00	Total Medicare program liability (see instructions)		5, 546, 68		4, 162, 734	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1.00	2.00	
	Name of Contractor	(	,	1.00	2.00	8

Heal th	Financial Systems ST. JOSEPHS REG MED C	ENTER PLYMOUTH	In Lie	u of Form CMS-	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0076	Period: From 07/01/2020	Worksheet E- Part II			
			To 06/30/2021	Date/Time Pre			
		<b>T</b>		11/30/2021 12	2:37 pm		
		Title XVIII	Hospi tal	PPS			
				1.00			
	TO DE CONDUCTED DV CONTRACTOR FOR NONCTANDARD COST REPORTS			1.00	-		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2						
	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12						
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 li				6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of co	ertified HIT technology	Wkst. S-2, Pt. I		7.00		
	line 168						
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		
31.00	Other Adjustment (specify)				31.00		

	SHEET (If you are nonproprietary and do not maintain	Provider C	CN: 15-0076	Period: From 07/01/2020	Worksheet G	
na-ty Iy)	pe accounting records, complete the General Fund column			To 06/30/2021	Date/Time Pre 11/30/2021 12	epare
		General Fund	Specific Purpose Fund	Endowment Fund		
	NURDENT ACCETO	1.00	2.00	3.00	4.00	
	CURRENT ASSETS Cash on hand in banks	467, 698		0 0	0	1 1
	Temporary investments	407,098		0 0		
	Notes receivable	0		0 0	0	
	Accounts receivable	81, 494, 233		0 0	0	
	Other receivable	0		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	0		0 0	0	6
00 0	Inventory	1, 335, 585		0 0	0	7
1 OC	Prepaid expenses	0		0 0	0	8
	Other current assets	45, 766		0 0	0	
	Due from other funds	0		0 0		
	Total current assets (sum of lines 1-10)	83, 343, 282		0 0	0	11
	I XED ASSETS	177.000				1
	Land	477, 930		0 0		
	Land improvements Accumulated depreciation	0		0 0	0	
	Buildings	44 672 700			0	
	Accumul ated depreciation	44, 673, 700 -32, 768, 343			0	
	Leasehold improvements	403, 970			0	
	Accumul ated depreciation	-403, 970		0 0	0	
	Fixed equipment	00,770		0 0	0	
	Accumul ated depreciation	0		0 0	0	
	Automobiles and trucks	146, 274		0 0	0	21
. 00 /	Accumulated depreciation	-120, 888		0 0	0	22
. 00  1	Major movable equipment	27, 869, 160		0 0	0	23
00 /	Accumul ated depreciation	-24, 399, 034		0 0	0	24
	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Minor equipment-nondepreciable	0		0 0		
	Total fixed assets (sum of lines 12-29) THER ASSETS	15, 878, 799		0 0	0	30
	Investments	0		0 0	0	31
	Deposits on Leases	0		0 0	0	
	Due from owners/officers	0		0 0	0	
	Other assets	56, 220, 624		0 0	0	
	Total other assets (sum of lines 31-34)	56, 220, 624		0 0		
	Total assets (sum of lines 11, 30, and 35)	155, 442, 705		0 0	0	36
	CURRENT LI ABI LI TI ES					
. 00 7	Accounts payable	59, 581, 919		0 0	0	37
	Salaries, wages, and fees payable	22, 228, 297		0 0	0	38
	Payroll taxes payable	0		0 0		
	Notes and loans payable (short term)	763, 459		0 0	0	
	Deferred income	96, 900		0 0	0	41
	Accelerated payments	0				42
	Due to other funds	0		0 0	0	
	Other current liabilities	147, 731		0 0		
	Total current liabilities (sum of lines 37 thru 44)	82, 818, 306		0 0	0	45
	LONG TERM LIABILITIES	0		0 0	0	46
	Notes payable	0			0	
	Unsecured Loans	0			0	
	Other long term liabilities	8, 158, 236		0 0		
	Total long term liabilities (sum of lines 46 thru 49)	8, 158, 236		0 0		
	Total liabilities (sum of lines 45 and 50)	90, 976, 542		0 0		
	CAPITAL ACCOUNTS	., ., .,				1
	General fund balance	64, 466, 163				52
00	Specific purpose fund			0		53
00 [	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion	64 464 440			_	
	Total fund balances (sum of lines 52 thru 58)	64, 466, 163			0	
1111	Total liabilities and fund balances (sum of lines 51 and	155, 442, 705	1	0 0	0	60

STATEN	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0076	Period: From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	2.00	1.00	F. 00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Unrest NA rel from rest for cap Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	1.00 0 41,914 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 53,893,409 10,530,839 64,424,248 41,914 64,466,162	3.00			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		0 64, 466, 162				18.00 19.00
		Endowment Fund	PI ant				
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Unrest NA rel from rest for cap	0	0 0 0 0 0		0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0		0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0 0		18.00 19.00

Heal th	Fi nanci al	Systems	

		То	om 07/01/2020 06/30/2021	Parts I & II Date/Time Pre 11/30/2021 12	
	Cost Center Description	Inpati ent	Outpati ent	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				+
00	General Inpatient Routine Services	0.005.020		0.005.020	1 1 00
. 00		9, 005, 839		9, 005, 839	1.00
. 00 . 00	SUBPROVIDER - IPF SUBPROVIDER - IRF				3.0
. 00	SUBPROVIDER - TRP				4.00
. 00	Swing bed - SNF	0		0	5.0
. 00	Swing bed - NF	0		0	6.0
. 00	SKILLED NURSING FACILITY	0		0	7.0
. 00	NURSING FACILITY				8.0
. 00	OTHER LONG TERM CARE				9.0
	Total general inpatient care services (sum of lines 1-9)	9, 005, 839		9, 005, 839	
0.00	Intensi ve Care Type Inpatient Hospital Services	7,000,007		7,000,007	10.0
1.00	INTENSIVE CARE UNIT	5, 178, 495		5, 178, 495	11.0
2.00	CORONARY CARE UNIT	0,110,110		07 17 07 17 0	12.0
	BURN I NTENSI VE CARE UNI T				13.0
	SURGICAL INTENSIVE CARE UNIT	0		0	14.0
	OTHER SPECIAL CARE (SPECIFY)			0	15.0
	Total intensive care type inpatient hospital services (sum of lines	5, 178, 495		5, 178, 495	
	11-15)	-,,		-,,	
7.00	Total inpatient routine care services (sum of lines 10 and 16)	14, 184, 334		14, 184, 334	17. C
8.00	Ancillary services	32, 546, 184	140, 531, 144	173, 077, 328	
	Outpatient services	2, 861, 475	18, 357, 350	21, 218, 825	
0.00	RURAL HEALTH CLINIC	0	0	0	20.0
1.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.0
2.00	HOME HEALTH AGENCY				22.0
3.00	AMBULANCE SERVICES				23.0
4.00	СМНС				24.0
5.00	AMBULATORY SURGICAL CENTER (D. P.)				25.0
6.00	HOSPICE				26.0
7.00	ADMIN & OTHER	-59, 554	60, 354	800	27. C
7.02	HOSPI TALI ST	982, 597	468, 136	1, 450, 733	27.0
7.03	I NTENSI VI STS	415, 965	24, 942	440, 907	27.0
7.04	FOOT & ANKLE SPORTS MED PLY	21, 391	624, 186	645, 577	27. C
7.99	REVENUE ADJUSTMENTS	557, 651	3, 145, 910	3, 703, 561	27.9
8.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	51, 510, 043	163, 212, 022	214, 722, 065	28.0
	G-3, line 1)				1
	PART II - OPERATING EXPENSES				
9.00	Operating expenses (per Wkst. A, column 3, line 200)		58, 817, 526		29.0
0.00	ADD (SPECI FY)	0			30.0
1.00		0			31.0
2.00		0			32.0
3.00		0			33.0
4.00		0			34.0
5.00	Tetel edditions (sum of lines 20.25)	0	0		35.0
	Total additions (sum of lines 30-35)		0		36.0
7.00	DEDUCT (SPECI FY)	0			37.0
8.00		0			38.0
9.00		0			39.0
0.00		0			40.0
1.00		0	_		41.0
2.00	Total deductions (sum of lines 37-41)		0		42. C
3.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe		58, 817, 526		

Heal th	Financial Systems ST. JOSE	ST. JOSEPHS REG MED CENTER PLYMOUTH In L			2552-10
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0076	Peri od:	Worksheet G-3	
			From 07/01/2020 To 06/30/2021	Date/Time Prep 11/30/2021 12:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I,	column 3, line 28)		214, 722, 065	1.00
2.00	Less contractual allowances and discounts on pat	ients' accounts		153, 598, 527	2.00
3.00	Net patient revenues (line 1 minus line 2)			61, 123, 538	3.00
4.00	Less total operating expenses (from Wkst. G-2, P	art II, line 43)		58, 817, 526	4.00
5.00	Net income from service to patients (line 3 minu	sline 4)		2, 306, 012	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous	communication services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			620, 927	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical suppli	es to other than patients		0	16.00
17.00	Revenue from sale of drugs to other than patient	S		0	17.00
18.00	Revenue from sale of medical records and abstrac	ts		0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.	)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and c	anteen		764	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	Other specify			10, 896, 292	24.00
24.50	COVI D-19 PHE Funding			-3, 293, 156	24.50
25.00	Total other income (sum of lines 6-24)			8, 224, 827	25.00
26.00	Total (line 5 plus line 25)			10, 530, 839	26.00
27.00	Other expenses specify			0	27.00
28.00	Total other expenses (sum of line 27 and subscri	pts)		0	28.00
29.00	Net income (or loss) for the period (line 26 min	us line 28)		10, 530, 839	29.00

Health Financial Systems

ST.	JOSEPHS	REG	MED	CENTER	PLYMOUTH	

Heal th Financial Systems     ST. JOSEPHS REG MED CENTER PLYMOUTH     In Lie       CALCULATION OF CAPITAL PAYMENT     Provider CCN: 15-0076     Period: From 07/01/2020 To 06/30/2021       Title XVIII       Hospital       PART 1 - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT       1.00       CAPITAL PAYMENT		
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT	Date/Time Pre 11/30/2021 12 PPS	
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT	11/30/2021 12 PPS	
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT	PPS	
PART I – FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT		:37 pr
CAPI TAL FEDERAL AMOUNT	1,00	
CAPITAL FEDERAL AMOUNT	1,00	
CAPITAL FEDERAL AMOUNT		
1.00 Capital DRG other than outlier		
	316, 088	1.0
1.01 Model 4 BPCI Capital DRG other than outlier	0	1.0
2.00 Capital DRG outlier payments	2, 034	2.0
2.01 Model 4 BPCI Capital DRG outlier payments	0	2.0
3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions)	14, 99	
.00 Number of interns & residents (see instructions)	0.00	
.00 Indirect medical education percentage (see instructions)	0.00	
.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and	0.00	6.0
1.01) (see instructions)		0.0
7.00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line	0.00	7.0
30) (see instructions)	0.00	/.0
8.00 Percentage of Medicaid patient days to total days (see instructions)	0.00	8.0
0.00 Sum of Lines 7 and 8	0.00	
	0.00	•
0.00 Allowable disproportionate share percentage (see instructions)		
1.00 Disproportionate share adjustment (see instructions)	0	11.0
2.00 Total prospective capital payments (see instructions)	318, 122	12.0
	1.00	
PART II - PAYMENT UNDER REASONABLE COST		
Program inpatient routine capital cost (see instructions)	0	1.0
2.00 Program inpatient ancillary capital cost (see instructions)	0	2.0
2.00 Total inpatient program capital cost (line 1 plus line 2)	0	3.0
1.00 Capital cost payment factor (see instructions)	0	4.0
5.00  Total inpatient program capital cost (line 3 x line 4)	0	5.0
	1.00	
PART 111 - COMPUTATION OF EXCEPTION PAYMENTS		
.00 Program inpatient capital costs (see instructions)	0	1.0
.00 Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.0
.00 Net program inpatient capital costs (line 1 minus line 2)	0	3.0
.00 Applicable exception percentage (see instructions)	0.00	
.00 Capital cost for comparison to payments (line 3 x line 4)	0	
00 Dependence adjustment for autroprediment, a normations ( !++!)	0.00	6.0
00 Percentage adjustment for extraordinary circumstances (see instructions)	0	7.0
	0	8.0
00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		9. (
<ul> <li>Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)</li> <li>Capital minimum payment level (line 5 plus line 7)</li> </ul>	0	10. (
<ul> <li>Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as applicable)</li> </ul>	0	11. (
<ul> <li>Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as applicable)</li> <li>Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)</li> </ul>		
<ul> <li>Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as applicable)</li> <li>Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)</li> </ul>	0	
<ul> <li>Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as applicable)</li> <li>Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)</li> <li>Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)</li> </ul>	0	12.0
<ul> <li>Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as applicable)</li> <li>Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)</li> <li>Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)</li> <li>Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)</li> </ul>	0	
<ul> <li>Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as applicable)</li> <li>Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)</li> <li>Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)</li> <li>Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)</li> <li>Current year exception payment (if line 12 is positive, enter the amount on this line)</li> </ul>	000000000000000000000000000000000000000	13. (
<ul> <li>Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as applicable)</li> <li>Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)</li> <li>Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)</li> <li>Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)</li> <li>Current year exception payment (if line 12 is positive, enter the amount on this line)</li> <li>Carryover of accumulated capital minimum payment level over capital payment for the following period</li> </ul>	0	13. (
<ul> <li>Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as applicable)</li> <li>Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)</li> <li>Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)</li> <li>Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)</li> <li>Current year exception payment (if line 12 is positive, enter the amount on this line)</li> <li>Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)</li> </ul>	0 0 0 0	13. ( 14. (
<ul> <li>Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as applicable)</li> <li>Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)</li> <li>Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)</li> <li>Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)</li> <li>Current year exception payment (if line 12 is positive, enter the amount on this line)</li> <li>Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)</li> <li>Current year allowable operating and capital payment (see instructions)</li> </ul>	0 0 0 0 0	13. ( 14. ( 15. (
<ul> <li>Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as applicable)</li> <li>Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)</li> <li>Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)</li> <li>Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)</li> <li>Current year exception payment (if line 12 is positive, enter the amount on this line)</li> <li>Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)</li> </ul>	0 0 0 0	13. 14. 15. 16.