	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai since the beginning of the cost reporting period being			OMB NO. 0938-0050
				EXPIRES 03-31-2022
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provider CCN: 15-0012	Peri od: From 07/01/2020 To 06/30/2021	
PART I - COST	REPORT STATUS			
Provi der use only	1. [ X ] Electronically prepared cost report 2. [ ] Manually prepared cost report 3. [ 0 ] If this is an amended report enter the number	of times the provider	Date: 11/30/2	
	4. [F] Medicare Utilization. Enter "F" for full or "L		resubilit teed till 5 e	ost report
Contractor use only	5. [ 1 ]Cost Report Status 6. Date Received:     (1) As Submitted 7. Contractor No.     (2) Settled without Audit 8. [ N ] Initial Report for     (3) Settled with Audit 9. [ N ] Final Report for     (4) Reopened     (5) Amended	11. or this Provider CCN 12.		

## PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. JOSEPHS REG MED CENTER S. BEND (15-0012) 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.

(Signed) ROBERT SINK
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	1, 095, 276	97, 680	0	0	1. 00
2.00	Subprovi der - I PF	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	1, 095, 276	97, 680	0	0	200. 00

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

Health Financial Systems ST. JOSEPHS REG MED CENTER S. BEND In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0012 Peri od: Worksheet S-2 From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/30/2021 12:30 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 5215 HOLY CROSS PARKWAY 1.00 PO Box: 1.00 State: IN 2.00 City: MISHAWAKA Zip Code: 46545 County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Number Number Certi fi ed Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST. JOSEPHS REG MED 150012 43780 07/01/1996 Ν 3.00 CENTER S. BEND Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2020 06/30/2021 20.00 21.00 Type of Control (see instructions) 21.00 1 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Υ Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

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

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

39. 00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39. 00
40 00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or	N		N		40. 00
10.00	"N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for					10.00
	no in column 2, for discharges on or after October 1. (see instructions)					
			V	XVIII	XI X	
			1. 00	2. 00	3.00	
	Prospective Payment System (PPS)-Capital					
45.00	Does this facility qualify and receive Capital payment for disproportionate share in acco	rdance	N	Y	N	45.00
	with 42 CFR Section §412.320? (see instructions)					
46. 00	Is this facility eligible for additional payment exception for extraordinary circumstance		N	N	N	46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I th	rough				
	Pt. III.					47.00
	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for	no.	N N	N N	N N	47. 00 48. 00
48. 00	The title that the title t					
F/ 00	Teaching Hospitals					F ( 00
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hosp		Y	Y		56. 00
	was involved in training residents in approved GME programs in the prior year or penultim					
	year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment redu					
	Enter "Y" for yes; otherwise, enter "N" for no in column 2.	Cti oii:				
57 00	If line 56 is yes, is this the first cost reporting period during which residents in appr	oved	N			57. 00
07.00	GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If c					07.00
	is "Y" did residents start training in the first month of this cost reporting period? En					
	for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column					
	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as		N			58. 00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					
59. 00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59. 00

Y/N

1.00

Y/N

2.00

greater than 1, subscript this line for the number of periods in excess of one and

enter subsequent dates.

	instructions) Enter in column i, the program name.					
	Enter in column 2, the program code. Enter in column					
	3, the IME FTE unweighted count. Enter in column 4,					
	the direct GME FTE unweighted count.					
					1.00	
	ACA Provisions Affecting the Health Resources and Se	rvices Administration	(HRSA)			
62.00	Enter the number of FTE residents that your hospital	trained in this cost r	reporting peri	od for which	0.00	62.00
	your hospital received HRSA PCRE funding (see instru	ctions)				
62. 01	2.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital					62. 01
	during in this cost reporting period of HRSA THC proj	gram. (see instructions	s)			
	Teaching Hospitals that Claim Residents in Nonprovid	er Settings				
63.00	Has your facility trained residents in nonprovider so	ettings during this cos	st reporting p	eriod? Enter	N	63.00
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 67	7. (see instru	ctions)		

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMP	ST. JOSEPHS LEX IDENTIFICATION DA			N: 15-0012	In Lie Period: From 07/01/2020 To 06/30/2021		pared:
				Unwei ghted FTEs Nonprovi der Si te 1.00	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year period that begins on or after .				This base yea	r is your cost i	reporti ng	
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				0. (	0.00	0. 000000	64. 00
	Program Name	Program		Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	0	Unwei ghted FTEs Nonprovi der Si te 1.00	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current beginning on or after July 1, 20	010			sEffective	· · · · · · · · · · · · · · · · · · ·		
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divided b	occurring in all nonpr unweighted non-primar tal. Enter in column 3	rovider setti ry care resid 3 the ratio d	ngs. dent	0. (			
	Program Name	Program		Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.0	U	3.00	4.00	5. 00 0. 000000	67.00

ealth Financial Systems ST. JOSEPHS REG MED CENTER S. BEND		In Lieu	of For		
OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0012	From 07/0	0/2021	Workshe Part I Date/Ti 11/30/2	me Pre	epared
		1.00	2. 00	3.00	-
Inpatient Psychiatric Facility PPS 0.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF	subprovi dor2	N			70.
Enter "Y" for yes or "N" for no.	subprovider?	I IN			/0.1
1.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program				0	71. (
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new					
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N"	for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost repo (see instructions)	rting period.				
Inpatient Rehabilitation Facility PPS					1
5.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an	I RF	N			75.
subprovider? Enter "Y" for yes and "N" for no. 6.00   If line 75 is yes: Column 1: Did the facility have an approved GME teaching program	in the most	l N	N	0	76.
recent cost reporting period ending on or before November 15, 2004? Enter "Y" for y		- 1	"		70.
no. Column 2: Did this facility train residents in a new teaching program in accord					
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 indicate which program year began during this cost reporting period. (see instructi					
,					
Long Term Care Hospital PPS			1. 0	00	+-
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.
1.00 Is this a LTCH co-located within another hospital for part or all of the cost repor	ting period?	Enter	N		81.
"Y" for yes and "N" for no. TEFRA Provi ders					-
Is this a new hospital under 42 CFR Section §413. 40(f)(1)(i) TEFRA? Enter "Y" for	yes or "N" fo	r no.	N		85.
6.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Se	ction				86.
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 7.00 Is this hospital an extended neoplastic disease care hospital classified under sect	i on		N		87.
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					1
	1. C		2. C		+
Title V and XIX Services		J			
0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" f	for N		Υ		90.
yes or "N" for no in the applicable column. 1.00  s this hospital reimbursed for title V and/or XIX through the cost report either i	n N		N		91.
full or in part? Enter "Y" for yes or "N" for no in the applicable column.					
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.	1		N		92.
3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Ent	er N		N		93.
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N.		N		94.
applicable column.	N		IN		94.
5.00 If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 0		0.0		95.
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.
7.00   If line 96 is "Y", enter the reduction percentage in the applicable column.	0.0	00	0.0	00	97.
8.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents pos	t Y		Υ		98.
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					
8.01 $\hspace{-0.1cm}$ Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on W		İ	Υ		98
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 title XIX.	for				
B. O2 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	n Y		Υ		98.
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column	1				
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (C	AH) N		N		98.
reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in colu					
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N		N		98.
outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V,			14		/0.
in column 2 for title XIX.			V		00
3.05   Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance   Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, an			Y		98.
column 2 for title XIX.					
8.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y		Y		98.
column 2 for title XIX.					
Rural Providers					105
O5.00 Does this hospital qualify as a CAH? O6.00 f this facility qualifies as a CAH, has it elected the all-inclusive method of pay	ment	-			105.
for outpatient services? (see instructions)					
07.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for 18					107.
training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an					
approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems ST. JOSEPHS REG MED HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	N: 15-0012 Pe	eriod: rom 07/01/2020		-2 repared:
			V	XI X	
108.00 s this a rural hospital qualifying for an exception to the	CRNA fee sched	dul e? See 42	1. 00 N	2.00	108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	,
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00	2.00	Speech 3. 00	4.00	109. 00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	'Y" for yes or	"N" for no. If	yes,	1.00 N	110. 00
			1. 00	2.00	
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting polumn 1 is Y, e ticipating in	period? Enter enter the column 2.	N N	2.00	111.00
		1. 00	2. 00	3.00	
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.	peri od? s "Y", enter ne	N			112. 00
Miscellaneous Cost Reporting Information  115.00 st this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0115.00
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					0113.00
the definition in CMS Pub.15-1, chapter 22, §2208.1.  116.00 s this facility classified as a referral center? Enter "Y" for yes or N					116. 00
"N" for no. 117.00 s this facility legally-required to carry malpractice insur	ance? Enter	N			117. 00
"Y" for yes or "N" for no.  118.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr		1			118. 00
		Premi ums	Losses	Insurance	
		1. 00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		1.00			0118.01
			1. 00	2.00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.			N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter ir "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments.	N	N	119. 00 120. 00		
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impla	antable devices	s charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			N		122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for		125. 00			
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00  f this is a Medicare certified kidney transplant center, er	,		N		126. 00
in column 1 and termination date, if applicable, in column 2  127.00  f this is a Medicare certified heart transplant center, ent	2.				127. 00
in column 1 and termination date, if applicable, in column 2	2.				
128.00   f this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	2.				128. 00
129.00  f this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.					129. 00
130.00   f this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col		TIFICATION			130. 00

Health Financial Systems	ST. JOSEPHS REG MED	CENTER S. BEND	)		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE		Provider CCN	: 15-0012	Peri od:		Worksheet S-2	
					7/01/2020 5/30/2021	Part     Date/Time Pre	epared:
						11/30/2021 12	2: 30 pm
					1. 00	2. 00	+
131.00 If this is a Medicare certified intesti			tification				131. 00
date in column 1 and termination date, 132.00 If this is a Medicare certified islet t			ation date				132. 00
in column 1 and termination date, if ap			ation date				132.00
133.00 Removed and reserved	•						133. 00
134.00  f this is an organ procurement organiz and termination date, if applicable, in	ation (OPO), enter the	e OPO number in	column 1				134. 00
All Providers	COI UIIII 2.						
140.00 Are there any related organization or h					Υ	15H034	140. 00
chapter 10? Enter "Y" for yes or "N" fo are claimed, enter in column 2 the home							
1.00	2. 00		UIS)		3. 00		
If this facility is part of a chain org				ame and	address	of the	
home office and enter the home office of 141.00 Name: ST JOSEPH REG MED CTR	<u>ontractor name and cor</u> Contractor's Name: WLS			or's Nu	mber: 0800	1	141. 00
141. OUNdille. ST JOSEPH REG MED CTR		VICES CO	Contracto	JI S INUI	ilbei . Uouu	1	141.00
	PO Box:						142. 00
143.00 Ci ty: MI SHAWAKA	State: IN		Zi p Code:	<u> </u>	4654	5	143. 00
						1. 00	-
144.00 Are provider based physicians' costs in	cluded in Worksheet A?	?				Y	144. 00
						0.00	
145.00 If costs for renal services are claimed	on Wkst A line 74	are the costs	for		1. 00 Y	2. 00	145. 00
inpatient services only? Enter "Y" for					'		143.00
no, does the dialysis facility include	Medicare utilization f	for this cost r	eporting				
period? Enter "Y" for yes or "N" for n 146.00 Has the cost allocation methodology cha		sly filed cost	renort?		N		146. 00
Enter "Y" for yes or "N" for no in colu							140.00
yes, enter the approval date (mm/dd/yyy	y) in column 2.	·					
						1. 00	-
147.00 Was there a change in the statistical b	asis? Enter "Y" for ye	es or "N" for n	10.			N N	147. 00
148.00 Was there a change in the order of allo	cation? Enter "Y" for	yes or "N" for	no.			N	148. 00
149.00 Was there a change to the simplified co	st finding method? Ent	ter "Y" for yes Part A	or "N" for Part B		itle V	N Title XIX	149. 00
		1, 00	2.00		3.00	4.00	+
Does this facility contain a provider t			the applica	ti on of	the lowe	r of costs	
or charges? Enter "Y" for yes or "N" for	r no for each componer	nt for Part A a		(See 42	! CFR §413 N	. 13) N	155.00
155. 00 Hospi tal 156. 00 Subprovi der - TPF		N I	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 N	159. 00 160. 00
161. 00 CMHC			N		N	N	161. 00
Multicampus						1. 00	
165.00 s this hospital part of a Multicampus	hospital that has one	or more campus	ses in diffe	rent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	·	<u> </u>					
	Name 0	County 1.00		p Code 3.00	4. 00	FTE/Campus 5.00	
166.00 If line 165 is yes, for each	U	1.00	2.00	3.00	4.00		166. 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) inc	entive in the American	n Recovery and	Rei nvestmen	t Act		1. 00	
167.00 Is this provider a meaningful user unde	r §1886(n)? Enter "Y"	' for yes or "N	l" for no.			Y	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the							168. 00
reasonable cost incurred for the HIT as 168.01 If this provider is a CAH and is not a			qualify for	a hard	shi p		168. 01
exception under §413.70(a)(6)(ii)? Ente	r "Y" for yes or "N" f	for no. (see in	structions)		·		
169.00 If this provider is a meaningful user (	line 167 is "Y") and i	s not a CAH (I	ine 105 is '	"N"), e	nter the	9. 9	9169. 00
transition factor. (see instructions)						I	1

Health Financial Systems	ST. JOSEPHS REG MED	CENTER S. BEND	In Lie	In Lieu of Form CMS-255		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CCN: 15-0012				
			From 07/01/2020			
			To 06/30/2021	Date/Time Pre		
				11/30/2021 12	: 30 pm	
			Begi nni ng	Endi ng		
			1. 00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170. 00	
			1. 00	2.00		
171.00 If line 167 is "Y", does this pro	vider have any days for ind	ividuals enrolled in	N	C	171. 00	
section 1876 Medicare cost plans	reported on Wkst. S-3, Pt.	I, line 2, col. 6? Enter				
"Y" for yes and "N" for no in col	umn 1. If column 1 is yes,	enter the number of sectio	n			
1876 Medicare days in column 2. (	see instructions)					

				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N for	all NO re	sponses. Enter	all dates in	the	
	mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					
	Has the provider changed ownership immediately prior to the begi	innina of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in column					
			Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare Progra		N			2. 00
	yes, enter in column 2 the date of termination and in column 3, voluntary or "I" for involuntary.	V TOP				
3. 00	Is the provider involved in business transactions, including mar	nagement	N			3.00
00	contracts, with individuals or entities (e.g., chain home office					0.00
	or medical supply companies) that are related to the provider or					
	officers, medical staff, management personnel, or members of the					
	of directors through ownership, control, or family and other sim	milar				
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports		1.00	2.00	0.00	1
. 00	Column 1: Were the financial statements prepared by a Certified	d Public	Υ	А		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for Co					
	or "R" for Reviewed. Submit complete copy or enter date available	lein				
. 00	column 3. (see instructions) If no, see instructions.	from	N			5. 00
. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcil		IN IN			5.00
	those on the fired financial statements: If yes, submit reconcil	11411011.		Y/N	Legal Oper.	
				1. 00	2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2: If y	yes, is th	e provider is	N		6. 00
00		legal operator of the program?				7.00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see instruction were nursing school and/or allied health programs approved and/or		during the	Y N		7. 00 8. 00
. 00	cost reporting period? If yes, see instructions.	or renewed	duiling the	į v		0.00
. 00	Are costs claimed for Interns and Residents in an approved graduate medical education Y					9.00
	program in the current cost report? If yes, see instructions.					
0. 00	Was an approved Intern and Resident GME program initiated or rer	newed in t	he current	N		10.00
1 00	cost reporting period? If yes, see instructions.	: 0		NI NI		11 00
1. 00	Are GME cost directly assigned to cost centers other than I & R Teaching Program on Worksheet A? If yes, see instructions.	in an App	rovea	N		11. 00
	reaching mogram on worksheet A: 11 yes, see mistractions.				Y/N	
					1.00	
	Bad Debts					
2. 00	Is the provider seeking reimbursement for bad debts? If yes, see				Y	12. 00
3. 00	If line 12 is yes, did the provider's bad debt collection policy	y change d	uring this cos	t reporting	N	13. 00
4 00	period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments w	waived2 lf	vas saa inst	ructi ons	N	14. 00
4.00	Bed Complement	war veur Ti	yes, see mist	ructions.	IN	14.00
5. 00	Did total beds available change from the prior cost reporting pe	eriod? If	yes, see instr	uctions.	Y	15. 00
			t A		rt B	
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
	PS&R Data Was the cost report prepared using the PS&R Report only?	Υ	10 /01 /2021		10 (01 (2021	1, 00
5. 00	If either column 1 or 3 is yes, enter the paid-through	Y	10/01/2021	Y	10/01/2021	16. 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	N		N		17. 00
7.00						
7. 00	totals and the provider's records for allocation? If					
7. 00	either column 1 or 3 is yes, enter the paid-through date					
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		18 00
	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
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		18. 00
	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	N		N		18. 00
8. 00	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.  If line 16 or 17 is yes, were adjustments made to PS&R	N N		N N		18. 00
7. 00 8. 00 9. 00	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.					

Heal th	Financial Systems ST. JOSEPHS REG ME	ED CENTER S. BE	:ND	In Lie	u of Form CMS	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0012	Peri od: From 07/01/2020 To 06/30/2021	Worksheet S Part II Date/Time P 11/30/2021	repared:
			i pti on	Y/N	Y/N	
20.00	If line 14 or 17 is yes were adjustments made to DSOD		0	1. 00 N	3. 00 N	20. 00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN IN	IN	20.00
	The period and a serior boson bottom and astimonics.	Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)		11.00	
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made dur	ing the cost		23. 00
24. 00	Were new leases and/or amendments to existing leases entere	ed into durina	this cost re	portina period?		24. 00
	If yes, see instructions	· · · · · · · · · · · · · · · · · · ·		J 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	'If yes, see		25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	an cost roporti	ng poriod2 L	f vos soo		26. 00
20.00	instructions.	ie cost reporti	ng perrous r	i yes, see		20.00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit		27. 00
28. 00	<pre>Interest Expense Were new Loans, mortgage agreements or Letters of credit er</pre>	atorod into dur	sing the cost	roporting		28. 00
20.00	period? If yes, see instructions.	iterea into dai	ring the cost	reporting		20.00
29. 00	Did the provider have a funded depreciation account and/or	bond funds (De	ebt Service R	eserve Fund)		29. 00
	treated as a funded depreciation account? If yes, see instr					
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	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.					
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvi ces furni she	ed through co	ntractual		32. 00
02.00	arrangements with suppliers of services? If yes, see instru		od till odgir od	inti do tadi		02.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competi	tive bidding? If		33. 00
	no, see instructions.					
34. 00	Provider-Based Physicians  Are services furnished at the provider facility under an ar	rrangement with	nrovi der-ha	sed physicians?		34.00
34.00	If yes, see instructions.	rangement witi	i provider-ba	ised physicians:		34.00
35. 00	If line 34 is yes, were there new agreements or amended exi	5 5	nts with the	provi der-based		35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
36. 00						36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	'		37. 00
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off	fice different	from that of	,		38. 00
00.00	the provider? If yes, enter in column 2 the fiscal year end	d of the home of	office.			00.00
39. 00	If line 36 is yes, did the provider render services to other	er chain compor	nents? If yes	i,		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If was saa			40. 00
40.00	instructions.	nome office:	11 yes, see			40.00
	Coot Deport Droporor Control Informati	] 1.	00	2.	00	
41. 00	Cost Report Preparer Contact Information  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,	INACI		MOLKINIVIA		41. 00
	respecti vel y.					
42. 00	Enter the employer/company name of the cost report	SAINT JOSEPH R				42. 00
43. 00	preparer. Enter the telephone number and email address of the cost	MEDI CAL CENTER (574) 335-4656		WORKMANT@SJRMC	COM	43.00
<del>-</del> 3.00	report preparer in columns 1 and 2, respectively.	333-4030	•	WORKINIAN I GOOKING	. JJW	43.00
		•		•		"

Heal th	Financial Systems	ST. JOSEPHS REG ME	D CENTER S. BEND		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provider CCN: 15-0	F	eriod: rom 07/01/2020 o 06/30/2021		pared:
			3.00	<u>'</u>		1	р
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the held by the cost report preparer in colur respectively.		FINANCE - REIMBURSEME	ENT			41. 00
42. 00	Enter the employer/company name of the copreparer.	ost report					42. 00
43. 00	Enter the telephone number and email addingeror preparer in columns 1 and 2, response.						43. 00

| Peri od: | Worksheet S-3 | From 07/01/2020 | Part | | Date/Time Prepared: | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02 Health Financial Systems ST. JOSEPHS REG MED CENTER S. BEND HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: Provider CCN: 15-0012

				10	06/30/2021	11/30/2021 12	
						I/P Days / 0/P	. 30 piii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Davs	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	213	77, 745	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		213	77, 745	0. 00	0	7. 00
	beds) (see instructions)					_	
8. 00	INTENSIVE CARE UNIT	31. 00	28	10, 220	0. 00	0	
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT					_	11.00
12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00		4, 380	0. 00	0	1
13. 00	NURSERY	43. 00				0	13. 00
14.00	Total (see instructions)		253	92, 345	0. 00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVI DER - I PF	44.00					16.00
17. 00	SUBPROVI DER - I RF	41. 00	0	0		0	
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE						21.00
23. 00	HOME HEALTH AGENCY						23.00
24. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)	30. 00					24. 00
25. 00	CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	253			0	27. 00
28. 00	Observation Bed Days		255			0	28.00
29. 00	Ambul ance Tri ps						29.00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31.00
32. 00	Labor & delivery days (see instructions)		4	1, 460			32.00
32. 00	Total ancillary labor & delivery room		-	1, 400			32. 00
52.01	outpatient days (see instructions)						52.01
33. 00	LTCH non-covered days						33. 00
	LTCH site neutral days and discharges						33. 01
	1 11 11 11 11 11 11 11 11 11 11 11 11 1	ı	'	ı	ı	•	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0012

Peri od: Worksheet S-3 From 07/01/2020 Part I To 06/30/2021 Date/Time Prepared:

11/30/2021 12:30 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 15, 128 3, 231 45, 874 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 8, 579 2 00 HMO and other (see instructions) 13, 652 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 15, 128 3, 231 45, 874 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 1,760 6, 373 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 NEONATAL INTENSIVE CARE UNIT 947 12.00 0 13.00 NURSERY 638 4, 461 13.00 14.00 Total (see instructions) 16,888 3,869 57,655 33. 94 1, 434. 10 14.00 CAH visits 15.00 0 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 0 0.00 17.00 0 0.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 58 24.10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26.25 0 C 0 26.25 27.00 Total (sum of lines 14-26) 33.94 1, 434. 10 27.00 28.00 Observation Bed Days 1,745 6,758 28.00 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 646 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 313 649 32.00 32.00 0 Total ancillary labor & delivery room 32.01 C 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

 Heal th Financial
 Systems
 ST.
 JOSEPHS

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE
 COMPLEX
 STATISTICAL
 DATA

Provider CCN: 15-0012

| Peri od: | Worksheet S-3 | From 07/01/2020 | Part I | Date/Time Prepared: |

					00/30/2021	11/30/2021 12	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12.00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	2, 200	377	11, 782	1.00
2.00	HMO and other (see instructions)			2, 469	1, 884		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	NEONATAL INTENSIVE CARE UNIT						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	533. 00	0	3, 233	377	11, 782	14. 00
15.00	CAH visits						15. 00
16.00	SUBPROVIDER - IPF						16. 00
17.00	SUBPROVIDER - IRF	0.00	0	0	o	0	17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	533. 00					27. 00
28. 00	Observation Bed Days						28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01				0			33. 01

| Peri od: | Worksheet S-3 | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0012

					T	06/30/2021	Date/Time Pre 11/30/2021 12	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	SALARI ES							1
1. 00	Total salaries (see instructions)	200. 00	103, 884, 754	. 0	103, 884, 754	2, 982, 933. 43	34. 83	1.00
2. 00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		C	0	О	0.00	0. 00	3. 00
4.00	Physician-Part A - Administrative		371, 959	0	371, 959	2, 938. 00	126. 60	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		2, 773, 793 2, 939, 825		2, 773, 793 2, 939, 825			1
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	2, 245, 550	89, 850	2, 335, 400	70, 545. 89	33. 10	7. 00
7. 01	Contracted interns and residents (in an approved		C	0	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		C	0	0	0.00	0.00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	3, 495, 600	0 193, 201	0 3, 688, 801	0. 00 136, 718. 16		
10.00	instructions) OTHER WAGES & RELATED COSTS		3, 473, 000	193, 201	3, 000, 001	130, 716. 10	20. 70	10.00
11. 00	Contract Labor: Direct Patient Care		9, 790, 779	0	9, 790, 779	89, 975. 00	108. 82	11. 00
12. 00	Contract labor: Top level management and other management and administrative		91, 309	0	91, 309	1, 996. 00	45. 75	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		2, 109, 905	0	2, 109, 905	18, 268. 00	115. 50	13. 00
14. 00	Home office and/or related organization salaries and		C	0	0	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		26, 767, 242	0	26, 767, 242	620, 079. 00	43. 17	14. 01
14. 02	Related organization salaries		C	0	0	0.00	•	14. 02
15. 00	Home office: Physician Part A - Administrative		C	0	0	0. 00	0.00	15. 00
16. 00	Home office and Contract		C	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A - Teaching		C	0	0	0.00	0. 00	16. 01
16. 02	j i		C	0	0	0.00	0.00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		35, 733, 774	0	35, 733, 774		I	17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		2, 589, 974	0	2, 589, 974			19. 00
20. 00	Non-physician anesthetist Part A		С	0	0			20.00
21. 00	Non-physician anesthetist Part B		C	0	0			21. 00
22. 00	Physician Part A - Administrative		39, 511		39, 511			22. 00
22. 01	Physician Part A - Teaching		322, 501	1	322, 501			22. 01 23. 00
23. 00 24. 00 25. 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		475, 878 0 872, 963	0	475, 878 0 872, 963			24. 00 25. 00
25. 50	approved program) Home office wage-related		7, 225, 045	0	7, 225, 045			25. 50
25. 51	(core) Related organization		C	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		C	0	0			25. 52
	- Administrative - wage-related (core)							

Maintenance of Personnel

Central Services and Supply

Medical Records & Medical

Nursing Administration

Pharmacy

Records Library Social Service

43.00 Other General Service

37.00

38.00

39.00

40.00

41.00

42.00

0.00

35. 63

17. 99

46. 39

37.00

38.00

39.00

40.00

27. 06 41. 00

36. 08 42. 00

20. 64 43. 00

0.00

88, 475. 48

29, 145. 03

90, 972. 68

63, 415. 37

62, 841. 83

48, 953. 46

3, 152, 153

4, 220, 159

1, 716, 098

2, 267, 020

1, 010, 241

524, 305

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0012 Peri od: Worksheet S-3 From 07/01/2020 Part II 06/30/2021 Date/Time Prepared: 11/30/2021 12:30 pm Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col.2 ± col. Salaries in A-6)3) col. 4 2.00 5. 00 1.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 4 00 190, 297 190, 297 3, 577. 00 26.00 Employee Benefits Department 53. 20 27.00 Administrative & General 5.00 11, 184, 739 0 11, 184, 739 168, 286. 00 66. 46 27.00 28.00 Administrative & General under 1, 450, 077 1, 450, 077 10, 657. 00 136.07 28.00 contract (see inst.) Maintenance & Repairs 6.00 29.00 0.00 29.00 0.00 Operation of Plant 1, 837, 526 0 1, 837, 526 62, 934. 50 29. 20 30.00 7.00 30.00 31.00 Laundry & Linen Service 8.00 127, 128 0 127, 128 6, 432. 50 19. 76 31.00 14. 73 32.00 Housekeepi ng 9.00 1, 440, 307 1, 440, 307 97, 781. 53 32.00 Housekeeping under contract 33.00 0 0 0.00 0.00 33.00 (see instructions) Di etary 34.00 10.00 1,865,084 -1, 230, 955 634, 129 36, 974. 26 17. 15 34.00 Dietary under contract (see instructions) 0.00 35.00 0.00 35.00 4, 105 17. 13 36, 00 Cafeteri a 11.00 1, 230, 955 1, 235, 060 72, 103. 77 36.00

3, 152, 153

4, 413, 360

1, 716, 098

2, 267, 020

1, 010, 241

524, 305

-193, 201

0

12.00

13.00

14.00

15.00

16.00

17.00

18.00

Total overhead cost (see

instructions)

7.00

36. 78

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0012 Peri od: Worksheet S-3 From 07/01/2020 To 06/30/2021 Part III Date/Time Prepared: 11/30/2021 12:30 pm Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 97, 375, 663 -89, 850 97, 285, 813 2, 863, 677. 54 33. 97 1.00 instructions) 2.00 3, 495, 600 193, 201 3, 688, 801 136, 718. 16 26. 98 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 93, 880, 063 -283, 051 93, 597, 012 2, 726, 959. 38 34.32 3.00 minus line 2) 4.00 Subtotal other wages & related 38, 759, 235 38, 759, 235 730, 318. 00 53.07 4.00 costs (see inst.) Subtotal wage-related costs 5.00 42, 998, 330 C 42, 998, 330 0.00 45.94 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 175, 637, 628 -283, 051 175, 354, 577 3, 457, 277. 38 50. 72

-193, 201

30, 989, 239

842, 550. 41

31, 182, 440

Health Financial Systems

ST. JOSEPHS REG MED CENTER S. BEND

HOSPITAL WAGE RELATED COSTS

Provider CCN: 15-0012

Period:
From 07/01/2020
To 06/30/2021

Part IV
Date/Time Prepared:
11/30/2021 12:30 pm

Amount
Reported
1.00

PART IV - WAGE RELATED COSTS

		11/30/2021 12:	:30 pm
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Empl oyer Contributions	4, 336, 767	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	3, 316, 154	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	151, 557	7. 00
	HEALTH AND INSURANCE COST		ĺ
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	l ol	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	18, 226, 073	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	3, 523, 574	9.00
10.00	Dental, Hearing and Vision Plan	919, 190	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	260, 054	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	754, 283	13.00
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	651, 148	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	212, 907	16.00
	Non cumulative portion)		
	TAXES		ĺ
17.00	FICA-Employers Portion Only	7, 491, 775	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	
23. 00		191, 118	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	40, 034, 600	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
		·	

Health Financial Systems	ST. JOSEPHS REG MED CENTER S. BEND	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: Worksheet S-3 From 07/01/2020 Part V To 06/30/2021 Date/Time Prepared:

		10 06/30/2021	11/30/2021 12:	
	Cost Center Description	Contract Labor		. 50 piii
	·	1. 00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	9, 790, 779	40, 034, 600	1. 00
2.00	Hospi tal	9, 790, 779	40, 034, 600	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16. 00	Hospi tal -Based-CMHC			16. 00
17.00	Renal Di al ysi s	0	0	17. 00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems ST. JOSEPHS REG MED C	ENTER S. BEND		In Lie	u of Form CMS-2	2552-10	
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0		eri od:	Worksheet S-10		
				om 07/01/2020	Date/Time Pre		
	To 06/30/2021						
					1 00		
	Uncompensated and indigent care cost computation				1. 00		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by line 202	column 8	3)	0. 261140	1. 00	
	Medicaid (see instructions for each line)						
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				61, 596, 742 Y	2. 00 3. 00	
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen	tal navments from	Medicai d	12	Ϋ́	4. 00	
5. 00	If line 4 is no, then enter DSH and/or supplemental payments f		mour our c		. 0	5. 00	
6.00	Medi cai d charges				210, 499, 302	6. 00	
7.00	Medicaid cost (line 1 times line 6)				54, 969, 788		
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 minus sum	of lines	2 and 5; if	0	8. 00	
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	or each line)					
9. 00	Net revenue from stand-alone CHIP	5. 646			0	9. 00	
10.00	Stand-alone CHIP charges				0	10.00	
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0		
12. 00	Difference between net revenue and costs for stand-alone CHIP	(line 11 minus lin	ne 9; if	< zero then	0	12. 00	
	enter zero) Other state or local government indigent care program (see ins	tructions for 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	·	,	lines 6 or	0		
	10)						
15. 00	State or local indigent care program cost (line 1 times line 1		(1 !	15	0	15.00	
16. 00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero)	digent care progra	am (iine	15 minus iine	0	16. 00	
	Grants, donations and total unreimbursed cost for Medicaid, CH	P and state/local	i ndi ger	it care program	ıs (see		
17 00	instructions for each line)	unding obority oor			0	17 00	
17. 00 18. 00	Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of				0	17. 00 18. 00	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loca			sum of lines	0		
	8, 12 and 16)						
			sured	Insured	Total (col. 1		
			ents 00	pati ents 2.00	+ col . 2) 3.00		
	Uncompensated Care (see instructions for each line)		00	2. 00	0.00		
20. 00	Charity care charges and uninsured discounts for the entire fa (see instructions)	cility 14,	703, 442	1, 256, 471	15, 959, 913	20. 00	
21. 00	Cost of patients approved for charity care and uninsured disco	unts (see 3.	839, 657	1, 256, 471	5, 096, 128	21. 00	
	instructions)			,			
22. 00	Payments received from patients for amounts previously written	off as	0	0	0	22. 00	
23. 00	charity care Cost of charity care (line 21 minus line 22)	3.	839, 657	1, 256, 471	5, 096, 128	23. 00	
		, ,	,				
24.00	December 20 column 2 include change for notice	-			1. 00	24. 00	
	4.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N imposed on patients covered by Medicaid or other indigent care program?						
25. 00	If line 24 is yes, enter the charges for patient days beyond t stay limit	he indigent care p	orogram's	length of	0	25. 00	
26. 00	Total bad debt expense for the entire hospital complex (see in	structions)			20, 326, 945	26. 00	
27. 00	Medicare reimbursable bad debts for the entire hospital comple	•	ns)		651, 059		
27. 01	Medicare allowable bad debts for the entire hospital complex (	see instructions)			1, 001, 630		
28. 00	Non-Medicare bad debt expense (see instructions)	nonco (coo inctrus	eti onc)		19, 325, 315	1	
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex Cost of uncompensated care (line 23 column 3 plus line 29)	hense (see instinc	. ( 1 0115		5, 397, 184 10, 493, 312		
	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			10, 493, 312		
		*					

LOLASSI	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO	F	eriod: rom 07/01/2020	Worksheet A	
				T		11/30/2021 12	
	Cost Center Description	Sal ari es	0ther	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				·		(col. 3 +-	
		1.00	2. 00	3. 00	4. 00	col . 4) 5.00	
	ENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		0	0	, ,		1. ( 2. (
	00300 OTHER CAP REL COSTS		0	0		0, 611, 403	3. (
. 00 0	00400 EMPLOYEE BENEFITS DEPARTMENT	190, 297	87, 536			277, 833	4. (
	00540 NONPATI ENT TELEPHONES 00570 ADMITTI NG	191, 687 1, 146, 036	68, 205 464, 605		0	259, 892 1, 610, 641	5. ( 5. (
1	00590 OTHER ADMINISTRATIVE & GENERAL	9, 847, 016	110, 610, 578		-20, 012, 977	100, 444, 617	5.0
	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 837, 526 127, 128	5, 138, 640 1, 204, 777	6, 976, 166 1, 331, 905			7. 8.
1	00900 HOUSEKEEPING	1, 440, 307	1, 360, 889	2, 801, 196			1
0. 00 0	01000 DI ETARY	1, 865, 084	2, 466, 401	4, 331, 485	-2, 869, 508	1, 461, 977	10.
	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	4, 105	44, 705 0	48, 810 0		2, 855, 561 0	11. (
	01300 NURSING ADMINISTRATION	3, 152, 153	5, 469, 124	8, 621, 277	-706, 720		13. (
	01400 CENTRAL SERVICES & SUPPLY	524, 305	479, 700	1, 004, 005			
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	4, 413, 360 1, 716, 098	24, 368, 037 708, 004	28, 781, 397 2, 424, 102			1
	01700 SOCIAL SERVICE	2, 267, 020	1, 120, 826	3, 387, 846			1
8. 00 0	01850 STERI LE SUPPLY	1, 010, 241	2, 743, 723	3, 753, 964		3, 671, 016	18.
	01900 NONPHYSICIAN ANESTHETISTS	0	727 (02	0	0	0	
	02100   &R SERVICES-SALARY & FRINGES APPRV 02200   &R SERVICES-OTHER PRGM COSTS APPRV	2, 245, 550 2, 506, 107	727, 603 761, 229				1
	2300 PARAMED ED PRGM-(SPECIFY)	0	0	0			1
	2302 PHARMACY RESIDENCY PROGRAM	152, 112	61, 614	213, 726	390, 806	604, 532	23.
	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	20, 118, 572	8, 334, 031	28, 452, 603	-1, 930, 768	26, 521, 835	30.
	03100 INTENSIVE CARE UNIT	4, 445, 270	3, 040, 534	· ·			
	02060 NEONATAL INTENSIVE CARE UNIT	1, 959, 969	949, 251	2, 909, 220		1	1
	04100  SUBPROVI DER - I RF 04300  NURSERY	0	0	_	_	ı	
А	NCILLARY SERVICE COST CENTERS	9		-	1,770,700		
	D5000 OPERATING ROOM D5100 RECOVERY ROOM	9, 994, 420 1, 124, 581	40, 584, 191				
	05200 DELIVERY ROOM & LABOR ROOM	2, 692, 845	376, 360 1, 044, 868				
4. 00 0	05400 RADI OLOGY-DI AGNOSTI C	3, 506, 613	3, 306, 876	6, 813, 489	-1, 689, 841	5, 123, 648	54.
	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	153, 403 798, 246	200, 615	354, 018 1, 337, 427		354, 018	ı
	05800 MRI	790, 240	539, 181 1, 039, 587	1, 039, 587	-151, 063 0	1, 186, 364 1, 039, 587	
	05900 CARDI AC CATHETERI ZATI ON	2, 840, 474	13, 356, 613	16, 197, 087		10, 552, 698	59.
	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 425, 713	10, 257, 114 0		-285, 197 0	l	
	06500 RESPIRATORY THERAPY	2, 126, 113	1, 010, 199	_	_	1	1
5. 01 0	03610 SLEEP LAB	5, 149	650, 656	655, 805	-92, 099	563, 706	65.
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 412, 061	1, 196, 522	3, 608, 583			
	06800 SPEECH PATHOLOGY	774, 149 290, 276	184, 330 70, 678	958, 479 360, 954		l	
9.00 0	06900 ELECTROCARDI OLOGY	1, 023, 329	668, 201	1, 691, 530		1, 388, 863	1
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	-451, 231	-451, 231	451, 231	0	1
1	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 417, 215	0 511, 749	0 928, 964	,,		
4. 00 0	07400 RENAL DIALYSIS	9, 311	1, 597, 057	1, 606, 368		l	
4	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0	0	41, 552 0	41, 552 0	1
	OUTPATIENT SERVICE COST CENTERS	91		0			70.
1	09000 CLINIC	0	270			l e	90.
	09001 MOBILE MEDICAL UNIT 09002 FAMILY MEDICINE CENTER	86, 355 780, 249	185, 731 969, 683	272, 086 1, 749, 932		129, 453 1, 324, 440	1
0. 04 0	09003 WOUND HEALING CENTER	612, 504	1, 472, 853	2, 085, 357	-529, 928		
	09004 OUTPATIENT TREATMENT & INFUSION	658, 796	237, 231	896, 027	00.450	,	1
	09005 PEDIATRIC SPECIALTY CLINIC 09006 SPORTS MED FELLOWSHIP CLINIC	241, 055 714, 795	226, 960 315, 472	468, 015 1, 030, 267	-90, 450 -193, 518	l	1
	199000 SPORTS WED FELLOWSHIP CLINIC 199007 PODIATRY RESIDENCY CLINIC	714, 793	371, 114	1, 100, 041	-53, 565		1
0. 09	99008 FACULTY PRACTICE CLINIC	403, 030	335, 381	738, 411	-139, 034	599, 377	90.
	09009 OUR LADY OF ROSARY CLINIC 09100 EMERGENCY	874, 461	410, 810		-64, 348 -233, 934		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 687, 253	3, 099, 528	7, 786, 781	-233, 934	7, 552, 847	91. 92.
S	PECIAL PURPOSE COST CENTERS						
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	100, 541, 266	253, 978, 611	354, 519, 877	233, 456	354, 753, 333	1118.

Health Financial Systems ST.	JOSEPHS REG MED	CENTER S. BE	ND	In Lie	eu of Form CMS-2	552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der Co		Peri od:	Worksheet A	
				From 07/01/2020 To 06/30/2021	Date/Time Prep 11/30/2021 12:	
Cost Center Description	Sal ari es	Other	Total (col. '	Reclassi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
NONREI MBURSABLE COST CENTERS				_		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40, 776	40, 77	6 0	40, 776	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0	192. 00
192. 01 19201 MATERNAL FETAL MEDICINE/LABORIST	0	0		0	0	192. 01
192. 02 19202 NEONATOLOGI STS	0	0		0	0	192. 02
192. 03 19203 HOSPI TALI STS/I NTENSI VI STS	0	0		0 0	0	192. 03
194.00 07950 SPORTS MED-ATHLETIC TRAINERS	0	0		0	0	194. 00
194. 01 07951 OUTREACH SERVICES	2, 851, 121	1, 243, 020	4, 094, 14	1 -85, 432	4, 008, 709	194. 01
194. 02 07952 KINDRED/OUR LADY OF PEACE	0	0		0	0	194. 02
194. 03 07953 ADVANCED SPECIALTIES	0	16, 194	16, 19	4 -8, 379	7, 815	194. 03
194.04 07954 AMBULATORY PHARMACY SERVICES	492, 367	172, 132	664, 49	9 -139, 645	524, 854	194. 04
200.00 TOTAL (SUM OF LINES 118 through 199)	103, 884, 754	255, 450, 733	359, 335, 48	7 0	359, 335, 487	200. 00

Health Financial Systems

ST. JOSEPHS REG MED CENTER S. BEND

In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0012

From 07/01/2020
To 06/30/2021

Date/Time Prepared:

				To 06/30/2021 Date/Time Pre	
	Cost Center Description	Adjustments	Net Expenses		. 30 piii
		(See A-8) 6.00	For Allocation 7.00	1	
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	5, 348, 110			1.00
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS	-25, 123 0	6, 586, 280 0	l I	2. 00 3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-392, 059	1		4. 00
5. 01	00540 NONPATIENT TELEPHONES	0	1		5. 01
5.04	00570 ADMITTING	0	1, 610, 641		5. 04
5. 06 6. 00	00590 OTHER ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	-34, 766, 306	65, 678, 311 0		5. 06 6. 00
7. 00	00700 OPERATION OF PLANT	-10, 692	1		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 302, 909	l I	8. 00
9.00	00900 HOUSEKEEPI NG	0	2, 800, 710		9. 00
10.00	01000 DI ETARY	0	1, 461, 977		10.00
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	-1, 134, 553 0	1, 721, 008	l I	11. 00 12. 00
13. 00	1 1		7, 914, 557	1	13.00
14.00	+ I	11, 471	993, 913		14. 00
15. 00		-26, 779			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-111, 681	2, 311, 149	l I	16.00
17. 00 18. 00		0	3, 343, 318 3, 671, 016		17. 00 18. 00
19. 00	1	Ö	0,071,010	1	19.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	2, 932, 469		21. 00
22. 00		-30, 100	1	1	22. 00
23. 00 23. 02	1 1	0			23. 00 23. 02
23.02	02302   PHARMACY RESIDENCY PROGRAM     I NPATIENT ROUTINE SERVICE COST CENTERS	0	604, 532		23.02
30. 00		-2, 784	26, 519, 051		30. 00
31. 00	+ I	0	,		31. 00
35. 00	1 1	0	2, 840, 684	l I	35. 00
41. 00 43. 00	+ I	0	l .		41. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS		1, 773, 700	·	43.00
50.00	05000 OPERATING ROOM	-3, 984, 986	26, 746, 552		50. 00
51.00	1	0	,		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	-345		l I	52. 00 54. 00
54. 00 55. 00		-15, 512 337	5, 108, 136 354, 355		55.00
57. 00	1 1	0	1, 186, 364		57. 00
58. 00	I I	0			58. 00
59.00	1 1	-1, 110		•	59.00
60. 00 62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		l I	60. 00 62. 30
65. 00	06500 RESPI RATORY THERAPY	0	3, 102, 740		65.00
65. 01	03610 SLEEP LAB	-1, 242	l		65. 01
66. 00	06600 PHYSI CAL THERAPY	-1, 400			66.00
67. 00 68. 00	1 1	0		l I	67. 00 68. 00
69. 00	1 1	0	1	1	69.00
71. 00	1 1	0	0		71. 00
72. 00	· · · · · · · · · · · · · · · · · · ·	0	23, 116, 382		72. 00
73. 00 74. 00	+ I	0	24, 907, 631		73. 00 74. 00
74. 00 76. 97		0	1, 603, 606 0		76. 97
76. 98	+ I	Ö	41, 552		76. 98
76. 99		0	0		76. 99
00.00	OUTPATIENT SERVICE COST CENTERS	1			00.00
90. 00 90. 02	1	0			90.00
90. 02	I I	-12, 396			90. 02
90. 04	1	0	1, 555, 429	l I	90. 04
90. 05	09004 OUTPATIENT TREATMENT & INFUSION	0	896, 027	l I	90. 05
90.06	1 1	-71, 129			90.06
90. 07 90. 08	09006 SPORTS MED FELLOWSHIP CLINIC 09007 PODIATRY RESIDENCY CLINIC	-2, 635 -784	l		90. 07 90. 08
90.08	09008 FACULTY PRACTICE CLINIC	-158			90.08
90. 10	09009 OUR LADY OF ROSARY CLINIC	0	1, 220, 923		90. 10
91. 00	+ +	-247, 381	7, 305, 466		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS				92.00
118. 0		-35, 479, 237	319, 274, 096		118. 00
	NONREI MBURSABLE COST CENTERS			1	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		l I	190. 00
192. 0	D 19200 PHYSICIANS' PRIVATE OFFICES	0	0	)	192. 00

Health Financial Systems

ST. JOSEPHS REG MED CENTER S. BEND

In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0012

From 07/01/2020
To 06/30/2021 12: 30 pm

			11/30/2021 12:30 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6.00	7.00	
192. 01 19201 MATERNAL FETAL MEDICINE/LABORIST	0	0	192. 01
192. 02 19202 NEONATOLOGI STS	0	0	192. 02
192. 03 19203 HOSPI TALI STS/I NTENSI VI STS	0	0	192. 03
194.00 07950 SPORTS MED-ATHLETIC TRAINERS	0	0	194. 00
194. 01 07951 OUTREACH SERVICES	0	4, 008, 709	194. 01
194.02 07952 KINDRED/OUR LADY OF PEACE	0	0	194. 02
194. 03 07953 ADVANCED SPECIALTIES	0	7, 815	194. 03
194.04 07954 AMBULATORY PHARMACY SERVICES	0	524, 854	194. 04
200.00 TOTAL (SUM OF LINES 118 through 199)	-35, 479, 237	323, 856, 250	200. 00

ST. JOSEPHS REG MED CENTER S. BEND
Provi der CCN: 15-0012 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 07/01/2020 To 06/30/2021 Date/Time Prepared: 11/30/2021 12:30 pm

		Increases			 11/30/2021 12:30 pm
	Cost Center	Li ne #	Salary	Other	
	2. 00	3. 00	4. 00	5. 00	
1. 00	B - Implantable Devices IMPL. DEV. CHARGED TO	72.00	ol	23, 116, 382	1.00
1.00	PATIENTS	72.00	٥	23, 110, 302	1.00
2.00		0.00	0	0	2. 00
3. 00		0.00		0	3. 00
	TOTALS C - Drugs Charged to Patients		0	23, 116, 382	
1. 00	LABORATORY	60.00	0	4, 742	1. 00
2.00	SLEEP LAB	65. 01	0	27	2. 00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	23, 993, 853	3.00
4. 00 5. 00		0. 00 0. 00	ol	0	4. 00 5. 00
6. 00		0.00	o	o	6. 00
7.00		0.00	0	0	7. 00
8. 00 9. 00		0. 00 0. 00	0	0	8. 00 9. 00
10. 00		0.00	0	0	10.00
11. 00		0. 00	o	0	11. 00
12.00		0.00	0	0	12.00
13. 00 14. 00		0. 00 0. 00	0	0	13. 00 14. 00
15. 00		0.00	o	0	15. 00
16.00		0. 00	О	0	16. 00
17. 00		0.00	0	0	17. 00
18. 00 19. 00		0. 00 0. 00	0	0	18. 00 19. 00
17.00	TOTALS			23, 998, 622	17.00
	E - Building Depreciation				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9, 282, 362	1.00
2. 00 3. 00		0. 00 0. 00	0	0	2. 00 3. 00
4. 00		0.00	o	Ō	4. 00
5.00		0.00	0	0	5. 00
6. 00 7. 00		0. 00 0. 00	0	0	6. 00 7. 00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9. 00
10.00		0.00	0	0	10.00
11. 00 12. 00		0. 00 0. 00	0	0	11. 00 12. 00
13. 00		0.00	o	o	13. 00
14.00		0.00	o	0	14. 00
15.00		0.00	0	0	15.00
16. 00 17. 00		0. 00 0. 00	0	0	16. 00 17. 00
18. 00		0.00	Ö	0	18. 00
19. 00		0.00	0	0	19. 00
20.00		0. 00 0. 00	0	0	20. 00 21. 00
21. 00 22. 00		0.00	o	0	22. 00
23.00		0. 00	0	0	23. 00
24. 00		0.00	0	0	24. 00
25. 00 26. 00		0. 00 0. 00	0	0	25. 00 26. 00
27. 00		0.00	Ö	0	27. 00
28. 00		0.00	0	0	28. 00
29. 00 30. 00		0. 00 0. 00	0	0	29. 00 30. 00
31. 00		0.00	o	0	31.00
32. 00		0.00	0	0	32.00
	TOTALS		0	9, 282, 362	
1 00	F - Equipment Depreciation CAP REL COSTS-MVBLE EQUIP	2 00		6 611 402	1 00
1. 00 2. 00	CAF REL CUSIS-MVBLE EQUIP	2. 00		6, 611, 403	1. 00 2. 00
3.00					3. 00
4.00					4. 00
5. 00 6. 00					5. 00 6. 00
7. 00					7. 00
8.00					8. 00
9.00					9. 00
10. 00 11. 00					10.00
11.00					11. 00 12. 00
	1	1	I	l .	

ST. JOSEPHS REG MED CENTER S. BEND
Provi der CCN: 15-0012 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 07/01/2020 To 06/30/2021 Date/Time Prepared: 11/30/2021 12:30 pm

		Inono				Z. SU PIII
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
13.00						13. 00
14.00						14. 00
15.00						15. 00
16.00						16. 00
17. 00						17. 00
18. 00						18. 00
19. 00						19. 00
20.00						20. 00
21. 00						21. 00
22. 00						22. 00
23.00						23. 00
24.00						24. 00
25.00						25. 00
26.00						26. 00
27.00						27. 00
28. 00						28. 00
29. 00						29. 00
30. 00						30. 00
31. 00						31. 00
32. 00						32. 00
33. 00						33. 00
34.00						34. 00
35.00						35. 00
36.00						36. 00
37.00						37. 00
38. 00						38. 00
00.00		+	$-$	6, 611, 403		00.00
	G - Cafeteria	l	<u> </u>	0, 011, 403		
1 00		11. 00	1, 230, 955	1, 606, 999		1 00
1. 00	CAFETERI A					1. 00
	LI OR WILDOEDY		1, 230, 955	1, 606, 999		
	H - OB/NURSERY					
1.00	NURSERY	4300		49 <u>2, 7</u> 83		1. 00
			1, 126, 137	492, 783		
	I - Nursery and Labor/Delivery					
1. 00	NURSERY	<u>43.</u> 00	27 <u>4, 7</u> 50	100, 316		1. 00
			274, 750	100, 316		
	K - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		11, 332, 407		1. 00
2.00						2. 00
				11, 332, 407		
	L - SBMF CAPITAL		5	11/002/107		
1.00	CAP REL COSTS-BLDG & FLXT	1.00		144, 500		1. 00
2.00	CAL REE COSTS-BEDG & TIXI	1.00		144, 300		2. 00
2.00	oxdots	+		144, 500		2.00
	M. N. I. D. I		U	144, 500		
	M - Negative Balances	74 00		154 004		4
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00		451, 231		1. 00
	PATI ENT					
2.00		↓	↓			2. 00
			0	451, 231		
	N - Hyperbaric Oxygen					
1.00	HYPERBARIC OXYGEN THERAPY	76. 98	19, 524	22, 028		1. 00
			19, 524	22, 028		İ
	0 - 2nd YR PHARMACY RESIDENTS					Ī
1.00	PHARMACY RESIDENCY PROGRAM	23. 02	300, 620	90, 186		1. 00
2. 00		20.02	000, 020	707 100		2. 00
2.00	oxdot =+	+	300, 620	90, 186		2.00
	P - OTHER MEDICAL EDUCATION EX	/DENSES	300, 020	70, 100		$\dashv$
				157 400		1 00
1. 00	I &R SERVI CES-OTHER PRGM	22. 00		157, 489		1. 00
	COSTS APPRV	+				
			0	157, 489		4
	Q - CLINIC MEDICAL EDUCATION					
	I&R SERVICES-SALARY &	21. 00	89, 850	26, 955		1. 00
	FRI NGES APPRV					
			89, 850	26, 955		
500.00	Grand Total: Increases		3, 041, 836	77, 433, 663		500.00
	'	·	'			

Peri od: Worksheet A-6 From 07/01/2020 To 06/30/2021 Date/Time Prepared:

2.00   PHARMACY   15.00   0   22,377,654   0   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00							11/30/2021 Date/Trille Pi	
Description   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00								
R								
December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   December   100   Dece			7. 00	8. 00	9. 00	10. 00		
2.00   CABRIAC CATHETRY ATT ON   59 00   0   5,300,598   0   0   2.00   0   3.00   0   0   0   0   0   0   0   0   0	1 00		F0, 00		17 420 004			1 00
DOLLAND TRAILING CHIEFE   90.04   0   301.08   0   1   1   1   1   1   1   1   1   1		1	•			1		1
TOTALS   0 23.116.982   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00		1				l		1
C - Drugs Changed to Patients   14.00	3.00							3.00
1.00					20, 110, 002			
3.00   SCALAL STRATCE   17.00   3 44.528   0   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00	1.00			0	6, 900	0		1.00
3.00   SCALAL STRATCE   17.00   3 44.528   0   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00	2.00	PHARMACY	15. 00	0		o		2. 00
OSTS APPROV OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDATRICS OMENING S PEDATRICS OMENING S PEDATRICS OMENING S PEDATRICS OMENING S PEDIATRICS OMENING S PEDIATRICS OMENING S PEDATRICS OMENING S PEDIATRICS S PEDIATRICS OMENING S PEDIATRICS S PEDIATRI	3.00	SOCIAL SERVICE	17. 00	0		o		3. 00
5.00   ADULTS & PEDIATRICS   30.00   0   198,271   0   5.00   ON INTERSIVE CARE UNIT   31 00   0   299,434   0   7.00   6.00   ON INTERSIVE CARE UNIT   31 00   0   299,434   0   7.00   8.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00	4.00	I&R SERVICES-OTHER PRGM	22. 00	0	17	0		4. 00
O.   O.   O.   O.   O.   O.   O.   O.								
0.00   OPERATING ROOM   S.O.00   0   299,436   0   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00			•			- I		1
0.00		1				0		1
9.00 DELIVERY PROON & LABOR ROOM 52.00 G 35, 092 G 9.00 11.00 C PART DOLOGY DIA PARSET ST. 57.00 G 155, 380 G 11.00 C 17 SCAN TEGAPY 57.00 G 155, 380 G 11.00 G 12.00 RESPIRATORY TEGAPY 65.00 G 1.60 G 0 11.00 G 12.00 RESPIRATORY TEGAPY 65.00 G 1.60 G 0 12.00 G 12.00 G 12.00 RESPIRATORY TEGAPY 65.00 G 1.60 G 0 13.00 G 12.00 G		l l	•			0		1
10. 00   RADIOLOCY-JUAGUSTIC		1	•			0		4
11.00 CI SCAM  12.00 RESPIRATORY HERAPY  66.00 0 1,608 0 12.00  PHYSICAL THERAPY  66.00 0 1,505 0 0 13.00  14.00  15.00 ELECTROCARD LOCY  67.00 0 1,505 0 0 13.00  15.00 ELECTROCARD LOCY  67.00 0 1,505 0 0 15.00  15.00 ELECTROCARD LOCY  67.00 0 1,500 0 15.00  16.00 PABLY WERD CINE CENTER  90.00 0 1,500 0 15.00  18.00 PACULTY PRACTICE CLINIC  10.00 PABLY CONTROL THE STATION  10.00 PARCHAIN STRATI VE & 5.00 0 0 1,5179 0 18.00  10.00 CHERRANTION OF PLANT  10.00 0 10.00 0 1,000 0 0 1,000 0 0 1,000 0 1,000 0 1.00  10.00 CALETERIA 1 10.00 0 0 0,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0 1,000 0		l l		-		0		1
12 00   RESPIRATORY HIERAPY   05.00   0   1.008   0   13.00   14.00   OCCUPATIONAL THERAPY   67.00   0   510   0   14.00   15.00   ELECTROCARDIOLOGY   67.00   0   510   0   14.00   16.00   FAULLY WEIL/OLD RECRIFER   90.03   0   129.394   0   16.00   17.00   MOUND HALL INC CENTER   90.03   0   129.394   0   16.00   18.00   PACULTY PRACTICE CLINIC   90.09   0   15.179   0   18.00   19.00   FACULTY PRACTICE CLINIC   90.09   0   15.179   0   18.00   19.00   TOTAL STATIVE & 5.00   0   23.396.622   0   0   0    E Buil ding Depreciation   0   0   0   0   0   0   0   0   0    COMPARTION OF PLANT   7.00   0   113.505   0   0   0   0   0   0   0   0   0		l l				0		1
13.0 0 PHYSICAL THERAPY 66.00 0 1.505 0 13.400 15.00 14.400 15.00 0 14.400 15.00 0 15.00 0 14.400 15.00 0 15.00 0 14.400 15.00 15.00 0 15.00 0 14.400 15.00 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 15		1				0		1
14. 00     COUDATIONAL THERAPY				-	.,	0		1
15. 00   ELECTROCARDIOLOCY			•					1
16.00   FAMILY MEDICAINE CENTER   90.03   0   129,394   0   16.00   17.00   18.00   FACULTY PRACTICE CLINIC   90.09   0   15.179   0   18.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00			•			o		1
18. 00   FACULTY PRACTICE CLINIC   90. 00   0   181,179   0   18. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19			•	0		o		16. 00
19, 00	17.00	WOUND HEALING CENTER	90. 04	0		o		17. 00
TOTALS	18.00	FACULTY PRACTICE CLINIC	90. 09	0	15, 179	o		18. 00
E - Building Depreciation  0.00  1.00  2.00  OTHER ADMINISTRATIVE & 5.06  0.00  0.345,412  0.00  OPERATION OF PLANT  7.00  0.113,505  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00	19.00	EMERGENCY	91.00	0	181, 084	o		19. 00
1.00		TOTALS		0	23, 998, 622			
2. 00 OTHER ADMINISTRATIVE & 5. 0.6 O 6. 345, 412 O GREATION OF PLANT 7. 0.0 O 113, 505 O 3.00 OPERATION OF PLANT 7. 0.0 O 113, 505 O 3.00 O 5. 0.0 CAFETERIA 1.0.0 O 0 0 16, 933 O 5. 0.0 CAFETERIA 1.0.0 O 0 16, 933 O 5. 0.0 CAFETERIA 1.0.0 O 0 16, 933 O 5. 0.0 CAFETERIA 1.0.0 O 0 16, 933 O 6. 0.0 O 0.0 CAFETERIA 1.0.0 O 0 16, 933 O 7. 0.0 CENTRAL SERVICES & SUPPLY 14. 0.0 O 7. 0.0 O 7. 0.0 CENTRAL SERVICES & SUPPLY 14. 0.0 O 7. 0.0		E - Building Depreciation			T			
GENERAL 3.00 OPERATION OF PLANT 7.00 0 1133,505 0 3.00 4.00 DIETARY 10.00 0 3,000 0 4.00 5.00 CAFETERIA 11.00 0 1.6,933 0 5.00 6.00 NURSI NG ADMINI STRATION 133.00 0 346,248 0 6.00 6.00 NURSI NG ADMINI STRATION 133.00 0 346,248 0 7.00 6.00 PHARMACY 15.00 0 7.010 0 7.00 8.00 PHARMACY 15.00 0 26,420 0 8.00 8.00 PHARMACY 15.00 0 126,420 0 8.00 8.00 PHARMACY 16.00 0 1 0 9.00 8.00 PHARMACY 16.00 0 1 0 9.00 8.00 STERILE SUPPLY 18.00 0 10,681 0 10.00 11.00 STERILE SUPPLY 18.00 0 10,681 0 10.00 12.00 ADMINISTRATION 22.00 0 180,602 0 11.00 13.00 INTERNSIVE CARE UNIT 31.00 0 39,788 0 12.00 13.00 INTERNSIVE CARE UNIT 31.00 0 39,788 0 13.00 15.00 OPERATING ROOM 50.00 0 61,142 0 15.00 15.00 OPERATING ROOM 50.00 0 61,142 0 15.00 15.00 OPERATING ROOM 50.00 0 61,142 0 15.00 17.00 CARDIAC CATHETERIZATION 59.00 0 61,142 0 15.00 17.00 CARDIAC CATHETERIZATION 59.00 0 27,485 0 17,00 18.00 LABORATORY 60.00 0 145,439 0 18.00 19.00 SLEEP LAB 65.01 0 91,858 0 17,00 19.00 SLEEP LAB 65.01 0 91,858 0 17,00 19.00 SLEEP LAB 65.01 0 91,858 0 19,00 19.00 SLEEP LAB 65.01 0 91,858 0 12,00 19.00 SLEEP LAB 65.01 0 91,859 0 12,855 0 22,00 19.00 SLEEP LAB 65.01 0 91,859 0 12,855 0 22,00 10.00 SPORTS MED FELLOWSHIP CLINIC 90.09 0 123,855 0 22,00 10.00 SPORTS MED FELLOWSHIP CLINIC 90.09 0 123,855 0 22,00 10.00 SPORTS MED FELLOWSHIP CLINIC 90.09 0 123,855 0 22,00 10.00 SPORTS MED FELLOWSHIP CLINIC 90.09 0 123,855 0 22,00 10.00 SPORTS MED FELLOWSHIP CLINIC 90.09 0 92,282,362  F - EQUIPMENT LERVEY 8 5.00 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,860 0 1,		OTHER ARMINI CTRATINE 0			•	I .		1
3. 00   OPERATION OF PLANT	2. 00		5.06	Ü	6, 345, 412	U		2.00
4.00 DI ETARY	2 00	l l	7 00	0	112 505			2 00
5.00 CAFETERIA 1.1.00 0 1.6.933 0 0 5.00 6.00 NURSING ADMINISTRATION 13.00 0 3.46, 248 0 6.00 7.00 CENTRAL SERVICES & SUPPLY 14.00 0 7.010 0 7.000 8.00 PHARMACY 15.00 0 26, 420 0 8.00 9.00 MEDICAL RECORDS & LIERARY 16.00 0 1 1 0 9.000 9.00 MEDICAL RECORDS & LIERARY 18.00 0 10.6611 0 9.000 11.00 STERILE SUPPLY 18.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 6031 0 10.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 6031 0 10.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 6031 0 10.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 22.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 20.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 20.00 180, 602 0 11.000 11.00 IAR SERVICES-OTHER PRGM 20.00 0 180, 602 0 11.000 11.00 IAR SERVICES-OTHER 90.00 0 180, 602 0 11.000 11.00 IAR SERVICES 194, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180, 600 0 180,		l l				0		1
6.00 NURSI NG ADMINI STRATION 13.00 0 346, 248 0 0 6.00 6.00 7.010 0 7.010 0 7.010 0 7.00 CATEFRAL SERVICES & SUPPLY 14.00 0 7.010 0 9.00 PHARMACY 15.00 0 26, 420 0 9.00 PHARMACY 15.00 0 0 26, 420 0 9.00 MEDI CAL RECORDS & LI BRARY 16.00 0 1 1 0 9.00 10.00 STERI LE SUPPLY 18.00 0 10.681 0 10.00 11.00 11.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.0			•			0		1
7. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 7, 010 0 8. 00 9. 00 MEDI CAL RECORDS & LI BRARY 16. 00 0 1 1 0 0 9. 00 10. 00 STEPL IE SUPPLY 18. 00 0 110. 00 STEPL IE SUPPLY 19. 00 ST			•					1
8. 00 PHARMACY 15. 00 0 26, 420 0 9. 00 PHARMACY 16. 00 0 1 1 0 9. 00 0 10. 00 STERILE SUPPLY 18. 00 0 1 10. 681 0 10. 00 11. 00 STERILE SUPPLY 18. 00 0 1 18. 681 0 10. 00 11. 00 18. 8 SERVICES-OTHER PRGM 22. 00 0 180, 602 0 111. 00 18. 8 SERVICES-OTHER PRGM 22. 00 0 18. 00 18. 119 0 112. 00 113. 00 18. 119 0 112. 00 113. 00 18. 119 0 112. 00 113. 00 18. 119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 0119 0 113. 00 18. 01 18. 00 18. 0119 0 113. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 01 18. 00 18. 00 18. 01 18. 00 18. 00 18. 01 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18			I			o		7. 00
9.00 MEDI CAL RECORDS & LI BRARY   10.00			•	0		o		8. 00
11.00   IAR SERVICES-OTHER PRGM   22.00   0   180,602   0	9.00	MEDICAL RECORDS & LIBRARY	16.00	0	1	o		9. 00
COSTS APPRV   CODULTS & PEDIATRICS   SO	10.00	STERI LE SUPPLY	18. 00	0	10, 681	o		10. 00
12. 00 ADULTS & PEDIATRICS 13. 00 INTENSIVE CARE UNIT 13. 00 0 39, 788 0 13. 00 INTENSIVE CARE UNIT 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPERATING ROOM 15. 00 OPE	11. 00	I&R SERVICES-OTHER PRGM	22. 00	0	180, 602	0		11. 00
13. 00   INTENSIVE CARE UNIT   31. 00   0   39,788   0   113. 00   14. 00   NEONATAL INTENSIVE CARE UNIT   35. 00   0   3,453   0   14. 00   15. 00   OPERATI NG ROOM   50. 00   0   61,142   0   15. 00   OPERATI NG ROOM   50. 00   0   61,142   0   15. 00   0   0   17. 00   CAPETATI NG ROOM   50. 00   0   27,485   0   17. 00   CAPETATI NG ROOM   59. 00   0   27,485   0   17. 00   CAPETATI NG ROOM   71. 00   17. 00   CAPETATI NG ROOM   71. 00   17. 00   18. 00   LABORATORY   60. 00   0   145,439   0   18. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19.		1						
14. 00 NEONATAL INTENSIVE CARE UNIT		1				l 1		1
15.00   OPERATING ROOM   50.00   0   61,142   0   15.00   16.00   17.00   16.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.0						0		1
16.00 RADI OLOGY-DI AGNOSTIC 54.00 0 553, 596 0 17.00 CARDI AGC CATHETER 12ATI ON 59.00 0 27.485 0 17.00 17.00 CARDI AGC CATHETER 12ATI ON 59.00 0 27.485 0 17.00 18.00 LABORATORY 60.00 0 145, 439 0 188.00 19.00 SLEEP LAB 65.01 0 91, 858 0 19.00 20.00 PHYSI CAL THERAPY 66.00 0 330, 148 0 20.00 21.00 ELECTROCARDI OLOGY 69.00 0 135, 426 0 21.00 22.00 MOBILE MEDI CAL UNIT 90.02 0 7.231 0 22.00 MOBILE MEDI CAL UNIT 90.02 0 7.231 0 22.00 WOUND HEALING CENTER 90.03 0 280, 533 0 224.00 WOUND HEALING CENTER 90.04 0 117, 915 0 24.00 25.00 PEDI ATRI C SPECI ALTY CLINI C 90.06 0 90, 377 0 25.00 PORTS MED FELLOWSHIP CLINI C 90.07 0 57, 529 0 26.00 SPORTS MED FELLOWSHIP CLINI C 90.07 0 57, 529 0 26.00 SPORTS MED FELLOWSHIP CLINI C 90.09 0 123, 855 0 27.00 PODI ATRY RESIDENCY CLINI C 90.09 0 123, 855 0 28.00 FACULTY PRACTI CE CLINI C 90.09 0 123, 855 0 28.00 131.00 UNI LADY OF ROSARY CLINI C 90.10 0 33, 707 0 29.00 UNI LADY OF ROSARY CLINI C 90.10 0 33, 707 0 29.00 UNI LADY OF ROSARY CLINI C 90.10 0 33, 707 0 29.00 31.00 EMERGENCY 91.00 0 1, 0555 0 30.00 MERGENCY 91.00 0 0 1, 0555 0 30.00 ADVANCED SPECIALTIES 194.03 0 8, 379 0 32.00 ADVANCED SPECIALTIES 194.03 0 9, 282, 362 F - Equipment Depreciation 9, 00 486 5.00 400 SERVER 10 SERVICES 8.00 28, 906 4.00 SERVER 10 SERVICES 8.00 28, 906 5.00 SERVER 1						0		1
17. 00 CARDIAC CATHETERIZATION 59. 00 0 27, 485 0 17. 00 18. 00 LABORATORY 60. 00 0 145, 439 0 18. 00 19. 00 SLEEP LAB 65. 01 0 91, 858 0 19. 00 20. 00 PHYSICAL THERAPY 66. 00 0 330, 148 0 20. 00 21. 00 ELECTROCARDIOLOGY 69. 00 0 135, 426 0 21. 00 22. 00 MOBILE MEDICAL UNIT 90. 02 0 7, 231 0 22. 00 23. 00 FAMILY MEDICINE CENTER 90. 03 0 280, 533 0 230, 240, 00 WOUND HEALING CENTER 90. 04 0 117, 915 0 23. 00 24. 00 WOUND HEALING CENTER 90. 06 0 90, 377 0 24. 00 25. 00 PEDIATRIC SPECIALTY CLINIC 90. 06 0 90, 377 0 25. 00 26. 00 SPORTS MED FELLOWSHIP CLINIC 90. 06 0 90, 377 0 25. 00 27. 00 PODIATRY RESIDENCY CLINIC 90. 08 0 51, 459 0 27. 00 28. 00 FACULTY PRACTICE CLINIC 90. 09 0 123, 855 0 28. 00 29. 00 UR LADY OF ROSARY CLINIC 90. 10 0 33, 707 0 29. 00 30. 00 EMERGENCY 91. 00 0 1, 055 0 30. 00 31. 00 OUTREACH SERVICES 194. 01 0 64, 036 0 31. 00 31. 00 OUTREACH SERVICES 194. 01 0 64, 036 0 31. 00 32. 00 OUTREACH SERVICES 194. 01 0 64, 036 0 31. 00 31. 00 OUTREACH SERVICES 194. 01 0 64, 036 0 31. 00 32. 00 OTHER ADMINISTRATIVE & 5. 06 1, 884, 197 (200, 200, 200, 200, 200, 200, 200, 200		1	•			0		1
18. 00 LABORATORY 60. 00 0 145, 439 0 18. 00 19. 00 SLEEP LAB 66. 01 0 91, 858 0 20. 00 19. 00 PHYSI CAL THERAPY 66. 00 330, 148 0 20. 00 21. 00 ELECTROCARDI OLOGY 69. 00 0 135, 426 0 21. 00 22. 00 MOBI LE MEDI CAL UNI T 90. 02 0 7, 231 0 22. 00 23. 00 FAMI LY MEDI CI NE CENTER 90. 03 0 280, 533 0 23. 30 24. 00 WOUND HEALI NG CENTER 90. 04 0 117, 915 0 24. 00 25. 00 PEDI ATRI C SPECI ALTY CLI NI C 90. 06 0 90, 377 0 25. 00 26. 00 SPORTS MED FELLOWSHI P CLI NI C 90. 07 0 57, 529 0 26. 00 27. 00 PODI ATRY RESI DENCY CLI NI C 90. 08 0 51, 459 0 27. 00 28. 00 FACULTY PRACTI CE CLI NI C 90. 09 0 123, 855 0 28. 00 29. 00 OUR LADY OF ROSARY CLI NI C 90. 10 0 33, 707 0 29. 00 30. 00 EMERGENCY 91. 00 0 12, 3855 0 30. 00 31. 00 OUTREACH SERVI CES 194, 01 0 64, 036 0 31. 00 32. 00 ADVANCED SPECI ALTI ES 194. 03 0 8, 379 0 32. 00 32. 00 OTHER ADMI NI STRATI VE & 5. 06 ENERGY 3. 00 OPERATI ON OF PLANT 7. 00 175, 364 4. 00 LAUNDRY & LI NEN SERVI CE 8. 00 28, 996 5. 00 HOUSEKEEPI NG 9. 00 486 6. 00 DI ETARY 11. 00 486 6. 00 DI ETARY 11. 00 1 14, 270 7. 00 CAFETERI A 11. 00 14, 270 NUNSI NG ADMI NI STRATI ON 13. 00 360, 472				-		0		1
19. 00 SLEEP LAB 65. 01 0 91,858 0 19. 00 20. 00 PHYSI CAL THERAPY 66. 00 0 330, 148 0 20. 00 21. 00 ELECTROCARDI OLOGY 69. 00 0 135, 426 0 21. 00 22. 00 MOBI LE MEDI CAL UNIT 90. 02 0 7, 231 0 22. 00 23. 00 FAMI LY MEDI CINE CENTER 90. 03 0 280, 533 0 24. 00 WOUND HEALI NG CENTER 90. 04 0 117, 915 0 24. 00 25. 00 PEDI ATRI C SPECI ALTY CLINI C 90. 06 0 90, 377 0 25. 00 26. 00 SPORTS MED FELLOWSHI P CLINI C 90. 07 0 57, 529 0 26. 00 27. 00 PODI ATRY RESI DENCY CLINI C 90. 08 0 51, 459 0 27. 00 29. 00 OUR LADY OF ROSARY CLINI C 90. 10 0 33, 707 0 28. 00 31. 00 OUR LADY OF ROSARY CLINI C 90. 10 0 33, 707 0 29. 00 31. 00 OUTREACH SERVI CES 194. 01 0 64, 036 0 31. 00 32. 00 ADVANCED SPECI ALTI ES 194. 01 0 64, 036 0 31. 00 32. 00 OUTREACH SERVI CES 194. 01 0 64, 036 0 31. 00 32. 00 OUTREACH SERVI CES 194. 01 0 64, 036 0 31. 00 32. 00 OPERATION OF PLANT 7. 00 175, 364 4. 00 4. 00 LAUNDRY & LINEN SERVI CE 8. 00 5. 00 HOUSEKEEPING 9. 00 486 5. 00 6. 00 DI ETARY 10. 00 28, 534 6. 00 8. 00 NURSI NG ADMINI STRATI ON 13. 00 36, 0472 8. 80			•			0		1
20. 00 PHYSICAL THERAPY 66. 00 0 330, 148 0 20. 00 21. 00 ELECTROCARDI OLOGY 69. 00 0 135, 426 0 0 21. 00 MOBI LE MEDI CAL UNIT 90. 02 0 7, 231 0 22. 00 23. 00 FAMI LY MEDI CINE CENTER 90. 03 0 280, 533 0 230, 24. 00 24. 00 WOUND HEALING CENTER 90. 04 0 117, 915 0 24. 00 25. 00 PEDI ATRI C SPECI ALTY CLINI C 90. 06 0 90, 377 0 25. 00 26. 00 SPORTS MED FELLOWSHI P CLINI C 90. 06 0 90, 377 0 26. 00 27. 00 PODI ATRY RESI DENCY CLINI C 90. 08 0 51, 459 0 27. 00 28. 00 FACULTY PRACTI CE CLINI C 90. 09 0 123, 855 0 28. 00 29. 00 OUR LADY OF ROSARY CLINI C 90. 10 0 33, 707 0 29. 00 30. 00 EMERGENCY 91. 00 0 1, 055 0 30. 00 31. 00 OUTREACH SERVI CES 194. 01 0 64, 036 0 31. 00 32. 00 ADVANCED SPECI ALTI ES 194. 03 0 8.379 0 32. 00  ADVANCED SPECI ALTI ES 194. 03 0 8.379 0 70  1. 00 2. 00 OTHER ADMINISTRATI VE & 5. 06 CENERAL 3. 00 OPERATION OF PLANT 7. 00 175, 364 4. 00 4. 00 LAUNDRY & LI NEN SERVI CE 8. 00 28, 996 5. 00 6. 00 DI ETARY 1. 00 10. 00 28, 534 6. 00 6. 00 DI ETARY 1. 00 11. 00 486 6. 00 7. 00 CAFETERI A 11. 00 36, 0472 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMINISTRATI ON 13. 00 8. 00 NURSI NG ADMI		ı ı				l 1		1
21. 00   ELECTROCARDI OLOGY   69. 00   0   135, 426   0   21. 00   22. 00   MOBILE MEDI CAL UNIT   90. 02   0   7, 231   0   22. 00   23. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   25. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26.					1	l 1		
22. 00 MOBILE MEDICAL UNIT 90. 02 0 7, 231 0 22. 00 23. 00 FAMILY MEDICINE CENTER 90. 03 0 280, 533 0 23. 00 24. 00 WOUND HEALING CENTER 90. 04 0 117, 915 0 24. 00 25. 00 PEDIATRIC SPECIALTY CLINIC 90. 06 0 90, 377 0 25. 00 26. 00 SPORTS MED FELLOWSHIP CLINIC 90. 07 0 57, 529 0 26. 00 27. 00 PODIATRY RESIDENCY CLINIC 90. 08 0 51, 459 0 27. 00 28. 00 FACULTY PRACTICE CLINIC 90. 09 0 123, 855 0 28. 00 29. 00 OUR LADY OF ROSARY CLINIC 90. 10 0 33, 707 0 29. 00 30. 00 EMERGENCY 91. 00 0 1, 055 0 30. 00 31. 00 OUTREACH SERVICES 194. 01 0 64, 036 0 31. 00 32. 00 ADVANCED SPECIALTIES 194. 03 0 8, 379 0 32. 00 30. 00 OTHER ADMINISTRATIVE & 5. 06 1, 884, 197 GENERAL 9. 0 9, 282, 362  F - Equipment Depreciation 175. 00 175, 364 0 0. 00 3. 00 OPERATION OF PLANT 7. 00 175, 364 0. 00 3. 00 OPERATION OF PLANT 7. 00 486 0. 00 3. 00 OPERATION OF PLANT 7. 00 486 0. 00 3. 00 ODERATION OF DLANT 7. 00 486 0. 00 3. 00 ODERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 486 0. 00 3. 00 OPERATION OF DLANT 7. 00 7. 00 3. 00 CAFETER A 11. 00 14, 270 7. 00 3. 00 NURSING ADMINISTRATION 13. 00 360, 472 8. 00					1	l .		21. 00
24. 00 WOUND HEALING CENTER 90. 04 0 117, 915 0 24. 00 25. 00 PEDIATRIC SPECIALTY CLINIC 90. 06 0 90, 377 0 25. 00 26. 00 SPORTS MED FELLOWSHIP CLINIC 90. 07 0 57, 529 0 26. 00 27. 00 PODIATRY RESIDENCY CLINIC 90. 08 0 51, 459 0 27. 00 28. 00 FACULTY PRACTICE CLINIC 90. 09 0 123, 855 0 28. 00 29. 00 OUR LADY OF ROSARY CLINIC 90. 10 0 33, 707 0 29. 00 30. 00 EMERGENCY 91. 00 0 1, 055 0 30. 00 31. 00 OUTREACH SERVICES 194. 01 0 64, 036 0 31. 00 32. 00 ADVANCED SPECIALTIES 194. 03 0 8, 379 0 32. 00  TOTALS 9 0 9, 282, 362 9  1. 00 2. 00 OTHER ADMINISTRATIVE & 5. 06 1, 884, 197 GENERAL 3. 00 PERATION OF PLANT 7. 00 175, 364 3. 00 2. 00 OPERATION OF PLANT 7. 00 175, 364 4. 00 2. 00 LAUNDRY & LINEN SERVICE 8. 00 28, 996 4. 00 5. 00 HOUSEKEEPING 9. 00 486 5. 00 6. 00 DIETARY 11. 00 128, 534 6. 00 8. 00 NURSING ADMINISTRATION 13. 00 360, 472 8. 00	22.00	MOBILE MEDICAL UNIT	90. 02	0	7, 231	o		22. 00
25. 00 PEDI ATRI C SPECI ALTY CLINI C 90. 06 0 90, 377 0 26. 00 SPORTS MED FELLOWSHIP CLINI C 90. 07 0 57, 529 0 26. 00 27. 00 PODI ATRY RESI DENCY CLINI C 90. 08 0 51, 459 0 27. 00 28. 00 FACULTY PRACTI CE CLINI C 90. 09 0 123, 855 0 28. 00 PACULTY PRACTI CE CLINI C 90. 10 0 33, 707 0 29. 00 OUR LADY OF ROSARY CLINI C 90. 10 0 33, 707 0 29. 00 0UR LADY OF ROSARY CLINI C 90. 10 0 1, 055 0 30. 00 EMERGENCY 91. 00 0 1, 055 0 30. 00 31. 00 OUTREACH SERVI CES 194. 01 0 64, 036 0 31. 00 32. 00 ADVANCED SPECIALTIES 194. 03 0 8, 379 0 32. 00 F - Equipment Depreciation 9, 282, 362 F - Equipment Depreciation 9, 282, 362 F - Equipment Depreciation 9, 282, 362 F - Equipment Depreciation 9, 282, 362 F - Equipment Depreciation 9, 282, 362 F - Equipment Depreciation 9, 283, 394 0 3. 00 00 00 00 00 00 00 00 00 00 00 00 00	23.00	FAMILY MEDICINE CENTER	90. 03	0	280, 533	o		23. 00
26. 00 SPORTS MED FELLOWSHIP CLINIC 90. 07 0 57, 529 0 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 28. 00 51, 459 0 27. 00 27. 00 28. 00 FACULTY PRACTICE CLINIC 90. 09 0 123, 855 0 28. 00 29. 00 0UR LADY OF ROSARY CLINIC 90. 10 0 33, 707 0 29. 00 30. 00 EMERGENCY 91. 00 0 1, 055 0 30. 00 31. 00 0UTREACH SERVICES 194. 01 0 64, 036 0 31. 00 32. 00 ADVANCED SPECIALTIES 194. 03 0 8, 379 0 32. 00 TOTALS 90. 00 9, 282, 362 9 1. 00 0 9, 282, 362 9 1. 00 0 9, 282, 362 9 1. 00 0 9, 282, 362 9 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1.	24.00	WOUND HEALING CENTER	90. 04	0	117, 915	0		24. 00
27. 00 PODI ATRY RESIDENCY CLINIC 90. 08 0 51, 459 0 28. 00	25.00	PEDIATRIC SPECIALTY CLINIC	•	0	90, 377	0		25. 00
28. 00 FACULTY PRACTICE CLINIC 90. 09 0 123, 855 0 29. 00 0UR LADY OF ROSARY CLINIC 90. 10 0 33, 707 0 29. 00 30. 00 EMERGENCY 91. 00 0 1, 055 0 30. 00 31. 00 0UTREACH SERVICES 194. 01 0 64, 036 0 31. 00 ADVANCED SPECIALTIES 194. 03 0 8, 379 0 70 32. 00 TOTALS 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 282, 362 9 9, 28			•			0		26. 00
29. 00 OUR LADY OF ROSARY CLINIC 90. 10 0 33, 707 0 29. 00 30. 00 EMERGENCY 91. 00 0 1, 055 0 30. 00 31. 00 OUTREACH SERVICES 194. 01 0 64, 036 0 31. 00 32. 00 ADVANCED SPECIALTIES 194. 03 0 8, 379 0 32. 00  F - Equipment Depreciation  1. 00 2. 00 OTHER ADMINISTRATIVE & 5. 06 1, 884, 197  9 1. 00 GENERAL 3. 00 OPERATION OF PLANT 7. 00 175, 364 3. 00 4. 00 LAUNDRY & LINEN SERVICE 8. 00 28, 996 4. 00 5. 00 HOUSEKEEPING 9. 00 486 5. 00 6. 00 DIETARY 11. 00 28, 534 6. 00 7. 00 CAFETERIA 11. 00 14, 270 7. 00 8. 00 NURSING ADMINISTRATION 13. 00 360, 472 8. 00		1				0		1
30. 00   EMERGENCY   91. 00   0   1, 055   0   30. 00   31. 00   31. 00   31. 00   32. 00   ADVANCED SPECIALTIES   194. 03   0   8, 379   0   0   32. 00   70   70   70   70   70   70   70				-		0		1
31. 00 OUTREACH SERVICES 194. 01 0 64, 036 0 31. 00 32. 00 ADVANCED SPECIALTIES 194. 03 0 8, 379 0  TOTALS 0 9, 282, 362  F - Equipment Depreciation  2. 00 OTHER ADMINISTRATIVE & 5. 06 1, 884, 197 GENERAL  3. 00 OPERATION OF PLANT 7. 00 175, 364 4. 00 LAUNDRY & LINEN SERVICE 8. 00 28, 996 5. 00 HOUSEKEEPING 9. 00 486 6. 00 DIETARY 10. 00 28, 534 6. 00 7. 00 CAFETERIA 11. 00 14, 270 8. 00 NURSING ADMINISTRATION 13. 00 360, 472 8. 00 NURSING ADMINISTRATION 13. 00 360, 472		1				0		1
32. 00 ADVANCED SPECIALTIES 194. 03 0 8, 379 0 1 32. 00 TOTALS 0 9, 282, 362				ŭ		0		1
TOTALS  F - Equi pment Depreciation  1. 00 2. 00 OTHER ADMINISTRATIVE & 5. 06 1, 884, 197  GENERAL  3. 00 OPERATION OF PLANT 7. 00 175, 364 4. 00 LAUNDRY & LINEN SERVICE 8. 00 28, 996 5. 00 HOUSEKEEPING 9. 00 486 6. 00 DI ETARY 10. 00 28, 534 7. 00 CAFETERIA 11. 00 14, 270 8. 00 NURSI NG ADMINISTRATION 13. 00 360, 472 8. 00		l l	•			l 1		
F - Equi pment Depreciation  1.00 2.00 OTHER ADMINISTRATIVE & 5.06 1,884,197 GENERAL 3.00 OPERATION OF PLANT 7.00 175,364 4.00 LAUNDRY & LINEN SERVICE 8.00 28,996 5.00 HOUSEKEEPING 9.00 486 6.00 DI ETARY 10.00 28,534 7.00 CAFETERIA 11.00 14,270 8.00 NURSI NG ADMINISTRATION 13.00 360,472 8.00	32.00		194.03					32.00
1. 00 2. 00 OTHER ADMINISTRATIVE & 5. 06 3. 00 OPERATION OF PLANT 7. 00 175, 364 4. 00 LAUNDRY & LINEN SERVICE 8. 00 28, 996 5. 00 HOUSEKEEPING 9. 00 486 6. 00 DIETARY 10. 00 28, 534 7. 00 CAFETERIA 11. 00 14, 270 8. 00 NURSING ADMINISTRATION 13. 00 360, 472 8. 00				0	7, 202, 302			
2. 00 OTHER ADMINISTRATIVE & 5. 06 SENERAL STATION OF PLANT SENERAL STATION OF PLANT SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL SENERAL S	1.00	. Equ. psire bopi coi atti oii				9		1.00
GENERAL 3. 00 OPERATION OF PLANT 7. 00 175, 364 4. 00 LAUNDRY & LI NEN SERVI CE 8. 00 28, 996 5. 00 HOUSEKEEPI NG 9. 00 486 6. 00 DI ETARY 10. 00 28, 534 7. 00 CAFETERI A 11. 00 14, 270 8. 00 NURSI NG ADMI NI STRATI ON 13. 00 360, 472 8. 00		OTHER ADMINISTRATIVE &	5. 06		1, 884, 197			2. 00
4. 00     LAUNDRY & LI NEN SERVI CE     8. 00     28, 996     4. 00       5. 00     HOUSEKEEPI NG     9. 00     486     5. 00       6. 00     DI ETARY     10. 00     28, 534     6. 00       7. 00     CAFETERI A     11. 00     14, 270     7. 00       8. 00     NURSI NG ADMI NI STRATI ON     13. 00     360, 472     8. 00								
5. 00     HOUSEKEEPI NG     9. 00     486     5. 00       6. 00     DI ETARY     10. 00     28, 534     6. 00       7. 00     CAFETERI A     11. 00     14, 270     7. 00       8. 00     NURSI NG ADMI NI STRATI ON     13. 00     360, 472     8. 00								3. 00
6. 00 DI ETARY 10. 00 28, 534 6. 00 7. 00 CAFETERI A 11. 00 14, 270 8. 00 NURSI NG ADMI NI STRATI ON 13. 00 360, 472 8. 00		1	•					4. 00
7. 00 CAFETERIA 11. 00 14, 270 7. 00 8. 00 NURSI NG ADMI NI STRATI ON 13. 00 360, 472 8. 00		1	•					5. 00
8.00 NURSING ADMINISTRATION 13.00 360, 472 8.00		l l						6. 00
		l l				l 1		1
9. 00		1						
	7.00	POLINIKAL SEKVICES & SUPPLY	14.00		l /, 653			9.00

2.00

1.00

1.00

2.00

1.00

1.00

500.00

RECLASSIFICATIONS Provider CCN: 15-0012 Period: W

Period: Worksheet A-6 From 07/01/2020

06/30/2021 Date/Time Prepared: 11/30/2021 12:30 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 PHARMACY 10.00 15.00 212,030 10.00 11.00 MEDICAL RECORDS & LIBRARY 16.00 1, 271 11.00 72, 267 12.00 STERILE SUPPLY 18.00 12.00 ADULTS & PEDIATRICS 30.00 105.458 13.00 13.00 14.00 INTENSIVE CARE UNIT 31.00 71, 791 14.00 NEONATAL INTENSIVE CARE UNIT 35.00 15.00 65,083 15.00 16.00 OPERATING ROOM 50.00 2.058.399 16.00 RECOVERY ROOM 51.00 17.00 4, 161 17.00 18.00 DELIVERY ROOM & LABOR ROOM 52.00 26, 570 18.00 RADI OLOGY-DI AGNOSTI C 699, 129 19.00 54.00 19.00 20 00 CT SCAN 57.00 20 00 15 683 CARDIAC CATHETERIZATION 21.00 59.00 256, 306 21.00 31, 964 22.00 RESPIRATORY THERAPY 65.00 22.00 23.00 SLEEP LAB 65.01 268 23.00 PHYSICAL THERAPY 24 00 66.00 21, 723 24 00 OCCUPATIONAL THERAPY 25.00 67.00 390 25, 00 26.00 SPEECH PATHOLOGY 68.00 7,018 26.00 27.00 ELECTROCARDI OLOGY 69.00 165, 866 27.00 DRUGS CHARGED TO PATIENTS 73.00 15.186 28.00 28.00 29. 00 RENAL DIALYSIS 74.00 2,762 29.00 MOBILE MEDICAL UNIT 90.02 135, 402 30.00 30.00 FAMILY MEDICINE CENTER 90.03 31.00 15, 565 31.00 32.00 WOUND HEALING CENTER 90.04 1, 944 32.00 PEDIATRIC SPECIALTY CLINIC 90.06 73 33.00 33.00 34.00 SPORTS MED FELLOWSHIP CLINIC 90.07 19, 184 34.00 PODIATRY RESIDENCY CLINIC 90.08 35 00 2.106 35 00 36.00 OUR LADY OF ROSARY CLINIC 90.10 30, 641 36.00 91.00 51, 795 EMERGENCY 37.00 37.00 21, 396 38.00 38.00 OUTREACH SERVICES 194.01 6, 611, 403 - Cafeteria 1.00 DI ETARY 10.00 1, 230, 955 1, 606, 999 1.00 1, 230, 955 1, 606, 999 H - OB/NURSERY ADULTS & PEDIATRICS 1, 126, 137 492, 783 1.00 30.00 1.00 492, 783 1, 126, 137 - Nursery and Labor/Delivery 1.00 DELIVERY ROOM & LABOR ROOM 52.00 274, 750 100, 316 1.00 274, 750 100, 316 K - Interest Expense 1.00 11 1.00 2.00 OTHER ADMINISTRATIVE & 5.06 11, 332, 407 2.00 GENERAL 11, 332, 407 L - SBMF CAPITAL 1.00 14 1.00 2.00 LABORATORY 60.00 144, 500 2.00 144, 500 M - Negative Balances 1.00 OTHER ADMINISTRATIVE & 5.06 450, 961 1.00

270

451, 231

22, 028

22.028

57, 960

32, 226

90, 186

157, 489

157, 489

2<u>6, 9</u>55

26, 955

77, 433, 663

90.00

90.04

15.00

21.00

90.07

194.04

19, 524

19, 524

193, 201

107, 419

300, 620

89, 850

89,850

3, 041, 836

GENERAL

CLINIC

PHARMACY

N - Hyperbaric Oxygen

WOUND HEALING CENTER

I&R SERVICES-SALARY &

FRI NGES APPRV

500.00 Grand Total: Decreases

0 - 2nd YR PHARMACY RESIDENTS

AMBULATORY PHARMACY SERVICES

Q - CLINIC MEDICAL EDUCATION

SPORTS MED FELLOWSHIP CLINIC

P - OTHER MEDICAL EDUCATION EXPENSES

2.00

1.00

1.00

2.00

1.00

1.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0012 Peri od: Worksheet A-7 From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/30/2021 12:30 pm Acqui si ti ons Begi nni ng Total Di sposal s and Purchases Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 289, 730 0 0 1.00 0 2.00 Land Improvements 0 0 0 0 0 0 2.00 3.00 306, 651, 963 3.00 Buildings and Fixtures 0 0 0 4.00 Building Improvements 2, 530, 859 0 0 4.00 5.00 Fixed Equipment 0 5.00 0 0 74, 913 6.00 Movable Equipment 117, 539, 562 6.00 0 7.00 HIT designated Assets 0 0 7.00 0 0 8.00 Subtotal (sum of lines 1-7) 427, 012, 114 74, 913 8.00 9.00 Reconciling Items 0 0 9.00 74, 913 Total (line 8 minus line 9) 427, 012, 114 10.00 0 10.00 0 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 289, 730 1.00 2.00 Land Improvements 2.00 3.00 Buildings and Fixtures 306, 651, 963 8, 305, 949 3.00 4.00 Building Improvements 2, 530, 859 547, 215 4.00 5.00 Fi xed Equipment 5.00 Movable Equipment 6.00 117, 464, 649 73, 757, 604 6.00 7.00 HIT designated Assets 7.00

426, 937, 201

426, 937, 201

82, 610, 768

82, 610, 768

Heal th	Financial Systems ST.	JOSEPHS REG ME	D CENTER S. E	BEND	In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 15-0012	Peri od:	Worksheet A-7	
					From 07/01/2020 To 06/30/2021		nared·
					10 00,00,2021	11/30/2021 12	: 30 pm
				SUMMARY OF CAP	PLTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLUM	N 2, LINES 1	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	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 O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sı	um			
		Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)					
	DART LL BESSHOLLLATION OF MOUNTS FROM WAY	14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLUM	N 2, LINES 1	and 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		O			3. 00

Heal th	Financial Systems ST.	JOSEPHS REG ME	ED CENTER S. BE	ND	In Li∈	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 07/01/2020 To 06/30/2021	Worksheet A-7 Part III	pared:
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	)	1. 000000		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	)	0. 000000		2.00
3.00	Total (sum of lines 1-2)	0	0	)	0 1.000000		3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	)	0 14, 630, 472	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	)	0 6, 586, 280	0	2.00
3.00	Total (sum of lines 1-2)	0	0	)	0 21, 216, 752	0	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate		
			Í	,	d Costs (see	through 14)	
					instructions)		
		11. 00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1 00	CAP DEL COSTS_BLDG & FLYT	11 332 407	0	1	144 500	26 107 370	1 00

11, 332, 407

0 11, 332, 407

0 0 0

144, 500

0

0 0 0

26, 107, 379 1. 00 6, 586, 280 2. 00 32, 693, 659 3. 00

1.00

CAP REL COSTS-BLDG & FLXT

CAP REL COSTS-MVBLE EQUIP

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

Heal th Financial Systems

ST. JOSEPHS REG MED CENTER S. BEND

In Lieu of Form CMS-2552-10

Provider CCN: 15-0012

Period:
From 07/01/2020
To 06/30/2021

Pate/Time Prepared:
11/30/2021 12: 30 pm

Expense Classification on Worksheet A

To/From Which the Amount is to be Adjusted

					0 06/30/2021	Date/lime Prep 11/30/2021 12:	
				Expense Classification on To/From Which the Amount is			
				10/FIOII WITCH THE AMOUNT IS	to be Aujusteu		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00		1. 00
2. 00	COSTS-BLDG & FLXT (chapter 2)		0	CAD DEL COSTS MADLE FOLLID	2.00		2 00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		U	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3. 00	Investment income - other	В		OTHER ADMINISTRATIVE & GENERAL	5. 06	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0	GENERAL	0.00	0	4.00
F 00	discounts (chapter 8)		0		0.00	0	F 00
5. 00	Refunds and rebates of expenses (chapter 8)		O		0.00	U	5.00
6. 00	Rental of provider space by		0		0.00	0	6.00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		0		0.00	0	8.00
9. 00	(chapter 21)		0		0.00	0	9.00
10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-7, 416, 556		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
11.00	(chapter 23)		O		0.00		11.00
12. 00	Related organization transactions (chapter 10)	A-8-1	-3, 739, 185			0	12.00
13. 00	Laundry and Linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		-943, 192	CAFETERI A	11.00		
15. 00	Rental of quarters to employee and others		U		0.00	0	15.00
16. 00	Sale of medical and surgical supplies to other than	В	0	EMERGENCY	91. 00	0	16. 00
	pati ents						
17. 00	Sale of drugs to other than patients	В	-26, 779	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19.00
17.00	education (tuition, fees,		9		0.00	Ŭ	17.00
20. 00	books, etc.) Vending machines	В	-191 361	CAFETERI A	11. 00	0	20.00
21. 00	Income from imposition of		0	on Elemin	0.00		1
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27 00	COSTS-BLDG & FLXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		O O	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00		28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	O	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of		3		35.00		- 7. 50
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32.00
	Depreciation and Interest						

| Period: | Worksheet A-8 | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES ST. JOSEPHS REG MED CENTER S. BEND
Provi der CCN: 15-0012

				To	06/30/2021	Date/Time Prep 11/30/2021 12	
				Expense Classification on To/From Which the Amount is 1		11/30/2021 12	. 30 piii
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
33. 00	Other Operating Rev - Adults	В		ADULTS & PEDIATRICS	30.00	0	33. 00
33. 01	and Peds OTHER REVENUE	В	0	OTHER ADMINISTRATIVE & GENERAL	5. 06	0	33. 01
33. 02	Other Operating Rev - Cardiac Cath	В	-1, 110	CARDI AC CATHETERI ZATI ON	59. 00	0	33. 02
33. 03	Other Operating Rev - Resp Care	В	0	RESPI RATORY THERAPY	65.00	0	33. 03
33. 04	Other Operating Rev - Radiation Oncology	В	337	RADI OLOGY-THERAPEUTI C	55. 00	0	33. 04
33. 06 33. 08	Other Operating Rev - Imaging Other Operating Rev - Physical	B B		RADI OLOGY-DI AGNOSTI C PHYSI CAL THERAPY	54. 00 66. 00	0	33. 06 33. 08
33. 09	Therapy OTHER REVENUE	В	0	I&R SERVICES-OTHER PRGM COSTS APPRV	22. 00	0	33. 09
33. 10	Other Operating Rev - Sports Med Fellowship	В	-2, 635	SPORTS MED FELLOWSHIP CLINIC	90. 07	0	33. 10
33. 11	Other Operating Rev - Emergency Room	В	-1, 531	EMERGENCY	91. 00	0	33. 11
33. 12	Other Operating Rev - Information Resources	В	-111, 681	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 12
33. 13 33. 14	Other Operating Rev - Security Other Operating Rev -	B B		OPERATION OF PLANT OTHER ADMINISTRATIVE &	7. 00 5. 06	0	
33. 15	Administration Other Operating Rev - Dual Employee	В	-48, 436	GENERAL OTHER ADMINISTRATIVE & GENERAL	5. 06	0	33. 15
33. 16	Other Operating Rev - Mobile Medical Unit	В	100	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 16
33. 17 33. 18	OTHER REVENUE Other Operating Rev - Med Ed	B B		RADI OLOGY-THERAPEUTI C I &R SERVI CES-OTHER PRGM	55. 00 22. 00	0	33. 17 33. 18
33. 19	Non-Labor Other Operating Rev - Family Medicine Center	В	-12, 396	COSTS APPRV FAMILY MEDICINE CENTER	90. 03	0	33. 19
33. 20	Other Operating Rev - Faculty Practice	В	-158	FACULTY PRACTICE CLINIC	90. 09	0	33. 20
33. 21	Other Operating Rev - St Joe Foot & Ankle	В	-784	PODIATRY RESIDENCY CLINIC	90. 08	0	33. 21
33. 22	Other Operating Rev - Emergency Medical Srvs	В		PARAMED ED PRGM-(SPECIFY)	23. 00	0	33. 22
33. 23	Other Operating Rev - Labor and Delivery	В		DELIVERY ROOM & LABOR ROOM	52. 00	0	33. 23
33. 24 33. 25	Other Operating Rev - Physical Therapy OTHER REVENUE	B B		PHYSICAL THERAPY SPORTS MED FELLOWSHIP CLINIC	66. 00 90. 07	0	
33. 29	OTHER REVENUE	В		EMERGENCY	91.00	0	
33. 30	Gain Loss on Sale of Building	В		CAP REL COSTS-BLDG & FIXT	1.00	14	
33. 31 33. 32	Gain Loss on Sale of Equipment Other NG Revenue Peds Clinic	B B		CAP REL COSTS-MVBLE EQUIP PEDIATRIC SPECIALTY CLINIC	2. 00 90. 06		
33. 33	OTHER REVENUE - CDU	В		OPERATING ROOM	50.00		
33. 34	Other NG Rev - Foot & Ankle	В		PODIATRY RESIDENCY CLINIC	90. 08	Ō	
33. 35	Other NG Revenue - Fam Medicine	В		FAMILY MEDICINE CENTER	90. 03		
33. 36	Other Revenue - Dual Employee	В		OTHER ADMINISTRATIVE & GENERAL	5. 06		
33. 40 34. 00	Non-Operating Adjustment  Medicaid Provider Bed Tax	B A		OTHER ADMINISTRATIVE & GENERAL OTHER ADMINISTRATIVE &	5. 06 5. 06	0	
34. 40	Donations Expense	A		GENERAL OTHER ADMINISTRATIVE &	5. 06		
35. 00	Di scounts	A		GENERAL OTHER ADMINISTRATIVE &	5. 06	0	
35. 01 35. 10	Di scounts Property Tax	A A		GENERAL CENTRAL SERVICES & SUPPLY OTHER ADMINISTRATIVE &	14. 00 5. 06	0	
36. 00	PROPERTY TAX	A		GENERAL SUBPROVI DER - I RF	41. 00		
37. 00	DI SCOUNTS	A		OTHER ADMINISTRATIVE & GENERAL	5. 06		37. 00
37. 01	DI SCOUNTS	A	0	CENTRAL SERVICES & SUPPLY	14. 00	0	37. 01

Health Financial Systems	ST.	JOSEPHS REG ME	D CENTER S. BEND	In Li∈	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				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		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2.00	3. 00	4. 00	5. 00	
50.00 TOTAL (sum of lines 1 thru 49)		-35, 479, 237				50.00
(Transfer to Worksheet A,						
column 6 line 200 )					1	1

- 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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-0012

Peri od: Worksheet A-8-1 From 07/01/2020 OFFICE COSTS 06/30/2021 Date/Time Prepared:

					11/30/2021 12	2:30 pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5. 06	OTHER ADMINISTRATIVE & GENER	HO NON CAPITAL COSTS	45, 148, 806	51, 760, 234	1. 00
2.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP	580, 964	484, 261	2. 00
3.00	5. 06	OTHER ADMINISTRATIVE & GENER	I NSURANCE	961, 980	3, 036, 234	3. 00
3. 01	5. 06	OTHER ADMINISTRATIVE & GENER	PENSI ON	138, 419	147, 973	3. 01
3.02	4. 00	EMPLOYEE BENEFITS DEPARTMENT	RETIREE HEALTH COSTS	0	199, 179	3. 02
3.03	1.00	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS	5, 348, 110	0	3. 03
3.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMP HEALTH STOP LOSS	0	289, 583	3. 04
4.00	0.00			0	0	4. 00
5.00	TOTALS (sum of lines 1-4).			52, 178, 279	55, 917, 464	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.

			Related Organization(s) and/	or Home Office	
			norated organization(e) and	0 0 00	
0 1 1 (1)				5	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownership		Ownarahi n	
		Owner Sni p		Ownershi p	
1. 00	2.00	3.00	4. 00	5. 00	
1.00	2.00	3.00	4.00	3.00	
R INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			
B. THIERRELATIONSHIT TO RELAT	LD ORGANIZATION(3) AND OR THE	WL OITTOL.			d .

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

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

6.00	G		O. OO TRINITY HEALTH	0. 00	6. 00
7.00	G		O. OO SJRMC - INC	0.00	7.00
8.00	G	SJRMC - PLY	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) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Heal th	Financial Syste	ems		ST. JOSEI	PHS REG MED	CENTER S.	BEND		In Lie	eu of Form CMS-	2552-10
STATEME OFFICE	INT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ON	IS AND HOME	Provi der	CCN:	15-0012	Peri od: From 07/01/2020	Worksheet A-8	3-1
OTTICL									To 06/30/2021		
	Net	Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUST	MENTS REC	QUIRED AS A F	RESULT OF TI	RANSACTI ONS	WITH	H RELATED C	ORGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO	STS:									
1.00	-6, 611, 428	C									1.00
2.00	96, 703	C									2.00
3.00	-2, 074, 254	l c									3.00
3. 01	-9, 554										3. 01
3.02	-199, 179										3. 02
3. 03	5. 348. 110	9									3. 03

\* 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.

3.04

4.00

5 00

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

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

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

6. 00 7. 00 8. 00	6.00
7. 00	7.00
8. 00	8.00
9. 00	9.00
9. 00 10. 00 100. 00	10.00
100.00	100.00

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

Ó

3.04

4.00

5.00

-289, 583

-3, 739, 185

- 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.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- 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.

PROVI DER BASED PHYSI CI AN ADJUSTMENT

Provider CCN: 15-0012

Peri od: Worksheet A-8-2 From 07/01/2020 To 06/30/2021 Date/Ti me Prepared:

11/30/2021 12:30 pm Wkst. A Line # Cost Center/Physician Professi onal Provi der RCE Amount Physi ci an/Prov Total Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 4.00 3.00 5. 00 6, 00 7.00 13. 00 NURSI NG ADMI NI STRATI ON 1. 00 1.00 -1, 1420 -1, 142179,000 6 2.00 0.00 Ω 0 2.00 3.00 5.06 OTHER ADMINISTRATIVE & 977, 303 947, 513 29, 790 179,000 213 3.00 GENERAL 4.00 31. 00 INTENSIVE CARE UNIT 179,000 -2.690-2,6904.00 5.00 50.00 OPERATING ROOM 3, 960, 622 3, 984, 986 -24, 364 246, 400 102 5.00 54. 00 RADI OLOGY-DI AGNOSTI C 6.00 -97, 251 12,000 -109, 251 271, 900 482 6.00 7.00 0.00 7.00 0 59. 00 CARDI AC CATHETERI ZATI ON 8.00 -165 0 -165 179,000 1 8.00 9.00 0.00 0 0 9.00 10.00 90.06 PEDIATRIC SPECIALTY CLINIC 68, 504 71, 129 -2, 625 169,700 20 10.00 179,000 91. 00 EMERGENCY 52,000 12 00 471 493 419 493 2 622 12 00 69. 00 ELECTROCARDI OLOGY 14.00 -4,080 -4,080 179,000 13 14.00 16.00 5. 06 OTHER ADMINISTRATIVE & 1, 534, 275 1, 534, 275 0 16.00 GENERAL 17.00 5. 06 OTHER ADMINISTRATIVE & 608, 101 0 17.00 608.101 GENERAL 18.00 65. 01 SLEEP LAB 2.963 2.963 179,000 20 18.00 200.00 7, 517, 933 7, 210, 004 307, 929 3, 483 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der Physician Cost I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Conti nui ng Share of col Insurance Limit Educati on 12 1.00 2.00 8.00 9.00 12. 00 13.00 14.00 1.00 13. 00 NURSING ADMINISTRATION 516 26 1.00 0 2.00 0.00 0 0 2.00 0 οĺ 5. 06 OTHER ADMINISTRATIVE & 917 0 0 3.00 18, 330 3.00 GENERAL 4.00 31.00 INTENSIVE CARE UNIT 344 17 4.00 5.00 50.00 OPERATING ROOM 12,083 604 0 0 0 5.00 0 0 54. 00 RADI OLOGY-DI AGNOSTI C 0 6.00 63.008 3.150 6.00 7.00 0.00 0 0 0 7.00 0 8.00 59. 00 CARDI AC CATHETERI ZATI ON 86 0 8.00 0 9.00 0.00 0 0 9.00 0 90.06 PEDIATRIC SPECIALTY CLINIC 10.00 1,632 82 0 10.00 12.00 91. 00 EMERGENCY 225, 643 11, 282 0 0 12.00 14.00 69. 00 ELECTROCARDI OLOGY 0 0 0 14.00 1, 119 56 5. 06 OTHER ADMINISTRATIVE & 0 0 C 0 16.00 16.00 GENERAL 17.00 5. 06 OTHER ADMINISTRATIVE & 0 C 0 17.00 GENERAL 18.00 65. 01 SLEEP LAB 1, 721 18.00 86 200.00 324, 482 0 200.00 16 224 Cost Center/Physician Wkst. A Line # 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 1.00 13.00 NURSING ADMINISTRATION 516 Ω 2.00 0.00 2.00 3.00 5. 06 OTHER ADMINISTRATIVE & 18, 330 11, 460 958, 973 3.00 GENERAL 4 00 31.00 INTENSIVE CARE UNIT 4 00 344 5.00 50. 00 OPERATING ROOM 12,083 0 3, 984, 986 5.00 6.00 54. 00 RADI OLOGY-DI AGNOSTI C 63, 008 12,000 6.00 7.00 0.00 0 0 0 0 7.00 59. 00 CARDI AC CATHETERI ZATI ON 8.00 86 0 0 8.00 9.00 0.00 0 0 9.00 90.06 PEDIATRIC SPECIALTY CLINIC 10.00 1,632 71, 129 10.00 91. 00 EMERGENCY 225, 643 193,850 12.00 12.00 245,850 14.00 69. 00 ELECTROCARDI OLOGY 1, 119 14.00 5. 06 OTHER ADMINISTRATIVE & 1, 534, 275 16.00 C 16.00 GENERAL 5. 06 OTHER ADMINISTRATIVE & 17.00 0 608, 101 17.00 GENERAL 65. 01 SLEEP LAB 18 00 18 00 1.721 1.242 1.242 200.00 324, 482 206, 552 7, 416, 556 200.00

In Lieu of Form CMS-2552-10
Worksheet B
01/2020 Part |
030/2021 Date/Time Prepared:
11/30/2021 12: 30 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012 Peri od: From 07/01/2020 To 06/30/2021 CAPITAL RELATED COSTS

			CAPITAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	NONPATI ENT	
	oost conten beschiptron	for Cost	DEDO U TIXI	MVDLL LGOTT	BENEFI TS	TELEPHONES	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
	OFWERN OFFICE OF SEVERE	0	1.00	2. 00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS	0, 107, 070	0, 107 070	1			
1.00	00100 CAP REL COSTS-BLDG & FIXT	26, 107, 379		1			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	6, 586, 280		6, 586, 280			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-114, 226			-92, 964		4. 00
5. 01	00540 NONPATIENT TELEPHONES	259, 892		1	0	,	5. 01
5. 04 5. 06	00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL	1, 610, 641 65, 678, 311	100, 261	1	0		5. 04 5. 06
6. 00	00600 MAINTENANCE & REPAIRS	05, 078, 311	3, 286, 856	1	0	1	6. 00
7. 00	00700 OPERATION OF PLANT	6, 676, 605		1	0	9, 168	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 302, 909		1, 077, 202	0		8. 00
9. 00	00900 HOUSEKEEPI NG	2, 800, 710			0	1	9. 00
10. 00	01000 DI ETARY	1, 461, 977		1	0	.,	10.00
11. 00	01100 CAFETERI A	1, 721, 008	625, 638		0		11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	01300 NURSING ADMINISTRATION	7, 914, 557	102, 142	25, 768	0	3, 020	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	993, 913		0	0	324	14.00
15. 00	01500 PHARMACY	5, 887, 353	357, 308	90, 140	0	6, 148	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 311, 149	52, 387		0	4, 746	16. 00
17. 00	01700 SOCIAL SERVICE	3, 343, 318			0	.,	17. 00
18. 00	01850 STERI LE SUPPLY	3, 671, 016	413, 832	1	0	.,	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	ı "	19. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	2, 932, 469			0		21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	3, 214, 106			0	3, 775	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0		23. 00
23. 02	02302 PHARMACY RESIDENCY PROGRAM	604, 532	0	0	0	324	23. 02
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	26, 519, 051	6, 114, 262	1, 542, 485	0	59, 106	30. 00
31. 00	03100 INTENSIVE CARE UNIT	7, 288, 903			0		31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	2, 840, 684			0		35. 00
41. 00	04100 SUBPROVI DER – I RF	2, 040, 004	271, 984		0	_,,	41. 00
43. 00	04300 NURSERY	1, 993, 986			0		43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	177707700		<u> </u>			10.00
50.00	05000 OPERATING ROOM	26, 746, 552	2, 566, 974	647, 587	0	26, 965	50.00
51.00	05100 RECOVERY ROOM	1, 489, 358	170, 111	42, 915	0	3, 991	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 300, 640	0	0	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 108, 136	725, 093	182, 924	0	15, 208	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	354, 355		0	0		55. 00
57. 00	05700 CT SCAN	1, 186, 364	91, 664	1	0		57. 00
58. 00	05800 MRI	1, 039, 587		0	0	.,	
59. 00	05900 CARDI AC CATHETERI ZATI ON	10, 551, 588		1	0		
60.00	06000 LABORATORY	11, 397, 630	105, 742	1	0	4, 206	
62. 30 65. 00	06250   BLOOD CLOTTING FOR HEMOPHILIACS   06500   RESPIRATORY THERAPY	2 102 740	102.044	0	0	-	62. 30
65. 00	03610 SLEEP LAB	3, 102, 740 562, 464			0	4, 206 0	
	06600 PHYSI CAL THERAPY	3, 253, 807			0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	957, 579		44, 100	0	971	67. 00
68. 00	06800 SPEECH PATHOLOGY	353, 936		Ö	0	431	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 388, 863			0	3, 451	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	23, 116, 382	0	O	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	24, 907, 631	25, 146	6, 344	0	647	73. 00
74.00	07400 RENAL DIALYSIS	1, 603, 606	60, 877	15, 358	0	108	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	41, 552	0	0	0	216	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0		0	1	90. 00
90. 02	09001 MOBILE MEDICAL UNIT	129, 453			0	-	90. 02
90. 03	09002 FAMILY MEDICINE CENTER	1, 312, 044		0	0	6, 040	
90. 04	09003 WOUND HEALING CENTER	1, 555, 429		0	0	1, 618	
90.05	09004 OUTPATIENT TREATMENT & INFUSION	896, 027	83, 175		0	1, 294	90. 05
90. 06 90. 07	09005 PEDIATRIC SPECIALTY CLINIC 09006 SPORTS MED FELLOWSHIP CLINIC	306, 436 834, 114		0	0	1, 834 755	90. 06 90. 07
90.07	09007 PODIATRY RESIDENCY CLINIC	1, 045, 692			0	1, 726	90.07
90.08	09008 FACULTY PRACTICE CLINIC	599, 219			0	1, 720	90.08
90. 10	09009 OUR LADY OF ROSARY CLINIC	1, 220, 923			0	0	90. 09
91. 00	09100 EMERGENCY	7, 305, 466		286, 552	0	15, 208	
	09200 OBSERVATION BEDS (NON-DISTINCT PART			===, ===	· ·		92.00
	•	•	•	. '			

Health Finan	cial Systems ST.	JOSEPHS REG ME	D CENTER S. BEI	ND	In Lie	u of Form CMS-2	2552-10
COST ALLOCAT	TION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B	
					From 07/01/2020	Part I	narad.
					To 06/30/2021	Date/Time Pre 11/30/2021 12	
			CAPI TAL REL	ATED COSTS		117 307 2021 12	. 30 piii
			ON TIME REE	31120 00010			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	NONPATI ENT	
		for Cost			BENEFITS	TELEPHONES	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
		0	1.00	2.00	4. 00	5. 01	
SPECIA	AL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	319, 274, 096	25, 994, 544	6, 557, 81	5 0	254, 762	118. 00
NONRE	MBURSABLE COST CENTERS						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40, 776	101, 175	25, 52	4 0	539	190. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	6, 233	1, 57	2 0	28, 798	192. 00
192. 01 19201	MATERNAL FETAL MEDICINE/LABORIST	0	5, 427	1, 36	9 0	0	192. 01
192. 02 19202	NEONATOLOGI STS	0	0		0 0	324	192. 02
192. 03 19203	HOSPI TALI STS/INTENSI VI STS	0	0		0 0	1, 294	192. 03
194. 00 07950	SPORTS MED-ATHLETIC TRAINERS	0	0		0 0	0	194. 00
194. 01 07951	OUTREACH SERVICES	4, 008, 709	0		0 0	4, 961	194. 01
194. 02 07952	KINDRED/OUR LADY OF PEACE	0	0		0 0	2, 049	194. 02
194. 03 07953	ADVANCED SPECIALTIES	7, 815	0		0 0	0	194. 03
194. 04 07954	AMBULATORY PHARMACY SERVICES	524, 854	0		o o	0	194. 04
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers		0		0 -92, 964	0	201. 00
000 00	TOTAL ( 1' 440 II I 004)	1 000 05/ 050	0/ 407 070	/ 50/ 00	ام مم	000 707	1000 00

323, 856, 250

26, 107, 379

6, 586, 280

-92, 964

292, 727 202. 00

Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)

202.00

Provider CCN: 15-0012

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2020 | Part I | To 06/30/2021 | Date/Time Prepared: | 11/30/2021 | 12:30 pm

					0 00/30/2021	11/30/2021 12	
	Cost Center Description	ADMI TTI NG	Subtotal	OTHER	MAINTENANCE &	OPERATION OF	
				ADMI NI STRATI VE	REPAI RS	PLANT	
		5. 04	5A. 04	& GENERAL 5.06	6. 00	7. 00	
	GENERAL SERVICE COST CENTERS	3.04	5A. 04	3.00	0.00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5.04	00570 ADMI TTI NG	1, 740, 402					5. 04
5.06	00590 OTHER ADMINISTRATIVE & GENERAL	0	69, 833, 301	69, 833, 301			5. 06
6. 00	00600 MAI NTENANCE & REPAI RS	0	C	0	0		6. 00
7.00	00700 OPERATION OF PLANT	0	15, 110, 917		0	19, 265, 664	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 303, 448	1		0	8. 00
9.00	00900 HOUSEKEEPI NG	0	3, 208, 814	1		391, 885	9.00
10.00	01000 DI ETARY	0	2, 041, 068	1		556, 090	
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	2, 506, 745 C	1		755, 733 0	11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	8, 045, 487	1 °			1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	994, 237			123, 301	14. 00
15. 00	01500 PHARMACY	3	6, 340, 952	1		431, 606	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	2, 381, 498			63, 281	1
17. 00	01700 SOCIAL SERVICE	0	3, 387, 101	1		38, 488	1
18. 00	01850 STERI LE SUPPLY	o	4, 190, 434	1		499, 884	1
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	C		0	0	1
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	2, 993, 025	822, 932	0	58, 413	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	3, 217, 881	884, 756	0	0	22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	C	0	0	0	23. 00
23. 02	02302 PHARMACY RESIDENCY PROGRAM	0	604, 856	166, 305	0	0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00	03000 ADULTS & PEDI ATRI CS	186, 493	34, 421, 397				30. 00
31. 00	03100 INTENSIVE CARE UNIT	49, 593	8, 306, 070			928, 635	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	16, 494	3, 200, 042	1	0	,	
41. 00	04100 SUBPROVI DER - I RF	0		0	0	0	
43. 00	04300 NURSERY	5, 629	1, 999, 615	549, 794	0	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	221 700	20 210 70/	0 227 425		2 100 740	F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	331, 708	30, 319, 786				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	28, 141 22, 960	1, 734, 516 3, 323, 600				52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	92, 984	6, 124, 345	1			1
55. 00	05500 RADI OLOGY-THERAPEUTI C	761	355, 116			075,000	55.00
57. 00	05700 CT SCAN	115, 097	1, 417, 221	1			1
58. 00	05800 MRI	12, 303	1, 053, 292	1		0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	114, 995	11, 661, 871	1			1
60.00	06000 LABORATORY	218, 381	11, 752, 635		0	127, 729	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	25, 097	3, 373, 665	927, 589	0	233, 067	65. 00
65. 01	03610 SLEEP LAB	6, 666	569, 130			0	65. 01
66.00	06600 PHYSI CAL THERAPY	22, 322	3, 501, 008	962, 602	0	211, 195	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	8, 701	967, 251	265, 946	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 060	357, 427	1			
69. 00	06900 ELECTROCARDI OLOGY	40, 306	1, 613, 618	1			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	0	_	-	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	122, 665	23, 239, 047			0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	206, 008	25, 145, 776			30, 375	1
74.00	07400 RENAL DIALYSIS	3, 137	1, 683, 086	1	0	73, 535	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	42.246	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	600	42, 368	11, 649		· -	76. 98 76. 99
76. 99	OUTPATIENT SERVICE COST CENTERS	UU		<u> </u>			70.99
90. 00	09000 CLINIC	O	C		0	0	90.00
90. 02	09001 MOBILE MEDICAL UNIT	708	130, 161	1			90.02
90. 03	09002 FAMILY MEDICINE CENTER	5, 251	1, 323, 335	1		Ö	90. 03
90. 04	09003 WOUND HEALING CENTER	7, 824	1, 564, 871	1	0	Ö	90. 04
90. 05	09004 OUTPATIENT TREATMENT & INFUSION	2, 039	1, 003, 518		0		90. 05
90. 06	09005 PEDIATRIC SPECIALTY CLINIC	299	308, 569	1		0	90.06
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	0	834, 869	1		Ō	
90. 08	09007 PODIATRY RESIDENCY CLINIC	O	1, 047, 418			0	90. 08
90. 09	09008 FACULTY PRACTICE CLINIC	1, 097	600, 316			0	90. 09
90. 10	09009 OUR LADY OF ROSARY CLINIC	1, 898	1, 222, 821	1		0	90. 10
91. 00	09100 EMERGENCY	78, 674	8, 821, 763	1		1, 372, 053	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		C	)			92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		1, 731, 894	319, 179, 287	68, 521, 810	0	19, 129, 367	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	168, 014	1			
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	36, 603	3 10, 064	0	7, 529	192. 00

194. 04 07954 AMBULATORY PHARMACY SERVICES

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202.00

0

0

0 194, 04

0 201. 00

19, 265, 664 202. 00

200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0012 Worksheet B Peri od: From 07/01/2020 Part I 06/30/2021 Date/Time Prepared: 11/30/2021 12:30 pm Cost Center Description ADMI TTI NG Subtotal OTHER MAINTENANCE & OPERATION OF ADMI NI STRATI VE **REPAI RS** PLANT & GENERAL 5.04 5A. 04 6. 00 7. 00 5.06 192. 01 19201 MATERNAL FETAL MEDICINE/LABORIST 192. 02 19202 NEONATOLOGISTS 7, 233 1, 989 6, 555 192. 01 437 0 0 0 0 0 0 0 0 192. 02 2, 251 2, 575 708 1, 303 192. 03 19203 HOSPI TALI STS/I NTENSI VI STS 3, 446 4, 740 0 192. 03 194. 00 07950 SPORTS MED-ATHLETIC TRAINERS 0 194. 00 C 0 194. 01 07951 OUTREACH SERVICES 0 194. 01 2, 374 4, 016, 044 1, 104, 211 194. 02 07952 KINDRED/OUR LADY OF PEACE 0 2,049 563 0 194. 02 194. 03 07953 ADVANCED SPECIALTIES 7, 815 0 194. 03 0 2, 149

0

1, 740, 402

524, 854

-92, 964

323, 856, 250

144, 309

69, 833, 301

Provider CCN: 15-0012

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2020 | Part I | To 06/30/2021 | Date/Time Prepared: 11/30/2021 12: 30 pm

					11/30/2021 12	30 pm
Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	
	8. 00	9. 00	10.00	11. 00	12.00	
GENERAL SERVICE COST CENTERS	0.00	71 00	10100		121 00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01   00540 NONPATI ENT TELEPHONES						5. 01
5. 04   00570 ADMI TTI NG						5. 04
5.06   00590 OTHER ADMINISTRATIVE & GENERAL						5. 06
6.00 00600 MAI NTENANCE & REPAI RS						6. 00
7.00 OO700 OPERATION OF PLANT						7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	1, 661, 831					8. 00
9. 00   00900   HOUSEKEEPI NG	0	4, 482, 962				9. 00
10. 00   01000   DI ETARY	0	132, 084	3, 290, 434			10.00
11. 00   01100   CAFETERI A	0	179, 504	0	4, 131, 212		11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	20, 20,	0	107 551	0	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	29, 306	0	137, 551	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	100 517	0	48, 012	0	14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	3	102, 517	0	148, 195	0	15.00
17. 00   01700   SOCIAL SERVICE	0	15, 031 9, 142	0	102, 582 100, 671	0	16. 00 17. 00
18. 00   01850   STERI LE SUPPLY	0	118, 734	0	80, 169	0	18.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	110, 734	0	00, 109	0	19.00
21. 00   02100   I &R SERVI CES-SALARY & FRINGES APPRV	0	13, 874	0	124, 021	0	21.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	13, 074	0	43, 102	0	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	43, 102	0	23. 00
23. 02 02302 PHARMACY RESI DENCY PROGRAM	Ö	0	0	22, 188	0	23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			<u> </u>	227 .00		20.02
30. 00 03000 ADULTS & PEDIATRICS	178, 108	1, 754, 265	3, 030, 662	944, 263	0	30.00
31.00 03100 INTENSIVE CARE UNIT	47, 363	220, 572	87, 578	206, 589	0	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	15, 753	78, 036	31, 328	84, 105	0	35. 00
41. 00   04100   SUBPROVI DER - 1 RF	0	0	0	o	0	41.00
43. 00 04300 NURSERY	5, 376	0	0	64, 990	0	43.00
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATING ROOM	316, 470	736, 500	94, 979	464, 450	0	50. 00
51.00   05100   RECOVERY ROOM	26, 876	48, 807	4, 116	55, 470	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	21, 928	0	0	111, 465	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	88, 803	208, 039	0	175, 593	0	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	727	0	0	6, 559	0	55. 00
57.00  05700 CT SCAN	109, 922	26, 300	0	35, 194	0	57. 00
58. 00   05800   MRI	11, 750	0	0	0	0	58. 00
59. 00  05900  CARDI AC CATHETERI ZATI ON	109, 825	226, 107	0	114, 501	0	59. 00
60. 00  06000 LAB0RAT0RY	208, 563	30, 339	0	98, 197	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	23, 968	55, 359	0	103, 219	0	65. 00
65. 01   03610   SLEEP LAB	6, 367	0	0	150	0	65. 01
66. 00   06600   PHYSI CAL THERAPY	21, 319	50, 164	0	104, 044	0	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	8, 310	0	0	28, 335	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	2, 923	0	0	10, 269	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	38, 494	41, 469		48, 574	0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	117 150	0	0	0	0	71.00
72. 00 07200 DRUCS CHARGED TO PATIENTS	117, 150	7 215	0	17 502	0	72.00
73.00   07300   DRUGS CHARGED TO PATIENTS 74.00   07400   RENAL DIALYSIS	196, 746	7, 215	0	17, 503	0	73.00
74. 00   07400   RENAL DIALYSIS 76. 97   07697   CARDIAC REHABILITATION	2, 996	17, 466	0	U O	0	74. 00 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	573	0	0	937	0	76. 98
76. 99   07699 LI THOTRI PSY	0	0	0	737	0	76. 99
OUTPATIENT SERVICE COST CENTERS		<u> </u>	0	<u> </u>		70. 77
90. 00 09000 CLINIC	0	0	0	O	0	90.00
90. 02   09001   MOBI LE   MEDI CAL   UNI T	676	0	0	5, 360	0	90. 02
90. 03 09002 FAMILY MEDICINE CENTER	5, 015	0	0	57, 232	0	90. 03
90. 04 09003 WOUND HEALING CENTER	7, 472	0	0	28, 897	0	90. 04
90. 05 09004 OUTPATIENT TREATMENT & INFUSION	1, 947	23, 864	1, 744	27, 173	0	90. 05
90. 06 09005 PEDIATRIC SPECIALTY CLINIC	285	20,00.	0	10, 157	0	90. 06
90. 07 09006 SPORTS MED FELLOWSHIP CLINIC	0	0	0	18, 065	0	90. 07
90. 08 09007 PODI ATRY RESI DENCY CLI NI C	o o	n	n	25, 936	0	90. 08
90. 09 09008 FACULTY PRACTICE CLINIC	1, 048	n	0	16, 679	0	90. 09
90. 10 09009 OUR LADY OF ROSARY CLINIC	1, 813	o	l ol	33, 619	0	90. 10
91. 00   09100   EMERGENCY	75, 137	325, 895	40, 027	228, 065	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		-,		-, -, -		92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 1, 653, 706	4, 450, 589	3, 290, 434	3, 932, 081	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29, 028		0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 788		0		192. 00
192.01 19201 MATERNAL FETAL MEDICINE/LABORIST	417	1, 557	0	0	0	192. 01

Heal th Financial Systems ST. JOSEPHS REG MED CENTER S. BEND In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0012
Period: Worksheet B
From 07/01/2020 Part I

			Т	o 06/30/2021	Date/Time Pre 11/30/2021 12	
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	
	LINEN SERVICE				PERSONNEL	
	8. 00	9. 00	10.00	11.00	12.00	
192. 02 19202 NEONATOLOGI STS	2, 150	0	C	0	0	192. 02
192. 03 19203 HOSPI TALI STS/I NTENSI VI STS	3, 291	0	C	0	0	192. 03
194.00 07950 SPORTS MED-ATHLETIC TRAINERS	0	0	C	0	0	194. 00
194. 01 07951 OUTREACH SERVICES	2, 267	0	C	184, 551	0	194. 01
194.02 07952 KINDRED/OUR LADY OF PEACE	0	0	C	0	0	194. 02
194. 03 07953 ADVANCED SPECIALTIES	0	0	C	0	0	194. 03
194.04 07954 AMBULATORY PHARMACY SERVICES	0	0	C	14, 580	0	194. 04

4, 482, 962

3, 290, 434

4, 131, 212

1, 661, 831

200. 00 0 201. 00 0 202. 00

200. 00 201. 00 202. 00 Cross Foot Adjustments Negative Cost Centers

TOTAL (sum lines 118 through 201)

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0012

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2020 | Part I | To 06/30/2021 | Date/Time Prepared: | 11/30/2021 | 12:30 pm

						11/30/2021 12	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
		13. 00	14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
5. 01	OO400					ļ	4. 00 5. 01
5. 04	00570 ADMITTING						5. 04
5. 06	00590 OTHER ADMINISTRATIVE & GENERAL						5. 06
6. 00	00600 MAI NTENANCE & REPAI RS						6. 00
7.00	00700 OPERATION OF PLANT					ļ	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					ļ	8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11.00	01100 CAFETERI A						11.00
12.00	01200 MAI NTENANCE OF PERSONNEL	10 547 022					12.00
13. 00 14. 00	O1300   NURSI NG ADMI NI STRATI ON   O1400   CENTRAL SERVI CES & SUPPLY	10, 547, 832 126, 806	1 442 420				13. 00 14. 00
15. 00	01500 PHARMACY	391, 405	1, 442, 420	9, 158, 126			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	270, 934	0	7, 130, 120	3, 488, 119		16. 00
17. 00	01700 SOCIAL SERVICE	265, 886	0	Ö	0, 100, 117	4, 732, 571	17. 00
18. 00	01850 STERI LE SUPPLY	211, 739	0	7	ō	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	О	0	19. 00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	327, 556	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	113, 838	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	23. 00
23. 02	02302 PHARMACY RESIDENCY PROGRAM	58, 602	0	4, 502	0	0	23. 02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 402 042	154 (0)		272 075	4 204 720	20.00
30. 00 31. 00	03000   ADULTS & PEDI ATRI CS   03100   I NTENSI VE CARE UNI T	2, 493, 942 545, 630	154, 606 41, 114	0	373, 875 99, 423	4, 206, 730 473, 257	30. 00 31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	222, 133	13, 674	142	33, 067	52, 584	35.00
41. 00	04100 SUBPROVI DER - I RF	222, 133	13, 074	0	33, 007	0	41. 00
43. 00	04300 NURSERY	171, 648	4, 666	0	11, 284	0	43. 00
10.00	ANCILLARY SERVICE COST CENTERS	1717010	1,7000	<u> </u>	,20.1		10.00
50.00	05000 OPERATI NG ROOM	1, 226, 679	274, 583	0	664, 021	0	50. 00
51.00	05100 RECOVERY ROOM	146, 505	23, 330	0	56, 417	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	294, 395	19, 034	0	46, 029	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	463, 766	77, 085	0	186, 411	0	54.00
55. 00	O5500   RADI OLOGY-THERAPEUTI C	17, 323	631	0	1, 526	0	55. 00
57. 00	05700 CT SCAN	92, 951	95, 418		230, 743	0	57.00
58. 00 59. 00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON	302, 413	10, 200 95, 333		24, 665 230, 538	0	58. 00 59. 00
60. 00	06000 LABORATORY	259, 353	181, 042		437, 803	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	257, 555	101, 042	0	437, 003	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	272, 617	20, 806	o o	50, 313	0	65. 00
65. 01	03610 SLEEP LAB	396	5, 527	0	13, 365	0	65. 01
66.00	06600 PHYSI CAL THERAPY	274, 795	18, 506	0	44, 751	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	74, 836	7, 213	0	17, 443	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	27, 123	2, 537		6, 135	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	128, 290	33, 415		80, 805	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	4/ 220	101, 692	0 001 071	245, 915	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	46, 228	170, 784 2, 601	9, 021, 071 0	412, 998 6, 289	0	73. 00 74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON		2, 601	0	0, 209	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	2, 475	497	20	1, 202	0	76. 98
76. 99	07699 LI THOTRI PSY	2, 170	0		1, 202	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	-,	-		-,	-	
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 02	09001 MOBILE MEDICAL UNIT	14, 156	587	0	1, 420	0	90. 02
90. 03	09002 FAMILY MEDICINE CENTER	151, 157	4, 353	0	10, 526	0	90. 03
90. 04	09003 WOUND HEALING CENTER	76, 321	6, 486		15, 685	0	90. 04
90. 05	09004 OUTPATIENT TREATMENT & INFUSION	71, 767	1, 690		4, 087	0	90. 05
90.06	09005 PEDIATRIC SPECIALTY CLINIC	26, 826	248		599	0	90.06
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	47, 713	0	6, 587	0	0	90. 07
90. 08 90. 09	O9007   PODIATRY RESIDENCY CLINIC   O9008   FACULTY PRACTICE CLINIC	68, 501	909	1, 078 0	2 100	0	90. 08 90. 09
90. 09	09009 OUR LADY OF ROSARY CLINIC	44, 050 88, 794	1, 574		2, 199 3, 806	0	90. 09
91. 00	09100 EMERGENCY	602, 351	65, 223		157, 724	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	332,301	33, 220		.5., .21	١	92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		10, 021, 900	1, 435, 367	9, 132, 661	3, 471, 064	4, 732, 571	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
192. 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2020 | Part |
| To 06/30/2021 | Date/Time Prepared: | 11/30/2021 | 12:30 pm

					11/30/2021 12	:30 pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	13.00	14.00	15. 00	16. 00	17. 00	
192. 01 19201 MATERNAL FETAL MEDICINE/LABORIST	0	362	0	876	0	192. 01
192. 02 19202 NEONATOLOGI STS	0	1, 866	0	4, 512	0	192. 02
192. 03 19203 HOSPI TALI STS/I NTENSI VI STS	0	2, 857	0	6, 909	0	192. 03
194.00 07950 SPORTS MED-ATHLETIC TRAINERS	0	0	0	0	0	194. 00
194. 01 07951 OUTREACH SERVICES	487, 425	1, 968	25, 465	4, 758	0	194. 01
194.02 07952 KINDRED/OUR LADY OF PEACE	0	0	0	0	0	194. 02
194. 03 07953 ADVANCED SPECIALTIES	0	0	0	0	0	194. 03
194.04 07954 AMBULATORY PHARMACY SERVICES	38, 507	0	0	0	0	194. 04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	10, 547, 832	1, 442, 420	9, 158, 126	3, 488, 119	4, 732, 571	202. 00

Provider CCN: 15-0012

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2020 | Part |
| To 06/30/2021 | Date/Time Prepared: | 11/30/2021 | 12:30 pm

					0 06/30/2021	11/30/2021 12	
		OTHER GENERAL		INTERNS &	RESI DENTS		
	Cost Center Description	SERVI CE STERI LE SUPPLY	NONPHYSI CI AN	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
	, , , , , , , , , , , , , , , , , , ,		ANESTHETI STS	Y & FRINGES	PRGM COSTS	PRGM	
		10.00	10.00	APPRV	APPRV	22.00	
	GENERAL SERVICE COST CENTERS	18. 00	19. 00	21. 00	22. 00	23. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 04 5. 06	00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL				-		5. 04 5. 06
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 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY						15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16. 00 17. 00
18. 00	01850 STERI LE SUPPLY	6, 253, 127					18.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	O				19. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		4, 339, 821			21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0			4, 259, 577		22. 00
23. 00 23. 02	02300 PARAMED ED PRGM-(SPECIFY)	0				0	23. 00
23. 02	02302 PHARMACY RESIDENCY PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	1 0			<u> </u>		23. 02
30. 00	03000 ADULTS & PEDIATRICS	102, 809	C	2, 408, 296	2, 363, 766	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	950	O	226, 160	221, 978	0	31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	5, 350	0		59, 994	0	35. 00
41. 00 43. 00	04100  SUBPROVI DER - I RF   04300  NURSERY	0 0	0		0 269, 973	0	41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	0		J 275, 059	209, 973	0	43.00
50.00	05000 OPERATI NG ROOM	5, 695, 017	C	134, 473	131, 987	0	50. 00
51.00	05100 RECOVERY ROOM	0	O	1	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	30, 562		0	52.00
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	5, 526 0	0	30, 562	29, 997	0	54. 00 55. 00
57. 00	05700 CT SCAN	0	0		0	0	57.00
58. 00	05800 MRI	0	Ö	o o	o	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	30, 621	O	0	0	0	59. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0 11, 650	0	0	0	0	62. 30 65. 00
65. 01	03610 SLEEP LAB	0 11,030	0		0	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0	O	o o	O	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	O	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	103, 911	101, 990	0	69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	18, 337	17, 998	0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0		0	0	76. 98 76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS	0		, <sub>1</sub>	ı oı		70. 77
90.00	09000 CLI NI C	0	O	0	0	0	90. 00
90. 02	09001 MOBI LE MEDI CAL UNI T	0	0	0		0	90. 02
90. 03	09002 FAMILY MEDICINE CENTER	32, 451	0	788, 503	773, 923	0	90. 03
90. 04 90. 05	09003 WOUND HEALING CENTER 09004 OUTPATIENT TREATMENT & INFUSION	22, 490	0		0	0	90. 04 90. 05
90. 06	09005 PEDIATRIC SPECIALTY CLINIC	0	Ö	ól ő	o	0	90.06
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	1, 584	0	0	0	0	90. 07
90. 08	09007 PODIATRY RESIDENCY CLINIC	0	0	0	0	0	90. 08
90.09	09008 FACULTY PRACTICE CLINIC	1, 021	0	0	0	0	90.09
90. 10 91. 00	09009 OUR LADY OF ROSARY CLINIC 09100 EMERGENCY	5, 526	0	) 262, 834	257, 974	0	90. 10 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	5,526		, 202, 034	201, 714	U	91.00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 914, 995	O	4, 339, 821	4, 259, 577	0	118. 00

192. 02 19202 NEONATOLOGI STS

200.00

201.00

202.00

194. 01 07951 OUTREACH SERVICES

194. 03 07953 ADVANCED SPECIALTIES

192. 03 19203 HOSPI TALI STS/I NTENSI VI STS

194. 02 07952 KINDRED/OUR LADY OF PEACE

194.00 07950 SPORTS MED-ATHLETIC TRAINERS

194.04 07954 AMBULATORY PHARMACY SERVICES

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

0 192. 02

0 192. 03

0 194.00

0 194. 01

0 194. 02

0 194. 03

0 194. 04

0 200.00

0 201.00

0 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0012 Peri od: Worksheet B From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 To 11/30/2021 12:30 pm OTHER GENERAL INTERNS & RESIDENTS SERVI CE STERILE SUPPLY NONPHYSI CI AN SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Cost Center Description ANESTHETI STS Y & FRINGES PRGM COSTS PRGM **APPRV** APPRV 19.00 23.00 18. 00 21.00 22.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 190. 00 0 0 192.00 0 0 0 0 0 0 0 0 0 0 192.01 19201 MATERNAL FETAL MEDICINE/LABORIST 0 192. 01 0

0

0

0

242, 292

95.840

6, 253, 127

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

4, 339, 821

0

4, 259, 577

| Period: | Worksheet B | From 07/01/2020 | Part | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0012

				To	06/30/2021	Date/Time Prepared: 11/30/2021 12:30 pm
	Cost Center Description	PHARMACY RESI DENCY PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	11/30/2021 12.30 piii
		23. 02	24. 00	25. 00	26. 00	
1 00	GENERAL SERVICE COST CENTERS				T T	1.00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01	00540 NONPATIENT TELEPHONES					5. 01
5.04	00570 ADMITTING					5. 04
5. 06 6. 00	00590 OTHER ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS					5. 06 6. 00
7. 00	00700 OPERATION OF PLANT					7.00
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00 12. 00	01100   CAFETERI A   01200   MAI NTENANCE OF PERSONNEL					11. 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 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE					16.00
18. 00	01850 STERI LE SUPPLY					17. 00 18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS					19. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV					21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV					22.00
23. 00 23. 02	02300 PARAMED ED PRGM-(SPECIFY) 02302 PHARMACY RESIDENCY PROGRAM	856, 453				23. 00
25. 02	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	030, 433				23. 02
30.00	03000 ADULTS & PEDIATRICS	0	69, 282, 458		64, 510, 396	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	13, 689, 073		13, 240, 935	31.00
35. 00 41. 00	02060   NEONATAL INTENSIVE CARE UNIT   04100   SUBPROVIDER - IRF	0	5, 065, 724	-121, 118	4, 944, 606 0	35. 00 41. 00
43. 00	04300 NURSERY	0	3, 352, 405	1	2, 807, 373	43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	51, 496, 119		51, 229, 659	50.00
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0	2, 778, 425 4, 790, 834		2, 778, 425 4, 730, 275	51. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	9, 949, 884		9, 889, 325	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	479, 521		479, 521	55. 00
57. 00	05700 CT SCAN	0	2, 508, 139	1	2, 508, 139	57.00
58. 00 59. 00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON	0	1, 389, 510 17, 006, 619		1, 389, 510 17, 006, 619	58. 00 59. 00
60. 00	06000 LABORATORY	0	16, 327, 048		16, 327, 048	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	Ö	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	5, 072, 253		5, 072, 253	65. 00
65. 01 66. 00	03610 SLEEP LAB 06600 PHYSI CAL THERAPY	0	751, 417 5, 188, 384		751, 417 5, 188, 384	65. 01 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 369, 334		1, 369, 334	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	504, 689		504, 689	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	2, 808, 820	-205, 901	2, 602, 919	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	20 002 200		20, 002, 290	71.00
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	856, 453	30, 093, 380 42, 818, 980		30, 093, 380 42, 818, 980	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	0	2, 285, 072	1	2, 248, 737	74. 00
76. 97	07697 CARDI AC REHABILITATION	0	C	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	59, 721	1	59, 721	76. 98
76. 99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0		0	0	76. 99
90. 00	09000 CLINIC	0	C	0	0	90.00
90. 02	09001 MOBILE MEDICAL UNIT	0	152, 360		152, 360	90. 02
90. 03	09002 FAMILY MEDICINE CENTER	0	3, 510, 346		1, 947, 920	90. 03
90. 04 90. 05	09003 WOUND HEALING CENTER 09004 OUTPATIENT TREATMENT & INFUSION	0	2, 153, 369 1, 513, 498		2, 153, 369 1, 513, 498	90. 04
90. 06	09005 PEDIATRIC SPECIALTY CLINIC	o	431, 766		431, 766	90.06
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	o	1, 138, 365	0	1, 138, 365	90. 07
90. 08	09007 PODIATRY RESIDENCY CLINIC	0	1, 430, 921		1, 430, 921	90. 08
90. 09	09008 FACULTY PRACTICE CLINIC	0	831, 279		831, 279	90. 09
90. 10 91. 00	09009 OUR LADY OF ROSARY CLINIC 09100 EMERGENCY	0	1, 708, 404 14, 640, 116		1, 708, 404 14, 119, 308	90. 10
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0		92. 00
4-5 :	SPECIAL PURPOSE COST CENTERS	25, 15,1	044 577		207 277 77	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	856, 453	316, 578, 233	-8, 599, 398	307, 978, 835	118. 00

In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0012 Peri od: Worksheet B From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/30/2021 12:30 pm Cost Center Description PHARMACY Subtotal Intern & Total RESI DENCY Residents Cost PROGRAM & Post Stepdown Adjustments 23. 02 24.00 26.00 25.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 190. 00 0 0 0 0 0 0 0 0 365, 450 365, 450 0 55, 984 55, 984 192. 00 192.01 19201 MATERNAL FETAL MEDICINE/LABORIST 18, 989 18, 989 192. 01 192. 02 19202 NEONATOLOGI STS 11, 811 0 11, 811 192. 02 192. 03 19203 HOSPI TALI STS/I NTENSI VI STS 19, 100 0 19, 100 192. 03 194.00 07950 SPORTS MED-ATHLETIC TRAINERS 0 194. 00 194. 01 07951 OUTREACH SERVICES 0 6, 068, 981 6,068,981 194. 01 194. 02 07952 KINDRED/OUR LADY OF PEACE 2, 612 0 2, 612 194. 02 194. 03 07953 ADVANCED SPECIALTIES 105, 804 0 105, 804 194. 03 194.04 07954 AMBULATORY PHARMACY SERVICES 0 194. 04 722, 250 722, 250 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 -92, 964 -92, 964 201.00 0

856, 453

323, 856, 250

-8, 599, 398

315, 256, 852

202. 00

202.00

TOTAL (sum lines 118 through 201)

| Peri od: | Worksheet B | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0012

			To	06/30/2021	Date/Time Pre 11/30/2021 12	
		CAPI TAL REI	LATED COSTS		117 307 2021 12	JO piii
Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal Rel ated Costs				DEPARTMENT	
	0	1. 00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	16, 979		21, 262	21, 262	4. 00
5. 01   00540   NONPATI ENT TELEPHONES 5. 04   00570   ADMITTI NG	0	26, 220 100, 261	6, 615 25, 294	32, 835 125, 555	0	5. 01 5. 04
5. 06 00590 OTHER ADMINISTRATIVE & GENERAL	0	3, 286, 856		4, 116, 053	0	5. 04
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7.00   00700   OPERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE	0	6, 727, 862	1, 697, 282	8, 425, 144	0	7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG	0	324, 425	81, 845	406, 270	0	9. 00
10. 00 01000 DI ETARY	0	460, 363		576, 502	0	10. 00
11. 00   01100   CAFETERI A 12. 00   01200   MAI NTENANCE OF PERSONNEL	0	625, 638	157, 834	783, 472	0	11. 00 12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	102, 142	25, 768	127, 910	0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	357, 308 52, 387		447, 448 65, 603	0	15. 00 16. 00
17. 00 01700 SOCI AL SERVI CE	0	31, 862		39, 900	0	17. 00
18. 00 01850 STERI LE SUPPLY	0	413, 832	104, 400	518, 232	0	18. 00
19. 00   01900   NONPHYSICIAN ANESTHETISTS 21. 00   02100   L&R SERVICES-SALARY & FRINGES APPRV	,   0	0 48, 357	0 12, 199	0 60, 556	0	19. 00 21. 00
22. 00   02200   &R SERVICES-OTHER PRGM COSTS APPRI		48, 337	12, 199	00, 550	0	22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 02   02302   PHARMACY RESIDENCY PROGRAM   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23. 02
30. 00 03000 ADULTS & PEDIATRICS	0	6, 114, 262	1, 542, 485	7, 656, 747	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	768, 776		962, 720	0	31.00
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT 41. 00   04100   SUBPROVIDER -   IRF	0	271, 984	68, 615 0	340, 599	0	35. 00 41. 00
43. 00   04300   NURSERY	0	0	l "	0	0	43. 00
ANCILLARY SERVICE COST CENTERS		0.544.074		0 04 5 5		
50.00   05000   OPERATI NG ROOM 51.00   05100   RECOVERY ROOM	0	2, 566, 974 170, 111	647, 587 42, 915	3, 214, 561 213, 026	0	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	42, 713	213, 020	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	725, 093	182, 924	908, 017	0	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C 57. 00   05700   CT   SCAN	0	0 91, 664	0 23, 125	0 114, 789	0	55. 00 57. 00
58. 00 05800 MRI	0	91,004	23, 123	114, 707	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	788, 065		986, 875	0	59. 00
60. 00   06000   LABORATORY 62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0	105, 742	26, 676	132, 418	0	60. 00 62. 30
65. 00 06500 RESPIRATORY THERAPY	0	192, 946	48, 676	241, 622	0	65. 00
65. 01   03610   SLEEP LAB	0	0	0	0	0	65. 01
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	0	174, 839	44, 108	218, 947	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	144, 535	36, 463	180, 998	0	69. 00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	25, 146	6, 344	31, 490	0	73.00
74.00 07400 RENAL DIALYSIS	0	60, 877	15, 358	76, 235	0	74. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON 76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 97 76. 98
76. 99   07699   LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000  CLI NI C 90. 02   09001  MOBI LE MEDI CAL UNI T	0	0	0	0	0	90. 00 90. 02
90. 03 09002 FAMILY MEDICINE CENTER		0	0	0	0	90.02
90. 04 09003 WOUND HEALING CENTER	0	0	0	0	0	90. 04
90. 05 09004 OUTPATIENT TREATMENT & INFUSION	0	83, 175	20, 983	104, 158	0	90.05
90. 06   09005   PEDIATRIC SPECIALTY CLINIC 90. 07   09006   SPORTS MED FELLOWSHIP CLINIC	0	0		0	0	90. 06 90. 07
90.08 09007 PODIATRY RESIDENCY CLINIC	Ö	0	o	o	0	90. 08
90. 09 09008 FACULTY PRACTICE CLINIC	0	0	0	0	0	90. 09
90. 10   09009 OUR LADY OF ROSARY CLINIC 91. 00   09100 EMERGENCY	0	0 1, 135, 863	0 286, 552	0 1, 422, 415	0	90. 10 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		., .55, 555	233, 332	0		92. 00
SPECIAL PURPOSE COST CENTERS	117)	DE 004 544	/ EE7 045	22 552 252	^	110 00
118.00   SUBTOTALS (SUM OF LINES 1 through	117)   0	25, 994, 544	6, 557, 815	32, 552, 359	0	118. 00

| Peri od: | Worksheet B | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/

				00/30/2021	11/30/2021 12	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capital Related Costs				DEPARTMENT	
	nerated costs	1. 00	2.00	2A	4. 00	
NONREI MBURSABLE COST CENTERS		1.00	2.00	2/1	1. 00	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	101, 175	25, 524	126, 699	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	6, 233	1, 572	7, 805	0	192. 00
192.01 19201 MATERNAL FETAL MEDICINE/LABORIST	0	5, 427	1, 369	6, 796	0	192. 01
192. 02 19202 NEONATOLOGI STS	0	0	0	0	_	192. 02
192. 03 19203 HOSPI TALI STS/I NTENSI VI STS	0	0	0	0		192. 03
194. 00 07950 SPORTS MED-ATHLETIC TRAINERS	0	0	0	0	_	194. 00
194. 01 07951 OUTREACH SERVI CES	0	0	0	0		194. 01
194. 02 07952 KI NDRED/OUR LADY OF PEACE	0	0	0	0	_	194. 02
194. 03 07953 ADVANCED SPECIALTIES	0	0	0	0	_	194. 03
194. 04 07954 AMBULATORY PHARMACY SERVICES	0	O	0	0		194. 04
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)		26, 107, 379	6, 586, 280	32, 693, 659	-	201. 00
202.00   TOTAL (Suil TITIES TO UTITOUGH 201)	1	20, 107, 379	0, 360, 260	32, 093, 039	21, 202	1202.00

| Peri od: | Worksheet B | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0012

				Ť	06/30/2021	Date/Time Pre 11/30/2021 12	
	Cost Center Description	NONPATI ENT TELEPHONES	ADMI TTI NG	OTHER ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	50 р
		5. 01	5. 04	5.06	6. 00	7. 00	
1 00	GENERAL SERVICE COST CENTERS			T			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			•			4.00
5. 01	00540 NONPATIENT TELEPHONES	32, 835					5. 01
5. 04	00570 ADMI TTI NG	472	126, 027				5. 04
5.06	00590 OTHER ADMINISTRATIVE & GENERAL	4, 368	0	1			5. 06
6.00	00600 MAINTENANCE & REPAIRS	0	0		0		6. 00
7.00	00700 OPERATION OF PLANT	1, 028	0			8, 671, 316	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	60	0		0	0	8. 00
9. 00 10. 00	O0900   HOUSEKEEPI NG   O1000   DI ETARY	206 290	0		0	176, 384 250, 292	9. 00 10. 00
11. 00	01100 CAFETERI A	254	0	1	0	340, 149	1
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	1	0	0 10, 117	12. 00
13.00	01300 NURSING ADMINISTRATION	339	0	130, 522	0	55, 533	1
14.00	01400 CENTRAL SERVICES & SUPPLY	36	0	16, 130	0	0	14. 00
15. 00	01500 PHARMACY	690	0			194, 262	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	532	0	1		28, 482	
17. 00	01700 SOCIAL SERVICE	436	0	,		17, 323	1
18. 00 19. 00	01850   STERI LE SUPPLY   01900   NONPHYSI CI AN ANESTHETI STS	133	0		0	224, 994 0	18. 00 19. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	_	0	26, 291	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	423	0	,	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	1	0	0	23. 00
23. 02	02302 PHARMACY RESIDENCY PROGRAM	36	0	9, 813	0	0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	6, 630	13, 466			3, 324, 223	30.00
31.00	03100 I NTENSI VE CARE UNI T	544	3, 581	1		417, 971	31.00
35. 00 41. 00	02060   NEONATAL   INTENSIVE CARE UNIT   04100   SUBPROVIDER -   IRF	254 0	1, 191 0	51, 914	0	147, 873 0	35. 00 41. 00
43. 00	04300 NURSERY	0	406	_	_	0	43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	+00	32, 440		0	73.00
50.00	05000 OPERATING ROOM	3, 025	24, 311	491, 878	0	1, 395, 622	50.00
51.00	05100 RECOVERY ROOM	448	2, 032	28, 139	0	92, 486	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 658	1		0	52. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	1, 706	6, 714	99, 355		394, 221	54.00
55. 00 57. 00	O5500   RADI OLOGY-THERAPEUTI C   O5700   CT   SCAN	109	55 8, 311		0	0 49, 836	55.00
58. 00	05800 MRI	157	888	1		49, 630	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	944	8, 303	· ·	0	428, 458	1
60.00	06000 LABORATORY	472	15, 769		0	57, 490	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	472	1, 812		0	104, 902	65. 00
65. 01	03610 SLEEP LAB	0	481	1	0	0 05 057	65. 01
66. 00 67. 00	O6600   PHYSI CAL THERAPY   O6700   OCCUPATI ONAL THERAPY	665 109	1, 612 628	1	0	95, 057 0	66. 00 67. 00
	06800 SPEECH PATHOLOGY	48	221	·		0	
	06900 ELECTROCARDI OLOGY	387	2, 910			78, 581	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	0	1		0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	8, 857	1		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	73	14, 875			13, 671	1
74.00	07400 RENAL DIALYSIS	12	227	1		33, 098	1
76. 97 76. 98	O7697   CARDI AC REHABI LI TATI ON   O7698   HYPERBARI C OXYGEN THERAPY	0 24	0 43		0	0	76. 97 76. 98
76. 99	07699 LI THOTRI PSY	0	0	1		0	76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>				<u> </u>	70. 77
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 02	09001 MOBILE MEDICAL UNIT	0	51	0	0	0	90. 02
90. 03	09002 FAMILY MEDICINE CENTER	678	379	1		0	90. 03
90. 04	09003 WOUND HEALING CENTER	181	565	1		0	90. 04
90. 05	09004 OUTPATIENT TREATMENT & INFUSION	145	147			45, 221	90. 05
90. 06 90. 07	09005 PEDIATRIC SPECIALTY CLINIC 09006 SPORTS MED FELLOWSHIP CLINIC	206 85	22 0	1		0	90. 06 90. 07
90. 07	09007 PODIATRY RESIDENCY CLINIC	194	0	1		0	90.07
90. 09	09008 FACULTY PRACTICE CLINIC	0	79			0	90. 09
90. 10	09009 OUR LADY OF ROSARY CLINIC	O	137			0	90. 10
91. 00	09100 EMERGENCY	1, 706	5, 681	143, 115	0	617, 550	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
110.00	SPECIAL PURPOSE COST CENTERS	00 533	405 410	4 040 633		0 (00 072	110 00
118. 00	3 /	28, 577	125, 412	4, 043, 038	0	8, 609, 970	J118.00
190 00	NONREIMBURSABLE COST CENTERS   1900  GIFT, FLOWER, COFFEE SHOP & CANTEEN	60	0	2, 726	0	55 007	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	3, 230	0				192. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	, 9			<u>.                                     </u>	-1-21	<u> </u>

TOTAL (sum lines 118 through 201)

202.00

Provi der CCN: 15-0012

126, 027

4, 120, 421

Peri od:

8, 671, 316 202. 00

0

From 07/01/2020 Part II Date/Time Prepared: 11/30/2021 12:30 pm 06/30/2021 MAINTENANCE & Cost Center Description NONPATI ENT ADMI TTI NG OTHER OPERATION OF TELEPHONES ADMI NI STRATI VE **REPAI RS** PLANT & GENERAL 5. 01 5.04 6. 00 7. 00 5. 06 192. 01 19201 MATERNAL FETAL MEDICINE/LABORIST 192. 02 19202 NEONATOLOGISTS 2, 950 192. 01 117 0 32 0 0 0 0 0 0 0 0 192. 02 36 163 42 192. 03 19203 HOSPI TALI STS/I NTENSI VI STS 145 249 77 0 192. 03 194.00 07950 SPORTS MED-ATHLETIC TRAINERS 0 194. 00 0 0 C 194. 01 07951 OUTREACH SERVICES 0 194. 01 557 171 65, 152 194. 02 07952 KINDRED/OUR LADY OF PEACE 230 33 0 194. 02 194. 03 07953 ADVANCED SPECIALTIES 0 194. 03 0 0 127 194. 04 07954 AMBULATORY PHARMACY SERVICES 0 194, 04 0 C 8, 515 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 0 201. 00

32, 835

Provider CCN: 15-0012

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 07/01/2020 Part II | To 06/30/2021 Date/Time Prepared: 11/30/2021 12:30 pm

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	11/30/2021 12 MAINTENANCE OF PERSONNEL	
		8. 00	9. 00	10. 00	11. 00	12.00	
	GENERAL SERVI CE 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 5. 01	OO4OO						4. 00 5. 01
5. 04	00570 ADMI TTI NG						5. 04
5. 06	00590 OTHER ADMINISTRATIVE & GENERAL						5.06
6. 00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	21, 206					8. 00
9.00	00900 HOUSEKEEPI NG	0	634, 917				9. 00
10.00	01000 DI ETARY	0	18, 707	878, 903			10. 00
11. 00	01100 CAFETERI A	0	25, 423	0	1, 189, 965		11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	4, 151	0	39, 621	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	13, 829	0	
15. 00	01500 PHARMACY	0	14, 519	0	42, 687	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	2, 129	0	29, 548 28, 997	0	
17. 00 18. 00	01700   SOCIAL SERVICE   01850   STERILE SUPPLY	0	1, 295 16, 816	0	28, 997 23, 092	0	17. 00 18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	10, 810	0	23, 092	0	19.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	1, 965	0	35, 723	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	12, 415	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	1
23. 02	02302 PHARMACY RESI DENCY PROGRAM	0	o	0	6, 391	0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 287	248, 455	809, 515	271, 988	0	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	608	31, 239	23, 393	59, 506	0	31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	202	11, 052	8, 368	24, 226	0	35. 00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	
43. 00	04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	69	0	0	18, 720	0	43. 00
50. 00	05000 OPERATING ROOM	3, 933	104, 310	25, 370	133, 781	0	50.00
51. 00	05100 RECOVERY ROOM	3, 733	6, 912	1, 099	15, 978	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	282	0, 712	0	32, 107	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 140	29, 464	0	50, 578	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	9	0	0	1, 889	0	55. 00
57.00	05700 CT SCAN	1, 411	3, 725	0	10, 137	0	57. 00
58.00	05800 MRI	151	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 410	32, 023	0	32, 981	0	59. 00
60. 00	06000 LABORATORY	2, 678	4, 297	0	28, 285	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	308	7, 840	0	29, 732	0	
65. 01 66. 00	03610 SLEEP LAB	82 274	7 105	0	43 29, 969	0	65. 01 66. 00
67. 00	O6600  PHYSI CAL THERAPY   O6700  OCCUPATI ONAL THERAPY	107	7, 105 0	0	29, 909 8, 162	0	67.00
68. 00	06800 SPEECH PATHOLOGY	38	0	0	2, 958	0	
69. 00	06900 ELECTROCARDI OLOGY	494	5, 873	- 1	13, 991	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 504	О	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 526	1, 022	0	5, 042	0	73. 00
74. 00	07400 RENAL DIALYSIS	38	2, 474	0	0	0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	7	0	0	270	0	
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0	O	0	0	90.00
90. 02	09001 MOBI LE MEDI CAL UNIT	9	0	0	1, 544	0	
90. 02	09002 FAMILY MEDICINE CENTER	64	0	0	16, 485	0	
90. 03	09003 WOUND HEALING CENTER	96	n	0	8, 324	0	90. 04
90. 05	09004 OUTPATIENT TREATMENT & INFUSION	25	3, 380	466	7, 827	0	90. 05
90. 06	09005 PEDIATRIC SPECIALTY CLINIC	4	0	0	2, 926	0	90.06
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	0	o	0	5, 204	0	90. 07
90. 08	09007 PODIATRY RESIDENCY CLINIC	0	o	0	7, 471	0	90. 08
90. 09	09008 FACULTY PRACTICE CLINIC	13	0	0	4, 804	0	
90. 10	09009 OUR LADY OF ROSARY CLINIC	23	0	0	9, 684	0	
	09100 EMERGENCY	965	46, 156	10, 692	65, 692	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
110 00	SPECIAL PURPOSE COST CENTERS	24 400	420 220	070 000	1 100 /07	^	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	21, 102	630, 332	878, 903	1, 132, 607	0	118. 00
190 00	19000  GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4, 111	Λ	n	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	253	0	0		192.00
	19201 MATERNAL FETAL MEDICINE/LABORIST	5	221	Ö	0		192. 01

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012

| Period: | Worksheet B | From 07/01/2020 | Part II | Date/Time Prepared: | 11/30/2021 | 12:30 pm

					11/30/2021 12	:30 pm
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	
	LINEN SERVICE				PERSONNEL	
	8. 00	9. 00	10.00	11. 00	12. 00	
192. 02 19202 NEONATOLOGI STS	28	0	0	0	0	192. 02
192. 03 19203 HOSPI TALI STS/I NTENSI VI STS	42	0	0	0	0	192. 03
194.00 07950 SPORTS MED-ATHLETIC TRAINERS	0	0	0	0	0	194. 00
194. 01 07951 OUTREACH SERVICES	29	0	0	53, 158	0	194. 01
194.02 07952 KINDRED/OUR LADY OF PEACE	0	0	0	0	0	194. 02
194. 03 07953 ADVANCED SPECIALTIES	0	0	0	0	0	194. 03
194.04 07954 AMBULATORY PHARMACY SERVICES	0	0	0	4, 200	0	194. 04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	21, 206	634, 917	878, 903	1, 189, 965	0	202. 00

Health Financial Systems

ST. JOSEPHS REG MED CENTER S. BEND

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0012
From 07/01/2020
To 06/30/2021
Date/Time Prepared:

				То		Date/Time Pre 11/30/2021 12	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	RECORDS &	SOCIAL SERVICE	
		13.00	SUPPLY 14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS BLDG & FLXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 04	00570 ADMI TTI NG						5. 04
5. 06	00590 OTHER ADMINISTRATIVE & GENERAL						5. 06
6. 00	00600 MAI NTENANCE & REPAI RS						6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	250.07/					12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	358, 076 4, 305	34, 300				13. 00 14. 00
15. 00	01500 PHARMACY	13, 287	0, 300				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	9, 198	0		174, 127		16. 00
17. 00	01700 SOCI AL SERVI CE	9, 026	0	0	0	151, 926	17. 00
18.00	01850 STERI LE SUPPLY	7, 188	0	1	0	0	18.00
19. 00 21. 00	01900   NONPHYSICIAN ANESTHETISTS   02100   I&R SERVICES-SALARY & FRINGES APPRV	11, 120	0	0	0	0	19. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	3, 865	0		0	0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 02	02302 PHARMACY RESIDENCY PROGRAM	1, 989	0	401	0	0	23. 02
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	04 445	2 404		18. 675	125 045	20 00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	84, 665 18, 523	3, 684 980		18, 675 4, 966	135, 045 15, 193	1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	7, 541	326		1, 652	1, 688	1
41.00	04100 SUBPROVI DER - I RF	0	0		0	0	41. 00
43.00	04300 NURSERY	5, 827	111	0	564	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	41, 643	6, 469	0	33, 067	0	50. 00
51. 00	05100 RECOVERY ROOM	41, 643	556		2, 818	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	9, 994	454	1	2, 299	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	15, 744	1, 837	0	9, 311	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	588	15		76	0	55. 00
57. 00 58. 00	05700 CT SCAN 05800 MRI	3, 155	2, 274 243		11, 525 1, 232	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	10, 266	2, 272	-	11, 515	0	59.00
60.00	06000 LABORATORY	8, 804	4, 314		21, 868	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY 03610 SLEEP LAB	9, 255	496	1	2, 513	0	65.00
65. 01 66. 00	06600 PHYSI CAL THERAPY	13 9, 329	132 441		668 2, 235	0	65. 01 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 541	172		871	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	921	60	0	306	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	4, 355	796		4, 036	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	0	0 2, 423		12, 283	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 569	4, 070		20, 629	0	73. 00
74.00	07400 RENAL DIALYSIS	0	62		314	0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	- 1	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	84	12		60	0	76. 98
76. 99	O7699 LITHOTRIPSY   OUTPATIENT SERVICE COST CENTERS	l U	0	0	0	0	76. 99
90. 00	09000 CLINIC	0	0	0	0	0	90.00
90. 02	09001 MOBILE MEDICAL UNIT	481	14	0	71	0	90. 02
90. 03	09002 FAMILY MEDICINE CENTER	5, 131	104		526	0	90. 03
90. 04 90. 05	09003 WOUND HEALING CENTER 09004 OUTPATIENT TREATMENT & INFUSION	2, 591 2, 436	155 40	1	783 204	0	90. 04 90. 05
90. 05	09005 PEDIATRIC SPECIALTY CLINIC	911	6		30	0	90.05
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	1, 620	0		0	0	90. 07
90. 08	09007 PODI ATRY RESI DENCY CLI NI C	2, 325	0	96	0	0	90.08
90. 09	09008 FACULTY PRACTICE CLINIC	1, 495	22		110 100	0	90. 09 90. 10
90. 10 91. 00	09009 OUR LADY OF ROSARY CLINIC 09100 EMERGENCY	3, 014 20, 449	38 1, 554		190 7, 878	0	90.10
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		., 50 1				92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	5 /	340, 222	34, 132	813, 494	173, 275	151, 926	J118. 00
190. 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	0	n	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	o o	Ö		ő		192. 00
		·		,,			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

TOTAL (sum lines 118 through 201)

202.00

ST. JOSEPHS REG MED CENTER S. BEND

Provi der CCN: 15-0012

34, 300

Peri od:

815, 762

174, 127

In Lieu of Form CMS-2552-10 Worksheet B

151, 926 202. 00

From 07/01/2020 Part II Date/Time Prepared: 11/30/2021 12:30 pm 06/30/2021 Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & RECORDS & SUPPLY LI BRARY 13.00 14.00 15.00 16.00 17. 00 192. 01 19201 MATERNAL FETAL MEDICINE/LABORIST 192. 02 19202 NEONATOLOGISTS 0 192. 01 44 0 225 0 192. 02 0 44 0 192. 03 19203 HOSPI TALI STS/I NTENSI VI STS 0 68 0 345 0 192. 03 194.00 07950 SPORTS MED-ATHLETIC TRAINERS 0 194. 00 0 0 0 194. 01 07951 OUTREACH SERVICES 0 194. 01 16, 547 47 2, 268 238 194. 02 07952 KINDRED/OUR LADY OF PEACE 0 0 194. 02 194. 03 07953 ADVANCED SPECIALTIES 0 0 0 194. 03 0 194. 04 07954 AMBULATORY PHARMACY SERVICES 1, 307 0 0 194, 04 0 C 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201. 00

358, 076

| Peri od: | Worksheet B | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0012

				Τ̈́	o 06/30/2021	Date/Time Pre	
		OTHER GENERAL		INTERNS &	RESI DENTS	1173072021 12	. 30 piii
	Cost Contan Decemintion	SERVI CE	NONDHIVELCLAN	CEDVICES CALAE	SERVI CES-OTHER	DADAMED ED	
	Cost Center Description	STERILE SUPPLY	NONPHYSICIAN ANESTHETISTS	Y & FRINGES	PRGM COSTS	PARAMED ED PRGM	
				APPRV	APPRV		
	JOSUS DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONTROL DE LA CONT	18. 00	19. 00	21. 00	22. 00	23. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	T					1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 04 5. 06	00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL						5. 04 5. 06
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 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
12. 00	01200 MAINTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15. 00 16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
18. 00	01850 STERI LE SUPPLY	858, 437					18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	C	1			19. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		184, 211	1		21. 00
22. 00 23. 00	02200   L&R SERVICES-OTHER PRGM COSTS APPRV 02300   PARAMED ED PRGM-(SPECIFY)	0 0			68, 907	0	22. 00 23. 00
23. 02	02302 PHARMACY RESI DENCY PROGRAM	0				Ö	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	14, 114					30.00
31. 00 35. 00	03100   NTENSI VE CARE UNIT 02060   NEONATAL   NTENSI VE CARE UNIT	130 734	<b>l</b>				31. 00 35. 00
41. 00	04100 SUBPROVI DER - I RF	0					41. 00
43.00	04300 NURSERY	0					43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	701 010	I				50.00
50.00	05100 RECOVERY ROOM	781, 819	l I				50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0					52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	759	l e				54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	l .				55. 00
57. 00 58. 00	05700   CT   SCAN     05800   MRI	0					57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 204					59. 00
60.00	06000 LABORATORY	0					60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0					62. 30
65. 00 65. 01	06500 RESPI RATORY THERAPY 03610 SLEEP LAB	1, 599					65. 00 65. 01
66. 00	06600 PHYSI CAL THERAPY	0					66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0					67. 00
68. 00	06800 SPEECH PATHOLOGY	0					68. 00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0					69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0					73. 00
74.00	07400 RENAL DI ALYSI S	0					74.00
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0 0	l				76. 97 76. 98
76. 99	07699 LI THOTRI PSY	0	ł				76. 99
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0					90.00
90. 02 90. 03	09001 MOBILE MEDICAL UNIT	0	l				90. 02
90. 03	09002 FAMILY MEDICINE CENTER 09003 WOUND HEALING CENTER	4, 455 3, 088	l e				90. 03 90. 04
90. 05	09004 OUTPATIENT TREATMENT & INFUSION	0	l e				90. 05
90. 06	09005 PEDIATRIC SPECIALTY CLINIC	0					90. 06
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	217					90. 07
90. 08 90. 09	09007   PODIATRY RESIDENCY CLINIC   09008   FACULTY PRACTICE CLINIC	0 140					90. 08 90. 09
90. 10	09009 OUR LADY OF ROSARY CLINIC	0					90. 10
91. 00	09100 EMERGENCY	759					91. 00
92. 00							92. 00
118. 00	SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)	812, 018	C		0	0	118. 00
		312,010			, Y	O	,

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202.00

0 200.00

0 201.00

0 202. 00

ALLOCATION OF CAPITAL RELATED COSTS Worksheet B Provi der CCN: 15-0012 Peri od: From 07/01/2020 To 06/30/2021 Part II Date/Time Prepared: 11/30/2021 12:30 pm OTHER GENERAL INTERNS & RESIDENTS SERVI CE STERILE SUPPLY NONPHYSI CI AN SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Cost Center Description ANESTHETI STS Y & FRINGES PRGM COSTS PRGM APPRV APPRV 19.00 23.00 18. 00 21.00 22.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 190. 00 0 0 0 0 0 192. 00 192.01 19201 MATERNAL FETAL MEDICINE/LABORIST 192. 01 192. 02 19202 NEONATOLOGI STS 192. 02 192. 03 19203 HOSPI TALI STS/I NTENSI VI STS 192. 03 194.00 07950 SPORTS MED-ATHLETIC TRAINERS 194. 00 194. 01 07951 OUTREACH SERVICES 194. 01 33, 262 194. 02 07952 KINDRED/OUR LADY OF PEACE 194. 02 194. 03 07953 ADVANCED SPECIALTIES 194. 03 13, 157 194. 04 07954 AMBULATORY PHARMACY SERVICES 194. 04

858, 437

184, 211

184, 211

68, 907

68, 907

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0012 Peri od: Worksheet B From 07/01/2020 Part II Date/Time Prepared: 06/30/2021 11/30/2021 12:30 pm Cost Center Description **PHARMACY** Subtotal Total Intern & RESI DENCY Residents Cost **PROGRAM** & Post Stepdown Adjustments 23.02 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00570 ADMITTING 5.04 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 5.06 5.06 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 SOCIAL SERVICE 17.00 01850 STERI LE SUPPLY 18.00 18.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 19 00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 02302 PHARMACY RESIDENCY PROGRAM 18,630 23.02 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 13, 147, 920 0 13, 147, 920 30.00 03100 INTENSIVE CARE UNIT 1, 674, 103 0 1, 674, 103 31.00 31.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 0 597, 633 597, 633 35.00 41.00 04100 SUBPROVIDER - IRF 0 41.00 04300 NURSERY 43.00 58, 137 0 58, 137 43 00 ANCILLARY SERVICE COST CENTERS 50.00 6, 259, 789 50.00 05000 OPERATING ROOM 6, 259, 789 0 51.00 05100 RECOVERY ROOM 368, 813 368, 813 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 100, 713 100, 713 52.00 05400 RADI OLOGY-DI AGNOSTI C 1, 518, 846 0 1, 518, 846 54.00 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 8, 393 8, 393 55.00 57.00 05700 CT SCAN 228, 264 0 228, 264 57.00 58.00 05800 MRI 19, 759 0 19, 759 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 1, 715, 305 1, 715, 305 59 00 60.00 06000 LABORATORY 467, 058 0 467, 058 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 06500 RESPIRATORY THERAPY 455, 282 455, 282 65.00 65.00 03610 SLEEP LAB 0 65.01 10, 652 10, 652 65.01 66.00 06600 PHYSI CAL THERAPY 422, 431 422, 431 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 28, 282 28, 282 67.00 0 06800 SPEECH PATHOLOGY 68.00 10.351 10.351 68 00 69.00 06900 ELECTROCARDI OLOGY 318, 599 318, 599 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 402.074 402.074 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 1, 306, 460 73.00 1, 306, 460 73.00 74.00 07400 RENAL DIALYSIS 139, 765 0 139, 765 74.00 07697 CARDIAC REHABILITATION 0 76. 97 76.97 0 76 98 07698 HYPERBARI C OXYGEN THERAPY 1, 189 1, 189 76. 98 07699 LI THOTRI PSY 0 76.99 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 MOBILE MEDICAL UNIT 0 2, 170 90 02 2, 170 90 02 90.03 09002 FAMILY MEDICINE CENTER 49, 290 49, 290 90.03 09003 WOUND HEALING CENTER 41, 249 0 41, 249 90.04 90.04 90.05 09004 OUTPATIENT TREATMENT & INFUSION 180, 447 0 180, 447 90.05 09005 PEDIATRIC SPECIALTY CLINIC 9, 132 0 90.06 90.06 9, 132 0 90.07 09006 SPORTS MED FELLOWSHIP CLINIC 21, 257 21, 257 90.07 09007 PODIATRY RESIDENCY CLINIC 0 27, 078 90.08 27,078 90.08 90.09 09008 FACULTY PRACTICE CLINIC 16, 402 0 16, 402 90.09 90.10 09009 OUR LADY OF ROSARY CLINIC 34, 684 0 34, 684 90.10 09100 EMERGENCY 0 91.00 2, 344, 612 2, 344, 612 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 31, 986, 139 0 31, 986, 139 118. 00

Health Financial Systems SI.	JUSEPHS REG MEL	CENTER S. BEI	ND .	in Lie	U OT FORM CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Peri od:	Worksheet B
				From 07/01/2020	Part II
				To 06/30/2021	Date/Time Prepared: 11/30/2021 12:30 pm
Cost Center Description	PHARMACY	Subtotal	Intern &	Total	11/30/2021 12.30 piii
COST Center Description					
	RESI DENCY		Residents Cos	١ ا	
	PROGRAM		& Post		
			Stepdown		
	00.00	04.00	Adjustments	0/ 00	
NONDEL MOUDO ADLE COOT OFFITEDO	23. 02	24. 00	25. 00	26. 00	
NONREI MBURSABLE COST CENTERS	1				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		188, 603		0 188, 603	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		15, 271		0 15, 271	192. 00
192.01 19201 MATERNAL FETAL MEDICINE/LABORIST		10, 174		0 10, 174	192. 01
192. 02 19202  NEONATOLOGI STS		538		0 538	192. 02
192. 03 19203 HOSPI TALI STS/I NTENSI VI STS		926		0 926	192. 03
194.00 07950 SPORTS MED-ATHLETIC TRAINERS		0		0 0	194. 00
194. 01 07951 OUTREACH SERVICES		171, 429		0 171, 429	194. 01
194. 02 07952 KINDRED/OUR LADY OF PEACE		263		0 263	194. 02
194. 03 07953 ADVANCED SPECIALTIES		13, 284		0 13, 284	194. 03
194.04 07954 AMBULATORY PHARMACY SERVICES		14, 022		0 14, 022	194. 04
200.00 Cross Foot Adjustments	18, 630	271, 748		0 271, 748	200. 00
201.00 Negative Cost Centers	0	21, 262		0 21, 262	201. 00
202.00 TOTAL (sum lines 118 through 201)	18, 630	32, 693, 659		0 32, 693, 659	202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ST. JOSEPHS REG MED CENTER S. BEND In Lieu of Form CMS-2552-10 Provider CCN: 15-0012 

					To	06/30/2021	Date/Time Prep 11/30/2021 12	
			CAPITAL REI	LATED COSTS			117 007 2021 12	, 00 p
		Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	NONPATI ENT TELEPHONES (PHONE EXTE NSI ONS)	ADMI TTI NG (GROSS REVE NUE)	
					SALARI ES)	,		
	CENED	AL CEDIU CE COCT CENTEDO	1. 00	2.00	4. 00	5. 01	5. 04	
1.00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT	485, 895					1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP	403,073	485, 895				2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	316					4. 00
5. 01		NONPATI ENT TELEPHONES	488		· ·	2, 714		5. 01
5. 04 5. 06		ADMITTING OTHER ADMINISTRATIVE & GENERAL	1, 866			39 361	1, 185, 161, 265 0	5. 04 5. 06
6.00		MAINTENANCE & REPAIRS	61, 173	61, 173	9, 647, 016	0	0	6.00
7.00	00700	OPERATION OF PLANT	125, 215	125, 215	1, 837, 526	85	0	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	0	127, 128	5	0	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	6, 038 8, 568			17 24	0	9. 00 10. 00
11. 00		CAFETERIA	11, 644			21	0	11. 00
12.00	1	MAINTENANCE OF PERSONNEL	0	0	0	o	0	12. 00
13.00		NURSI NG ADMI NI STRATI ON	1, 901	1, 901	3, 152, 153	28	0	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	6, 650	0 6, 650	524, 305 4, 220, 159	3 57	0 2, 164	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	975			44	2, 104	16. 00
17. 00	01700	SOCIAL SERVICE	593	593		36	0	17. 00
18.00	1	STERILE SUPPLY	7, 702			11	0	18. 00
19. 00 21. 00		NONPHYSICIAN ANESTHETISTS I&R SERVICES-SALARY & FRINGES APPRV	900		0 2, 335, 400	0	0	19. 00 21. 00
22. 00		I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	2, 506, 107	35	0	22. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)	0	0	0	О	0	23. 00
23. 02		PHARMACY RESIDENCY PROGRAM	0	0	452, 732	3	0	23. 02
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	113, 795	113, 795	18, 992, 435	548	127, 038, 749	30. 00
31. 00	1	INTENSIVE CARE UNIT	14, 308			45	33, 782, 721	31. 00
35. 00		NEONATAL INTENSIVE CARE UNIT	5, 062			21	11, 235, 857	35. 00
41. 00 43. 00		SUBPROVI DER - I RF NURSERY	0	0		0	0 3, 834, 274	41. 00 43. 00
43.00		LARY SERVICE COST CENTERS		0	1, 400, 667	O <sub>I</sub>	3, 634, 274	43.00
50.00	05000	OPERATING ROOM	47, 775			250	225, 560, 559	50. 00
51.00		RECOVERY ROOM	3, 166			37	19, 169, 815	•
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	13, 495	0 13, 495	2, 418, 095 3, 506, 613	0 141	15, 640, 276 63, 340, 385	
55. 00		RADI OLOGY-THERAPEUTI C	0	0	153, 403	0	518, 550	
57. 00	1	CT SCAN	1, 706		798, 246	9	78, 403, 910	
58. 00 59. 00	05800	MRI CARDI AC CATHETERI ZATI ON	14 447	14 447	0 2 940 474	13 78	8, 381, 005 78, 334, 386	
60.00		LABORATORY	14, 667 1, 968		2, 840, 474 1, 425, 713	39	148, 760, 867	60.00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65.00		RESPIRATORY THERAPY	3, 591	3, 591		39	17, 095, 739	
65. 01 66. 00	1	SLEEP LAB PHYSI CAL THERAPY	0 3, 254	_		0 55	4, 541, 146 15, 206, 024	
67. 00		OCCUPATIONAL THERAPY	0, 234	0, 234		9	5, 926, 979	
68. 00	1	SPEECH PATHOLOGY	0	0		4	2, 084, 659	
69.00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	2, 690	2, 690	1, 023, 329 0	32	27, 456, 573 0	
71. 00 72. 00	1	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	83, 559, 415	71. 00 72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	468	468	417, 215	6	140, 332, 190	
74. 00	1	RENAL DIALYSIS	1, 133			1	2, 136, 946	
76. 97 76. 98		CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	0	0		0	0 408, 388	
76. 99	1	LI THOTRI PSY		0	,	0	400, 300	1
		TIENT SERVICE COST CENTERS						
90.00		CLINIC	0	0	04 355	0	402.333	
90. 02 90. 03	1	MOBILE MEDICAL UNIT FAMILY MEDICINE CENTER	0	0	86, 355 780, 249	0 56	482, 332 3, 576, 711	•
90. 04	1	WOUND HEALING CENTER		Ö	592, 980	15	5, 329, 756	•
90. 05	09004	OUTPATIENT TREATMENT & INFUSION	1, 548	1, 548	658, 796	12	1, 388, 763	90. 05
90.06		PEDIATRIC SPECIALTY CLINIC	0	0	241, 055 624, 045	17	203, 407 0	
90. 07 90. 08		SPORTS MED FELLOWSHIP CLINIC PODIATRY RESIDENCY CLINIC	0	0	624, 945 728, 927	7 16	0	90. 07 90. 08
90. 09	1	FACULTY PRACTICE CLINIC	0	Ö	403, 030	0	747, 199	90. 09
		OUR LADY OF ROSARY CLINIC	0	0	874, 461	0	1, 293, 246	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	21, 140	21, 140	4, 687, 253	141	53, 592, 860	91. 00 92. 00
,2.00	10 /200	1 SEE THE PERSON NOW DISTINCT TAKE	T.	I		ı	l	, ,2.00

Health Financial Systems	ST. JOSEPHS REG ME	D CENTER S. BE	ND	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO	CN: 15-0012	Peri od: From 07/01/2020 To 06/30/2021	Worksheet B-1 Date/Time Pre 11/30/2021 12	pared:
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	NONPATI ENT TELEPHONES	ADMITTING (GROSS REVE	

Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATI ENT TELEPHONES (PHONE EXTE NSI ONS)	ADMITTING (GROSS REVE NUE)	
	1.00	2.00	4. 00	5. 01	5. 04	
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through	117) 483, 795	483, 795	100, 458, 388	2, 362	1, 179, 365, 851	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE			0	5		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	116		0	267		192. 00
192. 01 19201 MATERNAL FETAL MEDICINE/LABORIST	101	101	0	0	297, 589	1
192. 02 19202 NEONATOLOGI STS	0	0	0	3	1, 533, 271	
192. 03 19203 HOSPI TALI STS/I NTENSI VI STS	0	0	0	12	2, 347, 670	
194. 00 07950 SPORTS MED-ATHLETIC TRAINERS	0	0	0	0		194. 00
194. 01 07951 OUTREACH SERVICES	0	0	2, 851, 121	46	1, 616, 884	
194. 02 07952 KI NDRED/OUR LADY OF PEACE	0	0	0	19		194. 02
194. 03 07953 ADVANCED SPECIALTIES	0	0	204 040	0		194. 03
194. 04 07954 AMBULATORY PHARMACY SERVICES	0	U	384, 948	U	0	194. 04 200. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	24 107 270	/ FO/ 200	02.044	202 727	1 740 402	
202.00   Cost to be allocated (per Wkst. B, Part I)	26, 107, 379	6, 586, 280	-92, 964	292, 727	1, 740, 402	202.00
203.00 Unit cost multiplier (Wkst. B, Par	t I) 53. 730495	13. 554945	0.000000	107. 858143	0. 001468	203. 00
204.00   Cost to be allocated (per Wkst. B, Part II)			21, 262	32, 835	126, 027	204. 00
205.00 Unit cost multiplier (Wkst. B, Par	t		0. 000205	12. 098379	0. 000106	205. 00
206.00 NAHE adjustment amount to be allocation (per Wkst. B-2)	ated					206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)	,					207. 00

Provider CCN: 15-0012

				1	0 06/30/2021	Date/lime Pre 11/30/2021 12	
	Cost Center Description	Reconciliation	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	, 00 p
			ADMI NI STRATI VE		PLANT	LINEN SERVICE	
			& GENERAL (ACCUM COST)	(SQUARE FEET)	(SQUARE FEET)	(GROSS REVE NUE)	
		5A. 06	5. 06	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	OO200   CAP REL COSTS-MVBLE EQUIP   OO400   EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 04	00570 ADMITTING						5. 04
5.06	00590 OTHER ADMINISTRATIVE & GENERAL	-69, 833, 301	253, 985, 752				5. 06
6.00	00600 MAINTENANCE & REPAIRS	0	0	0			6. 00
7.00	00700 OPERATION OF PLANT	0	15, 110, 917	0	296, 837		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	1, 303, 448	1	0	1, 185, 161, 265	
9.00	00900 HOUSEKEEPI NG	0	3, 208, 814		-,	0	
10. 00 11. 00	01000  DI ETARY  01100  CAFETERI A		2, 041, 068 2, 506, 745		8, 568 11, 644	0	
12. 00	01200 MAINTENANCE OF PERSONNEL	0	2,300,743		11,044	0	12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	Ō	8, 045, 487	0	1, 901	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	994, 237	0	0	0	14. 00
15. 00	01500 PHARMACY	0	6, 340, 952		6, 650	2, 164	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	2, 381, 498			0	16. 00
	01700   SOCI AL SERVI CE   01850   STERI LE SUPPLY	0	3, 387, 101		593	0	17. 00 18. 00
	01900 NONPHYSICIAN ANESTHETISTS	0	4, 190, 434		7, 702 0	0	19.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	o o	2, 993, 025		900	Ö	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	3, 217, 881	0	0	0	22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 02	02302 PHARMACY RESIDENCY PROGRAM	0	604, 856	0	0	0	23. 02
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1	110 705	107.000.710	
30. 00 31. 00	03000   ADULTS & PEDI ATRI CS   03100   I NTENSI VE CARE UNI T	0	34, 421, 397 8, 306, 070	0		127, 038, 749 33, 782, 721	30. 00 31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT		1			11, 235, 857	35.00
41. 00	04100 SUBPROVI DER - I RF	0	0, 200, 012	Ö		0	41. 00
43.00	04300 NURSERY	0	1, 999, 615	0	0	3, 834, 274	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0					
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0	1, 734, 516 3, 323, 600		3, 166	19, 169, 815 15, 640, 276	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	6, 124, 345	1	_	63, 340, 385	ı
55. 00	05500 RADI OLOGY-THERAPEUTI C	Ö	355, 116		0	518, 550	ı
57.00	05700 CT SCAN	0	1, 417, 221	0	1, 706	78, 403, 910	57. 00
58. 00	05800 MRI	0	1, 053, 292		0	8, 381, 005	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	11, 661, 871		,	78, 334, 386	
60. 00 62. 30	06000 LABORATORY	0	11, 752, 635	0	1, 968 0	148, 760, 867	1
65. 00	06250   BLOOD CLOTTING FOR HEMOPHILIACS   06500   RESPIRATORY THERAPY	0	3, 373, 665		3, 591	0 17, 095, 739	1
65. 01	03610 SLEEP LAB	o o	569, 130		0,071	4, 541, 146	1
66. 00	06600 PHYSI CAL THERAPY	0			3, 254		
	06700 OCCUPATI ONAL THERAPY	0	967, 251	0	0		
	06800 SPEECH PATHOLOGY	0	1				1
69. 00	06900 ELECTROCARDI OLOGY	0	1, 613, 618	0	2, 690	27, 456, 573	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	0	23, 239, 047		0	0 83, 559, 415	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	25, 145, 776		468		
74.00	07400 RENAL DIALYSIS	0	1, 683, 086		1, 133		
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	42, 368			408, 388	
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	1 0		0	0	0	90.00
	09001 MOBILE MEDICAL UNIT	-130, 161	0	0		482, 332	
90. 03	09002 FAMILY MEDICINE CENTER	0	1, 323, 335			3, 576, 711	1
90.04	09003 WOUND HEALING CENTER	0	1, 564, 871	0	0	5, 329, 756	90. 04
90. 05	09004 OUTPATIENT TREATMENT & INFUSION	0	1, 003, 518		1, 548		
	09005 PEDIATRIC SPECIALTY CLINIC	0	308, 569		0	203, 407	1
90. 07 90. 08	09006 SPORTS MED FELLOWSHIP CLINIC 09007 PODIATRY RESIDENCY CLINIC	0	834, 869		0	0	90. 07 90. 08
90.08	09008 FACULTY PRACTICE CLINIC	0	1, 047, 418 600, 316	1	0	747, 199	
90. 10	09009 OUR LADY OF ROSARY CLINIC	0	1, 222, 821		0	1, 293, 246	1
91. 00	09100 EMERGENCY	0	8, 821, 763		21, 140		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
440.5-	SPECIAL PURPOSE COST CENTERS	(0.000.000	040 045 555	-	22	4 470 045 05:	440 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-69, 963, 462	249, 215, 825	0	294, 737	1, 179, 365, 851	J178. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	168, 014	0	1, 883	n	190. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			1	., 300	<u> </u>	

| Peri od: | Worksheet B-1 | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0012

			10	06/30/2021	11/30/2021 12	
Cost Center Description	Reconciliation	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	JO pili
5551 5511td. 25551 Ft. 611		ADMI NI STRATI VE			LINEN SERVICE	
		& GENERAL	(SQUARE FEET)	(SQUARE FEET)	(GROSS REVE	
		(ACCUM COST)	, ,	·	NUE)	
	5A. 06	5. 06	6. 00	7. 00	8. 00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	36, 603	0	116	0	192. 00
192.01 19201 MATERNAL FETAL MEDICINE/LABORIST	0	7, 233	0	101	297, 589	192. 01
192. 02 19202 NEONATOLOGI STS	0	2, 575		0	1, 533, 271	
192. 03 19203 HOSPI TALI STS/I NTENSI VI STS	0	4, 740	0	0	2, 347, 670	192. 03
194.00 07950 SPORTS MED-ATHLETIC TRAINERS	0	0	0	0		194. 00
194. 01 07951 OUTREACH SERVICES	0	4, 016, 044	0	0	1, 616, 884	194. 01
194.02 07952 KINDRED/OUR LADY OF PEACE	0	2, 049		0		194. 02
194. 03 07953 ADVANCED SPECIALTIES	0	7, 815		0		194. 03
194.04 07954 AMBULATORY PHARMACY SERVICES	0	524, 854	0	0		194. 04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)		69, 833, 301	0	19, 265, 664	1, 661, 831	202. 00
203.00 Unit cost multiplier (Wkst. B, Part	1)	0. 274950	0.000000	64. 903176	0. 001402	203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)		4, 120, 421	0	8, 671, 316	21, 206	204. 00
205.00 Unit cost multiplier (Wkst. B, Part		0. 016223	0. 000000	29. 212383	0. 000018	205. 00
206.00 NAHE adjustment amount to be alloca (per Wkst. B-2)	ted					206. 00
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

Provider CCN: 15-0012

Peri od: Worksheet B-1 From 07/01/2020 To 06/30/2021 Date/Time Prepared:

					00/00/2021	11/30/2021 12	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY		MAINTENANCE OF	NURSI NG	
		(SQUARE FEET)	(MEALS SERVED)	(FTES)	PERSONNEL (NUMBER	ADMI NI STRATI ON	
					HOUSED)	(FTES)	
	OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OF	9. 00	10.00	11. 00	12. 00	13. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 NONPATIENT TELEPHONES						5. 01
5. 04	00570 ADMITTING						5. 04
5.06	00590 OTHER ADMINISTRATIVE & GENERAL						5. 06
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPING	290, 799					9. 00
10.00	01000 DI ETARY	8, 568	162, 272				10. 00
11. 00	01100 CAFETERI A	11, 644	0	110, 225	_		11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	l	12.00
13. 00 14. 00	O1300   NURSI NG   ADMI NI STRATI ON   O1400   CENTRAL   SERVI CES & SUPPLY	1, 901 0	0 0	3, 670 1, 281	0	106, 555 1, 281	13. 00 14. 00
15. 00	01500 PHARMACY	6, 650	0	3, 954	0	l	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	975	Ö	2, 737	0		16. 00
17. 00	01700 SOCIAL SERVICE	593	0	2, 686	0	2, 686	17. 00
18. 00	01850 STERI LE SUPPLY	7, 702	0	2, 139	0	2, 139	18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
21. 00 22. 00	02100   I&R SERVICES-SALARY & FRINGES APPRV   02200   I&R SERVICES-OTHER PRGM COSTS APPRV	900	0	3, 309 1, 150	0	3, 309	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	1, 150	0	.,	23. 00
23. 02	02302 PHARMACY RESIDENCY PROGRAM	0	o	592	0		23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	113, 795		25, 194	0		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	14, 308	4, 319	5, 512	0	-,	31.00
35. 00 41. 00	02060 NEONATAL INTENSIVE CARE UNIT	5, 062 0	1, 545 0	2, 244	0		35. 00 41. 00
43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	0	1, 734	0		43.00
43.00	ANCILLARY SERVICE COST CENTERS		<u> </u>	1, 754		1,754	43.00
50.00	05000 OPERATING ROOM	47, 775	4, 684	12, 392	0	12, 392	50. 00
51.00	05100 RECOVERY ROOM	3, 166	203	1, 480	0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	2, 974	0	_,	52. 00
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	13, 495	0	4, 685 175	0	4, 685 175	54. 00 55. 00
57. 00	05700 CT SCAN	1, 706	0	939	0	939	57. 00
58. 00	05800 MRI	0	o	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	14, 667	0	3, 055	0	3, 055	59. 00
60.00	06000 LABORATORY	1, 968	0	2, 620	0	2, 620	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 65. 01	06500 RESPI RATORY THERAPY 03610 SLEEP LAB	3, 591	0	2, 754	0	2, 754	65. 00 65. 01
66. 00	06600 PHYSI CAL THERAPY	3, 254	0	2, 776	0	2, 776	
67. 00	06700 OCCUPATI ONAL THERAPY	0	O	756	0	l	
68.00	06800 SPEECH PATHOLOGY	0	0	274	0	274	
69. 00	06900 ELECTROCARDI OLOGY	2, 690	0	1, 296	0	1, 296	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 468	0	0 467	0	0 467	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	1, 133	0	0	0	0	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	Ö	0	0	Ö	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	25	0	25	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS					_	00.00
90. 00 90. 02	09000 CLINIC 09001 MOBILE MEDICAL UNIT	0	0 0	0 143	0	1	90. 00 90. 02
90. 02	09001 MOBILE MEDICAL UNIT	0	0	1, 527	0	143 1, 527	90.02
90. 04	09003 WOUND HEALING CENTER	0	o	771	0	771	90. 04
90. 05	09004 OUTPATIENT TREATMENT & INFUSION	1, 548	86	725	0	725	90. 05
90. 06	09005 PEDIATRIC SPECIALTY CLINIC	0	0	271	0	271	90. 06
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	0	0	482	0	482	90. 07
90. 08	09007 PODIATRY RESIDENCY CLINIC	0	o o	692	0	692	90.08
90. 09 90. 10	09008 FACULTY PRACTICE CLINIC 09009 OUR LADY OF ROSARY CLINIC	0		445 897	0	445 897	90. 09 90. 10
91. 00	09100 EMERGENCY	21, 140	1, 974	6, 085	0	6, 085	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	21,110	1, ,, ,	5, 555	O	0,000	92. 00
	SPECIAL PURPOSE COST CENTERS		,				
118.00	, ,	288, 699	162, 272	104, 912	0	101, 242	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 883	ما	0	0	0	190. 00
170.00	7/1/000/0111, I LOWER, COLLE SHOP & CANTEEN	1,003	0	0	0	<u> </u>	1170.00

Provider CCN: 15-0012 | Peri od: | From 07/01/2020 | To 06/30/2021 | Date/Ti me Prepared:

				1'	0 00/30/2021	11/30/2021 12	
Cost (	Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF		
	•	(SQUARE FEET)	(MEALS SERVED)	(FTES)	PERSONNEL	ADMI NI STRATI ON	
				, ,	(NUMBER		
					HOUSED)	(FTES)	
		9. 00	10.00	11. 00	12.00	13. 00	
192. 00 19200 PHYSI (	CLANS' PRIVATE OFFICES	116	0	0	0	0	192. 00
192. 01 19201 MATERN	NAL FETAL MEDICINE/LABORIST	101	0	0	0	0	192. 01
192. 02 19202 NEONA	OLOGI STS	0	0	0	0	0	192. 02
192. 03 19203 HOSPI	TALI STS/I NTENSI VI STS	0	0	0	0	0	192. 03
	MED-ATHLETIC TRAINERS	0	0	0	0		194. 00
194. 01 07951 OUTREA	ACH SERVICES	0	0	4, 924	0		194. 01
	D/OUR LADY OF PEACE	0	0	0	0		194. 02
194. 03 07953 ADVANO		0	0	0	0		194. 03
	ATORY PHARMACY SERVICES	0	0	389	0	389	194. 04
	Foot Adjustments						200. 00
201.00 Negati	ve Cost Centers						201. 00
	o be allocated (per Wkst. B,	4, 482, 962	3, 290, 434	4, 131, 212	0	10, 547, 832	202. 00
Part I							
203.00 Unit	cost multiplier (Wkst. B, Part I)	15. 416016	20. 277275	37. 479809	0. 000000	98. 989555	
	o be allocated (per Wkst. B,	634, 917	878, 903	1, 189, 965	0	358, 076	204. 00
Part I							
	cost multiplier (Wkst. B, Part	2. 183353	5. 416233	10. 795781	0. 000000	3. 360481	205. 00
	adjustment amount to be allocated						206. 00
	/kst. B-2)						
	unit cost multiplier (Wkst. D,						207. 00
Parts	III and IV)	1		l			l

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0012 Peri od: Worksheet B-1 From 07/01/2020 06/30/2021 Date/Time Prepared: 11/30/2021 12:30 pm OTHER GENERAL SERVI CE CENTRAL **PHARMACY** MEDI CAL SOCIAL SERVICE STERILE SUPPLY Cost Center Description SERVICES & (COSTED RECORDS & REQUIS.) (TIME SPENT) (TIME SPENT) LI BRARY SUPPLY (GROSS REVE (GROSS REVE NUE) NUE) 15. 00 17. 00 18. 00 14.00 16, 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATI ENT TELEPHONES 5 01 5 01 5.04 00570 ADMITTING 5.04 5.06 00590 OTHER ADMINISTRATIVE & GENERAL 5.06 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 1, 185, 161, 265 14.00 14.00 15 00 01500 PHARMACY 2, 164 23, 219, 171 15 00 01600 MEDICAL RECORDS & LIBRARY 1, 185, 159, 101 16.00 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 01850 STERI LE SUPPLY 0 18.00 0 0 177, 664 18.00 18 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 C Λ 19.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 o 22.00 0 22.00 Ω 0 23 00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 23.00 0 02302 PHARMACY RESIDENCY PROGRAM 23.02 11, 414 0 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 127, 038, 749 n 127, 038, 749 80 2, 921 30.00 31.00 03100 INTENSIVE CARE UNIT 33, 782, 721 r 33, 782, 721 27 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 11, 235, 857 360 11, 235, 857 152 35.00 04100 SUBPROVIDER - IRF 41.00 C 0 0 41.00 04300 NURSERY 3, 834, 274 43.00 3, 834, 274 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 225, 560, 559 225, 560, 559 0 161, 807 50.00 05100 RECOVERY ROOM 19, 169, 815 19, 169, 815 0 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 15, 640, 276 0 15, 640, 276 52.00 Λ 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 63, 340, 385 0 63, 340, 385 157 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 518, 550 518, 550 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 55.00 0 05700 CT SCAN 78, 403, 910 78, 403, 910 57 00 Ω 0 57 00 58.00 05800 MRI 8, 381, 005 C 8, 381, 005 Ω 58.00 59.00 05900 CARDIAC CATHETERIZATION 78, 334, 386 195, 334 78, 334, 386 870 59.00 60.00 06000 LABORATORY 148, 760, 867 C 148, 760, 867 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62 30 Ω 0 62 30 65.00 06500 RESPIRATORY THERAPY 17, 095, 739 0 17, 095, 739 331 65.00 03610 SLEEP LAB 4, 541, 146 4, 541, 146 65.01 0 65.01 06600 PHYSI CAL THERAPY 66.00 15, 206, 024 15, 206, 024 66, 00 0 06700 OCCUPATIONAL THERAPY 5, 926, 979 5, 926, 979 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 2, 084, 659 0 2, 084, 659 0 68.00 06900 ELECTROCARDI OLOGY 69.00 27, 456, 573 27, 456, 573 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 83, 559, 415 83, 559, 415 72 00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 140, 332, 190 22, 871, 686 140, 332, 190 0 73.00 07400 RENAL DIALYSIS 74 00 2, 136, 946 C 2, 136, 946 0 74.00 76 97 07697 CARDIAC REHABILITATION 76.97 C C 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 408, 388 51 408, 388 0 76.98 07699 LI THOTRI PSY 0 76.99 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C Ω 0 0 0 90.02 09001 MOBILE MEDICAL UNIT 482, 332 482, 332 0 0 90.02 0 09002 FAMILY MEDICINE CENTER 90.03 3, 576, 711 3, 576, 711 0 0 0 0 0 922 90.03 09003 WOUND HEALING CENTER 5, 329, 756 5, 329, 756 90.04 90.04 2.247 639 09004 OUTPATIENT TREATMENT & INFUSION 90.05 1, 388, 763 3, 350 1, 388, 763 Ω 90.05 09005 PEDIATRIC SPECIALTY CLINIC 203, 407 203, 407 90.06 90.06 610 0 90.07 09006 SPORTS MED FELLOWSHIP CLINIC 0 16, 700 C 45 90.07 09007 PODLATRY RESIDENCY CLINIC 90.08 2, 734 0 0 90.08 90.09 09008 FACULTY PRACTICE CLINIC 747, 199 747, 199 29 90.09 90.10 09009 OUR LADY OF ROSARY CLINIC 1, 293, 246 50, 105 1, 293, 246 0 0 90.10 09100 EMERGENCY 53, 592, 860 53, 592, 860 91.00 91.00 157 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00

Usalah Eisas	of all Company	IOCEDIIC DEC ME	D CENTED C DE	ND	1 11-	£ F CMC	2552 40
	icial Systems ST. FLON - STATESTECAL BASES	JOSEPHS REG ME	Provider C		Peri od:	eu of Form CMS-: Worksheet B-1	
CUST ALLUCA	ITON - STATISTICAL DASIS		Provider Co		rom 07/01/2020		
					o 06/30/2021	Date/Time Pre	
						11/30/2021 12	:30 pm
						OTHER GENERAL SERVI CE	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	STERI LE SUPPLY	
	cost center bescription	SERVICES &	(COSTED	RECORDS &	SOCIAL SERVICE	STERTEL SOFTET	
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	(TIME SPENT)	
		(GROSS REVE		(GROSS REVE	(11.11.2 0.1 2.11.)	(	
		NUE)		NUE)			
		14.00	15. 00	16. 00	17. 00	18. 00	
SPECI	AL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 179, 365, 851	23, 154, 609	1, 179, 363, 687	90	168, 057	118. 00
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0		190. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	(	0		192. 00
4	MATERNAL FETAL MEDICINE/LABORIST	297, 589	0	297, 589			192. 01
	NEONATOLOGI STS	1, 533, 271	0	1, 533, 271	0		192. 02
4	HOSPI TALI STS/I NTENSI VI STS	2, 347, 670	0	2, 347, 670	0		192. 03
	SPORTS MED-ATHLETIC TRAINERS	0	0	(	0		194. 00
	OUTREACH SERVICES	1, 616, 884	64, 562	1, 616, 884	0		194. 01
1	KINDRED/OUR LADY OF PEACE	0	0	C	0		194. 02
	ADVANCED SPECIALTIES	0	0	C	0		194. 03
1	AMBULATORY PHARMACY SERVICES	0	0	(	0	0	194. 04
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	4 440 400	0.450.407				201. 00
202. 00	Cost to be allocated (per Wkst. B,	1, 442, 420	9, 158, 126	3, 488, 119	4, 732, 571	6, 253, 127	202.00
202.00	Part I)	0.001017	0.204421	0.000043	F2 F04 122222	25 10/2/5	202 00
203.00	Unit cost multiplier (Wkst. B, Part I)				52, 584. 122222		
204. 00	Cost to be allocated (per Wkst. B, Part II)	34, 300	815, 762	174, 127	151, 926	858, 437	204.00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000029	0. 035133	0. 000147	1, 688. 066667	4. 831800	205. 00
_55.55	II)	0.00027	2. 223100	0.000117	1,000.00007		
	l	1			1	1	

206. 00

207. 00

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

Parts III and IV)

206. 00 207. 00 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ST. JOSEPHS REG MED CENTER S. BEND In Lieu of Form CMS-2552-10 Provider CCN: 15-0012 

				To	06/30/2021	Date/Time Pre 11/30/2021 12	
			INTERNS & RESIDENTS				. 30 рііі
	Cost Center Description	t Center Description NONPHYSICIAN SERVICES-SALARSERVICES-OTH		SERVI CES-OTHER	PARAMED ED	PHARMACY	
	<b>'</b>	ANESTHETI STS	Y & FRINGES	PRGM COSTS	PRGM	RESI DENCY	
		(ASSI GNED TIME)	APPRV (ASSI GNED	APPRV (ASSI GNED	(ASSIGNED TIME)	PROGRAM (PATIENT DA	
		11 WL)	TI ME)	TI ME)	TT WL)	YS)	
	CENEDAL CEDILLOS COCT CENTEDO	19. 00	21. 00	22. 00	23. 00	23. 02	
1. 00	GENERAL SERVICE COST CENTERS  OO100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 04	OO540   NONPATI ENT   TELEPHONES   OO570   ADMI TTI NG						5. 01 5. 04
5. 06	00590 OTHER ADMINISTRATIVE & GENERAL						5. 06
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE						7. 00 8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000  DI ETARY  01100  CAFETERI A						10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12.00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 00 15. 00
	01600 MEDI CAL RECORDS & LI BRARY						16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
	01850   STERI LE SUPPLY   01900   NONPHYSI CLAN ANESTHETI STS	(					18. 00 19. 00
	02100   &R SERVICES-SALARY & FRINGES APPRV		710				21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			710			22. 00
23. 00 23. 02	02300 PARAMED ED PRGM-(SPECIFY)				0	100	23. 00 23. 02
23. 02	02302   PHARMACY RESIDENCY PROGRAM   INPATIENT ROUTINE SERVICE COST CENTERS					100	23.02
30. 00	03000 ADULTS & PEDI ATRI CS	(	394	394	0	0	30. 00
31. 00	03100 I NTENSI VE CARE UNI T				0	0	31.00
35. 00 41. 00	02060   NEONATAL INTENSIVE CARE UNIT   04100   SUBPROVIDER - IRF		1		0	0	35. 00 41. 00
43. 00	04300 NURSERY	(	l	45	0	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM		22	22	0	0	50.00
51. 00	05100 RECOVERY ROOM		l		0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	C	5	5	0	0	52. 00
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C		) 5 ) 0	5	0	0	54. 00 55. 00
57. 00	05700 CT SCAN			1	0	0	57. 00
58. 00	05800 MRI	C	0	0	0	0	58. 00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	(	0	0	0	0	59. 00 60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	C	0	0	0	0	00.00
65. 01 66. 00	03610 SLEEP LAB 06600 PHYSI CAL THERAPY		0	0	0	0	65. 01 66. 00
	06700 OCCUPATI ONAL THERAPY			o	0	0	67. 00
	06800 SPEECH PATHOLOGY	C	0	0	0	0	68. 00
	06900  ELECTROCARDI OLOGY   07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENT	(	17	17	0	0	69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS		o o	Ö	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	(	0	0	0	100	1
	07400  RENAL DIALYSIS   07697  CARDIAC REHABILITATION	(	3	3	0	0	74. 00 76. 97
	07698 HYPERBARI C OXYGEN THERAPY			0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	C	0	0	0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		) 0	0	0	0	90. 00
	09001 MOBILE MEDICAL UNIT			0	0	0	90.00
	09002 FAMILY MEDICINE CENTER	C	129	129	0	0	90. 03
	O9003  WOUND HEALING CENTER   O9004  OUTPATIENT TREATMENT & INFUSION		) 0	0	0	0	90. 04 90. 05
	09005 PEDIATRIC SPECIALTY CLINIC		ó  0		0	0	90.05
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	C	0	0	0	0	90. 07
	09007   PODIATRY RESIDENCY CLINIC   09008   FACULTY PRACTICE CLINIC		0	0	0	0	90. 08 90. 09
	09009 OUR LADY OF ROSARY CLINIC		ó  0		0	0	90. 09
91. 00	09100 EMERGENCY		43	43	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00

0

0

0.000000

0.000000

0

0

C

4, 339, 821

184, 211

259. 452113

6, 112. 423944

0

0

O

4, 259, 577

97.052113

68, 907

5, 999. 404225

0

0

0

0

0.000000

0.000000

0.000000

0 194. 01

0 194. 02

0 194. 03

0 194. 04

856, 453 202. 00

18, 630 204. 00

0 206.00

8, 564. 530000 203. 00

186. 300000 205. 00

0.000000 207.00

200.00

201.00

194. 01 07951 OUTREACH SERVICES

200.00

201.00

202.00

203.00

204.00

205.00

206.00

207.00

194. 03 07953 ADVANCED SPECIALTIES

Part I)

Part II)

II)

194. 02 07952 KINDRED/OUR LADY OF PEACE

194. 04 07954 AMBULATORY PHARMACY SERVICES

(per Wkst. B-2)

Parts III and IV)

Cross Foot Adjustments

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

Negative Cost Centers

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0012 Peri od: Worksheet C From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/30/2021 12:30 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 64, 510, 396 64, 510, 396 64, 510, 396 30.00 03100 INTENSIVE CARE UNIT 13, 240, 935 13, 240, 935 0 13, 240, 935 31.00 31.00 02060 NEONATAL INTENSIVE CARE UNIT o 35.00 4, 944, 606 4, 944, 606 4, 944, 606 35.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 C 0 04300 NURSERY 43.00 2.807.373 2, 807, 373 2, 807, 373 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 51, 229, 659 51, 229, 659 51, 229, 659 50.00 0 2, 778, 425 05100 RECOVERY ROOM 2, 778, 425 51 00 2, 778, 425 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 4, 730, 275 4, 730, 275 0 4, 730, 275 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 889, 325 9, 889, 325 0 0 0 9, 889, 325 54.00 05500 RADI OLOGY-THERAPEUTI C 479, 521 479, 521 479, 521 55.00 55.00 05700 CT SCAN 2, 508, 139 57.00 2, 508, 139 2, 508, 139 57.00 58.00 05800 MRI 1, 389, 510 1, 389, 510 1, 389, 510 58.00 05900 CARDIAC CATHETERIZATION 59.00 17, 006, 619 17, 006, 619 0 17, 006, 619 59.00 06000 LABORATORY 60 00 16, 327, 048 16, 327, 048 16, 327, 048 60 00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS Ω 62.30 06500 RESPIRATORY THERAPY 5, 072, 253 5, 072, 253 0 5, 072, 253 65.00 65.00 65.01 03610 SLEEP LAB 751, 417 751, 417 1, 242 752, 659 65.01 06600 PHYSI CAL THERAPY 5, 188, 384 5, 188, 384 5, 188, 384 66 00 0 66 00 67.00 06700 OCCUPATI ONAL THERAPY 1, 369, 334 1, 369, 334 0 1, 369, 334 67.00 68.00 06800 SPEECH PATHOLOGY 504, 689 504, 689 504, 689 68.00 2, 602, 919 2, 602, 919 69 00 06900 ELECTROCARDI OLOGY 0 2, 602, 919 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT C Λ 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 30, 093, 380 30, 093, 380 30, 093, 380 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 42, 818, 980 42, 818, 980 0 42, 818, 980 73.00 07400 RENAL DIALYSIS 74 00 2, 248, 737 2, 248, 737 74 00 2, 248, 737 76.97 07697 CARDIAC REHABILITATION 0 C 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 59, 721 59, 721 0 59, 721 76. 98 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09001 MOBILE MEDICAL UNIT 152, 360 152, 360 0 152, 360 90.02 90.02 0 90.03 09002 FAMILY MEDICINE CENTER 1, 947, 920 1, 947, 920 1, 947, 920 90.03 90.04 09003 WOUND HEALING CENTER 2, 153, 369 2, 153, 369 2, 153, 369 90 04 90.05 09004 OUTPATIENT TREATMENT & INFUSION 1, 513, 498 1, 513, 498 1, 513, 498 90.05 90 06 09005 PEDIATRIC SPECIALTY CLINIC 431, 766 431, 766 0 431, 766 90 06 09006 SPORTS MED FELLOWSHIP CLINIC 1.138.365 90.07 1, 138, 365 1, 138, 365 90.07 09007 PODIATRY RESIDENCY CLINIC 90.08 1, 430, 921 1, 430, 921 1, 430, 921 90.08 90.09 09008 FACULTY PRACTICE CLINIC 831, 279 831, 279 0 831, 279 90.09 90. 10 09009 OUR LADY OF ROSARY CLINIC 1, 708, 404 1, 708, 404 1, 708, 404 90.10 09100 EMERGENCY 14, 119, 308 14, 119, 308 14, 313, 158 91.00 193, 850 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 8, 283, 213 8, 283, 213 8, 283, 213 92.00 200.00 Subtotal (see instructions) 316, 262, 048 316, 262, 048 195, 092 316, 457, 140 200. 00

8.283.213

307, 978, 835

8, 283, 213

195, 092

307, 978, 835

8, 283, 213 201. 00

308, 173, 927 202. 00

201.00

202.00

Less Observation Beds

Total (see instructions)

200.00

201.00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0012 Peri od: Worksheet C From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/30/2021 12:30 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 117, 862, 806 117, 862, 806 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 33, 782, 721 33, 782, 721 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 11, 235, 857 11, 235, 857 35.00 04100 SUBPROVIDER - IRF 41.00 41.00 04300 NURSERY 43.00 3.834.274 3, 834, 274 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 93, 859, 139 131, 701, 420 225, 560, 559 0 227122 0.000000 50.00 05100 RECOVERY ROOM 6, 633, 060 0.144937 12, 536, 755 19, 169, 815 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 302442 52 00 14, 576, 835 1,063,441 15, 640, 276 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 15, 457, 537 47, 882, 847 63, 340, 384 0.156130 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 412, 747 105, 803 518, 550 0. 924734 0.000000 55.00 05700 CT SCAN 51, 941, 269 78, 403, 910 0.031990 0.000000 57.00 26, 462, 641 57.00 58.00 05800 MRI 6,008,705 2, 372, 300 8, 381, 005 0.165793 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 32, 701, 674 45, 632, 712 78, 334, 386 0. 217103 0.000000 59.00 60.00 06000 LABORATORY 95, 823, 235 52, 937, 632 148, 760, 867 0.109754 0.000000 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 0.000000 62.30 65.00 06500 RESPIRATORY THERAPY 14, 881, 170 2, 214, 569 17, 095, 739 0. 296697 0.000000 65.00 03610 SLEEP LAB 4, 536, 744 4, 541, 146 0.000000 65.01 4, 402 0.165469 65.01 06600 PHYSI CAL THERAPY 4, 193, 649 11, 012, 375 15, 206, 024 0.000000 66.00 0.341206 66.00 06700 OCCUPATIONAL THERAPY 67.00 3, 462, 197 2, 464, 782 5, 926, 979 0. 231034 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1, 396, 743 687, 916 2, 084, 659 0.242097 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 11, 827, 251 15, 629, 322 27, 456, 573 0.094801 0.000000 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 000000 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 45, 417, 879 38, 141, 536 83, 559, 415 0.360143 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 75, 196, 974 65, 135, 217 140, 332, 191 0.305126 0.000000 73.00 73.00 74.00 07400 RENAL DIALYSIS 1,550,059 586, 887 2, 136, 946 1.052313 0.000000 74.00 76.97 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 408, 388 408, 388 0.146236 0.000000 76.98 07699 LI THOTRI PSY 76. 99 0 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 90.02 09001 MOBILE MEDICAL UNIT 0 482, 332 482, 332 0.315882 0.000000 90.02 90.03 09002 FAMILY MEDICINE CENTER 720, 192 2, 856, 519 3, 576, 711 0.544612 0.000000 90.03 09003 WOUND HEALING CENTER 39 452 5, 290, 304 5, 329, 756 0 404028 90 04 0.000000 90 04 1, 101, 990 1.089817 90.05 09004 OUTPATIENT TREATMENT & INFUSION 286, 773 1, 388, 763 0.000000 90.05 09005 PEDIATRIC SPECIALTY CLINIC 203, 407 203, 407 2. 122670 0.000000 90.06 90.06 90.07 09006 SPORTS MED FELLOWSHIP CLINIC 0 Λ 0.000000 0.000000 90.07  $\cap$ 09007 PODIATRY RESIDENCY CLINIC 90.08 0.000000 0.000000 0 0 90 08 90.09 09008 FACULTY PRACTICE CLINIC 56, 374 690, 825 747, 199 1. 112527 0.000000 90.09 90.10 09009 OUR LADY OF ROSARY CLINIC 225, 525 1,067,721 1, 293, 246 1.321020 0.000000 90.10 09100 EMERGENCY 15, 674, 102 37, 918, 758 53, 592, 860 91.00 0.263455 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 6, 863, 629 92.00 2. 312. 314 9, 175, 943 0 902710 0.000000

635, 896, 287

635, 896, 287

543, 467, 400

1, 179, 363, 687

543, 467, 400 1, 179, 363, 687

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

			10 06/30/2021	11/30/2021 12:30 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
·	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT				35. 00
41. 00   04100   SUBPROVI DER -   RF				41. 00
43. 00   04300   NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 227122			50.00
51.00   O5100   RECOVERY ROOM	0. 144937			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 302442			52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 156130			54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 924734			55. 00
57. 00   05700   CT   SCAN	0. 031990			57. 00
58. 00   05800   MRI	0. 165793			58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 217103			59. 00
60. 00   06000   LABORATORY	0. 109754			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 296697			65. 00
65. 01   03610   SLEEP LAB	0. 165742			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 341206			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 231034			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 242097			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 094801			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 360143			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 305126			73. 00
74.00 07400 RENAL DIALYSIS	1. 052313			74. 00
76. 97   07697   CARDI AC   REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 146236			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00  09000   CLI NI C	0. 000000			90.00
90. 02   09001   MOBILE MEDICAL UNIT	0. 315882			90. 02
90. 03 09002 FAMILY MEDICINE CENTER	0. 544612			90. 03
90. 04 09003 WOUND HEALING CENTER	0. 404028			90. 04
90.05  09004 OUTPATIENT TREATMENT & INFUSION	1. 089817			90. 05
90. 06   09005   PEDIATRIC SPECIALTY CLINIC	2. 122670			90. 06
90. 07   09006 SPORTS MED FELLOWSHIP CLINIC	0. 000000			90. 07
90.08 09007 PODIATRY RESIDENCY CLINIC	0. 000000			90. 08
90.09 09008 FACULTY PRACTICE CLINIC	1. 112527			90. 09
90. 10 09009 OUR LADY OF ROSARY CLINIC	1. 321020			90. 10
91. 00   09100   EMERGENCY	0. 267072			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 902710			92. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00  Total (see instructions)				202. 00

Heal th	Financial Systems ST.	JOSEPHS REG ME	ED CENTER S. BE	ND	In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre	pared:
						11/30/2021 12	:30 pm
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	0.00	0.00	4.00	F 00	
	INDATIENT DOUTINE SERVICE COST SENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS   03000   ADULTS & PEDIATRICS	64, 510, 396		64, 510, 39	6 0	64, 510, 396	30.00
31. 00	03100   NTENSIVE CARE UNIT	13, 240, 935	1	13, 240, 93		13, 240, 935	
35.00	02060 NEONATAL INTENSIVE CARE UNIT	4, 944, 606		4, 944, 60		4, 944, 606	
41. 00	04100 SUBPROVI DER – I RF	4, 744, 000		4, 744, 00	0 0	4, 944, 000	41. 00
43. 00	04300 NURSERY	2, 807, 373	()	2, 807, 37		2, 807, 373	1
43.00	ANCI LLARY SERVICE COST CENTERS	2,007,373	1	2,007,37	3  0	2,007,373	43.00
50. 00	05000 OPERATING ROOM	51, 229, 659	)	51, 229, 65	9 0	51, 229, 659	50.00
51. 00	05100 RECOVERY ROOM	2, 778, 425	1	2, 778, 42		2, 778, 425	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	4, 730, 275	1	4, 730, 27		4, 730, 275	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 889, 325		9, 889, 32		9, 889, 325	
55. 00	05500 RADI OLOGY-THERAPEUTI C	479, 521		479, 52		479, 521	55. 00
57. 00	05700 CT SCAN	2, 508, 139		2, 508, 13		2, 508, 139	
58. 00	05800 MRI	1, 389, 510		1, 389, 51		1, 389, 510	
59. 00	05900 CARDI AC CATHETERI ZATI ON	17, 006, 619	<b>1</b>	17, 006, 61		17, 006, 619	59. 00
60.00	06000 LABORATORY	16, 327, 048		16, 327, 04		16, 327, 048	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	10, 027, 010		10,027,01	0 0	0,027,010	62. 30
65. 00	06500 RESPIRATORY THERAPY	5, 072, 253	o	5, 072, 25	-	5, 072, 253	65. 00
65. 01	03610 SLEEP LAB	751, 417		751, 41		752, 659	65. 01
66. 00	06600 PHYSI CAL THERAPY	5, 188, 384	1			5, 188, 384	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 369, 334	1	1, 369, 33		1, 369, 334	67. 00
68.00	06800 SPEECH PATHOLOGY	504, 689		504, 68		504, 689	68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 602, 919		2, 602, 91	9 0	2, 602, 919	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30, 093, 380	)	30, 093, 38	0	30, 093, 380	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	42, 818, 980	)	42, 818, 98	0 0	42, 818, 980	73. 00
74.00	07400 RENAL DI ALYSI S	2, 248, 737	1	2, 248, 73	7 0	2, 248, 737	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	1	l .	0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	59, 721		59, 72		59, 721	76. 98
76. 99	07699 LI THOTRI PSY	0	)		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	_	1	1	_1	_	
90. 00	09000 CLI NI C	0	1	1	0	0	
90. 02	09001 MOBILE MEDICAL UNIT	152, 360		152, 36		152, 360	
90. 03	09002 FAMILY MEDICINE CENTER	1, 947, 920		1, 947, 92		1, 947, 920	
90. 04	09003 WOUND HEALING CENTER	2, 153, 369	•	2, 153, 36		2, 153, 369	90. 04
90.05	09004 OUTPATIENT TREATMENT & INFUSION	1, 513, 498		1, 513, 49		1, 513, 498	ı
90.06	09005 PEDIATRIC SPECIALTY CLINIC	431, 766	1	431, 76		431, 766	
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	1, 138, 365		1, 138, 36		1, 138, 365	
90. 08 90. 09	O9007   PODIATRY RESIDENCY CLINIC   O9008   FACULTY   PRACTICE CLINIC	1, 430, 921 831, 279		1, 430, 92 831, 27		1, 430, 921 831, 279	90. 08 90. 09
90. 09	09009 OUR LADY OF ROSARY CLINIC	1, 708, 404		1, 708, 40		1, 708, 404	
90. 10	09100 EMERGENCY		1			1, 708, 404	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	14, 119, 308 8, 283, 213		14, 119, 30 8, 283, 21		8, 283, 213	
200.00		316, 262, 048				316, 457, 140	
201.00	,	8, 283, 213	1	8, 283, 21		8, 283, 213	
202.00	1 1	307, 978, 835	1				
202.00	1.0141 (300 111311 4011 0113)	1 007, 770, 000		1 557, 775, 65	175, 072	555, 175, 727	1202.00

201.00

202.00

635, 896, 287

543, 467, 400 1, 179, 363, 687

201.00

202.00

Less Observation Beds

Total (see instructions)

Peri od: Worksheet C From 07/01/2020 Part I To 06/30/2021 Date/Time Prepared: 11/30/2021 12: 30 pm

				11/30/2021 12:30 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
31. 00   03100   I NTENSI VE CARE UNIT				31.00
35.00   02060   NEONATAL INTENSIVE CARE UNIT				35. 00
41. 00   04100   SUBPROVI DER - I RF				41. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 227122			50. 00
51.00   05100   RECOVERY ROOM	0. 144937			51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 302442			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 156130			54. 00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 924734			55. 00
57. 00  05700 CT SCAN	0. 031990			57. 00
58. 00   05800   MRI	0. 165793			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 217103			59. 00
60. 00 06000 LABORATORY	0. 109754			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 296697			65. 00
65. 01   03610   SLEEP LAB	0. 165742			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 341206			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 231034			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 242097			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 094801			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 360143			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 305126			73. 00
74.00 07400 RENAL DIALYSIS	1. 052313			74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 146236			76. 98
76. 99   07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 02 09001 MOBILE MEDICAL UNIT	0. 315882			90. 02
90. 03 09002 FAMILY MEDICINE CENTER	0. 544612			90. 03
90. 04 09003 WOUND HEALING CENTER	0. 404028			90. 04
90.05 09004 OUTPATIENT TREATMENT & INFUSION	1. 089817			90. 05
90.06 09005 PEDIATRIC SPECIALTY CLINIC	2. 122670			90.06
90. 07 09006 SPORTS MED FELLOWSHIP CLINIC	0. 000000			90. 07
90. 08 09007 PODIATRY RESIDENCY CLINIC	0. 000000			90. 08
90. 09 09008 FACULTY PRACTICE CLINIC	1. 112527			90. 09
90. 10 09009 OUR LADY OF ROSARY CLINIC	1. 321020			90. 10
91. 00   09100   EMERGENCY	0. 267072			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 902710			92.00
200.00 Subtotal (see instructions)	0.752.10			200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1 !			1=32.00

Heal th Financial Systems ST. JOSEPHS REG CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 07/01/2020 | Part II | Date/Time Prepared: | Provider CCN: 15-0012

					10 00/30/2021	11/30/2021 12	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
	, and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second	(Wkst. B, Part				Reduction	
		I, col. 26)		Cost (col. 1		Amount	
		, , ,	,	col . 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			•		•	
50.00	05000 OPERATING ROOM	51, 229, 659	6, 259, 789	44, 969, 87	0 0	0	50.00
51. 00	05100 RECOVERY ROOM	2, 778, 425					51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	4, 730, 275			-		52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 889, 325				-	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	479, 521	8, 393		-	1	55. 00
57. 00	05700 CT SCAN	2, 508, 139					57. 00
58. 00	05800 MRI	1, 389, 510				1	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	17, 006, 619				-	59.00
60.00	06000 LABORATORY	16, 327, 048					60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	10, 327, 046	407,038	1	0 0	-	62. 30
	06500 RESPIRATORY THERAPY	F 072 2F2	_		-	-	ł
65. 00	03610 SLEEP LAB	5, 072, 253	455, 282		-	1	65.00
		751, 417	10, 652			_	65. 01
66.00	06600 PHYSI CAL THERAPY	5, 188, 384	422, 431		-	-	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 369, 334					67. 00
68. 00	06800 SPEECH PATHOLOGY	504, 689	•			-	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 602, 919				-	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	1	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	30, 093, 380				1	72. 00
	07300 DRUGS CHARGED TO PATIENTS	42, 818, 980				0	73. 00
74.00	07400 RENAL DI ALYSI S	2, 248, 737	139, 765				74. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	1	0	_	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	59, 721	1, 189	58, 53			76. 98
76. 99	07699 LI THOTRI PSY	0	0		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000  CLI NI C	0	0		0 0	0	90. 00
90. 02	09001 MOBILE MEDICAL UNIT	152, 360	2, 170	150, 19	0	0	90. 02
90. 03	09002 FAMILY MEDICINE CENTER	1, 947, 920	49, 290	1, 898, 63	0	0	90. 03
90.04	09003 WOUND HEALING CENTER	2, 153, 369	41, 249	2, 112, 12	0 0	0	90. 04
90.05	09004 OUTPATIENT TREATMENT & INFUSION	1, 513, 498	180, 447	1, 333, 05	1 0	0	90. 05
90.06	09005 PEDIATRIC SPECIALTY CLINIC	431, 766	9, 132	422, 63	4 0	0	90.06
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	1, 138, 365	21, 257	1, 117, 10	8 0	0	90. 07
90. 08	09007 PODIATRY RESIDENCY CLINIC	1, 430, 921	27, 078			0	90. 08
90.09	09008 FACULTY PRACTICE CLINIC	831, 279	16, 402	814, 87	7 0	0	90. 09
90. 10	09009 OUR LADY OF ROSARY CLINIC	1, 708, 404					90. 10
91. 00	09100 EMERGENCY	14, 119, 308				0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	8, 283, 213			-	-	92. 00
200.00		230, 758, 738			-	_	200. 00
201.00	1 1 ,	8, 283, 213					201. 00
202.00		222, 475, 525					202.00
_52.50	1.010. (0 200	1 222, 170, 525		1 200, 707, 17	-1	,	1-02.00

Health Financial Systems ST. JOSEPHS REG MED CENTER S. BEND CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN: REDUCTIONS FOR MEDICALD ONLY In Lieu of Form CMS-2552-10

Period: Worksheet C
From 07/01/2020 Part II
To 06/30/2021 Date/Time Prepared: 11/30/2021 12:30 pm Provider CCN: 15-0012

							11/30/2021 1	2: 30 pm
			Ti tl	e XIX		Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent				
	·	Capital and	(Worksheet C,	Cost to Charg	ge			
		Operating Cost	Part I, column	Ratio (col.	6			
		Reduction	8)	/ col. 7)				
		6.00	7. 00	8. 00				
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	51, 229, 659	225, 560, 559	0. 22712	22			50. 00
51.00	05100 RECOVERY ROOM	2, 778, 425	19, 169, 815	0. 14493	37			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 730, 275	15, 640, 276	0. 30244	12			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 889, 325	63, 340, 384	0. 15613	30			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	479, 521	518, 550					55. 00
57. 00	05700 CT SCAN	2, 508, 139						57. 00
58. 00	05800 MRI	1, 389, 510						58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	17, 006, 619						59. 00
60. 00	06000 LABORATORY	16, 327, 048		1				60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	10, 327, 040	140, 700, 007	1				62. 30
65. 00	06500 RESPIRATORY THERAPY	5, 072, 253	17, 095, 739					65. 00
65. 01	03610 SLEEP LAB	751, 417	4, 541, 146	1				65. 01
66. 00	06600 PHYSI CAL THERAPY							66. 00
		5, 188, 384	15, 206, 024					
67. 00	06700 OCCUPATI ONAL THERAPY	1, 369, 334						67. 00
68. 00	06800 SPEECH PATHOLOGY	504, 689		1				68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 602, 919						69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	ı	1 0.0000				71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	30, 093, 380		1				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	42, 818, 980						73. 00
74. 00	07400 RENAL DI ALYSI S	2, 248, 737	2, 136, 946	1				74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0.0000				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	59, 721	408, 388	0. 14623	36			76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.00000	00			76. 99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0	0	0.00000	00			90.00
90.02	09001 MOBILE MEDICAL UNIT	152, 360	482, 332	0. 31588	32			90. 02
90. 03	09002 FAMILY MEDICINE CENTER	1, 947, 920	3, 576, 711	0. 54461	12			90. 03
90.04	09003 WOUND HEALING CENTER	2, 153, 369	5, 329, 756	0. 40402	28			90. 04
90.05	09004 OUTPATIENT TREATMENT & INFUSION	1, 513, 498	1, 388, 763	1. 08981	17			90. 05
90.06	09005 PEDIATRIC SPECIALTY CLINIC	431, 766			70			90. 06
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	1, 138, 365		i	00			90. 07
90. 08	09007 PODIATRY RESIDENCY CLINIC	1, 430, 921	O	i				90. 08
90. 09	09008 FACULTY PRACTICE CLINIC	831, 279	747, 199	1				90. 09
90. 10	09009 OUR LADY OF ROSARY CLINIC	1, 708, 404		1				90. 10
91. 00	09100 EMERGENCY	14, 119, 308						91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	8, 283, 213		1				92. 00
200.00			1, 012, 648, 029	1				200. 00
200.00		8, 283, 213		1				200. 00
201.00			1, 012, 648, 029					201.00
202.00		222,413,323	1,012,040,029	I	- 1			1202.00

Health Financial Systems ST.	JOSEPHS REG ME	D CENTER S. BE	ND	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 07/01/2020 Fo 06/30/2021	Worksheet D Part I Date/Time Pre 11/30/2021 12	pared: :30 pm
		Title	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	13, 147, 920	0	13, 147, 920	52, 632		30. 00
31.00 INTENSIVE CARE UNIT	1, 674, 103		1, 674, 103			
35.00 NEONATAL INTENSIVE CARE UNIT	597, 633		597, 633	3 947	631.08	35. 00
41. 00   SUBPROVI DER - I RF	0	0	) (	0	0.00	41. 00
43. 00 NURSERY	58, 137		58, 13	7 4, 461	13. 03	43.00
200.00 Total (lines 30 through 199)	15, 477, 793		15, 477, 793	64, 413		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	15, 128		1			30. 00
31. 00   I NTENSI VE CARE UNIT	1, 760	462, 334				31. 00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0	)			35. 00
41. 00 SUBPROVI DER - I RF	0	0				41. 00
43. 00 NURSERY	0	0	)			43. 00
200.00 Total (lines 30 through 199)	16, 888	4, 241, 460				200. 00

	JOSEPHS REG ME				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 07/01/2020 To 06/30/2021	Part II	nared:
				10 00/00/2021	Date/Time Pre 11/30/2021 12	: 30 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T	T	1			
50. 00   05000   OPERATI NG ROOM	6, 259, 789		1		819, 065	
51. 00   05100   RECOVERY ROOM	368, 813		1		38, 625	
52. 00   05200   DELIVERY ROOM & LABOR ROOM	100, 713				123	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 518, 846				123, 285	
55. 00 05500 RADI OLOGY-THERAPEUTI C	8, 393				2, 911	55. 00
57. 00   05700   CT   SCAN	228, 264		1		25, 987	57.00
58. 00   05800   MRI	19, 759				4, 538	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	1, 715, 305		1		235, 421	59.00
60. 00   06000   LABORATORY	467, 058				98, 249	60.00
62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	455 202	_	0.00000		125 (42	62. 30
65. 00   06500 RESPIRATORY THERAPY	455, 282				125, 643	65. 00
65. 01   03610   SLEEP LAB	10, 652				5	65. 01
66. 00   06600   PHYSI CAL THERAPY	422, 431		1		43, 443	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	28, 282				6, 471	67.00
68. 00   06800   SPEECH PATHOLOGY	10, 351				2, 784	68.00
69. 00   06900   ELECTROCARDI OLOGY	318, 599				50, 595	69.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS	402, 074		0. 00000 0. 00481		0 78, 627	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS						73.00
74. 00   07400   RENAL DIALYSIS	1, 306, 460 139, 765				211, 752 49, 355	74.00
74. 00   07400   RENAL DI ALTSI S 76. 97   07697   CARDI AC   REHABI LI TATI ON	139, 703		1		49, 300	76. 97
76. 98   07698   HYPERBARI C OXYGEN THERAPY	1, 189	_	1		0	76. 98
76. 99 07699 LI THOTRI PSY	1, 107		1		0	76. 99
OUTPATIENT SERVICE COST CENTERS			0.00000	0		10.77
90. 00   09000   CLI NI C		0	0.00000	0	0	90.00
90. 02   09001   MOBILE   MEDICAL   UNIT	2, 170	_	1		0	90.02
90. 03   09002   FAMILY MEDICINE CENTER	49, 290		0.00443		0	90.03
90. 04 09003 WOUND HEALING CENTER	41, 249		1		186	90.04
90. 05 09004 OUTPATIENT TREATMENT & INFUSION	180, 447				12. 474	90.05
90. 06 09005 PEDIATRIC SPECIALTY CLINIC	9, 132				12, 4,4	90.06
90. 07 09006 SPORTS MED FELLOWSHIP CLINIC	21, 257		1		0	90.07
90. 08   09007   PODI ATRY RESI DENCY CLINI C	27, 078	l .	0.00000		0	90.08
90. 09   09008   FACULTY PRACTICE CLINIC	16, 402		1		0	90.09
90. 10   09009   OUR LADY OF ROSARY CLINIC	34, 684				0	90. 10
91. 00   09100   EMERGENCY	2, 344, 612		1		-	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 688, 210				190, 472	92.00
200.00 Total (lines 50 through 199)		1, 012, 648, 029		148, 486, 323		
(	1	,	1		_, , 0 . 0	

Health Financial Systems ST.	JOSEPHS REG ME	D CENTER S. BE	ND	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider CO		Peri od:	Worksheet D	
				From 07/01/2020 Fo 06/30/2021	Part III Date/Time Pre	nared:
				10 00/30/2021	11/30/2021 12	
			XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
LANDATI ENT. DOUTLAND OFFICE COOT OFFITEDO	1A	1. 00	2A	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						00.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(	0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	(	0	0	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	(	0	0	35.00
41. 00   04100   SUBPROVI DER -   RF 43. 00   04300   NURSERY	0	0	(	0	0	41. 00 43. 00
200.00 Total (lines 30 through 199)	0	0				200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Dationt	Per Diem (col.	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Days	3 ÷ COI . O)	l 110graiii bays	
	instructions)					
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					1
	U	0	52, 632	0.00	15, 128	30.00
31.00 03100 INTENSIVE CARE UNIT		0	52, 632 6, 373			
31.00 03100 INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT		0 0	•	0.00	1, 760	
35.00 02060 NEONATAL INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF	0	0 0	6, 37	0.00	1, 760 0	31. 00
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT 41. 00   04100   SUBPROVIDER -   IRF 43. 00   04300   NURSERY	_	0 0	6, 37; 94 ( 4, 46	3 0.00 7 0.00 0 0.00	1, 760 0 0 0	31. 00 35. 00 41. 00 43. 00
35. 00   02060   NEONATAL INTENSIVE CARE UNIT 41. 00   04100   SUBPROVIDER - IRF 43. 00   04300   NURSERY 200. 00   Total (lines 30 through 199)	0	0 0 0 0 0	6, 373 94	3 0.00 7 0.00 0 0.00	1, 760 0 0	31. 00 35. 00 41. 00 43. 00
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT 41. 00   04100   SUBPROVIDER -   IRF 43. 00   04300   NURSERY	0 Inpatient	0 0 0 0	6, 37; 94 ( 4, 46	3 0.00 7 0.00 0 0.00	1, 760 0 0 0	31. 00 35. 00 41. 00 43. 00
35. 00   02060   NEONATAL INTENSIVE CARE UNIT 41. 00   04100   SUBPROVIDER - IRF 43. 00   04300   NURSERY 200. 00   Total (lines 30 through 199)	O Inpatient Program	0 0 0 0	6, 37; 94 ( 4, 46	3 0.00 7 0.00 0 0.00	1, 760 0 0 0	31. 00 35. 00 41. 00 43. 00
35. 00   02060   NEONATAL INTENSIVE CARE UNIT 41. 00   04100   SUBPROVIDER - IRF 43. 00   04300   NURSERY 200. 00   Total (lines 30 through 199)	Inpatient Program Pass-Through	000000000000000000000000000000000000000	6, 37; 94 ( 4, 46	3 0.00 7 0.00 0 0.00	1, 760 0 0 0	31. 00 35. 00 41. 00 43. 00
35. 00   02060   NEONATAL INTENSIVE CARE UNIT 41. 00   04100   SUBPROVIDER - IRF 43. 00   04300   NURSERY 200. 00   Total (lines 30 through 199)	Inpatient Program Pass-Through Cost (col. 7 x	000000000000000000000000000000000000000	6, 37; 94 ( 4, 46	3 0.00 7 0.00 0 0.00	1, 760 0 0 0	31. 00 35. 00 41. 00 43. 00
35. 00   02060   NEONATAL INTENSIVE CARE UNIT 41. 00   04100   SUBPROVIDER - IRF 43. 00   04300   NURSERY 200. 00   Total (lines 30 through 199)	Inpatient Program Pass-Through	000000000000000000000000000000000000000	6, 37; 94 ( 4, 46	3 0.00 7 0.00 0 0.00	1, 760 0 0 0	31. 00 35. 00 41. 00 43. 00

30.00

31. 00 35. 00 41. 00 43. 00

200.00

INPATIENT ROUTINE SERVICE COST CENTERS

30. 00 03000 ADULTS & PEDIATRICS
31. 00 03100 INTENSIVE CARE UNIT
35. 00 02060 NEONATAL INTENSIVE CARE UNIT
41. 00 04100 SUBPROVIDER - IRF
43. 00 04300 NURSERY
200. 00 Total (lines 30 through 199)

Health Financial Systems ST. JOSEPHS REG MED CENTER S. BEND

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0012 | Peri od: | Worksheet D | From 07/01/2020 | Part IV | To 06/30/2021 | Date/Time Prepared: | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/ THROUGH COSTS

					00/30/2021	11/30/2021 12	
-			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(	0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0	(	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52. 00
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	55. 00
57.00	05700 CT SCAN	0	0	(	0	0	57. 00
58.00	05800 MRI	0	0	(	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	O	0	(	0	0	59. 00
60.00	06000 LABORATORY	O	0	(	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	O	0	) (	o	0	62. 30
65.00	06500 RESPIRATORY THERAPY	O	0	) (	o	0	65. 00
65. 01	03610 SLEEP LAB	O	0		o	0	65. 01
66.00	06600 PHYSI CAL THERAPY	o	0		o	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		o o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0		o o	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	o	0		o o	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0		o o	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0		o o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		o o	856, 453	73. 00
74.00	07400 RENAL DIALYSIS	o	0		o o	0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	o	0		o o	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o	0		o o	0	76. 98
76. 99	07699 LI THOTRI PSY	O	0		o o	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	,		•			
90.00	09000 CLI NI C	0	0	(	0	0	90. 00
90. 02	09001 MOBILE MEDICAL UNIT	0	0		o	0	90. 02
90. 03	09002 FAMILY MEDICINE CENTER	0	0		o	0	90. 03
90. 04	09003 WOUND HEALING CENTER	o	0		o o	0	90. 04
90. 05	09004 OUTPATIENT TREATMENT & INFUSION	o	0		ol o	0	90. 05
90. 06	09005 PEDIATRIC SPECIALTY CLINIC	0	0		0	0	90.06
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	0	0		0	0	90. 07
90. 08	09007 PODIATRY RESIDENCY CLINIC	0	0		0	0	90. 08
90. 09	09008 FACULTY PRACTICE CLINIC	0	0		0	0	90. 09
90. 10	09009 OUR LADY OF ROSARY CLINIC	o	0		ol o	0	
91. 00	09100 EMERGENCY	o	0		ol o	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o				0	92.00
200.00		o	0		o	856, 453	200.00
				•	•	•	•

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 07/01/2020 | Part IV | To 06/30/2021 | Date/Time Prepared: 11/30/2021 12:30 pm | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PP Health Financial Systems ST. JOSEPHS REG MED CENTER S. BEND APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: Provider CCN: 15-0012 THROUGH COSTS Title XVIII

			II LI E	XVIII	Hospi tai	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	0	225, 560, 559	0. 000000	50. 00
	05100 RECOVERY ROOM	0	0	0	19, 169, 815	0.000000	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	15, 640, 276	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	63, 340, 384	0.000000	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	518, 550	0.000000	55. 00
57. 00	05700 CT SCAN	0	0	0	78, 403, 910	0.000000	57. 00
58. 00	05800 MRI	0	0	0	8, 381, 005	0.000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	78, 334, 386	0.000000	59. 00
	06000 LABORATORY	0	0	l 0	148, 760, 867	0.000000	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0. 000000	62. 30
	06500 RESPIRATORY THERAPY	0	0	0	17, 095, 739	0. 000000	
	03610 SLEEP LAB	0	0	0	4, 541, 146	0. 000000	65. 01
	06600 PHYSI CAL THERAPY	0	0	0	15, 206, 024	0. 000000	
	06700 OCCUPATI ONAL THERAPY	0	0	0	5, 926, 979	0. 000000	
	06800 SPEECH PATHOLOGY		0	١	2, 084, 659	0. 000000	68. 00
	06900 ELECTROCARDI OLOGY			0	27, 456, 573	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				27, 430, 373	0.000000	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS				83, 559, 415	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS		856, 453	856, 453		0.006103	
	07400 RENAL DIALYSIS		050, 455	050, 455	2, 136, 946	0.000103	74.00
	07697 CARDI AC REHABILI TATI ON				2, 130, 740	0. 000000	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0		0. 000000	76. 97 76. 98
			0	-	408, 388		
76. 99	07699 LI THOTRI PSY	1 0	0	0	0	0. 000000	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	1 0	0	0		0. 000000	90. 00
		_	1	-	_		
	09001 MOBILE MEDICAL UNIT	0	1	1		0.000000	90. 02
	09002 FAMILY MEDICINE CENTER	0	0	0	3, 576, 711	0.000000	
	09003 WOUND HEALING CENTER	0	0	0	5, 329, 756	0. 000000	90. 04
	09004 OUTPATIENT TREATMENT & INFUSION	0	0	0	1, 388, 763	0. 000000	90. 05
	09005 PEDIATRIC SPECIALTY CLINIC	0	0	0	203, 407	0. 000000	90. 06
	09006 SPORTS MED FELLOWSHIP CLINIC	0	0	0	0	0. 000000	90. 07
	09007 PODIATRY RESIDENCY CLINIC	0	0	0	0	0. 000000	90. 08
	09008 FACULTY PRACTICE CLINIC	0	0	0	747, 199	0. 000000	90. 09
	09009 OUR LADY OF ROSARY CLINIC	0	0	0	1, 293, 246	0. 000000	
	09100 EMERGENCY	0	0	0	53, 592, 860		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9, 175, 943		
200.00	Total (lines 50 through 199)	0	856, 453	856, 453	1, 012, 648, 029		200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0012 Peri od: Worksheet D From 07/01/2020 THROUGH COSTS Part IV 06/30/2021 Date/Time Prepared: 11/30/2021 12:30 pm Title XVIII Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col . 12) 13.00 7) x col. 10) 9.00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 29, 513, 717 24, 337, 649 50.00 0 05100 RECOVERY ROOM 0 51.00 0.000000 2,007,632 2, 383, 842 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 19, 099 0 52.00 643 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 5, 141, 389 0 8, 341, 721 54.00 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 179, 852 19, 665 55.00 0 57.00 05700 CT SCAN 0.000000 8, 927, 201 0 10, 470, 582 0 57.00 58.00 05800 MRI 0.000000 1, 924, 318 678, 056 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 10, 751, 303 0 15, 578, 347 59.00 0 06000 LABORATORY 0 60.00 0.000000 31, 289, 449 8, 762, 173 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62.30 06500 RESPIRATORY THERAPY 65.00 0.000000 4, 717, 912 431, 990 0 65.00 03610 SLEEP LAB 670, 098 0.000000 65 01 2, 192 0 65 01 0 66.00 06600 PHYSI CAL THERAPY 0.000000 1, 563, 750 88, 882 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.000000 1, 356, 087 25, 335 0 67.00 06800 SPEECH PATHOLOGY 560, 711 0 68 00 0.000000 27 309 0 68 00 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 4, 360, 161 3, 852, 486 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 16, 339, 730 0 11, 358, 831 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73 00 0.006103 22, 744, 537 138, 810 22, 221, 070 135, 615 73 00 74.00 07400 RENAL DIALYSIS 0.000000 754, 615 0 76, 319 0 74.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 142, 820 0 76.98 76. 99 07699 LITHOTRI PSY 0.000000 0 76. 99 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 90.00 09000 CLI NI C 0 0 09001 MOBILE MEDICAL UNIT 0.000000 0 90.02 90.02 0 0 0 ol 09002 FAMILY MEDICINE CENTER 0.000000 90.03 90.03 0 0 90.04 09003 WOUND HEALING CENTER 0.000000 24, 042 0 1, 810, 817 0 90.04 09004 OUTPATIENT TREATMENT & INFUSION 90.05 0.000000 96,000 477, 027 90.05 90.06 09005 PEDIATRIC SPECIALTY CLINIC 0.000000 0 0 0 90.06 0 09006 SPORTS MED FELLOWSHIP CLINIC 0 90 07 0.000000 C 0 0 90.07 09007 PODIATRY RESIDENCY CLINIC 0.000000 0 0 90.08 90.08 09008 FACULTY PRACTICE CLINIC 0 o 90.09 0.000000 0 90.09 09009 OUR LADY OF ROSARY CLINIC 0 90.10 90. 10 0.000000 0 0 91. 00 09100 EMERGENCY 0 0.000000 5, 177, 352 6, 125, 487 0 91.00

0.000000

1,035,274

148, 486, 323

0

138, 810

2, 087, 080

119, 968, 229

0 92.00

135, 615 200. 00

92.00

200.00

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0012 Peri od: Worksheet D From 07/01/2020 Part V 06/30/2021 Date/Time Prepared: 11/30/2021 12:30 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 11, 797 0 50.00 51.00 05100 RECOVERY ROOM 0 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 57.00 05700 CT SCAN 0 57.00 05800 MRI 0 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 06000 LABORATORY 0 60.00 381 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62 30 62 30 65.00 06500 RESPIRATORY THERAPY 0 65.00 65.01 03610 SLEEP LAB 00000000000 0 65.01 06600 PHYSI CAL THERAPY 66.00 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 13, 572 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 76. 97 07697 CARDIAC REHABILITATION 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76. 98 0 07699 LI THOTRI PSY 76. 99 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 000000000 0 09001 MOBILE MEDICAL UNIT 90.02 0 90.02 90. 03 09002 FAMILY MEDICINE CENTER 0 90.03 09003 WOUND HEALING CENTER 0 90. 04 90.04 0 09004 OUTPATIENT TREATMENT & INFUSION 90.05 90.05 09005 PEDIATRIC SPECIALTY CLINIC 0 90.06 90.06 09006 SPORTS MED FELLOWSHIP CLINIC 0 90.07 90.07 09007 PODIATRY RESIDENCY CLINIC 0 90.08 90.08 09008 FACULTY PRACTICE CLINIC 90.09 0 90.09 90.10 09009 OUR LADY OF ROSARY CLINIC 0 0 90.10 91.00 09100 EMERGENCY 0 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 200.00 Subtotal (see instructions) 12, 178 13, 572 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 12, 178 202.00

13, 572

Health Financial Systems ST.	JOSEPHS REG ME	D CENTER S. BE	ND	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co	F	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part I Date/Time Pre 11/30/2021 12	
		Ti tl	e XIX	Hospi tal PPS		<u> </u>
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 & PEDI ATRI CS	13, 147, 920	0	13, 147, 920	52, 632	249. 81	30. 00
31.00 INTENSIVE CARE UNIT	1, 674, 103		1, 674, 103	6, 373	262. 69	31. 00
35.00 NEONATAL INTENSIVE CARE UNIT	597, 633		597, 633	947	631.08	35. 00
41. 00 SUBPROVI DER - I RF	0	0	(	o	0.00	41. 00
43. 00 NURSERY	58, 137		58, 137	4, 461	13. 03	43.00
200.00 Total (lines 30 through 199)	15, 477, 793		15, 477, 793	64, 413		200. 00
Cost Center Description	Inpatient	Inpatient				
· ·	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	3, 231	807, 136				30. 00
31.00 INTENSIVE CARE UNIT	0	0				31. 00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35. 00
41. 00 SUBPROVI DER - I RF	0	0				41. 00
43. 00 NURSERY	638	8, 313				43.00
200.00 Total (lines 30 through 199)	3, 869					200. 00

Health Financial Systems ST.	JOSEPHS REG ME	ED CENTER S. BE	ND	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C	CN: 15-0012	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre 11/30/2021 12	pared: :30 pm
		Ti tI	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	6, 259, 789	225, 560, 559	0. 02775	2 15, 670, 340	434, 883	50.00
51.00   05100   RECOVERY ROOM	368, 813	19, 169, 815	0. 01923	9 917, 834	17, 658	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	100, 713	15, 640, 276	0. 00643	9 6, 050, 638	38, 960	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 518, 846	63, 340, 384	0. 02397	9 2, 357, 074	56, 520	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	8, 393	518, 550	0. 01618	6 52, 622	852	55.00
57. 00   05700   CT   SCAN	228, 264	78, 403, 910	0. 00291	1 4, 056, 655	11, 809	57.00
58. 00   05800   MRI	19, 759	8, 381, 005	0. 00235	8 1, 017, 388	2, 399	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 715, 305	78, 334, 386	0. 02189	7 3, 591, 296	78, 639	59.00
60. 00   06000   LABORATORY	467, 058	148, 760, 867	0. 00314	0 15, 581, 459	48, 926	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	O	0.00000		0	62. 30
65. 00 06500 RESPIRATORY THERAPY	455, 282	17, 095, 739	0. 02663	1 2, 327, 502	61, 984	65.00
65. 01 03610 SLEEP LAB	10, 652	4, 541, 146	0. 00234		0	65. 01
66. 00 06600 PHYSI CAL THERAPY	422, 431			1 490, 451	13, 625	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	28, 282				1, 713	1
68. 00 06800 SPEECH PATHOLOGY	10, 351			•	867	
69. 00 06900 ELECTROCARDI OLOGY	318, 599		1	•	18, 958	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.0,0,7		0. 00000		0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	402, 074	83, 559, 415	1		0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 306, 460				106, 220	
74. 00 07400 RENAL DIALYSIS	139, 765				11, 969	1
76. 97 07697 CARDI AC REHABI LI TATI ON	1077700	2, 100, 710	0.00000	•	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 189	408, 388			0	
76. 99 07699 LI THOTRI PSY	1, 10,	l .	ı		0	
OUTPATIENT SERVICE COST CENTERS			0.0000	<u> </u>		10.77
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90. 02   09001   MOBILE   MEDICAL UNIT	2, 170	_	1		0	
90. 03 09002 FAMILY MEDICINE CENTER	49, 290				0	
90. 04 09003 WOUND HEALING CENTER	41, 249		1		33	
90. 05 09004 OUTPATIENT TREATMENT & INFUSION	180, 447		1		1, 033	
90. 06 09005 PEDIATRIC SPECIALTY CLINIC	9, 132				1, 033	
90. 07 09006 SPORTS MED FELLOWSHIP CLINIC	21, 257		1		0	
90. 08 09007 PODIATRY RESIDENCY CLINIC	27, 078		0. 00000		0	
90. 09   09008   FACULTY PRACTICE CLINIC	16, 402				0	
90. 10 09009 OUR LADY OF ROSARY CLINIC	34, 684				0	
91. 00   09100   EMERGENCY	2, 344, 612				147, 572	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	1, 688, 210				147, 572	
200.00 Total (lines 50 through 199)		1, 012, 648, 029		69, 258, 263		
200.00   Total (Titles 30 tillough 199)	10, 190, 550	1,012,040,029	T	09, 200, 203	1, 034, 620	<sub>1</sub> 200.00

		ED CENTER S. BE			eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				From 07/01/2020 To 06/30/2021		narod:
				10 00/30/2021	11/30/2021 12	: 30 pm
		Ti tl	e XIX	Hospi tal	PPS	оо р
Cost Center Description	Nursing School	Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	)	0	0	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	35. 00
41. 00   04100   SUBPROVI DER - I RF	0	0		0	0	41.00
43. 00   04300 NURSERY	0	0	)	0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)					
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	52, 63			
31.00 03100 INTENSIVE CARE UNIT		0	6, 37			000
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	94			35. 00
41. 00   04100   SUBPROVI DER - I RF	0	0		0.00		1 00
43. 00   04300   NURSERY		0	4, 46			
200.00 Total (lines 30 through 199)		0	64, 41	3	3, 869	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8) 9.00	-				
INDATIENT DOUTINE SERVICE COST CENTERS	9.00					

30.00

31. 00 35. 00 41. 00 43. 00

200.00

INPATIENT ROUTINE SERVICE COST CENTERS

30. 00 03000 ADULTS & PEDIATRICS
31. 00 03100 INTENSIVE CARE UNIT
35. 00 02060 NEONATAL INTENSIVE CARE UNIT
41. 00 04100 SUBPROVIDER - IRF
43. 00 04300 NURSERY
200. 00 Total (lines 30 through 199)

Health Financial Systems ST. JOSEPHS REG MED CENTER S. BEND

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0012 | Peri od: | Worksheet D | From 07/01/2020 | Part IV | To 06/30/2021 | Date/Time Prepared: | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/02/2021 | 12/ THROUGH COSTS

					10 00/30/2021	11/30/2021 12	
			Ti tl	e XIX	Hospi tal	PPS	. оо р
	Cost Center Description	Non Physician			Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C	)	0 0	0	50. 00
51.00	05100 RECOVERY ROOM	0	l c		0 0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	l c		0 0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	l c		0 0	0	55. 00
57. 00	05700 CT SCAN	0			0	0	57. 00
58. 00	05800 MRI	0	l c		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	l d		0	0	59. 00
60. 00	06000 LABORATORY	0	Ĭ		0	0	60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	آ ا		0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	0	Ì				65. 00
65. 01	03610 SLEEP LAB		Ì			o o	65. 01
66. 00	06600 PHYSI CAL THERAPY	0	7				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		7				67. 00
68. 00	06800 SPEECH PATHOLOGY						68. 00
69. 00	06900 ELECTROCARDI OLOGY						69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT						71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0					71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0				856, 453	73. 00
74. 00	07400 RENAL DIALYSIS	0				050, 455	74.00
76. 97	07697 CARDIAC REHABILITATION	0					76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY					_	76. 98
76. 96 76. 99	07699 LI THOTRI PSY	0				1	76. 96 76. 99
70. 99	OUTPATIENT SERVICE COST CENTERS			′1	U C	·  U	70. 99
90. 00	09000 CLINIC				0 0	0	90. 00
90. 02	09001 MOBILE MEDICAL UNIT					1	90.00
90. 02	09002 FAMILY MEDICINE CENTER	0					90.02
90.03	09003 WOUND HEALING CENTER						90.03
90. 04	09004 OUTPATIENT TREATMENT & INFUSION			()			90.04
		0		(		0	
90. 06 90. 07	09005 PEDIATRIC SPECIALTY CLINIC	0		(		_	90.06
90.07	09006 SPORTS MED FELLOWSHIP CLINIC 09007 PODIATRY RESIDENCY CLINIC	0		(		0	90. 07 90. 08
90.08	09007 PODIATRY RESIDENCY CLINIC	0		(		0	
		0		(		1	90. 09
90. 10	09009 OUR LADY OF ROSARY CLINIC			(		0	90. 10
91.00	09100 EMERGENCY		١	'		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		,	J	0	1	92.00
200.00	Total (lines 50 through 199)	1	[ C	יו	0 0	856, 453	<sub> </sub> 200.00

Health Financial Systems ST. JOSEPHS REG MED OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS | Period: | Worksheet D | From 07/01/2020 | Part IV | To 06/30/2021 | Date/Time Prepared: Provider CCN: 15-0012 THROUGH COSTS

TTIKOOC	31 3313			Т	o 06/30/2021	Date/Time Pre 11/30/2021 12	
			Ti tl	e XIX	Hospi tal	PPS	. 00 piii
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of	•	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	TANGLE ARE SERVICE COST OFFITERS	4.00	5. 00	6. 00	7. 00	8. 00	
F0 00	ANCI LLARY SERVI CE COST CENTERS				005 5/0 550	0.00000	F0 00
50.00	05000 OPERATI NG ROOM	0	0				1
51.00	05100 RECOVERY ROOM	0	0			0.000000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0.000000	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0		0. 000000	•
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0			0. 000000	
57. 00	05700 CT SCAN	0	0	0	707 1007 710	0. 000000	ı
58. 00	05800  MRI	0	0	0	-, ,	0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0		0. 000000	1
60.00	06000 LABORATORY	0	0	0	, ,	0. 000000	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0	0	17, 095, 739	0. 000000	65. 00
65. 01	03610 SLEEP LAB	0	0	0	4, 541, 146	0.000000	65. 01
66.00	06600 PHYSI CAL THERAPY	0	0	0		0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	-, ,	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	2, 084, 659	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	27, 456, 573	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	83, 559, 415	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	856, 453	856, 453	140, 332, 191	0. 006103	73. 00
74.00	07400 RENAL DIALYSIS	o	0	0	2, 136, 946	0.000000	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	o	0	0	0	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o	0	0	408, 388	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	o	0	0	0	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS			•			
90.00	09000 CLI NI C	0	0	0	0	0.000000	90.00
90. 02	09001 MOBILE MEDICAL UNIT	o	0	0	482, 332	0.000000	90. 02
90. 03	09002 FAMILY MEDICINE CENTER	o	0	0	3, 576, 711	0.000000	90. 03
90. 04	09003 WOUND HEALING CENTER	o	0	0	5, 329, 756	0.000000	90. 04
90. 05	09004 OUTPATIENT TREATMENT & INFUSION	o	0	0	1, 388, 763	0. 000000	90. 05
90.06	09005 PEDIATRIC SPECIALTY CLINIC	ol	0	l o	203, 407	0. 000000	1
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	o	0	0	0	0.000000	•
90. 08	09007 PODIATRY RESIDENCY CLINIC	o	0	0	0	0. 000000	•
90. 09	09008 FACULTY PRACTICE CLINIC		0	l	747, 199	0. 000000	1
90. 10	09009 OUR LADY OF ROSARY CLINIC	ام	0	ĺ		0. 000000	•
91. 00	09100 EMERGENCY	ام	0			0. 000000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	ا	0			0. 000000	1
200.00	1		856, 453	ľ	1, 012, 648, 029		200.00
200.00	, (11105 00 thi ough 177)	ı Ч	555, 455	1 000, 400	., 512, 515, 627	I	1-50. 00

		JUSEFIIS REG WED	_			u or roriii cws	2332-10
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI SH COSTS	RVICE OTHER PASS	Provi der Co		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre 11/30/2021 12	
			Ti tl	e XIX	Hospi tal	PPS	·
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	'	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	3	Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	15, 670, 340		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	917, 834		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	6, 050, 638		0 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 357, 074		0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	52, 622		0 0	0	55. 00
57. 00	05700 CT SCAN	0. 000000	4, 056, 655		o o	Ö	57. 00
58. 00	05800 MRI	0. 000000	1, 017, 388		0 0	l ő	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	3, 591, 296		0 0	l ő	59. 00
60. 00	06000 LABORATORY	0. 000000	15, 581, 459		0 0	o o	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	13, 301, 437		0 0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	0. 000000	2, 327, 502	l .	0	0	65. 00
65. 01	03610 SLEEP LAB	0. 000000	2, 327, 302		0	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0. 000000	490, 451		0	0	66. 00
		1		•	0 0	0	1
67.00	06700 OCCUPATIONAL THERAPY	0.000000	358, 964		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	174, 555		0 0	ľ	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	1, 633, 775		0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 006103	11, 409, 284		1 0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0. 000000	183, 008		0	0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	T		T		Г	
90. 00	09000 CLI NI C	0. 000000	0	1	0	0	90. 00
90. 02	09001 MOBILE MEDICAL UNIT	0. 000000	0		0	0	90. 02
90. 03	09002 FAMILY MEDICINE CENTER	0. 000000	0		0	0	90. 03
90. 04	09003 WOUND HEALING CENTER	0. 000000	4, 308		0	0	90. 04
90. 05	09004 OUTPATIENT TREATMENT & INFUSION	0. 000000	7, 949		0	0	90. 05
90.06	09005 PEDIATRIC SPECIALTY CLINIC	0. 000000	0		0	0	90. 06
90. 07	09006 SPORTS MED FELLOWSHIP CLINIC	0. 000000	0		0	0	90. 07
90. 08	09007 PODIATRY RESIDENCY CLINIC	0. 000000	0		0	0	90. 08
90. 09	09008 FACULTY PRACTICE CLINIC	0. 000000	0		0 0	0	90. 09
90. 10	09009 OUR LADY OF ROSARY CLINIC	0. 000000	0		0	0	90. 10
91.00	09100 EMERGENCY	0. 000000	3, 373, 161		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00	Total (lines 50 through 199)		69, 258, 263	69, 63	1 0	0	200. 00
		·					

	Financial Systems	ST. JOSEPHS REG MED	-		u of Form CMS-2	
COMPUTA	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0012	Peri od: From 07/01/2020	Worksheet D-1	
				To 06/30/2021	Date/Time Pre 11/30/2021 12	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					-
1 00	INPATIENT DAYS	som dava and aut na had dav	o ovaludina nauhama)		52, 632	1 00
1. 00 2. 00	Inpatient days (including private r Inpatient days (including private r				52, 632 52, 632	
3. 00	Private room days (excluding swing-			ivate room days	0 32,032	
3.00	do not complete this line.	bed and observation bed da	iys). The you have only pr	Tvate room days,	O	3.00
4.00	Semi-private room days (excluding s	wing-bed and observation b	ed days)		45, 874	4. 00
5.00	Total swing-bed SNF type inpatient			er 31 of the cost	0	
	reporting period	3 (	3,7			
6.00	Total swing-bed SNF type inpatient		oom days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year,					
7. 00	Total swing-bed NF type inpatient d	ays (including private roc	om days) through December	31 of the cost	0	7. 00
0.00	reporting period	Z: 1 !:				0.00
8. 00	Total swing-bed NF type inpatient d		om days) after December 3	of the cost	0	8. 00
9. 00	reporting period (if calendar year, Total inpatient days including priv		to the Program (eyeluding	swing bod and	15, 128	9. 00
9.00	newborn days) (see instructions)	ate room days appricable t	the Program (excluding	Swirig-bed and	10, 120	9.00
10. 00	Swing-bed SNF type inpatient days a	policable to title XVIII o	only (including private r	room days)	0	10.00
10.00	through December 31 of the cost rep			oom days)	Ŭ	10.00
11. 00	Swing-bed SNF type inpatient days a			oom days) after	0	11. 00
	December 31 of the cost reporting p			,		
12.00	Swing-bed NF type inpatient days ap		X only (including privat	e room days)	0	12. 00
	through December 31 of the cost rep					
13. 00	Swing-bed NF type inpatient days ap				0	13. 00
14 00	after December 31 of the cost repor Medically necessary private room da				0	14. 00
14. 00 15. 00			all (excluding Swing-bed	uays)	0	
	Nursery days (title V or XIX only)	on y)			0	
10.00	SWING BED ADJUSTMENT				U	10.00
17. 00	Medicare rate for swing-bed SNF ser	vices applicable to servic	es through December 31 o	f the cost	0.00	17. 00
	reporting period		3			
18. 00	Medicare rate for swing-bed SNF ser	vices applicable to servic	es after December 31 of	the cost	0.00	18. 00
	reporting period					
19. 00	Medicaid rate for swing-bed NF serv	ices applicable to service	es through December 31 of	the cost	0.00	19. 00
	reporting period		6. 5 . 6.			
20. 00	Medicaid rate for swing-bed NF serv	ices applicable to service	es after December 31 of t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine ser	vice cost (see instruction	ne)		64, 510, 396	21. 00
	Swing-bed cost applicable to SNF ty			ing period (line	04, 510, 390	
22.00	5 x line 17)	pe services through becenic	on 31 of the cost report	ing period (illie		22.00
23. 00	Swing-bed cost applicable to SNF ty	pe services after December	31 of the cost reportin	g period (line 6	0	23. 00
	x line 18)	,				
24. 00	Swing-bed cost applicable to NF typ	e services through Decembe	er 31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)					
25. 00	Swing-bed cost applicable to NF typ	e services after December	31 of the cost reporting	period (line 8	0	25. 00
24 00	x line 20)	one)			0	24 00

	PART I - ALL PROVIDER COMPONENTS		
1 00	INPATIENT DAYS	F2 (22	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)	52, 632 52, 632	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	52, 632	3. 00
3.00	do not complete this line.	U <sub> </sub>	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	45, 874	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	43, 674	5. 00
3.00	reporting period	٥	3.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	١	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
,, ,,	reporting period	١	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	١	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	15, 128	9. 00
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00		0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
40.00	reporting period		40.00
19. 00		0.00	19. 00
20.00	reporting period	0.00	20. 00
20.00	Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	64, 510, 396	21 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	04, 510, 340	
22.00	5 x line 17)	٥	22.00
23. 00	,	0	23. 00
23.00	x line 18)	١	23.00
24 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
2 00	7 x line 19)	١	21.00
25.00	,	0	25. 00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	64, 510, 396	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00		0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	64, 510, 396	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 225. 69	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	18, 542, 238	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	18, 542, 238	41. 00

COMI O I	ATION OF INPATIENT OPERATING COST		Provi der CC	N: 15-0012	Peri od:	Worksheet D-1	2552-10
					From 07/01/2020 To 06/30/2021		
			Title		Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	3	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0. (	00 0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	12 240 025	6, 373	2, 077. 6	66 1, 760	3, 656, 682	43.00
44. 00	CORONARY CARE UNIT	13, 240, 935	0, 3/3	2,077.0	1, 700	3, 000, 002	44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT	4, 944, 606	947	5, 221. 3	34 0	0	47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 33, 188, 315	48. 00
49. 00	Total Program inpatient costs (sum of lines			ns)		55, 387, 235	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>		•			1
50. 00	Pass through costs applicable to Program inp	atient routine s	services (from	Wkst. D, sur	n of Parts I and	4, 241, 460	50.00
51. 00	Dass through costs applicable to Drogram in	ationt ancillars	, convices (fr	om Wko+ D (	sum of Dorte II	2, 485, 325	E1 00
51.00	Pass through costs applicable to Program inpland IV)	atrent andiriary	services (iii	JIII WKSt. D, S	sum of Parts II	2, 485, 325	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				6, 726, 785	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital rel	ated, non-phys	sician anesth	netist, and	48, 660, 450	53.00
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54. 00
55. 00							55.00
56. 00	Target amount (line 54 x line 55)					0	1
57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (li	ne 56 minus	line 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 e	ending 1996, up	dated and co	ompounded by the	0.001	59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report upo	dated by the ma	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0	l .
	which operating costs (line 53) are less tha		s (lines 54 x 6	50), or 1% of	f the target		
	amount (line 56), otherwise enter zero (see	instructions)					
62.00	, ,	ant (see instruc	rtione)			0	62.00
03.00	00 Allowable Inpatient cost plus incentive payment (see instructions) 0 PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64.00
	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the co	ost reportino	j period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 65	5)(title XVII	l only) For	0	66.00
00.00	CAH (see instructions)		7. p. do o o	,, (			00.00
67. 00	9 1	e costs through	December 31 of	the cost re	eporting period	0	67.00
(0.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costo often De	soombor 21 of t	the cost work	anting paried		/ 0 00
58.00	(line 13 x line 20)	e costs arter be	ecember 31 01 i	.ne cost repo	orting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N						]
70.00	Skilled nursing facility/other nursing facil				)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /U ÷ IIne 2	<u>')</u>			71.00
73. 00	Medically necessary private room cost applications	,	(line 14 x lir	ne 35)			73.00
74. 00	Total Program general inpatient routine serv	9	•	,			74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from Wo	orksheet B, F	Part II, column		75. 00
74 00	26, line 45)	2)					74 ~
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	, ,						78.00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from pr		•			79.00
80.00	Total Program routine service costs for comp		st limitation	(line 78 mir	nus line 79)		80.0
81. 00 82. 00	Inpatient routine service cost per diem limi						81. 0 82. 0
82.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						83.0
84. 00	Program inpatient ancillary services (see in		-,				84. 0
	Utilization review - physician compensation		ns)				85. 0
86. 00	Total Program inpatient operating costs (sum		ough 85)				86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS					/ 750	07.00
07 00	Total observation had days (see instructions)						
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			6, 758 1, 225. 69	

Health Financial Systems ST.	JOSEPHS REG ME	D CENTER S. BEI	ND	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 07/01/2020	Worksheet D-1	
				To 06/30/2021		pared: :30 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	13, 147, 920	64, 510, 396	0. 20381	1 8, 283, 213	1, 688, 210	90.00
91.00 Nursing School cost	0	64, 510, 396	0.00000	0 8, 283, 213	0	91.00
92.00 Allied health cost	0	64, 510, 396	0.00000	0 8, 283, 213	0	92.00
93.00 All other Medical Education	0	64, 510, 396	0. 00000	0 8, 283, 213	0	93. 00

Heal th	Financial Systems ST.	JOSEPHS REG MED C	ENTER S. BEND	In Lie	u of Form CMS-2	2552-10			
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0012	Peri od:	Worksheet D-1				
	From 07/01/2020   To 06/30/2021   Date/Time Prepared   11/30/2021 12:30 p								
			Title XIX	Hospi tal	PPS	. 30 piii			
	Cost Center Description		THE MIX	1103pt tui	110				
	555 Conton 2555 (per 6)				1. 00				
	PART I - ALL PROVIDER COMPONENTS								
	I NPATI ENT DAYS								
1.00	Inpatient days (including private room days	9	. ,		52, 632	1. 00			
2.00	Inpatient days (including private room days,				52, 632	2. 00			
3. 00	Private room days (excluding swing-bed and o do not complete this line.	bservation bed day	/s). If you have only pr	ivate room days,	0	3. 00			
4.00	Semi-private room days (excluding swing-bed	and observation be	ed days)		45, 874	4. 00			
5.00	Total swing-bed SNF type inpatient days (inc			r 31 of the cost	0	5. 00			
	reporting period	• .							
6.00	Total swing-bed SNF type inpatient days (inc		om days) after December	31 of the cost	0	6. 00			
7.00	reporting period (if calendar year, enter 0			04 6 11		7.00			
7. 00	Total swing-bed NF type inpatient days (incl reporting period	uding private room	n days) through December	31 OF the COST	0	7. 00			
8.00	Total swing-bed NF type inpatient days (incl		n days) after December 3	1 of the cost	0	8. 00			
9. 00	reporting period (if calendar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and 3,231)								
7. 00	newborn days) (see instructions)								
10.00									
11 00	through December 31 of the cost reporting period (see instructions)  .00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 1								
11. 00	December 31 of the cost reporting period (if			days) arter	0	11. 00			
12. 00	Swing-bed NF type inpatient days applicable			e room days)	0	12. 00			
	through December 31 of the cost reporting pe		3 (						
13. 00	Swing-bed NF type inpatient days applicable after December 31 of the cost reporting periods.				0	13. 00			
14. 00	Medically necessary private room days applic				0	14. 00			
15. 00	Total nursery days (title V or XIX only)	able to the frogre	an (exer daring swring bed	days)	4, 461	15. 00			
16. 00	Nursery days (title V or XIX only)				638	16. 00			
	SWING BED ADJUSTMENT								
17.00	Medicare rate for swing-bed SNF services app	licable to service	es through December 31 c	f the cost	0.00	17. 00			
	reporting period								
18. 00	Medicare rate for swing-bed SNF services app	licable to service	es after December 31 of	the cost	0.00	18. 00			
19. 00	reporting period Medicaid rate for swing-bed NF services appl	i aabla ta aamul aas	through December 21 of	: +ba aaa+	0.00	19. 00			
19.00	reporting period	icable to services	through becember 31 of	the cost	0.00	19.00			
20.00	Medicald rate for swing-bed NF services appl	icable to services	s after December 31 of t	he cost	0.00	20. 00			
	reporting period								
21.00	Total general inpatient routine service cost	(see instructions	s)		64, 510, 396	21. 00			
22. 00	Swing-bed cost applicable to SNF type service 5 x line 17)	es through Decembe	er 31 of the cost report	ing period (line	0	22. 00			
23. 00	Swing-bed cost applicable to SNF type service	es after December	31 of the cost reportin	g period (line 6	0	23. 00			
	x line 18)		·						
24. 00	Swing-bed cost applicable to NF type service 7 x line 19)	s through December	31 of the cost reporti	ng period (line	0	24. 00			
25. 00	Swing-bed cost applicable to NF type service	s after December 3	31 of the cost reporting	period (line 8	0	25. 00			
	x line 20)				_				
26. 00	Total swing-bed cost (see instructions)				0	26. 00			

	PART I - ALL PROVIDER COMPONENTS		
1 00	INPATIENT DAYS	F2 (22	1 00
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	52, 632 52, 632	1. 00 2. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	45, 874	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	43, 674	
5.00	reporting period	U	3.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	O	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	3, 231	9. 00
7. 00	newborn days) (see instructions)	0, 20.	7.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)	-	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		14. 00
	Total nursery days (title V or XIX only)		15. 00
16. 00	Nursery days (title V or XIX only)	638	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
04 00	reporting period	(4 540 00/	04 00
21. 00	Total general inpatient routine service cost (see instructions)	64, 510, 396	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line $5 \times 1$ line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6)	0	23. 00
23.00	while tost approache to shi type services after beceined 51 of the cost reporting period (fine 18)	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	_	
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	64, 510, 396	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32. 00
	Average semi-private room per diem charge (line 30 ÷ line 4)		33. 00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	64, 510, 396	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 225. 69	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	3, 960, 204	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3, 960, 204	41. 00
	·		

Heal th	Financial Systems ST. JOSEPHS REG MED CENTER S. BEND In Lie	u of Form CMS-2	<u> 2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0012 Period: From 07/01/2020	Worksheet D-1	
	To 06/30/2021	Date/Time Prep	pared:
	Title XIX Hospital	11/30/2021 12: PPS	: 30 piii
	Cost Center Description Total Total Average Per Program Days	Program Cost	
	Inpati ent Cost   Inpati ent Days   Di em (col. 1 ÷   col. 2)	(col. 3 x col. 4)	
40.00	1.00 2.00 3.00 4.00	5. 00	40.00
42.00	NURSERY (title V & XIX only) 2,807,373 4,461 629.31 638 Intensive Care Type Inpatient Hospital Units	401, 500	42.00
43.00	I NTENSI VE CARE UNI T 13, 240, 935 6, 373 2, 077. 66 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT		46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT	0	47. 00
	COST CERTER DESCRIPTION	1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	14, 450, 117	•
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)  PASS THROUGH COST ADJUSTMENTS	18, 811, 821	49. 00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	815, 449	50. 00
51. 00		1, 124, 251	51. 00
	and IV)		
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	1, 939, 700 16, 872, 121	•
00.00	medical education costs (line 49 minus line 52)	10, 072, 121	00.00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	54. 00
55. 00		0. 00	
56. 00 57. 00	Target amount (line 54 x line 55)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0. 00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0. 00	60. 00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		
62.00	Relief payment (see instructions)	0	
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	U	63. 00
64. 00		0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
// 00	instructions)(title XVIII only)		// 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00		0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
(0.00	(line 13 x line 20)	0	69. 00
09.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	U	09.00
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 71)		72.00
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)		73.00
75. 00	Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
74 00	26, line 45)		74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limitation		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		82. 00 83. 00
84. 00	Program inpatient ancillary services (see instructions)		84. 00
85. 00 86. 00	Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)		85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	6, 758 1, 225. 69	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see instructions)	8, 283, 213	

Health Financial Systems ST.	JOSEPHS REG ME	D CENTER S. BEI	ND	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 07/01/2020	Worksheet D-1	
				To 06/30/2021		pared: :30 pm
		Ti tl	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	13, 147, 920	64, 510, 396	0. 20381	1 8, 283, 213	1, 688, 210	90.00
91.00 Nursing School cost	0	64, 510, 396	0.00000	0 8, 283, 213	0	91.00
92.00 Allied health cost	0	64, 510, 396	0.00000	0 8, 283, 213	0	92.00
93.00 All other Medical Education	0	64, 510, 396	0. 00000	0 8, 283, 213	0	93. 00

Health Financial Systems	ST. JOSEPHS REG MED CENTER S. BEND	In Lieu of Form CMS-2552-10
INDATIENT ANGLI LADV CEDVICE COCT ADDODTI ONMENT	Dravi dan CCN, 1E 0012	Dariad Warkshoot D 2

Health Financial Systems ST. JOSEPHS REG MED	CENTER S. BEND	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Period: From 07/01/2020	Worksheet D-3	
		To 06/30/2021	Date/Time Pre 11/30/2021 12	
	Title XVIII	Hospi tal	PPS	
Cost Center Description	Ratio of Cost	Inpati ent	I npati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS		40, 525, 024		30. 00
31.00  03100   INTENSIVE CARE UNIT		9, 148, 509		31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0		35. 00
41. 00   04100   SUBPROVI DER -   RF		0		41.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 22712	29, 513, 717	6, 703, 214	50.00
51. 00   05100   RECOVERY ROOM	0. 14493	7 2, 007, 632	290, 980	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0. 30244	2 19, 099	5, 776	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 15613	0 5, 141, 389	802, 725	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 92473	4 179, 852	166, 315	55. 00
57. 00  05700 CT SCAN	0. 03199	0 8, 927, 201	285, 581	57. 00
58. 00   05800   MRI	0. 16579		319, 038	
59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 21710		2, 334, 140	1
60. 00   06000   LABORATORY	0. 10975		3, 434, 142	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 00000		0, 10 1, 1 12	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 29669		1, 399, 790	
65. 01   03610   SLEEP LAB	0. 16574		363	1
66. 00   06600   PHYSI CAL THERAPY	0. 34120	·	533, 561	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 23103		313, 302	67.00
68. 00   06800   SPEECH PATHOLOGY	0. 24209		135, 746	
69. 00   06900  SELECT FATHOLOGY	0. 24204	·	413, 348	
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT			413, 346	71.00
	0.00000		_	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 36014			
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 30512		6, 939, 950	
74. 00   07400   RENAL DI ALYSI S	1. 05231		794, 091	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0.00000		0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0. 14623		0	76. 98
76. 99 07699 LI THOTRI PSY	0.00000	0 0	0	76. 99
90. 00 09000 CLI NI C	0.00000	0 0	0	90.00
90. 02   09001   MOBI LE   MEDI CAL   UNI T	0. 31588		0	90.00
			0	90.02
	0. 54461			
90. 04   09003   WOUND HEALING CENTER	0. 40402	· ·	9, 714	90. 04
90. 05   09004   OUTPATIENT TREATMENT & INFUSION	1. 08981		104, 622	
90. 06   09005   PEDI ATRI C SPECI ALTY CLINI C	2. 12267		0	90.06
90. 07   09006   SPORTS MED FELLOWSHIP CLINIC	0.00000		0	90. 07
90. 08   09007   PODI ATRY RESI DENCY CLI NI C	0.00000		0	90. 08
90. 09   09008 FACULTY PRACTICE CLINIC	1. 11252		0	90. 09
90. 10   09009   OUR LADY OF ROSARY CLINIC	1. 32102		0	90. 10
91. 00   09100   EMERGENCY	0. 26707		1, 382, 726	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 90271		934, 552	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		148, 486, 323	33, 188, 315	
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)	0		201. 00
202.00 Net charges (line 200 minus line 201)		148, 486, 323		202. 00

Health Financial Systems	ST. JOSEPHS REG MED C	CENTER S. BEND	In Lie	u of Form CMS-2552-10
INDATIENT ANGLE ADV CEDULOE COCT ADDODE CAMENT		D 1 1 00N 4E 0040	D . I	W 1 1 1 D 0

Health Financial Systems ST. JOSEPHS REG MED	CENTER S. BEND	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Peri od:	Worksheet D-3	
		From 07/01/2020		
		To 06/30/2021	Date/Time Pre	
	T' II VIV		11/30/2021 12	:30 pm
	Title XIX	Hospi tal	PPS	
Cost Center Description	Ratio of Cost	· ·	Inpati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS		19, 460, 832		30. 00
31. 00  03100   I NTENSI VE CARE UNI T		5, 300, 153		31.00
35. 00   02060   NEONATAL INTENSIVE CARE UNIT		6, 070, 266		35. 00
41. 00   04100   SUBPROVI DER - I RF		0		41.00
43. 00   04300   NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000   OPERATING ROOM	0. 22712	2 15, 670, 340	3, 559, 079	50.00
51. 00   05100   RECOVERY ROOM	0. 14493	7 917, 834	133, 028	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 30244	2 6, 050, 638	1, 829, 967	52.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0. 15613		368, 010	54.00
55. 00   05500   RADI OLOGY - THERAPEUTI C	0. 92473		48, 661	55. 00
57. 00   05700   CT   SCAN	0. 03199		129, 772	57.00
58. 00   05800   MRI	0. 16579		168, 676	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 21710		779, 681	59.00
60. 00   06000   LABORATORY	0. 21710		1, 710, 127	60.00
				1
62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0.00000		0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 29669		690, 563	65. 00
65. 01   03610   SLEEP LAB	0. 16574		0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 34120		167, 345	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 23103		82, 933	67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 24209	·	42, 259	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 09480	1, 633, 775	154, 884	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.00000	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 36014	3 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 30512	6 11, 409, 284	3, 481, 269	73.00
74. 00   07400   RENAL DI ALYSI S	1. 05231	3 183, 008	192, 582	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 00000	0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 14623		0	76. 98
76. 99 07699 LI THOTRI PSY	0. 00000		0	76. 99
OUTPATIENT SERVICE COST CENTERS		-		
90. 00 09000 CLI NI C	0.00000	0 0	0	90.00
90. 02   09001   MOBI LE   MEDI CAL   UNI T	0. 31588		0	90. 02
90. 03   09002   FAMI LY MEDI CI NE CENTER	0. 54461		0	90. 03
90. 04   09003   WOUND HEALING CENTER	0. 40402		1, 741	90. 04
90. 05   09004   OUTPATI ENT TREATMENT & INFUSION	1. 08981		8, 663	90.05
90. 06   09005   PEDI ATRI C SPECI ALTY CLINI C	2. 12267		0,003	90.05
90. 07   09006  SPORTS MED FELLOWSHIP CLINIC	0.00000		0	90.00
				ł
90. 08   09007   PODI ATRY RESI DENCY CLINI C	0.00000		0	90.08
90. 09   09008 FACULTY PRACTICE CLINIC	1. 11252		0	90. 09
90. 10   09009   OUR LADY OF ROSARY CLINIC	1. 32102		0	90. 10
91. 00   09100   EMERGENCY	0. 26707		900, 877	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 90271		0	92. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		69, 258, 263	14, 450, 117	
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)	0		201. 00
202.00 Net charges (line 200 minus line 201)		69, 258, 263		202. 00

Health Financial Systems	ST. JOSEPHS REG MED C	CENTER S. BEND	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0012	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 12:30 pm

PART A - INMATLENT HOSPITAL SERVICES UNDER IPPS   1.00				10 00/30/2021	11/30/2021 12	
Name			Title XVIII	Hospi tal	PPS	
1.00   RSS Amounts ofter than outlier payments for discharges occurring prior to October 1 (see   0.6,523,78   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1					1. 00	
1.01   DRG amounts other than outlier payments for discharges occurring prior to October 1 (see   36.523,178   1.01   Instructions)   Instructions   1.02   DRG amounts atter than outlier payments for discharges occurring on or after October 1 (see   1.02   1.03   1.03   1.04   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.05   1.						
DBG amounts other than outlier payments for discharges occurring on or after October 1 (see		DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (	see		
1.03   16 (see instructions)   1.04   18   16   16   16   16   16   16   16	1. 02	DRG amounts other than outlier payments for discharges occurr	ng on or after October	1 (see	0	1. 02
1.04   Oktober   Lisee Instructions   2.00   Oktober   Lisee Instructions   2.00   Oktober   Lisee Instructions   2.00   Outlier payments for discharges (see instructions)   2.00   Outlier payments for discharges (see instructions)   2.00   Outlier payments for discharges occurring prior to Oktober   Lisee Instructions   2.002, 919   2.03   Outlier payments for discharges occurring prior to Oktober   Lisee Instructions   2.002, 919   2.03   Outlier payments for discharges occurring or or after Oktober   Lisee Instructions   2.002, 919   2.03   Outlier payments for discharges occurring or or after Oktober   Lisee Instructions   2.002, 919   2.03   Outlier payments for discharges occurring or or after Oktober   Lisee Instructions   2.002, 919   2.03   Outlier payments for discharges occurring or or after Oktober   Lisee Instructions   2.002, 919   2.03   Outlier payments for discharges occurring or or after Oktober   Lisee Instructions   2.002, 91, 92, 93   3.00   Outlier payments for discharges occurring or or after Oktober   Lisee Instructions   2.002, 91, 92, 93   3.00   Outlier payments for discharges occurring or or after Oktober   Lisee Instructions   2.002, 91, 92, 93   3.00   Outlier payments for discharges occurring or or after Oktober   Lisee Instructions   2.002, 91, 92, 93   3.00   Outlier payments for discharges   Lisee Instructions   2.002, 91, 92, 93   3.00   Outlier   Lisee Instructions   2.002, 93, 93, 93, 93, 93, 93, 93, 93, 93, 93	1. 03	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	prior to October	0	1. 03
2.00   Outlier payments for discharges (see Instructions)   2.00   Outlier payment for discharges (see Instructions)   2.00   2.02   2.02   2.02   2.03   Outlier payment for discharges occurring prior to October 1 (see instructions)   2.000   91   2.03   2.04   2.04   2.04   2.05   2.04   2.05   2.04   2.05   2.04   2.05   2.04   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05   2.05	1. 04	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	on or after	0	1. 04
2.00         Outlier payment for discharges cocurring prior to October 1 (see Instructions)         0         2.02, 90         2.02, 90 yet payments for discharges occurring on or after October 1 (see instructions)         2.02, 90 yet 2.03         2.04         0         2.04         0         2.04         0         2.04         0         2.04         3.04         0         2.04         3.04         0         2.04         3.04         0         2.04         3.04         0         2.04         3.04         0         2.04         3.04         3.04         0         2.04         3.04         0         2.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04		Outlier payments for discharges. (see instructions)			0	
2.02			ons)			
2.04   Outlier payments for discharges occurring on or after October 1 (see instructions)   0   2.04		, ,	•		2, 020, 919	
Bed days available divided by number of days in the cost reporting period (see instructions)   238.33   4.00     Indirect Medical Education Adjustment   5.00   FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)   7.00   6.00   FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00	2.04	Outlier payments for discharges occurring on or after October	1 (see instructions)		0	2. 04
Indirect Medical Education Adjustment   5.00   FIE count for all opathic and ostepathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00						ł
or before 12/31/19% (see Instructions)  6. 00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)  7. 00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cook of cost report straddles July 1, 2011 then see instructions  8. 00 AGA \$503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cook of cost report straddles July 1, 2011 then see instructions, 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 report straddles July 1, 2011, see instructions.  8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$5506 of ACA. (see instructions)  9. 02 Sun of lines \$ plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 22.46 instructions)  10. 06 FTE count for residents in dental and podiatric programs.  10. 07 FTE count for residents in dental and podiatric programs.  10. 08 FTE count for residents in dental and podiatric programs.  10. 09 FTE count for residents in dental and podiatric programs.  10. 00 Total allowable FTE count for the perior year.  10. 00 Total allowable FTE count for the perior year.  10. 00 Total allowable FTE count for the perior year.  10. 00 The period of the period year of the program of the period year of the period year of the year of the year of the year year year year year year year yea	4. 00		rting period (see instru	ctions)	238. 33	4. 00
new programs in accordance with 42 CFR 413.79(e)   7.00   MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost cost report straddles July 1, 2011 then see instructions   8.00   AGA § 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost ost preport straddles July 1, 2011 then see instructions   8.00   Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(c) (1)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).   8.01   The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.   8.02   Instructions   8.02   Instructions   8.03   Instructions   8.04   Instructions   8.04   Instructions   8.05 of ACA. (see instructions)   8.05 of ACA. (see instructions)   8.01   Instructions   8.02   Instructions   8.02   Instructions   8.03   Instructions   8.04   Instructions   8.04   Instructions   8.05 of ACA. (see instructions)   8.05 of ACA. (see instructions)   8.06   Instructions   8.07   Instructions   8.08   Instructions   8.09 of Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructions   8.00   Instructio	5. 00	or before 12/31/1996. (see instructions)				
7.01         ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(i)(i)(B)(2) if the cost report straddles July 1, 2011 them see instructions.         0.00         7.01           8.00         Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002).         0.00         8.01           8.01         The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.         0.00         8.01           9.00         Smooth FTE Count for ease if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)         1.5.87         8.02           9.00         Smooth FTE Count for all opathic and osteopathic programs in the current year from your records         28.28         10.00           11.00         FTE count for residents in dental and podiatric programs.         5.67         11.00           12.00         Current year all owable FTE count for the prior year.         28.46         12.00           13.00         Total all owable FTE count for the prior year.         28.02         18.00           16.00         Adjustment for residents in initial years of the program or hospital closure         0.00         17.00           16.00         Adjustment for residents in initial years of the prog		new programs in accordance with 42 CFR 413.79(e)				
Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.79(c)/2 (iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		ACA § 5503 reduction amount to the IME cap as specified under				ł
8.01   The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)   Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)   Dotton   FTE count for residents in dental and podiatric programs in the current year from your records   28,28 in 10,00     1.00   FTE count for residents in dental and podiatric programs.   28,13 in 12,00     1.00   Current year all lowable FTE (see instructions)   28,13 in 12,00     1.00   Current year all lowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero.   28,02 in 13,00     1.00   Total all lowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero.   28,02 in 13,00     1.00   Adjustment for residents in in lital years of the program   28,02 in 13,00     1.00   Adjustment for residents displaced by program or hospital closure   0,00 in 17,00     1.00   Adjustment for residents in in lital years of the program   0,00 in 17,00     1.00   One of the program of hospital closure   0,00 in 17,00     1.00   One of the program of hospital closure   0,00 in 17,00     1.00   One of the program of hospital closure   0,00 in 17,00     2.00   One of the program of hospital closure   0,00 in 17,00     2.01   One of the program of hospital closure   0,00 in 17,00     2.02   One of the program of hospital closure   0,00 in 17,00     2.03   One of in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in 18,00 in	8. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	8. 00
1.00   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slo	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
Sum of   lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see   22.46   9.00	8. 02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospital	5. 87	8. 02
11. 00   TEC count for residents in dental and podiatric programs.   5. 67   11. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 0	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (	see	22. 46	9. 00
12.00   Current year allowable FTE (see instructions)   28.13   12.00   13.00   Total allowable FTE count for the prior year.   28.46   13.00   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.10   10.1			ent year from your recor	ds		ı
13.00   Total allowable FTE count for the prior year.   28.46   13.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, or total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, or total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, or total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, or total allowable FTE count for the program						
14.00						
therwise enter zero.  Sum of lines 12 through 14 divided by 3.  15.00 Sum of lines 12 through 14 divided by 3.  16.00 Adj ustment for residents in initial years of the program			or anded on or after Con	+amban 20 1007		l
15.00   Sum of lines 12 through 14 divided by 3.   28.02   15.00   Adjustment for residents in initial years of the program   0.00   16.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   28.02   18.00   28.02   18.00   28.02   19.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   2	14.00		ar ended on or arter sep	telliber 30, 1997,	27.40	14.00
16.00   Adj ustment for residents in initial years of the program   0.00   16.00   17.00   Adj ustment for residents displaced by program or hospital closure   0.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00	15. 00				28. 02	15. 00
17. 00						1
19.00       Current year resident to bed ratio (line 18 divided by line 4).       0. 117568       19. 00         20.00       Prior year resident to bed ratio (see instructions)       0. 118811       20. 00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0. 117568       21. 00         22.01       IME payment adjustment (see instructions)       2, 270, 334       22. 00         22.01       IME payment adjustment - Managed Care (see instructions)       1, 780, 093       22. 01         Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.00       23. 00         (f)(1)(iv)(C).       0.00       23. 00         (f)(1)(iv)(C).       0.00       23. 00         IME FTE Resident Count Over Cap (see instructions)       5. 82       24. 00         25.00       IME free amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0. 00       25. 00         26.00       Resident to bed ratio (divide line 25 by line 4)       0. 000000       25. 00         27.00       IME payments adjustment factor. (see instructions)       0. 000000       27. 00         28.01       IME add-on adjustment amount (see instructions)       0. 28. 01         29.00       Total IME payment (sum of lines 22 and 28)       2, 270, 354       29. 00 <td< td=""><td>17. 00</td><td>Adjustment for residents displaced by program or hospital clos</td><td>sure</td><td></td><td>0.00</td><td>17. 00</td></td<>	17. 00	Adjustment for residents displaced by program or hospital clos	sure		0.00	17. 00
20.00   Prior year resident to bed ratio (see instructions)   0.118811   20.00   21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.117568   21.00   22.00   IME payment adjustment (see instructions)   2,270,354   22.00   IME payment adjustment - Managed Care (see instructions)   1,780,093   22.01   IME payment adjustment - Managed Care (see instructions)   1,780,093   22.01   IME payment adjustment for the Add-on for § 422 of the MMA   23.00   Mumber of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00   (f)(1)(i)(c))   (f)(1)(i)(c)(c)   (f)(1)(i)(c)(c)   (f)(1)(i)(c)(c)   (f)(1)(i)(c)(c)   (f)(1)(i)(c)(c)   (f)(1)(i)(c)(c)   (f)(1)(i)(c)(c)(c)   (f)(1)(i)(c)(c)(c)   (f)(1)(i)(c)(c)(c)(c)(c)(c)(c)(c)(c)(c)(c)(c)(c)		Adjusted rolling average FTE count				
21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.117568   21.00   22.00   IME payment adjustment (see instructions)   2,270,354   22.00   IME payment adjustment - Managed Care (see instructions)   1,780,093   22.01   Imdirect Medical Education Adjustment for the Add-on for § 422 of the MMA   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00   (f)(1)(iv)(c).     (f)(1)(iv)(c).     (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f)(1)(iv)(c).   (f			).			ł
22.00 IME payment adjustment (see instructions) 2.270, 354 22.00 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see occurrence) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (see instructions) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 20.02 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 32.01 Iou and Iouable disproportionate share percentage (see instructions) 32.02 Total Iouable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions)		` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `				
22. 01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f) (1) (iv) (C).  24. 00 IME FTE Resident Count Over Cap (see instructions)  25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions)  26. 00 Resident to bed ratio (divide line 25 by line 4)  27. 00 IME payments adjustment factor. (see instructions)  28. 00 IME add-on adjustment amount (see instructions)  29. 01 IME add-on adjustment amount (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  20. 00 Allowable disproportionate share percentage (see instructions)  20. 01 Allowable disproportionate share percentage (see instructions)  20. 01 Oncoordinate of the MMA  22. 01 IME Add-on adjustment amount (see instructions)  22. 03 Oncoordinate of the MMA  23. 00 IME add-on adjustment amount (see instructions)  24. 00 IME add-on adjustment amount (see instructions)  25. 00 IME add-on adjustment amount (see instructions)  26. 00 IME add-on adjustment amount (see instructions)  27. 00 IME payment (sum of lines 22 and 28)  28. 01 IME payment (sum of lines 22 and 28)  29. 01 IME payment (sum of lines 22 and 28)  20. 02 IME add-on adjustment amount (see instructions)  20. 03 IME add-on adjustment amount (see instructions)  21. 65 31. 00  22. 04 IME Payment (sum of lines 22 and 28)  23. 00 IME add-on adjustment amount (see instructions)  24. 00 IME add-on adjustment amount (see instructions)  25. 24 32. 00  28. 01 IME payment (sum of lines 22 and 28)  29. 01 IME payment (sum of lines 22 and 28)  20. 02 IME add-on adjustment amount (see instructions)  20. 03. 00 IME add-on adjustment amount (see in						
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions) 5.82 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 Total IME payment (sum of lines 22 and 28) 2, 270, 354 29.00 Total IME payment (sum of lines 22 and 28) 2, 270, 354 29.00 Insproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3.59 30.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 10.04 33.00						
23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00	22.01		of the MMA		1, 700, 073	22.01
24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 01 IME payments adjustment amount (see instructions) 29. 01 IME add-on adjustment amount (see instructions) 29. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29. 01 Disproportionate Share Adjustment 20. 00 Sum of lines 30 and 31 31. 00 Percentage of Medicaid patient days (see instructions) 31. 00 Sum of lines 30 and 31 32. 00 Allowable disproportionate share percentage (see instructions) 31. 00 IME add-on adjustment amount - Managed Care (sum of lines 22.01 and 28.01) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 31. 00 IME add-on adjustment amount - Managed Care (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 33. 00 IME add-on adjustment amount (see instructions) 35. 82 24. 00 36. 00 Care instructions (see instructions) 37. 00 Sum of lines 24 (see instructions) 38. 00 Sum of lines 30 and 31 39. 00 Allowable disproportionate share percentage (see instructions)	23. 00	Number of additional allopathic and osteopathic IME FTE resid		FR 412. 105	0.00	23. 00
25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0. 00 25. 00 instructions)  26. 00 Resident to bed ratio (divide line 25 by line 4)  27. 00 IME payments adjustment factor. (see instructions)  28. 00 IME add-on adjustment amount (see instructions)  28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  10. 00 000000  26. 00  27. 00  28. 01  27. 00  28. 01  29. 01  29. 01  20. 20. 01  20. 02. 01  20. 02. 01  20. 02. 01  20. 02. 02  20. 02. 02  20. 02. 02  20. 02. 03  20. 03. 00  21. 05  22. 04  23. 00  25. 04	24.00				5. 82	24. 00
27. 00 IME payments adjustment factor. (see instructions)  28. 00 IME add-on adjustment amount (see instructions)  28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  29. 01 Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  17. 00 0.000000 27. 00  28. 01  29. 01  1, 780, 093  29. 01  30. 00  21. 65  31. 00  32. 00  33. 00 Allowable disproportionate share percentage (see instructions)  10. 04 33. 00	25. 00	If the amount on line 24 is greater than -O-, then enter the	ower of line 23 or line	24 (see	0. 00	25. 00
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  10.04 28.00  28.00  29.01  1,780,093  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.	26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26. 00
28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  10. 04 28. 01  29. 00  29. 01  1, 780, 093  29. 01  30. 00  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  29.	27.00				0.000000	27. 00
29. 00 Total IME payment (sum of lines 22 and 28) 29. 00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 1,780,093 29. 01  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3. 59 30. 00 31. 00 Sum of lines 30 and 31 25. 24 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 10. 04 33. 00		, , , , , , , , , , , , , , , , , , ,				1
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  1, 780, 093  30. 00  3. 59  30. 00  21. 65  31. 00  25. 24  32. 00  33. 00 Allowable disproportionate share percentage (see instructions)  10. 04  33. 00			)			•
Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  10.04 33.00						1
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Percentage of SSI recipient patient days (see instructions) 33.00 21.65 31.00 25.24 32.00 33.00	29. 01		1)		1, 780, 093	j 29. 01
31.00 Percentage of Medicaid patient days (see instructions) 21.65 31.00 32.00 Sum of lines 30 and 31 25.24 32.00 33.00 Allowable disproportionate share percentage (see instructions) 10.04 33.00	30 00		ationt days (soo instruc	tions)	2 EO	30 00
32.00 Sum of lines 30 and 31 25.24 32.00 33.00 Allowable disproportionate share percentage (see instructions) 10.04 33.00			atrent days (See Thistruc	LI UIIS)		1
33.00 Allowable disproportionate share percentage (see instructions) 10.04 33.00		, , , , , , , , , , , , , , , , , , , ,				1
			)		10.04	33. 00
	34. 00					

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0012	Period: From 07/01/2020 To 06/30/2021		pare
		Ti II MALL		11/30/2021 12	
		Title XVIII	Hospi tal	PPS On/After 10/1	
			1. 00	2.00	
	Uncompensated Care Adjustment				
. 00	Total uncompensated care amount (see instructions)		0 00000000	1	
. 01	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, ent	or zoro on this line) (s	0. 000000000 ee 4, 124, 698		1
02	instructions)	er zero on tilis i ille) (s	4, 124, 070	2, 440, 044	33
03	Pro rata share of the hospital uncompensated care payment am	ount (see instructions)	1, 036, 809	1, 831, 451	35
00	Total uncompensated care (sum of columns 1 and 2 on line 35.		2, 868, 260		36
00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges, excluding MS-DRGs 652, 682, 683,		ugn 46)		40
00	instructions)	004 and 005. (See			40
			Before 1/1	On/After 1/1	
	T + 1 5000 H II	(00 (04 (05 (	1.00	1. 01	4.4
00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0	0	41
01	Total ESRD Medicare covered and paid discharges excluding MS	-DRGs 652, 682, 683, 68	4 0	0	41
	an 685. (see instructions)				
00	Divide line 41 by line 40 (if less than 10%, you do not qual		0.00		42
00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6 instructions)	82, 683, 684 an 685. (Se	e		43
00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44
	days)				
00	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line 4	,	0.00	0.00	45
00	Subtotal (see instructions)	1.01)	44, 599, 443		47
00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only. (see instructions)				
				Amount 1.00	
00	Total payment for inpatient operating costs (see instructions	s)		46, 379, 536	49
00	Payment for inpatient program capital (from Wkst. L, Pt. I a		)	3, 528, 019	50
00	Exception payment for inpatient program capital (Wkst. L, Pt			0	
00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment	The 49 see Instructions)		1, 489, 954 35, 935	
00	Special add-on payments for new technologies			794, 877	
01	Islet isolation add-on payment			0	
00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55
00	Cost of physicians' services in a teaching hospital (see int	•		0	
00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	
00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	IV, COI. II ITHE 200)		138, 810 52, 367, 131	
00	Primary payer payments			0 32, 307, 131	
	Total amount payable for program beneficiaries (line 59 minus	s line 60)		52, 367, 131	
		,		3, 503, 180	
00	Coinsurance billed to program beneficiaries			36, 065	63
00 00	corrisorance birred to program beneficialities			416, 134	64
00 00 00	1			270 407	
00 00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			270, 487	
00 00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		46, 882	66
00 00 00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	•	:	46, 882 49, 098, 373	66 67
00 00 00 00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (		46, 882 49, 098, 373 0	66 67 68
00 00 00 00 00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)	applicable to MS-DRGs (		46, 882 49, 098, 373 0 0	66 67 68 69
00 00 00 00 00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	applicable to MS-DRGs ( .(For SCH see instruction	ns)	46, 882 49, 098, 373 0 0	66 67 68 69 70
00 00 00 00 00 00 00 00 00 50	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	applicable to MS-DRGs ( .(For SCH see instruction) adjustment (see	ns)	46, 882 49, 098, 373 0 0	66 67 68 69 70
00 00 00 00 00 00 00 00 00 50 87	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration	applicable to MS-DRGs ( .(For SCH see instruction) adjustment (see	ns)	46, 882 49, 098, 373 0 0 0	66 68 69 70 70
00 00 00 00 00 00 00 00 50 87 88	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	applicable to MS-DRGs ( .(For SCH see instruction tration) adjustment (see	ns)	46, 882 49, 098, 373 0 0 0 0	66 68 69 70 70 70
00 00 00 00 00 00 00 00 50 87 88 89	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	applicable to MS-DRGs ( .(For SCH see instruction tration) adjustment (see	ns)	46, 882 49, 098, 373 0 0 0 0	66 67 68 69 70 70 70 70
00 00 00 00 00 00 00 00 50 87 88 89 90 91	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	applicable to MS-DRGs ( .(For SCH see instruction tration) adjustment (see	ns)	46, 882 49, 098, 373 0 0 0 0 0	66 68 69 70 70 70 70 70
.00 .00 .00 .00 .00 .00 .00 .00 .00 .50 .87 .88 .89 .90 .91	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	applicable to MS-DRGs ( .(For SCH see instruction tration) adjustment (see	ns)	46, 882 49, 098, 373 0 0 0 0 0 0	67 68 69 70 70 70 70 70 70
.00 .00 .00 .00 .00 .00 .00 .00 .00 .50 .88 .89 .90	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	applicable to MS-DRGs ( .(For SCH see instruction tration) adjustment (see	ns)	46, 882 49, 098, 373 0 0 0 0 0 0	666 670 700 700 700 700 700 700 700 700

Health Financial Systems	ST. JOSEPHS REG MED C	ENTER S. BEI	ND	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CC	CN: 15-0012	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Pre 11/30/2021 12	
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	

				From 07/01/2020 To 06/30/2021	Part A Date/Time Prep 11/30/2021 12:	
		Titl∈	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0	0	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
70. 98	the corresponding federal year for the period ending on or af- Low Volume Payment-3	ter 10/1)			0	70. 98
70. 98	HAC adjustment amount (see instructions)				0	70. <del>9</del> 8 70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			48, 951, 688	
71. 01	Sequestration adjustment (see instructions)	, u , u,			0	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				47, 856, 412	72.00
72. 01	Interim payments-PARHM					72. 01
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, 71.02	2, 72, and			1, 095, 276	74. 00
7. 0.	73)					7. 0.
74. 01	Balance due provider/program-PARHM (see instructions)				4 700 400	74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordal CMS Pub. 15-2, chapter 1, §115.2	nce with			1, 703, 199	75. 00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)		1			
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2.03			0	90.00
	plus 2.04 (see instructions)				_	
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruc	tions)			0	93.00
94.00	The rate used to calculate the time value of money (see instr	uctions)			0.00	94.00
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	tions)		T=	0	96. 00
				Prior to 10/1		
	HSP Bonus Payment Amount			1. 00	2.00	
100 00	HSP bonus amount (see instructions)			O	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment			<u> </u>	0	100.00
101.00	HVBP adjustment factor (see instructions)			0.000000000	0.0000000000	101. 00
	HVBP adjustment amount for HSP bonus payment (see instructions	s)		0		102.00
	HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstr					
200.00	Is this the first year of the current 5-year demonstration per	riod under t	the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
201 00	Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	2 40)				201. 00
	Medicare discharges (see instructions)	= 49)				201.00
	Case-mix adjustment factor (see instructions)					202. 00
200.00	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the curren	t 5-vear demonst		203.00
	period)	or you.	0. 1 04	t o you. domonot		
204.00	Medicare target amount					204. 00
205.00	Case-mix adjusted target amount (line 203 times line 204)					205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement					
	Program reimbursement under the §410A Demonstration (see inst					207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	line 59)				208. 00
	Adjustment to Medicare IPPS payments (see instructions)					209. 00
	Reserved for future use					210.00
∠11.UC	Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement					211. 00
212 00	Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212. 00
	Low-volume adjustment (see instructions)	- 117				212.00
	Net Medicare Part A IPPS adjustment (difference between PPS a	nd cost reim	nbursement)			213. 00
2.30			/			
	(line 212 minus line 213) (see instructions)					

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 ST. JOSEPHS REG MED CENTER S. BEND Provider CCN: 15-0012 Title XVIII Hospital

			Amounts (from		Period Prior	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier payments		0					1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	36, 523, 178	0	36, 523, 178		36, 523, 178	1. 01
1. 02	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	0	0	0		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	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	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	2, 020, 919	0	2, 020, 919		2, 020, 919	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	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	28, 636, 359	0	28, 636, 359	0	28, 636, 359	4. 00
	Indirect Medical Education Adju	ustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 117568	0. 117568	0. 117568	0. 117568		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	2, 270, 354	0	2, 270, 354	0	2, 270, 354	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	1, 780, 093	0	1, 780, 093	0	1, 780, 093	6. 01
	instructions) Indirect Medical Education Adju	etment for the	Add-on for Se	ction 122 of t	he MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000			0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	2, 270, 354	0	2, 270, 354	0	2, 270, 354	9. 00
9. 01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29. 01	1, 780, 093	0	1, 780, 093	0	1, 780, 093	9. 01
	8. 01)	L .						
10. 00	Disproportionate Share Adjustme Allowable disproportionate share percentage (see	33. 00	0. 1004	0. 1004	0. 1004	0. 1004		10. 00
11. 00	instructions) Disproportionate share	34. 00	916, 732	0	916, 732	0	916, 732	11. 00
	adjustment (see instructions) Uncompensated care payments	36. 00	2, 868, 260		·			
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00						
13. 00	(see instructions) Subtotal (see instructions)	47. 00	44, 599, 443	0				
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	14, 377, 443	0	72, 707, 772	0 0	74, 377, 443	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	46, 379, 536	0	44, 548, 085	1, 831, 451	46, 379, 536	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3, 528, 019	0	3, 528, 019	0	3, 528, 019	16. 00

Heal th	Financial Systems	ST.	JOSEPHS REG ME	D CENTER S. BE	ND	In Li∈	eu of Form CMS-	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CO	CN: 15-0012	Peri od:	Worksheet E	
						From 07/01/2020	Part A Exhibi	t 4
						To 06/30/2021	Date/Time Pre 11/30/2021 12	parea:
				Ti +l o	XVIII	Hospi tal	PPS	. 30 piii
		W/S F Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5, 00	
17. 00	Special add-on payments for	54.00	794, 877	0				17.00
17.00	new technologies	01.00	771,077	J	,,,,,		771,077	17.00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	0	0		0	0	1
17.02	manufacturers for replaced	00.00		J		٩	Ĭ	17.02
	devices for applicable MS-DRGs							
18. 00	Capital outlier reconciliation	93.00	0	0		0 0	0	18.00
	adjustment amount (see	70.00		Ĭ				1
	instructions)							
19.00	SUBTOTAL			0	48, 870, 98	1, 831, 451	50, 702, 432	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	2, 787, 625	0	2, 787, 62	25 0	2, 787, 625	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0		0 0	0	
	than outlier							
21.00	Capital DRG outlier payments	2. 00	442, 675	0	442, 67	75 0	442, 675	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. 0544	0.0544	0. 054	0. 0544		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	151, 647	0	151, 64	17 0	151, 647	23.00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0524	0. 0524	0. 052	0. 0524		24.00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11. 00	146, 072	0	146, 07	<sup>'</sup> 2 0	146, 072	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	3, 528, 019	0	3, 528, 0	9 0	3, 528, 019	26. 00
	payments (see instructions)		_					
			(Amounts to E,					
		line	Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 00000			27. 00
28. 00	Low volume adjustment	70. 96				0	0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
100.00	Pt. A, line)		V					100.00
100.00	Transfer low volume		Y					100. 00

adjustments to Wkst. E, Pt. A.

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 07/01/2020 Part A Exhibit 5 Date/Time Prepared: 11/30/2021 12:30 pm 06/30/2021 Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 36, 523, 178 36, 523, 178 36, 523, 178 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 1.02 0 0 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 0 O 1.03 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 2,020,919 2, 020, 919 2, 020, 919 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 2.03 0 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 3.00 Managed care simulated payments 28, 636, 359 28, 636, 359 28, 636, 359 4.00 3.00 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.117568 0. 117568 0.117568 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 2, 270, 354 2, 270, 354 2, 270, 354 6.00 0 1, 780, 093 IME payment adjustment for managed care (see 6.01 22.01 1, 780, 093 1, 780, 093 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 2, 270, 354 2, 270, 354 2, 270, 354 9.00 Total IME payment for managed care (sum of 1, 780, 093 1, 780, 093 9.01 29.01 1, 780, 093 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1004 0.1004 0.1004 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 916, 732 916, 732 916, 732 11.00 0 instructions) 11.01 1, 036, 809 Uncompensated care payments 36, 00 2,868,260 1, 831, 451 2, 868, 260 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 44, 599, 443 42, 767, 992 44, 599, 443 Subtotal (see instructions) 1, 831, 451 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 46, 379, 536 44, 548, 085 1, 831, 451 46, 379, 536 15.00 15.00 (see instructions) 16.00 50 00 3, 528, 019 3 528 019 3, 528, 019 16.00 Payment for inpatient program capital (from 0 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 794, 877 794, 877 794, 877 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 C 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 C 18.00 0 amount (see instructions) 19.00 SUBTOTAL 48, 870, 981 1, 831, 451 50, 702, 432 19. 00

Provider CCN: 15-0012

Peri od:

Heal th	Financial Systems ST.	JOSEPHS REG ME	D CENTER S. BEI	ND	In Lie	eu of Form CMS-:	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Peri od: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 12	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	2, 787, 625	2, 787, 62	25 0	2, 787, 625	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	442, 675	442, 67	75 0	442, 675	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	·	0 0	0	1
22. 00	Indirect medical education percentage (see	5. 00	0.0544	0. 054	0. 0544		22. 00
	instructions)						
23. 00	Indirect medical education adjustment (see instructions)	6. 00	151, 647	151, 64	17 0	151, 647	23. 00
24. 00	Allowable disproportionate share percentage	10. 00	0. 0524	0. 052	0. 0524		24. 00
	(see instructions)						
25. 00	Disproportionate share adjustment (see instructions)	11. 00	146, 072	146, 07	72 0	146, 072	25. 00
26. 00	Total prospective capital payments (see linstructions)	12.00	3, 528, 019	3, 528, 0°	0	3, 528, 019	26. 00
	[THSTFUCTIONS)	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		A, TITIE	A)				
		0	1, 00	2.00	3. 00	4. 00	
27. 00		U	1.00	2.00	3.00	4.00	27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0		0	0	
29. 00	Low volume adjustment on or after October 1	70. 97	0		٥	0	
30.00	HVBP payment adjustment (see instructions)	70. 93	-146, 685	-146, 68	-	-146, 685	
30. 00	HVBP payment adjustment for HSP bonus	70. 93	-140,000	- 140, 00	0	- 140, 003	1
30. 01	payment (see instructions)	70. 90				0	30.01
31. 00	HRR adjustment (see instructions)	70. 94	o		0 0	0	31.00
31. 01	HRR adjustment for HSP bonus payment (see	70, 91	0		0 0	0	31. 01
	instructions)						
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2. 00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to		N				100. 00
	Wkst. E, Pt. A.						

Health Financial Systems	ST. JOSEPHS REG MED CENTER S. BEN	ND	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CC		From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared:

			10 00/00/2021	11/30/2021 12	
		Title XVIII	Hospi tal	PPS	
				1 00	
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)			25, 750	1.00
2. 00	Medical and other services (see instructions)  Medical and other services reimbursed under OPPS (see instructions)	ons)		28, 218, 038	2.00
3. 00	OPPS payments	0113)		24, 051, 866	3. 00
4. 00	Outlier payment (see instructions)			113, 876	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5. 00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		135, 615	
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			25, 750	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			99, 895	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		99, 893	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)	e 07)		99, 895	14. 00
11.00	Customary charges			77, 070	11.00
15. 00	Aggregate amount actually collected from patients liable for pa	vment for services on a	charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for	•	•	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		Ü		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18. 00	Total customary charges (see instructions)			99, 895	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lir	ie 11) (see	74, 145	19. 00
	instructions)		40) (		
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	IT line ii exceeds iir	ie 18) (see	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			25, 750	21. 00
22. 00	Interns and residents (see instructions)			25, 750	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			24, 301, 357	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			10, 388	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line	24 (for CAH, see instru	ıcti ons)	3, 396, 796	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23] (see	20, 919, 923	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		763, 074	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29)			21, 682, 997 13, 075	30. 00 31. 00
32. 00	Primary payer payments Subtotal (line 30 minus line 31)			21, 669, 922	32.00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)		21,007,722	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			585, 496	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			380, 572	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		285, 223	36. 00
37.00	Subtotal (see instructions)			22, 050, 494	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			125	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruct	ions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			22, 050, 369	40.00
40. 01 40. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			0	40. 01 40. 02
40. 02	Sequestration adjustment-PARHM pass-throughs			U	40. 02
41. 00	Interim payments			21, 952, 689	41. 00
41. 01	Interim payments  Interim payments-PARHM			21, 702, 007	41. 01
42. 00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			97, 680	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, c	chapter 1,	0	44. 00
	§115. 2				
00.05	TO BE COMPLETED BY CONTRACTOR			=	00.55
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 0. 00	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)			0	94.00
00	1				

Health Financial Systems ST. JOSEI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED ST. JOSEPHS REG MED CENTER S. BEND In Lieu of Form CMS-2552-10 Provider CCN: 15-0012 Title XVIII Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount

		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		47, 856, 412		21, 952, 689	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.01	Program to Provider					0.01
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3. 04 3. 05			0			3. 04 3. 05
3.05	Provider to Program		U U		U	3. 05
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 50	ADJUSTINIENTS TO PROGRAM		0			3. 50
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		47, 856, 412		21, 952, 689	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR				1	
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 01	TENTATIVE TO PROVIDER		0			5. 01
5. 02			o		0	5. 02
3.03	Provider to Program		<u> </u>			5. 05
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			o		l ol	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		1, 095, 276		97, 680	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		48, 951, 688		22, 050, 369	7. 00
				Contractor	NPR Date	
			)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor	(	J	1.00	2.00	8. 00
0.00	Thame of contractor	I	ļ		1	0.00

Heal th	Financial Systems ST. JOSEPHS REG MED	CENTER S. BEND	In Lie	u of Form CMS-	-2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0012	Peri od: From 07/01/2020 To 06/30/2021		epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	1	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12		1	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		1	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l			1	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I	1	7. 00
	line 168			1	
8. 00	Calculation of the HIT incentive payment (see instructions)			1	8. 00
9.00	Sequestration adjustment amount (see instructions)			1	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)			1	30.00
31.00	Other Adjustment (specify)			i	31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32. 00

Heal th	Financial Systems ST. JOSEPHS REG ME	D CENTER S. BE	ND	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der Co	CN: 15-0012	Period: From 07/01/2020	Worksheet E-4	
MEDI CA	IL EDUCATION COSTS			To 06/30/2021	Date/Time Pre 11/30/2021 12	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
1. 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathi	c programs for	cost reporti	na nari ods	22. 87	1.00
1.00	ending on or before December 31, 1996.	. 0	•	0 .	22.07	1.00
2. 00 3. 00	Unweighted FTE resident cap add-on for new programs per 42 Amount of reduction to Direct GME cap under section 422 of		1) (see instr	uctions)	0. 00 2. 14	
3. 00	Direct GME cap reduction amount under ACA §5503 in accordar		§413.79 (m).	(see	0.00	
4.00	instructions for cost reporting periods straddling 7/1/2011 Adjustment (plus or minus) to the FTE cap for allopathic ar	nd osteopathic	programs due	to a Medicare	0.00	4. 00
4. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 ( ACA Section 5503 increase to the Direct GME FTE Cap (see in		cost reporti	ng periods	0.00	4. 01
4. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap sl periods straddling 7/1/2011)	ots (see inst	ructions for	cost reporting	7. 00	4. 02
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 4.02 plus applicable subscripts	plus or minus	line 4 plus l	ines 4.01 and	27. 73	5. 00
6. 00	records (see instructions)				33. 95	6. 00
7. 00	Enter the lesser of line 5 or line 6		Primary Care	Other	27. 73 Total	7. 00
			1. 00	2.00	3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and oste	eopathi c	27. 7	8 0.00	27. 78	8. 00
9. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, other multiply line 8 times the result of line 5 divided by the a		22. 6	9 0.00	22. 69	9. 00
	6.					
10. 00 10. 01	Weighted dental and podiatric resident FTE count for the cu Unweighted dental and podiatric resident FTE count for the			5. 67 5. 67		10.00
11. 00	Total weighted FTE count	current year	22. 6			11. 00
12. 00	Total weighted resident FTE count for the prior cost report instructions)	ing year (see	21. 9	2 6.83		12. 00
13. 00	Total weighted resident FTE count for the penultimate cost year (see instructions)		26. 6			13.00
14. 00 15. 00	Rolling average FTE count (sum of lines 11 through 13 divid Adjustment for residents in initial years of new programs	led by 3).	23. 7			14. 00 15. 00
15. 01	Unweighted adjustment for residents in initial years of new	, programs	0.0			15. 01
16. 00	Adjustment for residents displaced by program or hospital of		0.0			16. 00
16. 01	Unweighted adjustment for residents displaced by program or	hospi tal	0.0	0.00		16. 01
17. 00	closure Adjusted rolling average FTE count		23. 7	5 6.09		17. 00
18. 00	Per resident amount		136, 983. 4			18. 00
19. 00	Approved amount for resident costs		3, 253, 35	7 792, 409	4, 045, 766	19. 00
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME	FTE resident	cap slots rec	eived under 42	0.00	20. 00
21. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see inst	ructions)			6. 22	21. 00
22. 00	Allowable additional direct GME FTE Resident Count (see ins				0.00	
23. 00	Enter the locality adjustment national average per resident	amount (see i	nstructions)		0.00	23. 00
24. 00	Multiply line 22 time line 23				0	
25. 00	Total direct GME amount (sum of lines 19 and 24)	Inpatient Part	Managed Care	Managed Care	4, 045, 766 Total	25. 00
		A A	Prior to 1/1	On or after	Total	
		1.00	2.00	2. 01	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD	1.00			3.00	
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	16, 888	13, 65	2 0		26. 00
27. 00	Total Inpatient Days (see instructions)	53, 843				27. 00
28. 00	Ratio of inpatient days to total inpatient days	0. 313653			2 204 770	28. 00
29. 00 29. 01	Program direct GME amount Percent reduction for MA DGME	1, 268, 967	1, 025, 81 4. 0		2, 294, 779	29. 00 29. 01
30. 00	Reduction for direct GME payments for Medicare Advantage		41, 75		41, 751	
31. 00	Net Program direct GME amount				2, 253, 028	

Heal th	Financial Systems ST. JOSEPHS REG MED (	CENTER S. BEND	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0012	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 12	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	`		CAL	
32.00	Renal dialysis direct medical education costs (from Wkst. B, I	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
	and 94)				
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.		74 and 94)	2, 136, 946	
34.00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line 33)		0. 000000	1
	Medicare outpatient ESRD charges (see instructions)	0.4		0	
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	UNLY			
37. 00	Part A Reasonable Cost Reasonable cost (see instructions)			55, 387, 235	37. 00
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			00, 367, 230	38.00
	Cost of physicians' services in a teaching hospital (see inst	rustions)		0	
40. 00	Primary payer payments (see instructions)	ructions)		0	
	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)		55, 387, 235	
41.00	Part B Reasonable Cost	3 11110 40)		33, 301, 233	41.00
42 00	Reasonable cost (see instructions)			28, 379, 403	42 00
43. 00	Primary payer payments (see instructions)			13, 075	1
44. 00	Total Part B reasonable cost (line 42 minus line 43)			28, 366, 328	
45. 00	Total reasonable cost (sum of lines 41 and 44)			83, 753, 563	1
46.00	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line 45)		0. 661312	46. 00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line	e 44 ÷ line 45)		0. 338688	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	RT B			
48.00	Total program GME payment (line 31)			2, 253, 028	48. 00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		1, 489, 954	49. 00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		763, 074	50. 00

Health Financial Systems ST. JOSEPHS REG BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-0012

Control Fund   Specific   Profession   Pro	oni y)			'	10 00/00/2021	11/30/2021 12	: 30 pm
CUBERINE ASSETS			General Fund		Endowment Fund		
Cash on hand in banks			1.00		3. 00	4.00	
Temporary investments					-1 -1		
Notes receivable				1			1
Accounts receivable		' 3	13,027,611	•			
Other receivable   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.			58 206 310	1	1 1		
A   lowances for uncell ectible notes and accounts receivable   -8, 671, 501   0   0   0   0   0   0   0   0   0				1	ol ol		
8.00   Preparid expenses   0.73, 785   0   0   0   0   0   0   0   0   0	6.00	Allowances for uncollectible notes and accounts receivable		1	o	0	6. 00
Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   Online   O				1	0		
10.00   Due from other funds			673, 785	(	0		
11.00   Display			0				
TIXED ASSETS			0 250 045 211		1		
12.00   Land improvements	11.00		330, 603, 211		<u> </u>	0	11.00
14.00   Accumulated depreciation	12. 00		289, 730	(	0	0	12. 00
15.00   Buildings	13.00	Land improvements	0	(	o	0	13. 00
16.00   Accumul ated depreciation   -168, 526   0   0   0   0   0   0   0   0   0			0	(	0		1
17.00   Leasehol d Improvements   309, 182, 821   0   0   0   0   0   0   0   0   0			0	1	1		
18.00   Accumulated depreciation   0   0   0   0   0   0   0   0   0				1	1		1
19,00   Fixed equipment		•	309, 182, 821				
20.00   Accumul ated depreciation   0   0   0   0   0   0   0   0   0		·					1
21.00   Automobil es and trucks			0				
23.00		!	0		o o		
24.00 Accumulated depreciation	22. 00	Accumulated depreciation	0	(	o	0	22. 00
25.00   Minor equipment depreciable   0   0   0   0   0   0   0   0   0		, ,		1	0		1
26.00 Accumul ated depreciation			-190, 556, 703	(	0		
27.00   HIT designated Assets   0   0   0   0   0   0   0   0   0			0				
Accumulated depreciation		·	0				
29.00   Minor equipment-nondepreciable   0   0   0   0   0   0   0   0   0		g and a second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s					
30.00   Total fixed assets (sum of lines 12-29)   236, 211, 971   0   0   0		·	Ö		ol ol		
31.00   Deposits on leases	30. 00	Total fixed assets (sum of lines 12-29)	236, 211, 971	(	0	0	30. 00
32 00   Deposits on Leases   0   0   0   0   0   0   0   0   0							
33.00   Due from owners/officers			0				
34.00		·	0	`	1 1		
35.00			39 741 796	`	1 1		1
Total assets (sum of lines 11, 30, and 35)   634,818,978   0   0   0				1	1 1		
37.00   Accounts payable				1	o o		1
38.00 Salaries, wages, and fees payable 9, 288, 235 0 0 0 39.00 Payroll taxes payable 0 0 0 0 0 39.00 Payroll taxes payable 0 0 0 0 0 0 40.00 Notes and loans payable (short term) 8, 983, 393 0 0 0 0 41.00 Deferred income 0 0 0 0 0 0 42.00 Accelerated payments 0 0 0 0 0 0 44.00 Other current liabilities 0 0 0 0 0 0 0 44.00 Other current liabilities 0 0 0 0 0 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 253, 331, 935 0 0 0 0 46.00 Mortgage payable 0 0 0 0 0 0 47.00 Notes payable 269, 170, 355 0 0 0 0 48.00 Unsecured loans 0 0 0 0 0 0 48.00 Unsecured loans 0 0 0 0 0 0 50.00 Total liabilities (sum of lines 46 thru 49) 282, 751, 708 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 536, 083, 643 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 536, 083, 643 0 0 0 50.00 Total liabilities (sum of lines 46 thru 49) 282, 751, 708 0 0 0 50.00 Total liabilities (sum of lines 46 thru 49) 282, 751, 708 0 0 0 50.00 Total liabilities (sum of lines 46 thru 49) 282, 751, 708 0 0 0 50.00 Total liabilities (sum of lines 46 thru 49) 282, 751, 708 0 0 0 50.00 Total liabilities (sum of lines 46 thru 49) 282, 751, 708 0 0 0 50.00 Total liabilities (sum of lines 46 thru 49) 282, 751, 708 0 0 0 50.00 Total liabilities (sum of lines 46 thru 49) 282, 751, 708 0 0 0 50.00 Total liabilities (sum of lines 46 thru 49) 282, 751, 708 0 0 0 50.00 Total liabilities (sum of lines 46 thru 49) 282, 751, 708 0 0 0 50.00 Total liabilities (sum of lines 46 thru 49) 282, 751, 708 0 0 0 50.00 Total liabilities (sum of lines 52 thru 58) 98, 735, 335 0 0 50.00 Total liabilities and fund balances (sum of lines 51 and 634, 818, 978 0 0 50.00 Total liabilities and fund balances (sum of lines 51 and 634, 818, 978 0		CURRENT LIABILITIES					
39.00   Payroll taxes payable   0   0   0   0   0   0   0   0   0							1
40.00 Notes and Loans payable (short term)			9, 288, 235	1	1		
41. 00 Deferred income 42. 00 Accelerated payments 0			0 002 202	1			
42.00       Accelerated payments       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0        0       0       0       0       0       0       0       0       0       0       0       0       0       0       0        0       0       0       0       0       0       0       0       0       0       0       0       0       0       0        0       0       0       0       0       0       0       0       0       0       0       0       0       0       0        0       0       0       0       0       0       0       0       0       0       0 <td< td=""><td></td><td></td><td>0, 703, 373</td><td></td><td></td><td></td><td></td></td<>			0, 703, 373				
43.00   Due to other funds   0   0   0   0   0   0   0   0   0			ĺ	`			42. 00
Total current liabilities (sum of lines 37 thru 44)   253, 331, 935   0   0   0   0			0	(	o	0	1
LONG TERM LIABILITIES	44. 00		648, 687	1	-		44. 00
46.00       Mortgage payable       0       0       0       0         47.00       Notes payable       269, 170, 355       0       0       0         48.00       Unsecured loans       0       0       0       0       0         49.00       Other long term liabilities       13, 581, 353       0       0       0       0         50.00       Total long term liabilities (sum of lines 46 thru 49)       282, 751, 708       0       0       0       0         51.00       Total liabilities (sum of lines 45 and 50)       536, 083, 643       0       0       0       0         62PITAL ACCOUNTS       CAPITAL ACCOUNTS       0       0       0       0       0       0       0         53.00       Specific purpose fund       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td< td=""><td>45. 00</td><td></td><td>253, 331, 935</td><td>(</td><td>0</td><td>0</td><td>45. 00</td></td<>	45. 00		253, 331, 935	(	0	0	45. 00
47. 00 Notes payable 269, 170, 355 0 0 0 0 48. 00 Unsecured Loans 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	47 00		1 0	.1		0	47.00
48.00 Unsecured Loans 0 0 0 0 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 13,581,353 0 0 0 0 51.00 Total Liabilities (sum of Lines 46 thru 49) 282,751,708 0 0 0 536,083,643 0 0 0  CAPLTAL ACCOUNTS  52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance 60 Donor created - endowment fund balance 61 Donor created - endowment fund balance 62 Donor created - endowment fund balance 63 Donor created - endowment fund balance 64 Donor created - endowment fund balance 65 Donor created - endowment fund balance 65 Donor created - endowment fund balance 65 Donor created - endowment fund balance 65 Donor created - endowment fund balance 65 Donor created - endowment fund balance 65 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60 Donor created - endowment fund balance 60			0 260 170 355	`	1 1		
49.00       Other long term liabilities       13,581,353       0       0       0         50.00       Total long term liabilities (sum of lines 46 thru 49)       282,751,708       0       0       0         51.00       Total liabilities (sum of lines 45 and 50)       536,083,643       0       0       0         52.00       General fund balance       98,735,335       0       0         53.00       Specific purpose fund       0       0         54.00       Donor created - endowment fund balance - restricted       0       0         55.00       Donor created - endowment fund balance - unrestricted       0       0         60.00       Governing body created - endowment fund balance       0         77.00       Plant fund balance - invested in plant       0         78.00       Plant fund balance - reserve for plant improvement, replacement, and expansion       0         79.00       Total fund balances (sum of lines 52 thru 58)       98,735,335       0       0         60.00       Total liabilities and fund balances (sum of lines 51 and       634,818,978       0       0			209, 170, 333	1			1
50.00         Total long term liabilities (sum of lines 46 thru 49)         282, 751, 708         0         0         0           51.00         Total liabilities (sum of lines 45 and 50)         536, 083, 643         0         0         0           52.00         General fund balance         98, 735, 335         0         0         0           53.00         Specific purpose fund         0         0         0         0           54.00         Donor created - endowment fund balance - restricted         0         0         0           55.00         Governing body created - endowment fund balance         0         0         0           57.00         Plant fund balance - invested in plant         0         0         0           58.00         Plant fund balance - reserve for plant improvement, replacement, and expansion         0         0         0           59.00         Total fund balances (sum of lines 52 thru 58)         98, 735, 335         0         0         0           60.00         Total liabilities and fund balances (sum of lines 51 and         634, 818, 978         0         0         0			13, 581, 353				
CAPITAL ACCOUNTS           52.00         General fund balance         98,735,335         0           53.00         Specific purpose fund         0         0           54.00         Donor created - endowment fund balance - restricted         0         0           55.00         Donor created - endowment fund balance - unrestricted         0         0           56.00         Governing body created - endowment fund balance         0           57.00         Plant fund balance - invested in plant         0           58.00         Plant fund balance - reserve for plant improvement, replacement, and expansion         0           59.00         Total fund balances (sum of lines 52 thru 58)         98,735,335         0         0         0           60.00         Total liabilities and fund balances (sum of lines 51 and         634,818,978         0         0         0				1	o		1
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 66.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 634,818,978  0  0  0  0  0  0  0  0  0  0  0  0  0	51. 00	, ,	536, 083, 643	(	0	0	51.00
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 66.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 634,818,978  0  0  0  0  0  0  0  0  0  0  0  0  0	52.00	General fund balance	98, 735, 335				52. 00
55.00 Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 634,818,978  0  0  0  0  0  0  0  0  0  0  0  0  0				(			53. 00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 634,818,978  0  0  0  0  0  0  0  0  0  0  0  0  0					0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 634,818,978 0 0 0					0		55.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 634,818,978 0 0 0					0	0	56. 00 57. 00
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 634,818,978 0 0 0		·					
59.00       Total fund balances (sum of lines 52 thru 58)       98,735,335       0       0       0         60.00       Total liabilities and fund balances (sum of lines 51 and 634,818,978       0       0       0	55. 00						55. 55
	59. 00	Total fund balances (sum of lines 52 thru 58)	98, 735, 335	(	ol ol		
[59]	60. 00		634, 818, 978	(	0	0	60. 00
		[59]	I	ĺ	1		I

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

18.00

19.00

0

0

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0012 Peri od: Worksheet G-1 From 07/01/2020 06/30/2021 Date/Time Prepared: 11/30/2021 12:30 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 66, 668, 244 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 31, 780, 863 2.00 3.00 Total (sum of line 1 and line 2) 98, 449, 107 0 3.00 4.00 Additions (credit adjustments) (specify) 0 0 4.00 5.00 Unrest NA Rel From Rest For Cap 276, 224 0 5.00 6.00 Unrest Contr Long Lived Assets 10,000 6.00 0 7.00 0 0 7.00 0 8.00 0 0 8.00 0 9.00 0 0 9.00 10.00 Total additions (sum of line 4-9) 286, 224 10.00 Subtotal (line 3 plus line 10) 11.00 98, 735, 331 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 13.00 0000 13.00 14.00 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 98, 735, 331 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 Additions (credit adjustments) (specify) 4.00 4.00 5.00 Unrest NA Rel From Rest For Cap 0 5.00 Unrest Contr Long Lived Assets 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00

0

18.00

19.00

Health Financial Systems ST. JOSTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0012

			o 06/30/2021	Date/lime Prep 11/30/2021 12	
	Cost Center Description	Inpati ent	Outpati ent	Total	00 p
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	121, 697, 080		121, 697, 080	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF	C		0	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	C		0	5. 00
6.00	Swing bed - NF	C		0	6. 00
7. 00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	121, 697, 080		121, 697, 080	10. 00
	Intensive Care Type Inpatient Hospital Services	1 00 700 704	T	00 700 701	
11. 00	INTENSIVE CARE UNIT	33, 782, 721		33, 782, 721	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGICAL INTENSIVE CARE UNIT	11 225 057		11 225 057	14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	11, 235, 857		11, 235, 857	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines 11-15)	45, 018, 578		45, 018, 578	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	166, 715, 658		166, 715, 658	17. 00
18. 00	Ancillary services	449, 865, 898			
19. 00	Outpatient services	19, 314, 732		75, 790, 217	
	RURAL HEALTH CLINIC	19, 314, 732		75, 790, 217	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		_	-	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26. 00
	PHARMACY	-399, 444	401, 608	2, 164	
27. 01	MATERNAL FETAL MEDICINE/LABORIST	110, 427		·	
27. 02	NEONATI OLOGI STS	1, 531, 121	2, 150	1, 533, 271	
27. 03	HOSPI TALI STS/I NTENSI VI STS	2, 286, 370		2, 347, 670	
27. 99	REVENUE ADJUSTMENTS	7, 222, 998			27. 99
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	646, 647, 760		1, 211, 379, 763	
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		359, 335, 487		29. 00
30.00	ADD (SPECIFY)	C			30.00
31.00		C			31.00
32.00		C			32.00
33.00		C			33.00
34.00		C			34.00
35. 00		C			35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECI FY)	C			37. 00
38. 00		C			38. 00
39. 00		C			39. 00
40. 00		C			40. 00
41. 00		C			41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	359, 335, 487		43. 00
	to Wkst. G-3, line 4)	I	I		

Usalah Firansial Customa		NEED 40
	of Form CMS-2 Worksheet G-3	.552-10
From 07/01/2020	WOT KSTICCT O 5	
	Date/Time Prep	
	11/30/2021 12	30 pm
<del>-</del>	1. 00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1, 211, 379, 763	1. 00
2.00 Less contractual allowances and discounts on patients' accounts	854, 869, 152	
3.00 Net patient revenues (line 1 minus line 2)	356, 510, 611	3. 00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	359, 335, 487	4. 00
5.00 Net income from service to patients (line 3 minus line 4)	-2, 824, 876	5. 00
OTHER I NCOME		
6.00 Contributions, donations, bequests, etc	0	6.00
7.00 Income from investments	0	7.00
8.00 Revenues from telephone and other miscellaneous communication services	0	8.00
9.00 Revenue from television and radio service	0	9. 00
10.00 Purchase discounts	0	10.00
11.00 Rebates and refunds of expenses	0	11.00
12.00 Parking Lot receipts	0	12.00
13.00 Revenue from Laundry and Linen service	0	13.00
14.00 Revenue from meals sold to employees and guests		14.00
15.00 Revenue from rental of living quarters	0	15. 00
16.00 Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17.00 Revenue from sale of drugs to other than patients	0	17. 00
18.00 Revenue from sale of medical records and abstracts	0	18. 00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20.00 Revenue from gifts, flowers, coffee shops, and canteen	10, 520	
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	11, 662, 774	
24. 50 COVI D-19 PHE Fundi ng	22, 932, 445	
25. 00 Total other income (sum of lines 6-24)		
26. 00 Total (line 5 plus line 25)		
27.00 Other expenses specify 28.00 Total other expenses (sum of line 27 and subscripts)	0	27. 00 28. 00
29.00 Net income (or loss) for the period (line 26 minus line 28)	31, 780, 863	
27. 00   met income (or 1033) for the period (fille 20 millios fille 20)	31, 700, 603	∠7. UU

CALCUI	Financial Systems ST. JOSEPHS REG   ATION OF CAPITAL PAYMENT	Provider CCN: 15-0012	Peri od:	Worksheet L	2552-10
			From 07/01/2020	Parts I-III	
			To 06/30/2021	Date/Time Prep 11/30/2021 12	pared:
		Title XVIII	Hospi tal	PPS	. 30 piii
		THE XVIII	1103pi tui	113	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
4 00	CAPI TAL FEDERAL AMOUNT			0.707.405	1 00
1. 00 1. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier			2, 787, 625 0	
2. 00	Capital DRG outlier payments			442, 675	
2. 00	Model 4 BPCI Capital DRG outlier payments			442, 073	2.00
3. 00	Total inpatient days divided by number of days in the cos	t reporting period (see inst	tructions)	149. 28	3. 00
4. 00	Number of interns & residents (see instructions)	t reporting period (see mis	tructrons)	28. 02	4. 00
5. 00	Indirect medical education percentage (see instructions)			5. 44	5. 00
6. 00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1.0	1, columns 1 and	151, 647	6. 00
	1.01) (see instructions)			·	
7.00	Percentage of SSI recipient patient days to Medicare Part	A patient days (Worksheet B	E, part A line	3. 59	7. 00
0.00	30) (see instructions)			04 (5	
8.00	Percentage of Medicaid patient days to total days (see in	structions)		21. 65	
9. 00 10. 00	Sum of lines 7 and 8	i ons)		25. 24 5. 24	
11. 00	Allowable disproportionate share percentage (see instruct Disproportionate share adjustment (see instructions)	10115)		146, 072	
12. 00	Total prospective capital payments (see instructions)			3, 528, 019	
12.00	prospective depited payments (see this true trois)			0,020,017	12.00
				1. 00	
1 00	PART II - PAYMENT UNDER REASONABLE COST				1 00
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instruction Total inpatient program capital cost (line 1 plus line 2)	5)		0	2. 00 3. 00
4. 00	Capital cost payment factor (see instructions)				4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)				
3.00	Total impatrent program capital cost (iiie 3 x iiiie 4)			0	3.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums	tances (see instructions)		0	2. 00
2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)	tances (see instructions)		0	2. 00 3. 00
2.00 3.00 4.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	tances (see instructions)		0 0 0.00	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0 0 0.00 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see	e instructions)	v line 6)	0 0 0.00 0 0.00	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi	e instructions)	κline 6)	0 0.00 0 0.00 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7)	e instructions) nary circumstances (line 2 x	κline 6)	0 0.00 0 0.00 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a	e instructions) nary circumstances (line 2 ) pplicable)	·	0 0.00 0 0.00 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7)	e instructions) nary circumstances (line 2 x pplicable) to capital payments (line 8	less line 9)	0 0.00 0 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level	e instructions) nary circumstances (line 2 x pplicable) to capital payments (line 8	less line 9)	0 0.00 0 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	e instructions) nary circumstances (line 2 pplicable) to capital payments (line 8 er capital payment (from pri	less line 9) or year ne 11)	0 0.00 0.00 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)	e instructions) nary circumstances (line 2 s pplicable) to capital payments (line 8 er capital payment (from pri l payments (line 10 plus line nter the amount on this line	less line 9) or year ne 11)	0 0.00 0.00 0.00 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

15.00 0 16.00 0 17.00

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)